Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

DBTH Tackling Health Inequalities

Strategy 2023 – 2028

Contents

Foreword

I am pleased to present Doncaster and Bassetlaw Teaching Hospitals' (DBTH) first Health Inequalities Strategy, marking a significant step forward in our commitment to working to address the disparities in health outcomes within our communities. This strategy is a testament to our dedication to the principle that everyone deserves an equal opportunity to live a healthy life.

It is completely unreasonable that someone's ethnic background or place of birth could be a determinant of their health. The urgency of DBTH's mission to address this is clear within the statistics, which shows over 40% of the Doncaster and 21% of the Bassetlaw populations live in some of the most deprived circumstances. Life expectancy for both males and females in these areas is lower than the national average, with many living for many years of their lives in ill health.

This strategy is our proactive response to these challenges, acknowledging the societal, economic, and health system costs associated with health inequalities. The strategy recognises the need for a fundamental shift in the way we operate, emphasising the importance of targeted support based on individual needs. By addressing systemic barriers and focusing on equitable access, we can make substantial strides in reducing health inequalities.

Aligned with national and local plans, to avoid duplication and to maximise collective resources, the strategy outlines key focus areas for the next five years, covering prevention, elective care pathways, urgent and emergency care, maternity and best start in life, children and young people, and research and innovation. It also focuses on enhancing awareness and understanding of health inequalities among our staff.

In line with the nature of the strategy, this is the first of our strategies developed to be fully accessible; meaning it can be put into digital software, such as a screen reader, or translation software, and be converted to be understandable format for a range of communities, something we are committed to do with all future strategies.

Thank you to everyone involved in shaping, reading and committing to the delivery of this strategy. It reflects our shared commitment to a healthier, fairer future for all of our communities.

Sincerely,

Richard Parker
Chief Executive
Doncaster and Bassetlaw Teaching Hospitals

Executive Summary

Health inequalities are "avoidable, unfair and systematic differences in health between different groups of people". They mean that some population groups have significantly worse health experiences and outcomes than others. These differences can be due to a range of factors including a person's social, economic and environmental circumstances – and we know that greater deprivation in any of these factors is associated with an increased risk of becoming ill earlier and dying younger. People with certain characteristics, such as certain ethnicities, sexual orientation, age, and disabilities, also have a lower chance of living a long and healthy life compared to others. This is often due to the exclusion from society that people with these characteristics face.

At Doncaster and Bassetlaw Teaching Hospitals Foundation Trust (DBTH) we want to do all we can to tackle unfair health inequalities so have developed this strategy with the aim to **embed the reduction of health inequalities in everything we do to ensure equitable access and excellent experience, thereby providing optimal outcomes for our patients and the communities that we serve.** In order to achieve this aim, our strategy has set out 6 priority areas of focus which include:

1. **Prevention**
2. **Elective care pathways / recovery**
3. **Urgent and emergency care pathways**
4. **Maternity and best start in life**
5. **Children and young people**
6. **Research and innovation**

The 6 priority areas are underpinned by 1 base and 5 pillars. The base provides the foundation to the delivery of this strategy and refers to enhancing our communications, awareness and education of health inequalities for our people, our patients and our local communities. The 5 pillars encompass behaviours, models of practice and a general ethos/ culture shift which when implemented will support all the work across all 6 priority areas. These pillars include:

1. **Understanding our communities** – to ensure accurate, complete and timely access to population health data in conjunction with community voices to better understand the health inequalities and where to focus our action.
2. **Connecting people** – to work closely with partners and build on existing relationships, networks, and trust. This will ensure work is aligned and supported and will prevent silo-working allowing health inequalities to be addressed using a whole system approach.
3. **Model of delivery** – to move towards a more needs-led, compassionate social model of care and to use co-production to improve existing services and/or develop new services based on the needs of our communities.
4. **Access to and experience of services** – to focus on the Core20PLUS5, ensuring targeted support is provided for the Core20 and PLUS groups, including inclusion health groups, particularly (but not exclusively) across the 5 service areas for adults and children and young people.
5. **Leadership and accountability** – strong leadership and clear accountability and governance structures will support a culture shift and help to embed health inequalities in everything we do, acknowledging that our staff may also be experiencing health inequalities.

DBTH's Tackling Health Inequalities Strategy: 1 Base, 5 Pillars and 6 Priority Areas:

Base

To enhance communications, awareness, and education of health inequalities.

Pillars

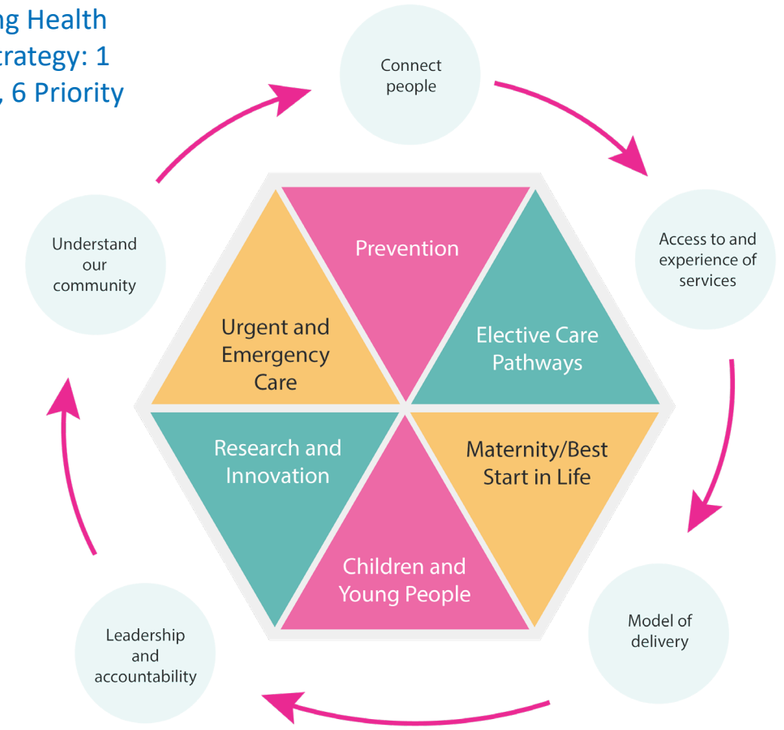
Our pillars are circular and interconnect with one another.

- Understanding our communities
- Connect people
- Access to and experience of services
- Model of delivery
- Leadership and accountability.

Priorities

- Prevention
- Elective Care Pathways
- Urgent and Emergency Care
- Maternity/Best Start in Life
- Children and Young People
- Research and Innovation

DBTH's Tackling Health Inequalities Strategy: 1 Base, 5 Pillars, 6 Priority Areas



Enhance communications, awareness and education of health inequalities

To support the delivery of our strategy, we have also provided a 3-tier framework. The framework outlines work that we can do to tackle health inequalities by: 1) increasing support/developing new services, 2) improving our existing services, and 3) influencing the wider determinants of health in our Anchor Institution role. This framework will support teams, services, and divisions to guide thinking/act as a prompt for action.

We have also developed an associated action plan which outlines our planned areas of work, associated key performance indicators and anticipated timeframes for completion.

Three-tier framework

DBTH's 3-tier framework for improving health and tackling health inequalities (adapted with permission from Barnsley's Integrated Care Partnership framework)

Tier 1 -

Increase support

The first layer of action is to increase engagement, opportunities, services and support to address the key drivers of health inequalities for people in need and making every contact count.

To ensure people have access to support that prevents them getting sick and reduces the drivers of inequality in their life, we need our teams (both clinical and non-clinical) across the Trust to be discussing health inequalities, to highlight where gaps in knowledge may be and/or to identify potential areas for improvement.

Tier 2 -

Improve care

The second layer of action is to improve all health and care services in such a way that they are targeted to greatest need and reduce inequalities in care.

To ensure that DBTH does all that it can to provide care and support to those with the greatest need first, teams / services should consider reframing the phrase "hard to reach groups" to instead answer the question "why are our services often hardest to access for the people who need them most?"

Tier 3 -

Influence others

The third layer is to influence those differences in health which are linked to things like housing conditions, the quality of green spaces and clean air, education and income, i.e. the wider determinants of health, by becoming the best anchor institution we can be and advocating for health equity across all sectors.

To ensure that due consideration is given to the impact that the Trust has on health and wellbeing by means other than the services it delivers, which can lead to huge impacts and far-reaching benefits.

