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## National Voices Response to the NHSE/I CorePLUS5 consultation

National Voices welcomes the opportunity to provide feedback on the proposed Core20PLUS5 approach.

National Voices is the leading coalition of health and social care charities in England. We have 190 members covering a diverse range of health conditions and communities, connecting us with the experiences of millions of people. We work together to strengthen the voice of patients, service users, carers, their families, and the voluntary organisations that work for them.

*Our mission is to make health and care more human, more democratic, and more equal.*

We welcome the intent to give a stronger profile to understanding and addressing inequalities within health and care. We particularly welcome the intention to focus on “the causes of the causes” of those inequalities. For too long, inequality has been the concern of small teams in large organisations, without access to big budgets or senior decision makers. We are hopeful the proposed approach will change that, and will make system leaders, clinical and managerial, responsible for narrowing the gap.

We welcome that the Core20PLUS5 approach is data driven, which will work well with a quality improvement approach and also raises questions of accountability for better outcomes. This is helpful. It is also helpful that there is a strong focus on deprivation as a driver of inequality [Question 3 of the survey]. Deprivation is of course linked to other ‘causes of causes’, such as

racism, discrimination or stigma. However, **we do believe there are pitfalls to a solely quantitative data-driven approach.**

While the 'PLUS' part of the overall approach recognises that some population groups experiencing poorer than average health access, experience and/or outcomes may not be captured in the 'Core20' alone, this part is also data-driven. We are hopeful that this part of the approach will enable local flexibility. However, **we emphasise the need for strong community engagement and centring Lived Experience to make this work** [Questions 5 & 6].

We are doubtful that even the ICS leaders who are exceptionally well-embedded within their communities will be able to comprehensively (and without organisational bias) develop the appropriate variables / specification to identify and reach these population groups solely on the basis of their own data. Therefore, **we would like to see much more consideration given to how Core20PLUS5 could use quality improvement methodologies that go beyond quantitative data and that centre Lived Experience** [Questions 4 & 6]. National Voices stands ready to support this, for example through sharing the learning from 'Our Voices for Improvement' work.<sup>1</sup> We are trialling an approach of partnering up people with lived experience of inequality with system leaders for reciprocal coaching – as one methodology that might centre community experience in the work. There are others: experience-based co-design, strategic co-production – we are confident we, and our network, can play a role in adding value to the work of system leaders and the centre on this agenda.

We think working with and alongside people and communities might also lead to a reassessment of the sole focus on life expectancy in the programme. We do know from our work with people and communities that **people value other outcomes equally**: life lived without the impact of severe ill health or disability, quality of life even where it is lived with impairments, and wider wellbeing will feature much more in people's ambitions.

**We welcome the Core20PLUS5 approach's recognition of VCSE organisations as key partners** in reducing inequalities. National Voices is a proud member of the consortium – together with the CSW CSU and

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<sup>1</sup>This project aims to build respectful relationships through which insight, knowledge and experience can be shared and used to improve health and social care. We know there are many well-established schemes across our membership to elevate Lived Experience and provide opportunities to influence and shape services. We want to connect, learn, and grow a community of Lived Experience Partners with coaching and mentoring skills who can take an active role to influence policy and decision makers. We particularly want to open opportunities for people in communities that are marginalised or overlooked.

Healthwatch England – that has been tasked with designing and delivering the Core20PLUS5 community connector programme. We believe there is a lot of potential in the additional reach, urgency, but also disruptive energy that can be harnessed from this programme – both for places and the wider system.

However, linked to our points above, we think it would be helpful to include **more detail about the wider role of the VCSE sector** in this work and how we and others can help voluntary organisations, community groups and social enterprises make sense and use of it. This includes recognising the role that some VCSE organisations have as providers of health and care services, but goes well beyond that: The VCSE's roles in this approach is about:

- Advocacy and voice
- Data and insight
- Convening and coordination of disparate agencies and services
- Provision of services

The involvement of the VCSE sector and people with lived experience is necessary to bringing about the changes sought by the Core20PLUS5 approach, so it is **disappointing that funding and resource is limited to NHS personnel**. The VCSE and communities themselves can create substantial value for very limited investment, but they cannot do so, at the levels that are required, for free.

We see the logic of tying the five focus clinical areas to improvement programmes that are already built into the Long Term Plan and therefore have budgets and workforce [Question 7]. They are certainly pertinent to some of the issues of health inequalities that we see at National Voices, but we are not necessarily sure that they are the five *most* pertinent. We do in particular **question whether sufficient consideration has been given to understanding and addressing issues of inequality – especially of access – that go beyond clinical areas**. For example, digital exclusion or primary care access, which underpin a lot of the identified clinical areas. At National Voices, we have learned that new remote ways of delivering care work for many people and issues, but they have also made exclusion worse for many others. We have also found that digital exclusion layers on top of existing inequalities and as such contributes to the inverse care law [Question 8].

In terms of support from the national Health Inequalities Improvement team to ICSs, we feel this should be led by what ICSs – working with their partners and communities – identify they need. **The national and regional teams should support ICSs with their self-identified needs**, and then encourage ICSs to draw on support as and when they need it. While we recognise some ongoing

role for national assurance, we strongly support the principle of subsidiarity and imagine the national and regional teams will actively seek to reduce their role and size over time, as ICSs become more established. As part of this devolution of decision-making power, **we would like to see more information about how we can strengthen people's ability to understand the ambition of ICSs, what ICSs do, how they do it, and how they are accountable to their populations** [Questions 11 & 12].

We are also mindful that only 20% of health outcomes are influenced by healthcare services, so we would like to see more information about **how the Core20PLUS5 approach and learning will inform and complement other ICS partners' work on reducing inequalities**. We assume there is an expectation it must do so (rather than sit in isolation), but collaboration needs time and proper resourcing to be effective. Are Health and Wellbeing Boards envisaged to have a role here? [Question 13]. We have considerable insight into cross-sector and multidisciplinary collaboration and stand ready to support this.

In summary, we are fully supportive of the ambition contained in the approach, and strongly welcome the increased focus it will provide, centring inequalities work in areas of large clinical spend, and making leaders accountable for much overdue progress on access, experience and outcomes for people at the wrong end of the inverse care law.

We would like to see a stronger focus on the contribution communities themselves and their organisations can make, both in terms of defining the approach a system should take and in delivering it.

We are at the heart of a network of organisations large and small that can help make this ambition a reality. We stand ready to help.

Yours sincerely



Dr. Charlotte Augst  
Chief Executive