Queen Mary University of London

Health Equity Evidence Centre

Guiding principles for equitable implementation of Modern Service Frameworks

Guiding principles for equitable implementation of Modern Service Frameworks

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About this document: This document sets out seven evidence-informed guiding principles for equitable implementation of Modern Service Frameworks (MSFs), based on a library of Health Equity Evidence Centre (HEEC) evidence briefs. Access to the evidence briefs can be found on the HEEC website and published in a mini-series of journal articles. While developed to inform the cardiovascular disease (CVD) MSF, the principles are intentionally transferable, and are intended to support equitable design, commissioning, delivery and evaluation across health and care services, including other 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.

Design and formatting: Becky Wolfe

Forewords

Sarah Price

Director of Public Health, NHS England

Public health has helped deliver some of the most significant improvements in population health, from clean water and seat belts to tobacco control legislation. Yet, while these interventions have improved outcomes for many, their benefits have not always been experienced equally across all communities.

Throughout my career, reducing health inequalities has been a central focus. This means understanding the needs of our diverse populations and using resources in the most effective way to address them. It also means drawing on robust evidence to determine what works, whether that is an approach needed universally or one targeted to specific communities.

The Health Equity Evidence Centre at Queen Mary University of London has produced practical, evidence-based guidance on how we should approach policy implementation and what should be reflected in our action plans. The seven evidence-based principles of equitable implementation provide a clear framework to help us deliver services that are safe, effective and person-centred for all the populations we serve.

Dr Jessica Randall-Carrick and Sir Andrew F Goddard

Clinical co-chairs for the Cardiovascular Disease Modern Service Framework

Cardiovascular disease remains a leading cause of premature mortality, and the pattern is clear: those in the most deprived communities experience the worst outcomes. This unwarranted variation is both unacceptable and avoidable. In clinical practice, the consequences are evident—later presentation, greater complexity, and poorer outcomes for those who already face the greatest barriers.

The Cardiovascular Disease Modern Service Framework sets out the evidence-based actions required to address this – preventing disease earlier, optimising treatment, and delivering high quality care across the pathway. However, it is equally clear that if these actions are implemented uniformly, without regard to need, inequalities will persist or worsen.

The seven principles for equitable implementation developed by Queen Mary colleagues are therefore fundamental to not only this framework, but all health and care programmes. They establish a clear expectation that systems must act proportionately to need, prioritise underserved populations, and design services that are accessible, culturally appropriate and responsive to local communities.

This is not discretionary – it is a requirement for effective clinical practice and system leadership to drive measurable improvements for the public and patients at scale.