Key Terms

Some key terms are (Office for Health Improvement and Disparities, 2021):

- **Health Inequalities:** Avoidable differences in health outcomes between groups or populations – such as differences in how long we live, or the age at which we get preventable diseases or health conditions.
- **Equity:** We want fair outcomes for everyone. What is important is addressing avoidable or remediable differences in health between groups of people. To achieve health equity, some groups may need more or different support or resources to achieve the same outcomes. Ideally, the barriers to good health would be removed for everyone, so adjustments wouldn't be required – however, this is not always possible.
- **Equality:** We want everyone to have equally good health. However, the term 'equality' is sometimes used to describe equal treatment or access for everyone regardless of need or outcome.
- **Access:** Ensuring everyone can access services equitably (that is according to need) is a key priority for the NHS. To achieve this, consideration needs to be given to access to information, services and support. Central to this is enabling people to access the right service at the right time for them, reducing variation in the avoidable use of urgent support such as accident and emergency services through better access to preventative care.

Introduction

Welcome to DBTH's new Tackling Health Inequalities Strategy!

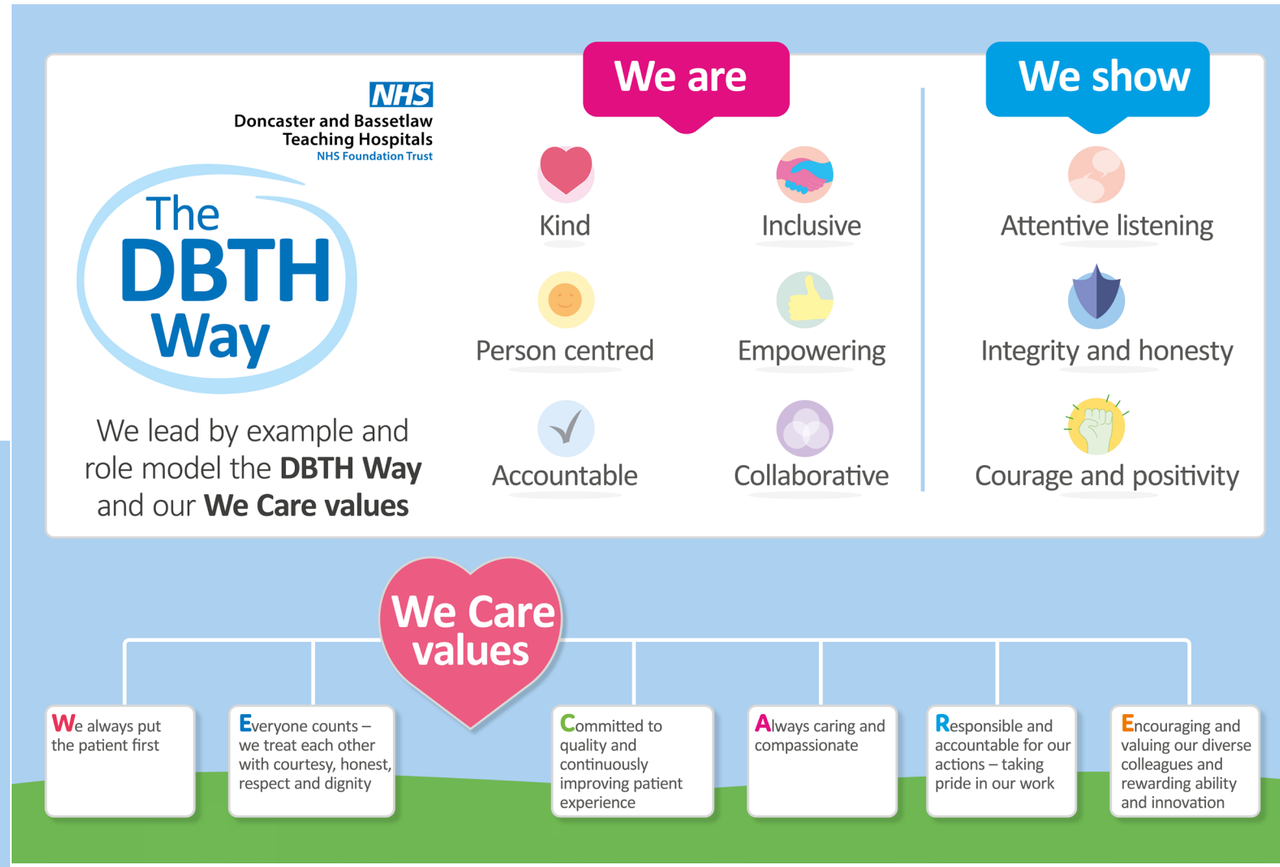
At Doncaster and Bassetlaw Teaching Hospital Foundation Trust (DBTH), we have the vision of being "the safest Trust in England, outstanding in all we do". The Tackling Health Inequalities Strategy described in this document is aligned to this vision and to the True North objectives of the Trust (to provide outstanding care and improve patient experience; everybody knows their role in achieving the vision; feedback from colleagues and learners is in the top 10% in the UK; the Trust is in recurrent surplus to invest in improving patient care).

Our Vision

To read about our core values and vision, visit https://www.dbth.nhs.uk/about-us/our-values-and-vision/

This strategy also aligns closely to the DBTH Way and our We Care values. Leading by example and role-modelling the DBTH Way and our We Care values will provide an appropriate ethos and a supportive environment for health inequalities work to be undertaken more effectively.

DBTH Way



To read about the DBTH Way, visit https://www.dbth.nhs.uk/about-us/our-values-and-vision/

What are Health Inequalities?

Health inequalities are "avoidable, unfair and systematic differences in health between different groups of people" (The Kings Fund, 2022). They mean that some population groups have significantly worse health experiences and outcomes than others. These differences can be due to a range of factors including a person's social, economic and environmental circumstances – and we know that greater deprivation in any of these factors is associated with an increased risk of becoming ill earlier and dying younger. People with certain characteristics, such as certain ethnicities, sexual orientation, age and disabilities, also have a lower chance of living a long and healthy life compared to others. This is often due to the exclusion from society that people with these characteristics face.

Comparing life expectancy in Doncaster and Bassetlaw between the most and least deprived communities:

In Doncaster: men living in the most deprived areas die on average 10 years earlier than men living in the least deprived areas; for women this difference is 8 years.

In Bassetlaw: men living in the most deprived areas die on average almost 8 years earlier than men

living in the least deprived areas; for women this difference is 6 years.

A wide range of factors influence our ability to be healthy. These factors often overlap with each other and are often outside the control of individuals themselves.

Figure 1 below demonstrates the complex interplay between the wider determinants of health (e.g. income, housing, built environment, education), psychosocial factors (e.g. isolation and social support), health behaviours (e.g. smoking, drinking alcohol), and the resulting physiological impacts (e.g. high blood pressure, anxiety and depression).

Systems map of the causes of health inequalities
The following factors are interlinked and can impact one another.

Health and Wellbeing

Physiological impacts

- High blood pressure
- High cholesterol
- Anxiety/depression

Health behaviours

- Smoking
- Diet
- Alcohol

Psycho-social factors

- Isolation
- Social support
- Social networks
- Self-esteem and self-worth
- Perceived level of control
- Meaning/ purpose of life

Wider determinants of health

- Income and debt
- Employability / quality of work
- Housing
- Education and skills
- Natural and built environment
- Access to goods / services
- Power and discrimination

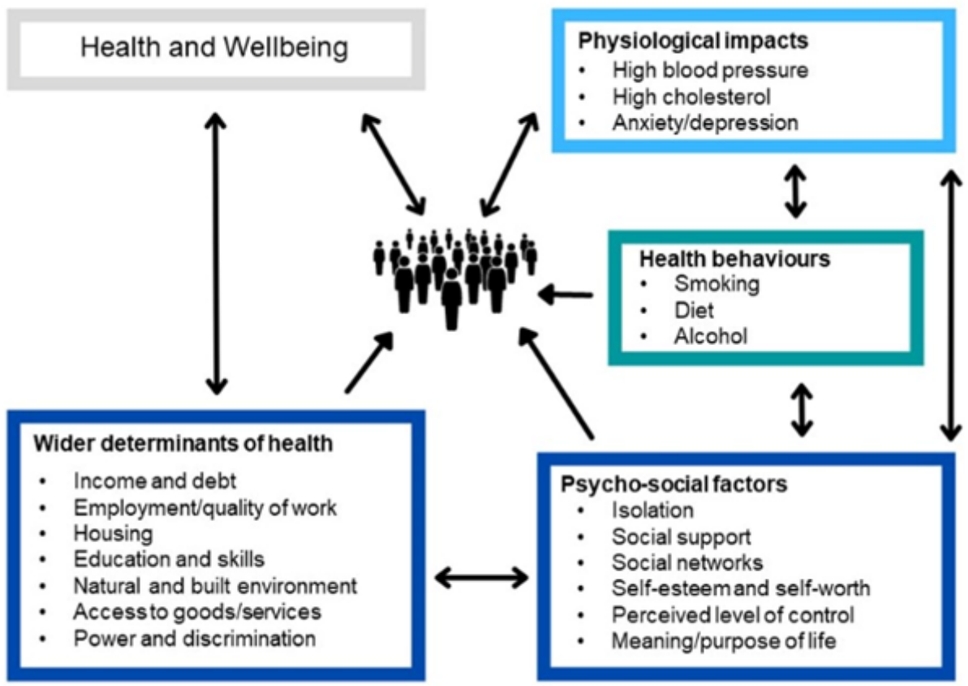


Figure 1: System map of the causes of health inequalities (Office for Health Improvement and Disparities, 2022)

Why do we need to tackle Health Inequalities?

