Taking service-level action on health inequalities

A step-by-step support guide for Derby and Derbyshire NHS Service Providers

February 2025

Joined Up Care Derbyshire

NHS
Derbyshire Community Health Services
NHS Foundation Trust

Introduction

Health is unfair, and lives are being cut short across the UK and here in both Derby and Derbyshire. NHS services can be part of a positive difference, through making healthcare services fairer and equal for all.

This guide has been designed to support those managing healthcare services across Derby and Derbyshire to take action on reducing local health inequalities, **at a service-level.**

This guide will take you through the following:

- **Part 1.** Defining on the focus of the service's health inequalities work.
- **Part 2.** Developing an understanding of the people behind the data.
- **Part 3.** Adjusting services pathways to ensure equity.
- **Part 4.** Evaluating action to address health inequalities.
- **Part 5.** Staff development and training to support service-level action.

Each part of this guide covers key areas that all need to be considered in effective and meaningful action on health inequalities.

Small, and large, service-level adjustments can make a big impact for people and communities, and can play a part in reducing health inequalities.

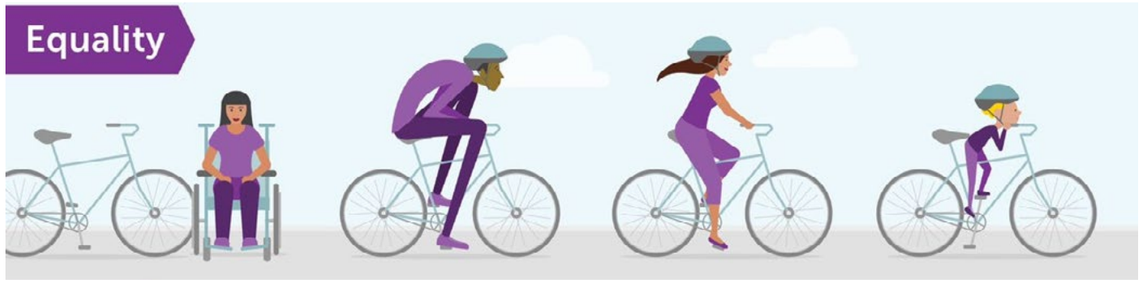
It is also important to be aware that NHS bodies have a legal duty to consistently have regard to the need to reduce health inequalities when exercising their functions:

- Reduce inequalities between patients with respect to their ability to access health services.
- Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

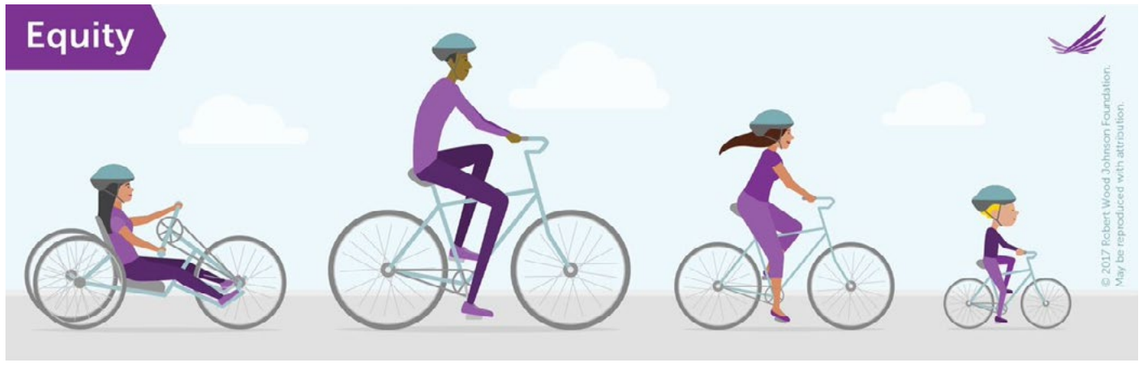
(Health and Care Act, 2022).

Equality vs. Equity

Equality (please see picture below) means everyone is treated the same way. You can see from the picture below that treating everyone the same can widen the health gap for some people.



Equity (please see the picture below) means recognising people have different needs and making adjustment for different needs.



This guide takes you through some steps it is important to consider when addressing the 'equity' or fairness of a health service. Increasing the fairness of a service should help play a part in reducing local health inequalities. It is important to say that meaningful action to address health inequalities at a service-level will not generally follow a neat and orderly process. However, action will hopefully be highly rewarding for all involved, generate significant learning and positively impact the people of Derby and Derbyshire.

Part One

Deciding where to focus as a service

This section will guide you through the four key steps to identifying who is missing or poorly represented from your service. This will help you to focus your service-level work on reducing health inequalities.

- Step 1. Exploring relevant service-level data.
- Step 2. Patient insights.
- Step 3 National and local data on health inequalities.
- Step 4. Combining service-level data, and data on health inequalities.

Step 1. Service-level data

Service-level data provides information about access, experience and outcomes for local people accessing your service. It should be considered alongside other data and insights as part of taking service-level action on health inequalities.

For example, you will have data such as opt-in rates, attendance rates, length of stay/input, missed appointments and outcomes.

From your service's routine equality and diversity monitoring data you should also have access to service-level data on the following areas:

- Carers
- Ethnicity
- Religion
- Sexual orientation
- Marital status
- Gender
- Pregnancy status
- Military service history

You will also have qualitative data from people who have experienced the service in terms of feedback (including Family and Friends Tests), incident data, complaints and compliments. Your service may also capture feedback from people who have accessed care, outcomes, or comments in other ways (e.g. through emails received).

Important note

Good quality data is key for service-level work on health inequalities.

A starting point for inequalities work in your service may be to look at how complete your service-level data is, and develop an action plan for how you can improve this.

Indications from service-level data of inequities may be seen through patterns in the people accessing healthcare. Look out for those who:

- Do not respond to invitation letters.
- Disengage before completing treatment, potentially leading to incomplete or ineffective treatment.
- Demonstrate poor treatment adherence.
- Experience challenging relationships with healthcare staff.
- Have a lack of shared understanding between the people accessing support and healthcare providers regarding health priorities, goals, and expectations.

For example, if data suggests people from a certain ethnic group are more likely to disengage from a service this is important information to act on as part of addressing health inequalities.

Important note

Remember that the groups most at risk of health inequalities, referred to as inclusion health groups, may be not be visible in your service data. For example, people experiencing homelessness – a fuller list of groups this may apply to are provided later in this guide.

Groups who appear to be absent (please see information around inclusion groups) should be prioritised for further research at a local level using trusted community partners. We include details of local partners to support you with this work in Part Two (place-based knowledge).

Step 2. Patient insights

Both service-level and other data need to be understood in context. There will often be a story behind the data that is emerging that is key to developing an effective intervention.

Local groups and stakeholders may already hold information which can be accessed. It is likely they have already engaged in talking to their respective communities which will reduce the need for services to engage in their own research. Details of these organisations in Derbyshire is provided in Part 2 of this guide.

A local guide to patient and public involvement has been developed by Joined Up Care Derbyshire and may support you to plan your health inequalities work Guide to working with people and communities » Joined Up Care Derbyshire

Here are some recommendations for activities to support a deeper understanding:

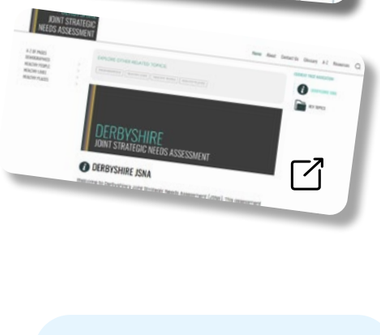
- Speaking to trusted local community leaders and groups, directly or via colleagues who have relationships with these individuals and groups.
- Engaging with diverse stakeholders: involve service users, staff, and community representatives in identifying who is not accessing the service.
- Partnering with community organisations: collaborate with organisations that work with underserved populations to understand their specific needs and concerns regarding healthcare access.

A best practice approach to identifying groups facing health inequalities is to combine information from existing data sources with information from trusted community partners.

We provide more information on community partners in Part 2: Understanding the people behind the data.

Step 3. Data on local health inequalities

There are a number of ways to understand the local context for your service using local and national data.



Deprivation across Derby and Derbyshire

For Derby City you can find data on socio-economic characteristics on the Info4Derby website . For Derbyshire you can find information on socio-economic characteristics on the Derbyshire Observatory.

The Index of Multiple Deprivation (IMD) can be used to identify how deprived areas in Derby and Derbyshire are. Different areas are then ranked based on their level of deprivation. These areas tend to have poorer health outcomes due to a variety of factors, including limited access to quality healthcare, unhealthy living conditions and social exclusion.

The Index of Multiple Deprivation (IMD) scores for areas in the UK range from 1 to 32,844, with 1 being the most deprived and 32,844 being the least deprived.

Joint Strategic Needs Assessments (JSNAs)

JSNAs are local assessments to help understand what people need to be healthy and well, and collects information about the things that are affecting the health of local people. JSNAs cover a range of topics that may help you plan your service's health inequalities work such as local demographics, smoking rates, physical activity, mental health and financial inclusion.