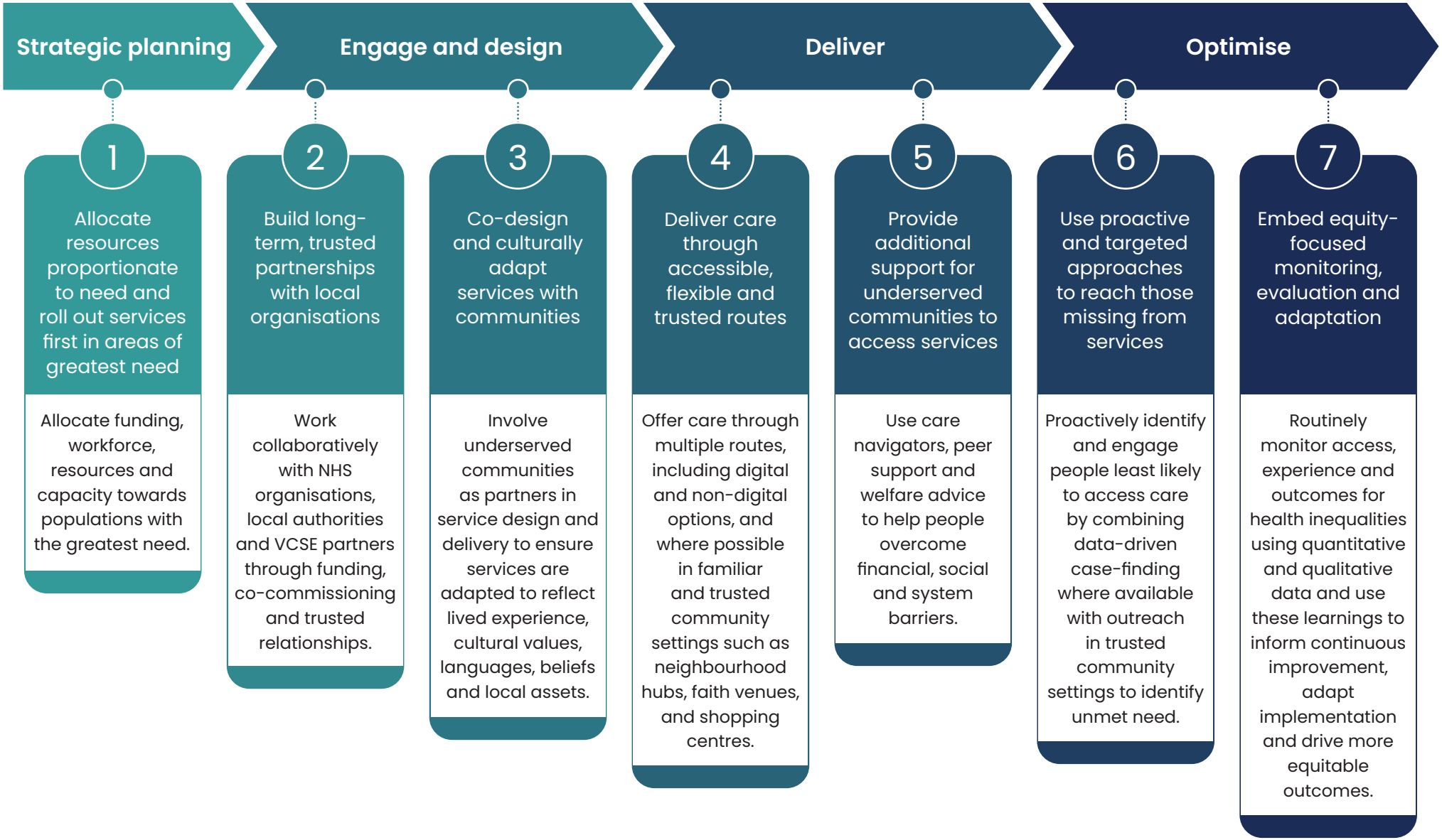
Background

Improving population health outcomes depends not only on effective interventions, services and programmes, but also on their effective implementation. Interventions shown to be effective in research studies, local areas or international contexts may fail to have the same real-world impact if implementation does not account for social, behavioural, cultural, economic and structural factors. Poorly designed implementation can also inadvertently exacerbate health and care inequalities through disproportionately improving access and care for those who already experience better health outcomes (Marmot et al., 2010; HEEC, 2023).

We present seven principles for equitable implementation of interventions, services and programmes. These principles have been drawn from a library of evidence briefs produced by the HEEC and are presented as themes, with the supporting evidence and case studies. They reflect patterns in the evidence to help decision-makers understand what works and apply this while also taking into account contextual factors, such as the organisational landscape and governance structures.

To successfully implement these principles, effective governance, capability and accountability are needed. Local systems should ensure governance, commissioning, workforce development and performance arrangements create the capacity and incentives to implement these principles consistently. This includes clear decision-making structures with partners, long-term funding mechanisms where needed, protected time and skills for co-design and outreach, and accountability for equity impacts.

The principles in summary



PRINCIPLE 1

Allocate resources proportionate to need and roll out services first in areas of greatest need

Key line of enquiry for implementers

Does implementation ensure that greater resources (funding, workforce, capacity and resources) are allocated to underserved communities with higher levels of need, and that services are rolled out first in underserved areas?

