

Ethnic health inequalities and the NHS

Driving progress in a changing system



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Ethnic health inequalities

This report has been edited and published by the NHS Race and Health Observatory. It was commissioned as an independent report from The King's Fund. The team at The King's Fund who worked on it are Ruth Robertson, Ethan Williams, David Buck and James Breckwoldt.

The NHS Race and Health Observatory was established by the NHS in 2021 to examine ethnic inequalities in health across England and beyond, and to support national bodies in implementing meaningful change for Black and minority ethnic communities, patients, and members of the health and care workforce.

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Foreword

In principle, race equality is sewn into the fabric of the NHS. From its inception, it has been framed as a universal service, available to all equally. More recently, we have seen the NHS go further, committing not just to deliver equality of access, but to actively pursue health equity by targeting groups and individuals whose health is not keeping pace with the rest of the population.

But this commitment is not yet being delivered upon and, in particular, we have seen Black and minority ethnic groups continue to lag behind their White counterparts in terms of living long and healthy lives. Despite continued efforts, and multiple restructures, the NHS has not managed to significantly close the gaps in health inequalities. As this report explores, some of that is down to the structure of the system itself. The NHS is a vast and complex web of organisations and individuals, each with slightly different constraints and under continuous pressure to improve and evolve.

It has proved too easy in the past for the system to lose focus on race equality, either because it is not prioritised by national leaders, or because it falls between the gaps left by all of these different organisations. This report, for the first time, examines each layer of the NHS system, considers its recent and coming changes, and explores how every aspect of this system might be better activated to achieve ethnic health equality. It makes broad but actionable recommendations taking in national policy, accountability measures and data capture. But importantly, it doesn't lose sight of the more human aspects of the NHS.

As policymakers, we are often required to think of the NHS as something mechanical. We use words like 'levers' and 'pipelines', as though the system is a machine that can be tweaked and tinkered with to make improvements. But this language risks ignoring the system's greatest strength – the human beings who make it resilient and responsive and, most important of all, compassionate. The report makes recommendations aimed at more representative leadership, better quality of life for Black and minority ethnic staff, and genuine engagement with the diverse communities that the NHS exists to serve. Only with this real human understanding and input can we hope to meaningfully move the dial on ethnic health inequality.

This report represents an important snapshot of an evolving system. The delivery of health and care in this country is always changing and it's important that while we explore the system we have, we must also look ahead to the system that will be. To the potential role of NHS-led provider collaboratives, the coming abolition of existing clinical commissioning groups, and the creation of whole new bodies such as the Office of Health Protection. We do not yet know exactly what these changes will mean, but this report provides an important foundation, indicating what the system needs to do now to close the gaps in ethnic health inequalities.

Ethnic health inequalities

The NHS Race and Health Observatory has only existed for a few short months but stands ready and able to help support this change, with a vital role to play in supporting many of the recommendations within this report. The Observatory will serve as a critical friend to the NHS, asking questions, but also providing answers, and supporting change.

This report represents one of many steps needed to help understand the factors that shape race inequality in health, including the forces of structural racism and discrimination, and to begin to respond to them with impactful changes. Knowing how the system works, and how it interacts with underserved communities, is an important step towards rebuilding that system in a way that truly has equality at its core. We invite those reading this report to join us on that journey.

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

Key messages

- People from Black and minority ethnic groups experience inequalities in health outcomes as well as inequalities in access to and experience of health services compared to White groups. However, the picture is complex, with variation between and within ethnic groups, and understanding is limited by a lack of good-quality data and analysis.
- Most Black and minority ethnic groups are disproportionately affected by socio-economic deprivation – a key determinant of health status. This is driven by a wider social context in which structural racism can reinforce inequalities among Black and minority ethnic groups – for example, in housing, employment and the criminal justice system – which in turn can have a negative impact on people's health.
- The COVID-19 pandemic has taken a disproportionate toll on groups already facing the worst health outcomes, including some Black and minority ethnic groups. This has encouraged the NHS to focus on its key role in improving population health and reducing inequalities. We welcome the prominence of actions to address inequalities, including ethnic health inequalities in the NHS's pandemic recovery plans.
- Although many of the causes of ethnic health inequalities are beyond its control, the NHS does have an important role to play in tackling them. It now needs to build on the work undertaken during the pandemic and urgently address some critical gaps in its capabilities to tackle ethnic health inequalities. These include:
 - accelerating action to diversify its senior leadership and improve the experience of staff from Black and minority ethnic groups. This is essential to create a workforce that reflects the community it serves and can therefore understand and respond to its needs. This is critically important as new integrated care systems (ICSs) are developed over the coming months and years
 - ensuring executive health inequality leads, a role established as part of the NHS's pandemic recovery plans, are fully enabled and supported to fulfil that critical function, including an understanding of local ethnic health inequalities, their root causes and the role that the NHS can play in addressing them
 - improving the quality of ethnicity data and using it to identify the specific health needs of Black and minority ethnic groups locally; and monitor access to and outcomes of care, to support action where needed
 - increased investment in community engagement work with Black and minority ethnic communities to develop and deliver culturally competent services - to build sustained and trusting relationships between services and communities.

Ethnic health inequalities

- The NHS must also invest in measures that identify and target communities at higher risk of poor health. Critically, this must include a significant increase in culturally competent primary prevention activity that targets risk factors such as obesity, diet, exercise and smoking, in national and local strategies that reflect the structural and environmental drivers of these risk factors, such as deprivation and discrimination.
- Actions to address ethnic health inequalities must sit within a broader approach to addressing the overlapping causes and dimensions of health inequalities – including intersectionality with other protected characteristics, socio-economic deprivation, and geography – and the role that structural racism and discrimination play in shaping and reinforcing ethnic health inequalities.
- Despite a strong legal and policy framework, individual commitment and pockets of success, the analysis presented in this report shows that the NHS has failed to make significant progress, both in reducing ethnic health inequalities and in tackling wider health inequalities. This is because, through its performance management and improvement approaches, an often-stretched health system has not given as much priority to reducing ethnic or wider health inequalities over the past decade as it has to other issues such as waiting times and financial targets.
- To address this, the NHS's structures need to reinforce the tackling of ethnic health inequalities as a priority without repeating previous errors of an overly centralised and top-down approach. Changes to structures and duties must support, rather than inhibit, the cultural and behavioural change that is critical to making a lasting difference. This means:
 - national government and NHS England and NHS Improvement establishing health inequalities as a national priority with ethnicity an explicit focus within that (the establishment of the NHS Race and Health Observatory is a significant step towards that) – being clear on the outcomes that matter, and holding local systems and leaders to account for those outcomes
 - NHS England and NHS Improvement giving local systems and places the freedom to determine which actions can best make progress locally but being clear that making progress is essential. This should be reflected throughout the performance and improvement approach
 - NHS planners and providers at national, regional and local levels mobilising existing evidence, tools and techniques to drive improvement. This ranges from information-sharing and peer challenge to harder tools (such as sanctions) used to address issues around waiting, safety and financial concerns
- The NHS has shifted its emphasis in recent years to systems and local 'places', and to the NHS working with local government and other partners. As new NHS structures continue to develop through the implementation of the Integration and Innovation White paper, there is an opportunity to elevate the priority given to inequalities by embedding it into the design of integrated care systems (ICSs) as they move to a statutory footing in 2022.
- We hope this report will be a call to action. The NHS must act urgently at every level from national government through to local neighborhoods to address ethnic health inequalities, and critically, the root causes of those inequalities – making this 'business as usual' rather than a sideshow.

Summary of recommendations

This report argues that the NHS has not made significant progress in reducing ethnic health inequalities in recent years because it has not acted on this issue as a clear priority. There has also been a lack of progress made in ensuring equality of experience and opportunity for the NHS workforce. We go on to argue that there is now an opportunity to address this by taking urgent action to address critical gaps in the NHS's capabilities to tackle ethnic health inequalities, and by building a broad health inequalities focus into new healthcare structures as a key priority, while supporting NHS staff to drive change.

Ethnic health inequalities are driven by multiple factors that overlap and interact. These factors include legally protected characteristics, including ethnicity and gender; the exclusion of certain groups, including people who are homeless; socio-economic factors, including levels of income and deprivation; and geography. Action on ethnic health inequalities must address these overlapping factors, taking into account their intersectionality as well as the structural factors, such as racism, that drive them. That is why in this report – when making recommendations on national policy, accountability and funding - we have in many cases recommended actions aimed at addressing health inequalities across all of the above dimensions. This approach is necessary to address the root causes of ethnic health inequalities and improve health outcomes for Black and minority ethnic groups. We also discuss the critical need for action focused specifically on Black and minority ethnic groups.

We anticipate a role for the NHS Race and Health Observatory in supporting the NHS to implement these recommendations, both in terms of funding supportive research, and in advising on appropriate implementation.

Our recommendations for the health system are as follows.

National policy and strategy

- NHS action to address ethnic health inequalities should be co-ordinated across every level of the system including national, regional, and what NHS England and NHS Improvement calls 'system', 'place' and 'neighbourhood' levels. This should be part of a broader approach to reducing health inequalities, with all local health and care partnerships, including ICSs, local place-based partnerships, health and wellbeing boards and primary care networks (PCNs), making this a central focus of their work. This must recognise and address the multiple factors that contribute to poorer health outcomes among people from Black and minority ethnic groups.

- As part of this, the NHS should invest in measures that identify and target communities at higher risk of poor health. Critically, this should include a significant increase in culturally competent primary prevention activity that targets risk factors such as obesity, diet, exercise and smoking, in national and local strategies that reflect the structural and environmental drivers of these risk factors, including discrimination as well as deprivation.
- This approach should sit within a broader cross-government strategy for reducing health inequalities that specifically addresses ethnic health inequalities as well as other groups who experience health inequalities. This must also look at the wider social context in which structural racism can reinforce inequalities among ethnic groups – for example, in housing, employment and the criminal justice system – which can in turn have a negative impact on people's health.

Accountability and improvement support

- The way in which the NHS is held to account for reducing health inequalities, including ethnic health inequalities, should be strengthened, and this must apply both to the experience and outcomes of patients. This is a critical area for improvement and addressing it should be a priority for the Department for Health and Social Care and for NHS England and NHS Improvement. This should include the following.
 - The Department for Health and Social Care should make health inequalities a core aspect of each element of the new 'triple aim' duty for the NHS that is proposed in the Innovation and Integration White Paper (Department of Health and Social Care 2021b), so inequality reduction is not seen as 'nice to have' but as a core purpose for the NHS.
 - NHS England and NHS Improvement should make reducing health inequalities a key priority for accountability, performance and improvement systems, giving it equal weight alongside other key priorities such as targets for waiting times and financial balance (while also ensuring that addressing inequalities is a key measure of success for these other priority areas). This approach should include a specific focus on ethnic health inequalities.
 - The Care Quality Commission (CQC) should ensure that progress in addressing health inequalities within the local population is given appropriate weighting and is at the core of any new processes it develops for inspecting ICSs from 2022.
- Alongside strengthened accountability, the NHS needs a stronger system for improvement that includes specific support to help people working at all levels in the NHS understand ethnic health inequalities, their causes, and the actions needed to address them. This system must be multifaceted, incorporating:
 - an approach to tracking the NHS' progress in tackling health inequalities. Metrics showing progress should include cuts by ethnicity.

- a new mandated process of peer review between ICSs to support learning and identify best practice and areas for improvement in addressing health inequalities, including ethnic health inequalities, co-ordinated by NHS England and NHS Improvement.
- support for leadership development and the mobilisation of evidence, outlined in the 'leadership' and 'data and evidence' sections below.

Funding

- National bodies involved in developing NHS financial allocations policy, including NHS England and NHS Improvement and the Advisory Committee on Resource Allocation, should continue to consider the impact of ethnicity on health as they develop the allocation formula to ICSs and develop guidance for ICSs who will set budgets at 'place' level.
- Where budgets for place-based partnerships are set within an ICS, this should be done in a transparent way, with a clear understanding of how allocation to place matches to identified health and health inequality need among local populations.

Leadership

- NHS England and NHS Improvement should ensure their processes for appointing senior leaders to new ICS roles during 2021/22 address the need to diversify the healthcare system's senior leadership and make it more representative of the diverse communities it serves.
- NHS England and NHS Improvement should continue to build on its work with local organisations and systems to provide a comprehensive, tailored package of development support for executive health inequality leads that is responsive to needs and local circumstances. This should include a focus on ethnic health inequalities, as well as on peer learning, evaluation and improvement.
- NHS England and NHS Improvement should support, co-ordinate and, where necessary, initiate leadership development programmes that increase the health systems' capacity to tackle health inequalities, including ethnic health inequalities. This should include broad programmes that develop NHS leaders' quality improvement capabilities, and programs that support increased awareness of diversity, inclusion and ethnic health inequalities.
- All NHS leaders and managers need to be held to account for their role in addressing inequalities in access, experience and outcomes, including ethnic inequalities via ongoing performance management conversations and through annual appraisals. This should also extend to considerations of ethnic inequality as experienced by the NHS workforce.