For the Derbyshire JSNA visit Derbyshire Joint Strategic Needs Assessment

For the Derby City JSNA visit Joint Strategic Needs Assessment - Derby City Council

The IMD considers:

- Income
- Employment
- Education
- Health
- Crime
- Barriers to housing and services
- Living environment

Life Expectancy

There is a significant difference in life expectancy and healthy life expectancy between people living in the most deprived areas than those in the least deprived areas. In the period 2018 to 2020, male life expectancy (LE) at birth in the most deprived areas of England was 73.5 years, compared with 83.2 years in the least deprived areas. For females, the equivalent estimates were 78.3 years and 86.3 years, respectively[1]. In Derby City, Life expectancy at birth is 77.7 years for males and 81.5 years for females, lower than the England averages (PHE, 2018-20). The average life expectancy of male Derbyshire residents was 79.2 years in 2018-20. The average life expectancy of female Derbyshire residents was 82.8 years in 2018-20.

Important note

The IMD is an important indicator of deprivation, however focusing on this tool alone might miss small areas of significant deprivation within less deprived areas.

Core20PLUS5 (adults) – an approach to reducing health inequalities

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

What is meant by Core20? The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation.

What is meant by PLUS? PLUS population groups are identified at a Derby and Derbyshire level.

This link outlines the Core20PLUS5 approach for adults Core20PLUS framework.

This approach has also been adapted for children and young people

[1] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/2018to2020

What are inclusion health groups? Inclusion health groups describe groups of people who are at risk of exclusion from services.

This includes the following groups:

- People experiencing homelessness
- Drug and alcohol dependence
- Vulnerable migrants
- Gypsy, Roma and Traveller communities
- Sex workers
- People in contact with the justice system
- Victims of modern slavery
- Other socially excluded groups.

What are the Core20 clinical areas of focus? There are five clinical areas of focus which require accelerated improvement. Governance for these five focus areas sits with national programmes; national and regional teams coordinate activity across local systems to achieve national aims.

- Maternity
- Severe mental illness (SMI)
- Chronic respiratory disease
- Early cancer diagnosis
- Hypertension case-finding and optimal management and lipid optimal management

PLUS groups

These are additional groups we would anticipate facing health inequalities at a local level. Examples of PLUS groups include: ethnic minority communities; inclusion health groups; people with a learning disability and autism; small areas of deprivation hidden among areas of relative affluence; people with multi-morbidities; and protected characteristics groups (e.g. sexual orientation and gender identity).

Derby and Derbyshire's PLUS five areas of focus are:

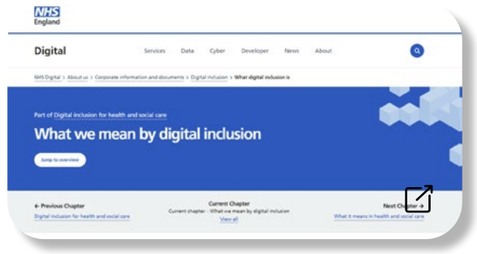
- Maternity: ensuring continuity of care for 75% of people from Black, Asian and minority ethnic communities and from the most deprived groups.
- Severe mental illness (SMI) and learning disabilities: ensuring annual health checks for 60% of those living with SMI or learning disabilities.
- Improving vaccination uptake: reducing inequalities in uptake of life course, COVID, flu and pneumonia vaccines.
- Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.
- Hypertension case-finding: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

Digital exclusion and health inequalities

Digital exclusion can compound health inequalities by exacerbating challenges with access to healthcare, skills and capability to navigate and use services, and the general resources needed to lead a healthy life.

It is important to consider the impact of digital exclusion throughout your work on addressing health inequalities within your service – including in terms of how it may have impacted on the data you're working with, and the opportunities for people to share their insights.

NHS have developed some web pages to help you understand more about the topic of digital inclusion. You can learn more about who is likely to be excluded, and helpful interventions.



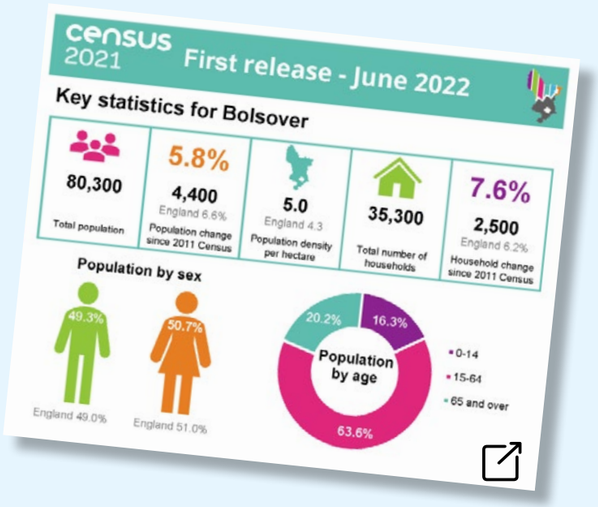
Rural Action Derbyshire is committed to reducing the County's Digital Divide. We recognise the value of being online, and want to ensure that everyone in the county has the opportunity to connect digitally.

Across Derby and Derbyshire there are computers and free WiFi available for people to use at Normanton, Alvaston, Mickleover and Riverside Libraries

Derby and Derbyshire's Census information

The UK census is conducted every 10 years in England and Wales. For findings for Derby City and Derbyshire look at this website.

The 2021 Derbyshire Census results are on this webpage. Derbyshire Observatory – Census 2021



For Census information for Derby City visit this webpage Census information - Derby City Council

Step 4. Combining insights for a full understanding

By combining service level data with other national and local sources information, you can identify which groups are most affected, who is missing, explore the potential causes, and inform targeted interventions to address these disparities effectively. Inclusion groups who are absent from your data require further research.

Useful questions to ask when analysing your service level data:

- Are there gaps in access to your service for certain groups or geographical areas? (e.g. due to cultural differences and barriers, digital exclusion, no/low health literacy skills, English not being a first language, sight/hearing issues).
- How do gaps in access compare to the evidence / literature on outcomes for these group(s) (if known)?
- Are certain groups or geographical areas experiencing poorer health outcomes, even when accessing care? How does this compare to the evidence / literature on outcomes for these group(s) (if known)?
- Are their specific points in your service pathway which is creating or exacerbating inequities? (e.g looking at DNA rates (did not attend), or looking at the pattern of drop-outs from the service for different patient groups).

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Other uses of service-level data:

- Look at your data to see whether any groups or geographical areas are under-represented in terms of appointments, procedures, and treatments.
- While aiming for proportional representation based on broad community demographics is important (ensuring the reference population profile is aligned to the geographical catchment eligible to access the service), it is also important to consider specific health needs within certain groups which might require them to be present at a higher percentage in your services for true access equity.
- Comparing healthcare use with demographic data from the census to identify geographic areas with high concentrations of underserved populations.
- Analysing patterns within this data can reveal disparities in treatment outcomes (e.g., recovery rates, complications), service effectiveness and service engagement between different groups of people.
- By linking service level data with Census and IMD data, you can explore how social and economic factors might influence health inequalities within your service.
- Enables you to identify inclusion groups who are absent from your service data.

Important note

Service-level data quality and accessibility can vary and is reliant on the robustness and consistency with which data is collected in the service. It may be that one action for your service is to increase the effectiveness of your service's equality and diversity monitoring. For example, many services report significant numbers of 'unknowns', which may mask health inequalities.

Key points to remember:

- Contextualisation: interpret your findings within the broader context of the local community, healthcare system, and social determinants of health.
- Data quality: ensure your service data is accurate and complete. Data errors or missing information can skew your analysis and misrepresent the actual demographics of people your service is supporting.
- Privacy and security: protect the privacy and security of people's data during analysis and ensure compliance with relevant regulations.
- Community engagement: collaborate with local stakeholders, community organisations, and healthcare providers to gain insights into the needs and preferences of diverse populations.

Remember, achieving true representation is an ongoing improvement process. It requires consistent effort, flexibility in adapting your strategies, and a commitment to serving all members of the community equitably.

A key question

Before you move to Part 2 - has a focus for this work been identified through data and insights (e.g. a locality or community).

Part Two

Understanding the people behind the data

Once there is a focus on the health inequalities work in a service, the next step is to understand the factors acting as barriers to access, positive experiences or outcomes. Data analysis patterns might suggest relationships like a correlation between distance and a specific group's utilisation. To avoid misleading conclusions, validate these potential associations through research and direct community engagement. Further investigation might reveal, for example, that a lack of trust in services is the key factor, with geography or transport issues being secondary.

This section covers three key steps to take to understand the people behind the data:

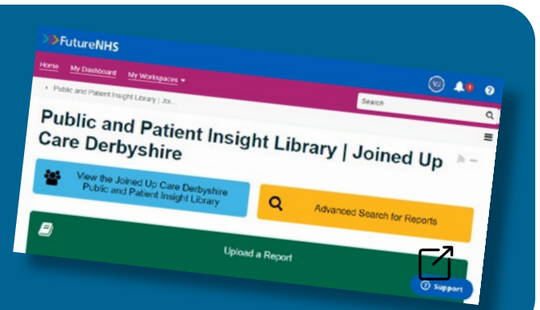
- Step 5. Undertaking (brief) literature reviews
- Step 6. Developing place-based knowledge and relationships
- Step 7. Community engagement and co-production

Step 5. Literature reviews

Researching existing studies and reports on healthcare challenges faced by similar populations can be a helpful first step.

