**Rapid Literature Review: Health Inequalities within a Local Area**

**Care Quality Commission**

October 2023

Executive Summary

#### Introduction and background

In March 2023, Care Quality Commission (CQC) commissioned RSM UK Consulting LLP (RSM) along with Professor Rosalind Raine at University College London (UCL) and the University of Birmingham Library Services to conduct a rapid literature review into addressing health inequalities within a local area. Health inequalities have been defined by the King’s Fund as:

*“Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. […] the term is also used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives – both of which can contribute to their health status. Health inequalities can therefore involve differences in:*

*health status, for example, life expectancy;*

*access to care, for example, availability of given services;*

*quality and experience of care, for example, levels of patient satisfaction;*

*behavioural risks to health, for example, smoking rates; and*

*wider determinants of health, for example, quality of housing”.*1

They are driven by the social, economic, structural and environmental conditions in which a person lives, as well as unequal access, experience and outcomes from healthcare and wider determinants. There is also interplay between all these factors and equality characteristics. All these can influence the opportunity for good mental and physical health – and are systematic, unfair and often avoidable.

The Health and Social Care Act 2022 states that local Integrated Care Systems (ICS) are responsible for tackling health inequalities within their local areas. However, many different organisations (eg Sustainability Transformation Partnerships, Strategic Health Authorities) had played a part in addressing health inequalities in the past 20 years, providing an opportunity to consolidate lessons learned.

#### Purpose of this research

According to the Health and Social Care Act 2022, the CQC is required to conduct reviews of ICSs to assess the function of the system in the provision of health and social care. This includes how systems are addressing health inequalities within their local area.

In 2021, CQC published a new strategy to make regulation more relevant to the way care is delivered. This literature review seeks to support CQC in the delivery of this strategy by providing a robust evidence base of good practice, strengthening the understanding of local interventions on health inequalities. It will also inform the way CQC assesses ICSs and consider how local systems can reduce health inequalities.

The aim of this research is to provide the CQC with an evidence base on what works within local areas in terms of addressing health inequalities. The search protocol for this literature review was designed to be framework / government policy agnostic – to broaden the literature available for extraction.

The primary research questions were set by CQC at the outset of the project and covered three key areas related to health inequalities:

* **Theme 1:** What are effective ways of identifying local health inequalities or potential health inequalities?
* **Theme 2:** What are the evidence-based interventions/approaches that work to address health inequalities within a local area?
* **Theme 3:** What does successful engagement with local people and communities look like?

**Methodology**

Our review methodology consisted of several stages. Firstly, a search protocol was developed to find all relevant peer-reviewed academic literature, as well as grey literature publications. As a result, a longlist of 1,415 titles was produced, which was then rigorously screened and narrowed down to 87 articles. These were subjected to a quality assessment, with 64 articles then included in the literature review: 46 academic and 18 grey literature publications. Key information was then extracted and mapped in a spreadsheet, including: title, author, date, country, study type, the study aims, methods/ evidence base, findings, strengths, and limitations reported in the study, key themes/topics, relevant outcomes, and a quality appraisal. All findings were synthesised in accordance with the primary research questions.

#### Findings from the literature review and expert panel reflections

**Theme 1: What are effective ways of identifying local health inequalities or potential health inequalities?**

Given the complexities of local areas and the specific needs of each, unsurprisingly, a range of different methods have been shown to identify health inequalities. These can be segmented into three overarching categories: (i) Population statistics, (ii) Combining health data with wider determinants and (iii) using experiential or qualitative data to understand experiences. However, no literature paid attention to exploring some of the tools that are already being used by systems, for example, the Public Health England (PHE) framework, and how these could be streamlined or enhanced in their use.

A number of considerations were identified which may help to determine what methods a local area may want to use in the identification of health inequalities. These include:

* Have specific areas of health inequalities been identified?;
* The use of wider determinants of health datasets; and
* The availability of data

Overall, it is clear that there is no “one size fits all” approach and different methods should be selected based on the specific requirements for each local area. Most research tends to focus on the ways of identifying inequalities, and presents limited evidence to support the effectiveness of these methods.

**Theme 2: What are the evidence-based methods/approaches that work to address health inequalities within a local area?**

The use of several different approaches that can be used to address health inequalities have been highlighted. The overarching approaches identified include:

* **Asset-based or place-based approaches:** which use both physical community assets (eg community centres, recreation facilities, transport systems, etc.)and Voluntary Community and Social Enterprise (VCSE) organisationsto support communities through a range of engagement-based or social-led programmes.
* **Proportionate universalism:** this is a method of allocating resources to services aimed at reducing health inequalities, with low-level support provided universally and stepped intensity of support for individuals and / or communities based on level of need.
* **Engagement-based approaches:** the use of community navigators (ie local area co-ordinators). Their role is often to co-produce or co-develop tailored methods for either whole communities or individuals as a mechanism of reducing health inequalities.

In terms of the specific methods for addressing health inequalities, a significant proportion of the literature focussed on improving health outcomes more generally (relative to the other areas which can address health inequalities such as prevention, improving access etc.). The most popular types of methods related to improving health outcomes included: advice, guidance and signposting; training and education programmes; social / leisure and engagement programmes; and wider system change.

Alternative services models (ie modified ways of health and care services being delivered to increase the use or access to services, such as extended hours) were also a popular method type for improving access to health and care services. Many of the methods aimed to address the barriers for access, such as tele-pharmacy for those living in rural areas30.

These methods should be tailored to meet the needs of the target populations and which health inequalities need to be addressed. Local areas should consider the specificity of the interventions required based on:

* their local area population;
* the geographic coverage of these areas; and
* the specificity of other interventions / existing services within the local area.

Many methods for addressing health inequalities were also targeted at individuals or communities who were socio-economically disadvantaged. This was often determined using socio-economic methods such as English Indices of Multiple Deprivation (IMD) and socio-economic status groups. Methods aimed at addressing health inequalities within urban or mixed areas were more diverse, with the focus methods mainly based on the specific community or the objective of the method. Within rural areas, methods were typically focussed on improving access to health and care services, such as issues around transport / travel distances.

There was limited research that explored the cost-effectiveness and sustainability of these approaches and methods, which would be required to scale these methods – with these two areas being highlighted by the expert panel as fundamental to the effectiveness of methods to address health inequalities in the long-term and should be an area for further research.

**Theme 3: What does successful engagement with local people and communities look like?**

**When to engage with local people and communities?**

The benefits of engaging with local people and communities was shown across the lifecycle of different initiatives. Ensuring that the communities targeted are included in the design and development were shown to result in successful implementation.

Successful engagement included bringing together a range of stakeholder groups and hearing from a range of diverse voices. Common engagement groups identified included: VCSE organisations, community champions, members of the public in the target community, researchers, healthcare providers and wider community support roles (such as police officers). Tailoring the approach to different communities’ needs and perspectives was shown to be key.

A number of different engagement approaches have been described but can be grouped into two broad categories:

* *Asset-based engagement* which rely on existing local community assets (people, groups, resources) to develop and strengthen communities; and
* *Community-centred engagement* models involved mobilising resources within community and co-production whilst building capabilities within the community.

Beyond the two categories for engagement, it was clear that collaboration across partners was essential to provide effective and inclusive ways of working to consider inequalities.

To ensure that communities are at the heart of the approach, community centred approaches should use participatory methods where community members are actively involved in design, delivery, and evaluation; use and build on local community assets in developing and delivering the project; and develop collaborations and partnerships with individuals and groups at most risk of poor health.

The research highlighted a range of challenges of integrating research and practice when it comes to complex community interventions. Successful community and stakeholder engagement requires their involvement from the beginning, and at all stages of method design, delivery, evaluation and dissemination. Within the expert panel, it was also highlighted that it can be challenging to engage meaningfully without culturally competent services that use local assets, including emphasising the need to consider cross cultural competence training not only for community members who are willing to get involved but also for the local services staff.

Whilst this research can highlight the benefits of effective community and local engagement, there was limited evidence in the direct links to improved health outcomes or reduced inequalities. Consideration in future research may be given to establish evidence to support the link between effective engagement and improving health outcomes.

#### Learning for CQC

To help CQC with their development of assessment criteria for ICS for how they address health inequalities, we identified a list of useful thematic considerations under each CQC theme in the below table:

Table A – Considerations for ICS assessment: Leadership, Integration and Quality & Safety themes (further details provided in Table 5)

| **Area** | **Considerations** |
| --- | --- |
| **Leadership** | * Vision and understanding of the system
* Collective ownership
* Whole pathway framework
 |
| **Integration** | * Length and amount of funding
* Partnership / joint working
* Commissioning arrangements / contracting
* Wider determinants of health
* Community assets
* Population profile
 |
| **Quality & Safety** | * Information governance & data sharing
* Use of data and data quality
* Co-production of services
* Engagement with communities
* Feedback from communities
* Engagement with populations at risk of inequality
 |

Please note: the considerations for ICS assessment have been grouped thematically, however, these may be categorised differently following the refinement of the ICS assessment themes. Considerations for Quality and Safety have been grouped based on the extent to which they could negatively impact on the quality and safety of services if these factors were not appropriately in place.

#### Considerations for future research

Based on the evidence from this literature review and the reflections from the expert panel, there are a number of considerations of areas for future research:

* **Whole pathway framework:** many of the studies cited within this literature review referenced a particular point in the process of addressing health inequalities (ie the identification of health inequalities, delivering on different methods, engaging within communities) as a standalone focus. To address this gap in evidence, a series of mini case studies could be undertaken with a stratified sample of systems to better understand these linkages in addressing health inequalities across the “whole improvement pathway”.
* **Improving the evaluation of interventions:** Further research into good practice in how to address these challenges would provide local systems with a robust evidence base to improve the evaluation of methods, enabling successful methods to be embedded and less successful methods to be improved or concluded.
* **Sustainability:** Further research could be undertaken to focus on understanding how successful one-off methods could be embedded into health and care systems and scaled (including the exploration of critical success factors for a sustainable method, models which support sustainability, economic / financial considerations and lessons learnt in embedding one-off methods into business as usual).