Workforce

- All NHS organisations should implement a board-level strategic commitment to achieving culture change in relation to the experience of Black and minority ethnic staff, focused on creating inclusive and compassionate cultures. Leadership practice, leadership development and team-working interventions should cultivate positively diverse and universally inclusive cultures at every level of the health system. All national healthcare bodies must lead from the front by prioritising this work within their own organisations.
- NHS England and NHS Improvement should consider how it can strengthen the way it holds providers and commissioners to account for actions taken in response to Workforce Race Equality Standard (WRES) data and the NHS Staff Survey, and build on commitments made in the most recent NHS People Plan (NHS England and NHS Improvement 2020d). As a minimum, this should be an obligatory line of enquiry in quarterly performance monitoring conversations with organisations and systems; a lack of progress should trigger appropriate support interventions and sanctions that are used to respond to other critical system issues.
- The CQC should review how it can ensure its regulatory methodology better assesses progress against the WRES, including by further strengthening how progress is taken into account in its inspections and in the use of the well-led framework.

Data and evidence

- NHS England and NHS Improvement should commission NHS Digital to issue guidance and standardised protocols to NHS providers and GPs for collecting and recording the ethnicity of service users, to ensure high quality ethnicity coding (and, although outside of the scope of this report, this should also be done in social care). Progress in improving the coverage and quality of ethnicity data recording should be a key component of NHS England and NHS Improvement's monitoring conversations with NHS providers and commissioners.
- ICSs should prioritise improving the quality of ethnicity coding, learning from local partners, and spreading best practice. They should also rebalance how they use their analytical and population health capacity to enable them to support systems to understand and act on health inequalities, including ethnic health inequalities.
- NHS England and NHS Improvement should consider how to develop a more systematic approach to building, sharing and mobilising the evidence base on interventions and good practice in tackling health inequalities. This should include a national rollout of existing tools. NHS England and NHS Improvement should work on this with the newly announced Office for Health Promotion and, at regional level, ICSs should also draw on relevant public health expertise.

Community engagement

- NHS commissioners, providers and national bodies should invest in strategic, ongoing programmes of engagement that build sustained, trusting relationships with Black and minority ethnic communities, as well as working in partnership with communities to develop, deliver, evaluate and improve services, prevention programmes and health promotion activities that are culturally competent and that reach Black and minority ethnic groups.
- National bodies should support the generation and sharing of learning from work with Black and minority ethnic communities that has taken place – for example, during the COVID-19 response, and in the wake of the Grenfell tower block fire tragedy of 2017.

1 Introduction

The longstanding inequalities experienced by people from Black and minority ethnic groups have been thrown into stark relief by the COVID-19 pandemic and its disproportionate impact on these communities.

Despite pockets of innovation and improvement in the NHS, progress in addressing inequalities in the health outcomes, access to and experiences of care of people from Black and minority ethnic groups has been patchy. As the health system emerges from the pandemic and starts to implement a more integrated approach to planning from 2022, as set out in the recent White Paper, there is a critical moment of opportunity to redouble efforts to address this enduring issue (Department of Health and Social Care 2021b).

About this report

The King's Fund was commissioned by the NHS Race and Health Observatory to examine the architecture within which the NHS operates and to consider the following questions:

- What policies are in place that enable the health care system to address ethnic health inequalities?
- Are these policies being implemented effectively, and if not, what can be done to improve implementation?
- What new measures would enable the health care system to make better progress and what is the role of emerging new health system structures in this?

To do this we conducted a rapid piece of policy analysis using literature searching and a small number of interviews (n=10) with key stakeholders from NHS organisations and relevant representative bodies. We also drew on knowledge and insights about the health and care system from colleagues at The King's Fund with expertise in ethnic health inequalities, workplace equality, health inequalities in the general population, and the development of new system structures such as ICSs and primary care networks (PCNs).

This report identifies areas where national and system leaders need to take urgent action to address longstanding inequalities not just in health outcomes but in access to and experience of care for Black and minority ethnic people, and the experiences of members of the NHS workforce.

In Section 2 we set out the context for the rest of the report, explaining what ethnic health inequalities are and what we know about their causes, and the key laws and policies that set the framework for NHS action on this agenda.

In Section 3 we look at the different organisations, networks and bodies in the health care system and consider the progress they have made in addressing these inequalities.

In Section 4 we look in more detail at the potential for two relatively new system structures - PCNs and ICSs - to play a key role in addressing ethnic inequalities in health.

Ethnic health inequalities

In Section 5 we consider the levers that must be used to provoke change and make recommendations for further actions needed to increase their impact.

Our final section concludes the report.

2 The issue

Ethnic health inequalities

In England, people from Black and minority ethnic groups face a range of inequalities compared to White groups in their health, as well as in their access to, experience of and outcomes from using health services (Raleigh and Holmes 2021).

However, the picture is complex, with variation between ethnic groups and across different conditions. For example, on some measures like cancer incidence, people from most Black and minority ethnic groups compare favourably with White groups (Raleigh and Holmes 2021). What is clear is that understanding of ethnic differences in health is limited by a lack of good-quality data. We outline the complexity of ethnic health inequalities in a separate briefing (Raleigh and Holmes 2021).

In the box (below), we outline how cardiovascular disease is a vivid illustration of ethnic health inequalities due to its disproportionate impact on people from Black and minority ethnic groups.

Cardiovascular disease: a key opportunity for integrated action on ethnic health inequalities

Cardiovascular disease (CVD) – a group of conditions affecting the circulatory system such as heart disease and stroke – is a leading cause of death, both nationally and among Black and minority ethnic groups (World Health Organization 2017). In 2019, CVD caused 24 per cent of all deaths in England and Wales (Office for National Statistics 2020). CVD has long been a major contributor to ethnic health inequalities in the UK, and there is strong reason to prioritise action to address CVD rates among Black and minority ethnic groups as part of wider efforts to reduce ethnic health inequalities (Raleigh and Holmes 2021).

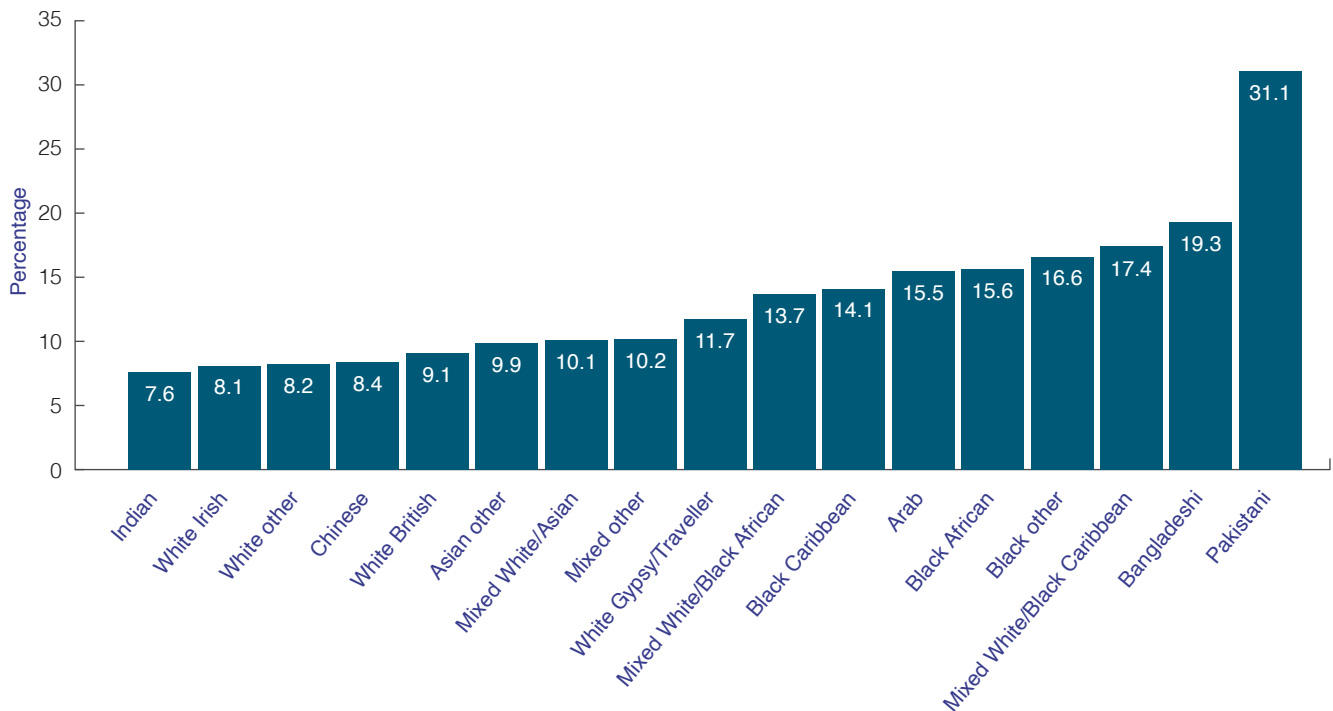
CVD rates are higher among Black and South Asian groups than White groups, causing significant morbidity among these groups. South Asian groups have a higher incidence of and mortality from heart disease and stroke than white groups and develop heart disease at a younger age (Volgman *et al* 2018; Misra *et al* 2017; Chaturvedi 2003; Yusuf *et al* 2001; McKeigue *et al* 1989). Black groups have a lower risk of heart disease compared to the general population, but a higher incidence of, and mortality from, hypertension and stroke, and have strokes at a younger age (Francis *et al* 2015; Lip *et al* 2007; NHS Digital 2006; Wild and McKeigue 1997). Both South Asian and Black groups also have significantly higher prevalence of diabetes (Goff 2019; Misra *et al* 2017) and lower rates of physical activity – major risk factors for CVD. Black groups also have significantly higher prevalence of the risk factor obesity (NHS Digital 2020). Furthermore, CVD mortality is almost double in the most deprived areas compared with the least deprived areas (Office for National Statistics 2017), and Black and minority ethnic groups are disproportionately affected by deprivation (Marmot *et al* 2020; Li *et al* 2018).

Narrowing ethnic health inequalities in CVD will require co-ordinated action across the health system. This should include primary prevention that targets underlying risk factors such as obesity, diet, exercise and smoking, through national and local strategies, with targeted public health outreach aimed at modifying behavioural risk factors, as well as equitable access and quality of treatment commensurate with need. All these initiatives must be tailored to local population needs and delivered through culturally competent services and interventions, working closely with communities and local networks to improve access and reach (Public Health England 2020).

Ethnic health inequalities

The causes of these inequalities are multiple and overlapping. For example, people from Black and minority ethnic groups are disproportionately affected by socio-economic deprivation – a key determinant of health status. As Figure 1 shows, the proportion of people from different ethnic groups who live in the most deprived areas of England is higher for nearly all groups than it is for White British people (Ministry of Housing, Communities and Local Government 2020).

Figure 1: Percentage of ethnic group populations living in the most deprived 10 per cent of neighbourhoods, England, 2019



Source: Raleigh and Holmes 2021

This situation is driven by a wider social context in which structural racism can reinforce inequalities among ethnic groups – for example, in housing, employment and the criminal justice system – which can in turn have a negative impact on people's health. Evidence shows that racism and discrimination can also have a negative impact on the physical and mental health of people from Black and minority ethnic groups (Nazroo 2003; Hui *et al* 2020; Williams *et al* 2019).

The COVID-19 pandemic has underlined the structural disadvantage experienced by people from Black and minority ethnic groups who have been at greater risk of contracting and dying from COVID-19 (Institute of Health Equity and Health Foundation 2020; Public Health England 2020). The economic and social consequences of the pandemic risk worsening these inequalities.

The factors that drive ethnic health inequalities operate across at least four dimensions:

- protected characteristics
- marginalised groups/excluded groups

Ethnic health inequalities

- socio-economic groups
- geography.

Action on ethnic health inequalities must address these overlapping factors, taking into account the intersectionality of factors such as gender, ethnicity, geography and socio-economic status, as well as the role of structural racism and discrimination in shaping ethnic health inequalities. That is why, in this report, we sometimes discuss initiatives aimed at addressing health inequalities across these broader dimensions, in addition to those focusing solely on ethnicity. This broad approach is necessary to address the causes of ethnic inequalities and improve outcomes for these groups.

Incorporating an explicit focus on ethnicity is important within health inequalities work because ethnic identities have implications for health independent of other factors – and without addressing the specific processes that produce poor health outcomes for Black and minority ethnic groups, opportunities will be missed. We therefore also highlight where we think specific action is needed that focuses solely on ethnicity.

