NHS RACE & HEALTH OBSERVATORY
Breaking barriers for better health

Supporting named leads for health inequalities on NHS boards

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The Kings Fund
Ideas that change health and care

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This report has been edited and published by the NHS Race and Health Observatory. It is based on an independent study commissioned from The King's Fund. The team at The King's Fund who worked on it are Kiran Chauhan, Jo Maybin, Deborah Ward, Mandip Randhawa and Simon Newitt.

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

There are many different tools available to policy-makers when they try to bring about change in the NHS. At the harder end of the spectrum, they can employ funding, or regulation, and even legislation – all of them get results, but they take time and come with sacrifices elsewhere. So national leaders more often turn to the softer (and usually cheaper) tools at their disposal. This might take the form of non-binding guidance, or efforts to highlight existing best practice.

Over the past few years, we've seen an increasing reliance in the NHS on the 'named lead' - a policy exercise whereby an individual, usually at board level, is nominated to lead on a priority area of work. The theory is that making an individual responsible for change will create a sense of more focused attention and provide committed leadership. However, critics of the 'named lead' policy might describe it as tokenistic, a hollow gesture designed to convey importance without delivering tangible change. This is evident where, despite being tasked with changing things, these individuals are often afforded no additional time or budget to do so.

Health inequalities is the latest priority area to receive the 'named lead' treatment. As of September 2020, all NHS providers are required to have in place an executive board member with explicit responsibility for reducing health inequalities in their area. This is, of course, an important step in the right direction, especially for race equality, where there has never yet been a sufficient board-level focus. But if this is to be more than tokenistic, then adequate frameworks of support and accountability must exist to empower individuals and motivate change.

This report draws on a longer study we commissioned from The King's Fund (Chauhan et al 2021) which finds that these new named leads occupy a variety of different posts and come from a variety of backgrounds. They have different motivations, levels of interest, and face different challenges. They are variably convinced of their power to change things, and variably confident of having the time to do so. But there is evidently still passion and commitment.

As recommended in this report, if this new cohort of named leads is to genuinely make a difference, national and regional leaders will need to cultivate the necessary environment of learning and challenge. There are many competing priorities in the NHS – especially as the system continues to grapple with the ongoing Covid-19 pandemic – but this policy intervention must not be allowed to become a tick-box exercise.

Passion around health inequalities including, critically, ethnic health inequalities, has rarely been at the high it is now. The challenge is to capitalise on that passion before it is too late. Our hope is that this report is not read only as a suggestion to policy-makers, but also an invitation to health inequalities leads to engage, to work with one another to share successes and failures, and to combine their expertise for the benefit of patients and service users.

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Introduction

The events of the past 18 months have created a unique moment where inequalities – both in populations and in the workforce – have come to the fore. Rather than having to push for interest, organisations are more likely than ever to be looking for ways to address the health and wider inequalities highlighted by the disproportionate impact of Covid-19 on those who are already disadvantaged or discriminated against (see, for example, Raleigh 2021; Public Health England 2020).

In summer 2020, NHS England and NHS Improvement (2020a, b) asked all NHS organisations to take several urgent actions to make progress on health inequalities and prevention. This included identifying a 'named executive board-level lead for tackling inequalities' (referred to as HI leads hereafter) by October 2020. The NHS Race and Health Observatory commissioned this mixed-methods study in April 2021, to provide a basis for planning what support would enable HI leads to create impact through their roles.

Building on The King's Fund's earlier collaborative report with the NHS Race and Health Observatory, *Ethnic health inequalities and the NHS: driving progress in a changing system* (Robertson et al 2021), we used interviews, focus groups and a survey with HI leads to explore their motivations, activities and support needs. This report draws on our findings to make recommendations about support, knowledge and learning interventions as well as the importance of an enabling political and policy environment and accountability framework.

While the recommendations are based on what we heard from HI leads, due to limitations of sample size, [1]the report is intended as the starting point for further engagement to co-produce an accessible and useful support offer.

Footnote

[1] Invitations to participate in the study were sent to more than 350 NHS organisations, and resulted in 40 people engaging in interviews and focus groups, and 45 responses to the survey. As such, the sample size for this study is too small to generalise about the views of the whole HI leads group.