Evidence

Health systems that allocate resources in proportion to population need are more effective at reducing inequalities in access, quality of care and health outcomes (HEEC, 2024). However, primary care provision has historically been inversely related to need (LaVeist et al., 2023). After adjusting for workload, GPs in England's most deprived areas receive 7% less funding per patient while managing around 10% more patients, often with a higher burden of illness and premature mortality, than practices in affluent areas (RCGP, 2024). Healthcare professionals working in areas of high deprivation are also twice as likely to experience stress and burnout, making workforce retention and continuity of care more challenging (Pedersen and Vedsted, 2014; Eley et al., 2018).

The least affluent areas experience the poorest health outcomes yet receive comparatively fewer resources, reflecting the Inverse Care Law, whereby those with the greatest need often receive the least care (Hart, 1971). Reforms to NHS resource allocation, including the Carr-Hill formula, which increased weighting for deprivation, were associated with reductions in inequalities in mortality amenable to healthcare (Barr et al., 2014; Holdroyd et al., 2025). Proportionate allocation extends beyond funding to include workforce capacity, longer consultations, multidisciplinary input and management attention (Cookson et al., 2015; Mercer et al., 2016).

Implementation

Extra Funding Allocation Inequality Tool (eFIT): eFIT is a practical software tool developed by the HEEC to help Integrated Care Boards (ICBs) allocate additional or discretionary funding to GP practices based on socio-economic indicators and local needs (e.g., the Index of Multiple Deprivation (IMD), prevalence of chronic disease, population characteristics). It allows commissioners to compare equitable scenarios rather than using simple per-head allocations.

PRINCIPLE 1

Allocate resources proportionate to need and roll out services first in areas of greatest need

Case studies

1. **NHS funding reform (England, 2001–2011):** The introduction of a deprivation-weighted funding formula resulted in an 81% increase in funding per capita in the most deprived areas compared to 70% in affluent areas. During this period, the gap in mortality amenable to healthcare between the richest and poorest areas narrowed from 72% to 67% among men and from 52% to 47% among women (Barr et al., 2014).

2. **Extended GP consultations (Glasgow):** A longitudinal study in a Glasgow general practice serving a highly deprived urban population allowed clinicians flexibility to identify complex consultations and adapt consultation length. The most effective approach, adopted in practice, was to leave a 10-minute buffer after every fifth routine appointment, enabling complex consultations to last up to 20 minutes. On average, consultation length for complex cases increased by 2.5 minutes. This targeted extension reached patients with the poorest health and was associated with higher patient satisfaction, reduced clinician stress, and the opportunity for opportunistic health screening, demonstrating how proportionate allocation of time improves care for high-need populations (Mercer et al., 2007).

3. **Enhanced primary care for people with severe mental illness (USA):** A study evaluated an enhanced primary care model in North Carolina for patients with severe mental illness which involved six proactive appointments per year of 30 minutes with a multidisciplinary primary care team. At 18 months, participants in the intervention group experienced a mean reduction in systolic blood pressure of 3.9mmHg and a mean reduction in HbA1c of 0.27 percentage points (Gertner et al., 2023).

4. **Targeted lung health checks rolled out in most socio-economically disadvantaged areas first:** Community-based, targeted, low-dose CT lung screening was first rolled out in areas of highest deprivation in Manchester. Smokers aged 55–74 years were invited to a lung health check next to a shopping centre. Of those who attended, 75% were in the most deprived quintile. Lung cancer was detected in 3% of attendees, 65% of whom had surgical resection (Crosbie et al., 2019).

PRINCIPLE 2

Build long-term, trusted partnerships with local organisations

Key line of enquiry for implementers

Does implementation facilitate partnerships between the NHS, local authorities and the voluntary, community and social enterprise (VCSE) sector, so that services are planned, delivered and improved together?

Evidence

Long-term, place-based partnerships are central to reducing health inequalities by enabling trust, continuity, cultural relevance and coordinated action on the wider determinants of health (HEEC, 2025). VCSE organisations often have greater reach, cultural concordance and credibility within underserved communities, supporting earlier engagement and more appropriate care. However, their contribution is frequently constrained by short-term funding cycles, transactional commissioning approaches and unequal power dynamics between statutory and community partners, which limit their ability to deliver sustained impact at scale (NHS, 2023).