The need for action is clear. Although there is no simple analysis that can tell us how 'ethnic health inequalities' have changed over time – the answer to this question will be different depending on which ethnic group and which indicator of health is considered in the analysis – we do know that health inequalities in the general population have widened in the past decade, particularly in relation to deprivation which is a major contributor to ethnic health inequalities. For example – males and females living in the most affluent areas of England saw a significant increase in life expectancy between 2014–16 and 2017–19; while in the most deprived areas there was no significant change (Raleigh 2021). Moreover, in 2020 COVID-19 exacerbated inequalities further with its disproportionate impact on deprived areas and Black and minority ethnic groups (Raleigh and Holmes 2021).

Policy background

The NHS has a long history of policies and laws that aim to tackle health inequalities including ethnic health inequalities. The current legal framework for this work hinges on two key pieces of legislation.

- **The Health and Social Care Act 2012**, which placed a specific duty on a range of health bodies – including the Department of Health and Social Care, Public Health England, clinical commissioning groups (CCGs) and NHS England – to have 'due regard' to reducing health inequalities when exercising their functions. This was the first time that the NHS's role in tackling health inequalities had been enshrined in legislation.
- **The Equality Act 2010**, which established equality duties for all public sector bodies, including NHS organisations. It means that equality considerations for people with 'protected characteristics', including race and ethnicity, should be taken into account in all decisions.

These laws create a strong framework for tackling inequalities. However, in practice (as we discuss in the next section) there is little evidence of these having had a significant impact on the actions taken by the NHS to address ethnic health inequalities – and legal challenges based on the NHS's duty to tackle health inequalities are very rare.

The NHS's current strategy was set by the NHS Long Term Plan, which commits to a 'more concerted and systematic approach to reducing health inequalities', with a commitment that action on inequalities would be central to everything that the NHS does (NHS England and NHS Improvement 2019c). However, in reality, although more time will be needed to fully assess its impact on deep seated health inequalities, this policy is yet to have a significant impact on how the NHS works to address health inequalities on the ground (as we discuss in more detail in Section 3).

New system structures and tiers

The Long Term Plan initiated some major changes in how health and care systems are organised. These are part of a broader shift in policy towards collaboration rather than competition as the key lever for improving NHS services. The new structures include the establishment of ICSs (Charles 2020) and PCNs (Baird and Beech 2020). We describe what these structures are and discuss the potential for them to play a critical role in efforts to tackle ethnic health inequalities in Sections 3 and 4.

The integration and innovation White Paper, published in spring 2021, sets out plans for ICSs to be put on a statutory footing and to become the main commissioners of NHS care in 2022 (taking over these functions from CCGs) (McKenna 2021). Under these plans, there will be a shared duty put on all NHS bodies (including ICSs) to pursue the 'triple aims' of the NHS Long Term Plan, which are better health and wellbeing, better quality health care, and ensuring the financial sustainability of the NHS. There will also be a duty to collaborate across the NHS and local government.

These new structures come with a new emphasis on local decision-making –creating the space for locally informed priorities and moving away from a centrally directed system to one that is much more connected to places and communities. They also put more emphasis on the NHS working with local government and other partners. These new structures have been accompanied by a new language used by NHS England and NHS Improvement to describe three geographical tiers at which services are planned and delivered. In this report we sometimes use this language when talking about relevant pieces of NHS policy and practice (see box).

NHS England and NHS Improvement definition of systems, places and neighbourhoods

Neighbourhoods (populations circa 30,000 to 50,000 people*): served by groups of GP practices working with NHS community services, social care and other providers to deliver more co-ordinated and proactive services, including through primary care networks (PCNs).

Places (populations circa 250,000 to 500,000 people*): served by a set of health and care providers in a town or district, connecting PCNs to broader services, including those provided by local councils, community hospitals or voluntary organisations.

Systems (populations circa 1 million to 3 million people*): in which the whole area's health and care partners in different sectors come together to set strategic direction and to develop economies of scale.

** Numbers vary from area to area, and may be larger or smaller than those presented here.*

Source: NHS England and NHS Improvement 2019a

The COVID-19 pandemic response and ethnic health inequalities

The NHS's response to the COVID-19 pandemic and NHS England and NHS Improvement's eight actions on health inequalities announced in August 2020 have created a new impetus for tackling health inequalities and opportunity for change (NHS England and NHS Improvement 2020a). Recent NHS guidance has distilled five key areas on health inequalities for the NHS to focus on this year (NHS England and NHS Improvement 2021a):

- restoring NHS services inclusively, including the use of data on deprivation and ethnicity to address the waiting list backlog
- mitigating against digital exclusion
- ensuring that datasets are complete and timely, including improving the recording of ethnicity data
- accelerating preventive programmes that proactively engage those at greatest risk of poor health outcomes
- strengthening leadership and accountability, ensuring that systems and providers have a named executive board-level lead for tackling health inequalities.

This approach, which starts to integrate health inequality concerns into the core business of the NHS, could be a powerful new enabler of change.

The creation of the NHS Race and Health Observatory in May 2020 provides further support to the healthcare system with its work to reduce ethnic inequalities in health, through the development of evidence-based recommendations for the system, supporting implementation and sharing best practice.

3 The role of key organisations and partnerships

Ethnic health inequalities

In this section we examine the roles of different parts of the health care system in addressing ethnic health inequalities. Understanding how different NHS structures are supposed to work to address these inequalities, and the progress they have made, is an important first step in developing recommendations for what needs to change. Our focus is on the key organisations and partnerships that oversee, co-ordinate, support, plan and provide NHS services. There is little published evidence on their progress with this agenda, so our analysis draws on interviews with a small number of leading experts and insights from colleagues at The King's Fund, as well as desk-based research.

We found that different parts of the health system have distinct and overlapping roles, as follows.

- **Clinical commissioning groups (CCGs):** As the main commissioners of NHS care, CCGs are required by law to 'have regard' to inequalities in their work (see Section 1). They shape local services and therefore have a key role in ensuring that access to those services and the way they are delivered meet the needs of people from Black and minority ethnic groups. From April 2022, subject to legislation, CCGs will cease to exist and integrated care systems (see below) will take over their commissioning functions. Public Health England has set out key actions that commissioners can take to embed inequalities in their commissioning plans, including through engagement with communities and targeted service design (Public Health England 2019). However, a recent systematic review found that CCGs have not prioritised tackling health inequalities, and this is often seen as a public health duty rather than part of 'core' commissioning work (Regmi and Mudrarabikwa 2020). Their predecessors, primary care trusts (PCTs), paid 'limited and patchy attention to ethnic diversity and inequality' and commissioners often felt uncertain about engaging with ethnic inequality as it was seen as a contentious and complex issue (Salway *et al* 2016). We heard during interviews that CCGs have prioritised work to meet operational and financial targets in line with what they understand to be national expectations from NHS England and NHS Improvement.
- **NHS providers and provider collaboratives:** These organisations play a key role in designing and delivering culturally competent services that reflect the differing needs of different population groups, and engaging with Black and minority ethnic groups to shape and deliver services and improve access. Providers' work in recording and improving the quality of patient ethnicity data can facilitate

improved understanding of ethnic health inequalities and inform appropriate action, but despite improvements in recent years, more action is needed (as we discuss in Section 5). Providers are also important 'anchor institutions' in local economies that can address wider determinants of health, such as income and job security, through their employment and procurement practices. Although there is enthusiasm in the NHS for this role and discrete examples of it being enacted, it is yet to be integrated into organisational and system strategies (Reed *et al* 2019). Provider collaboratives are an important part of the latest NHS reforms that provide an opportunity for providers to work together at scale to reduce inequalities in access to care, among other objectives (Murray and McKenna 2020). Provider collaboratives have an opportunity to engage more closely with the communities they serve, amplifying the voice of the local population in pursuit of greater equality.

- **Primary care networks (PCNs):** PCNs bring GP practices together to work at scale and are a critical enabler of action on health inequalities at 'neighbourhood' level through the new community-facing roles that they have been charged with recruiting into primary care. These include (for example) GP pharmacists, who can support better management of long-term conditions (some of which disproportionately affect people from Black and minority ethnic groups – see box on cardiovascular disease in Section 2); and community link workers, who can connect and build stronger relationships with local communities, as well as the role they will play in implementing population health management initiatives (NHS England and NHS Improvement 2020c; Baird and Beech 2020). One of the seven service specifications they are funded to deliver in 2021/22 is 'tackling neighbourhood inequalities', but this has been delayed due to the pandemic and it is not yet clear what it will involve. As we outline in more detail in Section 4, realising their potential may be hampered by issues like difficulties recruiting in areas of high deprivation, and gaps in available data and the capacity to analyse it.
- **Health and wellbeing boards:** These are key partnership vehicles for collaborative action to address health inequalities at 'place' level (see box 'NHS England and NHS Improvement definitions of system, places and neighbourhoods' in Section 1), bringing together senior local authority, health, political and community leaders, giving them a unique reach into the community and an ability to develop strong cross-system relationships. The boards have very limited formal powers, but they do have a statutory responsibility to produce a Joint Strategic Needs Assessment, which sets out the health needs of their area, and a Joint Health and Wellbeing Strategy, which commissioners are expected to respond to in their plans. We do not know the extent to which health and wellbeing boards have focused on Black and minority ethnic groups. Analyses of their overall effectiveness have found considerable variation across England (National Audit Office 2018).
- **Integrated care systems (ICSs):** ICSs are key partnership vehicles for collaborative action to address health inequalities at 'system' level as they bring NHS commissioners and providers in an area together with many of the organisations that address the wider determinants of health, including local authorities and the voluntary and community services organisations. Tackling unequal outcomes and access is one of the four fundamental purposes of ICSs set out by NHS England and NHS Improvement (NHS England and NHS Improvement 2020b), and tackling health inequalities – with specific actions to support people

from Black and minority ethnic groups – has become an increasingly important focus for ICSs, especially since the COVID-19 pandemic (Charles *et al* 2021), although most are at a fairly early stage with this, and more work is needed to translate ambitions into action (Briggs *et al* 2020; Ham *et al* 2017). West Yorkshire and Harrogate provides an example of a system that has embedded this throughout its work. In Section 4, we set out more detail on the potential for ICSs to drive change and the work of West Yorkshire and Harrogate Health and Care Partnership.

- **Local authorities:** Local authorities work closely in partnership with the NHS in their work to tackle health inequalities. Their public health teams are required to provide a public health advice service to CCGs to support their commissioning work, including their work to tackle health inequalities. And while there is no systematic national data on how local authorities work with the NHS on inequalities, we heard during interviews that they are seen as key partners in this work, although the extent of their contribution and their partnership with the NHS varies. Local authorities also contribute to this agenda through their extensive work on the wider determinants of health, their partnerships with the voluntary and community sector and their partnerships with the NHS through ICSs and health and wellbeing boards.
- **NHS England and NHS Improvement:** This organisation sets the national strategy and direction for the NHS, shaping the level of priority given to tackling ethnic health inequalities and workforce inequality throughout the system. It is required by the Health and Social Care Act to have due regard to health inequalities in its work as a commissioner, and plays an important role holding commissioners and providers to account. Although the latest strategy for the NHS, the Long Term Plan, has an apparent focus on tackling health inequalities and includes specific measures to support particular groups, this has not been brought together into an overall strategy to tackle inequalities in key areas such as multi-morbidity, and the NHS has not been set any direct goals to make measurable progress on the indicators that the Department of Health and Social Care monitors. Critically, the Long Term Plan does not outline how the NHS would be held to account for this work – a gap that we discuss in Section 5. NHS England and NHS Improvement also provides tools and support such as RightCare, which works to address variation in health care access and outcomes, although this is voluntary and therefore only supports areas that choose to engage. We heard in interviews that national programmes and policies have often not adequately taken into account their potential impact on health inequalities. However, the recent publication by NHS England and NHS Improvement of eight urgent actions to tackle health inequalities has provided a welcome new momentum for this work (NHS England and Improvement 2020a).
- **The Department of Health and Social Care:** The Department sets the overarching strategy for the health and care system, including the NHS and currently sets its priorities annually through the mandate. Although it has made requests of different organisations to take actions to address inequalities, this has not been co-ordinated into a cohesive approach. There has been no comprehensive national cross-government strategy on health inequalities for more than a decade, when the Labour government's national health inequalities strategy ended (see '1997–2010 health inequalities strategy' in chapter 4). The Secretary of State has a legal duty to report on the Department's assessment of how efforts to reduce health inequalities are progressing. In practice, this has been restricted

to short statements in the Department's annual reports. The latest assessment, pre-COVID, shows that of the 13 indicators the Department monitors to assess progress on health inequalities, only one has significantly narrowed while six have significantly widened since baseline (Department of Health and Social Care 2021a).