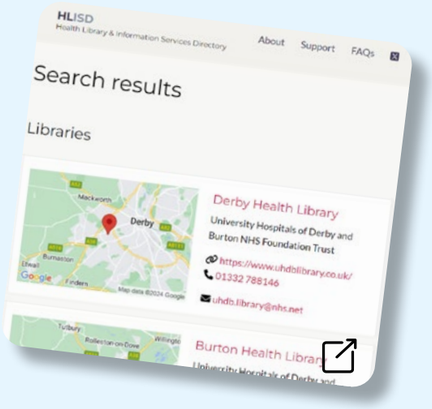
Derby and Derbyshire libraries

Joined Up Care Derbyshire (JUCD) Public and Patient Insight Library - The JUCD Public and Patient Insight Library, is central hub for collating and storing patient and public



You can look up the topic, group, or area you're interested in using this library. Access to the insights library requires an NHS Futures account , but setting one up is open to everyone.

For local library services you can look on the ‘Derbyshire’ page of the Health Services and Information Services Directory.
HLISD: Derby Library Services -
HLISD: Derbyshire Library Services-



Literature searching can be time-consuming. A library service can often provide invaluable assistance with searching databases, finding grey literature, and navigating the research landscape. Speak to your Trust’s research team to find out how to contact your library service.

Conducting the literature search independently

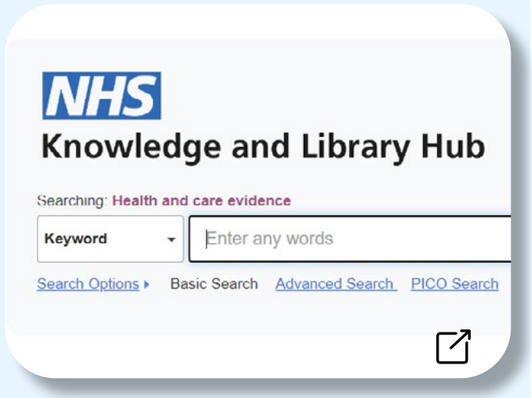
You may not have access to library support, or the timescales they can offer may not meet your needs. Conducting a ‘literature review’ brief, or systematic may feel familiar to you – or may feel like a new task.

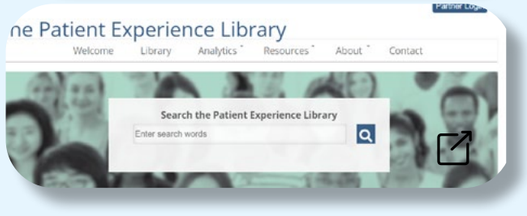
For more information on how to conduct an effective literature search, you could consider this NHS England e-learning.

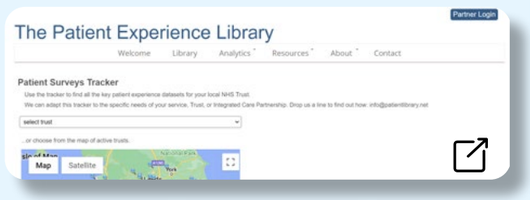
UK-wide library resources

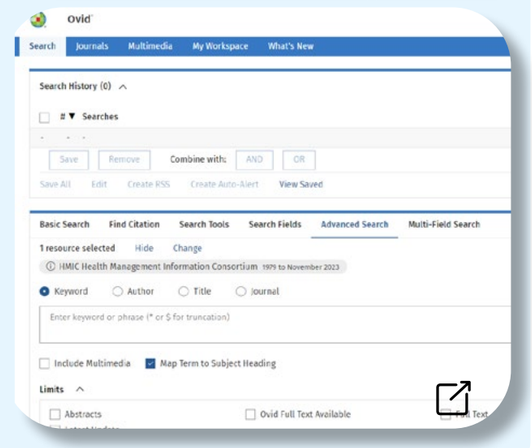
When conducting a literature search into health inequalities in the UK, there are several starting points you can consider depending on your specific research question and focus. Here are some examples:

- **NHS Knowledge and Library Hub**:
  The ‘Hub’ connects you to journal articles, e-books, guidelines, and evidence summary tools provided nationally and by your local NHS library team. It avoids the less-reliable sources you might find in a general web search.
- **Patient Experience Library:**
  A collection of UK intelligence on patient experience.
- **Patient Surveys Tracker:** A search tool which will enable you to find patient experience data sets for any NHS Trust.
- **Health Management Information Consortium (HMIC):** HMIC is produced by the library services of the UK’s Department of Health and the King’s Fund. The HMIC database covers official publications, journal articles, and grey literature relating to health and social care management





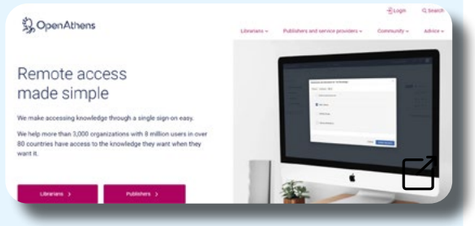




- **The Cochrane Database of Systematic Reviews (CDSR):** This is the leading resource for systematic reviews in healthcare. It's a collection of high-quality, evidence-based reviews that summarise the current state of research on a specific healthcare topic.

- **Public Health England and GOV.UK:** These are repositories of public health information and policies.

- **Others:** Explore resources from institutions like the King's Fund, Nuffield Trust, Health Foundation, and the Joseph Rowntree Foundation for their research and analysis on health inequalities in the UK.
- **Open Athens:** Registering for an Athens account enables access to this and many other repositories of information. It is free to register for a wide range of NHS and social care staff.



A key read on Health Equity in England

An important starting point for addressing health inequalities is the work of Marmot. This is pivotal work and highlights key groups experiencing health inequalities, and key factors that impact this.

Health Equity in England: The Marmot Review 10 Years On

Step 6. Place-based knowledge and relationships

Relying solely on national research and data can lead to overlooking the voices and perspectives of local communities directly affected by health inequalities in Derby and Derbyshire.

Understanding local barriers: While national and external research offer valuable insights into broader patterns, it is important to avoid assuming their findings automatically translate to smaller, local populations. Similarly, applying research to entire groups, like asylum seekers, can mask significant internal diversity. Some groups within a community might face specific health challenges due to their unique circumstances. Local knowledge can help identify these hidden vulnerabilities and avoid stereotyping needs.

Localisation of interventions: Active engagement with community members, healthcare providers, and policymakers can support accurate localisation. Localisation ensures that interventions are culturally sensitive and nuanced to the local context. This includes:

- Translation into the local language with idioms, slang, and references adapted to ensure clear and accurate communication. Speak to your organisation's communications team for more details on this.
- Cultural References: Images, symbols, and metaphors should be carefully chosen to resonate with the target locality.
- Content and Functionality: This might involve adding features relevant to local social contexts, adjusting information formats, or tailoring messaging to resonate with cultural values and beliefs within a given locality.

Localisation goes beyond surface-level changes and requires a deep understanding and respect for the cultural context of the target users. Partnering with others who have deep knowledge of the target culture can be invaluable and increase sensitivity to diversity among sub-groups within a region.

Locality partnerships

In England, locality partnerships refer to collaborative frameworks established to improve health and well-being at the local level. Each locality partnership operates within a defined geographical area, typically encompassing a city, town, or group of villages. This allows them to tailor their efforts to the specific needs and demographics of their local population.

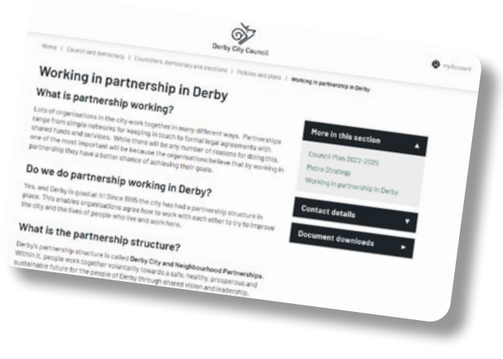
These partnerships bring together different groups to work together to understand local communities and meet their needs. They usually comprise:

- **Health services:** This includes local NHS providers, such as GPs, community health services, and hospitals;
- **Social care:** Local authorities and the social care teams are involved;
- **Voluntary sector:** Charities, community groups, and social enterprises actively contribute; and
- **Citizens and communities:** Local residents themselves are considered equal partners, providing invaluable insights and perspectives.

Locality partnerships work together to develop joint priorities and strategies based on data analysis, community engagement, and consultations with partner organisations.

They often focus on improving access to healthcare, reducing health inequalities, and addressing social determinants of health (such as housing or finances). They bring together in one group a focused repository of local cultural knowledge or where this can be accessed.

For more information about Derby City's partnerships, visit Working in partnership in Derby - Derby City Council



There are 8 partnerships in Derbyshire:

- Amber Valley
- Bolsover Bolsover
- Derbyshire Dales
- North East Derbyshire
- South Derbyshire
- Chesterfield
- Erewash
- High Peak

To connect with the partnerships you can contact the local district councils directly, or the Derbyshire County Council Public Health department and ask to speak to the relevant 'locality' service development officer: Contact us - Derbyshire County Council

Speciality partnerships: There are also speciality partnerships or organisations that can help with understanding the needs of different local groups of identity. For example:

- **Derby City Health Inequalities Partnership:** They can link you up to groups and forums to help you address local health inequalities in your service Website
- **Derby & Derbyshire's All Age Mental Health, Neurodiversity and Learning Disability Alliance:** Led by Derby and Derbyshire ICB this group is a focus for information on needs of people with mental health needs, neurodiversity and Learning Disabilities. Neurodiversity includes neurodevelopmental conditions such as Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD). (link to contact us page

- **LGBTQIA+ Derbyshire** Derbyshire LGBT+ is Derbyshire's only LGBT-specific support service, supporting anyone who is Lesbian, Gay, Bisexual & Transgender, or anyone who is having issues with their sexual identity or gender identity, this includes family and friends. Email: info@derbyshirelgbt.org.uk for more details.
- **Derbyshire Black and Minority Ethnic (BME) Forum** supports the development of an infrastructure that enables BME community groups to be actively engaged with and provide feedback on policy and service developments. If you would like to know more about what the BME Forum does, or if you would like to attend a forum meeting, please you can find further details on the two webpages below:

  Black and Minority Ethnic (BME) Forum - Derbyshire County Council

  https://www.linkscvs.org.uk/derbyshire-bme-forum

Healthwatch Derbyshire: This is an independent statutory body, tasked with the role of ensuring local views and feedback are made available to NHS leaders and other decision-makers to improve care. They actively seek views from children, young people, and adults about health and social care services, whether that be praise, criticism or ideas for improvement (website).

