NHS
Queen Victoria Hospital
NHS Foundation Trust

2025-2030 Enabling Strategies

PILLAR 2

Health Inequalities Strategy

2025-2030

Strategic Context

This document illustrates our strategy supporting Pillar 2:

Health Inequalities

ANCHOR INSTITUTION

- Employment and skills
- Procurement
- Environmental impact
- General social, economic and civic impact

HEALTH INEQUALITIES

- System partner
- Provider of services
- Anchor Institution
- Health promoting hospital

GREEN PLAN

- Evolving care
- Places
- Circular economy
- Journeys
- Climate adaption

DIGITAL

- Patient outcomes and experience
- Staff experience
- Interoperability
- Operational transparency
- Efficient and reliable

PARTNERSHIPS

- Academic
- Providers
- ICB/P
- Voluntary
- Commercial

PEOPLE & CULTURE

- Being a great place to work
- Looking after the wellbeing of our people
- Being compassionate and Inclusive
- Empowering and supporting our people to learn and develop

FINANCE

- Long-term Financial Model (LTFM)
- Deliver best value
- Environmental impact
- Commercial
- Financial support

RESEARCH & INNOVATION

- Leadership and culture of research
- Workforce, infrastructure and governance
- Sustainable growth
- Collaboration and partnerships

ESTATES

- Growth
- Buildings
- Maintenance
- Contracts
- Waste

Contents

INTRODUCTION

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. These differences are often associated with social, economic and environmental factors, including the wider determinants of health such as housing, employment and education in addition to geography, protected characteristics and socially excluded groups.

Health inequalities can present in various ways, including differences in life expectancy, and likelihood of certain health conditions and diseases. Risk factors of poor health, such as smoking, poor diet, alcohol use, and physical inactivity, are often affected by a person's social and financial conditions. This contributes significantly to widening health inequalities.

This strategy sets out QVH's ambition to tackle health inequalities. It considers the factors that impact QVH patients and populations and also aligns with the national and local challenges and requirements.
It is approached through the lens of the following four roles of QVH; as a healthcare provider, a system partner, a health promoting hospital and an anchor institution.

IN THE WORDS OF PATIENTS, CARERS AND STAFF

Through this strategy we aim to influence and deliver improvements in health access and outcomes for patients, staff and the local community. Everything we do at QVH is informed by our passion for providing the highest quality care, the best clinical outcomes and a safe and positive patient experience, and therefore our patients are at the heart of this strategy.

We know there is more to do as an organisation to accurately collect details of our patients' protected characteristics. Of our patients, where ethnicity is recorded, 84% are White British or Irish; 2.3% are Black/Black British Caribbean, African or Mixed White and Black African or Caribbean; 3.2% are Asian/Asian British-Bangladeshi, Indian, Pakistani or Other Asian background or mixed White-Asian; and 10.2% are mixed background or any other ethnic background. In 2023, 12% or our patients were under 17 years of age, 30% were over the age of 65 and 7% were over the age of 85. In 2023 49% of patients were male and 50% were female.

The Indices of Multiple Deprivation (IMD) is the official measure for relative deprivation for small areas in England. Deciles range from 1-10, with 1 being the most deprived 10% of small areas, and 10 being the least deprived 10% of small areas. At QVH, 5% of our patients' home address was in an area scoring 1 or 2, and therefore within the most 20% of deprived areas in England.

NHS staff can face the same inequalities as the broader population, and poor employment is linked to the fundamental causes of health inequality. Sections of this strategy therefore also have a staff focus.

QVH employs c.1,200 staff, made up of over 50 nationalities and 72 different countries of birth. 21% of our staff are from an ethnically diverse background; 6.7% of staff have declared a disability; 3% of those who declared their sexuality were lesbian, gay, bisexual or undecided; 76% of our staff identify as female; and 39% of our staff report that they are East Grinstead residents.

We acknowledge the impact of engagement in improving health outcomes for people and their communities. When specialist knowledge and familiarity is required to progress actions relating to Health Inequalities, (e.g. for a specific diagnosis or treatment) we will seek out those with relevant and lived experience and involve them in the development process. When we need a broader view, we will ensure our consultation group is fully inclusive using supporting organisations where required.

Our wider strategic engagement to date has provided some reflections and hopes for the future in the words of our patients, carers and staff:

> "The people have been amazing and so caring. Thank you so much. They were really good with dealing with my sensory needs so thank you."

> "Patient care can be improved by offering better facilities, adult changing spaces for disabled patients, provide full support for neurodiversity, offer safe rooms or quiet spaces for patients and staff when they are overwhelmed."

> "Focus on providing safe, reliable, much more accessible services to people."

> "I would like a digital solution for hard to reach patients who may need support to access the virtual provision."

VISION AND VALUES

Our vision has been co-produced with patients and staff and aligns to the Trust ambition to be a provider of specialist and regional services and to deliver an innovative offer for the local population.

We want all of our staff to feel valued and supported in their personal wellbeing and their professional ambition, to be proud of the work they do for our patients and each other, and to embody the Trust vision. Our vision is underpinned by our values, which have been refreshed alongside the development of our five year strategy.

Living our values requires us to:

- Regularly and purposefully review what our values and strategy mean for QVH, as individuals, as teams and as an organisation.
- Recognise the prejudice in all of us, even when we cannot see it for ourselves.

Our vision is:

To be a centre of excellence that **rebuilds lives** and **supports communities** for a healthier future

To achieve that, our values are:

We treat everyone with respect, kindness and compassion.