- **The Care Quality Commission (CQC):** The CQC monitors, inspects, and rates health and care providers, and has the power to require improvements. The focus of their inspections sends a strong signal to providers about what the centre thinks they should be prioritising. CQC inspections consider whether services are delivered, made accessible, and co-ordinated to take account of the needs of different people in assessing how responsive a service is. Performance against the Workforce Race Equality Standard (WRES) (see Section 5, 'Workforce' for more information on the WRES) is also considered in its assessments of whether an NHS provider is well-led. However, it does not provide a summative assessment of performance in addressing health inequalities or ethnic health inequalities, and providers are also not assessed on every aspect of care at each visit.
- **Public Health England:** This organisation provides data, guidance and tools to support collaborative working by local authorities, the NHS, and others to address health inequalities. Its 'fingertips' data tool – which allows users to view a range of health and wellbeing indicators at different geographical levels with regional and national benchmarks - has been commended in an international evaluation (Public Health Institutes of the World 2017). Use of tools such as the 'place-based approaches to health inequalities' toolkits voluntary, and our understanding is that it could be more widespread, although there are examples of Public Health England tools supporting local systems to take action on inequalities. The government recently announced plans to disband Public Health England with functions relevant to health inequalities transferring to a newly established UK Health Security Agency and Office for Health Promotion (Department of Health and Social Care 2021c)

This analysis shows that all the NHS's key organisations and partnerships have an important role to play in addressing ethnic health inequalities. However, reducing health inequalities – including ethnic health inequalities - has been one among many ambitions for the NHS and has not been prioritised by commissioners or providers, despite pockets of progress and innovation. This is in part because oversight and regulatory bodies have focused on other issues such as operational performance and financial targets, tilting the health system's focus away from reducing health inequalities. It is also notable that some of the key support mechanisms and tools are voluntary and appear to be underused.

It is crucial that the different parts of the NHS work together in a coherent and co-ordinated way to address the factors driving ethnic health inequalities, given their complex, multifaceted nature. It is also crucial to recognise that the NHS cannot address ethnic health inequalities on its own and that collaboration with wider partners is key – including the voluntary and community sector, with its connections to and understanding of local communities and its important role in supporting communities to speak up and share their experiences, as well as with local governments, with their close connections to local communities and their influence on many of the wider determinants of health. The NHS can benefit from the expertise and insight that other sectors and organisations have regarding the causes of ethnic health inequalities, how they relate to wider health inequalities, and effective approaches in addressing them. As well as using these links to develop culturally competent services that

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respond to the needs of local communities, the NHS can also use its role as an employer and purchaser in the local market to support the economic wellbeing of their local communities (Fenney and Buck 2021).

The NHS does not need to reinvent the wheel for this work – there is much to learn from others who must be seen as key partners, rather than just organisations to periodically 'consult'. This means the networks and partnerships that facilitate this collaboration – ICSs, health and wellbeing boards and PCNs - are critical enablers of change. However, they are yet to exert a powerful influence on the NHS in relation to health inequalities, including ethnic health inequalities.

As these new structures develop - and in the case of ICSs, move onto a statutory footing in 2022 to become the main commissioners of NHS care, there is an opportunity to embed work to address inequalities and ethnic health inequalities into their design and shift the health systems focus towards this critical issue.

4 The potential of ICSs and PCNs

Integrated care systems

The NHS Long Term Plan and its ongoing implementation has led to the establishment of a range of new initiatives and structures that have the potential to motivate people in systems, places and neighbourhoods to step up their action on ethnic health inequalities. Here, we look in more detail at two of these relatively new structures: integrated care systems (ICSs) and primary care networks (PCNs).

In Section 1 we set out three tiers that NHS England and NHS Improvement uses to describe different geographical footprints over which services are planned and delivered (see 'NHS England and NHS Improvement definitions of systems, places and neighbourhoods'). Although much of the work needed to address ethnic health inequalities happens in local communities at neighbourhood level, or in local places, ICSs – which typically cover populations of more than a million – have a key role to play in driving change over a larger system area and providing leadership for this agenda.

ICSs are partnerships that bring together providers and commissioners of NHS services, local authorities, and other partners to plan services for their local area (Charles 2020). They have developed from sustainability and transformation partnerships (STPs) at different rates in different parts of the country, but as of April 2021 every area of England is covered by an ICS. From 2022, subject to legislation, it is planned that they will take on the functions of clinical commissioning groups (CCGs), becoming the main commissioners of NHS care (Department of Health and Social Care 2021b).

Tackling unequal outcomes and access is one of the four fundamental purposes of ICSs as set out by NHS England and NHS Improvement (NHS England and NHS Improvement 2020b), and the NHS Long Term Plan asked all local systems to set out 'specific measurable goals and mechanisms by which they will contribute to narrowing health inequalities over the next five and ten years' (NHS England and NHS Improvement 2019c). ICSs are particularly well placed to support work to reduce ethnic health inequalities in that they bring together NHS organisations with local authorities and the voluntary and community sector and are therefore able to facilitate collaboration between organisations that address many of the wider determinants of health.

Research has found that tackling health inequalities is an increasingly important focus for ICSs. An analysis of London ICS plans in 2016 and 2019 found that the most striking difference was an explicit focus on reducing health inequalities in the 2019 plans; some (but not all) also included specific targets for reducing inequalities (Charles *et al* 2021). The same piece of research found that health inequalities had become an even stronger priority following the COVID-19 pandemic, including a particular focus on people from Black and minority ethnic groups. However, although many ICSs have ambitions to improve prevention and address inequalities, their plans provide little detail on how this will actually be implemented (Briggs *et al* 2020; Ham *et al* 2017). The challenge now is to move from ambitions to delivery.

ICSs and their predecessors, sustainability and transformation partnerships (STPs), have been criticised for a lack of engagement with local authorities and with communities – two things we know are critical for understanding and acting on ethnic health inequalities. However, there does appear to have been a marked improvement in both in recent years (Charles *et al* 2021).

Although most ICSs are still at the planning stage with this work, there are examples of systems that have gone further. West Yorkshire and Harrogate ICS is a leader, having embedded health inequalities throughout its work and having also focused on supporting staff in their system who are from Black and minority ethnic groups. The box below describes their approach.

West Yorkshire and Harrogate Health and Care Partnership's approach to addressing ethnic health inequalities

West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) has a strong focus on reducing health inequalities and a specific focus on reducing inequalities for people from Black and minority ethnic groups (West Yorkshire and Harrogate Health and Care Partnership 2019).

It recognises that the work to tackle inequalities needs to be led at neighbourhood and place level, where there is a greater connection to local communities. It sees its role as adding 'capacity, capability and intelligence' by supporting the system to understand health inequalities, providing the tools to identify them, and supporting the actions needed to address them by sharing good practice and creating collective ambition to address these issues systematically.

The partnership's work includes the following activities:

- supporting staff from Black and minority ethnic groups and working to diversify their leadership through a Black, Asian and minority ethnic Staff Network and Fellowship programme
- providing funding for specific initiatives through a £450,000 Health Inequalities Grant Fund, which focused on tackling health inequalities during COVID-19 and funding a number of programmes to support people from Black and minority ethnic groups
- equipping staff with the skills needed to understand and address inequalities through its Health Inequalities Academy
- identifying inequalities experienced by people from Black and minority ethnic groups in the system through the WY&H HCP BAME Inequalities Review Report 2020 and implementing a plan of action to address them. The main areas of focus are: improving access to safe work for Black, Asian and minority ethnic colleagues; ensuring that the partnership's leadership is reflective of communities; population planning; and reducing inequalities in mental health outcomes by ethnicity.

Leaders at WY&H HCP told us that this work has been facilitated by:

- dedicated staff that lead work on health inequalities, including recruitment of a consultant in public health and programme director in population health. A key part of their role is providing an important link between the NHS and local authority public health
- strong support from senior leaders who prioritise work on health inequalities across the ICS
- the development of relationships and partnerships with communities and the voluntary and community sector (VCS) in the region, using the concept of an 'equal ICS partnership' and ensuring that there is VCS representation at the partnership board and in their networks
- a strong sense of accountability to the community. We heard during interviews that the partnership is motivated to 'do the right thing' for the population because they want to rather than because they have been told to
- the good reputation that the health inequalities team has within the system enabling them to 'infect' other areas of work with a focus on health inequalities.

The potential role of ICSs

The work under way in West Yorkshire and Harrogate shows the potential for ICSs to support the providers, commissioners and local networks in their area to address ethnic inequalities by bringing capacity and capability to their work. Working at scale, they can play a critical role in the following areas.

- Providing leadership for tackling ethnic health inequalities, advocating for and asserting this issue as a key priority in their local area. This includes prioritising work that addresses the underlying drivers of the main causes of morbidity in these groups – like population health management and tailored prevention initiatives. Critically, ICSs should ensure that this work is not on the margins of what their system does, but is embedded throughout.
- Building stronger relationships and supporting partnership working to join up plans and harness the broader assets in local communities. This includes identifying collective priorities and opportunities for collaboration and working with health and wellbeing boards to bring their knowledge and work into the NHS more systematically.
- Promoting workforce diversity – for example, by setting up networks and fellowship programmes to support staff from Black and minority ethnic groups and ensuring that they have ‘a seat at the table’ in ICS discussions. The NHS People Plan asks ICSs to make this a key priority in their local people plans (NHS England and NHS Improvement 2020d) and the latest planning guidance requires them to assess progress and develop improvement plans responding to the latest Workforce Race Equality Standard (WRES) findings.
- Providing data and tools to support local areas to identify and act on inequalities – including using population health management tools to identify high-risk groups to target preventive interventions. This will be critical to support the inclusive restoration of services as the NHS emerges from the COVID-19 pandemic. ICSs should also play an active role in enabling data collection – including improving the quality of data (that ethnicity information is collected in a consistent and granular way) and enabling data to be shared across organisations.
- Supporting staff across the system to increase their knowledge and understanding of ethnic inequalities and strategies to address them – for example, by running education sessions. Sharing evidence and best practice is also an important part of this.

While some ICSs are doing some of the things set out above, the key challenge is how to *get all* ICSs to prioritise this work. This hinges on some of the change levers we outlined in Section 5 of this report, including refocusing the system’s accountability mechanisms on inequalities and developing processes for peer learning between systems.

The Phase 3 actions on inequalities set out by NHS England and NHS Improvement to guide the NHS in its approach to Covid recovery create a renewed focus on the role of ICSs in reducing inequalities (NHS England and NHS Improvement 2020a). The priorities identified by NHS England and NHS Improvement for 2021/22 include critical action by systems to improve the quality of ethnicity data, to ensure that services are restored inclusively, to accelerate preventive programmes, and to strengthen leadership and accountability arrangements (NHS England and NHS Improvement 2021a). This includes a named board-level lead for health inequalities on every ICS. The new responsibilities being passed onto ICSs in 2022 also provide an important opportunity to develop their role.

Changes from 2022

Subject to parliament, from April 2022, planned legislation will establish ICSs as statutory bodies that will take on the functions of CCGs. Each ICS will be composed of an ICS NHS body responsible for NHS strategic planning and allocation decisions and an ICS health and care partnership, comprising key NHS, local authority and other partners from the local system, responsible for developing a plan to address the system's health, public health and social care needs. The ICS NHS body and local authorities will be required to 'have regard to' this plan when making decisions. These new structures provide an important opportunity to prioritise and elevate action to address ethnic health inequalities.

ICS health and care partnerships will drive joint working between NHS organisations and local government at the system level and, to further support collaboration, ICS boundaries will be aligned with upper-tier local authority boundaries unless agreed otherwise by exception (NHS England and NHS Improvement 2021a). This partnership will have an important role in advocating for reductions in ethnic health inequalities, outlining how this can be done and leading change at a system level. The response to the COVID-19 pandemic, including the vaccination programme and the test and trace system, have demonstrated the impact that these partnerships can have on inequalities, and it is important that the NHS works to deploy similar approaches elsewhere.

The relationship between the NHS England and NHS Improvement regional teams (which oversee and performance manage systems) and the ICS will be critical to enabling this work. They must agree a memorandum of understanding that sets out strategic priorities for the ICS, the delivery and governance arrangements that will be used to deliver those priorities, and the oversight mechanisms to be used for ongoing assurance (NHS England and NHS Improvement 2021a). Action to address health inequalities, including ethnic health inequalities, must not only be a key priority for the ICS, but should also be embedded in the delivery, governance and oversight arrangements it agrees with the NHS England and NHS Improvement regional team.

The new cohort of leadership roles created in ICSs provide an opportunity to make senior NHS leadership more reflective of the communities they serve (Dunhill 2021). As we discuss in Section 5, there are very few Black and minority ethnic NHS chief executives, which means (based on what we have heard) that the pool this recruitment is likely to draw on is limited. ICSs have been asked to appoint their Chief Executive Officer and Chair by the autumn of 2021, so must take urgent action to ensure that recruitment processes support the diversification of healthcare leadership that is necessary for the system to drive reductions in ethnic health inequalities.