Healthwatch Derby: This is the equivalent Healthwatch branch for Derby City. (website).

Derbyshire Patient Participation Group Network: A group set up and facilitated by Joined Up Care Derbyshire to bring together chairs of Patient Participation Group chairs from across Derby and Derbyshire (website).

Derbyshire Voluntary, Community and Social Enterprise Alliance: An alliance supporting coordinated activities in this sector, and a route to contact a range of organisations that may be able to support health inequalities (website).

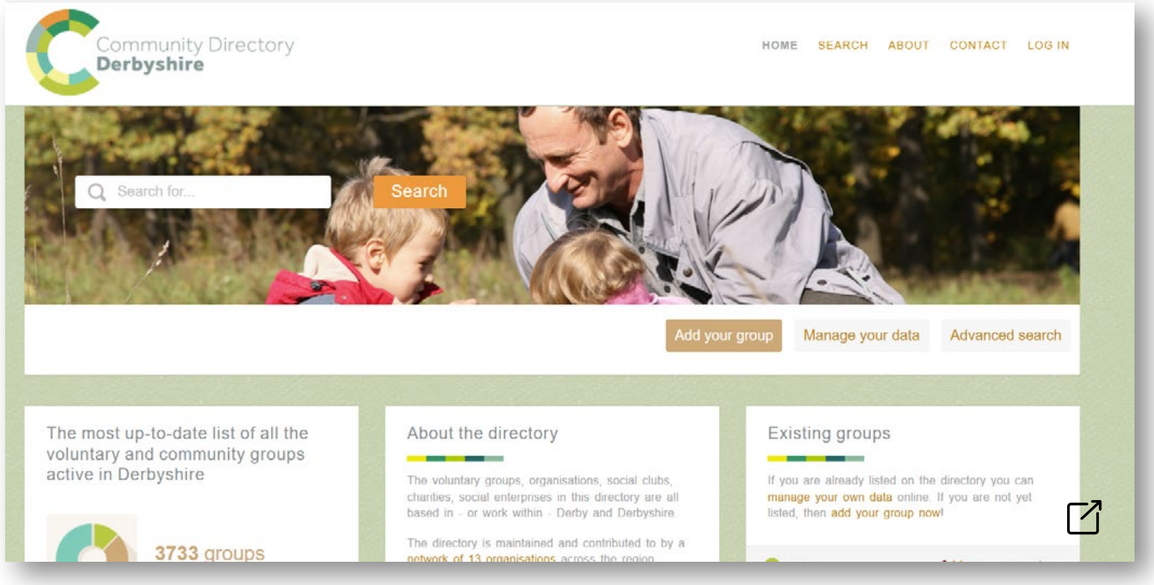
Voluntary organisations and Community groups

The Derbyshire Community Directory

There are a number of local groups who represent the needs of some inclusion groups in Derby and Derbyshire. The Derbyshire Community Directory is a searchable database of organisations, many of whom represent the needs of inclusion health groups. It includes local voluntary groups, organisations, social clubs, charities, and social enterprises.

For example:

- **Chesterfield Interfaith Forum** chesterfieldinterfaithforum@gmail.com
- **Derby Deaf Forum** (website)
- **Staveley Seniors Forum** (website)
- **50+ Forum** (website)
- **Older People's Forum Bolsover and District** (website)
- **Kirk Hallam Parents Forum** enquiries@erewashcvs.org.uk
- **Derby Dementia Action Forum** (website)



Councils for Voluntary Service and Action (CVS)

There are a number of CVSs across the region who act as a support to various voluntary organisations and community groups within their locality, for example:

- **Links CVS:** Links provides support to voluntary organisations and community groups operating in the local government districts of Chesterfield and North East Derbyshire (website).
- **Amber Valley CVS** (website)
- **Community Action Derby** (website)
- **Derbyshire Dales CVS** (website)
- **Erewash Voluntary Action (EVA)** (website)
- **South Derbyshire** (website)
- **High Peak CVS** (website)
- **The Bureau** (website)
- **New Mills Volunteer Centre** (website)
- **Derbyshire Voluntary Action (DVA)** (website)
- **Chesterfield and North East Derbyshire Volunteer Centre** (website)
- **Bolsover CVS** (website)
- **Rural Action Derbyshire (RAD)** (website)
- **Connex (based in Buxton and Ashbourne** (website)

Step 7. Community engagement and co-production

To understand the views and problems faced by specific community groups, a variety of research approaches can be considered, tailored to the unique context and needs of the group. Direct outreach and community engagement can be undertaken independently or in collaboration with trusted partner organisations to deepen or bridge knowledge gaps.

Co-production:

In healthcare, co-production refers to a way of working where people and communities become equal partners in the design, delivery, and evaluation of health

services. It's a shift from the traditional model where professionals hold most of the power and responsibility, moving towards a more collaborative and user-centred approach.

You can watch a video introduction to co-production here.

For support around co-production, you can link with the Joined Up Care Derbyshire Engagement team (website)

Here are some key aspects of co-production in healthcare:

- Shared power and responsibility: Both professionals and users share decision-making and have equal voices in shaping how services work.
- Early engagement: Users are involved from the very beginning, not just consulted after decisions have already been made.
- Focus on lived experience: Users' unique perspectives and experiences of using the service are valued and inform how it's designed and delivered.
- Mutual learning and knowledge exchange: Professionals learn from users, and users learn from professionals, creating a more informed and responsive system.

The benefits of co-production include:

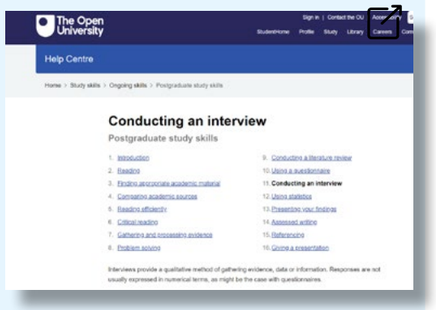
- Improved quality of care: Services are more likely to meet the needs of users when they are designed with their input.
- Greater satisfaction of patient accessing services: People report feeling more empowered and in control of their health.
- Increased efficiency and cost-effectiveness: Co-production can lead to more targeted and effective use of resources.
- Stronger relationships between professionals and users: Working together builds trust and understanding.

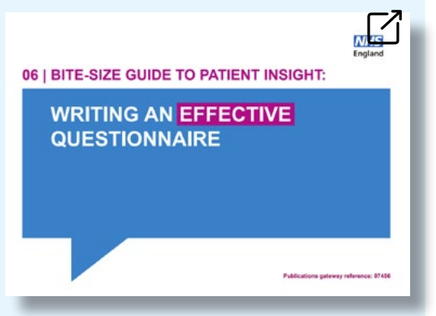
Of course, implementing co-production effectively requires careful planning and commitment from all parties involved.

To support you with this, Joined Up Care Derbyshire have developed the Insight Framework Insight Framework . This is a development tool to help you work effectively with community-led insight.

Here are some 'approaches' to 'community engagement' to consider:

- **Going to where people are:** Arranging to visit a location or group to have a conversation.
- **Focus groups:** Gathering a small group of individuals from the targeted community to discuss their experiences, perspectives, and challenges is a valuable way to gain in-depth insights. For tips on setting up and facilitating focus groups consider looking at this brief NHS PDF guide.
- **Semi-structured interviews:** In-depth interviews with individuals facing access barriers can offer rich personal narratives and uncover specific reasons for non-utilisation. This guide will support you with setting up, conducting, recording and making sense of your interviews.
- **Surveys:** While qualitative methods provide deeper understanding, surveys can reach a larger sample and quantify specific issues faced by the group. Culturally sensitive questionnaire design and appropriate recruitment strategies are crucial. How questionnaires and surveys are written is key for this work; this NHS PDF guide will support your work.





Additional key considerations:

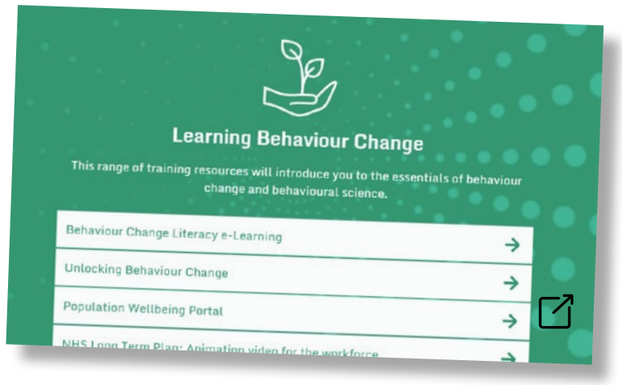
- **Participatory action research:** Involves collaboration with members of the group throughout the research process, from co-designing the research questions to interpreting findings. A PDF example from Public Health England can be seen here
- **Building trust and rapport:** Establishing genuine relationships with the community group is essential for obtaining accurate and meaningful data. Respectful communication, cultural sensitivity, and transparency are key. Joined Up Care Derbyshire have developed the Insight Framework to support you to consider how you approach this work.
- **Mutual benefit:** How can you work together on topics of interest providing benefits to one another? For example, through training offered as part of the collaboration, support towards employment readiness/ CVs, alignment with an ongoing training course/ learning need, positive feedback, rewards and recognition. University College London has developed a co-producer payment policy.