Evidence from the HEEC Integrated Neighbourhood Teams (INTs) briefing highlights INTs as a key delivery model for embedding long-term, trusted partnerships at the neighbourhood level (HEEC, 2025), aligning with the neighbourhood health framework. INTs can bring together primary care, community health services, local authorities and VCSE organisations around defined populations, enabling shared ownership of outcomes and relational continuity over time. HEEC evidence indicates that INTs are most effective in reducing inequalities when VCSE partners are embedded as equal contributors in governance, service design and delivery, rather than positioned as short-term or referral-only providers.

Historical evidence from the English Health Inequalities Strategy (1999–2010) demonstrates the potential impact of sustained, cross-sector partnership at scale (Barr et al., 2014; Holdroyd et al., 2025). During this period, coordinated action across healthcare, housing, education, employment and early years services was associated with a narrowing of inequalities in life expectancy and significant reduction in infant mortality, particularly in more deprived areas (Marmot et al., 2010).

PRINCIPLE 2

Build long-term, trusted partnerships with local organisations

Case studies

1. **Sussex ICS VCSE Commissioning Framework:** A co-developed framework that outlines principles to strengthen partnership working, transparency, shared learning, social value, and the reduction of health inequalities. It emphasises early engagement with VCSE organisations in planning and commissioning, promotes flexible, outcomes-focused contracts to support innovation, and encourages measures to build capacity and inclusion for smaller VCSE organisations. The framework positions VCSE partners as equal strategic contributors, aiming to enhance service continuity, community reach, and responsiveness to local population needs (Sussex Health & Care, 2023).

2. **Integrated Neighbourhood Mental Health Teams (City & Hackney):** City and Hackney established eight neighbourhood-based, multidisciplinary, trauma-informed teams operating in partnership with local VCSE organisations (NHS England, 2021). Individuals referred to the service become 'members' for up to two years, enabling continuity of support across health and social needs. This makes support available fast and can prevent deterioration. The range of groups and activities in each team is tailored to local needs, working with the local voluntary sector and support services. Independent evaluation indicates that neighbourhood-related proactive care pathways in City & Hackney had a positive impact on participant quality of life, contributing an additional 73 quality-adjusted life years for residents supported by the programme (City & Hackney Neighbourhoods, 2025).

3. **Bromley By Bow Centre (East London):** The Bromley by Bow Centre represents a long-standing, embedded partnership between primary care, local government and the VCSE sector, developed over several decades. It operates as part of a neighbourhood-based integrated care model, and combines GP services with welfare advice, employment support, education, social prescribing and community development. Its success is underpinned by long-term investment, shared leadership and deep trust within the local community. Evaluations have demonstrated improved access to care, reduced service fragmentation and positive impacts on wellbeing and social outcomes among highly deprived populations (Hall, 2018).

PRINCIPLE 3

Co-design and culturally adapt services with communities

Key line of enquiry for implementers

Are underserved communities actively involved in the design, delivery and adaptation of services, and are services culturally adapted to reflect local values, languages, beliefs and lived experience?

Evidence

Community-centred and co-designed approaches consistently improve access, engagement and outcomes for underserved communities (HEEC, 2024). Actively involving communities as partners ensures services are culturally relevant, responsive to lived experience and aligned with local assets and priorities. NICE identifies meaningful community participation as a core component of effective public health interventions, particularly for reducing health inequalities (NICE, 2016). HEEC guidance provides practical tools for co-production in health and care settings, including templates for community workshops, a structured feedback mechanism and participatory design methods, and a community co-production guide.

Culturally tailored services further improve engagement, adherence and health outcomes, particularly for ethnic minority and marginalised populations (HEEC, 2024; HEEC, 2024; Resnicow et al., 1999). Effective adaptations include: language support and translation services; communication styles tailored to cultural norms; recognition of family and community roles; and, respectful engagement with traditional beliefs and practices (HEEC, 2024).