We are inclusive and celebrate diversity.

We take time to support and look out for one another.

This includes sometimes challenging and holding one another to account, even if it feels uncomfortable.

We seek out and listen to feedback from patients, colleagues and partners with openness, and act with honesty and transparency to continuously improve the quality of our care.

We value working together in teams, within QVH and with local partners, to provide outstanding care and support each other to deliver shared goals.

TRUST STRATEGIC OBJECTIVES

Our new key strategic objectives guide our priorities and focus. They frame everything from significant service level decisions through to individual objectives with a view to delivering improved outcomes for our patients and populations and improving our staff experience. Addressing inequality is key to the delivery of our objectives.

Our objectives are:

Quality at the **centre** of what we are and do for patients, families and communities.

To reflect our **future commitment and aspiration** to research, innovation and continuous improvement underpinning all that we do.

Our **people** are our greatest asset and we need to work hard to develop and deliver our workforce for the future.

That we are **cost effective**, deliver best value, are committed to our role to support a sustainable environment and the key role of digital in our future pathways and delivery model.

Core to our future as part of a system, as a leader delivering to multiple systems and reflecting our **ambition** in regard to anchor, NHS, academic and commercial activities for the future.

CONTEXT (NATIONAL AND SYSTEM CONTEXT AND DRIVERS)

Queen Victoria Hospital Foundation Trust provides reconstructive surgery, burns care and rehabilitation services for people who have been damaged or disfigured through accidents or disease. It also provides a suite of services for the local population.

Due to the specialist nature of many QVH services, patients attend the hospital from all over the UK. For some QVH services, QVH is the sole provider in the South East and/or Kent Surrey and Sussex (KSS). A map of where QVH patients attended from, and the areas associated IMD score is provided in Appendix A. When considering the health inequalities that impact QVH patients we therefore consider a national and local perspective.

National

NHS England's Healthcare Inequalities Improvement Programme vision is for the NHS to deliver "exceptional quality healthcare for all, ensuring equitable access, excellent experience and optimal outcomes". When addressing health inequalities, QVH will align to the three aspects of this vision; access, experience and outcomes. In order to define the characteristics impacted by health inequalities, this strategy uses the domains of health inequality Venn, Public Health England (Appendix B), and NHS health inclusion groups (Appendix C). There is some overlap between the two domains, however using them in parallel gives a comprehensive approach.

Building on the mandated obligations of the Equality Act 2010, the NHS Long Term Plan sets out the importance of addressing health inequalities. The supporting operational guidance sets out' five priorities for change: restoring NHS services inclusively, mitigating against digital exclusion, ensuring datasets are complete and timely, accelerating preventative programmes and strengthening leadership and accountability.

Further national priorities are provided in the NHS Core20Plus5 approach for adults and children and young people (Appendix E), created to inform action to reduce healthcare inequalities at both national and system level. "Core20" refers to the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). "PLUS" refers to population groups that are identified at a local level. The 'Plus' group identified by West Sussex Joint Health and Wellbeing Strategy (2019-24) are minority ethnic groups; people with special educational needs and disabilities, LGBTQ+, those who are deprived or living in poverty, carers and people with long term mental health conditions (Appendix D). '5' refers to the five clinical area that have been identified as having particular health inequalities.

Local

In addition to the national priorities this strategy will align to the Sussex Health and Care Improving Lives Together Strategy. Priorities will align in relation to tobacco treatment services, improving outcomes for those in deprived areas, and those with protected characteristics.

At a more local level there is a geographical context to consider when understanding health inequalities at QVH. The Health Foundation's 2022 report on addressing the leading risk factors for ill health notes that the most effective interventions to tackle inequalities are done at a population-level.

As part of the strategy development programme the 'local population' for QVH has been identified (Appendix F) and health needs analysis undertaken. The analysis showed that while the area local to QVH appears affluent, closer examination reveals 24 out of 58 wards exhibited significantly worse health outcomes than the average for England, against one or more indicator.

For the five local authorities in the local catchment area, there are nine indicators below the England median, including:

- Emergency hospital admissions for intentional self-harm,
- Estimated dementia and diabetes diagnosis rates,
- Percentage of physically active adults,
- Overweight or obese adults,
- Smoking during delivery,
- Children in low-income levels,
- Homelessness
- Tuberculosis (TB) incidence.

These areas have been taken into account when developing the priorities for this strategy.

WHY WE NEED TO CHANGE

Demand for health and care services has grown significantly in recent years due to an increasing and aging population, the impact of the pandemic and the range of social, economic and environmental factors which influence health.

In the next 20 years the population in the south east is set to increase by 6.1%. By 2043 it is anticipated that there will be an increase of over 36% in the over 65 age range.

There is a similar picture for the local geography. For West Sussex and Kent an 8% population increase is expected by 2031 and 2028 respectively. East Sussex is anticipated to increase 3% by 2025. Surrey is also expected to see increases, albeit at a slower rate, of 3% by 2043 – however by 2030 more than 20% of the population will be over 65. Demographic changes will have a considerable impact on the requirements of health and care services.

In addition to demographic changes, there is growing awareness of the impact of socio-economic factors that not only impact demand for health care but also can significantly impact health outcomes. The environment in which people are born, grow, live, work and age has a profound effect on the quality of their health and wellbeing. Many of the strongest predictors of health and wellbeing therefore fall outside the healthcare setting. The poorest and most deprived are more likely to be in poor health, have lower life expectancy are likely to have a long-term health condition or disability.