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Glossary of Terms

| **Abbreviation** | **Definition / Explanation** |
| --- | --- |
| **Anchor institution** | Anchor institutions are large organisations that are unlikely to relocate and have a significant stake in their local area. They have sizeable assets that can be used to support their local community’s health and wellbeing and tackle health inequalities, for example, through procurement, training, employment, professional development, and buildings and land use ([source](https://www.kingsfund.org.uk/publications/anchor-institutions-and-peoples-health)). |
| **Asset-based / place-based approaches** | The approaches use both physical community assetsand Voluntary Community and Social Enterprise (VCSE) organisationsto support communities through a range of engagement-based or social-led programmes, with a focus on addressing health inequalities |
| **BEIS** | Department for Business, Energy & Industrial Strategy |
| **CHD** | Coronary Heart Disease |
| **COVID-19** | Coronavirus disease |
| **CQC** | Care Quality Commission |
| **CWBC** | Community and Well-Being Champion.Community and wellbeing champions are community members who volunteer to promote health and wellbeing or improve conditions in their local community. Champions use their social networks and life experience to address barriers to engagement and improve connections between services and communities ([source](https://www.gov.uk/government/publications/community-champions-programme-guidance-and-resources/community-champions-programme-guidance-and-resources)). |
| **DfE** | Department for Education |
| **Engagement-based approaches** | Approaches that use community navigators (ie local area co-ordinators). The navigator role is often to co-produce or co-develop tailored methods for either whole communities or individuals as a mechanism of reducing health inequalities. |
| **GP** | General Practitioner |
| **GRADE** | Grading of Recommendations, Assessment, Development, and Evaluations A systematic and transparent approach for rating the certainty of evidence in systematic reviews and clinical practice guidelines, and for developing and determining the strength of clinical practice recommendations ([source](https://bestpractice.bmj.com/info/toolkit/learn-ebm/what-is-grade/)). |
| **HES** | Hospital Episode Statistics |
| **HLA** | Healthy Living ApproachA community-led process of identifying and addressing issues affecting local health and wellbeing.  |
| **ICS** | Integrated Care SystemA partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area ([source](https://www.england.nhs.uk/integratedcare/what-is-integrated-care/)). |
| **IMD** | Indices of Multiple DeprivationA measure of relative deprivation for small, fixed geographic areas of the UK. |
| **LSOA** | Lower layer Super Output AreasA geographic hierarchy designed to improve the reporting of small area statistics in England and Wales. |
| **NACR** | National Audit of Cardiac Rehabilitation |
| **NHS** | National Health Service |
| **OHID** | Office of Health Improvement and Disparities |
| **ONS** | Office of National Statistics |
| **PA** | Physical Activity |
| **PCA** | Personalised Care AdjustmentPersonalised Care Adjustment data presents information on numbers of patients with specific clinical conditions who are not included in the Quality and Outcomes Framework (QOF – see the definition below) indicator data ([source](https://www.gov.uk/government/statistics/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data-2021-22)). |
| **PF** | Proportional FlowThis is a method where geographic units are assigned to a trust if the proportion of all patients resident within the geographic unit attending a trust exceeds a pre-defined threshold ([source](https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-021-12373-5)). |
| **PHE** | Public Health England |
| **PRESS** | Peer Review of Electronic Search StrategiesA structured checklist tool for reviewing electronic literature search strategies ([source](https://kib.ki.se/en/search-evaluate/systematic-reviews/press-2015-checklist-search-strategies)). |
| **PRISMA** | Preferred Reporting Items for Systematic Reviews and Meta-analysesGuidance on producing literature reviews, which was designed to help reviewers transparently report why the review was done, what the authors of the literature did, and what they found. |
| **Proportionate universalism approach** | A method of allocating resources to services aimed at reducing health inequalities, with low-level support provided universally and stepped intensity of support for individuals and / or communities based on level of need. |
| **Population segmentation approach** | Population segmentation approaches can provide detailed insights into the needs of various populations through applying analytical methods to large integrated data sets from various health and care settings. |
| **QOF** | Quality Outcomes FrameworkA system for the performance management and payment of general practitioners (GPs) in England. The objective of is to improve the quality-of-care patients are given by rewarding practices for the quality of care they provide to their patients, based on several indicators across a range of key areas of clinical care and public health ([source](https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2021-22#summary)). |
| **RII** | Relative Index of InequalitiesA measure of inequality. It is a measure of the social gradient in an indicator and shows how much the indicator varies with deprivation. It takes account of inequalities across the whole range of deprivation within England and summarises this into a single number ([source](https://www.gov.uk/government/publications/health-profile-for-england-2018/methods-data-and-definitions#relative-index-of-inequality-rii)). |
| **RSM** | RSM UK Consulting LLP |
| **SPT** | Social Practice TheoryA theory within the field of psychology that seeks to determine the link between practice and context within social situations. |
| **UCL** | University College London |
| **VCSE** | Voluntary Community and Social EnterpriseAn organisation which serves communities within England ([source](https://www.tnlcommunityfund.org.uk/funding/thinking-of-applying-for-funding/who-can-apply/voluntary-community-and-social-enterprise-vcse-definition#:~:text=VCSE%20means%20an%20incorporated%20voluntary,the%20relevant%20registry%20body%3B%20or)). These can be either charities or unregulated organisations. |

1. Introduction and background

RSM UK Consulting LLP (RSM) along with Professor Rosalind Raine at University College London (UCL) and the University of Birmingham Library Services were commissioned by Care Quality Commission (CQC) in March 2023 to conduct a rapid literature review into what works in addressing health inequalities within a local area.

* 1. Evolution of local systems addressing health inequalities

Health inequalities have been defined by the King’s Fund as:

*“Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. […] the term is also used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives – both of which can contribute to their health status. Health inequalities can therefore involve differences in:*

*health status, for example, life expectancy;*

*access to care, for example, availability of given services;*

*quality and experience of care, for example, levels of patient satisfaction;*

*behavioural risks to health, for example, smoking rates; and*

*wider determinants of health, for example, quality of housing”.*1

They are driven by the social, economic, structural and environmental conditions in which a person lives, which can influence their opportunity for good mental and physical health – and are systematic, unfair and often avoidable. [Addressing these social, economic and environmental conditions is a fundamental part of](https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on) reducing health inequalities. Examples of the factors which can drive health inequalities include:

* Age;
* Disability;
* Gender reassignment;
* Marriage and civil partnership;
* Pregnancy and maternity;
* Ethnicity / race;
* Religion / belief;
* Sex;
* Sexual orientation;
* Income;
* Employment;
* Education;
* Poverty;
* Housing;
* Living environment;
* Geographical location;
* Access to services;
* Crime;
* Caring responsibilities; and
* Any combination of the above.

The Health and Social Care Act 2022 states that local Integrated Care Systems (ICS) are responsible for tackling health inequalities within their local areas. Before the development of ICS in their current structure, a range of different organisations – from Strategic Health Authorities to Sustainability Transformation Partnerships –have been responsible for addressing health inequalities over the last 20 years. While the level of centralisation of these organisations has varied, there is opportunity to learn from good practice and build an evidence base to share learning.

* 1. Purpose of this research

The Health and Social Care Act 20223 requires CQC to conduct reviews of ICSs to assess the function of the system in the provision of health and social care – this also includes how systems are addressing health inequalities within their local system.

In 2021 CQC published a new strategy for the changing world of health and social care.4 The strategy aims to make CQC’s regulation more relevant to the way care is now delivered, more flexible to manage risk and uncertainty, to enable CQC to respond in a quicker and more proportionate way as the health and care environment continues to evolve.

CQC’s strategy was published under the themes:

* People and communities
* Smarter regulation
* Safety through learning
* Accelerating improvement

The aim of this research is to provide CQC with an evidence base on what works within local areas in terms of addressing health inequalities. The search protocol for this literature was designed to be framework / government policy agnostic – to broaden the literature available for extraction. Throughout each theme, there is the ambition to assess local systems and tackle inequalities in health and care. This research has been conducted in order to strengthen CQC’s understanding and have a robust evidence base to support delivery on these strategic aims. This evidence base will also be used by CQC to support the delivery of its strategy, and to inform the way the organisation assesses ICSs and considers how local systems can reduce health inequalities.

* 1. Research questions to be explored

The review determined and commented of the breadth and volume of existing research (including research gaps). The primary research questions were set by CQC at the outset of the project and covered three key areas related to health inequalities. These included:

* **Theme 1:** What are effective ways of identifying local health inequalities or potential health inequalities?
* **Theme 2:** What are the evidence-based methods/approaches that work to address health inequalities within a local area?
* **Theme 3:** What does successful engagement with local people and communities look like?

These were supported by further sub-questions across each theme, each of which is outlined in Annex A.

1. Method
	1. **Approach to the literature review**

**Project initiation and governance**

At the outset, a project initiation meeting was undertaken with key members of the RSM research team and representatives from CQC’s research team, which included staff responsible for developing CQC work on tackling inequalities and ICS assessments. Key research questions and methods were agreed upon. An expert panel was set up to allow opportunities to test back findings with those working with health inequalities, those with expert knowledge of health inequalities and those from local health and care systems. The insights of the expert panel were used across two workshops: one to test back the methodological approach and another to test back findings and implications for CQC.

**Development of the search protocol**

Relevant literature was reviewed from two types of sources: published studies in scientific journals and grey literature from government and other public agency sources. The search for peer-reviewed, academic literature was conducted via the University of Birmingham Library Services based on agreed search terms which can be found in Annex B. To structure our search strategy and optimise the time available, the Peer Review of Electronic Search Strategies (PRESS) checklist was used.5

**Screening of titles and abstracts**

Altogether, the searches produced a longlist of 1,415 titles which were rigorously screened as detailed in Figure 1. This resulted in a shortlist of 64 articles. At each stage, two reviewers were involved in screening and any discrepancies were resolved through discussion and consensus development. A third reviewer also screened 10% of reports at each stage to ensure consistency.

**Figure 1 PRISMA style reporting of records at each stage of screening**



**Quality assessment of full texts**

Full texts were reviewed to identify the most relevant studies to be included within the literature review. This included 87 articles. The selection of peer reviewed articles was based on quality measures eg the extent to which methodologies are robust using the Grading of Recommendations, Assessment, Development, and Evaluations (GRADE) criteria.6 In agreement with CQC, we decided to assess grey literature for quality based solely on its relevance to the research questions. This approach aims to create a comprehensive and equitable literature review that includes valuable insights from qualitative and user-led research. While such studies may not always meet the robustness criteria of published articles, they can offer rich and nuanced understandings of human experiences, opinions, and behaviours.

**Relevancy assessment of full texts**

Each full text was also assessed for its relevancy to the research questions of this literature review. Texts were marked either ‘low’, ‘moderate’ or ‘high’ relevance for each of the research questions across both peer-reviewed and grey literature.

**Full review and data extraction**

A total of 64 full-text articles were selected for inclusion in the literature review. This included 18 articles from grey literature and 46 from the peer-reviewed, academic literature base. Key information was transferred to a spreadsheet for mapping and included: title, author, date, country, study type, the study aims, methods/ evidence base, findings, strengths, and limitations reported in the study, key themes/topics, relevant outcomes, and a quality appraisal. Findings were synthesised in accordance with the primary research questions. The full texts which have been included within this literature review are listed within Annex F.

Table 1 sets out the number of articles reviewed to support each research question. It is important to note that some papers informed responses to multiple questions. The largest number of papers were linked to the types of methods and approaches that address health inequalities.

**Table 1 Research questions and literature reviewed**

| **Primary research questions**  | **Total number of papers reviewed**  | **Peer-reviewed papers** | **Grey literature papers** |
| --- | --- | --- | --- |
| What are effective ways of identifying local health inequalities or potential health inequalities? | 9 | 5 | 4 |
| What are the evidence-based methods/approaches that work to address health inequalities within a local area?  | 51 | 36 | 15 |
| What does successful engagement with local people and communities look like? | 30 | 23 | 8 |

* 1. **Methodological limitations**

The limitations of a literature review of this nature can be grounded in the reliance on previously published research and the availability of these studies (using the agreed search methodology and inclusion/exclusion criteria). For example, the volume of research that is able to provide demonstratable and measurable outcomes is limited within a complex system environment, where linking characteristics and enablers to positive outcomes is not always easy.

