The Royal Society of Medicine

Community for Health Equity

Session 1 Report
‘Reaching the Unreached’

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Executive summary

This report captures learning from the first session of the Community for Health Equity programme, which examined why people with the greatest health needs are often the least likely to be reached by health and care services. The session also examined how innovation, including medicines, technologies and data-enabled tools, can be designed, evidenced and implemented so that benefits reach underserved groups rather than widening gaps.

The session brought together NHS, industry, charity and community perspectives to focus on three practical challenges: how underserved populations are identified in practice; how data and frontline insight can be used together to make unmet need visible; and how services, pathways and products can be designed to reach people who are currently missed.

Across presentations and discussion, participants highlighted a consistent pattern. Health inequalities are well described at a population level, but delivery systems frequently rely on access routes that favour people who are already engaged, stable, and able to navigate complexity. Groups experiencing exclusion are often missing from routine data, filtered out by process design, or deprioritised because they are not explicitly named.

The session emphasised that progress depends less on new frameworks and more on changing how decisions are made at points of delivery. This includes identifying who is most likely to be missed by specific services, combining data with community and frontline intelligence to locate unmet need that routine datasets do not capture and to target outreach and support accordingly and addressing known access barriers such as registration requirements, non-response rules and digital-only contact routes.

Participants also stressed the importance of sustained collaboration across sectors, particularly roles and relationships that operate across clinical and community settings. Evidence, data and co-designed materials were viewed as most effective when used to support concrete delivery decisions rather than as standalone outputs.

The report concludes with a small set of practical actions that can be taken by policymakers, delivery teams and partners to improve equity of access within existing systems and programmes.

Programme overview

The Royal Society of Medicine (RSM) and the NHS have a shared commitment to reducing health inequalities, as outlined in the NHS Core20PLUS5 initiative and the NHS 10 Year Plan. The Community for Health Equity (CHE) Programme builds on this partnership, recognising that healthcare industry professionals (pharmaceutical, biotechnology and medical technology companies) possess unique resources and expertise that can support NHS goals. This includes supporting the adoption and spread of innovation and improving how equity considerations are built into value propositions, evidence generation and implementation.

By engaging industry, patients, clinicians and other stakeholders, this programme aims to bridge gaps between commercial innovation and public health and NHS needs. The RSM, as an independent professional body, acts as a a neutral convener where industry, NHS leaders and other stakeholders can have dialogue and co-create solutions. This alignment ensures that NHS leader's priorities – such as equitable access to medicines and advancing national strategic goals – are informed by industry insights, while industry is guided toward addressing unmet needs in underserved communities.

Ultimately, the initiative seeks to deliver tangible health improvements on the ground through a series of targeted engagements and outputs.

Co-development and status

This report has been co-developed with programme members. It reflects perspectives shared during the session and does not represent formal policy positions of the Royal Society of Medicine or participating organisations.

Financial contributions and independence

We would like to thank Bayer plc, which has financially supported the delivery of this programme through a sponsorship agreement. Bayer plc provided insights to inform the initial scope of the programme, with no further involvement in the content, programme, or organisation of this meeting.

We would like to thank our Industry Members [AstraZeneca, Boehringer Ingelheim, Gilead, Merck Group, Novartis and Pfizer] for their financial support of this event.

Organisations represented across this session

Association of British HealthTech Industries (ABHI)
Boehringer Ingelheim UK
Brook
Cheshire and Merseyside Cancer Alliance
Faculty of Pharmaceutical Medicine
Friends, Families and Travellers
Gilead Sciences
Health Equity Evidence Centre
Health Innovation Network
Imperial College London
Marie Curie
North Central London Cancer Alliance
Novartis
Patients Association
Pfizer UK
Prescribing Services
Royal Society of Medicine
Southampton University Hospitals
The Association of the British Pharmaceutical Industry (ABPI)
UK Health Security Agency