Primary care networks

PCNs are groups of GP practices that work together at scale, covering populations of roughly 30,000 to 50,000 people. They are funded through an extension of the GP contract, which requires them to deliver a set of service specifications. One of the seven planned service specifications for 2021/22 is 'tackling neighbourhood inequalities'. This was due to come into place in April 2021 but has been delayed by the pandemic. It is not yet clear when this service specification will come into effect or precisely what it will involve. An urgent action set out in the Phase 3 letter required PCNs to nominate their clinical director or an alternative lead to champion health equality (NHS England and NHS Improvement 2020a).

PCNs are focused on service delivery rather than planning or funding. They are expected to take a proactive approach to managing population health and will enable a wider set of services and staff roles within primary care than might be feasible in individual practices. They can also play a key role in helping to integrate primary care with wider health and community services; community and mental health services will be expected to configure their services around PCN boundaries (Baird and Beech 2020).

PCNs have the potential to play a key role in addressing ethnic health inequalities, particularly through their ability to recruit to several new types of role, the connections they can build with their local communities, and their use of population health management.

New primary care roles

PCNs are able to recruit to a range of new roles, enabling them to expand the primary care workforce in their area and deliver care in different ways. Many of the new roles present a real opportunity to address ethnic inequalities. For example, GP pharmacists can support better management of long-term conditions (a range of which disproportionately affect Black and minority ethnic groups), and community link workers can connect and build stronger relationships between local communities, health services and the voluntary and community sector – bringing the potential to develop trust, improve access and help address some of the wider determinants of health (Raleigh and Holmes 2021; Public Health England 2020).

However, more deprived areas can face a range of potential recruitment challenges in primary care compared to less deprived areas. They have fewer GPs per head of need-adjusted population, and between 2008 and 2017, the number of GPs working in the most deprived fifth of areas fell by 511, in contrast to the wealthiest fifth, where 134 additional GPs were recruited (Fisher *et al* 2020; Fisher and Baird 2019). Given the ethnic patterning of deprivation (see Figure 1), it is important that mechanisms are put in place to address any such challenges that might apply to recruiting to these new roles. Otherwise, there is a risk that the new recruitment opportunities being offered to PCNs could serve to widen rather than reduce ethnic health inequalities.

Connection to local communities

While ICSs operate at a 'system' level and the integrated care partnerships (ICPs) that exist within some ICSs operate at the level of 'place', PCNs operate at the level of 'neighbourhood'. This can enable a better connection to, and a closer understanding of, local populations than ICSs or ICPs. As a result, PCNs are in a good position to work with local populations to build trust, tap into community assets, and understand and address the specific needs of the populations they serve. This opportunity can be further strengthened through the new community-focused roles mentioned earlier, like community link workers. To make the most of this opportunity, PCNs must prioritise and properly resource community engagement, including by involving people from local Black and minority ethnic communities in governance structures and decision-making, as well as building links with existing community groups, networks and voluntary and community sector organisations (see 'Community engagement' in next section).

PCNs will be expected to take a proactive approach to population health management and assessing the needs of their local population to identify people who would benefit from targeted support (Baird and Beech 2020). The scale on which PCNs operate enables them to understand local community needs on a nuanced level, which could help shape tailored approaches to the needs within particular local demographics. However, to realise this potential, they need both better-quality data and the analytical capacity to make good use of it (Baird and Reeve 2018). Improved linkage of records and data across PCNs and partner organisations, including local public health teams, could support smoother pathways at an individual patient level, and greater understanding of population needs. Support will be needed to help PCNs establish secure and effective information governance frameworks to enable this linkage (Stafford *et al* 2019). Because of limited analytical capacity at PCN level, they will need to be pragmatic, work with others and use existing work already under way – for example, through public health teams. Analytical capacity could be provided through support from teams at CCG, ICS or national level, local public health teams or external providers.

Key questions for how PCNs develop

It is currently unclear how the voice of individual PCNs will be heard by ICSs, which might have up to 90 PCNs within their patch. This may be particularly important in areas where there are concentrated pockets of high Black and minority ethnic populations at neighbourhood level within a low overall Black and minority ethnic population at ICS level. One way of approaching this would be to find a mechanism that incentivises systems to seek out the voices of these PCNs (Fisher *et al* 2019), but critically, it has to be driven by strong leadership and direction within PCNs and from ICSs and NHS England and NHS Improvement. A similar question applies to PCNs themselves in cases where there are small pockets of practices serving diverse communities within a PCN patch that is less diverse.

To support progress on reducing ethnic health inequalities, service specifications – as well as other potential sources of extra funding tied to achieving specific targets like reductions in accident and emergency (A&E) admissions – will need to take into account the impact of deprivation and ethnicity on the ability of areas to meet targets (for example, due to language barriers, complexity of health needs or levels of patient activation) (Fisher *et al* 2020).

5 Levers for change

In the previous two sections we looked at the role played by and the potential of different NHS structures in addressing ethnic inequalities. Clinical, managerial, and administrative staff in the NHS are, to some extent, guided by these organisations in their day-to-day work. In addition to these system structures, there are cross-cutting 'levers' that provide the framework within which they operate. In this section, we describe the levers for addressing ethnic health inequalities and make recommendations about what can be done to increase their impact. As we go on to conclude in Section 6, any comprehensive strategy to address these inequalities will need to incorporate action using all these levers to be effective.

The levers are:

- **national policy and strategy**
- **workforce**
- **accountability and improvement**
- **data and evidence**
- **funding**
- **community engagement**
- **leadership**

National policy and strategy

Work to address ethnic health inequalities must not be a strategy on the margins of what systems do – it needs to be central to their core work designing and delivering services for their local populations (Salway *et al* 2013). To enable this, reducing ethnic inequalities needs to be prioritised at every level of the system, including central government.

As we discussed in Section 2, the causes of ethnic health inequalities are multiple and complex. When people from Black and minority ethnic groups experience poorer health, it can be for a range of reasons that include factors linked to their ethnicity as well as other factors such as deprivation. A comprehensive national strategy to tackle health inequalities in the general population across their multiple dimensions will improve outcomes for Black and minority ethnic communities. This type of strategy must not just be implemented in the Department of Health and Social Care but needs to span government to include areas such as education, housing and the economy, which all affect the wider determinants of health.

Past experiences demonstrate the potential of a cross-government national strategy (accompanied by local support) to make a real impact in reducing inequalities. The box below describes the health inequalities strategy that operated in England between 1997 and 2010, which provides some important high-level insights about what is needed from national policy and strategy to bring about change. It shows that sustained cross-government action can have a measurable impact on inequalities in hard-to-shift indicators such as life expectancy, if given sufficient time to develop. It also highlights the role that a small number of broad high-level targets can play in bringing about coherent action across government and motivating change.

1997–2010 health inequalities strategy: lessons for the future

The strategy was a cross-government commitment to reduce health inequalities, through the actions of the NHS and Department of Health and wider government (Department of Health 2003). It was operationalised through 83 cross-government commitments and through a commitment to two targets, implemented through a public service agreement (PSA) between the Department and the Treasury. These were as follows.

- Starting with local authorities, by 2010 to reduce by at least 10 per cent the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole.
- Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between the routine and manual group and the population as a whole.

In practice, most of the focus, resources and effort was directed towards the first of these targets. This was accompanied by strong performance support to local areas through the Health Inequalities National Support Team (HINST) (Department of Health undated), clear monitoring and reporting by the Department of Health (Department of Health 2009), the central development of analytical tools that were focused on the practical actions that could deliver the targets (such as the Health Inequalities Intervention Tool (HIINT) and an associated commissioning guide (Fitzpatrick 2013)) and were designed to be localised.

Local areas received additional direct funding in some years, and NHS resource allocation was amended to include a health inequalities component as part of the approach.

There was a strong system of independent performance assessment associated with the targets. National targets were cascaded to primary care trusts (PCTs) and the Healthcare Commission had statutory responsibility to assess performance in meeting those targets as part of its annual ratings. The independent Scientific Reference Group assessed and reported to parliament on national progress (Department of Health 2008).

Did it work?

Several early independent studies concluded that the strategy did not work. However, these tended to assess it on metrics that it was not designed to achieve (Mackenbach 2011; Costa-Font *et al* 2010). The National Audit Office reviewed progress on the life expectancy element and concluded that the practical support part of the strategy had started late, and it was unlikely to meet its targets (National Audit Office 2010).

Independent studies published since then have focused more directly on the stated goals and have shown findings that are consistent with the strategy having had an effect on reducing health inequalities in life expectancy and inequalities in infant mortality (Robinson *et al* 2019; Barr *et al* 2017; Maguire and Buck 2015; Barr *et al* 2014;).

Since the strategy was dismantled in 2010, inequalities in life expectancy and similar measures have widened in England (Public Health England 2018a).

Lessons for the future

- Concerted, comprehensive and consistent effort on health inequalities can have an effect, but this needs to be continual and sustained over the long term.
- Establishing reducing health inequalities as a key national priority is necessary to ensure that it is also a key local priority, stimulating action on the ground.
- National direction and support is needed, with some local discretion on how to implement. Relying on local systems alone is not sufficient to drive systematic progress across geographies. The national system can provide tools, support and expertise, but this needs to be interpreted in local contexts.
- A high-level, challenging but achievable, goal (or goals) is needed to help cohere, focus and direct action. Future targets need to be broad enough to draw in contributions from many partners, and be measurable so that progress can be assessed.
- Although tackling health inequalities takes time, it is possible to see change in a reasonable timescale, but this is beyond the annual cycle of performance management and funding.

Disclosure: This perspective was written by David Buck who was a deputy director in the Department of Health until the end of 2010 working to implement the health inequalities strategy.

The context has moved on in the decade since the health inequalities strategy was implemented. For example, since 2010, there has been a greater focus on the NHS's wider civic and economic impact in society, and a greater acceptance that it has a role to play in 'creating' health as well as treating illness. Various factors – including the creation of the Health Anchors Learning Network (HALN), the fact that a core principle of ICSs is 'helping the NHS to support broader social and economic development' (NHS England and NHS Improvement 2020b), and an interest in the wider objectives that the NHS can contribute to, such as tackling poverty (Fenney and Buck 2021) – mean that there is an opportunity for the NHS to make a bigger impact on the social determinants of health that drive ethnic health inequalities.

Some of the levers used by policymakers up to 2010 are no longer focused on reducing health inequalities. This includes strong performance management that gave the ability to drive policy and practice on complex issues, systematically and at scale. Change now relies more on local and regional systems, ICSs and PCNs and others 'owning' and acting on inequalities (see Section 3). A local approach is vital to address health inequalities because of the ways in which they overlap; understanding how factors such as ethnicity, gender, socio-economic status and geography interact in a particular part of the country is key to forming effective strategies to improve health for those with the worst outcomes. Therefore, any national strategy and goal(s) need to leave flexibility for local health care planners in ICSs and other local health system structures to develop their own approaches based on their understanding of local needs.

Most importantly, up to 2010 and since then, there has been a tendency for the broader dimensions of health inequalities (socio-economic, protected characteristics, geography and excluded groups) to be considered separately. The experience of COVID-19 has shown more than ever that these overlay one another, and that any approach to health inequalities needs to recognise that they should be seen as complementary and interdependent. We cannot work on one to the exclusion of the others – action needs to be taken across the four dimensions.

Recommendations

- NHS action to address ethnic health inequalities should be co-ordinated across every level of the system including national, regional, and what NHS England and NHS Improvement calls 'system', 'place' and 'neighbourhood' levels. This should be part of a broader approach to reducing health inequalities, with all local health and care partnerships, including ICSs, local place-based partnerships, health and wellbeing boards and primary care networks (PCNs), making this a central focus of their work. This must recognise and address the multiple factors that contribute to poorer health outcomes among people from Black and minority ethnic groups.
- As part of this, the NHS should invest in measures that identify and target communities at higher risk of poor health. Critically, this should include a significant increase in culturally competent primary prevention activity that targets risk factors such as obesity, diet, exercise and smoking, in national and local strategies that reflect the structural and environmental drivers of these risk factors, including discrimination as well as deprivation.
- This approach should sit within a broader cross-government strategy for reducing health inequalities that specifically addresses ethnic health inequalities, as well as other groups who experience health inequalities. This must also look at the wider social context in which structural racism can reinforce inequalities among ethnic groups – for example, in housing, employment and the criminal justice system – which can in turn have a negative impact on people's health.

Accountability and improvement support

The NHS's accountability structures incorporate assessments of the actions taken to address health inequalities, but this element has not been prioritised. Alongside culture and leadership, accountability is a critical area for improvement, and addressing it should be a priority for the Department of Health and Social Care. To be effective it must be accompanied by a comprehensive program of improvement support.