Summary of recommendations

This report makes five key recommendations, which are explored in more detail in the following sections. All of these actions should be aligned with the NHS' existing work to support chairs and non-executive directors in tackling health inequalities, including the leadership framework that is currently being developed.

Many HI leads report high levels of personal or professional interest in inequalities and good engagement among board colleagues. To support HI leads and their teams to create impact, we recommend that NHS England and NHS Improvement put in place/continue to provide the following.

- An induction offer including role guides, example activities and measures, and signposting to knowledge and support resources. These could be co-produced with HI leads based on their experience so far.

- National and local action learning sets to develop capability and explore the specific challenges HI leads are facing. These could be developed into communities of practice or learning/improvement collaboratives, as the start of a social movement within the health and care system.

- A repository of high-quality evidence, knowledge resources, methods and regularly updated case studies that reflect the progress that's being made. These could be tailored to different professional groups and, in time, could be supplemented by facilitated reading or study groups and a non-mandatory qualification for those who wish to take their learning further.

Further, if addressing inequalities is one priority among many that board members are dealing with, these recommendations are likely to have more impact if there is a clear political and policy commitment to working on inequalities. We therefore also recommend the following.

- A long-term policy focus and a cross-government strategy that places addressing inequalities at the heart of system development. This could include establishing HI leads as critical members of emerging integrated care system (ICS) structures, eg, within place-based partnerships.

- An enabling accountability framework that puts inequalities on an equal footing with the most important performance metrics, and encourages innovation and experimentation to reflect the complex nature of inequalities. While potentially involving significant changes in local, regional and national approaches to managing performance, this may give more weight to the effort being made by those who are already more engaged, while also helping to overcome scepticism about the longevity of the current focus on inequalities.

Clarifying HI leads' roles: activities, measures and signposting to support

Organisations are setting up the HI lead role in a wide range of ways. Some have prioritised alignment with existing portfolios, eg, with medical directors, or directors of public and population health; others have chosen to make chief executives or chief operating officers the HI lead because of the organisation-spanning opportunities these create to embed inequalities in all work areas. Some organisations have defined portfolios of work, and for others, this is still emerging. These differences may be due to differences in organisational governance structures, how work on inequalities has historically been shared between system partners, as well as organisational pressures and priorities. These local differences mean what works in one place may not work in others.

Clarity about roles and sufficient time to do the necessary work are both seen as important for board effectiveness (Cornforth 2001), and while some HI leads are using the freedom that their role currently offers to innovate, we also heard that more guidance would be helpful – this was especially the case for those new in role, or those without a relevant professional background. This guidance could include how roles can be structured and shared with board colleagues, and what activities and outcomes could be involved in the role.

We heard that many of the HI leads were highly motivated to work on inequalities because of their professional background or personal experience. Any guidance should therefore aim to help those who may be less clear about what their role could involve, but not stifle the creativity and innovation currently happening in some places. It could helpfully be co-produced with HI leads to make sure it is useful and relevant.

The following two figures bring together examples of activities and conceptions of impact we heard about from HI leads and could be developed further through engagement and co-design.

- Figure 1 shows activities mapped to the cycle of board activities framework developed by Mannion et al (2015).
- Figure 2 shows example process and outcomes measures.

Further, there were also varying levels of awareness and participation in existing support (eg, webinars and learning sets) offered by NHS England and NHS Improvement. An induction offer could signpost to these (and related programmes) more clearly.

Figure 1 Example activities described by study participants, mapped to board activities framework (Mannion et al 2015)