Whilst the selected full-text articles were relevant to the topic, the source quality of evidence was low on the research hierarchy – meaning that some of the evidence provided in these articles did not come from high quality/rigorous research. For example, these included a range of scoping reviews, case studies and qualitative studies amongst others.

Relevant extracts from the literature were mapped to the research questions. However, within the literature, one of the main gaps that has been identified is the extent to which the literature encompasses the addressing of health inequalities pathway (ie from identification of health inequalities to development an intervention method and conducting an evaluation).

Additionally, a number of gaps have been identified within the literature, through the triangulation of evidence with discussion from the expert panel workshops. Gaps included ongoing evidence of sustainability, with many methods described in literature being one-off / short-term in nature.

1. Findings from the rapid literature review

This chapter focuses on the findings from the literature against each of our research themes. It also provides a summary of the common conditions for success and challenges under each theme.

* 1. Theme 1: What are effective ways of identifying local health inequalities or potential health inequalities?

This section outlines methods and methodological considerations for identifying health inequalities for local areas. We address:

* The methods for identifying health inequalities;
* The considerations for local areas when determining what methods to use to identify health inequalities; and
* Critical success factors for engagement.

**The methods for identifying health inequalities**

Given the complexities of local areas and the specific needs of each, unsurprisingly, a range of different methods have been shown to identify health inequalities. These can be segmented into three overarching categories:

*Population statistics*

The use of population statistics was shown to be effective in a number of different cases. For example, in a hospital trust area in West London population data helped to identify and define core ‘catchment populations’. This was done by employing a ‘proportional flow method’ which identified areas within the hospital catchment where 30% or more of the residents attended or required hospital treatment. From this, health indicators were derived for the ‘catchment populations’ and the health needs of the community were more accurately understood. This was an important development to support the understanding of the patient population as a result of the new integrated care systems.7

Similarly, a data-driven approach was used to **identify those facing health inequalities by looking at how people use services** in South Wales Valleys. Researchers from the University of Plymouth used ‘cluster analysis’ to group together people with distinct healthcare needs based on variables such as elective impatient admissions and Emergency Department visits8, and identified 10 population segments. This information could then be used to inform decisions around local service planning such as tailoring of integrated health and care services for each population segment, particularly those that have complex needs.

*Combining health data with wider determinants*

Using data related to the wider determinants of health (such as e.g., housing, transport, environmental) was a relatively common approach adopted within the literature for the identification of health inequalities. This is because health inequalities are highly interlinked with the physical, social, and environmental factors faced by a local area.

Examples of methods include:

Using secondary data and **Statistical Control Charts** to analyse physical and social environments (eg nuisance complaints) to routinely monitor the relationship between hazards and disease and to address local health issues.9 A pilot project conducted in a Birmingham housing estate identified environmental and social aspects of the area, such as anti-social behaviour, that needed further investigation as they were far worse than the City average.9 This type of analysis could allow local government to better identify ways to address environmental and social problems that are associated with poor public health outcomes.

Another example is the **Relative Index of Inequalities** (RII). The Strategy Unit used the RII in their report for the British Heart Foundation on economic inequalities in the progression and pathways of coronary heart disease.11. The calculation for determining the RII is: the extent to which the rate of an activity or event varies across socio-economic groups defined by deciles of deprivation. The factors used to calculate deciles of deprivation include crime, barriers to housing and services, and living environment.11 A benefit of the RII approach is that it takes into account the values for all deprivation deciles, as well as the population size of each group. This means that smaller groups do not unduly skew the results when looking at inequalities across a population.11

**Net migration and residential mobility** were identified within the literature as measures that can be used to identify local health inequalities. Open access area-level data on migration has shown that areas differ in their rates of net migration among people in good health and people in poor health12. For instance, areas that had a high net migration of young people also had a high net migration of healthy people, whereas, areas with a high net migration of old people tended to have a high net migration of people in poor health. Understanding these trends can help areas understand the needs of a local area population, and prepare for how these could change over time.

*Using experiential or qualitative data to understand experiences*

In addition, there is a wide range of more experiential or qualitative methods that can be used to identify health inequalities.

Within the literature, a **systems thinking approach** was identified. This is where an approach to problem-solving looks to understanding the system within which the problem occurs, rather than at the specific incidence of the problem, to avoid looking at some challenges as discrete to one group or one cause. Academics from the University of Bristol and the University of Sheffield used this method to explore commonalities between two area-specific system maps (while removing locality-specific factors) to develop a map of the determinants of child health inequalities that could be applied in any English local area.10 From this, they identified 125 factors across 6 domains that were determinants of child health inequalities as well as 300 links between individual factors10. Evidence of outcomes is limited but potential applications of systems thinking approaches has particular importance to the development of collaborative equity-orientated practice across ICSs.

**The considerations for local areas when determining what methods to use to identify health inequalities**

Throughout the literature, a number of considerations were identified which may help to determine what methods a local area may want to use in the identification of health inequalities. These include:

**Whether or not specific areas of health inequalities have been identified:** Much of the literature focuses on health inequalities as a public health issue7,8,12 (e.g. general mental or physical health) with some consideration of specific areas, such as children’s health10 and Coronary Heart Disease (CHD) pathways11. Methods have often been tailored for specific locations and population groups and may require adjustments if replicated in different contexts.

**Data associated with the wider determinants of health:** these factors that can be used to identify health inequalities and offer a broader perspective on the determinants of health have included air pollution15, housing tenure13, fuel poverty14, and community experience and hazards9. Existing studies have relied more on the combination of secondary and primary data (eg using approaches such as systems thinking, through engaging with professionals, communities and experts in public health).

**The availability of data:** Challenges are associated with data availability and access, which constrain the robustness of methods which can be applied. The reliance on publicly available data is clear from the literature, with limited use of patient record data8. Common sources of data were ONS7,9,11,14, HES7,11 and PHE9, with less common sources including police and fire departments9 and governmental departments (eg Department of Education9 and BEIS14). Issues with data availability include:

* obtaining permissions for linkage of health and social care data8 and to other external datasets7;
* few indicators are available at small geographical level7; and
* inconsistencies in data collection by different health and care organisations8.

Overall, the literature outlines a range of methods to identifying health inequalities. However, there is no “one size fits all” approach and different methods should be selected based on the specific requirements for each local area.

Several gaps in the existing literature have been revealed. Firstly, most papers tend to focus on researching ways of identifying inequalities and present limited evidence to support the effectiveness of these methods as they do not establish a clear link to methods. Secondly, there is often a lack of clarity regarding the rationale behind the selection of specific methods or populations for study. Hence, there is limited evidence to suggest that it is feasible to apply these approaches in another local area or extend these to other axes of inequality.

Common conditions for success and areas of challenge

Throughout the above literature, several common conditions for success and areas of challenge have been identified. These have been grouped based on the three themes for the assessment of ICS in the table below.

**Table 2 – Theme 1: common conditions for success and areas of challenge**

|  | Common conditions for success | Common areas of challenge |
| --- | --- | --- |
| Leadership | * Taking a **systems approach (‘local system’) to the breadth of health inequalities** as a single public health issue (eg child health inequalities), rather than tackling single issues such as obesity, healthy eating or physical (eg unlike for adult health inequalities)10.
 | * Due to cuts to local authority budgets, taking a systems approach to health inequalities (eg child health inequalities) is not presently viable as many local services contracting to deliver only statutory responsibilities.10
 |
| Integration | * Need to **identify the core population/unique population segments** in the area of interest (ie served by a specific trust, registered via a particular GP). “*Segmenting a heterogeneous population into discrete and relatively homogenous groups with similar healthcare needs can enable the development of integrated health and care systems that are more targeted and efficient*”.8
 | * Using mutually exclusive areas to identify a profile of a population presents issues for an urban area where there tend to be several commissioning and provider organisations.7 In addition, some measures (eg residential mobility) present a challenge for ICS as they can potentially alter the health profile of the area.12
 |
| Quality and safety | * **Leveraging publicly available local and national datasets** (eg Hospital Episode Statistics (HES)), Lower layer Super Output Areas (LSOA) level data and access to primary and secondary care datasets.
 | * **Data challenges:** missing data can obstruct reflection of local patterns. For example, fewer indicators are available at smaller geographical levels and typically there is reduced granularity. Issues with data linkage, such as, HES linkage to other external datasets can prevent from building in health need predictions. Data issues also reduce robustness of the methods developed.
 |

Please note: the common conditions for success and areas of challenge have been grouped thematically, however, these may be categorised differently following the refinement of the ICS assessment themes.

* 1. Theme 2: What are the evidence-based methods/approaches that work to address health inequalities within a local area?

This section explores the overarching approaches and specific methods that work to address health inequalities, including the types of approaches or methods, factors for success and areas of challenge. We address:

* The approaches implemented in local areas to address health inequalities;
* Different methods that are used to address health inequalities within a local area;
* Methods generic or specific to specific communities or types of area; and
* Common conditions for success and areas of challenge.

**Approaches implemented in local systems to address health inequalities.**

The use of several different approaches that can be used to address health inequalities have been highlighted. The overarching approaches include:

* **Asset-based or place-based approaches:** which use both physical community assets (eg community centres, recreation facilities, transport systems, etc.)and Voluntary Community and Social Enterprise (VCSE) organisationsto support communities through a range of engagement-based or social-led programmes, with a focus on addressing health inequalities.
* **Proportionate universalism:** this is a method of allocating resources to services aimed at reducing health inequalities, with low-level support provided universally and stepped intensity of support for individuals and / or communities based on level of need. Proportionate universalism is also a very commonly cited approach within an early-years setting.
* **Engagement-based approaches:** the use of community navigators (ie local area co-ordinators). Their role is often to co-produce or co-develop tailored methods for either whole communities or individuals as a mechanism of reducing health inequalities.

A number of studies have referenced a combination of these approaches rather than using them in a standalone manner. For example, one study used Link Workers, who were members of the target community, to enact a social prescribing model that directed individuals with long term conditions to facilities and services that already existed in the community.23 **.** The majority of asset or place-based approaches use a range of behavioural and engagement mechanisms as a part of their approach, allowing the range of methods / initiatives to be flexible to meet the needs of the engaged population. They also tend to leverage existing community assets (both in terms of physical buildings and VCSE organisations). These approaches have also been determined ‘salutogenic’16,17, which is defined as approaches to wellbeing that focus on health rather than disease, and while these approaches have not been evaluated extensively within the literature, there is evidence to suggest that such approaches are effective:

*“salutogenic approaches are useful in the treatment and prevention of long-term conditions, can take pressure off of socialised healthcare systems and can be effective in increasing resilience and wellbeing in individuals and communities. [However,] despite evidence of the positive impact of cultural engagement on the population in general, there remains inconsistency in the evidence for community assets as reducers of health inequity in disadvantaged, marginalised or vulnerable communities”.16*

This is due to a lack of clarity in the literature on the impact of these initiatives as many only provide anecdotal evidence. This is important as disadvantaged, marginalised, and vulnerable groups are the ones that require the most assistance if health inequities are to be addressed.