NHS England and NHS Improvement holds CCGs to account for their legal duty to address health inequalities through the NHS oversight framework, which includes two indicators on health inequalities (NHS England and NHS Improvement 2019b). However, we heard in interviews that the accountability relationship between NHS England and NHS Improvement and CCGs has focused on financial performance and meeting waiting time targets in recent years, and (perhaps in part because of this) research has found that many CCGs do not see action on inequalities as a core part of their work (Regmi and Mudyarabikwa 2020) (see Section 3).

The NHS oversight framework is also used by NHS England and NHS Improvement to hold NHS providers to account, but the health inequality indicators do not apply to them. The CQC considers some of the work providers do to tackle health inequalities in their population under the 'responsive' domain during inspections (see Section 3), but this forms a small part of the inspection, and there is no overall assessment of progress on reducing inequalities.

Strengthening accountability for action on health inequalities is one of the priorities set out by NHS England and NHS Improvement in its plans for Covid recovery in 2020/21 (NHS England and NHS Improvement 2021a). This includes developing a 'health inequalities dashboard' – a set of key indicators that can be used to assess progress on reducing inequalities. All systems have submitted returns detailing progress to date on the 'eight urgent actions' but an analysis of these returns is yet to be published. These actions and the accountability mechanisms that accompany them are an important first step to making reducing ethnic health inequalities part of the NHS's business as usual.

Action on ethnic health inequalities happens in local communities when partners work together across the NHS, local authorities, and voluntary and community sector (VCS) to understand and address the causes of inequality. Therefore, in strengthening accountability arrangements, the NHS needs to focus on driving collaborative action by systems. Critically, a new approach also needs to incorporate ways that communities can hold providers and systems to account for this work, for example by involving communities and community leaders in assessments of progress.

Top-down targets and penalties can bring quick and clear results but they can also stifle innovation and have perverse consequences, and systems can only respond to a small number of targets at any one time. Too much emphasis on national directives will drive out the passion and intrinsic motivation that is central to many successful initiatives.

Tighter accountability arrangements will not make any difference unless organisations and systems know how to respond to the results and have the skills and resources to do so. In other sectors, and in the NHS in the past, 'horizontal' improvement mechanisms based on peer challenge have been used to provide critical challenge and share learning and best practice between organisations. Examples include the sector-led improvement approach used in local authorities and the Race for Health initiative developed for PCTs in the past (Local Government Association 2020). However, if this type of mechanism were introduced for systems in the NHS, the process would need to be universal, with all ICSs required to take part. Voluntary processes can exacerbate inequalities by not addressing issues in areas that do not engage.

Recommendations

- The way in which the NHS is held to account for reducing health inequalities, including ethnic health inequalities, should be strengthened. This is a critical area for improvement and addressing it should be a priority for the Department and for NHS England and NHS Improvement. This should include the following:
 - The Department for Health and Social Care should health inequalities a core aspect of each element of the new 'triple aim' duty for the NHS that is proposed in the Innovation and Integration White Paper (Department of Health and Social Care 2021b), so inequality reduction is not seen as 'nice to have' but as a core purpose for the NHS.

Ethnic health inequalities

- NHS England and NHS Improvement should make reducing inequalities in health a key priority for accountability, performance and improvement systems, giving it equal weight alongside other key priorities such as targets for waiting times and financial balance (while also ensuring that addressing inequalities is a key measure of success for these other priority areas). This approach should include a specific focus on ethnic health inequalities.
- The Care Quality Commission (CQC) should ensure that progress in addressing health inequalities within the local population is given appropriate weighting and is at the core of any new processes it develops for inspecting ICSs from 2022.
- Alongside strengthened accountability, the NHS needs a stronger system for improvement that includes specific support to help people working at all levels in the NHS understand ethnic health inequalities, their causes, and the actions needed to address them. This system must be multifaceted, incorporating:
 - an approach to tracking the NHS' progress in tackling health inequalities. Metrics showing progress should include cuts by ethnicity.
 - a new mandated process of peer review between ICSs to support learning and identify best practice and areas for improvement in addressing health inequalities, including ethnic health inequalities, co-ordinated by NHS England and NHS Improvement.
 - support for leadership development and the mobilisation of evidence, outlined in the 'leadership' and 'data and evidence' sections below.

Funding

There are a range of opportunities to explore how funding and changes to NHS financial structures could support the reduction of ethnic health inequalities. Funding alone is unlikely to have a meaningful impact; culture and strong leadership (discussed below) are crucial. There are three key ways in which funding could be used to enable greater progress on this goal.

First, the financial structures in the NHS could be reviewed. This includes the allocation formulae that are used to decide how resources for primary and secondary care are distributed across the country based on various factors, including the characteristics of the local population. These formulae can be reviewed and adjusted to reflect the need for health care services, and, for example, a recent adjustment to allocations for 2019/20 to 2023/24 increased funding for CCGs in the most deprived areas (NHS England 2019). ICSs will be put on a statutory footing in 2022 and will start to receive NHS commissioning budget allocations. Where ICSs then go on to set budgets within their system (for example, to place-based partnerships), this allocation should also be done in a way that reflects local needs and has regard to the needs of Black and minority ethnic populations in these areas.

Second, the use of existing financial and non-financial incentives should be reviewed to see if they could support greater action or focus on reducing ethnic health inequalities. However, financial incentives alone are likely to be too blunt an instrument to address a multifaceted and complex issue such as ethnic health inequalities (Monitor 2014).

The final area for potential action is providing direct financial support for initiatives targeted at reducing ethnic health inequalities. This might (for example) mean creating a dedicated pool of funding to support action on ethnic health inequalities. It might also be about using funding to support some of the other levers that we describe in this section, such as community engagement, supporting and developing leaders, and improving data collection processes. As noted in the previous section, ICSs are key leaders in efforts to address ethnic health inequalities, and transformation funding could be used at a system level to provoke action. ICSs should also work with their local authority partners to co-ordinate any NHS transformation funds with local authority funding that is focused on social and economic inequality.

Recommendations

- National bodies involved in developing NHS financial allocations policy, including NHS England and NHS Improvement and the Advisory Committee on Resource Allocation, should continue to consider the impact of ethnicity on health as they develop the allocation formula to ICSs and develop guidance for ICSs who will set budgets at 'place' level.
- Where budgets for place-based partnerships are set within an ICS, this should be done in a transparent way, with a clear understanding of how allocation to place matches to identified health and health inequality need among local populations.

Leadership

While policy, accountability arrangements, and funding levels set the framework within which change happens, their impact relies on the actions of people working in the NHS and the relationships they form with one another. We have shown that the NHS's policy, performance and funding framework includes tackling ethnic health inequalities as one of many priorities; these overlapping priorities have been described by leaders as dense 'policy thickets' from which it is difficult to pull out coherent local visions and strategies (Dixon-Woods *et al* 2014).

While national bodies need to reprioritise and untangle these 'thickets', leaders also have an opportunity to cut through this and drive change by setting a clear vision, prioritising and advocating for actions that address health inequalities, and modelling that vision's importance through their actions. Success will hinge on leaders communicating that vision effectively and promoting the development of the right culture, governance and organisational structures to make the strategy a core part of how their organisations operate (Salway *et al* 2013).

To do this, the NHS needs a cohort of leaders that better reflect the communities they serve. As we discuss in the 'workforce' section below, this is a key enabler of meaningful progress on ethnic health inequalities. There is strong evidence of the positive impact that diverse leadership has on organisational culture and performance (Corbett-Nolan 2018; NHS England 2018a). And there is growing evidence linking culture and leadership to patient outcomes (West *et al* 2014). However, NHS boards are less diverse than they were a decade ago. The proportion of NHS chairs and non-executive board members who are from Black and minority ethnic groups peaked in 2010 at 15 per cent but had fallen to just 8 per cent by 2019 (NHS Confederation 2019).

The latest WRES data for 2020 shows that boards are becoming more diverse (10 per cent of board members are now from Black and minority ethnic groups) but there is still some way to go until they are representative of the NHS workforce or the English population (NHS England and NHS Improvement 2021b). Similarly, the number of very senior managers from Black and minority ethnic groups is increasing, but more progress is needed (ibid). NHS clinicians are a more diverse group and provide a potential pool of talent for leadership roles (NHS Digital 2021). Drawing on their expertise would align with NHS England and NHS Improvement's drive to put clinical and professional leadership at the heart of transformation efforts and support a practice of collective leadership that harnesses the informal influence of clinical and professional leaders (NHS England and NHS Improvement 2021a). As we discussed in Section 4, the establishment of ICSs as statutory bodies in April 2022 and the planned recruitment this autumn of their chairs and chief executives provide an important opportunity to make senior healthcare leadership more diverse and reflective of the communities they serve.

Change is not just about who the leaders are, but also what they do. Tackling ethnic inequalities should be a core role of all leaders, whatever their ethnic background. People from Black and minority ethnic groups need allies who promote and advocate for them and challenge the discrimination that can stop them thriving at work and progressing (Ross *et al* 2020).

Salway *et al* (2013) set out the actions that leaders should take to ensure that addressing ethnic inequalities becomes core business for NHS organisations and systems. They include the following.

- Make it clear to staff that race equality is a priority area for which everyone is responsible.
- Make public statements in high-profile gatherings to this effect.
- Commit adequate resources to this agenda.
- Ensure effective linkages and synergies across work-streams.
- Establish structures and processes that enhance the confidence and competence of all staff, hold them to account and reward progress in this area.
- Actively support and value the work of 'champions' for this agenda.

Other research by The King's Fund finds that leaders who role-model behaviours like these are a powerful and inspiring motivator for staff (Ross *et al* 2020).

Leaders need to be confident in talking about and acting on ethnic inequalities and motivated to do this work, and to do so, they will need support and training. Understanding how to bring about change is key; work such as reducing variation in care requires a continuous improvement approach and a quality improvement skillset.

There are existing development programmes for Black and minority ethnic staff run by national organisations and in-house by NHS organisations. However, by focussing only on Black and minority ethnic staff, these risk misdiagnosing the problem. These programmes will need to be supplemented and/or revised with additional targeted support to increase the knowledge, understanding and confidence of all NHS staff to understand concepts of 'race', 'racism' and 'privilege', and tackle ethnic inequalities (understanding the benefits for all in doing so).

Recognising the critical role that leaders play in supporting change, NHS England and NHS Improvement (see Section 2) had asked all systems, NHS organisations and PCNs to identify (by October 2020) a board-level executive lead for tackling health inequalities (NHS England and NHS Improvement 2020a). These leads should be a key cadre of senior leaders, located across the system, whose work must be valued and prioritised. The leads vary widely in their level of knowledge about health inequalities and, as critical change makers in high-level positions, they need a comprehensive package of support to enable them to drive change in their organisations and across their local health care systems. This support needs to help leaders understand the complex connections between the multiple causes of health inequalities so that they can develop comprehensive strategies to address them.

To underline the importance of this role for NHS leaders, they should be held to account for reducing health inequalities, including how they support people from minority ethnic groups and the race equality agenda in general.

Recommendations

- NHS England and NHS Improvement should ensure their processes for appointing senior leaders to new ICS roles during 2021/22 address the need to diversify the healthcare system's senior leadership and make it more representative of the diverse communities it serves.
- NHS England and NHS Improvement should continue to build on its work with local organisations and systems to provide a comprehensive, tailored package of development support for executive health inequality leads that is responsive to needs and local circumstances. This should include a focus on ethnic health inequalities, as well as on peer learning, evaluation and improvement.
- NHS England and NHS Improvement should support, co-ordinate and, where necessary, initiate leadership development programmes that increase the health systems' capacity to tackle health inequalities, including ethnic health inequalities. This should include broad programmes that develop NHS leaders' quality improvement capabilities, and programs that support increased awareness of diversity, inclusion and ethnic health inequalities.
- All NHS leaders and managers need to be held to account for their role in addressing inequalities in access, experience and outcomes, including ethnic inequalities via ongoing performance management conversations and through annual appraisals. This should also extend to considerations of ethnic inequality as experienced by the NHS workforce.

Workforce

Race equality and inclusion within the NHS workforce is essential not only because this is what justice and fairness demand for NHS staff, but also because of the potential impact this can have on efforts to tackle ethnic health inequalities (Public Health England 2018b). First, the NHS can demonstrate and model its wider commitment to equality and inclusion through how it treats its staff, with implications for patient access and building relationships of trust with the communities it serves. Similarly, ensuring that there is diversity and representativeness at all levels can lead to greater connectedness with communities and a wider range of perspectives involved in shaping how the NHS works, including how it works with Black and minority ethnic communities (NHS Confederation 2013). The NHS is also a major employer (at national level, but particularly in areas of higher deprivation), and its employment practices impact many of the wider determinants of health for its staff and their communities – including the quality and safety of their work, their income and their job security (Maguire 2020).

