How do hospitals address health inequalities experienced by children and young people: a grey literature scoping review protocol

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ABSTRACT

Introduction Health inequalities are unfair, systematic differences in health between people. In the UK, the Health and Social Care Act 2012 recognised health inequalities as a responsibility of the National Health Service (NHS). Health inequalities were foregrounded in the publication of 2019 NHS Long Term Plan and during the SARS-CoV-2/COVID-19 pandemic. Hospitals are well placed to address health inequalities through their role as anchor institutions. While many hospitals have begun to address inequalities, children are often overlooked or assumed to have the same needs as adult populations. This grey literature scoping review aims to identify, collate and present approaches taken by hospitals to address health inequalities in children and young people.

Methods and analysis This scoping review will follow Joanna Briggs Institute guidance. A four-step approach to identifying grey literature will be used. Literature will be examined to identify approaches that aim to address health inequalities. Literature must describe the health inequality they aim to address and be initiated by the hospital. It will exclude literature not available in English and published before 2010. Two reviewers will independently review the results of the searches using the inclusion and exclusion criteria. Data will be extracted using a data extraction tool. Study findings will be presented in tabular form detailing the interventions identified.

Dissemination The review will synthesise information on worldwide hospital approaches to addressing child health inequalities. The findings will be used to inform guidelines for children’s hospitals in the UK and will be disseminated through national and international professional bodies, conferences and research papers.

INTRODUCTION

Health inequalities are systematic differences in health between people that are both unfair and avoidable.1 The link between socioeconomic deprivation (a multidimensional concept referring to the disadvantage in access and control of social, economic or material resources and opportunities2) and health inequalities is well evidenced.3-6 While intertwined with socioeconomic status, other types of social inequalities also predict health inequalities, for example, those based around disability,7 race,8 religious beliefs9 and sexual orientation.10

A commonly used measure of health inequalities is life expectancy. In the UK, people living in the most deprived areas of England have a life expectancy of 14 years shorter than people living in the least deprived areas.11 For healthy life expectancy — a measure of how much time people spend in good health during their lives — the differences are even more stark, with an 18-year difference.12 These inequalities present worldwide. Children born in sub-Saharan Africa are 14 times more likely to die before the age of 5 than the rest of the world.13

Health inequalities start before birth, with children and young people born into, and living in, more socioeconomically disadvantaged areas experiencing worse health outcomes than their peers.14 Research in the USA observed ethnic disparities in the birth weight of infants. Low birthweight rates were three times higher in black mothers with low education compared with babies born to white mothers with college education.15 In the UK, children living in areas of

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ The search strategy focuses solely on grey literature.
⇒ Grey literature is appropriate for exploring this topic due to the fast-paced, changing nature of the field and a dearth of peer-reviewed literature on this specific subject.
⇒ Literature will be considered from across the globe, if published in English, post-2010.
⇒ The four-step approach we will use to identify literature has been successfully applied in previous grey literature studies.


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Protocol

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deprivation are more likely to suffer from conditions such as asthma, tooth decay, obesity and diabetes, as well as a higher risk of accidents and accidental death. A recent study found that 36% of children treated in intensive care units for asthma were from the most deprived neighbourhoods, compared with 11% from the least deprived neighbourhoods.

However, inequalities are not just measured in health outcomes; patterns in how people access care are also different across the socioeconomic gradient, with children from the most deprived areas of the UK less likely to be brought for outpatient appointments, but more likely to attend the emergency department than those from the least deprived areas.

In the UK, the National Health Service (NHS), a government-funded free at the point of access, universal medical and healthcare service) has a legal duty to address health inequalities. The Equality Act 2010 defined nine protected characteristics (age, sex, race, disability, sexual orientation, gender reassignment, marriage and civil partnerships, pregnancy and maternity, religion or belief discrimination) but excluded deprivation. However, the Health and Social Care Act 2012 recognised reduction of health inequalities in access to care and outcomes as a responsibility of the NHS.

In 2019, the NHS Long Term Plan committed to tackling health inequalities, setting requirements for local areas to agree goals to narrow health inequalities. During the SARS-CoV-2/COVID-19 pandemic, health inequalities were forced to the forefront of strategic thinking and greater emphasis was given to the urgent need to address the widening gap in healthcare and its outcomes. However, critics have argued that the lack of clarity in the UK, and an absence of a national health inequalities strategy, has led to local healthcare systems, including hospitals, struggling to develop their own approach to addressing health inequalities.

**Rationale**

As we begin to emerge from a global health crisis, where health inequalities have been foregrounded and exacerbated, it is of vital importance that recovery work looking at inequalities does not forget children. Although less affected by COVID-19-related mortality and morbidity than adults, children living in poverty have been disproportionately affected by the pandemic and will have to live the longest with the long-term impacts on healthcare provision and health outcomes. It is, therefore, imperative that efforts are made to reduce inequalities in health for children at this time.

Interventions to address child health inequalities are traditionally based in the community (eg, English Sure-Start Children’s Centres) or led by primary care settings (such as interventions based on proportionate universalism and incentives linked to Quality Outcomes Framework scores). However, children’s hospitals may be well placed to address health inequalities through their role as anchor institutions (large public sector organisations whose long-term sustainability is intricately linked with the well-being of the populations they serve). As large local employers and providers of care to local, regional and national populations, hospitals have the potential for intervention at multiple levels as employers and care providers.