As these approaches focus on particular communities or neighbourhoods, there will often be a requirement to establish new ways of working across partnership organisations18-19. For example, the Healthy Wigan Partnership is aimed at reducing health inequalities in one of the most economically deprived areas of the country, and is a partnership of primary care, community services, early years, mental health and public health services.19 It is also hypothesised that new ways of working not only have the potential to improve health outcomes, they may also have positive influences on cost effectiveness, due to reducing the amount of structural re-organisation through a focus on place.20 For example, a place-based working pilot in a small rural market town in the North of England fitted within existing service delivery remits, avoiding any reorganisations, and, therefore, had the potential to reduce health inequities despite austerity measures, according to key stakeholders20. These approaches typically only impact the individuals and communities that engage within the methods and there has been limited evidence around the sustainability of the approach.

Proportionate universalism is a recommended approach19, though there has been limited evaluation, and there is limited evidence of the impact and extent of sustained improvements in health inequalities. This remains a recommended approach as the policy aim should not just be to improve the conditions of those worst off but also those who are relatively disadvantaged and proportionate universalism could achieve this.20 However, the lack of evidence of the effectiveness of this approach means that this is an area that would benefit from further research.

The Champs Prevention programme, being implemented by the public health teams in Cheshire and Merseyside,21 came up in multiple case studies within the literature and is an alternative approach for addressing health inequalities. It is focused on tackling a number of high-level universal priorities that are common to every area, such as high blood pressure, mental health and wellbeing, and reducing alcohol harm. The programme has facilitated clearer messaging around early intervention, prevention and self-care. However, there has not been sufficient evaluation of this approach within the literature to comment on its efficacy.

**What are the different methods that are used to address health inequalities within a local area**

A significant number of methods in the literature focussed on improving health outcomes more generally (relative to the other areas which can address health inequalities such as improving access etc.), and the majority cited achieving at least some of their expected outcomes as a result of their methods, including participation outcomes (e.g. recruitment, retention and completion of assessments24 ) and health-related outcomes (eg Body Mass Index (BMI),27 life expectancy,27 and smoking status29).

The most popular types of methods related to improving health outcomes included:

* **Advice, guidance and signposting** (eg referrals to partner organisations who can support with wider determinants of health such as housing22, social prescribing based on individual’s needs23) These methods can help increase individual’s access to the specific help that they need and lead to greater engagement.22, 23 They are particularly helpful for those with multiple needs. 22, 23
* **Training and education programmes** (eg education programmes to promote physical activity for older women24 training programme to support young people into employment22); These programmes can provide practical and emotional support and lead to greater understanding of the options available to individuals, which can lead to improved outcomes.22, 24
* **Social / Leisure and engagement programmes** (eg a community based music intervention to improve the wellbeing of young people,25 arts / nature based interventions to improve the health outcomes of people with long-term conditions23); These programmes lead to greater self-confidence for the participants which in turn leads to better health outcomes such as weight loss and improved mental health.23,25 These programmes are particularly helpful for those individuals who suffer from social isolation. 23, 25 and
* **Wider system change** (eg urban regeneration activities focussed on addressing health inequalities,26 ethical lettings agreements with providers in a local area19) These changes improve individual’s mental and physical health by improving their living conditions, particularly those in deprived areas37.

Alternative services models were also a popular method type for improving access to health and care services. Many of the methods aimed to address the barriers for access. Examples of such methods include: tele-pharmacy for those living in rural areas30, use of interpretation services31 and using methods such as extended consultations for people with multimorbidity complex care needs.18

The literature suggests addressing both mental and physical health with methods and approaches, recognising that these two types of health can be interlinked and emphasising the importance of a holistic approach in addressing health inequalities.

There was often a lack of clarity within the literature in terms of the length of an intervention method, but the majority of those methods which did state their length were over one year. Methods often have not been evaluated, and approaches to evaluation ranged in level of robustness. The literature does however include systematic reviews (3)32-34, randomised controlled trials (4)27,29,35-36, quasi-experimental methods (3) 37-39 and other evaluation methods (4) 30,40-42, and there is some evidence to suggest positive impact on health inequalities and/or value-for-money. This is commonly suggested as the focus for subsequent evaluation activity:

For example, a pilot study aimed at reducing smoking among Pakistani and Bangladeshi men that included trained community outreach workers found that*:*

*“The outreach worker model has the potential to increase community cessation rates and could prove cost-effective, but needs evaluating definitively in a larger, appropriately powered, randomised controlled trial. These future trials of outreach interventions need to be of sufficient duration to allow embedding of new models of service delivery”.*35

Are methods / approaches aimed at addressing health inequalities generic or specific to specific communities or types of area (eg inner city, rural, coastal)?

There were mixed specificity of methods in relation to target populations and in order to address health inequalities, local areas should consider the specificity of the interventions required based on:

* their local area population;
* the geographic coverage of these areas; and
* the specificity of other interventions / existing services within the local area.

Multiple case studies analysed by the Kings Fund suggest that public health institutions should “*Improve targeting of those with multiple risk factor*s”18 , whereas, the Marmot review recommends a focus on a proportionate universalism approach19. Methods / approaches may be targeted based on protected characteristics defined in the Equality Act 2010 (eg age, ethnicity, disability status), such as the aforementioned pilot study that targeted the smoking habits of Pakistani and Bangladeshi men35, or specific communities. Examples of specific communities include:

* Mothers in the deprived London borough of Southwark. These women were provided with social support and health education as part of the Parents and Children Together (PACT) Project. This led to improvements in their mental health and health literacy (capacity and capability to obtain, understand and make appropriate decisions about health and treatment). It also led to an increase in engagement from those less likely to access statutory health services; and
* Older LGBT individuals within a care home environment. As part of the Care Home Challenge action research project, an intervention was designed to increase the accessibility, inclusivity, and safety of residential care for older LGBT individuals. This included education for care home staff and managers as well as challenging the prejudicial beliefs of some staff members and this did lead to a positive shift in their attitudes towards LGBT individuals.42

Many also targeted individuals or communities who were socio-economically disadvantaged. This was often determined using socio-economic methods such as English Indices of Multiple Deprivation (IMD)11 and socio-economic status groups.40 For example, the Cancer Awareness roadshow targeted low socio-economic status areas as lack of awareness of cancer symptoms was particularly high amongst these groups, and can lead to a late diagnosis.40

The majority of the literature is focussed on urban or mixed (ie those containing both urban and rural areas) areas.

Methods based in urban or mixed areas were more diverse, with the focus methods mainly based on the specific community or the objective of the method. Within rural areas, methods were typically focussed on improving access to health and care services, such as issues around transport / travel distances.30 For example, one proof of concept study tested using tele-pharmacy to overcome the challenge of delivering community pharmacy services in a remote area of rural Scotland and found that over 80% of residents reported that they would use this service30.

Common conditions for success and areas of challenge

A number of common conditions for success and areas of challenge have been identified. Common success factors included joint / partnership working, resource that can work cross-organisational boundaries, use of pre-existing physical and social structures, and leveraging the use of anchor institutions, community and non-statutory organisations to support statutory health and care services. These have been grouped based on the three themes for the assessment of ICS in the table below.

**Table 3 – Theme 2: common conditions for success and areas of challenge**

|  | Common conditions for success | Common areas of challenge |
| --- | --- | --- |
| Leadership | * **Clear understanding of vision alongside a strong understanding of local health needs** (and efficacy of existing service provision).
* **Strong leadership buy-in to address health inequalities and system-wide working:** *“From the outset , [they] had a strong base of support among senior leaders that made it possible to communicate the approach, at least at managerial levels, across the council … The commitment across political and corporate strands of leadership to taking a whole-systems approach allowed several levers to be used at once to galvanise action”.19*
 | * **Leadership / Stakeholders having converging objectives**
* **A** **lack of clarity around objectives of a method:** *“Due to its evolving, localized nature, it was not initiallyclear what the intervention was. Its status as a pilot interventionmeant that there was no clear vision statement”.*20
* The **translation of statements relating to health inequalities into clear action plans or performance indicators.**
 |
| Integration | * **Joint / partnership working, resource that can work cross-organisational boundaries** (where required). The central co-ordination of methods is pivotal to this, to reduce the risk of duplication.
* **Leverage the use of anchor institutions, community and non-statutory organisations to support statutory health and care services**: *“Importantly, the community-led PACT intervention may provide a feasible gateway to health and social services for populations who may feel more insecure and are less likely to engage with the statutory services”.43*
* The **integrated commissioning of services** based on the current priorities of a local area
* Consideration of the **use of pre-existing physical and social structures** in which methods can be delivered (eg use of community leaders and advocates to send messages, use of community assets etc.).
* **Allocation of funds** for methods to be based on need
 | * **Challenges with integration**, such as the commissioning of integrated services, challenges with communication and data sharing etc.
* It can take a **long time to develop the trust and relationships** in order for true partnership / joint working.
* **Not all health needs are coterminous with health and care system boundaries** – which can lead to patchy coverage for different health needs geographically and some populations being underserved
* **The** **focus on methods can shift attention away from existing services** which may already be addressing health inequalities to some extent.
* **Ongoing** **resourcing / capacity challenges** within health and care systems (including within partnership organisations).
 |
| Quality and safety | * The **co-production of services with communities** alongside ongoing engagement in order to iteratively improve the delivery of an intervention method.
* **The importance of establishing trust with communities**: *“Ensuring that staff and those delivering interventions have an understanding of local issues “As such, deploying expertise of culturally competent psychological wellbeing practitioners was invaluable”.*43
* **Multiple mechanisms for referral and awareness raising of methods** (to reduce risk of communities encountering barriers when accessing the method)
 | * **Residential mobility** can reduce the impact of place-based public health interventions: *“People who have experienced a certain intervention may leave the area, taking any health benefits with them, while other people – who haven’t participated in the programme – move in, thereby diluting its local (perceived) impact”.12*
* Ensure that **barriers to accessing services are not embedded in methods to reduce health inequalities** (eg requiring documentation, digital be default, requiring availability of community assets such as green space, etc).
* **Difficulty evaluating impact to demonstrate whether methods are addressing health inequalities**: *“Inevitably, most evaluations provide snap-shots of activity, and coverage of outcomes is weak with regard to community and services / system change”.*34
* **Methods encountering challenges in meeting those most at need** due to stigma attached and mistrust with statutory organisations and professionals, similar to the issues encountered by existing services. This was particularly prevalent for Mental Health interventions.
 |

While there has been some scope for funding to be directed at addressing health inequalities from within existing health and care budgets at a local level, there was also an acknowledgment of the impact of government policy and funding regimes have on the overall sustainability of methods:

*“The nature of relatively short-term funding is also cited as not being focused long enough to create generational change. Another finding was the lack of connectivity between capital piecemeal funding and revenue piecemeal funding which creates unsustainable provision over the medium and long-term”.*4

Theme 3: What does successful engagement with local people and communities look like?