Context and background

Health inequalities in England include differences in health status, access to care and experience and outcomes from services. They are systematic, avoidable and shaped by socioeconomic factors, geography, protected characteristics and socially excluded groups.[1] This session aligns with a national shift towards using inequalities data as an operational tool. NHS England now sets explicit expectations that NHS bodies collect and disaggregate information, identify gaps in datasets and use a combination of quantitative and service insight to take action across commissioning and delivery, then evaluate impact.[2]

Core20PLUS5 provides a practical structure for that work. It combines the most deprived 20 percent of areas with locally identified "PLUS" groups who experience poorer access, experience and outcomes and may not be identified through area deprivation alone.[3] Inclusion health groups are a key example within this "PLUS" category. NHS England's inclusion health framework describes how stigma, discrimination, poverty, violence and complex trauma interact with service design barriers to produce poor experiences of care, avoidance of future contact and poorer outcomes despite high need.[4]

It also makes the delivery implication clear. Systems need more proactive approaches to understanding need and improving data and insight on inclusion health to drive improvement.

The "reaching the unreached" challenge is also shaped by information design. Where health information assumes high literacy, stable contact routes and confidence navigating systems, access gaps widen even when services exist. NHS evidence highlights that 43 percent of adults in England struggle with text-based health information, rising to 61 percent when numbers are included.[5]

This report summarises the first session, Reaching the Unreached. Building on the national policy context set out above, participants examined how definitions of need, approaches to data and design choices interact to determine who is reached in practice. The report focuses on practical methods to identify underserved populations, use data more effectively and co-design interventions and patient information so that equity is built in from the outset, including where partners are developing or deploying innovative medicines, technologies and digital tools rather than addressed after gaps emerge.

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[1] The King's Fund, *What are health inequalities?*
[2] NHS England, *NHS England's statement on information on health inequalities*
[3] NHS England, *Core20PLUS5 infographic*
[4] NHS England, A national framework for NHS - action on inclusion health
[5] NHS England, *Tackling digital exclusion and health literacy: How libraries can help bridge the gap*

Presentations

This section provides a summary of presentations given during the session and key insights gained. These informed the later discussion and provided framing to think about the recommendations and action to be taken.

1. Inclusion Health Groups: the PLUS in Core20PLUS5

Overview

Friends, Families and Travellers is a national charity working with and for Gypsy, Roma and Traveller communities, and more broadly across inclusion health populations. Its work spans advocacy, casework, policy engagement and cultural competency training, alongside a convening role through national partnerships and parliamentary activity.

Presentation summary

Sarah Mann, Chief Executive at Friends, Families and Travellers set out a practical framework for understanding inclusion health through the Core20PLUS5 approach, focusing in particular on the "PLUS" element. The presentation highlighted that while "inclusion health" is an established term within health policy, it is not always recognised or consistently understood across other sectors, where similar populations may be described using different terminology. This lack of shared language can slow collaboration, even where organisations are working with the same communities.

The presentation described inclusion health groups as people experiencing homelessness, vulnerable migrants and refugees, Gypsy, Roma and Traveller communities, sex workers, people in contact with the criminal justice system, and victims of modern slavery.

Key insights

- **Inclusion health groups experience overlapping barriers, including stigma and discrimination, poverty and exposure to violence and complex trauma, which combine to limit access to services and drive poorer health outcomes.**
- **Membership of an inclusion health group can have a greater influence on health outcomes than area-based deprivation alone, meaning place-based measures are necessary but insufficient for identifying need.**
- **Inclusion health populations are often absent from administrative datasets and health data dictionaries, reducing their visibility in planning and commissioning despite high levels of unmet need.**
- **Failure to address inclusion health explicitly contributes to higher emergency care use, delayed discharges and avoidable readmissions, with clear cost implications for the health system.**
- **Many access barriers are practical rather than structural, including misunderstandings around GP registration without a fixed address and limited use of outreach approaches.**
- **Reliance on passive access models disadvantages people with unstable housing, caring responsibilities, or chaotic lives, reinforcing existing inequalities unless mitigated through targeted design choices.**

If you only read one resource: National Inclusion Health Network

2. Health Inequalities and the 10 Year Health Plan: How population health and greater patient control can drive a more equitable health service

Overview

Prescribing Services is a healthcare data and analytics organisation that works with primary care, integrated care systems and national partners to support medicines optimisation, population health management and improvement in prescribing quality and outcomes. Its work focuses on using data to identify variation, support targeted intervention and improve value across health systems.