Strong evidence supports culturally adapted behavioural interventions, such as motivational interviewing, which has been shown to improve treatment adherence and clinical outcomes when aligned with cultural norms and values (Self et al., 2023).

Implementation

- HEEC community co-production guide.
- NHS England has produced statutory guidance to support ICBs and other NHS organisations with community engagement (NHS, 2022), while NICE has published a Community Engagement Quality Standard that sets out recommendations on identifying local priorities, evaluation, identifying community assets and peer and lay roles (NICE, 2017).

PRINCIPLE 3

Co-design and culturally adapt services with communities

Case studies

1. **COVID-19 vaccination campaign:** The COVID-19 vaccination campaign is a recent success in co-design. Adeagbo and colleagues (2022) reviewed 14 international studies which aimed to improve COVID-19 vaccine uptake in Black populations (Adeagbo et al., 2022). The authors found that communication, community engagement, and culturally inclusive resources significantly improved uptake. UK examples included community champions advising on culturally appropriate processes, languages and support, multi-stakeholder inequalities groups, focus groups in community venues, partnership with faith organisations, and community-informed location of mobile vaccination units and centres (Taplin et al., 2022, Vanderslott et al., 2024; Halvorsrud et al., 2023). Conversely, in their international scoping review of 38 studies, Seale and colleagues (2023) found that a lack of engagement with communities in service design was a barrier to uptake of COVID-19 vaccinations (Seale et al., 2023).

2. **Culturally adapted motivational interviewing (MI)**: Good evidence exists for culturally adapting motivational interviewing. Canadian researchers designed a motivational interviewing method tailored to South Asian people with hypertension to improve medication adherence. It focuses on norms around "collectivist culture" (such as the importance of family), consequences of behaviour, and appreciating traditional medicine within its cultural context. It provided clinicians with the means to proactively engage with poor health behaviours in this population.

3. **Aboriginal diabetes services (Australia):** An integrated diabetes programme for Aboriginal Australians in remote communities co-located specialist outreach services with primary care and embedded culturally competent practices, including Aboriginal Health Workers, culturally safe consultation styles and community-led service planning (AIHW, 2019). Evaluation of the programme reported clinically significant improvements in glycaemic control, with mean reduction in HbA1c of approximately 1.0 percentage points, alongside improvements in cholesterol management and service engagement (Hotu et al., 2018; McDermott et al., 2015; AIHW, 2019).

PRINCIPLE 4

Deliver care through accessible, flexible and trusted routes

Key line of enquiry for implementers

Are services delivered through accessible, familiar and trusted routes, with flexible digital and non-digital options that enable equitable access for people with different needs and circumstances?

Evidence

Delivering care closer to where people live and through trusted community settings can reduce barriers related to transport, cost, stigma and mistrust (HEEC, 2024; PHE, 2019). Evidence from integrated neighbourhood teams and community-based models highlights the importance of co-location, outreach, and relationship-based care in improving access and engagement (HEEC, 2025; Van Ens et al., 2024). Trusted settings such as faith venues, food banks, shopping centres and community centres can increase engagement, particularly for people with complex needs (Riley et al., 2015). Conversely, services dispersed across multiple locations with poor transport links are more likely to increase inequalities (Kelly et al., 2016; PHE, 2020).

How people access services is critical. Evidence shows that underserved groups benefit most from flexible access models, including blended digital and non-digital consultation routes, longer appointments, language support, and practical assistance such as navigation support (Gkiouleka et al., 2023; HEEC, 2024). Intersectional approaches recognise that barriers vary within and across groups, and that no single access route is sufficient to achieve equity (HEEC, 2025). Rigid, single-route access models are more likely to increase inequalities, as they disproportionately disadvantage people with lower health literacy, insecure employment, caring responsibilities or limited digital access (Paddison et al., 2022; HEEC, 2024).

While digital health solutions can improve efficiency, they risk excluding people with low digital skills, limited access to devices, or data poverty (HEEC, 2024). In 2024, 33% of the UK population lacked the essential digital skills needed for daily life, with one in two offline adults reporting difficulty engaging with digital services, particularly government and health services (Good Things Foundation – Digital Nation, 2024). Nearly one in five adults does not own a smartphone, and 14% lack internet access, with economic barriers disproportionately affecting minority ethnic groups (Ada Lovelace Institute, 2021).