Addressing health inequalities is a matter of social justice - some have less health than others and that is largely to do with structural factors not individual choices. It is unfair that just by virtue of someone's ethnic background or place of birth they should experience poorer health.

In addition, these avoidable differences in health pose a huge cost to societal, economic and health systems. Health inequalities contribute to increased demand for healthcare – as investment and action in the cost-effective approaches to maintain health and wellbeing shrinks, the need for less cost-effective diagnostic and treatment services grows. When wider costs are factored in, such as loss of workforce productivity, the overall economic burden of preventable and premature illness is staggering – around £31 billion a year in lost productivity and between £20 and £32 billion a year in lost tax revenue and benefit payments (Public Health England, 2021). What does this mean for the NHS? The higher burden of disease experienced by women living in the most deprived neighbourhoods costs the NHS 22% more per person than women living in the least deprived neighbourhoods, despite having shorter life expectancy (or £400 per person per year in secondary care costs). For men, this figure is 16% per person (or an additional £300 per person per year in secondary care costs). This results in an additional spend of £4.8 billion per year, almost 20% of the total hospital budget (Asaria M, 2016), without taking into account additional costs, including social care provision.

Health is therefore a major determinant of economic performance and prosperity. Consequently, taking action on health inequalities:

- improves the quality of lives of individuals
- reduces cost to the NHS and social care system of treating and caring for people with preventable conditions
- benefits the wider economy (Marmot, 2010).

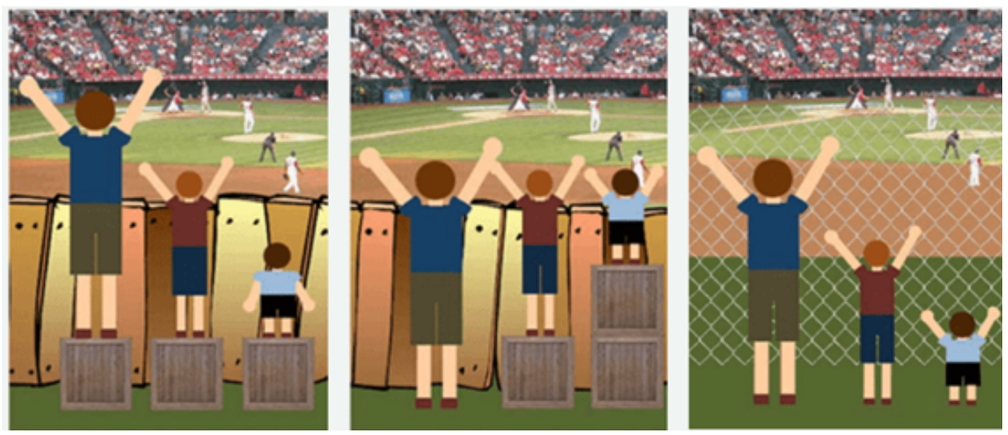
Much of the way our national and local systems have been set-up has inadvertently contributed to the increase in health inequalities – we therefore need to do things differently. Figure 2 (see page 12 below) demonstrates the difference between equality and equity. By treating people equally, e.g. offering an NHS which is free at the point of use to all (or providing everyone with the same sized box to see the ball game, as per the first image in Figure 2), we are assuming everyone has the same ability to access our services. In reality, some groups have significant barriers to accessing healthcare, such as physical disabilities, poor mental health, language or cultural barriers, mistrust of healthcare systems, inability to pay for transport to get to hospitals, other more significant life priorities, e.g. caring responsibilities, work, finances etc. By treating everyone equally, we are contributing to the widening of health inequalities as we're not taking into account these systemic barriers – those who can, will access health services and get better health outcomes as a result; those who can't, will be left with worsening health issues.

Instead, if we offer more targeted supports for those who need it, i.e. if we treat people equitably based on their needs, then we can help to ensure equal access (or providing the right number of boxes to each person to ensure they can see the ball game equally well, as per the second image in Figure 2), which in turn will help to reduce health inequalities.

The third image in Figure 2 is where we should aspire to be – the systemic barriers (in this case the wooden fence) have been removed so no extra supports are needed as everyone can see the ball game equally well already. It is predominantly national level shifts in policy and infrastructure change that are needed to remove the systemic barriers and address the cause of the inequalities, however, there are lots of things we can do locally which will make a difference. This strategy therefore highlight's DBTH's commitment to tackling health inequalities and lays out the key areas of focus for DBTH for the next five years.

Equality versus equity

Figure 2: Equality and equity explained



In the first image, it is assumed that everyone will benefit from the same supports. They are being treated equally.

In the second image, individuals are given different supports to make it possible for them to have equal access to the game. They are being treated equitably.

In the third image, all three can see the game without any supports or accommodations because the cause of the inequity was addressed. The systemic barrier has been removed.

Health Inequalities in Doncaster and Bassetlaw

Table 1 (see page 13 below) presents a few key figures which demonstrate the extent of some of the health inequalities facing people from Doncaster and Bassetlaw. To summarise:

- Over 40% of the Doncaster population and 21% of the Bassetlaw population are living in the 2 most deprived Index of Multiple Deprivation (IMD) deciles nationally, i.e. the "Core 20".
- In Doncaster, almost a quarter of our children are living in low-income families, and in Bassetlaw it's almost a fifth.
- In terms of life expectancy for males and females, both Doncaster and Bassetlaw are lower than the national average.
- The difference in life expectancy from the most to the least deprived areas in Doncaster is almost 10 years for males and 8 years for females. For Bassetlaw, the differences in life expectancy from the most to least deprived is almost 8 years for males and 6 years for females. Just to put that into context – a man from the most deprived area of Doncaster is living on average 11 years less than a man from the least deprived area. Similarly, a man living in the most deprived area of Bassetlaw is living on average 9 years less than a man from the least deprived area.
- Healthy life expectancy for males and females in both Doncaster and Bassetlaw is lower than the England average and if we just pull out the data here for females in Doncaster, we can see that the amount of time females are living in good health (i.e. their healthy life expectancy) is 56 years, but their average life expectancy is 81 years. This means that they are living for on average 25 years in poor health and during that time, will likely be accessing a range of health services.

Health inequalities in Doncaster and Bassetlaw

	Doncaster	Bassetlaw
% living in IMD Decile 1 (most deprived)	25.0%	8.0%
% living in IMD Deciles 1 & 2 (Core20)	41.3%	21.4%
% children (<16y) in low-income families	22.6%	16.0%
Life expectancy (LE) males (78.7y England)	77.8y	78.9y
LE females (82.7y England)	81.0y	82.0y
Diff in LE from least to most deprived males	10.0y	7.6y
Diff in LE from least to most deprived females	8.2y	5.8y
Healthy life expectancy males (63.1y England)	57.4y	62.0y
Healthy life expectancy females (63.9y England)	56.1y	61.9y

Table 1: Data demonstrating some of the health inequalities in Doncaster and Bassetlaw (Office for Health Improvement and Disparities, Fingertips, Public Health Data 2018-20)

Our Strategy

Our Tackling Health Inequalities Strategy 2023-2028 has been developed in alignment with various other national and local plans/strategies. By aligning our strategy with others, we will ensure that we are not producing a "standalone" strategy, but one that is working alongside and with our partners across the system. This will mean that work is not duplicated and where relevant we can collaborate, share resources (human and financial), and provide support when needed. Other plans and strategies we have considered during the development of our strategy include:

- The NHS Long Term Plan, which clearly sets out commitments for action that the NHS needs to take on improving prevention and tackling health inequalities
- NHS England's "Tackling inequalities in healthcare access, experience, and outcomes: Actionable Insights"
- Core20PLUS5 – a national framework for addressing healthcare inequalities
- NHS South Yorkshire Integrated Care Board (ICB) NHS Joint Forward Plan for South Yorkshire
- NHS Nottingham and Nottinghamshire ICB NHS Joint Forward Plan
- Doncaster 1 Plan 2023/24
- Bassetlaw Place Plan

It's worth highlighting the detail relating to the Core20PLUS5 framework as we will draw on this throughout our strategy.