This section describes learning and examples of successful engagement with local people and communities. To draw out practical and tangible learning, we address:

* When to engage with local people and communities?
* Who to engage with?
* How to engage with local people and communities? and
* Critical success factors for engagement.

**When to engage with local people and communities?**

The benefits of engaging with local people and communities was shown across the lifecycle of different intervention and initiatives. The importance of understanding the needs of a community even before the study design stage was clear to considering existing inequalities. In doing so, some described the use of behavioural, social or psychological theories to gain a better understand of human behaviour and motivation when designing intervention methods and programmes for the local population 26,46-47.

When considering prevention activities, it was shown that health promotion initiatives were unlikely to succeed without strong local involvement at all stages of the process and many programmes now use grass roots approaches.47 For example, the healthy living approach intervention trial in Pembrokeshire operated through existing community forums and trained local people to act as community researchers. This approach allowed communities to produce and disseminate action plans that were based on needs identified by local people. 47

Interestingly, many approaches described as part of this research were part of one-off studies, with only a small number of follow-ups24 or those that were implemented more broadly.50 Some programmes could not be sustained due to a lack of funding opportunities, while others were targeted one-off research projects to provide recommendations for future methods.

**Who to engage with?**

Successful engagement included bringing together a range of stakeholder groups and hearing from a range of diverse voices. As part of this research, common groups identified include VCSE organisations, community champions, members of the public in the target community, researchers, healthcare providers and wider community support roles (such as police officers).

Additionally, ensuring that the communities targeted by an intervention are included in the design and development were shown to result in successful implementation. Socio-economically disadvantaged areas in England were commonly explored. For example, the PACT community health project, designed to improve maternal health, engaged mothers in a deprived South London borough through co-production and community control of the project. This succeeded with 93% of participating mothers engaging with the project in some way, leading to improved mental health and increased health literacy of participants.41

Tailoring the approach to different communities’ needs and perspectives was shown to be key. For example, the Population Health Research Institute focussed on engaging with African and African Caribbean groups in South London to improve mental health in these communities and found that members of local faith groups who were already embedded in local communities were able to build community capacity to raise awareness of mental health problems.45

Similarly, the Centre for Primary Care at the University of Manchester engaged with South Asian communities in Greater Manchester to improve access to primary mental health care and found that a combination of community focus groups, working groups and community champions working together led to increased awareness. A key barrier they identified was communication and these groups were able to address this by tailoring information both culturally and linguistically46.

**How to engage with local people and communities?**

A number of different engagement approaches have been described but can be grouped into two broad categories:

***Asset-based engagement*** which rely on local community assets (people, groups, resources) to develop and strengthen communities. For example, a ‘Healthy Living’ approach trained local people as community researchers. They supported local community forums to coordinate and communicate across the partnerships47., which allowed for capabilities to be built within the community and supporting people within their own contexts.

***Community-centred engagement*** models involved mobilising resources within community and co-production. For example, consultation forums were conducted in a world café style with adults in one of the most socio-economically disadvantaged local authority areas in the UK48. A world café involves a number of timed roundtable discussions each on a pre-determined topic. This method was chosen as it is accessible for individuals with poor literacy or IT skills and because the target group were already participants in other round table community discussions. By the very nature of community-centred models, cultural engagement remains central. These included cultural focused activities, such as community-based arts, nature, music, and theatre. For example, the community organisation Heavy Sound aimed to improve the health and well-being of disadvantaged young people in Scotland by engaging them in creative activities that allow them to express their emotions.25

Beyond the two categories for engagement, it was clear that collaboration across partners was essential to provide effective and inclusive ways of working to consider inequalities. For example, one initiative set out to increase community engagement around primary mental health care and included health sector workers, members of voluntary or third sector organisations, faith leaders, community police, local business representatives and local councillors in the project. They described how:

*“Community members and local professionals working together fostered a sense of ownership of the interventions, developed and strengthened networks and empowered the community by demonstrating their capacity to act together to address local issues”.*46

This highlights the social impacts (and potentially wider) of effective engagement in local communities across different partnerships. Interestingly, whilst this research can highlight the benefits of effective community and local engagement, there was limited evidence in the direct links to improved health outcomes or reduced inequalities.

**Effective methods for engagement**

To ensure that communities are at the heart of approach, community centred approaches should use participatory methods where community members are actively involved in design, delivery and evaluation; use and build on local community assets in developing and delivering the project; and develop collaborations and partnerships with individuals and groups at most risk of poor health.51

The research highlighted a range of challenges of integrating research and practice when it comes to complex community interventions. Successful community and stakeholder engagement requires their involvement from the beginning, and at all stages of method design, delivery, evaluation, and dissemination. Testing the data with lived experience can give a better understanding between what the data shows and reasons behind it. For example, the DATA 1 project in Bradford aimed at tackling inequalities in the diagnosis, service access and support of people with autism and neurodiversity, tested their data with key stakeholders such as teachers, parents and pupils. This engagement from an early stage ensured backing, sign up and commitment from local leaders to overcome boundaries and identify available resources. The projects was a success and has been picked up at the national level.52,54

Based on their discussions with key stakeholders in the Better Start Bradford programme, it was suggested that establishing a Community Advisory Group made up of local people will facilitate this integrated involvement52. These Community Advisory Groups would be involved in every stage of intervention design and evaluation development and play a key role in the interpretation and the dissemination of findings prior to them being made public. The starting point for this is a careful mapping out of all key stakeholders followed by regular and effective communication. This contact would ensure that all stakeholders know how to work together and have a greater understanding of priorities and pressures to allow shared objectives to be agreed.

Common conditions for success and areas of challenge

Throughout the above literature, a number of common conditions for success and areas of challenge have been identified in relation to engaging with local communities. These have been grouped based on the three themes for the assessment of ICS in the table below.

**Table 4 – Theme 3: common conditions for success and areas of challenge**

|  | Common conditions for success | Common areas of challenge |
| --- | --- | --- |
| Leadership | * **Involve communities from the start** (ie setting priorities or design stage) and enable them to get involved as much or as little as they are able or wish to: *“Communication, trust and knowledge translation between stakeholders both strategically and operationally is paramount.”*46
 | * **Voluntary community-based organisations**, crucial to the success of our community engagement strategies, **are vulnerable to change** in economic, cultural and political circumstances.
* Local conflicts of interest and disparities of power and influence can hinder policy intent and create risks in partnership participation.
 |
| Integration | * **Bottom-up approach to community engagement:** Involvement of community champions in interventions can aid accessing underserved groups and provide culturally appropriate and competent ways of delivering health messages (especially if these are sensitive). This can help building sustained and trusting relationships between services and communities.
 | * For community champions to be able to translate approaches into practice, **support and training** is required (especially if they are supporting mental health).
* Lower levels of wellbeing and socioeconomic positions are individually associated with lower levels of cultural engagement. **Physical opportunity, educational attainment** and **socio-economic disadvantage of the area** **are** **barriers to participation**.
* **Longer time period:** establishing a partnership that will last requires building trust which takes time; co-production takes longer than working as a solo organisation or even a partnership
 |
| Quality and safety | * Community engagement needs to go beyond traditional individualistic approaches (eg monetary incentives) and ought to **consider socio-cultural influences on individual behaviour**.
* **Understanding communities:** For services to be culturally competent, they require to meet the cultural, social and linguistic needs of the communities, and understand cultural and religious perspectives and be able to adapt to them.
 | * Online approaches to engaging with communities might not be suitable for certain groups of people.
 |

Please note: the common conditions and factors for success have been grouped thematically, however, these may be categorised differently following the refinement of the ICS assessment themes.

1. Discussion of findings

This literature review describes the ways of identifying local inequalities, approaches and methods to addressing these, and types of successful community engagement approaches. In this section, we draw on findings from the literature and reflections from the expert panel to present areas of learning for CQC.

* 1. Reflections from the expert panel

Theme 1: What are effective ways of identifying local health inequalities or potential health inequalities?

It was mentioned within the expert panel workshop, the existence of national tools, profiles, indicators (developed by the Office of Health Improvement and Disparities) which are widely used to identify and monitor trends in inequalities. It was recognised by many in the workshop session that these types of tools are commonly used by systems to identify health inequalities, however, this practice was less commonly cited within the literature in-scope for this review. This might be due to these tools being well-established and less likely to be subject for further research.

There was also discussion around how segmentation approaches are typically less accurate within inner city populations – as health inequalities may not be coterminous with a particular health and care system geography. It was recognised that this may skew empirical analysis for some areas. This was also referenced within the literature2, through discussion that traditional segmenting approaches based on age and morbidity do not accurately reflect actual use of health and care services, however, cluster analysis of linked primary and secondary healthcare use data for a local GP-registered population can segment the population into distinct groups with defined health and care needs.

Transient populations and residential mobility were also identified as a challenge in addressing health inequalities as these people are less likely to be registered (eg homeless and Gypsy, Roma and Traveller communities). Some papers focused on factors such as residential mobility that should be accounted for when identifying health inequalities, as it is recognised that frequent mobility of residents can frequently alter the health of an area. The need to use Data Protection and Information Governance legislation as a mechanism for sharing data rather than as a barrier to prevent the sharing of data (in the identification of health inequalities) was also referenced. However, there was limited evidence within the literature in the areas of data sharing.

Theme 2: What are the evidence-based methods/approaches that work to address health inequalities within a local area?

From the expert panel review of initial findings, there was consideration of the extent to which the literature discussed sustainability and value for money. While there was some evidence relating to the cost-effectiveness of specific methods, there was less consideration of sustainability (outside of references to challenges around resource capacity and short-term nature of government funding). There was a general acknowledgement from the expert panel that these two considerations were fundamental to the effectiveness of methods to address health inequalities in the long-term.

There was also consideration from the expert panel around the extent of evidence which presents the rationale for specific methods (rather than methods being determined by national funding). From the literature within this review, there is limited evidence of health inequalities work being applied to the “whole pathway” – from the identification of health inequalities to the establishment and delivery of an intervention method to address this health inequality.

The balance within systems between methods that address health inequalities within specific communities (ie those right at the bottom of the inequality gradient) versus aiming to flattening the curve on health inequalities more generally was also a topic of discussion within the expert panel. For example, improving access / uptake / outcomes across the whole population, with greatest improvements in the most socially disadvantaged. There have been mixed views on the balance of these two approaches within the literature, although there was an acknowledgement that some universal services may exacerbate health inequalities for specific communities.

Theme 3: What does successful engagement with local people and communities look like?

While the importance of engaging with communities was recognised, our expert panel highlighted the importance of 'interveners' (eg clinicians, programme manager, strategic lead etc.) within local engagement. This, however, was not as strongly evident in the literature identified.

Funding was also discussed, including the importance of ensuring that engagement approaches are not putting excess burden on communities (or perceived as such by communities or VCSE organisations). The literature identified echoes the reflections from the panel as it also emphasises funding as a critical factor required for the success of community engagement, but which can also become a point of rivalry for the organisations involved, shifting the focus from communities served to competition for the organisations to survive.