PRINCIPLE 4

Deliver care through accessible, flexible and trusted routes

Case studies

1. **Halton Health Hub:** Warrington and Halton Teaching Hospitals NHS Foundation Trust has created an out-of-hospital clinical unit to provide outpatient services from a local shopping centre. Working with the Liverpool City Region Combined Authority and using Town Centre funding, the Trust contributed to planning the city centre's regeneration. After undertaking public consultation, the Trust focused on identifying opportunities to develop accessible health services and to boost economic activity and employment rates. In the first six months since its opening, the Trust served more than 3,000 appointments and is committed to continuing to bring care closer to the community while supporting the sustainability of community assets and employment opportunities for local populations (Warrington and Halton NHS Foundation Trust, 2022; Halton Health Hub case study, 2023).

2. **Mobile BP checks in barbershops:** Barbershops have been identified as trusted, culturally relevant community spaces and may be opportune locations for the delivery of health promotion services. Khosla and colleagues (2024) published a mini-review of barbershop interventions to address chronic disease. This included two randomised controlled trials in the USA that examined improving hypertension in Black men through barbershops owned by Black men. The BARBER-1 trial included 1297 customers across 17 shops and randomised them to hypertension education coupled with blood pressure monitoring and encouragement and connection to physician care, or a control group receiving blood pressure leaflets. The intervention led to an 8.8% higher hypertension control rate after 10 months and a 21 mmHg reduction in systolic blood pressure for those referred to a hypertension specialist (Victor et al., 2025).

3. **100% Digital Leeds:** A city-wide digital inclusion programme embedding Digital Health Hubs within trusted community organisations in deprived neighbourhoods (Leeds City Council, 2021). The hubs provide devices, connectivity, skills support and confidence-building, with direct referral pathways from GP practices and social prescribers. Evaluation data indicate that 568 participants reported improved mental health and wellbeing, 549 reported increased confidence and self-esteem, and 494 reported improved financial resilience (Leeds City Council, 2024). These outcomes demonstrate that embedding Digital Health Hubs within trusted community organisations not only improves digital skills and access but also contributes to improvements in factors linked to health and social wellbeing (Leeds City Council, 2021).

PRINCIPLE 5

Provide additional support for underserved communities to access services

Key line of enquiry for implementers

Does the intervention, service, or programme include navigation, advocacy, or peer support for people facing social, financial, or cultural barriers?

Evidence

People from ethnic minority backgrounds and socioeconomically disadvantaged backgrounds experience consistently worse health outcomes than their White British and more affluent counterparts (HEEC, 2024; Kings Fund, 2023). Many face social, financial or cultural barriers in accessing care, such as money for transport, language barriers or health literacy to navigate complex care pathways. There is strong evidence that care navigators, peer supporters, and community health workers (CHWs) improve access, continuity of care and health outcomes for underserved populations, with the strongest evidence for improvements in cancer screening uptake and reduced CVD risk factors (HEEC, 2024; Anderson et al., 2015).

CHWs help address practical, financial and psychosocial barriers, including navigating complex systems, attending appointments, accessing welfare support, and sustaining engagement with long-term condition management (McCollum et al., 2016; Mistry et al., 2021). Research links these approaches to improved screening uptake, treatment adherence and reduced avoidable service use, particularly for people on low incomes or with multiple long-term conditions (HEEC, 2024).

PRINCIPLE 5

Provide additional support for underserved communities to access services

Case studies

1. **Poverty Proofing (Children North East):** Children North East is a charity that delivers services and supports initiatives for children, young people and their families to remove cost-related barriers that prevent families on low incomes from accessing services (Children North East, 2020). In health settings, this includes staff training on poverty awareness, redesigning appointment systems, reducing hidden costs (such as travel or prescription charges), and continuous feedback from families. This approach improved access and engagement among families experiencing financial hardship.