	Short-term focus	Long-term focus
External focus	**Accountability** • Providing visibility and assurance to the board • Role modelling, challenging and advocating for addressing inequalities in the organisation and in systems • Providing assurance to regulators and ensuring compliance, • eg, in relation to elective recovery • Monitoring changes in compliance requirements • Embedding inequalities into system work	**Policy formulation** • Establishing long-term vision, mission and ambitions, including with system partners (as employers, as care providers and as anchor institutions) • Deepening understanding of inequalities and 'causes of causes', including integrating multi-sector data sets • Establishing a theory of change • Establishing governance, frameworks and standards • Setting targets, eg, for employment and service provision • Establishing training and support structures
Internal focus	**Supervision** • Championing and enabling work on health inequalities in organisations and systems, including at service level, in designing service provision, and workforce development • Creating momentum and enthusiasm, and maintaining focus • Trying to create an inequalities mindset • Ensuring equity of access, experience and outcomes for patients and staff, including in response to Covid-19 • Securing and managing resources focussed on inequalities • Ensuring responsibilities and work areas are clear • Creating implementation plans, supporting problem-solving, monitoring progress, and measuring impact	**Strategic thinking** • Providing strategic direction, leadership and alignment across multiple new and existing programmes, preventing scope creep, within the organisation, in systems and across regions • Working closely with system partners, especially public health and population health colleagues • Supporting data collection and analysis to inform decisions • Navigating policy or political dilemmas about priorities and • resource allocation, especially in the context of vested • interests in the status quo • Convening stakeholders, eg, though programme boards or multi-sector stakeholder groups • Learning from others

Figure 2 Example process and outcome measures for HI leads, as described by study participants

Processes

Short-term measures
- Addressing current access and experiences inequalities at service level (eg, elective restart and vaccine uptake)
- Process metrics for eg, prevention and screening services, workforce metrics and COVID-19 vaccinations
- Reaching groups who tend to be excluded
- Starting pilots - service and recruitment/ employment

Enabling action
- Agreeing the performance/assurance/ outcomes framework
- Improving quality and join up of data (quantitive and qualitative)
- Improving understanding of needs
- Agreeing priorities

Board Specific
- Awareness raising/visibility of inequalities eg, in board conversations
- Increasing interest of board collegues (eg, more questions/scrutiny)
- Improving understanding of relationship between population inequalities and workforce equalities
- Establishing governance and policies
- Establishing training and development infrastructure

Medium-term measures
- Culture shift to strategically embedding HI in all change
- System ownership
- Community and citizen engagement

Longer-term measures
- Shift in resources to greatest need
- Improved life expectancy
- Impact on long-term conditions
- Improvements in wellbeing, housing, employment and education

Outcomes

- Equitable access and experience for under-represented groups
- Improved diversity from board to ward, and in training

Offering support

HI leads described a wide range of support that they would find helpful, though it was also clear that many were very short of time. Offers therefore need to be both accessible and optional and respond to the diversity of levels of HI leads' experience and responsibility.

Collaborative learning opportunities

The scale and variety of the tasks involved in addressing health inequalities is vast and neighbourhoods, places, systems and regions all have different issues which makes replicating what has worked in one place difficult in another. We therefore recommend that action learning sets both nationally and in meaningful local geographies should be offered to HI leads and their teams and system partners as forums for sharing ideas, developing collective and distributed models of leadership, thinking through the challenges of scale, variation and localism, and getting support if they encounter resistance.

In time, these networks could be developed further into communities of practice or learning/improvement collaboratives organised around clearly identified improvement goals (see box). These forums could involve regular input from experts from within and beyond the NHS and outside of England, training in key improvement or leadership skills, buddying, group coaching, learning exchange visits and the showcasing of progress.

Action learning: a method of collaborative learning where small groups meet regularly to help each other to act on real work issues through reflection and questioning rather than giving advice (eg, Pedlar 2012).

Communities of practice: groups of people who share a common interest and improve their practice by interacting regularly with each other, sharing knowledge, experience and resources, and mapping and capturing learning (eg, Lave and Wenger 1991).

Learning/improvement collaboratives: structured approaches to bringing people together regularly on a specified topic to and share learning and make progress towards a goal over a defined period. Typically, the group will have access both to experts in the area to be improved, and to experts in application (eg, Institute for Healthcare Improvement 2003).

Accessible, up-to-date knowledge resources

We heard that HI leads and their teams would find high-quality evidence, knowledge resources, and up-to-date case studies in accessible and digestible formats useful to fill their knowledge gaps and get ideas. As part of the study, we heard many examples of innovation and progress that others would benefit from knowing about.

We recommend that a **repository of knowledge resources** is created, including introductory and more advanced content that can be used for self-managed learning by different groups of professionals. In time, this could be supplemented by **reading or study groups**, a **qualification** to support those who want to further advance their learning and share it with others, or a training/development offer that HI leads could offer to their boards.

