Queen Mary University of London

Health Equity Evidence Centre

Equity matrix for equitable implementation of Modern Service Frameworks

Self-assessment and improvement maturity matrix for equitable implementation of Modern Service Frameworks

To support implementation of the seven equity principles within the Modern Service Frameworks, we have developed a self-assessment and improvement maturity matrix. This outlines the seven equity principles to allow systems and decision-makers to assess the maturity of their equity approach.

Equity principle	Level 1: Aspirational	Level 2: Building	Level 3: Established	Level 4: Exemplary
1. Allocation	Awareness and commitment to allocate resources proportionate to need, but no structured process.	Using data (e.g. eFIT tool, JSNA) to identify high-need areas and allocation of resources, but in an ad hoc, non-systematic manner	Consistent allocation of funding proportionate to need using national data, such as IMD.	Bespoke data-driven model for allocating funding, workforce and programmes according to need and consistently implementing services first in areas of greatest need.
2. Partnerships	Commitment to local cross-sector partnerships working, but reliant on personal connections and lack of structures or processes in place.	Structured groups and forums in place with good representation to allow partners to meet and share learning, but without decision-making responsibilities.	Local partners are members of high-level decision-making groups with ability to influence strategic direction.	Several deep, long-term, trusting local partnerships with shared knowledge, insight and ownership of outcomes, through co-commissioning and joint delivery of services.
3. Co-design	Patient and public representatives consulted on decision-making, but later in the decision-making process with limited ability to influence decisions.	Early engagement with community leaders during the design of new or changing services, with ability to adapt the design and delivery of services.	Diverse community leaders and members are treated as equal partners in the design of local services.	Priorities and services are routinely co-designed with diverse communities, drawing upon policy and practitioner expertise in an effective and mutually respectful manner, to maximise benefits, with a particular focus on engaging historically underserved groups.

4. Access	Awareness of social, cultural, financial, digital and physical access barriers, with stated commitment to improve access, but services largely delivered through standard NHS routes.	Some adaptations made to improve access (e.g. extended hours, digital alternatives, translated materials), but approaches are inconsistent, limited in scale, or reliant on short-term initiatives.	Services are routinely delivered through a mix of accessible routes, including non-digital options and community-based settings, informed by local population needs and patterns of exclusion.	Access models are systematically designed around underserved populations, with flexible, blended delivery (digital and non-digital) embedded across pathways and routinely delivered through trusted community settings.
5. Navigation	Recognition that some populations require additional support to access services, but navigation or advocacy support is informal, inconsistent or absent.	Targeted navigation, peer support or welfare advice is available for some services or populations, often funded as pilots or time-limited programmes.	Navigation, advocacy and peer support are embedded within pathways for underserved groups, with clear referral routes, defined roles and links to wider support services.	Navigation and advocacy support are core components of service delivery, proportionately resourced according to need, and integrated across health, social care and VCSE partners to address structural barriers.
6. Missing groups	Limited understanding of which populations are missing from services or why.	Some use of data or local intelligence to identify gaps in access, with targeted outreach delivered intermittently or for specific programmes.	Systematic use of population health data, risk stratification and local insight to proactively identify and engage groups missing from services, combined with outreach in trusted community settings.	Proactive identification and engagement of underserved populations is routine and embedded across pathways, using integrated data, community partnerships and continuous learning to reduce unmet need.
7. Monitoring	Commitment to reducing inequalities is articulated, but limited routine monitoring of access, experience or outcomes by deprivation, ethnicity or other characteristics.	Some equity-relevant data is collected and reviewed (e.g. ethnicity, deprivation), but data quality, consistency or use in decision-making is variable.	Robust, routine monitoring of access, experience and outcomes across key population groups, with findings used to inform service improvement and accountability.	Equity-focused monitoring and evaluation are embedded across the system, combining quantitative and qualitative data, and used as part of a learning health system for continuous improvement and reduction of inequalities.

Lead authors

Hannah Mohammad, Elliot Clissold and John Ford, Health Equity Evidence Centre, Queen Mary University of London

About this document

This document sets out an equity maturity matrix to support the seven evidence-informed guiding principles for equitable implementation of Modern Service Frameworks (MSFs) developed by the Health Equity Evidence Centre (HEEC) based on a series of evidence briefs. Access to the evidence briefs can be found on our website and published in a mini-series of journal articles. While developed to inform the cardiovascular disease (CVD) MSF, the maturity matrix is intentionally transferable, and intended to support equitable design, commissioning, delivery and evaluation across all MSFs and future public health initiatives.

The views expressed in this publication are those of the author(s) and not necessarily those of NHS England, Department of Health and Social Care.

June 2026

Health Equity
Evidence Centre