The impact of health inequality is significant. Patients living in deprivation or those with serious mental illness live on average 10 years less than the general population and live up to one third of their lives spent unwell with chronic conditions. Those with a healthy life expectancy can live up to 20 years longer. These are unacceptable differences and QVH must have a role in the future to work with system partners to close this gap.

BEST PRACTICE AND EVIDENCE BASE

The King's Fund provides evidence demonstrating the prevalence of inequalities in the UK in life expectancy, healthy life expectancy, avoidable mortality, long-term health conditions, mental ill-health and access to, and experience of services. It also shows interactions between the factors driving health inequalities.

Therefore, based on factors outside of their direct control, people in England experience systematic, unfair and avoidable differences in their health, the care they receive and the opportunities they have to lead healthy lives. In terms of tackling these inequalities, The King's Fund notes three important factors. Firstly, that at population level inequalities in health are persistent and stubborn to shift, secondly that to shift them requires a multifactorial approach, across government and through the NHS. The third factor that when there isn't a focus on health inequalities, they are likely to widen.

Evidence from The Health Foundation identifies the impact of health inequalities on life expectancy and years lived in good health. People from the poorest areas suffered disproportionately from COVID-19, however in the decade prior to the pandemic, life expectancy improvements had already stalled. Their evidence suggests that health inequalities are significant and growing between different parts of the UK, and between the most and least deprived areas; the wider determinants of health shape our health and life expectancy. These inequalities are not inevitable, and best practice in addressing them requires action collaborative action from communities, business and government. Additionally, evidence from 'The Marmot Review: 10 Years On' shows that the last decade has been marked by deteriorating health and widening health inequalities, and that the increase in health inequalities in England points to social and economic conditions, many of which have shown increased inequalities, or deterioration since 2010. The Marmot Review recognises that ethnicity intersects with socioeconomic position to produce particularly poor outcomes for some minority ethnic groups. Lack of data limits our understanding of inequalities in health in ethnic communities. This supports QVH's priority focus in collecting and analysing patient ethnicity data so the most appropriate care can be provided to those who need it.

The National Institute for Health and Care Excellence (NICE) provides information on health inequalities including definition, factors, mapping NICE guidance to Core20plus5, NICE and the Marmot Review, as well as how NICE guidance can be used to tackle health inequalities. NICE highlights that because people from socioeconomically deprived populations and certain ethnic groups experience poorer health, it is particularly important to focus preventative services on these groups. There are ten elements of NICE guidance related to developing approaches to addressing health inequalities, of which the principles are built into the pillars of this strategy.

Finally, the Federation of Specialist Hospitals (FSH) conducted a member survey to collect information on the approaches taken by specialist hospitals to identify, understand and put in place interventions to reduce the health inequalities gap, including good practice, opportunities and areas for further support.

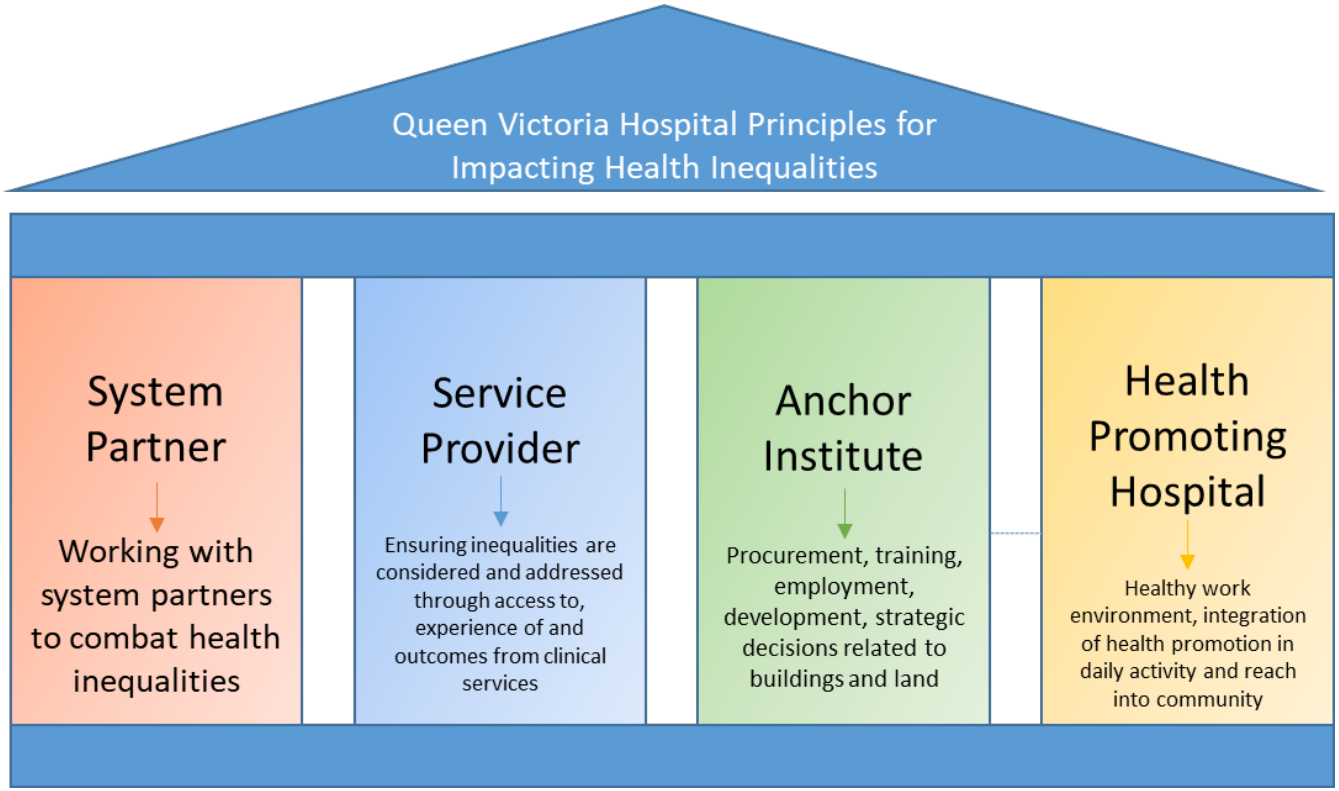
Early results suggest that the unique role of specialist hospitals in health inequalities means they are well placed to lead on health inequalities within their own specialties. This can be done by sharing findings on health inequalities encountered by different groups seeking care in clinical specialties and identifying actions to mitigate these inequalities through collaboration. Specialist hospitals should be acknowledging inequalities within their direct control and addressing with urgency, these actions are addressed in Pillar 2 of this strategy.