Presentation summary

Dr James Ferguson, a GP and Associate Director at Prescribing Services, examined health inequalities through the lens of primary care delivery and population health. The presentation linked the equity ambitions of the NHS 10 Year Health Plan to the operational realities of general practice, particularly how funding mechanisms, access routes and patterns of service use intersect with deprivation and risk. A central argument was that current models tend to respond to demand from people who are best able to engage, rather than proactively identifying and supporting those at greatest clinical risk.

The presentation emphasised that clinical risk is not evenly distributed within populations and that intervention effort should reflect this distribution. Data was positioned as a practical tool for understanding where risk sits, enabling earlier action and shifting care upstream. Data-enabled population health management was positioned as a practical innovation that can redirect limited capacity towards those at highest risk.

Key insights

- **Significant health inequalities exist within cities that are often perceived as affluent, with local data showing sharp gradients in A&E attendance and inpatient admissions by deprivation.**
- **Patterns of service use indicate that the most deprived patients account for a disproportionate share of acute and emergency activity, reflecting unmet need earlier in the care pathway.**
- **From a risk and cost perspective, focusing clinical time and resources on low-risk populations is inefficient when higher-risk patients generate avoidable emergency care.**
- **Funding mechanisms such as the Carr-Hill formula do not adequately account for burden of disease or intensity of contact, disadvantaging practices serving populations with higher levels of need, including so-called deep end practices.**
- **Population stratification enables systems to identify a small proportion of patients at highest risk and to prioritise proactive outreach, making the scale of the problem more manageable.**
- **Universal approaches can improve average outcomes but do not reduce inequality unless resources and effort are deliberately weighted towards populations with the greatest need.**

If you only read one resource: Prescribing Services: Population Health

3. Cancer Screening Resources for Gypsy, Roma and Traveller Communities: designed with communities for communities

Overview

This work led by Friends, Families and Travellers was funded via a grants programme.

Presentation summary

Michelle Gavin, Head of Development at Friends, Families and Travellers focused on implementation, setting out how culturally appropriate cancer screening resources can be developed in ways that are usable by communities and practical for professionals to deploy. The presentation translated the concept of equity by design into concrete decisions about language, imagery, format and distribution, grounded in extensive community co-development.

Key insights

- **Stigma, fear and cultural taboos associated with cancer act as primary barriers to screening engagement and need to be addressed through design choices as well as language changes.**
- **Barriers to screening are consistent across communities and can include fear of pain or embarrassment, prioritisation of family responsibilities, lack of GP registration while travelling, missed invitation letters, low literacy and digital confidence and uncertainty about clinician gender.**
- **Effective co-production requires clear infrastructure, including structured insight gathering, lived experience governance and robust ethical processes covering consent, safeguarding, data protection and fair recognition of participants.**
- **Resources are more likely to be used when cultural resonance and medical accuracy are developed together, with community sense-checking alongside clinical validation.**
- **Format and distribution influence uptake, with short-form video and platforms (e.g., TikTok) already used by communities often proving more effective than traditional written materials alone.**

If you only read one resource: Resources for health professionals (‘Cancer or the ‘bad thing’: Resources and support’)

4. How to work in partnership to design inclusive patient literature

Overview

The Patients Association is a national patient charity focused on patient rights, experience and influence within health and care. Its work aims to strengthen patient voice and ensure that people are able to understand, navigate and act within the health system.