2. **Community Health Worker programme (Westminster):** Home visits to 160 disadvantaged households over 10 months led to a 47% increase in immunisation uptake and an 84% increase in cancer screening participation compared with 502 unvisited households. The initiative also reduced unscheduled GP consultations by 7.3%. A national rollout of similar programmes is estimated to cost £2.2 billion annually but could generate a £4 return for every £1 invested in the most deprived areas by preventing chronic illnesses and improving health outcomes (Junghans et al., 2023).

3. **Altogether Better Health Champions (England):** From 2013 to 2015, over 1,100 Health Champions were recruited. Champions supported over 17,000 people, with 86% of participants reporting increased confidence and wellbeing. At The Ridge Medical Practice, 75 champions engaged in activities such as cancer support groups, which contributed to a 25% reduction in reactive GP visits. Champions also reported personal benefits, with 94% acquiring new knowledge related to health and wellbeing (Altogether Better, 2016).

PRINCIPLE 6

Use proactive and targeted approaches to reach those missing from services

Key line of enquiry for implementers

Does the intervention proactively identify and engage people who are least likely to access services?

Evidence

Proactive case-finding and targeted outreach are consistently more effective than passive approaches for identifying unmet need in disadvantaged populations (HEEC, 2024). Case-finding aligns with proportionate universalism by targeting additional resources to those at highest risk while maintaining universal provision. Evidence supports two complementary strategies:

1. Targeted searches of electronic health records (EHRs) and risk stratification tools, acknowledging that some patients are missing from data.

2. Proactive outreach in trusted, culturally or religiously concordant community settings such as mosques, churches, barbershops (Khosla et al., 2024) and pharmacies (HEEC, 2024; Dalton et al., 2018).

Population health management (PHM) approaches further strengthen targeting, follow-up and monitoring by enabling systematic recall, stratification and evaluation of outcomes, particularly for conditions such as hypertension and hypercholesterolaemia (NHS England, 2025). For example, a modelling study found that statins were responsible for nearly one-third of the decline in mean total cholesterol in England over two decades, and that approximately 20% of people with cardiovascular disease were not receiving optimal treatment — a gap that proactive identification and follow-up could help close (Kypridemos et al., 2015). Reducing suboptimal treatment by just 5% could prevent more than 6,500 CVD events and 805 related deaths over three years (HEEC, 2024).

PRINCIPLE 6

Use proactive and targeted approaches to reach those missing from services

Case studies

1. **Hypertension case-finding (Derby):** A pilot hypertension case-finding programme combined targeted searches of EHRs with outreach in community and mobile settings to identify people aged over 40 who were less likely to engage with routine NHS services. Over the course of the initiative, 3,224 blood pressure checks were completed, and approximately one-third of those screened were found to have hypertension, demonstrating the effectiveness of proactive, data-informed case-finding linked to community engagement (HEEC, 2024).

2. **Faith-based addiction outreach (Canada):** Canadian Muslims, while having lower prevalence of alcohol misuse and addiction, have poorer rates of recovery due to stigma. This can make people more difficult to identify and support. A Canadian study found that spiritually adapted psychoeducation intervention delivered in mosques to address stigma around addiction and therefore improve treatment among Muslim communities was effective at not only increasing self-reported knowledge but also willingness to seek help from medical professionals. The 90-minute seminar incorporated Islamic readings and culturally adapted education around mental health (Hassan et al., 2020).

3. **Hypercholesterolaemia (Bristol, North Somerset and South Gloucestershire (BNSSG))**: High cholesterol is an important risk factor for cardiovascular disease, with risk reduced by 23% for every 1 mmol/L reduction in LDL. BNSSG Integrated Care Board identified five Primary Care Networks in the most deprived communities to improve cholesterol diagnosis and management. General practices ran searches within their electronic patient records to identify people with a cardiac event and high cholesterol alongside a pharmacist or GP-led clinical review. The initiative led to a 20% increase in the number of patients reviewed, with over 56,000 contacts to improve cholesterol management (Health Innovation West of England, 2025).