Figure 3 (see page 14 below) depicts the Core20PLUS5 framework for adults. The "Core20" refers to the most deprived 20% of the national population as identified by the Index of Multiple Deprivation (IMD). The key word there is national. For clarity, the IMD score ranks small geographical areas from most to least deprived. It then groups them together into 10 equal groups (or deciles) – from 1 (most deprived) to 10 (least deprived). The 20% most deprived areas nationally are therefore those in deciles 1 and 2. However, in Doncaster,

for example, 41% of our population fall into the 2 most deprived deciles nationally (as shown in Table 1 above).

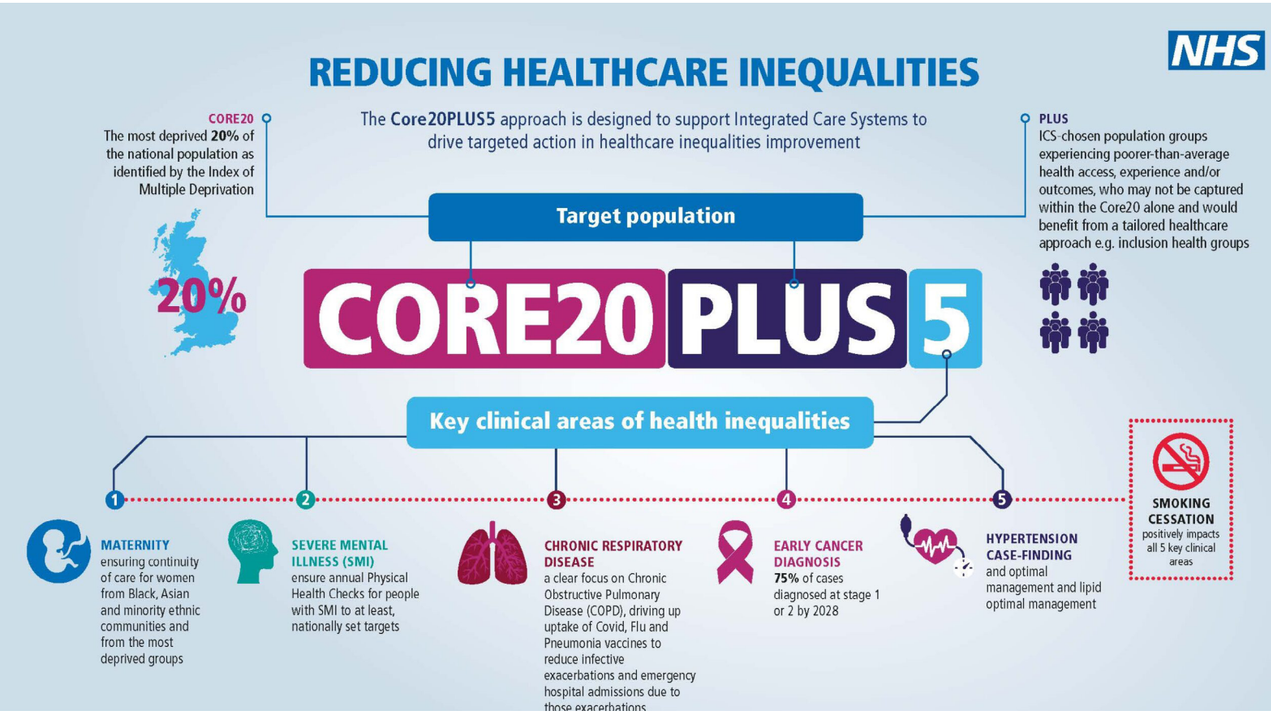
The "PLUS" refers to chosen population groups experiencing poorer than average health access, experience and/or outcomes who may not be captured in the Core20 alone and would benefit from a tailored healthcare approach. See appendix 1 for a list of "PLUS" groups (please note, this is not an exhaustive list). "PLUS" groups can include people with a protected characteristic, people in socio-economically deprived populations, people from specific geographies (the places where we live), e.g. urban/rural/coastal locations, and inclusion health and vulnerable groups, e.g. Gypsy, Roma, Traveller communities, people experiencing homelessness, offenders, sex workers. When individuals, groups or communities face more than one of these issues (intersectionality), then the risk of health inequalities is further increased.

The "5" refers to 5 key clinical areas of health inequalities and includes:

1. Maternity services
2. Severe mental illness
3. Chronic respiratory disease
4. Early cancer diagnosis
5. Hypertension case-finding

Finally, smoking cessation has been identified as something that would impact all 5 key clinical areas.

Figure 3: Core20PLUS5 framework for adults (Nov 2021)

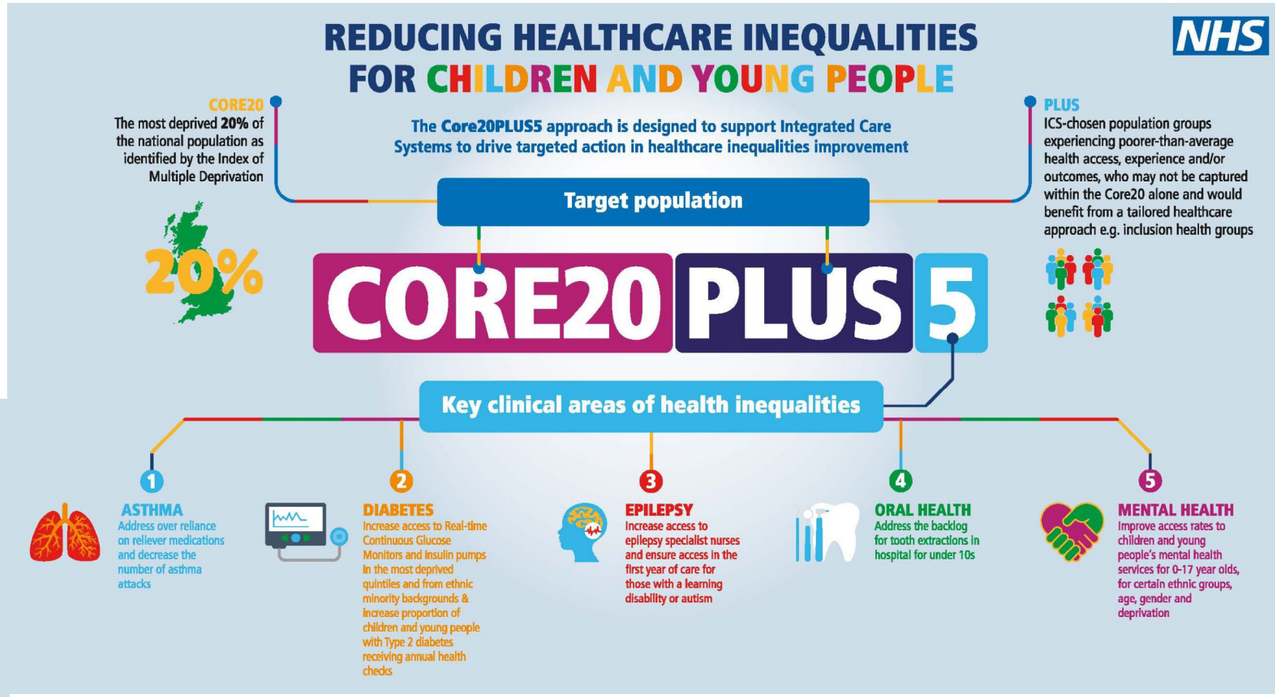


To read about the Core20PLUS5 framework, visit https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

Figure 4 shows the Core20PLUS5 framework for children and young people. The "Core20PLUS" elements are the same as for the adults (although we may wish to focus on different "PLUS" groups than those for adults), but the 5 key clinical areas are different, and include:

1. Asthma
2. Diabetes
3. Epilepsy
4. Oral health
5. Mental health

Figure 4: Core20PLUS5 framework for children and young people (Nov 2022)



To read about the Core20PLUS5 framework for children and young people, visit https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/

We have also reviewed some of our own strategies/ plans and feel that our Tackling Health Inequalities Strategy has clear links with DBTH's:

- **Quality Improvement and Innovation (Qii) Strategy 2023-2028** – The Qii Strategy has directly referenced our Tackling Health Inequalities Strategy and identified the synergies between the two. In particular, there are synergies between the co-production and leadership elements of the Qii Strategy and our 5 pillars (details to follow). Furthermore, health inequalities training is being included within Qii training to ensure that health inequalities are considered during any improvement initiative. We also intend to use Qii approaches to support health inequalities-specific improvement initiatives.
- **DBTH Green Plan 2022** – There are direct links between the actions identified as part of the Green Plan and health inequalities. For example, decarbonisation decreases air pollution. The health consequences of air pollution disproportionally effect people from lower socioeconomic backgrounds, so reductions in carbon supports the reduction in health inequalities. There is also a clear focus on improving access to preventative health advice in the Green Plan, acknowledging that prevention of ill health will reduce service demand, which in turn will reduce the Trust's carbon emissions. Both the sustainability and health inequalities

work also feeds into the Anchor Institution agenda, and supports DBTH in being a "good" Anchor Institute.

- **People Strategy 2023-2027** – There are several elements of the People Strategy that link into/ complement our Tackling Health Inequalities Strategy, particularly when considering that many of our people are also our patients, so we need include tackling health inequalities for our people as well as our patients. Some of the elements that link to our strategy include: the focus on Just culture; education (90% compliance on SET training – questions relating to health inequalities is included within the SET training); the Equality, Diversity and Inclusion (EDI) work which involves embedding an inclusive culture, representative of the communities we serve, and enhancing our inclusive recruitment practices and in addition we are supporting the delivery of the health inequalities actions within the EDI Improvement Plan; workforce planning and development (apprenticeships), anchor institution and widening participation activities through access to education and employment opportunities.
- **Nursing, Midwifery and Allied Health Professionals Quality Strategy 2023-2027** – There are clear links to Strategic Theme 2, Patient Experience, particularly embedding patient involvement and co-design into our organisations policies and procedures and holding community engagement events to gain insights from groups who are seldom heard and/ or affected by health inequalities, and links to the Accessible Information Standard. There are also links to Strategic Theme 3, Clinical Effectiveness, where health inequalities could be embedded into the Qii methodology to improve care. Finally, Strategic Theme 5, Care of our Most Vulnerable Patients, which specifically highlights reducing health inequalities by promoting equitable access to healthcare.
- **Research and Innovation (R&I) Strategy 2023-2028** – This strategy has tackling health inequalities as a cross-cutting theme throughout. The aim is to ensure that the research and innovation undertaken at DBTH will consider the impact on health inequalities across the research / innovation pipeline, from design to delivery and through to adoption. An area of strategic priority for the R&I Strategy relates to improving patient outcomes throughout prevention, early diagnosis and better management of cardiovascular and respiratory diseases and cancer. This links into the prevention agenda and the Core20PLUS5 framework.

Our strategy has also been developed through engagement with DBTH colleagues and leaders and is in support of our True North objectives and our strategic aim to be "the safest Trust in England, outstanding in all we do". This is an ambitious strategy, designed to challenge, promote innovation, and support action.

The strategy will be supported by an action plan, which will provide details of what we will be doing to tackle health inequalities across six priority areas of focus over the course of the next 5 years.

The aim of our strategy is to embed the reduction of health inequalities in everything we do to ensure equitable access and excellent experience, thereby providing optimal outcomes for our patients and the communities that we serve.

There are 6 key priority areas our strategy focuses on:

- Prevention
- Elective Care Pathways
- Urgent and Emergency Care
- Maternity/Best Start in Life
- Children and Young People
- Research and Innovation

There is a great deal of existing work already going on within many of these priority areas. The health inequalities team intends to support and provide advice and expertise to these existing areas of work, to ensure that tackling health inequalities is embedded within the work. We can also support the development of specific initiatives to reduce health inequalities.

1. Prevention

Primary prevention of ill health means taking action to reduce the incidence of disease and health problems within the population by intervening before there is evidence of injury or disease. This can be achieved via universal measures that reduce risks and their causes, e.g. anti-smoking campaigns/ smoke-free hospital messages, or by targeting high-risk groups e.g. vaccinations.

Secondary prevention means systematically detecting the early stages of disease and intervening before full symptoms develop, e.g. taking measures to reduce high blood pressure and cholesterol to prevent the development of cardiovascular disease or screening for cervical cancer.

Tertiary prevention means trying to reduce the impact of an ongoing illness or injury that has lasting effects. This can be done by helping people manage long-term, often complex health problems and injuries to improve as much as possible their ability to function, their quality of life and their life expectancy. For example, supporting patients with asthma to stop smoking.

Within the priority area of prevention, there are several strands which we will focus on from a health inequalities perspective and these include (in alignment with the Core20PLUS5):

1. Smoking cessation (QUIT Programme)
2. Alcohol and substance misuse services
3. Cardiovascular disease – with a focus hypertension case-finding and interventions to optimise blood pressure and lipid optimal management
4. Chronic respiratory disease – particularly focusing on Chronic Obstructive Pulmonary Disease (COPD) to drive uptake of COVID, flu and pneumonia vaccinations to reduce frequency of infective exacerbations and emergency hospital admissions due to those exacerbations
5. Early cancer diagnosis – with a focus on meeting the target set by NHS England of 75% of cases to be diagnosed at stage 1 or 2 by 2028
6. Vaccinations – can we support, for example, the delivery of the MMR vaccine to improve uptake in young children (if presenting to our services) to reduce the rates of measles?

Prevention is also a thread running through all the other priority areas.

2. Elective care pathways / elective recovery

There are national targets that we need to meet regarding elective recovery. However, we must be mindful, that whilst striving towards meeting these targets, we do not want to further exacerbate the already widening health inequalities. A letter from Sir James Mackay (National Director of Elective Recovery, NHS England) to all acute trusts on 23rd May 2023 states, "Systems are expected to outline health inequality actions put in place and the evidence and impact of the interventions as part of their planning returns. Disaggregated elective recovery data should support the development of these plans". Therefore, elective recovery work needs to have the reduction of health inequalities embedded within it and be supported by accurate, complete, and timely disaggregated data (broken down by, as a minimum, age, gender, ethnicity and level of deprivation (IMD score)) so the impact on health inequalities can be monitored and evidenced. The health inequalities team can help and support existing work focused on elective recovery to ensure it is adequately considering the impact on health inequalities and putting in place mechanisms to support the reduction of health inequalities.

As part of the elective recovery, and a key priority of the Trust Board, is to reduce "Did Not Attend" (DNA) and "Was Not Brought" (WBA) rates. For context, as a Trust our DNA/WNB rates across all services sit above 9% each month, by reducing this number we could expect to see an increase in productivity, improved patient experience and reduced waiting lists. By developing an understanding of why some people DNA and by taking a health inequalities perspective, we could both reduce DNA/WNB rates and reduce health inequalities simultaneously. For example, it may be that for some people, the cost of public transport / a taxi is prohibitive and means they are unable to attend appointments. One potential solution to this would be to arrange suitable transport to targeted groups of patients for whom this would mean they could attend an appointment.

One particular issue to highlight when considering the reduction in DNA rates is the impact of digital exclusion (and inclusion for that matter). For example, one potential solution to reducing DNA rates may be to send every patient a reminder text message or email a few days before their scheduled appointment. However, this excludes those who do not have access to digital forms of communication, e.g. the elderly, or those living in poverty, thereby could in and of itself result in the widening of health inequalities. Conversely, people experiencing homelessness are not able to easily receive letters and hence often rely on digital forms of communication. This is why any such interventions need to always consider the impact on health inequalities.

There's also an opportunity to link in with the prevention priority area by considering "waiting well" initiatives. This could focus on patients who may be deemed "high-risk" of worsening health whilst waiting for an appointment/procedure.

It should be noted that any proposed changes to the elective care pathways will need close consultation and collaboration with our primary care colleagues, as well as ICB partners to ensure that there are no unintended consequences in other parts of the system or duplication of efforts.