Presentation summary

Rachel Power, Chief Executive at the Patients Association, focused on the role of health literacy in shaping access and outcomes. The presentation linked the ambitions of the NHS 10 Year Health Plan to the practical reality of how patient information is produced and used. Patient information was presented as a core component of system design, with implications for access, choice and agency, rather than as a communications add-on.

Key insights

- Low health literacy affects a substantial proportion of the population. The average reading age of adults in the UK is 9-11.[6] 43% of adults struggle with low health literacy, rising to 61% when information includes numbers.[7] It is associated with poorer health outcomes, higher rates of hospital admission, lower vaccine uptake and reduced life expectancy, particularly among people facing language barriers, learning disabilities, or dementia.[8]
- Patients consistently identify similar design issues in health information, including overuse of jargon, unexplained acronyms, assumptions of professional-level understanding and limited use of visual aids to support comprehension.
- The CORE framework, Community, Offer, Respect and Ease, provides a practical structure for designing inclusive health information and was developed through engagement with patients from low-income and racially minoritised communities alongside expert input.
- Translation and adaptation are integral to equitable access, with co-production and the use of dual-language speakers improving accuracy, relevance and usability of patient materials.
- Where and how information is distributed affects who is reached in practice, with materials confined to clinical settings less likely to reach people who disengage from services or access care later.

If you only read one resource: the six principles of patient partnership

[6] North East North Cumbria Integrated Care Board, *Regional health literacy*
[7] NHS England, *Tackling digital exclusion and health literacy: How libraries can help bridge the gap*
[8] National Institute for Health and Care Research, *Health information: are you getting your message across?*

5. Equipping policymakers and practitioners with the evidence to tackle health inequalities

Overview

Health Equity Evidence Centre (HEEC) supports policymakers and practitioners by improving access to evidence that can inform real-world decisions. Its work focuses on navigating complex evidence bases, identifying transferable learning across contexts and producing practical tools that support implementation.

Presentation contribution

Dr Liam Loftus, Associate Director for Policy and Practice Engagement at HEEC, outlined a persistent imbalance in the evidence landscape. While health inequalities are well described through long-standing datasets and national reporting, far less evidence is available in forms that support decision-making about effective interventions. The Centre's role was positioned as enabling translation between research, policy and practice by curating evidence in ways that are accessible, relevant and usable.

Key insights

- **There is extensive evidence quantifying health inequalities, including large gaps in healthy life expectancy and systematic disadvantages in funding, capacity and outcomes for services operating in deprived areas.**
- **Evidence on interventions that reduce inequalities is harder to generate and access, partly because solutions cut across health, social, economic and environmental factors rather than single conditions.**
- **Traditional funding and evaluation models are less well suited to equity-focused work, which often involves complex pathways, long timeframes and multiple interacting influences.**
- **Transferable evidence is frequently underused, despite the availability of relevant insights that can inform action across different populations, conditions, or settings when appropriately interpreted.**
- **HEEC addresses these gaps through living evidence maps, concise evidence briefs and practical how-to guides that support users to move from problem identification to implementation.**

If you only read one resource: How to: a guide to co-production in the NHS

Discussion

The discussion examined why progress on health inequalities remains uneven, despite well-established evidence on scale and impact. Participants focused on the practical constraints that shape how need is defined, how data is used and how action is taken across systems.

Defining need and inclusion

Participants agreed that definitions matter because they influence visibility, funding and prioritisation. There was concern, however, that efforts to establish a single, comprehensive definition of need, in other words a single agreed way of deciding who counts as underserved, can slow action. Definitions were seen as most effective when they are specific to the decision or intervention in question, for example defining who is likely to be missed for a particular access route such as screening invitations or GP registration.

The discussion highlighted that the question of who is underserved varies by context. Redesigning GP registration processes, improving screening uptake, developing patient information, or making the case for investment each require different ways of identifying need. There was discussion about who is included in health inclusion groups, with participants noting that some groups can fall between existing frameworks. Care leavers were raised as an example of a group that could be considered as needing support under inclusion health approaches and in some councils they are included, though this is not consistent nationally. Other groups mentioned included looked-after children, alongside people whose needs are shaped by disability, trauma, or unstable living conditions.