Recent data shows that NHS staff from Black and minority ethnic groups continue to face alarming levels of racism, discrimination and disadvantage. Compared with their White colleagues, Black and minority ethnic staff are more likely to report bullying, harassment and abuse from patients and colleagues; they are more likely to enter into the formal disciplinary process; and they are less likely to be employed in senior positions (Ross *et al* 2020). In the 2020 NHS Staff Survey, 13.1 per cent of staff reported experiencing discrimination at work. In line with the past five years, ethnic background was the most common reason (48.2 per cent) cited for this discrimination (NHS Survey Coordination Centre 2021). The latest WRES figures show that White applicants were 1.61 times more likely to be appointed from shortlisting than Black and minority ethnic applicants, and that those staff were 1.16 times more likely to enter the formal disciplinary process than White staff (NHS England and NHS Improvement 2021b). These issues were highlighted in a recent review of diversity by the Royal College of Surgeons, which uncovered shocking examples of racism and other types of discrimination experienced by surgeons during training, throughout their careers and at the college, and set out an action plan to start addressing these issues (Royal College of Surgeons of England 2021).

The first wave of the COVID-19 pandemic has had a disproportionate impact on health and care staff from Black and minority ethnic groups across the UK. Early analysis conducted in May 2020 found that while 1 in 5 UK NHS staff are from Black and minority ethnic groups, this group accounted for 61 per cent of the first 200 deaths of staff due to COVID-19 (Marsh and McIntyre 2020).

Progress has been seen in some areas over recent years (Naqvi and Coghill 2020). For example, the relative likelihood of BME staff entering the formal disciplinary process compared to White staff has reduced year-on-year, from 1.37 in 2017 to 1.16 in 2020, and there has been a 22 per cent increase in Black and minority ethnic NHS trust board members since 2019 (NHS England and NHS Improvement 2021b). There are many examples of good practice taking place across the system (see box), and there is much to be gained from spreading learning from this work. But there is still large variation across organisations. While some trusts and CCGs are making excellent progress, others are making little or no improvement at all (NHS England and NHS Improvement 2021b).

An integrated racial equality and inclusion strategy: North East London NHS Foundation Trust

North East London NHS Foundation Trust (NELFT), a mental health and community services provider employing 6,000 staff working across 200 sites, has achieved sustained improvements across all Workforce Race Equality Standard (WRES) indicators from 2016 to 2018.

Equality and inclusion-related issues were discussed by the board, the ethnic minority network (EMN), and at meetings at all levels in the trust, including inductions for new starters. There was a clear message that race inequality was an issue that required the concerted effort of everyone in the trust. The board reviewed and endorsed a strategy to address racial inequality, and each executive board member worked with an EMN strategic ambassador to deliver specific actions for which they were accountable.

The delivery of the strategy was monitored through regular reviews against measurable ambitions at all levels, including: for Black and minority ethnic group representation at band 8c and above to reflect the proportion of Black and minority ethnic staff in the workforce as a whole; an increase in the number of minority ethnic group executive and non-executive directors; and a reduction in the number of Black and minority ethnic staff involved in any human resources (HR) procedures and litigation cases.

Recruitment

Changes were introduced to make recruitment practices fairer and more transparent. The trust trained 80 Black and minority ethnic staff to be part of diverse interview panels, and Black and minority ethnic panel members were enabled to overturn interview panel results and escalate them for review. As a result of these changes, the relative likelihood of White applicants being appointed from shortlisting compared to Black and minority ethnic applicants improved from 3.12 in 2016 to 1.46 in 2018.

Career progression

NELFT invested in training, coaching and better recruitment processes to help Black and minority ethnic staff develop to their full potential. As part of this, the recruitment policy was updated so that interviews for all band 8a and above posts needed an EMN panel member. The Black and minority ethnic staff who went through the training and sat on interview panels reported growth in their confidence and ambition, and a demystification of the interview process – particularly for senior posts. Between 2013 and 2017, the percentage of Black and minority ethnic staff at band 8a and above increased from 18.4 per cent to 29.3 per cent, and the number of staff at band 8c increased from 2 to 32.

Formal disciplinary cases

The trust sought to address the disproportionate representation of Black and minority ethnic staff in formal disciplinary cases. Alongside a review of policies and practices across the trust, white managers attended mandatory training to help them understand the differences in opportunities and experiences between Black and minority ethnic and White staff in the NHS. Investigation panel members were also given cultural awareness competency training. The relative likelihood of Black and minority ethnic staff entering the formal disciplinary process compared to White staff improved from 2.02 in 2016 to 1.18 in 2018.

Reverse mentoring

A key component of the trust's cultural transformation has been built on understanding the lived experiences and stories from Black and minority ethnic staff. All board members have a reverse mentor from a Black and minority ethnic background. NELFT has the highest proportion in London of Black and minority ethnic staff reporting that the organisation provides equal opportunities for career progression. It also has the second lowest proportion of Black and minority ethnic staff (and the fourth lowest proportion of White staff) reporting discrimination, harassment and bullying from colleagues.

Source: North East London NHS Foundation Trust 2019.

Meaningfully improving ethnic equality and diversity requires coherent, multi-level and sustained strategies, rather than simply sets of individual interventions (West *et al* 2020). Tackling ethnic inequality should be hardwired into corporate objectives and activities, progress should be tracked continuously as core management information, and leaders and line managers need to be held to account for taking action (Guillaume *et al* 2014). Demonstrable leadership and support for these strategies at every level of organisations and systems is a key condition for progress, alongside ongoing and meaningful engagement with people's lived experiences (Ross *et al* 2020; West *et al* 2014).

NHS organisations must urgently address the structural inequalities and barriers to career progression experienced by Black and minority ethnic staff, including through changes to appointment and promotion processes, disciplinary procedures and complaints handling, as well as through coaching, mentoring and development opportunities (West *et al* 2020).

However, evidence suggests that HR policies alone are not a solution. It is essential that organisations take a strategic approach to creating cultures of inclusion, built around a vision of high-quality, compassionate care and characterised by compassionate, collective leadership, as discussed in the previous subsection (West *et al* 2020; Guillaume *et al* 2017).

Organisations should make it clear that equity, diversity and inclusion are everyone's business, rather than placing the burden of responsibility on staff holding specific roles relating to diversity and inclusion, or those that are part of Black and minority ethnic group networks. As part of this, all staff should be equipped with an understanding of the evidence on the impact and prevalence of racism and discrimination in the health and care system (Ross *et al* 2020).

Interviewees stressed the need to focus efforts at national, system and organisational levels on developing expertise and leadership in workforce ethnic equality, supporting people leading this work and spreading learning and good practice (WRES Implementation team 2018; Naqvi 2020). NHS organisations can utilise the WRES experts programme, which aims to develop 'in-house' expertise to improve workforce race equality (NHS England 2018b). We heard during our interviews that establishing cross-organisational peer support networks for staff leading equality and inclusion work would be valuable as a source of coaching, mutual learning and emotional support.

Data on performance against the WRES feed into the CQC's assessment of how well-led an organisation is, and the CQC describes its inspections as one of the strongest levers for implementing the WRES (Care Quality Commission 2019). NHS England and NHS Improvement also publishes an annual report detailing progress against the WRES in NHS providers and, for the first time in 2020, CCGs (NHS England and NHS Improvement 2020e). However, it is not a rating limiting factor, and there have been calls to tighten accountability arrangements – for example by introducing penalties or by reviewing how the CQC scores employee equality and diversity considerations during its inspections (Kar 2021; Naqvi 2020). A new approach would need to combine better quantitative data with qualitative data from leaders with responsibility for developing and implementing plans in response to the WRES.

Currently, the WRES does not apply to primary care organisations, which means that discrimination and differential experience by ethnicity that may be occurring is not being picked up. It is crucial that primary care organisations track Black and minority ethnic staff representation and experiences and use this to inform action to address inequalities (Ross *et al* 2020).

The NHS People Plan, which expired at the end of March 2021, calls the COVID-19 pandemic a 'time of national awakening' on these issues and outlines a comprehensive set of actions NHS employers should take to address them (NHS England and NHS Improvement 2020d).

Recommendations

- All NHS organisations should implement a board-level strategic commitment to achieving culture change in relation to the experience of Black and minority ethnic staff, focused on creating inclusive and compassionate cultures. Leadership practice, leadership development and team-working interventions should cultivate positively diverse and universally inclusive cultures at every level of the health system. All national healthcare bodies must lead from the front by prioritising this work within their own organisations.
- NHS England and NHS Improvement should consider how it can strengthen the way it holds providers and commissioners to account for actions taken in response to Workforce Race Equality Standard (WRES) data and the NHS Staff Survey, and build on commitments made in the most recent NHS People Plan (NHS England and NHS Improvement 2020d). As a minimum, this should be an obligatory line of enquiry in quarterly performance monitoring conversations with organisations and systems; a lack of progress should trigger appropriate support interventions and sanctions that are used to respond to other critical system issues.
- The CQC should review how it can ensure its regulatory methodology better assesses progress against the WRES, including by further strengthening how progress is taken into account in its inspections and in the use of the well-led framework.

Data and evidence

Comprehensive and accurate ethnicity data is essential for improving the health and wellbeing of people from Black and minority ethnic groups and tackling ethnic health inequalities. It can play a crucial role in needs assessments, service planning, understanding population-level risks and inequalities, monitoring performance, and informing clinical and operational practice. It is also key in enabling public services to ensure and demonstrate compliance with equality legislation. However, evidence suggests significant limitations in both the completeness (the level of coverage) and quality (accuracy) of ethnicity data in health records. If datasets used in making decisions are not representative of the populations those decisions affect, then they will systematically fail to meet those populations' needs. We also heard during interviews that having data on ethnic health inequalities makes these inequalities more difficult for decision-makers to ignore and can thereby prompt action.

Over the past two decades, the coverage of ethnicity recording in health records has improved significantly, due in part to initiatives like the incentivisation of ethnicity recording within primary care under the Quality and Outcomes Framework (QOF) between 2006/07 and 2011/12 (Mathur *et al* 2014). There is still significant scope to improve coverage in all settings and to reduce variation in coverage between settings. NHS England and NHS Improvement's Phase 3 recovery letter urged NHS organisations to improve the completeness of ethnicity coding in patient records (NHS England and NHS Improvement 2020a, 2021a).

However, action is urgently needed to improve not only the coverage but also the quality of ethnicity recording to ensure that data is accurate, reliable and practically useful (Raleigh and Goldblatt 2020). Such action will help ensure that efforts to improve coverage, including the action prompted by the Phase 3 letter, do not simply result in a greater amount of poor-quality data.

Evidence suggests that the quality of ethnicity data in health records is poor, variable and shows signs of systematic bias (Spencer *et al* 2020). There is evidence of substantial discordance between ethnicity in health records and self-reported ethnicity (Mathur *et al* 2014; Saunders *et al* 2013), of a disproportionate number of records coded in 'other' categories (such as 'Black other') and of multiple ethnicities being recorded for the same patient in different episodes of care (Cabinet Office 2018; Morrison *et al* 2014). A recent review by the Office for National Statistics (2018) identified several potential issues with the comparability and coherence of data sources on ethnicity for equality monitoring purposes.

To improve data recording, NHS staff should be provided with fit-for-purpose, comprehensive guidance on how to record ethnicity, and should be encouraged and supported to comply with it. To our knowledge, no such guidance has been issued to NHS trusts since the Data Set Coding Notice in February 2001 (Raleigh and Goldblatt 2020). There is a strong case for issuing updated ethnicity coding guidance across the NHS. This refreshed guidance should make clear that ethnicity should be self-reported, using official classifications of ethnicity, and should establish a clear set of rules for situations in which the patient has a temporary or permanent lack of capacity. To our knowledge, no such guidance has ever been issued to GPs, and this must be addressed. The extent and causes of ethnicity miscoding in health records are unknown, and further research – including into the role of public perspectives and relationships between communities and the NHS – would be valuable in informing improvement efforts (*ibid*).

Data is an enabler – the impact of good data comes from how it is used. We heard that investment in developing the analytical capacity available to systems, particularly at ICS and place level, would enable them to generate more effective insights and action from their data. Several interviewees highlighted the role that population health management approaches could play in tackling ethnic health inequalities, by helping systems to identify priority groups, develop interventions and pathways that match their needs, and monitor impact to inform improvement efforts (Dougall 2021; Fenney and Buck 2021).

Interviewees emphasised the need to use data in combination with direct engagement with the communities being served to gain a deeper and more practically useful understanding of their experiences and needs. Conversations with communities can help explain what is behind the patterns seen in the data, to gain a more complete understanding of people's lives and priorities, and thereby inform services and interventions that better fit with their needs and preferences (see subsection on 'Community engagement', below).