3. Urgent and emergency care (UEC)

We know that health inequalities are impacting our UEC services and our UEC services are impacting health inequalities. Figure 5 demonstrates the relationship between emergency admissions and deprivation. The graph shows emergency admissions for all causes from 2013/14 to 2017/18 for South Yorkshire and Bassetlaw and highlights the fact that those from the most deprived areas are more likely to require emergency admission than those in the least deprived areas. Therefore, the health inequalities team will work with and support teams working on UEC pathways to ensure that we understand the current situation by obtaining accurate and timely disaggregated data (broken down by, as a minimum, age, ethnicity and IMD score), so that targeted improvements can be made.

Another more focussed initiative to incorporate into UEC pathways is "Making Every Contact Count (MECC)", so when patients present to our emergency departments, we have mechanisms in place to address other issues that they may be facing, e.g. lifestyle interventions (smoking cessation, alcohol and substance misuse, physical activity etc.), vaccination/screening catch-up, housing, finances, mental wellbeing. This could be in the form of simple signposting to different services or could incorporate the hosting of additional services, e.g. having a Citizens Advice presence within the department.

Targeting high intensity users, many of whom will likely be experiencing significant health inequalities, is another important strand of work within this priority area. British Red Cross research found that people who frequently attend A&E make up less than 1% of England's population but more than 16% of A&E attendances, 29% of ambulance journeys, and 26% of hospital admissions. Furthermore, the mortality rate among people aged 30-50 who frequently attend A&E is 7.5 times higher than among this age group in the general population and it is estimated that high intensity use of A&E services costs the NHS £2.5 billion per year (British Red Cross Research, Nowhere else to turn, Nov 2021). We will need to initially understand more about our high intensity users by analysing disaggregated data, to allow us to consider what initiatives we could implement to support these patients and support demand management in UEC. We can use data from ECIST (Emergency Care Improvement Support Team) to support this work.

Emergency admissions for all causes from 2013/14 to 2017/18

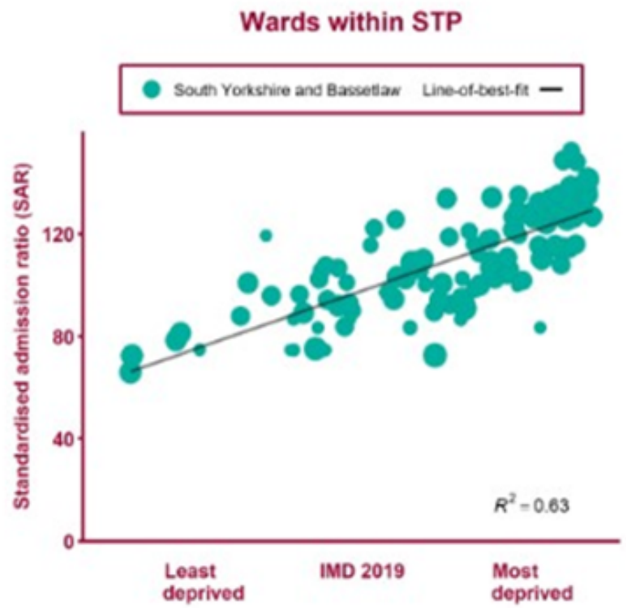


Figure 5: Graph showing a positive correlation relationship between emergency admissions and deprivation (provided by South Yorkshire ICB (when it was still SY & Bassetlaw ICB))

4. Maternity and best start in life

In line with the Core20PLUS5 framework and the South Yorkshire Local Maternity and Neonatal System (LMNS) Equity and Equality Plan 2022-2027 (which can be found here: https://syics.co.uk/lmns), we will support our maternity department to: improve equity for mothers and babies from Black, Asian, Mixed and minority ethnic backgrounds and those from the most deprived areas, and improve race equality for staff from minority ethnic backgrounds.

There are also some specific actions identified in the LMNS Plan, which the health inequalities team will further advise on and support. These actions include:

- Minimising the additional risk of COVID-19 to pregnant women and birthing people from ethnic minority backgrounds and their babies
- The use of personalised care and support plans following an initial assessment about the person's health and wellbeing needs.
- Access to accurate and reliable data relating to ethnicity and postcode.
- The development of maternal medicine networks, ensuring every pregnant woman and birthing person with medical problems has access to specialist advice and care.
- The use of midwifery continuity of care (MCoC) models which ensure that pregnant women and birthing people receive dedicated support from the same midwifery team throughout their pregnancy – this should be rolled out in a targeted way, prioritising those from Black, Asian, Mixed and minority ethnic backgrounds and those from the most deprived areas.
- Improving health – diabetes prevention programme, maternal mental health services, smoke-free pregnancy support, improving breastfeeding rates.
- Family support – antenatal care for pregnant women with complex social factors (e.g. drug or alcohol use, domestic abuse, migrants, asylum seekers or refugees), establishing community hubs in the areas of greatest need, addressing social determinants of health.

5. Children and young people (CYP)

For this priority area, we will be guided by the Core20PLUS5 framework. As outlined above, the "PLUS" groups for children and young people may be different to those we wish to use for adults. We therefore need to spend some time reviewing the data and consulting with colleagues and patients to understand which "PLUS" groups may be most relevant for us to focus on. For example, we may want to particularly consider children and young people with learning disabilities or neurodiversity, or children living in poverty.

The health inequalities team will work with the various paediatric teams to look at the 5 clinical areas (as per the Core20PLUS5):

1. **Asthma** – address the over-reliance on reliever medications and decrease the number of asthma attacks.
2. **Diabetes** – increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and increase proportion of those with Type 2 diabetes receiving recommended NICE care processes
3. **Epilepsy** – increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.
4. **Oral health** – address the backlog in tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under.
5. **Mental health** – improve access rates to children and young people's mental health services for 0–17-year-olds, for certain ethnic groups, age, gender, and deprivation. For DBTH, this will have a particular focus on improving access to our Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorder (ASD) services and how we work with RDaSH.

Although the initial focus will be on addressing the specific points from the Core20PLUS5 framework (as described above) we do not want to be constrained by these, and therefore we will take the opportunity to understand what issues are facing our patients and the communities we serve (using quantitative data as well as community voices). This will result in a more tailored, bespoke approach, ensuring we are tackling those health inequalities that are most important to our patients.

We will work closely with the CYP Alliance as well as our ICB and local authority partners to ensure that we are aligned with their work, not duplicating any existing work, and to develop some innovative solutions.

6. Research and innovation (R&I) opportunities

The DBTH Research and Innovation Strategy 2023-2028 has tackling health inequalities as a cross-cutting theme throughout. The aim is to ensure that the research and innovation undertaken at DBTH will consider the impact on health inequalities across the research / innovation pipeline, from design to delivery and through to adoption. The health inequalities team will work closely with the R&I team to support this work and provide advice and expertise when required.

An area of strategic priority for the R&I Strategy relates to improving patient outcomes throughout prevention, early diagnosis and better management of cardiovascular and respiratory diseases and cancer. This is in alignment with our priority area of prevention and links to the Core20PLUS5 framework. The R&I team intend to support, promote, and roll out prevention initiatives, in addition to maximising research opportunities to better understand the challenges to prevention of these diseases specific to our local population. There is an opportunity here to develop future research and innovation proposals which specifically focus on tackling health inequalities. We can use the knowledge we gain from the other priority areas to help inform this. Moreover, we could review existing research projects to see if there are any opportunities for a focus on health inequalities. For example, we could use knowledge gained from the maternity and best start in life priority area, to help identify pertinent research questions from the BaBi-D research project.