A recurring point was that exclusion can occur through category design. Groups that are not explicitly named are less likely to be prioritised in delivery, while rigid categorisation can limit flexibility and divert attention from practical action. The shared view was that need should be treated as fluid, with systems designed to adapt as patterns of exclusion change.

Understanding and using data

Data was recognised as essential but insufficient on its own. Participants observed that some of the most disadvantaged populations are often missing from routine datasets because they are highly mobile, reluctant to engage with services, excluded by administrative processes, or don't identify themselves, e.g., sex workers. This includes groups such as sex workers and people experiencing unstable housing.

There was strong support for combining quantitative data with other forms of intelligence. Examples discussed included insight from GP reception teams, community organisations, outreach workers, food banks and lived experience panels. These sources were seen as important for identifying unmet need that is not visible through coded data alone.

An important observation was that identifying people in need is not always the most difficult step. Participants described a range of available approaches, including population stratification, community engagement and frontline knowledge. The challenge more often lies in deciding which approach to use and acting with incomplete information. Too many competing methods and definitions were seen as discouraging decision-making rather than enabling it.

Participants supported the use of joined-up data where it is purposeful and proportionate. The emphasis was on earlier identification of unmet need, more targeted outreach and better assessment of whether interventions are reaching intended populations. Concerns were raised about data becoming an additional reporting burden if it is not current, relevant and clearly linked to delivery decisions.

Collaborative action and neighbourhood working

The discussion reinforced that no single organisation or sector can address health inequalities in isolation. Participants questioned assumptions that action must sit within traditional clinical boundaries, particularly in primary care, as this can limit opportunities to work with community assets and reach people who engage with services intermittently or late.

Industry participants also noted that they often hold a cross-pathway view of the patient journey, including evidence generation through clinical trials and real-world data, which can help identify where access breaks down and where additional implementation support is needed.

Examples were discussed of engaging people in settings where they already seek support, such as food banks or community venues. These settings were seen as potential points of contact for smaller groups at higher clinical risk and more likely to present late or through emergency routes. Participants also noted practical concerns around capacity, professional boundaries and perceived risk.

Progress was linked to the presence of individuals able to operate across systems e.g., between primary care, community organisations and settings (including food banks) and partner organisations such as industry. These roles were described as supporting coordination between clinical services and community settings, reducing friction and improving trust across sectors.

Neighbourhood health was framed as a network of local relationships rather than a formal structure. Participants described it in terms of schools, pharmacies, community organisations and local services working towards shared outcomes. Language was highlighted as relevant, with recognition that terms such as prevention may not resonate equally across communities.

Trust, risk and incentives

Participants identified trust as a factor shaping engagement and uptake. Trust was described as difficult to establish and easy to undermine, particularly where engagement is perceived as tokenistic or poorly designed. There was interest in whether the evidence base includes examples of trust being built effectively and safely, suggesting a potential focus for future research and shared learning.

Risk aversion was discussed as a constraint on action. Even where there is willingness to address inequalities, organisations may be reluctant to lead activity that carries perceived financial, reputational, or delivery risk. This was linked to incentive structures that prioritise short-term, easily measurable outcomes over longer-term equity impacts.

Participants also discussed the role of narrative in decision-making. While technical evidence remains important, it does not always align with how policy and funding decisions are made. Policymakers were described as more responsive to clear accounts of impact, particularly where economic return is expected within shorter timeframes. The implication was that evidence needs to be presented in ways that align with decision-making processes.

Suggested next steps

The suggested next steps below reflect where participants identified the greatest opportunity to improve equity of access through practical, collaborative change. They are intended to support collaboration, knowledge sharing, capacity building and co-creation across the stakeholder group.