Providers should also be developing internal training curriculums on delivering culturally appropriate care, and understanding social determinants, as well as training for external partners, such as primary and community providers. Specialist hospitals should also be ensuring minority communities are represented at all levels, and finally should be focussing on how to drive greater equality in research and innovation.

These elements of best practice will inform strategic implementation planning.

STRATEGIC PRIORITIES

The Trust has outlined its ambition for tackling Health Inequalities though the perspective of four roles: as a system partner, a provider of services, an anchor institute and a health promoting hospital. We will put in place governance, reporting and monitoring processes to ensure that we are making a difference through each of these roles, and against each of our commitments.



Pillar 1 – System Partner

Our ambition:

" We will prioritise actions to impact health inequalities as a system partner, in alignment with Sussex Integrated Care System and our local neighbourhood providers, because united regional and local ambitions will have the greatest potential impact."

Priorities will be:

- Continue the roll-out of the NHS funded offer of universal smoking tobacco treatment services and ensure investment at scale and its sustainability.
- Address inequalities and improve outcomes in priority clinical pathways for those in deprived geographical areas and with vulnerable or protected characteristics. This includes:
  - Reducing waiting times, Did Not Attends (DNA), and cancellation rates in our most deprived areas and those with protected characteristics.
  - Improve recording of ethnicity recording across all providers
  - Baselining of LGBTQ+ and Learning Disability data recording.
- Utilise approaches such as tobacco control, Cancer screening and health checks and work together with key stakeholders across the area to target our activity and resources where it is needed most based on need and evidence of what works.
- Seek to make care more personalised so that people can access health and care services that are more tailored to their needs, make sense to them and focus on what really matters in their lives.

As a neighbourhood partner, QVH will continue to develop strong partnerships with local GP surgeries and agree shared prevention priorities.

Pillar 2 – Provider of Services

Our ambition:

"Patients access to QVH services, the experience they have at the hospital, and the outcomes of their treatment, will not be dependent upon where they live, their income, their ethnicity or any other socioeconomic factor or protected characteristic."

Achieving this ambition requires a thorough understanding of how inequality influences access to services. The Trust will need to ensure timely and effective collection of appropriate datasets and ensure a clear understanding of factors impacting the QVH patient cohort. A clinical stakeholder survey was dispatched internally in May 2024 and analysed to understand prevalence of health inequalities in core clinical areas at QVH.

Priorities will be:

- The Trust will have accurate, complete and timely data in order to impact health inequalities in priority areas, aligning to NHS National Priority 3: Ensuring datasets are complete and timely.
- The trust will be able to use data to identify inequalities in access, outcomes and experience within QVH services, based on protected characteristics (as prioritised).
- We will ensure that our services are accessible using a hybrid approach making sure that no one is excluded face to face as well as digitally where appropriate.

QVH priorities for data improvement are determined by a gap analysis, our clinical stakeholder survey insights, and alignment to Sussex ICS priorities for data collection and analysis. Our data priorities, in order of focus over the 5-year period will be:

1. Analysis of patients Indices of Multiple Deprivation (IMD) score by service, determining actionable insights relating to access and experience.
2. Complete and timely collection of patient ethnicity (reaching 90% collection by March 2025), smoking and alcohol status.
3. Complete and timely collection of patient data relating to LGBTQ+ and Learning Disability status.
4. Agree prioritisation of data collection and analysis of other protected characteristics particularly relevant to QVH based on insights; including Armed Forces status, homelessness, dementia and obesity.

Reporting on health inequalities data will be built into the QVH integrated assurance framework. We will incorporate a health inequalities focus into reporting on (in order of priority):

- Excessive waits (in line with guidance standards)
- Time to diagnosis
- Time to treatment
- Digital exclusion (internet access and skills)
- Specialised services
- Patient outcomes and experience.

Pillar 3 – Anchor Institution

Our ambition:

" QVH will act as an anchor institution, in partnership with other local anchor institutions, to address the socio-economic factors that lead to inequalities in health."

The link between health and wealth is well understood. Social and economic development can improve health. NHS organisations functioning as an anchor system will foster a holistic approach to supporting people where they live, learn and work, alongside a longer-term move to preventative health.

Taking a holistic view of how people's lives can be improved can include access to good education, accessible healthcare, quality housing, as well as meaningful employment. As a system partner we will have an ambition to contribute to local social and economic development and work with others within our catchment area to address the identified inequalities.