- **Accessibility and inclusivity:** Choose research methods and tools that are accessible to all members of the group, considering language barriers, disabilities, and literacy levels.
- **Intersectionality:** Many individuals belong to multiple under-represented groups and their experiences may be shaped by multiple intersecting factors. Consider this when designing interventions and gathering data.
- **Dissemination and action:** Share research findings with the community group and other stakeholders and collaborate on developing interventions or solutions to address their identified problems.

Using behavioural frameworks to understand data and insights

Service improvements will often involve creating opportunities for behaviour change. Behaviour change theories can increase the effectiveness of these activities.

To learn more you can visit the Health Education England website for brief e-learning module



The EAST framework is useful to consider in your service adjustment work – to encourage behaviour (e.g. service opt-in) you can make the desired behaviour:

Easy Such as health literacy friendly letters and communications.

Attractive Help people know what they'll get from the appointment such as a signposting for a range of things that may be important in people's lives such as finances and housing.

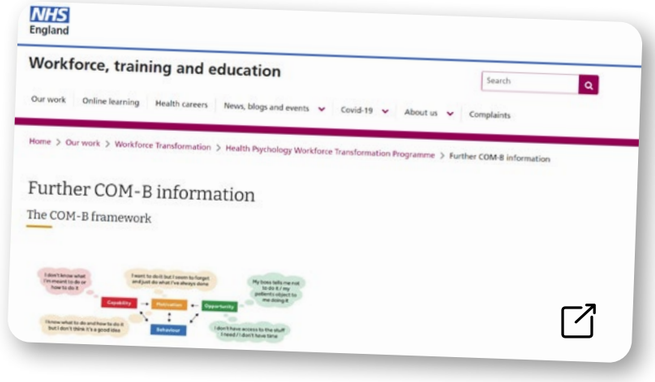
Social Highlight in communications that 'most people' attend these appointments (as opposed to highlighting did not attend rates, which normalises this undesired behaviour).

Timely Consider prompts and reminders at helpful moments.

For more information on EAST and using behavioural insights consider reading MINDSPACE: influencing behaviour through public policy (instituteforgovernment.org.uk)

The COM-B framework can be useful for considering the 'capability', 'opportunity', and 'motivation' of people in terms of accessing services. This can be a helpful way of organising insights and data and determining where to focus service adjustment activities.

Further COM-B information | Health Education England (hee.nhs.uk)



Summary

Overcoming under-representation in services requires an understanding of the barriers behind it. Data analysis can provide indicators to guide further exploration using other methods.

Key takeaways:

- Go beyond the data: Deepen understanding through research and direct community engagement.
- Partner locally: Work with organisations and providers who understand specific needs.
- Empower voices: Give under-represented communities a platform to share their experiences.
- Be inclusive and responsive: Tailor interventions to diverse needs and ensure accessibility.
- Build trust, inclusivity, and intersectionality when engaging with under-represented communities.
- Share your findings to increase local knowledge and avoid future duplication of activity.

A key question

‘Before you move to Part 3 of the guide – do you now understand more about the people behind the initial data?’

Part Three

Adjusting your service pathway to ensure equity

This part of this guide provides guidance on making flexible adjustments to services based on understanding the differences between people. Importantly, this should be considered alongside the data and insights you have gathered based on Part One and Part Two of this guide.

The section covers:

- Step 8. Understanding the scope of potential service adjustments to address health inequalities
- Step 9. Process mapping to support service pathway adjustments
- Step 10. Making individual-level adjustments to services

Step 8. Understanding the scope of potential service adjustments

Adjustments to service delivery to address health inequalities can be categorised into two levels:

- **Individualised adjustments** These adjustments embody the principle of individualised care by addressing the specific needs of a particular service user.
- **Overall pathway adjustments** These adjustments aim to accommodate the needs of broader groups of service users. Examples include providing interpretation services, adopting telemedicine, or introducing alternative communication formats.

Implementing both individual and whole pathway adjustments will support services to ensure equitable and effective service delivery for all service users.

Important note.

Before you implement any service-level adjustments plan how you will evaluate the action taken? How will you know what impact there's been? How will you learn from this activity? (See Part Four of the guide for more information on evaluation of service-level action on health inequalities).

Reducing health literacy barriers

Health Literacy is about a person's ability to understand and use information to make decisions about their health. Many adults across Derbyshire have low health literacy. This means they will struggle to read and understand health information.

Almost half of all adults have limited health literacy and struggle to understand everyday health information, that includes people here in Derby and Derbyshire.

Providing reliable easy-to-understand health information within your service can help people to:

- make the best decisions about their health
- be more confident to take an active part in planning their own care.

For more information, training and resources to help you make your service more health literacy friendly visit Health Literacy: Joined Up Care Derbyshire (website)

What should be considered when thinking about individual and pathway service adjustments?

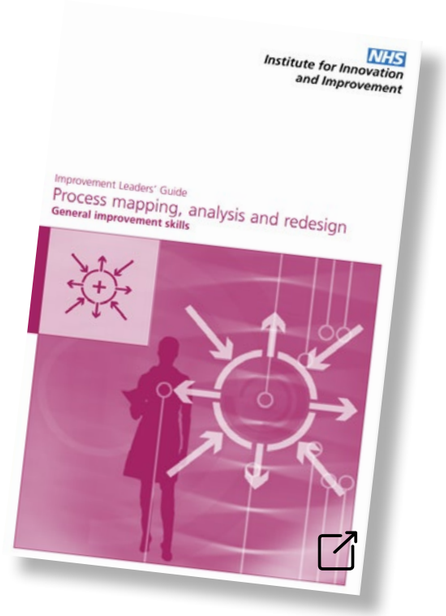
- Individuals from different backgrounds, cultures, and socio-economic groups may have **distinct needs, preferences, and expectations** regarding healthcare or other services.
- **Physical, sensory, or cognitive differences** may make it difficult to use a service pathway. Reasonable adjustments, such as providing accessible facilities, language interpretation, or alternative communication methods, can ensure that individuals with disabilities can fully access the service.
- **Cultural differences and communication needs** can hinder understanding between service providers and individuals. Addressing these issues can improve trust and the ability of individuals to follow health care advice.
- **Social determinants of health** such as how much money people have, education, and social support networks, significantly impact individuals' health outcomes and their ability to engage with health care.
- **Individuals with multiple needs.** Some individuals have a number of linked health needs related to their physical and/or mental health. Working to ensure the delivery of care takes account of these difficulties and results in better outcomes.
- **Trauma-informed healthcare environments** prioritise creating a safe and supportive space for individuals with trauma histories, minimising the risk of re-traumatisation (see Part Four for further information on trauma-informed services).
- **Prior experience of unfairness or discrimination.** Different groups may have different experiences of health care. For example, Stonewall found that 32% of people who were transgender report unfair treatment; while the NHS Race and Health Observatory reported that women from ethnic minority backgrounds experience a lack of cultural understanding and discrimination when accessing maternity services and neonatal units. [2]

2 Cited in the Kinds Fund briefing "What are Health Inequalities" https://www.kingsfund.org.uk/publications/what-are-health-inequalities#access

Important note.

Implementing digital services must be done with care, as unequal access to these services across different socio-economic groups can lead to worsening healthcare inequalities. Households with lower incomes, for example, may have limited internet access and lack the digital skills needed to make use of it. Disability may also contribute to difficulties accessing digital tools and inclusivity must be at the heart of their design.

Step 9. Process Mapping: Making Whole Pathway Adjustments



- Create a process map of the existing or proposed service pathway. A process map is a simple diagram which details each step of delivering the service. At its most basic, you can use post-it notes to illustrate the map. There are examples in this NHS guide about Process mapping, analysis and redesign
- Your process map should outline each step from initial contact to service completion on the person's care journey. Remember to complete the map from the perspective of the person accessing support. Alongside drawing on relevant data and community insights. You may need to do further research and consultation to understand this better (see the section on co-production).
- For each step, carefully consider the potential impact on the identified group that the data and insights suggest should be focussed upon.
- Consider how the current approach may affect or hinder access to care or treatment outcomes by whether it addresses the specific needs of each identified group. Be careful to avoid making assumptions by grounding your evaluation in research or co-production (See Part Two of the guide for further information on co-production).

- Based on the analysis, identify the specific adjustments required for each treatment aspect to effectively address the needs of each group.
- Identify the resources that are needed and the capacity of the service to deliver these changes. This may include the workforce, training, and physical resources (See Part Four of this guide for information on relevant workforce training).

Step 10. Making individualised adjustments and Personalised Care

- While generic pathway adjustments may be effective for a group, individualised adjustments may be helpful for specific people.
- There is a legal requirement to make reasonable adjustments for groups defined by the Equalities Act 2010, such as those with disabilities or other protective characteristics. NHS England » Reasonable adjustments

- However, there may be other individuals affected by health inequalities who are not defined by the act who would also benefit from 'adjustments'.

What kind of adjustments may an individual need?