1. Create shared visibility of funding opportunities and partnership landscape

Participants identified that people are not aware of resources available across organisations. Every organisation has a list of funding opportunities, but this information is not shared. Industry needs to know who is working in health inequalities spaces and community organisations need to know what support is available. The ABPI could communicate this better.

Ideas

- Produce a shared resource document listing funding opportunities and non-financial support available across stakeholder organisations, including eligibility criteria and contact details.
- Map organisations currently working in health inequalities spaces to enable stakeholders to identify potential partners and avoid duplication of effort.

2. Build collective understanding of community roles, community-led approaches and innovative engagement models

Participants noted that we don't fully understand the outreach of community workers and social prescribers and need to know more about how community-led approaches can be integrated into healthcare. There was recognition that bespoke and innovative approaches are needed to reach the most marginalised 3%, including meeting people where they are accessing care such as in foodbanks and community spaces, rather than expecting them to come to traditional healthcare settings.

Ideas

- Produce a briefing document on community roles (social prescribers, community workers, outreach staff) including how they operate, their reach and how they connect with health services.
- Gather and share innovative approaches to reaching and engaging the most marginalised populations across stakeholder networks, including outreach models, use of trusted intermediaries and engagement in non-traditional settings such as foodbanks.

3. Develop stakeholder engagement capability and share innovative collaboration models

Participants identified the need for earlier stakeholder engagement and learning how to engage with one another more effectively. Different sectors speak different languages and have different purposes, making collaboration difficult. There was discussion about adopting a whole different paradigm of working, building a community of practice where we improvise more, do things in slightly different ways and are proud of differences rather than trying to standardise everything.

Ideas

- Facilitate learning sessions focused on stakeholder engagement skills, including how to work effectively across clinical, industry, community and patient advocacy contexts.
- Share innovative models of multidisciplinary collaboration from current stakeholder projects, including new ways of working that break from traditional approaches, what made them successful and practical barriers overcome.

Additional resources

British Red Cross,
Exploring the high intensity use of Accident and Emergency services

Friends, Families and Travellers:
- YouTube
- Resources for healthcare professionals
- National Inclusion Health Network

Gilead Sciences,
'Look. And You Will C Us'

Health Equity Evidence Centre:
- How to: a guide to co-production in the NHS

Health Innovation Network:
- Forging a more equitable future through patient and public involvement and engagement
- Innovation for Healthcare Inequalities Programme: impact and learning report

The King's Fund
- What are health inequalities?
- The hidden problems behind delayed discharges and their costs

Lankelly Chase Foundation,
Hard Edges: Mapping sever and multiple disadvantage

Malden, S., Doi, L., Ng, L. et al. ***Reducing hospital readmissions amongst people experiencing homelessness: a mixed-methods evaluation of a multi-disciplinary hospital in-reach programme.***
BMC Public Health 23, 1117 (2023).
https://doi.org/10.1186/s12889-023-16048-1

National Institute for Health and Care Research,
Health information: are you getting your message across?

NHS England
- NHS England's statement on information on health inequalities
- Core20PLUS5 infographic
- A national framework for NHS - action on inclusion health
- Tackling digital exclusion and health literacy: How libraries can help bridge the gap
- Inclusion health groups

NHS Providers, Improving health literacy in the NHS

North East North Cumbria Integrated Care Board, Regional health literacy

Patients Association
- The six principles of patient partnership
- Advancing health equity through core: a new approach to inclusive communication
- Improving health equity for patients living with cancer and/or blood disorders
- Translating patient information resources to address health inequalities

Patient Information Forum and Ipsos,
Knowledge is Power

Prescribing Services:
- Population Health

Race Equality Foundation,
Exploring Ethnicity Data Use and Gaps in Health Care 2025 report

REAL Centre, Health inequalities in 2040: current and projected patterns of illness by deprivation in England

VCSE Health and Wellbeing Alliance,
Inclusion Health Tool for Primary Care Networks

World Health Organization,
Health literacy

Health Innovation Network

Local change, national impact

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