As well as good-quality patient and population data, commissioners, planners, practitioners and service designers need robust, practicable evidence on the kinds of action they can take to address ethnic health inequalities (Salway *et al* 2013). Better systematic evaluation, documentation and sharing of initiatives aimed at tackling ethnic health inequalities is needed in order to develop the evidence base on what works and to support improvement efforts through spreading good practice and lessons learnt (Public Health England 2018b). We heard, however, that a wide range of evidence-based tools and resources that can inform action already exist – for example, Public Health England's inequality tools and Sheffield Hallam University's Evidence and Ethnicity in Commissioning (EEiC) toolkit – and that part of the challenge is to encourage and support decision-makers to mobilise existing tools and evidence more effectively and systematically.

Recommendations

- NHS England and NHS Improvement should commission NHS Digital to issue guidance and standardised protocols to NHS providers and GPs for collecting and recording the ethnicity of service users, to ensure high quality ethnicity coding (and, although outside of the scope of this report, this should also be done in social care). Progress in improving the coverage and quality of ethnicity data recording should be a key component of NHS England and NHS Improvement's monitoring conversations with NHS providers and commissioners.
- ICSs should prioritise improving the quality of ethnicity coding, learning from local partners, and spreading best practice. They should also rebalance how they use their analytical and population health capacity to enable them to support systems to understand and act on health inequalities, including ethnic health inequalities.
- NHS England and NHS Improvement should consider how to develop a more systematic approach to building, sharing and mobilising the evidence base on interventions and good practice in tackling health inequalities. This should include a national rollout of existing tools. NHS England and NHS Improvement should work on this with the newly announced Office for Health Promotion and, at regional level, ICSs should also draw on relevant public health expertise.

Community engagement

Building effective relationships between NHS organisations and the Black and minority ethnic communities they serve can play a crucial role in addressing ethnic health inequalities. This starts with the recognition that people and communities have a range of assets that can support improved health and wellbeing, including insight and intelligence on what they need from health services, how well services and interventions are working for them and how they can be improved, as well as skills, experience, networks and resources. The task for NHS organisations is first to build strong, trusting and sustained relationships with local communities, and second, to develop, support and mobilise these assets to ensure that services genuinely meet people's needs and to empower communities to improve their own health and wellbeing.

The importance of community engagement in improving health and tackling health inequalities has been emphasised repeatedly in national plans and strategies. The 2014 NHS five year forward view stressed that the energy of patients and communities is no longer a 'discretionary extra' but instead is key to the sustainability of health and care services (NHS England *et al* 2014). In *Integrating care: next steps to building strong and effective integrated care systems across England*, it is stated that during 2021/22, every ICS should be able to show how it uses public involvement and insight to inform decision-making, with particular efforts made to 'understand and talk to people who have historically been excluded' (NHS England and NHS Improvement 2020b). Guidance from the National Institute for Health and Care Excellence (NICE) sets out how to use community engagement as a strategy for addressing health inequalities (NICE 2016).

Despite this, we heard that there is a wide degree of variation in the strength of community engagement work across different organisations and systems, with particular issues around how well engagement efforts connect with and involve people from Black and minority ethnic communities. Approaches and methods of community engagement are diverse, constantly evolving and need to be adapted to fit local contexts. However, this does not mean that they are mysterious, complicated or expensive, and it does not prevent organisations learning from each other (Think Local Act Personal 2016). ICSs present a significant opportunity for partners to share good practice, insights and resources, and to work together in a more joined-up way on community engagement within their local systems. There are many ways in which NHS organisations can work with communities to tackle ethnic health inequalities. Here, we focus on two: putting community voices at the heart of how services work and building and mobilising community assets.

Putting community voices at the heart of how services work

To generate genuine progress on ethnic health inequalities, the insights and perspectives of people and communities must be valued equally alongside professional expertise and other sources of data and must have a meaningful role in shaping how services work (Salway *et al* 2013). Meaningfully involving people from Black and minority ethnic groups in service planning, design, delivery and evaluation, and in setting priorities at organisation and system levels, can help shape services that reflect people's needs, lives and priorities (O'Mara-Eves *et al* 2013).

Hearing directly from groups experiencing ethnic health inequalities can shed light on how services are perceived and experienced, as well as gaps in provision, barriers to access, and opportunities for improving the way services work for people in those groups (NHS Confederation 2013). This insight and intelligence is an essential part of developing culturally competent services – services that meet the cultural, social and linguistic needs of all the communities they serve, rather than excluding particular groups (Latif 2010). Culturally competent services, communications and interventions might (for example) be sensitive to or adapted to work with particular cultural or religious perspectives and values – but this requires an understanding of those perspectives and values (Public Health England 2018b).

A wide array of evidence-based approaches exists for working with people and communities in this way, involving varying degrees of power-sharing (NICE 2016; Public Health England 2015). These range from surveys and consultations to co-production and long-term partnership working. Different approaches and methods will be better suited to different kinds of work and different community groups. Collaborative approaches that involve shared decision-making can lead to capacity-building among those involved, strengthened relationships between services and communities, as well as a sense of shared ownership of processes and solutions (Public Health England 2015). In all cases, participants should be clear from the outset on how their input will meaningfully influence services, and the results of their involvement should be communicated to them (NICE 2016). The insights generated should also be seen and used in a way that recognises intra-group diversity and avoids stereotyping (Public Health England 2018b).

Importantly, we heard that in order to generate effective and lasting benefits, particular engagement activities need to sit within a wider, ongoing process of engagement and relationship-building between NHS organisations and communities. This should be strategic, with a focus on transparency, clear and accessible communication, regular trust-building dialogue and mechanisms for turning community insights into action (NHS Confederation 2020; Public Health England 2020).

Building and mobilising community assets

Health services can draw on the skills, knowledge, networks, leadership and other resources held within the community in order to reach and connect with local populations, improve access and health literacy, widen the reach of health promotion initiatives and preventive interventions like screening, and address the wider determinants of health (Buck and Wenzel 2018). Here are some examples of these approaches.

- Social prescribing, or community referral, where health professionals can refer people to non-clinical community resources and groups to address their needs in a holistic way (Buck and Ewbank 2020).
- Community champions, ie. volunteers who are trained and supported to improve the health and wellbeing of their communities through activities like sharing health promotion messages, directing people to relevant services, and creating groups and networks to meet local needs (Strelitz and Bowers 2020).
- Peer support roles in which people can use their life experience, cultural awareness and social connections to connect people with services, help them navigate the health system and communicate in a way they understand (Public Health England 2018b).

- Working in partnership with local voluntary and community sector (VCS) organisations, who often have detailed insights into and strong relationships with local communities (Buck and Wenzel 2018).

Asset-based engagement approaches will vary across communities, since they are shaped by the specific assets, needs and contexts of the communities in which they operate. This means that there are no 'one-size-fits-all' models for this kind of work. The potential of these approaches is to provide solutions that are highly tailored to the local context. In terms of realising the contribution these approaches can make to tackling ethnic health inequalities, key enablers that were shared with us included carrying out participatory mapping to ensure that all parts of the community are involved and reached, as well as properly resourcing the training, co-ordination and expenses of those involved. The levels of social assets that exist within some areas and some communities will be less developed than in others. There will be a strong case for many NHS and system-level organisations to invest in building community capacity – for example, through supporting VCS organisations and community groups, or resourcing community development roles.

A great deal of valuable and innovative work with communities has taken place across the country in response to COVID-19 (see box) (Public Health England 2020). It is crucial that the progress and relationships that have developed during this period are sustained and built upon beyond the pandemic. There is also an important opportunity to generate learning from this work and share lessons and best practice across different systems, though doing so will require co-ordination, funding and guidance.

Other disasters have also highlighted the central importance of meaningful community engagement to recovery efforts. One example is the Grenfell tower block fire in 2017, where public services had to learn to listen and act differently to rebuild their relationship with the community (Elguenuni *et al* 2020; Warren 2020)

Newham's COVID-19 Health Champions programme

Newham's COVID-19 Health Champions programme connects Newham Council and its partners with the local community to enable open, timely conversations about the latest COVID-19 advice, as well as the problems people are experiencing and what support they need.

Newham is a highly diverse borough, with 75 per cent of the population from Black and minority ethnic groups, and with many people experiencing a range of economic challenges. More than 450 health champions work in partnership with the council, NHS partners and GPs to gather and share information quickly and responsively, in ways that will reach local communities. Newham Council and its partners bring public health expertise, resources, and the ability to influence the local system's COVID-19 response, while champions bring trusting relationships with and insights about their neighbours, friends, families, and co-workers.

The programme has shaped a COVID-19 response that better meets local needs. For example, it has shed light on the support needs of local multi-generational families and has enabled quick and direct responses to vaccine misinformation that resonate with local people. Channels including WhatsApp and Zoom are used to share information on topics ranging from mental health to money advice, as well as to listen, learn and respond. The team includes a designer who can create infographics shaped by what they are hearing.

If a champion sends something to someone in their network, it is likely that the person receiving it will pay more attention, trust it more and be more open to the content. Residents of Newham will say things to our champions they will never say directly to the council and they will listen to what champions say.

Jason Strelitz, Director of Public Health for Newham; and Anne Bowers, Programme Lead for Newham COVID-19 Health Champions.

Source: Strelitz and Bowers 2020.

Recommendations

- NHS commissioners, providers and national bodies should invest in strategic, ongoing programmes of engagement that build sustained, trusting relationships with Black and minority ethnic communities, as well as working in partnership with communities to develop, deliver, evaluate and improve services, prevention programmes and health promotion activities that are culturally competent and that reach Black and minority ethnic groups.
- National bodies should support the generation and sharing of learning from work with Black and minority ethnic communities that has taken place – for example, during the COVID-19 response, and in the wake of the Grenfell tower block fire tragedy of 2017.

6 Conclusion

This report has considered ethnic inequalities and their causes the key organisations and partnerships in and around the NHS and their role in reducing those inequalities; and the levers available to the health system to drive improvements. We found that the NHS has failed to make significant progress in reducing ethnic health inequalities because it has not identified this as a clear priority over the past decade. We go on to argue that there is now an opportunity to address this by taking urgent action to fill critical gaps in the NHS's capabilities to tackle ethnic health inequalities, and by building a broad health inequalities focus into new NHS structures as a key priority, while supporting NHS staff to drive change.

Our analysis identified urgent actions that the NHS should take to improve its ability to tackle ethnic health inequalities. These include accelerating action to diversify its senior leadership and create equality in its workforce, including in ICSs as they are developed over the coming months; ensuring those leading on health inequalities are fully supported in their roles, including with an understanding of ethnic health inequalities and their causes; increased investment in community engagement to support public health and prevention efforts and the development of culturally competent services; and improvements to the quality of ethnicity data.

Within the health system, tackling ethnic health inequalities needs to be a key thread that runs through the work of national bodies, regions, systems, places and neighbourhoods. Ongoing reforms of the health system – including the development of new collaborative approaches to planning and delivering services, like PCNs and ICSs, and changes set out in the Innovation and Integration White paper – provide an opportunity to embed a health inequalities focus, including ethnic health inequalities, into new structures and accountability mechanisms. Health inequalities should be a key focus for integrated care systems as they move onto a statutory footing in 2022.

Operational performance on issues such as waiting times and finances will always be priorities in the NHS, but actions to address health inequalities need to be elevated to the same level. This means that when performance falls below expectations, the same improvement support, sanctions and penalties should be used in response. At the same time, inequalities must be a lens used to judge progress on those other key priorities.

The NHS has recently started to make a welcome shift away from centralised planning and top-down performance management towards a more localised collaborative way of working that gives local systems flexibility to develop their own approaches to addressing local issues. This means the system goals and performance management approaches we recommend should be a backstop that ensure and support local action by local organisations and staff. A new approach will hinge on changes to the relationships and behaviours of staff and leaders throughout the NHS who must be properly supported in their roles.

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Any comprehensive approach to tackling ethnic health inequalities will need to address all the levers outlined in this report to be effective and address the overlaps and interactions between them. Thinking that action in one area will be effective is a mistake; the change levers we have outlined in this report are complementary and mutually reinforcing. For example, a national strategy will have no effect unless people who work in and lead teams in the health system understand ethnic health inequalities and have the right skills and support to address them.

The toll taken by the COVID-19 pandemic on those with the worst health outcomes including some Black and minority ethnic groups, the response of the NHS and its partners to this and the focus on addressing ethnic inequalities in NHS recovery plans create an opportunity for change. We welcome, for example, plans to address the elective care backlog in an inclusive way, taking deprivation and ethnicity data into account when planning the recovery, and the establishment of executive health inequality leads throughout the system.

As the NHS emerges from the COVID-19 pandemic, it must build on this by taking urgent action to address ethnic health inequalities, and critically, the causes of those inequalities— making this business as usual rather than a sideshow. This is within the NHS's reach if health inequalities are elevated to be a priority at national, regional and local levels, and if the health system works in partnership with local government, the voluntary sector and local communities to understand local issues and deliver improvements.

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