PRINCIPLE 7

Embed equity-focused monitoring, evaluation and adaptation

Key line of enquiry for implementers

Does implementation include ongoing monitoring of access, experience and outcomes across underserved communities, socioeconomic status, ethnicity, and other characteristics of disadvantage?

Evidence

Incomplete or poor-quality data can obscure inequalities and reinforce bias, limiting the ability of health systems to identify unmet need and act effectively (HEEC, 2025). Persistent challenges include organisational and logistical barriers to representative data collection, inconsistencies in recording (e.g., ethnic coding), and under-representation of disadvantaged groups. For example, only 33% of Black and minority ethnic individuals downloaded the NHS COVID-19 app, compared with 51% of White individuals (ONS, 2020), and only 11% of GP practices recorded sexual orientation in 2019 (Pollard et al., 2019).

National guidance emphasises the importance of improving data completeness, consistency and linkage, particularly for ethnicity and deprivation, to support population health management and equitable service planning (NHS England, 2023; NHS England, 2024). Equity-focused monitoring should combine quantitative indicators (access, uptake, outcomes) with qualitative insight, including lived-experience feedback, to understand why inequalities occur and to inform real-time service adaptation (Cookson et al., 2018; HEEC, 2025). Crucially, data collection alone is insufficient: evidence highlights that data must be actively used to inform improvement, enable accountability and support learning health systems that reduce, rather than reproduce, inequalities.

Implementation

NHS England has published an Ethnicity Recording Improvement Plan to support NHS organisations in improving ethnicity recording.

PRINCIPLE 7

Embed equity-focused monitoring, evaluation and adaptation

Case studies

1. **Cambridgeshire and Peterborough NHS Foundation Trust, ethnicity dashboard:** Developed a children's mental health services dashboard to track ethnicity data completion. Staff workshops and feedback led to improved data collection practices (NIHR ARC East of England, 2024).

2. **Suffolk and North East Essex ICS data linkage:** A population health management strategy to link data across the local population was initiated by the Suffolk and North East Essex (SNEE) Integrated Care System. The aim was to reduce health inequalities by better understanding the needs of the local population as it moved through the system, and to focus on preventative interventions that, over time, would be more effective at tackling health inequalities. Linking data increased the percentage of ethnicity recorded from 70% to 94% (NIHR ARC East of England, 2024).

3. **Guy's and St Thomas' Hospital, data-led Clinical Prioritisation tool:** Used EHRs to identify six risk factors that could be addressed to optimise diabetes care in the outpatient setting. The prioritisation tool identified 549 of 4022 patients (13.6%) as high risk (i.e., having one or more risk factors). These patients were more likely to be from a minority ethnic background with greater socioeconomic deprivation and were at the highest risk of attending A&E or secondary care settings. The tool was used to identify people needing earlier follow-up appointments (Karalliedde et al., 2023)

Appendix: Support tools

Audience: ICB leads, Trust executives, regional and local directors, health inequality leads

Purpose: To provide a tool that supports accountability for progress towards equitable implementation of the Modern Service Frameworks.

Summary of key lines of enquiry

1. Does implementation ensure that greater resources (funding, workforce, and capacity) are allocated in areas of greatest need?
2. Does implementation support long-term working relationships between the NHS, local authorities, and the voluntary, community and social enterprise (VCSE) sector, so that services are planned, delivered, and improved together?
3. Are underserved communities actively involved in the design, delivery, and adaptation of services, and are services culturally adapted to reflect local values, languages, beliefs, and lived experience?
4. Are services delivered through accessible, familiar, and trusted routes, with flexible digital and non-digital options that enable equitable access for people with different needs and circumstances?
5. Does the intervention, service, or programme include navigation, advocacy, or peer support for people facing social, financial, or cultural barriers?
6. Does the intervention proactively identify and engage people who are least likely to access services?
7. Does implementation include ongoing monitoring of access, experience, and outcomes across underserved communities, socioeconomic status, ethnicity, and other characteristics of disadvantage?

Health Equity
Evidence Centre