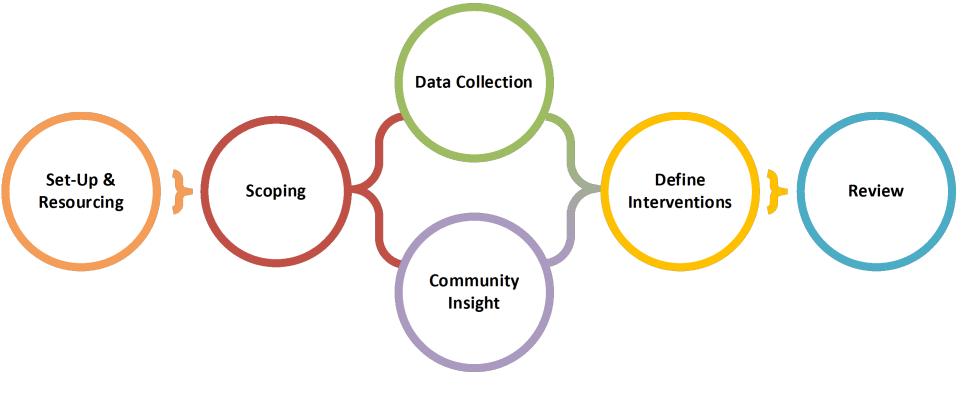# Blueprint Approach to Tackling Health Inequalities

January 2023

Blueprint Approach to Tackling Health Inequalities

1 Set-Up & Resourcing

- Owing to the diverse and varied nature of health inequalities, ensuring sufficient **resource** is a key step in the set-up of a health inequalities project.

- The project group should include a **range of skills and expertise**, including subject matter experts, data and business analysts and project management.

- Health inequalities are influenced by a broad spectrum of issues and have a strong relation to the wider determinants of health, therefore ensuring a range of **multi-disciplinary stakeholders** is essential.

- Due to the complex nature of multi-agency working, a **project sponsor and champion** is critical in shaping the direction of the project, promoting aims, objectives and benefits; and ensuring buy-in from stakeholders.

- It is important at this early stage to give consideration towards **patient and resident engagement**. Consider to what extent patients and residents will be involved and how their input may influence the direction of the project.

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2 **Scoping**

- Health inequalities can be attributed to a broad range of issues as described via the wider determinants of health. This can become overwhelming, so it's important to have a **clearly defined scope** of what you want to achieve.

- Establish your aims and objectives early on, and **understand the issue you want to address** – Tools such as Fingertips Public Health Profiles can aide in identifying issues in local wards and boroughs; whilst data sets such as hospital admissions and discharge planning can help identify common outliers.

- Determine your **key areas of focus**. This will provide a clear scope for the next two steps in the process regarding data collection and community insight. You can further narrow your focus from there.

- Be clear on **what you want to achieve**. Think about what the outcomes of this work will be and what the benefits are.

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3 Data Collection and Insight

- Data is **a core element of identifying and tackling health inequalities**; enabling high-level scoping of the project, providing detail to the defined area of scope, and informing outcome measures in order to evaluate the success of any agreed intervention.

- Due to the broad scope of health inequalities, and accounting for the wider determinants of health, it is key to **establish a joined-up data set** that captures health and social data.

- Consider whether data is to be collected at a **population level or at a person-centred level**. Population level data will provide an overview of an area and may indicate a wider issue affecting a ward, borough or county; however, person-centred data will offer more granular detail about a person's journey.

- Data should be replicable in order to measure changes over time.

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Community Insight

- Community insight **provides an invaluable source of data and information** from residents, patients and services about their priorities and experiences.

- It's important to recognise **engagement with residents may challenge assumptions** and even shift the work in another direction.

- Plan for community insight and resident engagement from the outset so that the project can **be flexible to change**.

- Residents are best placed to speak to **their experience with the system**, as well as the things that affect them the most.

- Local organisations can offer **insights into the issues their clients commonly raise**, as well as inform of gaps where they are unable to meet a demand.

- It's important to **build trust** with residents. Often people will have had a negative experience with services, and may be reluctant to engage. **Understanding trusted assets** and what makes something a trusted asset is a key step to building good relations with a community.

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5 Define Interventions

- A **system led approach to defining interventions** should be taken to ensure a range of possibilities are explored to address the target inequality.

- It is important to **continue engagement with stakeholders, patients and residents** when identifying and defining possible interventions.

- Consider **hidden barriers** to an intervention. Whilst a service might look ideal, residents may know of hidden barriers as to why it might not work.

- Tools such as **workshops, surveys and one-to-ones** help facilitate engagement and provide a good accompaniment to the information gathered through local insight and asset mapping.

- Consider other work being undertaken at both a system level and place level. **Identify interdependencies** with other programmes, projects and initiatives **which can be aligned** with the aims and objectives of the health inequalities project.

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Implementation & Review

- When seeking to implement an agreed intervention, it is critical to **be clear about what you want to achieve** and to **clearly understand how you will measure improvement**.

- Taking an **incremental approach to implementation** will create opportunities to understand what is and isn't working, and supports a gradual build of services whilst optimising the use of resources.

- Utilising **tools such as PDSA (Plan, Do, Study, Act) supports this approach** in defining what is to be done, delivering upon, reviewing how it is functioning, and make adjustments accordingly.

- **Benchmarking data before, during and after implementation** will provide a baseline to work and review an implementation against, demonstrating any impact and change delivered by the intervention.

- Continue to follow up on any resident engagement work that has taken place. **Co-production is a continuous process.** Have resident's views and experiences change with the implementation of an intervention?

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