Building trust with communities was acknowledged as fundamental, with recognition given to the complexities that sit behind this.Evidence from the literature suggests that, in order to build trust with specific communities, programmes need to recruit and train the members from that specific community as community researchers or wellbeing champions. If lay people are recruited as health trainers, they need to receive appropriate training in order to create culturally competent services. There was also recognition within the feedback from the expert panel around the importance of staff experiences and their ability to relate with the community. A few studies explored the importance of community champions and their life experiences which can help them to relate to the populations they engage with as part of an intervention method.

* 1. Learning for CQC

The literature review has provided evidence on “what works in addressing health inequalities” based on methods that have been shared externally to the health and care system. While there has been somewhat limited evaluation of methods, there has been some recognition that this literature review will relate to areas of potential “novelty” or considered “good practice” – as methods / approaches have been selected for either research or case study purposes within guidance documents. This may not however, be reflective of what is currently being implemented within all systems.

From the outset of the literature screening, it was evident that there is more literature to support themes two and three, and there is a limited amount of literature to support theme one. This points to the need for further studies to investigate effective ways of identifying inequalities specifically on a local level, whether it is for a local authority or a trust area.

Throughout the review, there was a limited acknowledgement of sustainability within the literature, with many methods being one-off or short-term in nature. As such, it is unclear whether these approaches and methods will have an impact on the extent to which health inequalities can be addressed in the long term. Additionally, the literature gathered through this review provides no learning in terms of supporting the scalability of the methods or approaches which presents a challenge to increase the implementation of these for bigger population groups or to replicate it elsewhere. One of the clear barriers to exploring the sustainability or scalability of the approaches is the funding, which was typically either limited throughout the method or ceased to exist at the end of the trial period leaving organisations and partnerships under-resourced.

To help CQC with their development of assessments criteria for ICS for how they address health inequalities, we identified a list of useful considerations under each CQC theme in the below table:

Table 5 – Considerations for ICS assessment: Leadership, Integration and Quality & Safety themes

| **Area** | **Considerations** |
| --- | --- |
| **Leadership** | * **Vision and understanding of the system:** a clear vision alongside a strong understanding of local health needs will enable translation of plans into clear actions and formation of performance indicators.
* **Collective ownership:** ICSs should involve voluntary community-based organisations and anchor institutions in the development of methods and engagement of communities. This creates a collective sense of ownership for addressing health inequalities across the community. Additionally, targeted populations might feel more confident in communicating with non-statutory partners.
* **Whole improvement pathway framework:** ICSs should consider developing a defined process / framework for addressing health inequalities. From the mechanisms they will use to identify health inequalities, moving into how that information is used to develop and implement methods or approaches alongside how these methods / approaches will be monitored / evaluated to ensure that they are delivering on their intended outcomes.
 |
| **Integration** | * **Length and amount of funding:** funding is the key to sustainable methods. Systems should be considering their available funding mechanisms to develop sustainable financial plans in order to address health inequalities (rather than relying on short-term funding alone). This should remove the need for resource rivalry between participating organisations and promote collaboration.
* **Partnership / joint working:** the capacity and capability of ICSs to deliver methods through partnership working (both with statutory organisations within the ICS and community, voluntary and anchor organisations). The ability to adopt joint working across the system will reduce the risk of duplication.
* **Commissioning arrangements / Contracting:** Alongside joint working, the ability to conduct commissioning processes and set-up contracting arrangements on a system-basis will reduce duplication of effort and allow for methods to be commissioned / contracted on an intervention basis, rather than an organisational basis. This will promote the focus on improving health outcomes.
* **Wider determinants of health:** consideration of wider determinants, such as housing and urban regeneration. This will affect the requirements of non-health and care partners on wider determinants to address health inequalities.
* **Community assets:** use of community assets (ie community members and local organisations) can help not only to better understand the cultural, social and linguistic needs of the communities but also build sustained and trusting relationships between services and communities.
* **Population profile:** using mutually exclusive areas to identify a profile of a population presents issues for an urban area where there tend to be several commissioning and provider organisations. In addition, some measures (eg residential mobility) present a challenge for ICSs as they can potentially alter the health profile of the area. of the area.
 |
| **Quality & Safety** | * **Information governance & data sharing:** collection of quality patient data on a local level should support identification of health inequalities; to support linkage of datasets granular data is required.
* **Use of data and data quality:** consideration of how systems are collecting and using data throughout the identification of health inequalities and the monitoring of methods / approaches to ensure that they are delivering on their intended outcomes. Data quality needs to meet a minimum standard in order for data analysis to provide accurate intelligence.
* **Co-production of services:** involvement of communities in co-production alongside ongoing engagement will support continuous improvement in the delivery of an intervention method and ensure its relevance to communities targeted.
* **Engagement with communities:** use of engagement approaches that go beyond traditional approaches (such as feedback surveys); exploration of various channels for communication with different population groups (ie online might not be suitable for older people, traveller communities, etc.) will help ensuring accessibility of services.
* **Feedback from communities:** getting feedback on engagement and approaches is paramount to success of intervention methods; understanding what works well and less well can enable services to target populations in ways that suit them and ensure maximised engagement and buy-in.
* **Engagement with populations at risk of inequality:** processes are required to engage populations at risk of inequality in order to gain trust and avoid deterring them from accessing the services; options include the use of non-statutory expert partner organisations or trained members of community with similar lived experiences.
 |

1. Conclusions and considerations for the future
	1. Conclusions

**Theme 1: What are effective ways of identifying local health inequalities or potential health inequalities?**

Given the complexities of local areas and the specific needs of each, unsurprisingly, a range of different methods have been shown to identify health inequalities. These can be segmented into three overarching categories: (i) Population statistics, (ii) Combining health data with wider determinants and (iii) using experiential or qualitative data to understand experiences. However, no literature paid attention to exploring some of the tools that are already being used by systems, for example, the PHE framework, and how these could be streamlined or enhanced in their use.

A number of considerations were identified which may help to determine what methods a local area may want to use in the identification of health inequalities. These include:

* Have specific areas of health inequalities been identified?;
* The use of wider determinants of health datasets; and
* The availability of data

Overall, the literature outlines a range of methods to identifying health inequalities. However, there is no “one size fits all” approach and different methods should be selected based on the specific requirements for each local area.

Several gaps in the existing literature have been revealed. Most papers tend to focus on researching ways of identifying inequalities and present limited evidence to support the effectiveness of these methods.

**Theme 2: What are the evidence-based methods/approaches that work to address health inequalities within a local area?**

The use of several different approaches that can be used to address health inequalities have been highlighted. The overarching approaches identified include: (i) Asset-based or place-based approaches, (ii) Proportionate universalism and (iii) Engagement-based approaches. A number of studies have referenced a combination of these approaches rather than using them in a standalone manner (for example, within Child Health).

In terms of the specific methods for addressing health inequalities, a significant proportion of the literature focussed on improving health outcomes more generally (relative to the other areas which can address health inequalities such as prevention, improving access etc.).The most popular types of methods related to improving health outcomes included: Advice, guidance and signposting; Training and education programmes; Social / Leisure and engagement programmes; and Wider system change.

Alternative services models were also a popular method type for improving access to health and care services. Many of the methods aimed to address the barriers for access, such as tele-pharmacy for those living in rural areas30.

There were mixed specificity of methods in relation to target populations and in order to address health inequalities, local areas should consider the specificity of the interventions required based on:

* their local area population;
* the geographic coverage of these areas; and
* the specificity of other interventions / existing services within the local area.

Many methods for addressing health inequalities were also targeted individuals or communities who were socio-economically disadvantaged. This was often determined using socio-economic methods such as English Indices of Multiple Deprivation (IMD) and socio-economic status groups. Methods aimed at addressing health inequalities within urban or mixed areas were more diverse, with the focus methods mainly based on the specific community or the objective of the method. Within rural areas, methods were typically focussed on improving access to health and care services, such as issues around transport / travel distances.

There was limited research that explored the cost-effectiveness and sustainability of these approaches and methods, which would be required to scale these methods – with these two areas being highlighted by the expert panel as fundamental to the effectiveness of methods to address health inequalities in the long-term and should be an area for further research.

**Theme 3: What does successful engagement with local people and communities look like?**

**When to engage with local people and communities?**

The benefits of engaging with local people and communities was shown across the lifecycle of different intervention and initiatives. Ensuring that the communities targeted by an intervention are included in the design and development were shown to result in successful implementation.

Successful engagement included bringing together a range of stakeholder groups and hearing from a range of diverse voices. Common engagement groups identified included: VCSE organisations, community champions, members of the public in the target community, researchers, healthcare providers and wider community support roles (such as police officers). Tailoring the approach to different communities’ needs and perspectives was shown to be key.

A number of different engagement approaches have been described but can be grouped into two broad categories:

* *Asset-based engagement* which rely on local community assets (people, groups, resources) to develop and strengthen communities; and
* *Community-centred engagement* models involved mobilising resources within community and co-production.

Beyond the two categories for engagement, it was clear that collaboration across partners was essential to provide effective and inclusive ways of working to consider inequalities.

To ensure that communities are at the heart of approach, community centred approaches should use participatory methods where community members are actively involved in design, delivery, and evaluation; use and build on local community assets in developing and delivering the project; and develop collaborations and partnerships with individuals and groups at most risk of poor health.

The research highlighted a range of challenges of integrating research and practice when it comes to complex community interventions. Successful community and stakeholder engagement requires their involvement from the beginning, and at all stages of method design, delivery, evaluation, and dissemination. Within the expert panel, it was also highlighted that it can be challenging to engage meaningfully without culturally competent services that use local assets, including emphasising the need to consider cross cultural competence training not only for community members who are willing to get involved but also for the local services staff.

Whilst this research can highlight the benefits of effective community and local engagement, there was limited evidence in the direct links to improved health outcomes or reduced inequalities. Consideration in future research may be given to establish evidence to support the link between effective engagement and improving health outcomes.

* 1. Considerations for future research

Based on the evidence from this literature review and the reflections from the expert panel, there are a number of considerations of areas for future research:

* **Whole improvement pathway framework:** many of the studies cited within this literature review referenced a particular point in the process of addressing health inequalities (ie the identification of health inequalities, delivering on intervention methods, engaging within communities) as a standalone focus. This has made it challenging to provide evidence as to how these elements of the process are interlinked – this is particularly prevalent for the steps between identifying a health inequality within a local area to then developing and delivering an intervention to address that health inequality. To address this gap, a series of mini case studies could be undertaken with a stratified sample of systems to better understand these linkages in addressing health inequalities across the “whole pathway” in order to have a holistic understanding of the process.
* **Sustainability:** within the broad scope of this literature review, sustainability was only cited to a limited extent. Sustainability was highlighted as a critical success factor by the expert panel for systems to be able to address health inequalities within their local area. Further research could be undertaken to focus on understanding how successful one-off intervention methods could be embedded into health and care systems and scaled (including the exploration of critical success factors for sustainable intervention methods, models which support sustainability, economic / financial considerations and lessons learnt in embedding one-off interventions into business as usual).
* **Improving the evaluation of methods:** within the research, many of the intervention methods which have been presented have provided limited detail around whether the intervention has been evaluated and whether it has been able to meet its intended outcome (via the quantification of impact) and / or provide value for money to the system (which links to the sustainability point above). One of the challenges with the quantification of impact / cost effectiveness for specific interventions can often be the linking of health outcome measures to methods and approaches to taking into account the complexities of estimating attribution. Further research into good practice in how to address these challenges would provide local systems with a robust evidence base to improve the evaluation of intervention methods, enabling successful interventions to be embedded and less successful intervention methods to be improved or concluded. Evidence around the quantification of impact / value for money also provides transparency around the use of public money to fund these interventions.