NHS England notes that while the main function of the NHS is to provide health services, it also has a significant part to play in supporting partner organisations and communities to address the wider determinants of health; the physical, social and environmental factors which can cause ill health. NHS England states that 80% of health outcomes are determined by non-health related inputs, e.g. education, employment, income, housing and access to green space. Working as anchor institutions offers NHS organisations the opportunity to act on the key causes of poor health and reduce inequalities. The QVH anchor institution strategy 2025-2030 outlines the 4 pillars of work in this area which align to NHS Sussex ICS strategy.

Priorities are as follows:
[Please see anchor institution strategy]

Procurement

Purchasing supplies and services, where feasible, from organisations that embed social value to make positive environmental, social and economic impacts.

Employment and skills

Widening access to quality work: Being a good inclusive employer, and creating opportunities for local communities to develop skills and access jobs in health and care especially those experiencing inequalities.

Net zero / environmental impact

Taking action to reduce carbon emissions and consumption, reduce waste and protect and enhance the natural environment.

Estates and general social, economic and civic impact

Widening access to community spaces, working with partners to support high-quality, affordable housing and supporting the local economy and regeneration.

QVH will collaborate with communities to help address local priorities, build on their energy and skills; and work with other anchors and partners to increase and scale impact.

Pillar 4 – Health Promoting Hospital

Our ambition:

"QVH will be a health promoting hospital, impacting the holistic health of everyone it comes into contact with; patients, carers, visitors, staff, partners and the community."

The World Health Organisation (WHO) describes a Health Promoting Hospital as one which takes action to promote the health of their patients, their staff, and the population in the community they are located in. A health promoting hospital not only provides quality services, but also develops a corporate identity that embraces the aims of health promotion.

QVH will develop a health promoting organisational culture and develop into a health promoting physical environment, actively partnering with other local organisations to promote health. This work will align with NHS National Priority 4: Accelerating preventative programmes.

Our ambition will seek to prioritise elements of being a health promoting hospital that target the areas of need determined by our local needs assessment including emergency hospital admissions for intentional self-harm; estimated dementia and diabetes diagnosis rates; % of physically active adults; overweight or obese adults; smoking during delivery; children in low-income levels; homelessness; and Tuberculosis (TB) incidence.

This may include a range of interventions including signposting, on site opportunities and working with other providers.

WHO states that eating healthy, exercising regularly, maintaining a healthy weight, and avoiding alcohol and tobacco are ways of preventing major lifestyle diseases such as cardiovascular disease, diabetes and cancers as well as their risk factors such as raised blood pressure, raised blood sugar level and being overweight. In order to take this holistic approach to health promotion into account and address the above areas of need, QVH will focus on these priority areas to support access to preventive programmes including:

- Nutrition and activity
- Mental wellbeing including children and young people (CYP)
- Smoking cessation
- Oral care including CYP.

INTERDEPENDENCIES

The health inequalities strategy aims to tackle disparities in health access, experience and outcomes by ensuring that individuals have equitable access to high-quality care, regardless of their socioeconomic status or other social determinants. It is therefore inherently linked to our Clinical Strategy, as improving health outcomes for underserved populations directly contributes to the Trust's vision of rebuilding lives and supporting communities for a healthier future.

This strategy is interdependent with the anchor institution strategy, relating to our role as an anchor institute, and therefore also the People and Culture Strategy. All three strategies have similar strategic objectives relating to employment and skills, widening access to quality work and being a good employer. These strategies address social need as a determinant of health.

Health inequalities objectives are driven by health access and outcomes; how we adapt NHS care to account for patients' social needs, how we link patients with resources to address social needs, and how we align local resources to improve population health.

The anchor institution strategy is directed towards how we use NHS resources to be a good citizen in our community and to improve social conditions. These strategies are also aligned to, and will be delivered in parallel with, the Trust's Green Strategy.

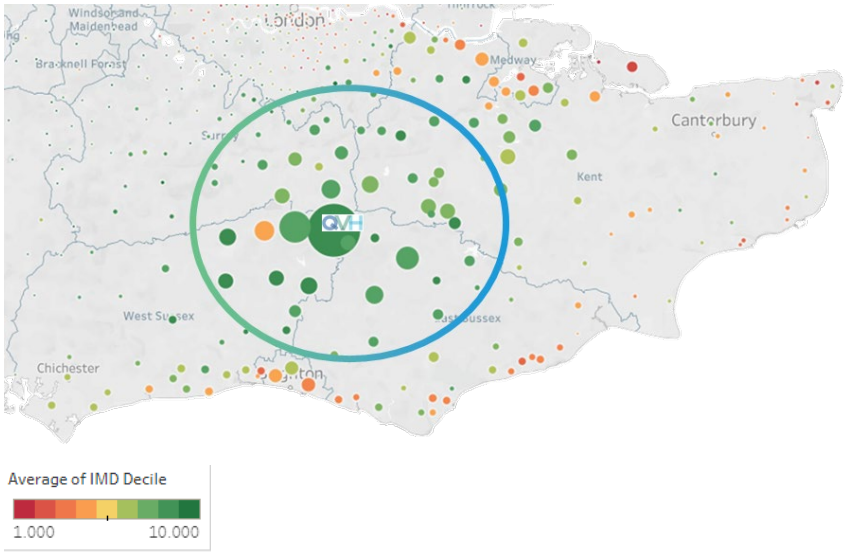
The Health Inequalities and Anchor Institution strategies set out our green ambition and intentions within the parameters of improving social conditions in the community, which has included high level principles on estates, waste and travel. These ambitions are in alignment with the Trust's existing green strategy, which has been developed around the eight elements of the 'Care without Carbon' framework, to ensure we continue to have an integrated and holistic approach to our sustainable healthcare programme.