Examples of service adjustments may relate to culture, disability or factors the person may not wish to disclose, such as the impact of trauma, help with managing anxiety triggered by being in a clinical setting, or understanding that they communicate pain in different ways. Practical issues such as care arrangements or difficulties with transport could also pose a barrier.

To address individual needs in a service, consider the following steps:

- Identifying individuals who require adjustments can be done based on criteria and screening of referral information Alternatively, you can offer everyone using the service the opportunity to self-identify. This self-identification approach eliminates guesswork and potential inequities in determining who receives this support. This information should be recorded and accompany people throughout their healthcare journey.
- Recording individual needs and preferences: Once identified, individuals should have the opportunity to discuss their unique needs and preferences before treatment begins. This information should be recorded in a comprehensive and accessible format.
- Flexible documentation: The documentation of individual needs and preferences should be flexible to accommodate changes and updates as the person's healthcare journey progresses. This could involve electronic health records, patient portals, or personalised care plans.

Health care passport

- Health care passports are one means by which a person can record their needs and make this information available to their health provider. There are a number of templates already in use.[3] Some existing templates have been developed for specific groups of people, such as the passport developed by the National Autistic Society.[4]
- A health passport allows the person using the service to keep the information up to date. However, some thought needs to be given to clearly defining the purpose and nature of information on the passport, how it will be made available to the health care workforce and in what circumstances it is shared.[5]

The Reasonable Adjustments Flag

The Reasonable Adjustments Flag (RAF) is part of the NHS Spine. With an individual's consent it can be added to their health record through the national care records system to indicate adjustments needed due to a disability or impairment, as defined by the Equality Act 2010. Once added, any healthcare worker can see the flag when accessing the individual's record. The flag may optionally specify the nature of the disability or long-term condition affecting the person and details of the adjustments required.

The types of conditions and impairments, and adjustments which can be recorded by the flag are prescribed by a list of categories. These are extensive and include 'bespoke categories'.

3 https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/03/healthcare-passport.pdf
4 https://www.autism.org.uk/advice-and-guidance/topics/physical-health/my-health-passport
5 Leavey G, Curran E, Fullerton D, Todd S, McIlfatrick S, Coates V, Watson M, Abbott A, Corry D. Patient and service-related barriers and facitators to the acceptance and use of interventions to promote communication in health and social care: a realist review. BMC Health Serv Res. 2020 Jun 4;20(1):503. doi: 10.1186/s12913-020-05366-4. PMID: 32498684; PMCID: PMC7271433.

A Case Study

Getting started: The Long Covid Service explored their available data on service access to understand whether there was any indication of inequitable service access. They decided from this initial data exploration to focus on access to the service from people living in areas of higher deprivation.

From looking at relevant literature, staff and patient insights, **health literacy was identified as a potential barrier** to service access.

The following service-level actions were taken:

- Staff across the service attended Health Literacy training, and key elements of the training were disseminated via in-house professional development sessions so that all staff were aware of the importance of health literate approaches in improving accessibility.
- From the training, the team then considered how Health Literacy might be particularly relevant to their patient group e.g. supporting service users with brain fog.
- Health Literate approaches were considered through the whole patient pathway (Part Three) involving patients in developments - including new service leaflets, group delivery, and a passport document to support patients through each stage of their journey with the service. Health literate approaches, for example, involved reducing the reading age of all materials.
- Key staff took on the role of health literacy promoters, to continue building on the work to reduce health literacy barriers across the service.

The outcome was evaluated: Changes in reading age were measured – the main service leaflet went from a reading age of 17 to 10.

Qualitative feedback from patients was recorded

·“This is great- really straightforward and easy to understand.”

“I think it has everything important covered since lots of text/ reading is hard for many to process.”

“A really good simple to understand leaflet, I like it and would use it.”

Feedback from staff involved has been positive:

“It has massively impacted the service and will give us an even better understanding for moving into and developing the new service in a patient centred manner”.

Ongoing data on service access will be examined to understand at the impact of these changes, and to understand further action on health inequalities which may be indicated.

Conclusion

While adjusting a service pathway may seem challenging initially, the investment in this process will be rewarded by improved ‘patient experience’, cost savings, and enhanced engagement, leading to fewer missed appointments, better communication with healthcare professionals, and a more positive overall experience.

Most importantly it will help to improve the health for all in a locality.

Key points

- Healthcare delivery shouldn't be "one size fits all." Different groups have diverse needs and preferences.
- Unequal access can lead to worse health outcomes.
- Reasonable adjustments are necessary to address these issues and ensure equitable care for all.
- Adjustments can be made at two levels:
    - **Whole pathway adjustments:** cater to broader groups, like offering interpretation services or adopting telemedicine.
    - **Individualised adjustments:** address specific needs of particular people accessing (or not accessing) support, considering factors like disability, culture, or trauma
- Co-production is an important way of doing things and being, working alongside people and communities to 'adjust' and develop services to address health inequalities.

A key question

Before you move to Part 4 of the guide – have you collaboratively planned some potential service-level adjustments, based on insights and data?

Part Four

Evaluating service-level action on health inequalities

Evaluating the outcome of service changes to address health inequalities can be addressed through a combination of quantitative, qualitative, and co-production methods. This creates a robust and insightful evaluation framework, however evaluation methods needs to be tailored to your specific service, intervention type, target inclusion group and the practical consideration of what is achievable for your service.

Where possible, before starting your health inequalities work, it is important to establish a baseline which can be used to measure change against. Be flexible and aim for learning not perfection.

This part of the guide covers three main areas of evaluation relevant to health inequalities action at the service-level

- Step 11. Quantitative methods
- Step 12. Qualitative methods
- Step 13. Dissemination and learning

Step 11. Planning Quantitative Evaluation Methods

- **Service utilisation data:** Track changes in access metrics like appointment bookings, wait times, consultation rates and referral patterns for inclusion groups compared to the general population. Disaggregate data by specific group to identify disparities.
- **Patient satisfaction surveys:** Develop surveys tailored to inclusion groups, capturing their experiences with accessibility, service quality, and cultural sensitivity.
- **Clinical outcome measures:** Assess the intervention's impact on health

outcomes relevant to inclusion groups, such as improved disease management, reduction in admissions and readmissions, reduced morbidity, change on validated clinical outcome measures, or increased adherence to treatment plans.

- **Cost-effectiveness analysis:** Where feasible evaluate the financial implications of the service improvements.

Step 12. Planning Qualitative Evaluation Methods

- **Focus groups and interviews:** Conduct in-depth discussions with service users and providers from inclusion groups to gather rich qualitative data. Explore their perspectives on service accessibility, barriers encountered, and perceived benefits of the intervention.
- **Case studies and patient stories:** Document the experiences of individual service users from different inclusion groups, highlighting their journeys through the intervention and its impact on their lives.
- **Workforce feedback:** Workforce morale can also be an index of success. NHS Staff Surveys and any additional wellbeing surveys conducted can support with this data.

Step 13. Dissemination and learning

Share evaluation findings with stakeholders, policymakers, and the wider community. This promotes transparency, accountability, and informs future service improvement initiatives.

Consider uploading your reports to the [Joined Up Care Derbyshire (JUCD) Public and Patient Insight Library] a central hub for collating and storing patient and public insight gathered across Derbyshire health, care, statutory and voluntary organisations.

Consider sharing your learning with [Joined Up Improvement Derbyshire.]

Tips to make evaluation do-able

The Institute for Health Care Improvement have the following tips for making projects and evaluation manageable:

Make it easy

- Use existing meetings, structures, and one-to-one check-ins to do improvement work.
- Make any improvement team meeting positive. For example, build in time to share stories about how the work is meaningfully helping and have fun activities.

Focus on learning, not perfection

- Equally celebrate success and learning from failure.
- Use sampling to avoid survey fatigue and accelerate learning

Have an end date

- Set a start and end date; stick to the end date.
- Create 30, 60, and 90-day plans for the end of the project
- We would also recommend setting project milestones as interim deadlines. Celebrate these when they are reached and use them to identify drift which may make your overall evaluation overrun.

You can read the full guidance on ways to evaluate quality improvement work such as activities to address health inequalities **in this PDF**

Further Resources

Evaluating improvement: This guide delves into different evaluation methods, including outcome and process evaluations, and provides strategies for collecting and analysing data to assess the impact of service changes.

A key question

Before you move to action – have you set out a robust and meaningful evaluation plan? Have you considered staff development needs around this work?

Part Five

Staff development and training to support service-level action

This section addresses how to support workforce development in relation to the understanding and skills needed to effectively work with diverse groups. This part of the guide underpins all action on health inequalities. Investing in workforce development is essential to developing a more inclusive and equitable environment for all people in need of support, and the workforce.

The section covers:

- Cultural competence and unconscious bias
- Workforce reflection
- Training and support
- A diverse workforce
- Trauma-informed practice

Cultural competence

Developing increased cultural competency is not about knowing everything about everyone. It is about:

- An attitude of humility and curiosity towards others;
- An awareness of one's own cultural lens;
- A willingness to learn about alternative perspectives, with empathy and respect
- Recognising the limitations of our own knowledge and being open to new perspectives.

Within health care, cultural competence supports:

- An understanding that people with different backgrounds and experiences may have different understandings and preferences in relation to health and health care.
- The ability to interact with people from different cultures and respond to their health needs.
- Working culture and practices that recognise, respect, value and harness difference for the benefit of the organisation and individuals.