# Annex A – Research Questions

Our focus in this research will be on literature gathered from several sources including academic publications as well as grey literature, such as policy/legislation, opinion pieces, government guidance, evaluations and media/news articles which provide evidence on interventions to reduce health inequalities in local areas.

**Research questions:**

|  |  |
| --- | --- |
| Primary research questions  | Sub-questions to be explored  |
| 1. What are effective ways of identifying local health inequalities or potential health inequalities?
 | * 1. What are the different approaches to identifying / segmenting local health inequalities?
	2. What are the common conditions for success in identifying local health inequalities?
	3. What are the common areas of challenge in identifying local health inequalities?
 |
| 1. What are the evidence-based interventions / approaches that work in a local area?
 | * 1. What are the approaches which prevent health inequalities?
	2. What are the approaches for addressing health inequalities in terms of access?
	3. What are the approaches for addressing health inequalities in terms of use?
	4. What are the approaches for addressing health inequalities in terms of outcomes?
	5. Are interventions / approaches generic or specific to reducing inequalities for people from specific communities or with specific characteristics?
	6. How reducing health inequalities within a local area varies between different types of area (eg inner city, rural, coastal)?
	7. What are the common conditions for success, including how this relates to commissioning, service provision, partnership working etc.
	8. What are the common areas of challenge, including how this relates to commissioning, service provision, partnership working etc.
 |
| 1. What does successful engagement with local people and communities look like?
 | * 1. What types of local engagement have been used to develop plans and approaches to reduce inequalities?
	2. What are the common conditions for success in engaging with local people and communities?
	3. What are the common areas of challenge in engaging with local people and communities?
 |

# Annex B – Research Protocol

Full search protocol for this research can be found embedded below:

**Protocol for searching, screening, and reviewing the literature**

**Stage 1. Database searches:**

We will be reviewing relevant literature from two types of sources: published studies in scientific journals and grey literature from government and other public agency sources. Rachael Posaner (University of Birmingham, Knowledge, and Evidence Services (KES)) will conduct the search for published/academic literature via the University of Birmingham Library Services based on agreed search terms. RSM will search the grey literature and co-ordinate the call for evidence. To structure our search strategy and optimise the time available, we will use the PRESS checklist.[[1]](#footnote-2)

Alongside the formal search strategy, our advisor Professor Rosalind Raine (UCL) will be asked to contribute any key sources, including those not yet published, based on their own knowledge and networks. RSM will also issue a call for evidence and ask the CQC expert panel, and our advisor to disseminate this call for evidence.

We propose to use the following search criteria and databases, but these may need to be further refined depending on the number of ‘hits’ returned from the database searches.

| Search terms and inclusion criteria |
| --- |
| **Language:** | English or accredited translations |
| **Countries:**  | Countries of the United Kingdom and Ireland |
| **Time period:** | January 2010 - Present (The above depends on the number of results up to a maximum 750 titles) |
| **Search strings:** | **[Terms for health inequalities:]** (Health inequality) OR (Inequality) OR (Disparity) OR (Unequal) OR (Exclusion) OR (Inequity) OR (Prejudice) OR (Marginalised communities) OR (Discrimination) OR (Indirect discrimination) OR (Bias) OR (Protected characteristic) OR (Wider determinants of health) OR (Social Determinants of health) OR **[Terms for inequality characteristics:]** (Ethnicity) OR (ethnic) OR (Race) OR (Racism) OR (BAME) OR (BME) OR (Socio-economic status) OR (Socio-economic) OR (Deprivation) OR (IMD) OR (Poverty) OR (Disability) OR (Disabled) OR (Long term condition) OR (Mental health) OR (Learning disability) OR (Sexual orientation) OR (Lesbian) OR (Gay) OR (Bisexual) OR (LGB) OR (LGBT) OR (LGBT+) OR (Gender reassignment) OR (Transgender) OR (Gender identity) OR (Religion) OR (Belief) OR (Religious) OR (Faith)AND**[Terms for intervention approaches:]** (interventions) OR (intervention approaches) OR (prevention) OR (prevention approaches) OR (addressing) OR (Good practice) OR (Person-centred) OR (Improvement) OR (Community-based approach) OR Co-produced approach) OR (Community engagement) NOT (Clinical interventions) NOT (Medical interventions)AND **[Terms for local area:]** (local areas) OR (local systems) OR (local health systems) OR (local health and care system) OR (Integrated Care System) OR (ICS) OR (Integrated Care Partnership) OR (ICP) OR (Sustainability and transformation partnerships) OR (STP) OR (place-based) OR (local communities) OR (local populations) OR (Health Action Zone) OR (HAZ) OR (Strategic Health Authority) OR (SHA) OR (Clinical Commissioning Group) OR (CCG) OR (Primary Care Trust) OR (PCT) OR (Integrated Care Board) OR (ICB) |
| **Databases / sources:** | **Published/Academic Literature**:Social Science Citation Index (Web of Science), ProQuest, Embase, Medline, Scopus**Grey Literature:*** International sources (eg WHO).
* Think tank organisations (eg Nuffield Trust, Health Foundation and the Kings Fund).
* Grey literature databases (eg OAIster, Social Care Online, Social Science Research Network).
* Public sector/ Arm’s length bodies sources such as Local Government Association, NHS England; National Audit Office, Social Care Institute for Excellence, National Council for Voluntary Orgs.
* Google scholar and Google search for published evaluations/ reviews of relevant health and care systems.
* Google search for news/campaigns/media reports.
* Call for evidence amongst CQC stakeholders, academic advisors and expert panel and their networks.
 |

**Stage 2. Screening of titles and abstracts:**

We will review the longlist of a maximum c.750 titles of published and unpublished studies, articles and reports (‘grey literature’) pertaining to the research questions on effective systems as specified above. The table below sets out the first level inclusion/ exclusion criteria which we will apply to each title. We anticipate excluding 25% to 50% of titles at this point either because they are not of central relevance to effective systems or they are duplicate studies in our sample.

| 1st level criteria | Inclusion criteria | Exclusion criteria |
| --- | --- | --- |
| **Topic** | Approaches and interventions, reducing health inequalities, preventing health inequalities, local areas | Nationally-adopted programmes aimed at reducing health inequalitiesPolicy / Research on health inequalities not related to specific approaches or interventions  |
| **Language** | English  | All other languages. |
| **Countries**  | Countries of the United Kingdom and Ireland | All other countries. |
| **Other** |  | Duplicates (RSM to remove most during search stage, but some duplicates are likely to remain). |

We will then review c. 250 abstracts; the second level inclusion/ exclusion criteria will then be applied to each abstract that passes the first level criteria. The second level criteria are listed below and relate to the detailed research questions. These may need to be refined depending on the number of studies retrieved. Abstracts which do not meet any second level inclusion criteria will be discarded and the remaining abstracts will form the shortlist of relevant literature for further screening and quality assessment.

|  |  |  |
| --- | --- | --- |
| 2nd level criteria | Inclusion criteria | Exclusion criteria |
| **Topics based on research questions:** | Related to one or more these topics:* What are effective ways of identifying local health inequalities or potential health inequalities?
* What are the evidence-based interventions / approaches that work in a local area?
* What does successful engagement with local people and communities look like?
 | Not related to any of the topics related to the research questions. |
| **Outcomes:** | * Interventions and approaches to addressing health inequalities
* Facilitators and barriers of reducing health inequalities
 | Does not have any of the outcomes associated with the research questions. |

**Stage 3. Quality assessment of full texts:**

We expect to generate a shortlist of a maximum of 250 studies. We will obtain and screen the full texts to identify the final list of the most relevant and pertinent studies to undergo full review. The selection will be based on tighter inclusion criteria including quality measures for academic literature ie, the extent to which methodologies/ evidence bases are robust using the AMSTAR[[2]](#footnote-3) checklist together with GRADE criteria.[[3]](#footnote-4) Grey literature will be screened for quality based on relevance, recognising that due to the nature of this type of research, assessing for robustness will not add value.

**Stage 4. Full review and data extraction:**

We will complete a review of a maximum 70 articles and extract information from the review literature into separate spreadsheets for each research question, using the headings suggested below. The final list of studies will be further interrogated for quality. The process for data extraction will be to start with systematic reviews, thus getting an overview of the evidence and then proceeding to individual studies.

We will specify the headings used to extract information into the data extraction spreadsheet. Headings will likely include title, author, date, country, study type, study aims, methods/ evidence base, findings, strengths, and limitations reported in study, key themes/topics, relevant outcomes, and a quality appraisal. We will also provide single-sentence evidence statements per research question, accompanied by a red-amber-green rating of the strength of the evidence, to aid as a quick reference point for decision-makers.

Quality appraisals will be completed concurrently with the extraction process. Given the breadth of research likely to be picked up in this review, we suggest using the Mixed Methods Appraisal Tool which has 19 screening questions to assess qualitative research, randomized controlled trials, non-randomized studies, quantitative descriptive studies, and mixed methods studies.[[4]](#footnote-5)

Findings will be synthesised according to the primary research questions and written up into separate report sections as well as into high level summary slides outlining the key findings.