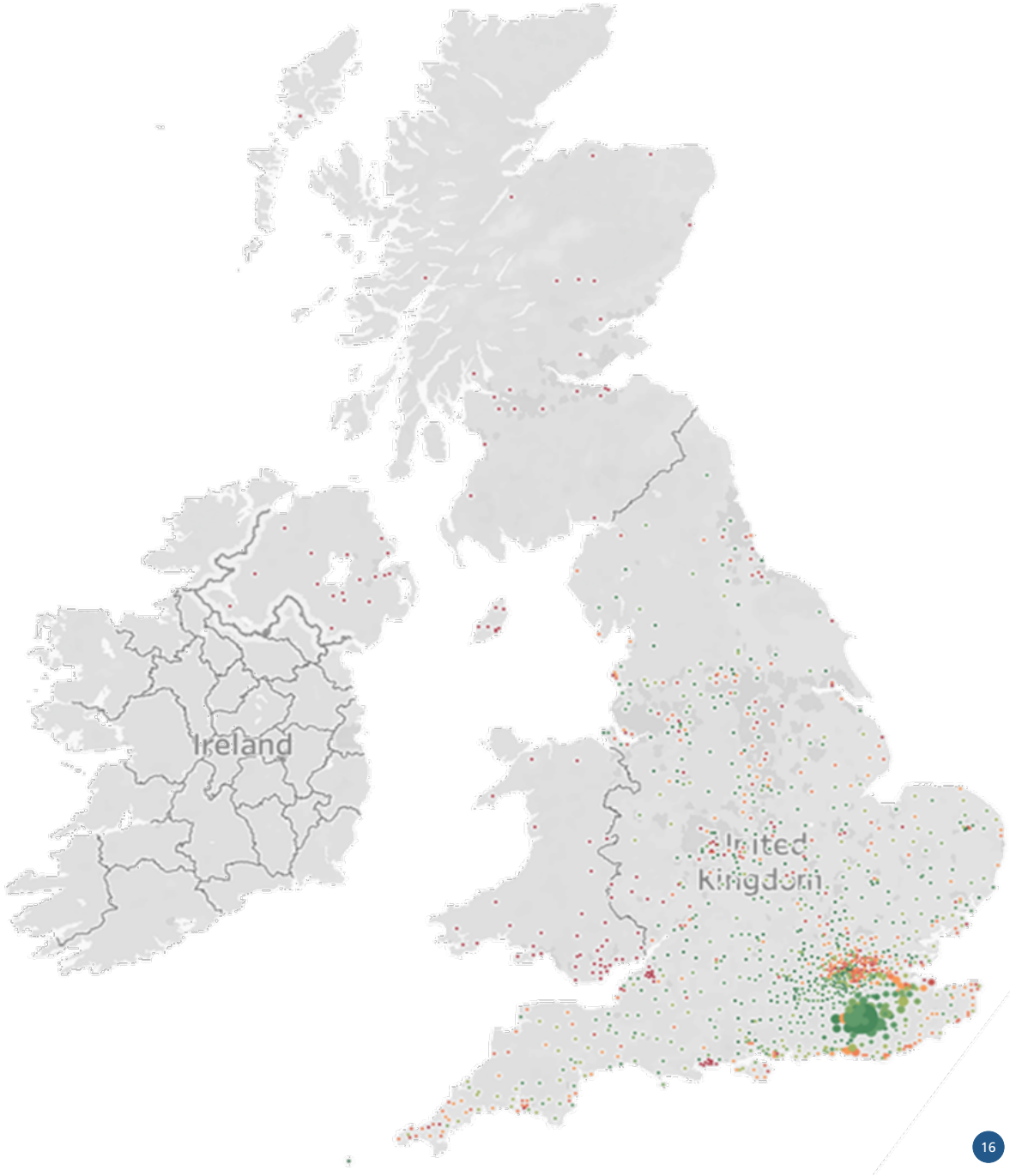
The delivery of the health inequalities strategy will be interdependent with the delivery of the Trust's Digital Strategy and Business Information function as well as operational teams. These will help the improvement and reporting of data and enhancing accessibility by providing digital tools which can overcome geographical and logistical barriers to access.