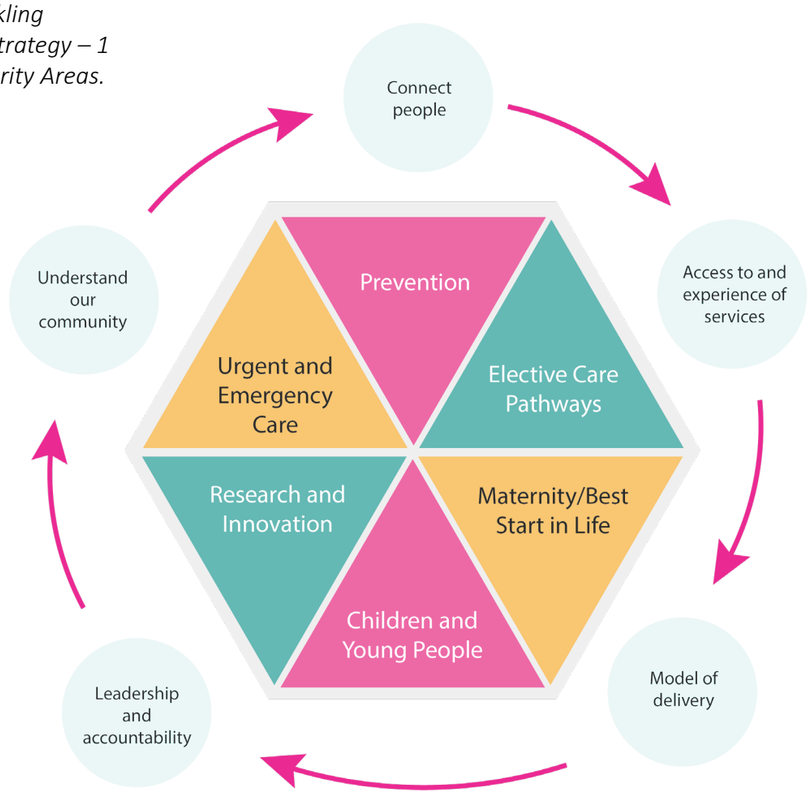
Enablers to delivering this strategy

The 6 priority areas are underpinned by 1 base and 5 pillars. The base provides the foundation to the delivery of this strategy and refers to enhancing our communications, awareness, and education of health inequalities for our people, our patients and our local communities.

There is currently a lack of awareness and understanding about what health inequalities are. Unless our staff understand what health inequalities are and the impact they have on the care patients receive and their outcomes, they will not be able to support us in developing solutions. We therefore intend to develop a training package (encompassing a range of formats, e.g. presentations, e-learning modules, webinars etc.) accessible to all our staff, as tackling health inequalities is everybody's responsibility. Furthermore, we intend to support the development of networks amongst our people to champion the importance of tackling health inequalities, which will in turn support the sustainability of this work. This focus on education and training of our people and the development of networks links in with DBTH's People Strategy 2023-2027.

The 5 pillars encompass behaviours, models of practice and a general ethos/culture shift which when implemented will support all the work across all 6 priority areas. These pillars include: understanding our communities, connecting people, model of delivery, access to and experience of services, and leadership and accountability.

Figure 6: DBTH's Tackling Health Inequalities Strategy – 1 Base, 5 Pillars, 6 Priority Areas.



Enhance communications, awareness and education of health inequalities

The Five Pillars

Pillar 1: Understanding our communities

To ensure accurate, complete and timely access to population health data (DBTH service-level data and other relevant data, e.g. from Joint Strategic Needs Assessments) in conjunction with community voices to better understand the health inequalities and where to focus our action.

Pillar 2: Connecting people

To work closely with partners and build on existing relationships, networks and trust. This will ensure work is aligned and supported and will prevent silo-working allowing health inequalities to be addressed using a whole system approach.

Pillar 3: Model of delivery

- To move towards a more needs-led, compassionate social model of care.
- To use co-production to improve existing services and/or develop new services based on the needs of our communities.

Pillar 4: Access to and experience of services

To focus on the Core20PLUS5, ensuring targeted support is provided for the Core20 and PLUS groups, including inclusion health groups, particularly (but not exclusively) across the 5 service areas for adults and children and young people.

Pillar 5: Leadership and accountability

Strong leadership and clear accountability and governance structures will support a culture shift and help to embed heath inequalities in everything we do, acknowledging that our staff may also be experiencing health inequalities.

How are we going to deliver this strategy?

The strategy will be delivered by using the enablers described above and a three-tier framework for improving health and reducing health inequalities (see page 25 for details of the three-tier framework). The framework outlines work that we can do to tackle health inequalities by: 1) increasing support/ developing new services, 2) improving our existing services, and 3) influencing the wider determinants of health in our Anchor Institution role. To support teams/services implementing the framework, there are a series of associated questions for each tier to guide thinking/to act as prompts for action. These questions are included as an appendix below (see Appendix 2).

In addition, as the "base" of our strategy is focused on training, education, and awareness, we intend to develop four levels of training, which link back to the three-tier framework (see Figure 7 on page 26) and have included relevant Key Performance Indicators for information on the right-hand side of the figure (this detail is also within the associated action plan).

Finally, the Health Inequalities Team will work with the Quality Improvement and Innovation (Qii) Team to ensure that a Qii approach is embedded within our programmes of work where appropriate and to support teams/divisions to use a Qii approach when undertaking any "tackling health inequalities" projects. To such end, we have developed a Health Inequalities Toolkit, with Qii methodology and the three-tier framework described above embedded within it.

The three tiers to support the strategy

DBTH's 3-tier framework for improving health and tackling health inequalities (adapted with permission from Barnsley's Integrated Care Partnership framework).

Tier 1: Increase Support

The first layer of action is to increase engagement, opportunities, services and support to address the key drivers of health inequalities for people in need and making every contact count.

To ensure people have access to support that prevents them getting sick and reduces the drivers of inequality in their life, we need our teams (both clinical and non-clinical) across the Trust to be discussing health inequalities, to highlight where gaps in knowledge may be and/or to identify potential areas for improvement.

Tier 2: Improve Care

The second layer of action is to improve all health and care services in such a way that they are targeted to greatest need and reduce inequalities in care.

To ensure that DBTH does all that it can to provide care and support to those with the greatest need first, teams / services should consider reframing the phrase "hard to reach groups" to instead answer the question "why are our services often hardest to access for the people who need them most?"

Tier 3: Influence Others

The third layer is to influence those differences in health which are linked to things like housing conditions, the quality of green spaces and clean air, education and income, i.e. the wider determinants of health, by becoming the best anchor institution we can be and advocating for health equity across all sectors.

To ensure that due consideration is given to the impact that the Trust has on health and wellbeing by means other than the services it delivers, which can lead to huge impacts and far-reaching benefits.

Training matrix

SET Training

Group: All Staff, governors, and volunteers

Level: Basic awareness

Target: 90% of staff by March 2024

Online Learning

Group: Frontline staff

Level: Understanding

Target: 30% of staff by 2025

Change Initiators

Group: Mangers / Level 1 coaches

Level: Able to identify and signpost

Target: 10% of staff by 2025

Health Inequalities Practitioners

Group: Project managers, Quality Improvement practitioners, and Senior Leaders

Level: Skills and knowledge to make a change

Target: 1% of staff by 2026

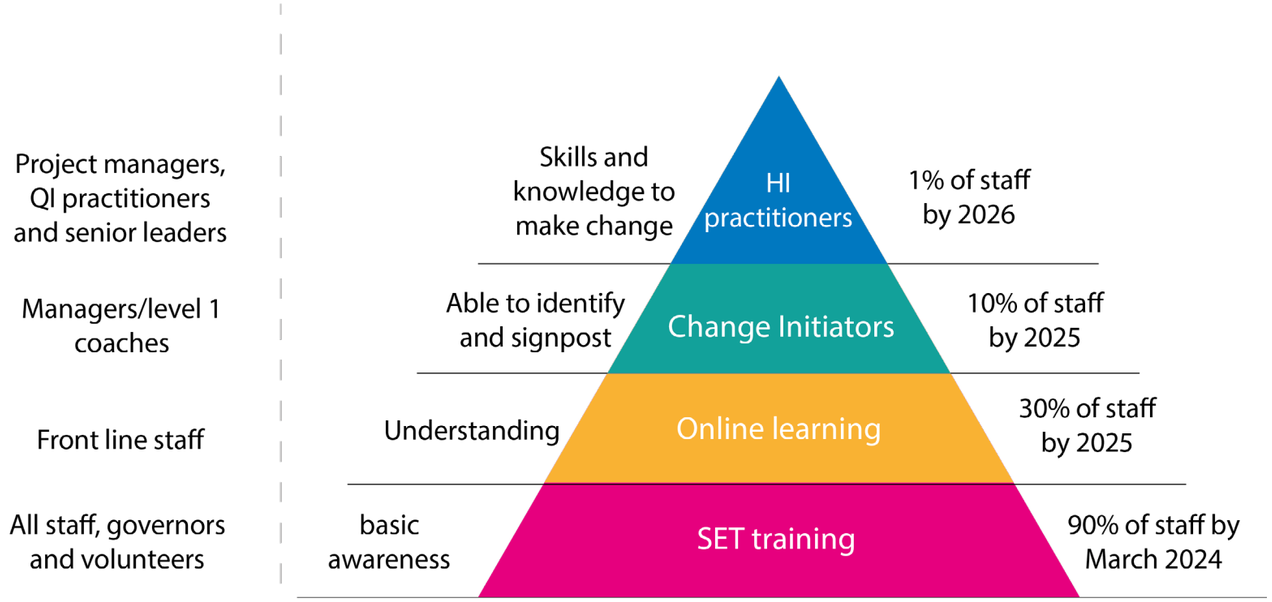


Figure 7: Training matrix

Key Performance Indicators

Evaluation and monitoring of performance against this strategy will be coordinated by the Health Inequalities Team, working in close partnership with relevant clinical and corporate colleagues. A five-year operational plan has been developed to accompany the strategy and will be the framework for which the monitoring process will occur. Annual delivery plans will be incorporated into the operational plan with clearly defined timescales against the actions to be taken to deliver the strategy objectives.