There were mixed opinions about the value of formal training for this role. Some felt that addressing inequalities was about a mindset, and so consciousness-raising experiences (Mirvis 2017), eg, hearing the lived experience of those experiencing inequalities, or learning with others in similar roles (using action learning or similar methods), might be more useful than more traditional forms of training by 'experts'. Others thought that training was important and potential topics were:

- the role of system partners, including citizens, in addressing health and wider inequalities
- creating sustainable economies
- the relationship between population and workforce inequalities
- structural inequality and bias
- combining datasets across sectors, data analysis and interpretation
- supporting communities to improve health
- listening and learning from communities
- embracing complexity
- working with relational dynamics.

Wider considerations

We heard that interventions to support HI leads may have limited impact if the focus on inequalities was seen to be short term or tokenistic, or if NHS organisations were thought of as being able to create impact in isolation from partners responsible for education, jobs and housing. Organisational commitment at all levels, the support of local partners, political appetite (especially at national level) and resources (especially data, evidence and staffing) were all important additional factors to consider. To that end, we re-emphasise the wider recommendations from our previous report (Robertson et al 2021) and make the following further recommendations.

A long-term policy focus

Addressing inequalities is a long-term endeavour and we reiterate The King's Fund and the NHS Race and Health Observatory's calls for a cross-government strategy on health inequalities (Robertson et al 2021; The King's Fund 2020) to ensure continued policy focus. This, together with assurances about political cover, especially nationally, for unpopular but necessary decisions, may help to maintain leaders' attention and overcome some of the scepticism and cynicism we heard. This means support is not just about helping individual HI leads to have impact, but rather about sustainably increasing system capability overall.

One practical way to do this could be to ensure that HI leads are established as critical members of emerging ICS structures, eg, within place-based partnerships.

An enabling accountability framework for organisations or systems

Appreciating the likely range of levels of interest and motivation in the whole group of HI leads, national bodies could consider how they both harness the intrinsic motivation of those who are already motivated by the inequalities agenda and encourage those who are less motivated to become engaged. Creating a sense of common endeavour around social justice in organisations and between system partners requires a different tone and approach, which should ideally run through all aspects of national and regional policy and regulation.

The 'hardwiring' of health inequalities in the 2021/22 priorities and operational planning guidance (NHS England and NHS Improvement 2021) is a welcome signal in this regard and it will be important that these accountabilities are given the same prominence as other performance metrics. However, treating health inequalities with the same attention as other metrics (eg, elective waiting times or A&E targets) is difficult. This is due to their long-term nature, the multi-sector collaboration we heard was needed to address them, and the complexity of the relationship between interventions and outcomes.
The emerging ICS structures provide an opportunity, eg, through place-based partnerships, to meaningfully embed a focus on inequalities in the next phase of the health and care system's development. A clear and ongoing commitment from politicians, policy-makers and regulators, will help those who are already motivated to go as fast and as far as possible, as well as persuading sceptics that inequalities really are a priority for the long term.

Conclusion

This report draws on the breadth of opinions we heard from HI leads about what would help them to have impact. A common thread throughout is that inequalities have long, deep and complex roots, and that tackling them needs sustained, multi-sector focus over a long time. Inequalities are unlikely to be amenable to silver bullets or pivotal actions, and we heard that access to evidence, improvement methods, space for experimentation and innovation, and the sharing of good practice would all be welcome.

The events of the past 18 months have created a unique moment where inequalities – both in populations and in the workforce – have come to the fore, despite having been on the public sector agenda for many years. Rather than having to push for interest, organisations are more likely than ever to be looking for solutions.

To that end, the people who are already ahead might benefit from being encouraged to do as much as they can in their localities, and to share what they are learning with others who are still working out what to do. This may, in time, develop into a movement, led by senior public sector leaders who can inspire and encourage others.

Of course, there are likely to be some – perhaps many – who lack the intrinsic motivation or are cynical about the current focus on inequalities, thinking it might be a fad or tokenistic. In these cases, a stronger accountability framework for organisations and systems, a long-term policy focus, and political cover will keep attention on inequalities, especially if they are given the same prominence as other performance indicators.

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