Appendices

Appendix A: QVH patients map

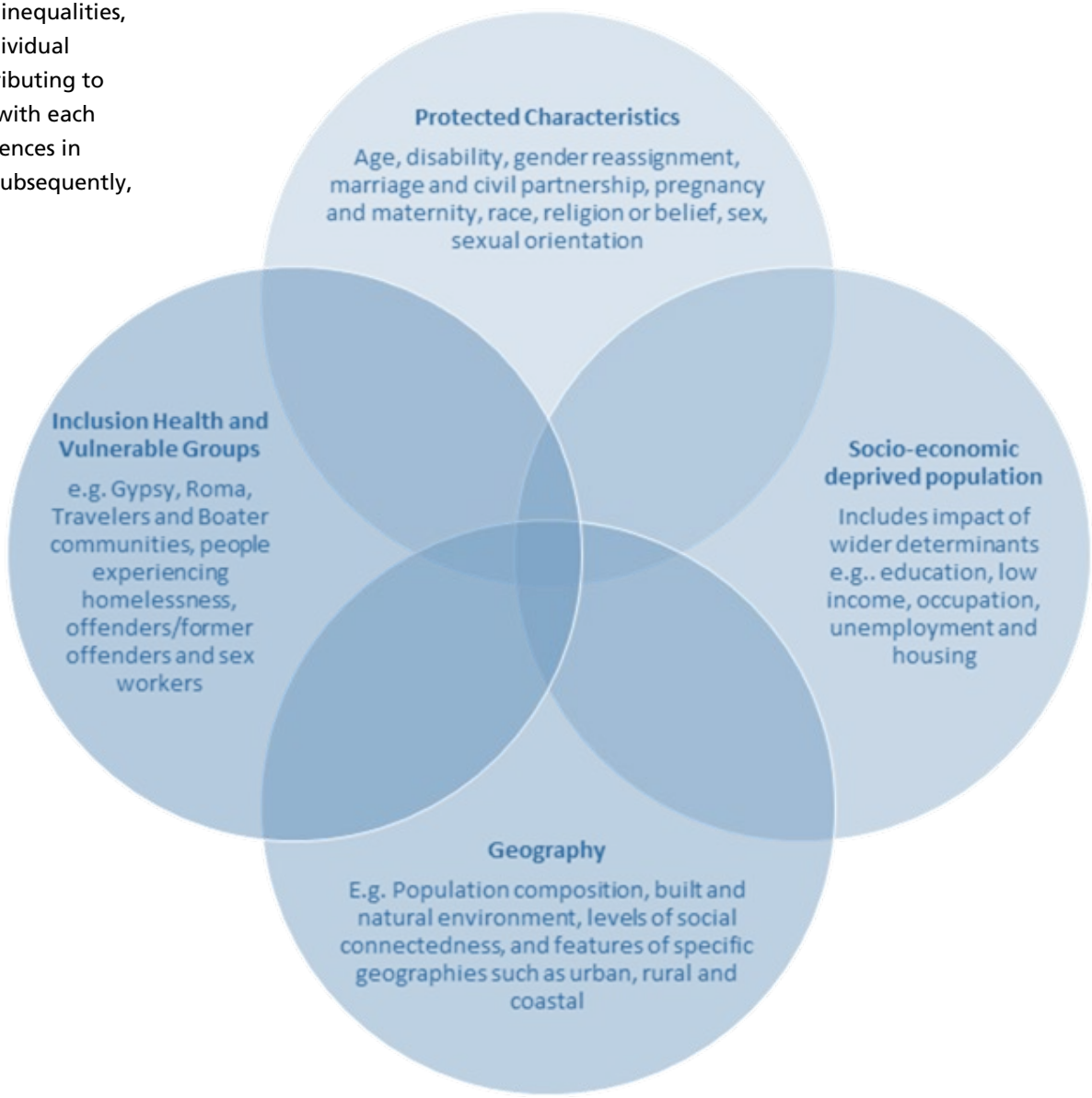
The maps show patient location data, taken from the date range 01 October 2022 – 30 September 2023. The data gives the first half of the patient's home postcode. The size of the circles indicates the volume of patients from the related area. The colour of the circle relates to the average IMD Decile of the area, with the colour key provided.





Appendix B: the domains of health inequality venn

Adapted from Health inequalities place-based approaches to health inequalities, the domains of health inequality venn shows the broad range of individual characteristics and societal factors that have been identified as contributing to health inequalities. The included domains are complex and interact with each other to benefit or disadvantage people or groups, leading to differences in health outcomes. Individuals fall into more than one category and, subsequently, may experience multiple drivers of poor health at the same time.



Appendix C: Inclusion health groups

Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple interacting risk factors for poor health, such as stigma, discrimination, poverty, violence, and complex trauma.

People in inclusion health groups include:

- People who experience homelessness
- People with drug and alcohol dependence
- Vulnerable migrants and refugees
- Gypsy, Roma, and Traveller communities
- People in contact with the justice system
- Victims of modern slavery
- Sex workers
- Current or previous service in the armed forces
- Other marginalised groups.

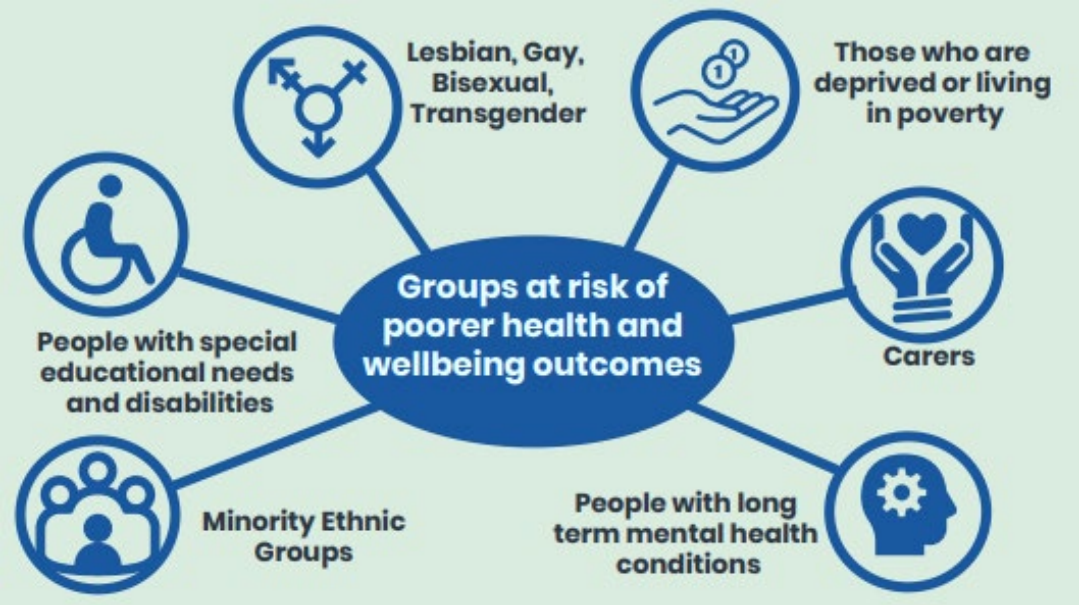
These groups are more likely to have the following experiences in common:

- Discrimination and stigma
- Violence and the experience of trauma
- Poverty
- Invisibility in health datasets.

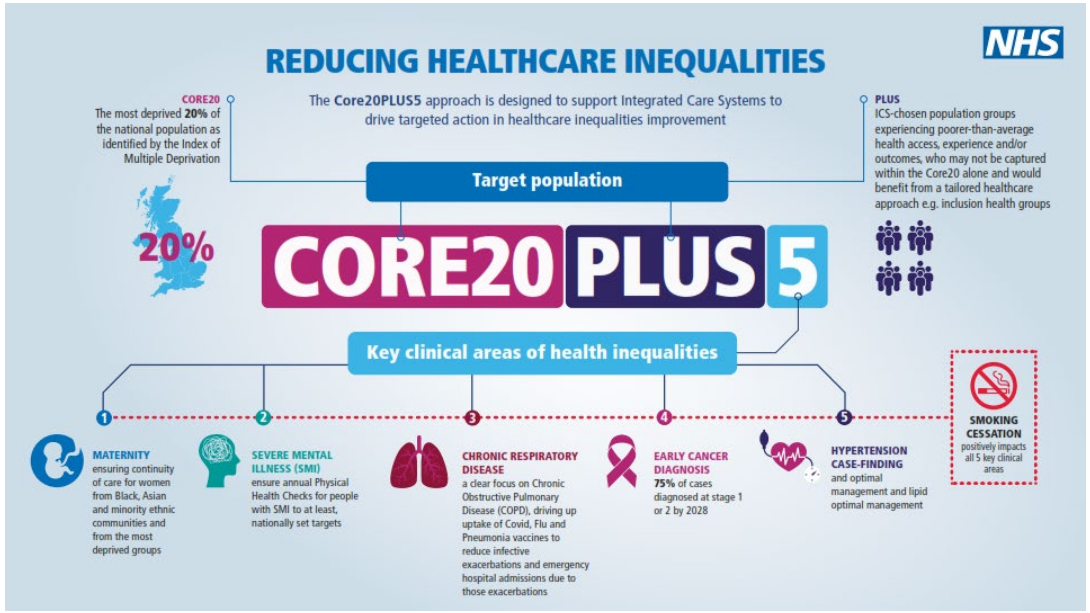
Which can result in:

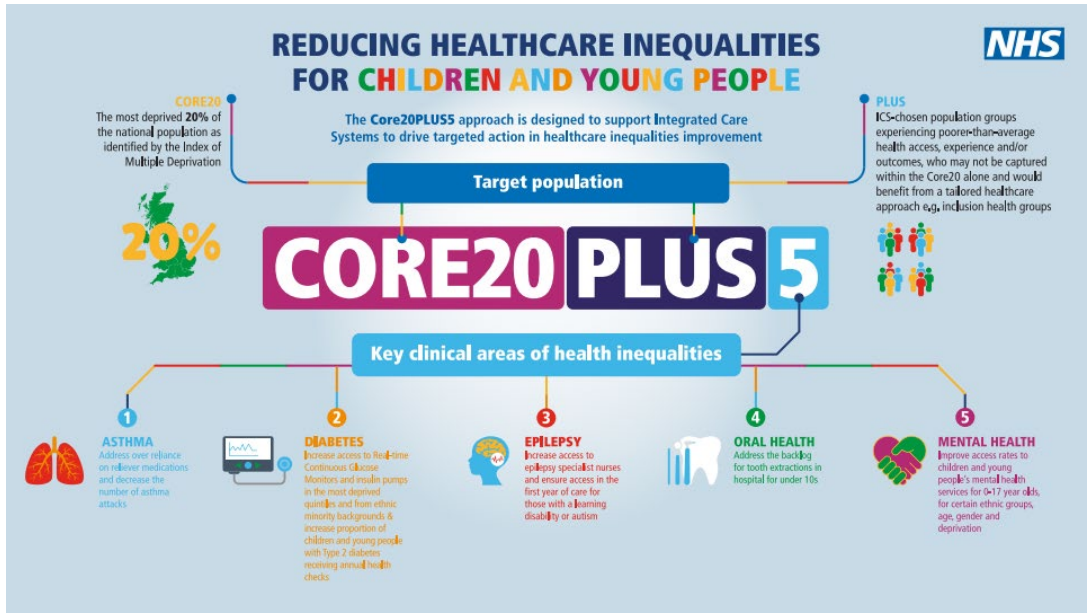
- Insecure and inadequate housing
- Very poor access to healthcare services due to service design
- Poor experience of public services
- Poorer health than people in other socially disadvantaged groups.

Appendix D: Sussex 'Plus' groups



Appendix E: Core20Plus5 adults, and children and young people (CYP)





Appendix F: QVH 'Local Population'