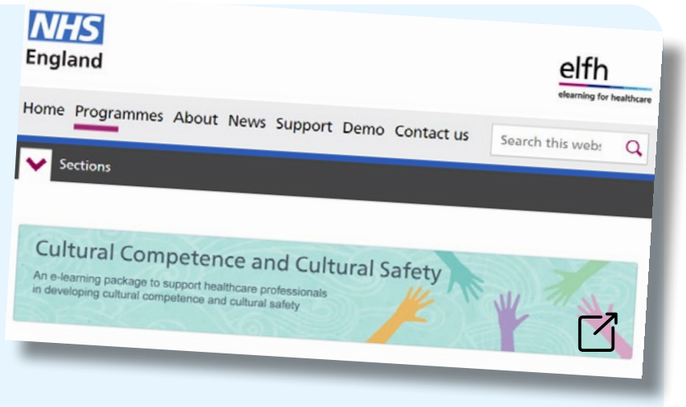
Things to remember

Cultural competence is not a one-time learning experience, it is a continuous process of growth and reflection. Specific training on the value of cultural competence can help start this process within an area.

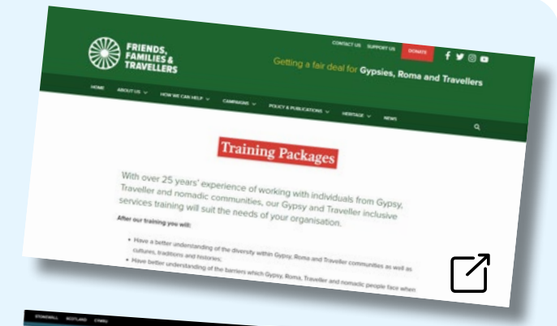
There is diversity within communities. Individuals within communities have varied beliefs and preferences. Cultural competence involves ongoing learning and adaptation to respect individual needs.

Training on cultural competence and cultural safety

An e-learning package has been developed by NHS England to support the development and understanding of cultural competence and cultural safety. This short programme aims to equip the workforce with knowledge and understanding of the issues around culture and health; and how this might influence health care outcomes.It can be accessed at: https://www.e-lfh.org.uk/programmes/cultural-competence/

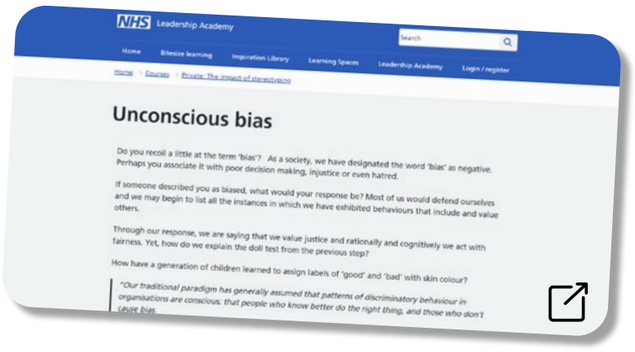


There are also specific training courses you can go on to understand more about certain communities, such as gypsy and traveller cultural awareness training. Stonewall offer e-learning on supporting LGBTQ+ children and young people Stonewall. There are many more options available.



Unconscious bias

Everyone has biases, and they only become an issue when people, including healthcare professionals, act them out. Some biases, if acted upon, can result in increasing health inequalities. It is therefore important for healthcare professionals to become aware of their biases and learn ways to become more intentional, compassionate and inclusive in their actions. To read more about unconscious bias read this page on the NHS Leadership Academy



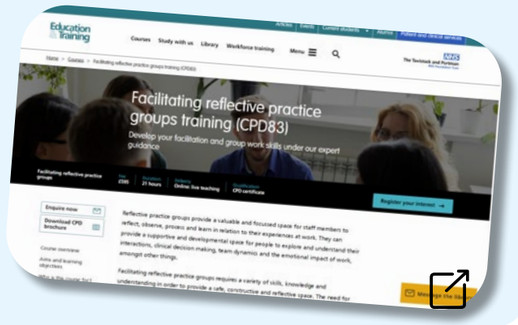
Reflective practice

Reflective practice is a way of making sense of the work we do, and is key to addressing health inequalities in services. Team-based reflective practice sessions can support services to more effectively support diverse groups of people through:

- Strengthening of relationships and cultural understandings within teams.
- Developing self-awareness, and recognition of unconscious assumptions about different cultures and backgrounds.
- Identifying and understanding the difficulties in communication experienced by the service, reflection on responses and insight into other perspectives.
- Increasing tolerance and willingness to listen to other perspectives through the experience of participating in sessions.
- Increasing empathy and awareness of others.
- Developing skills to understand and manage emotional responses to difficult or unfamiliar scenarios.

Important aspects of reflective practice facilitation are:

- Setting up a regular meeting (online or in person), in a space that is protected and comfortable for group members.
- Considering the numbers in each group (6 -10 people is optimal).
- Establishing ground rules and creating a safe space for exploration (including confidentiality).
- Introducing reflective frameworks which are appropriate for your team. The Tavistock Model of reflective practice in teams is one such approach.



- Guiding discussions
- Pulling out themes from discussions
- Helping teammates navigate sensitive topics
- Managing individual differences
- Providing neutral feedback and objective observations.

Things to remember

- **Consider the set-up, and do not rush it.** Rushing can lead to superficiality or discomfort and therefore workforce disengagement. Take time to explain the purpose of sessions and involve the workforce in decisions around the set-up.
- **Consider the facilitator.** External facilitation can provide support, especially during the initial stages and may be seen as more ‘neutral’, particularly where a team is stressed or struggling. Internal facilitation may be more practical for some services and can have different benefits. Different internal facilitators will be more or less suitable, given the group.
- **Effective sessions take trust.** Consider this in the set-up (e.g. the membership, location and agreements on confidentiality) and giving time for trust to build will be important.
- **Developing skills in reflecting together takes time.** Some team members will be more comfortable than others with talking openly or reflecting on their work/ service. It’s important to give sessions time to develop.
- **Respect individual boundaries.** Generally, it is not advisable to ‘pick on someone’ to contribute in reflective practice sessions.

Over time, teams can develop self-management of reflective practice groups.

Schwartz Rounds

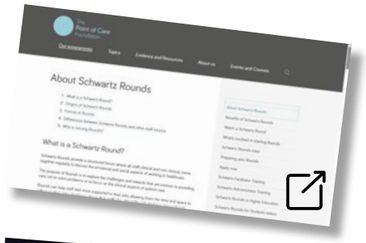
Schwartz Rounds are another form of reflective practice and can support services to become more able to meet the diverse needs of people and communities.

The rounds are an opportunity for the workforce from across the trust to come together once a month to discuss the emotional and professional challenges of their jobs.

What happens in a Schwartz Round?

- Typically they last for an hour.
- Two ‘presenters’ each tell a story about a ‘patient’ and the themes which emerged. This is then opened up for reflection to the audience members, comprising workforce from across the trust.
- The discussion is guided by skilled facilitators.
- An opportunity to reflect together on work experiences, outside of one service.

By doing this, the rounds aim to improve relationships and increase compassion and understanding within the workforce, across organisational hierarchies and between the workforce and people accessing healthcare.[9]



You can find out more about Schwartz Rounds from the Point of Care Foundation and in the following video on the Health Social Care Council’s website.

To find out more about Rounds within Joined Up Care Derbyshire contact the health and wellbeing team on dchst.yourwellbeingteam@nhs.net

9 The contribution of Schwartz Center Rounds® to hospital culture 2012

Quality improvement tools and support

It is useful to plan quality improvement activities and the Plan, Do, Study, Act cycle can be a useful framework for this – for a brief guide to PDSA cycle follow this PDF link.

Across Derby and Derbyshire NHS Trusts there are teams that may be able to guide or support you with Quality Improvement activities

- **Chesterfield Royal Hospital NHS Foundation Trust**
  Derbyshire Community Health Services Improvement, Innovation and Effectiveness Team
- **Derbyshire Healthcare NHS Foundation Trust Our Centre for Research & Development**
- **DHU - Derbyshire Continuous Quality Improvement Lead**
- **Derby Royal Hospital Library and Knowledge Service**
- **Joined Up Improvement Derbyshire** (includes an improvement network)

e-Learning for Healthcare

[e-Learning for Healthcare (e-LfH)](#) has a number of helpful resources available to support understanding of health inequalities, and how to address them in your service. We have selected a sample, but we encourage you to search the resource further to find what best meets the needs of your own team.

Health Inequalities: Learn about health inequalities, the effect of these on the quality and length of life of our populations and how sectors and communities can work together to tackle these.

Health Equalities Framework (HEF): This resource is designed to provide practitioners with a practical introduction to the Health Equalities Framework tool.

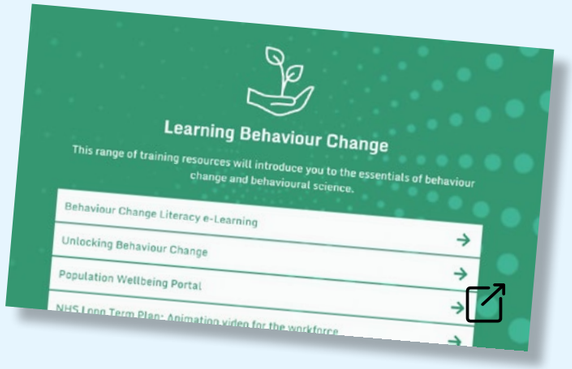
Health Equity Assessment Tool (HEAT): Public Health England has published an essential guide for those working in the health and public health arenas to apply a strong inequalities and equity focus to their work.