Governance Structure

The progress of DBTH Health Inequalities programme is monitored via quarterly reporting to the Finance and Performance Committee, with biannual updates to the Board of Directors.

The Health Inequalities and Sustainability programmes of work have come together under the umbrella of the Anchor Institution Strategy Group. There will then be a more operational Health Inequalities Steering Group and some specific task and finish groups the latter of which will be formed to deliver the priorities outlined on a time restricted basis (see Figure 8 below for details).

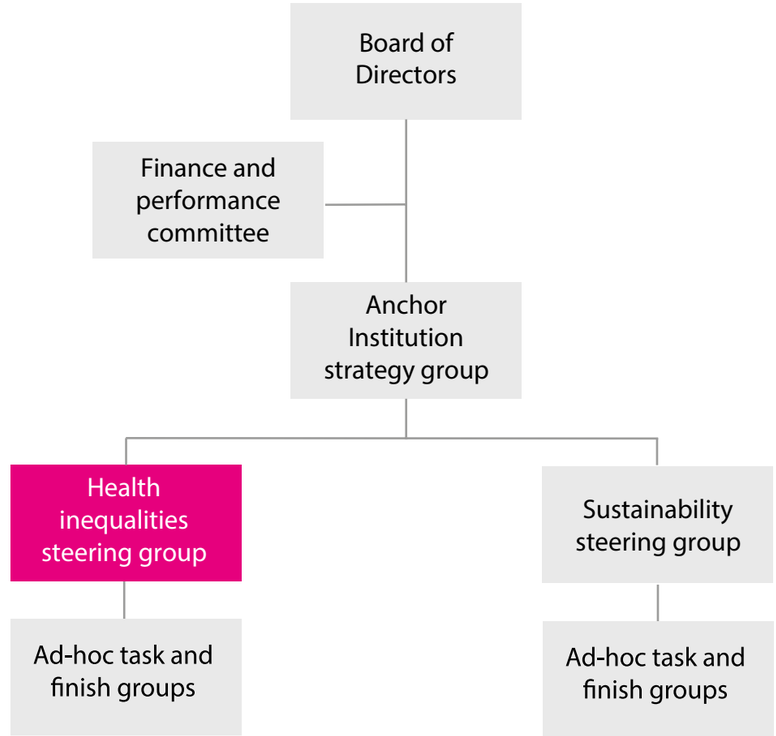
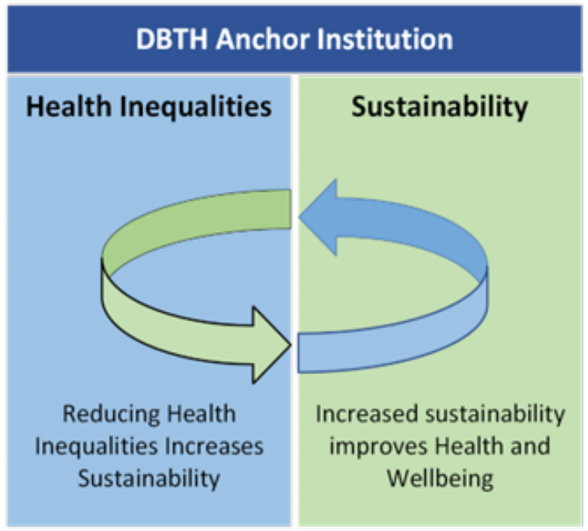


Figure 8: DBTH governance structure for health inequalities



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Appendix 1: List of all potential “PLUS” groups

Protected Characteristics

- Age
- Sex
- Gender reassignment
- Disability: includes physical impairments, learning disability, sensory impairments, mental health conditions, long-term medical conditions
- Marriage and civil partnership
- Pregnancy and maternity: women before and after childbirth / breastfeeding
- Race and ethnicity
- Religion and belief
- Sexual orientation

Socioeconomic status/ Geography

- People living in:
  - Deprived areas
  - Remote / rural / coastal locations
  - Overcrowded conditions
  - Areas with low levels of social connectedness
  - Poor quality housing
  - Prisons
  - Homeless people or those experiencing homelessness
- People with limited income due to:
  - Unemployment / inability to work
  - Employed on low incomes
- People with poor literacy or health literacy

Inclusion health and vulnerable groups

Individuals who are known to be / have:

- Clinically extremely vulnerable
- A long-term health condition
- Approaching end-of-life
- Addiction / substance misuse problems
- Living with or recovering from mental health problems including dementia
- Serious mental illness
- Learning disabilities and/or neurodiversity
- Sensory impairment (e.g. vision or hearing)
- Looked after or accommodated children and young people
- Carers: paid / unpaid (including family members)
- Involved in the criminal justice system (offenders in prison, on probation, ex-offenders)
- From Gypsy, Roma, Traveller communities
- Sex workers
- Vulnerable migrants
- Asylum seekers
- Modern slavery victims
- Veterans

Appendix 2: Questions to support the three-tier framework

Below are some key questions to consider within each tier, which can help us address some of the key issues.

Tier 1: Increase Support

The first layer of action is to increase engagement, opportunities, services and support to address the key drivers of health inequalities for people in need and making every contact count.

- What could you introduce that doesn't already exist to strengthen prevention and/or reduce inequalities for your people / patients?
- Which areas or services have historically been prioritised less than others resulting in inequalities?
- Do you have enough information about the drivers and causes of poor health and inequalities in your population and service users?
- Can you give examples of underlying assumptions you have about what is needed in your area or service?
- How effectively joined up and person-centred are the services that strengthen prevention and reduce inequalities?
- What engagement or resource commitments would help to sustainably reduce inequalities?

Tier 2: Improve Care

The second layer of action is to improve all health and care services in such a way that they are targeted to greatest need and reduce inequalities in care.

- Do we plan and prioritise our services based on existing demand or population need?
- Are there disparities between need and service use in certain communities and populations?
- Do we measure inequalities in service use and activity and consider narrowing gaps as a performance target?
- Which populations and communities have not been the focus of support for our services?
- Do some populations have easier / better access to our information and communications than others?
- What training for staff would build on their existing understanding of wider risks to peoples' health and wellbeing?
- How can we increase and co-produce engagement with excluded populations and those at greatest risk to encourage use of services earlier?
- How can we improve peoples' awareness of their own needs and build health literacy and expectations in the people at greatest risk?
- What opportunities are there for providing services in different locations that may improve access to priority groups?

Tier 3: Influence Others

The third layer is to influence those differences in health which are linked to things like housing conditions, the quality of green spaces and clean air, education and income, i.e. the wider determinants of health, by becoming the best anchor institution we can be and advocating for health equity across all sectors.

- What are our values and how do they permeate everything that we do?
- What is our impact on the climate and environment and how do we maximise benefit?
- How much waste do we produce and how can we manage it?
- How can we reduce emissions from travel and transport?
- How can we help to generate green, resilient and sustainable utilities (e.g. energy, water)?
- How can we use the most sustainable technologies (health and otherwise)?
- What is our impact on the local economy and how can we maximise benefit?
- How can we procure and spend more locally and regionally?
- How can we generate local production and supply of what we need?
- How can we make local supply economically viable through scale?
- What is our impact on communities and society locally and regionally?
- How can we engage with communities to ensure we are equitable?
- How can we share and distribute responsibility and power?
- How can our facilities, estates and assets provide social value?
- How can we create social mobility through recruitment and staff development?
- How can we support Doncaster and Bassetlaw to be the best places to be born?
- How can we strengthen education and equal opportunity in Doncaster and Bassetlaw?
- How can we make DBTH the best place to work?
- What is our impact through our influence on our partners, our suppliers, other sectors and through our reach into wider policy and development?

NHS

Doncaster and Bassetlaw Teaching Hospitals

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