Annex C – Theme 1 Detailed results from the literature

| Approach/Method | Population | Data source | Research background |
| --- | --- | --- | --- |
| High relevancy and high robustness |
| **Beaney et al. (2022)7:** a catchment population approach; a 30% proportional flow (PF) method. Any Lower layer Super Output Areas (LSOAs) where 30% or more of residents who attended any hospital for care did so at the example trust were assigned to the catchment area | Residents in a London borough | Office for National Statistics (ONS) statistics on LSOA level; Hospital Episode Statistics (HES) | **Empirical:** the PF method had been previously used in other studies and relies on publicly available data |
| **Nnoaham and Cann (2020)8:** a data-driven approach to population segmentation using utilisation-based cluster analysis and k-means methodology to group the population into segments with distinct healthcare utilisation patterns based on seven utilisation variables | A local GP-registered population in Wales | Patients records from primary and secondary care datasets | **Empirical:** previous explorations of using utilisation-based cluster analysis for segmentation |
| **Saunders et al. (2019)9:** secondary data and Statistical Control Charts | Residents in Welsh House Farm estate in Birmingham | Birmingham City Council, West Midlands Police, West Midlands Fire Service, ONS, PHE, National Health Service (NHS) Digital, Nomis service by ONS, Migration Observatory, Department for Education (DfE) | **Hybrid:** relies on previous theory to generate the hypotheses; uses data to examine it |
| High relevancy and moderate robustness |
| **Jessiman et al. (2021)10:** a systems thinking approach; a group concept mappingCommonalities between two area-specific system maps (and removal of locality-specific factors) were used to develop a map that could be applied in any English local area | Children from two local authorities in England | N/A (primary research) | **Theoretical:** using the systems thinking approach and Goldfield et al’s (2015)11 conceptual model of neighbourhood effects influencing early childhood; Kane and Trochim’s (2007)12 group concept mapping approach |

|  |
| --- |
| High relevancy and grey literature |
| **The Strategy Unit (2022)11:** The Relative Index of Inequalities (RII) - the extent to which the rate of an activity or event varies across socio-economic groups defined by deciles of deprivation. Whilst similar to the range, it takes into account the values for all deprivation deciles as well as the population size of each group, such that smaller groups do not unduly skew the results. | Patients with coronary heart disease (CHD) at LSOA level in England | The Quality Outcomes Framework (QOF) data via Fingertips; the Personalised Care Adjustment (PCA) data; HES; the National Audit of Cardiac Rehabilitation (NACR) data on cardiac rehabilitation; the ONS Death records | **Empirical:** the RII is a commonly used measures in health inequalities  |
| **The Health Foundation (2022)12:** net migration and residential mobility | All residents at LSOA level | Open access area-level data on migration from the 2011 census for England and Wales | **Hybrid:** relies on theoretical hypothesis from previous studies; uses census data to prove the association  |
| Moderate relevancy and moderate robustness |
| **Sharpe, Wyatt and Williams (2022)13:** survey using Short Warwick-Edinburgh Mental Wellbeing Scale; stratified stepwise models were estimated to generate hypotheses | Residents in Cornwall Council | N/A (primary research) | **Hybrid:** relies on previous theory to generate the hypotheses; uses data to prove it |
| Moderate relevancy and grey literature |
| **The Institute of Health Equity (2022)14:** secondary data only | Individuals affected by fuel poverty | Department for Business, Energy & Industrial Strategy (BEIS); ONS | **Hybrid:** relies on previous theory; used data from previous research |
| **Born in Bradford (2019)15:** primary and secondary data  | Residents in Bradford; children whose health is affected by air quality | Not available | **Hybrid:** relies on previous theory; used data from previous research |

Annex C – Theme 2 Detailed results from the literature

The table below provides a summary of the extent to which different method types for addressing health inequalities which have been adopted within the literature. This has been grouped into: prevention, improving access to services, improving use of services and outcomes:

**Table C1 – Number of methods referenced by area of health inequality and method type**

|  | Prevention | Access | Use | Outcomes | Total number of references  |
| --- | --- | --- | --- | --- | --- |
| Advice, guidance and signposting (eg social prescribing, helplines etc.) | N=4 (12.1%) | N=4 (12.1%) | N=1 (3.0%) | N=7 (21.2%) | 16 |
| Self-management programmes (eg self-help for managing stress and anxiety, wellbeing apps) | N=1(3%) | N=0(0.0%) | N=0(0.0%) | N=1(3.0%) | 2 |
| Training and education programmes (eg health literacy, employment programmes) | N=2(6.1%) | N=1(3.0%) | N=3(9.1%) | N=8(24.2%) | 14 |
| Social / Leisure and Engagement programmes | N=0(0.0%) | N=3(9.1%) | N=3(9.1%) | N=6(18.2%) | 12 |
| Support groups (eg debt support group, social connection group) | N=1(3.0%) | N=2 (6.1%) | N=0 (0.0%) | N=2(6.1%) | 5 |
| Alternative services models (eg interpreted services, co-produced services) | N=1 (3.0%) | N=7(21.2%) | N=2 (6.1%) | N=4 (12.1%) | 14 |
| System change (eg greater integration of services such as housing, economic development) | N=2 (6.1%) | N=1 (3.0%) | N=1 (3.0%) | N= 6 (18.2%) | 10 |

Note: In total 33 reports contained information on specific methods. Where a paper contains more than one method (ie a series of case studies) each method has been included (by theme) a maximum of once.

**Table C2 – Number of methods referenced by type of area**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Urban | Rural | Mixed | Coastal |
| Number of papers  | N=17 | N=4 | N=10 | N=1 |

Annex E – Theme 3 Detailed results from the literature

| Aim | Engagement approach | One-off or ongoing  | Outcomes | Population |
| --- | --- | --- | --- | --- |
| High relevancy and moderate robustness |
| **Mughal et al. (2022)16:** to assess the emergence of community-based arts, nature, music, theatre and other types of cultural engagement amongst UK communities in response to the Coronavirus disease (COVID-19) pandemic | Salutogenic approaches occur alongside and reinforce traditional community and public health approaches  | N/A | N/A | Socio-economically disadvantaged populations at risk of inequality  |
| **Snooks et al. (2011)47:** to develop a ‘Healthy Living’ Approach (HLA) to community development. | An HLA approach involves recruiting and training local people as community researchers; the action researcher supports community forums to coordinate and communicate across the statutory - voluntary - community partnership | One-off | Communities produced and disseminated action plans based on locally identified needs; few community changes had occurred due to a slow process; community participants gained skills and confidence; cross-sector partnership working was developed | Two socio-economically disadvantaged communities in Pembrokeshire, West Wales |
| **Lawlor et al. (2019)24:** to develop and test the feasibility of a physical activity (PA) promoting intervention for older women within existing community groups | This intervention was informed by Social Practice Theory (SPT) which enables behaviours to be considered as a social issue rather than focusing on individuals’ attitudes | One-off trial | Use of existing social support groups is an acceptable and attractive method of delivering a PA intervention to the specified population | Older women in socio-economically disadvantaged areas (Belfast area) |
| **Wright-Bevans et al. (2020)48:** to understand the mechanisms of successful community consultation for older adults in one of the most socio-economically disadvantaged local authority areas in the UK | Consultation forums in a view of a naturalistic world café was co‐designed with a community engagement service | Unclear, likely a one-off engagement | Forums were found to only offer space within which opinions could be voiced, supported information gathering, the adoption of civic responsibilities and social activities. Unclear whether forums had any impact on health | Older adults in socio-economically disadvantaged areas (Stoke-on-Trent) |
| High relevancy and low robustness |
| **Caperon, Saville and Ahern (2022)49:** to develop a socio-ecological model for community engagement in a health programme | Socio-ecological model reflects a highly interconnected relationship between society and ecosystems | N/A | This socio-ecological model highlights the overarching importance of the following factors. Socio-cultural environment factors: trust, social support and community mindedness.  | Socio-economically disadvantaged population in an urban area (Born in Bradford) |
| **Carlisle (2010)50:** to better understand the difficulties involved in implementing partnership and participation initiatives within a disadvantaged community | Social Inclusion Partnership tackling local health inequalities and social exclusion using a health promotion, partnership and community-led approach | 10-year funded pilot with community projects having to negotiate further funding at the end of projects | This partnership suffered from community-led initiatives competing for vital resources. Absence of community engagement at the beginning led to rivalries and contested legitimacy | East Kirkland, Scotland |
| **Lamb et al. (2014)46:** to develop and evaluate a community engagement model for the Improving Access to Mental Health in Primary Care (AMP) programme | Community engagement model involved four components which were based on action research theory | Unclear, likely a one-off intervention  | Better collaboration between statutory and third sectorThe community engagement approach needs to give communities a sense of collective ownership of the interventions by involving them in both the design and delivery | South Asian community in Longsight in Greater Manchester |
| **Mantovani, Pizzolati and Gillard (2015)41:** to evaluate a pilot outreach intervention which adopted a community engagement model to address the mental health needs of African and African Caribbean groups | Recruited Community and Well-Being Champions (CWBCs) from African and African Caribbean communities | One-off | CWBCs encountered resistance on the part of the people they engaged with, which resulted from a lack of knowledge about mental health, taboos and ascribed stigma. Better training for CWBCs is required to overcome these challenges  | African and African Caribbean groups in South London |
| Moderate relevancy and moderate robustness |
| **Stansfield, South and Mapplethorpe (2020)51:** to identify key elements of whole system approaches to building healthy communities and putting communities at the heart of public health with a focus on public health practice to reduce health inequalities | Community centred approach uses participatory methods where community members are actively involved in design, delivery and evaluation; uses and builds on local community assets in developing and delivering the project; develop collaborations and partnerships with individuals and groups at most risk of poor health | N/A | N/A | N/A |
| **Dickerson et al. (2019)52**: this guide provides strategies on how to overcome challenges of integrating research and practice when it comes to complex community interventions | Successful community and stakeholder engagement requires their involvement from the beginning, and at all stages of intervention design, delivery, evaluation and dissemination.Establishing a Community Advisory Group made up of local people will facilitate this integrated involvementThe starting point is a careful mapping out of all key stakeholders followed by regular and effective communication | N/A | N/A | Born in Bradford, Better Start |
| Moderate relevancy and grey literature |
| **The King’s Fund (2021)53:** to make recommendations aimed at genuine engagement with the diverse communities that the NHS exists to serve | These range from surveys and consultations to co-production and long-term partnership working Asset-based engagement approaches | N/A | N/A | Black and ethnic minorities |
| **The Health Foundation, NHS England and the Yorkshire and Humber Academic Health Science Network (2022)54:**to provide actionable insights on how to tackle inequalities; focusing on how communities should be engaged | (1) Test the data with lived experience: it can give a better understanding between what the data shows and reasons behind it, (2) Co-design solutions with the communities the services are intended to benefit and (3) Establish community engagement models | N/A | N/A | N/A |

Annex F – Full list of literature included within the review

Beaney, T., Clarke, J.M., Grundy, E. and Coronini-Cronberg, S. (2022). A picture of health: determining the core population served by an urban NHS hospital trust and understanding the key health needs. BMC Public Health, 22(1). doi:https://doi.org/10.1186/s12889-021-12373-5.

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Annex G - Member List of Expert Panel

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| Expert panel member | Organisation |
| Amanda Williams | Care Quality Commission |
| Anna Mathers | Care Quality Commission |
| Helen Ketcher | Care Quality Commission |
| Helen Rawlings | Care Quality Commission |
| Jillian Mardsen | Care Quality Commission |
| Karmon Hawley | Care Quality Commission |
| Liadan Buggy | Care Quality Commission |
| Lucy Wilkinson | Care Quality Commission |
| Fazilet Hadi | Disability Rights UK |
| Gwen Nightingale | Health Foundation |
| Louise Marshall | Health Foundation |
| David Buck | Kings Fund |
| Sam Rodger | NHS - Race and Health Observatory |
| Ranjit Senghera | NHS England |
| Sara Javid | NHS England |
| Jackie Driver | NHS Greater Manchester Integrated Care |
| Patricia Miller | NHS Dorset Integrated Care Board |
| Joanne McCormack | The National Institute for Health and Care Excellence (NICE) |
| Allan Baker | Office of Health Improvement and Disparities (OHID) |
| Joel Llewellyn | People’s Health Trust |
| Max Edelstyn | The Equality and Human Rights Commission |
| Professor Rosalind Raine | University College London |

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