Health Literacy: By completing this programme, learners will find out why health literacy is important and how to use some simple techniques including TeachBack, chunk and check, using pictures and simple language to improve how they communicate and check understanding with others.

The Oliver McGowan Mandatory Training on Learning Disability and Autism - Part 1 of 2: This training is named after Oliver McGowan. Oliver was a young man whose death shone a light on the need for the health and social care workforce to have better skills, knowledge and understanding of the needs of autistic people and people with a learning disability.

Handling difficult situations (caring for yourself and others with compassion): The training aims to upskill colleagues in how to handle difficult situations with compassion, using appropriate communication techniques and active listening skills, whilst very much focusing on how to keep yourself well if you feel affected by a situation.

Behaviour change: The training supports colleagues to understand how to use behaviour change approaches to support service adjustment activities.[(Link to behaviourchange.hee.nhs.uk toolkit)](#)



Developing further skills to support health inequalities action

For some people, digital skills and public health knowledge development will support participation in action on health inequalities. A few key online training resources are provided below:

- Excel video training [(link to microsoft.com)](#)
- Data analysis Learning and Development [(link to england.nhs.uk)](#)
- Royal Society for Public Health [(link to www.rsph.org.uk)](#)

Developing a more diverse team

Developing a more representative and diverse workforce can enable learning from each other. This also supports the ethos of the NHS framework to support a diverse and inclusive work force. [10]

Consider approaches to reduce bias in recruitment. This can include training on unconscious bias, standardising interviewing techniques and considerations related to the person specification. You can find support with this within your own trust by approaching human resources.

The **"De-bias recruitment and selection toolkit"** is a useful practical guide on raising awareness of how bias exists within recruitment processes and what actions can be taken to reduce or eliminate such bias. The toolkit can be accessed at the Future NHS website.

Consider the skill-mix of multi-disciplinary teams. A skills mix is not only the professionals which are represented in a team, it is also the backgrounds, culture and lived experience of team members. A diverse MDT can help upskill each other in cultural competence and also offer support with in-house opportunities for learning.

Other helpful resources include:

NHS Employers - Equality, Diversity and Inclusion Toolkit: This toolkit provides practical guidance and resources for NHS organisations to promote diversity and inclusion, including recruitment strategies. (link)

The Chartered Institute of Personnel and Development (CIPD) - Inclusive Recruitment Practices: This resource guide offers practical tips and tools for creating and implementing fair and inclusive recruitment processes. (Link)

Stonewall - Guide to Inclusive Recruitment: This guide provides specific guidance on creating an inclusive environment for LGBTQ+ candidates throughout the recruitment process. (link)

10 https://www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan/

Recruiting a workforce with lived experience. While one perspective cannot stand for all experiences within a given group, colleagues with lived experience can bring diversity and a richness of experience. Specific roles can be set up to actively recruit workers with lived experience. These are often in the form of peer support workers, where the role is actively prescribed by the person's experience. However, there is also the opportunity to include lived experience as a part of the person specification. Different NHS trusts may have their own initiative and policies on recruiting for lived experience. To take this forward, it is important to discuss with the Human Resources department in your own organisation.

Provide opportunities (not pressure) for colleagues to deliver training or share resources that harness their lived experience. This can help address knowledge gaps relating to single issues or a more general understanding of health inequities. It can also improve relationships between team members.

Develop cultural competence across the team to support the wellbeing of diverse individuals.

Trauma-informed practice

Those experiencing health inequalities have a disproportionately enhanced chance of being traumatised. Understanding the impact of trauma on engagement in health care is therefore an important part of addressing health inequalities.

Some examples of the interrelationship between health inequalities and trauma include:

- Factors like poverty, limited education, and housing situations which can expose individuals to violence, neglect, abuse, and chronic stress, increasing their risk of trauma.
- Racial and ethnic minorities often face systemic discrimination and social exclusion, limiting access to healthcare.
- Women and members of the LGBTQ+ community are more likely to experience specific forms of trauma like sexual assault or domestic violence.

Trauma-informed care is:

"An understanding of how reactions to traumatic events can affect health presentations, engagement in health care and health outcomes".

Trauma encompasses a broader range of experiences that are overwhelming or distressing to the extent that they significantly impact a person's sense of safety, security, and control in the world. Traumatic experiences can be single, such as witnessing violence, or multiple events such as domestic violence. Complex Trauma refers to the prolonged exposure to multiple and interconnected traumatic experiences, usually commencing in childhood.

Trauma can affect people in the immediate aftermath of a traumatic event at a psychological level. However for some, the effect may be most noticeable in the form of physical symptoms. When someone has experienced on going trauma early in their development through adverse childhood experiences (ACE's) this can have a profound and lasting effect on a person's neurological development, vulnerability to physical illness and disease and difficulties with interpersonal functioning. [11]

It is important to remember that what is traumatic for one person may not be for another. The individual's perception, context, and prior experiences influence how they perceive and respond to an event.

Example

A healthcare worker who experienced childhood neglect might find themselves avoiding opening up conversations with people they are supporting who have had difficult early life experiences, due to unconscious reminders of their own past experiences. Trauma-informed training can help healthcare professionals identify and manage these feelings in order to support different healthcare interactions.

11 Treatment Improvement Protocol (TIP) Series, No. 57.
Center for Substance Abuse Treatment (US).
Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014.

Impact on engagement with health care

Traumatic experiences, especially involving authority figures, can trigger fear and mistrust towards healthcare providers. This can lead to a variety of difficulties. For example, people may delay or avoiding seeking medical care. Feeling scared and frightened can also lead people to be sensitive to perceived threats to their safety, leading to conflict with the healthcare workforce. Alternatively, past experiences of powerlessness or abuse can also make individuals feel vulnerable and hesitant to assert their needs or ask questions within the healthcare system. People who have experienced trauma may be triggered by particular types of touch, people of certain genders, or other characteristics due to previous experiences.

Trauma-Informed Care

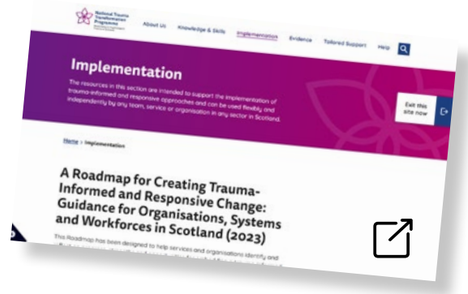
Understanding the diverse impacts of trauma can help healthcare providers to adopt a trauma-informed approach. This involves:

- Creating a safe and supportive environment.
- Building trust and respecting a person's autonomy.
- Recognising trauma-related symptoms and behaviours without assuming judgment.
- Using Quality Conversation principles to enable person-centred care and to give choice.

The impact of trauma on healthcare engagement is complex and individualised. It is essential to approach each person with empathy, understanding, and a commitment to providing respectful, trauma-informed care.

Training on becoming a trauma informed healthcare system

NHS Scotland has taken a lead on developing materials to support becoming trauma informed. The Road map for Creating Trauma Informed and Responsive Change provides 2 levels of guidance:



Part 1: provides an overview of why trauma-informed and responsive organisations, systems and workforces matter and what good looks like.

Part 2: is a self-assessment checklist that includes a roadmap of activities that, based on growing evidence, are most effective in supporting services and organisations in their journey towards becoming trauma informed and responsive.

Training materials are also available to support the road map. The following 10 minute video provides a powerful and helpful introduction to the topic:

Opening Doors Animation - This animation explains why and how trauma-informed is everyone's business. It is designed to support anyone to become trauma informed - no matter what their job or role in society. It covers traumatic events like childhood sexual abuse and domestic abuse, so it is important to look after yourself as you watch it.

Key Points

Investing in workforce development is essential to developing a more inclusive and equitable environment for all, and taking action on health inequalities.

1. Cultural Competence:

- **Definition:** understanding and respecting diverse backgrounds and experiences in healthcare.
- **Importance:** improves communication, reduces health inequalities, and fosters empathy.

2. Reflective Practice:

- **Benefits:** improves team communication, self-awareness, and understanding of cultural differences.
- **Challenges:** requires time, trust, and skilled facilitation.
- **Resources:** Schwartz Rounds and internal facilitators from psychology and staff wellbeing services.

3. Training:

- **Focus:** develop skills and understanding of different cultures and health inequalities.
- **Principles**: build on strengths, offer diverse learning methods, and promote collaboration.
- **Resources:** Local training offers, and national online courses.

4. Developing a Diverse Workforce:

- Benefits: encourages learning from each other and supports a representative NHS.
- Strategies: consider skill-mix, recruit colleagues with lived experience, and provide opportunities for knowledge sharing.

5. Trauma Informed Practice:

- **Understanding:** trauma can impact health presentations, engagement, and outcomes.
- **Relationship to health inequalities:** trauma and health inequalities often co-occur and perpetuate each other.
- **Impact on engagement:** trauma can lead to fear, mistrust, and difficulty seeking care.
- **Role of trauma-informed care:** create a safe environment, recognise trauma symptoms, and provide person-centred care.
- **Resources:** NHS Scotland's Road map, Opening Doors Animation, and training materials.

Conclusion

Addressing health inequalities is everyone's business. It can though feel overwhelming, particularly if this is a new area of work for a service. It can also feel hard to know who to contact locally, to drive this work forward.

This brief step-by-step guide is intended to support NHS services in Derby and Derbyshire plan and deliver action to reduce health inequalities, at a service-level.

This is highly rewarding work for the workforce and services, which can make significant differences to the health and wellbeing of local people and communities.

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