**Aim**

This scoping review aims to identify and collate information on how hospitals that deliver care to children, address health inequalities.

**METHODS AND ANALYSIS**

Scoping reviews are a method of systematic evidence synthesis, useful for mapping the breadth of research in a field, but not limited to detailed interventions or phenomena of interest like a traditional systematic review. This protocol follows the Joanna Briggs Institute methodology for conducting scoping reviews and will adhere to gold-standard reporting guidelines (Preferred Reporting Items for Systematic Reviews and Meta Analyses for Scoping Reviews (PRISMA-ScR)).

A preliminary search of MEDLINE, the Cochrane Database of Systematic Reviews and JBI Evidence Synthesis was conducted and no current or underway systematic reviews or scoping reviews on the topic were identified.

**Review questions**

1. What approaches do hospitals take to address health inequalities in children and young people?
2. What health inequalities do the approaches focus on?
3. How is effectiveness measured and demonstrated?

**Inclusion and exclusion criteria**

This proposed scoping review will include items published in all countries, from 2010 onwards; this date range was agreed on to ensure that the review would be manageable, while also ensuring that included interventions reflected the shift to an inequalities focus in the early 2010s. Publications in English will be included only, due to limited resources.
The intended beneficiaries of approaches will be children and young people up to the age of 25 (to include countries where systems continue care into adulthood). Settings will be hospitals where children and young people are cared for. Approaches will be led/designated/initiated by the hospitals, but could be delivered elsewhere, for example, in the community, satellite clinics or online. Analysis will consider context, based on available evidence of health inequalities in different countries. Considering good practice in addressing health inequalities will need to be sensitive to specific challenges faced by each country, but analysis will focus on broad principles that may be transferable beyond the immediate context where the intervention is delivered.

This review will consider literature if it addresses our research questions. In other words, we will consider grey literature where the purpose is to address health inequalities experienced by the children and young people attending their settings, and the health inequality/inequalities that the approach aims to address are clearly described.

Approaches may include hospital policies written as statements, intentions or strategies and/or interventions/initiatives designed to reduce inequalities relating to health.

Inequalities relating to health may encompass (but are not confined to) ease of access to the setting and its appointments/care, mortality rates, other health outcomes (such as treatment outcomes) or quality of care.

A detailed explanation of the inclusion and exclusion criteria is presented in Table 1.

### Table 1 Inclusion and exclusion criteria

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approaches that state reducing health inequalities/disparities/inequalities in their aim/focus.</td>
<td>Approaches that do not explicitly state that reducing health inequalities/disparities/inequalities is their aim/focus.</td>
</tr>
<tr>
<td>Approaches that have been designed/commissioned/initiated/led by the hospital setting.</td>
<td>Approaches that the hospital are involved in but have not been designed/commissioned/initiated/led by the hospital, for example, reports solely describing membership of partnerships addressing health inequalities will not be included unless initiated by the hospital themselves.</td>
</tr>
<tr>
<td>Approaches that clearly describe what inequality it aims to address and how this inequality impacts health.</td>
<td>Approaches that do not describe the health inequality it aims to address, for example, interventions to reduce poverty (without an explanation of how this impacts health inequalities) will not be included.</td>
</tr>
<tr>
<td>Literature published post-2010.</td>
<td>Literature published pre-2010.</td>
</tr>
<tr>
<td>Approaches that are aimed at reducing health inequalities for children and young people aged 0–25.</td>
<td>Approaches that are aimed at antenatal/prenatal services and young people over the age of 25. Whole hospital approaches (without a specific focus on children).</td>
</tr>
<tr>
<td>Literature aiming to reduce/address health inequalities.</td>
<td>Literature that does not aim to reduce/address health inequalities, for example, studies that identify inequalities but do not take approaches to address them will not be included.</td>
</tr>
</tbody>
</table>

Of whether the studies they describe are published (the original published study will not be sourced).

To identify relevant documents in the grey literature, we will take a four-step process adapted from previous grey literature review studies using keywords (online supplemental appendix 1).

1. Grey literature databases, including The Healthcare Management Information Consortium Database (containing the UK Department of Health Library and King’s Fund Library), policy database Overton (international coverage of 182 databases), OpenGrey (European database of grey literature pre-2021), Trip Medical Database (global database of medical information).
2. Google Search engines using the anonymous function in web browsers—a review of the first 10 pages of Google Search results generated from keywords will be screened. Relevancy ranking will be relied on and results from the first 10 pages will be screened.
4. Snowballing—any literature identified from the above methods will be screened for further references.

The keywords outlined in online supplemental appendix 1 will be used to run the initial search in steps 1–3, however, keywords will be adjusted iteratively, depending on the database and results from the initial search. The full search strategy will be described in the final review paper.

### Study selection

Step 1 of selection will involve recording screening the titles and extracting all potentially relevant literature retrieved by the four searches; this will be done by one reviewer. For each step of the search, a sheet will be created within Excel to record the title, source organisation and URL for the literature identified.
Next, the full text of all items identified in step 1 will be independently reviewed by two reviewers. Any that do not fit with the aims of the scoping review will be discussed and, if necessary, removed. Reasons for excluding full text literature will be documented and reported in the review. The results of the search will be reported in full in the final scoping review and presented in a PRISMA-ScR flow diagram.

Data extraction
Data will be extracted from papers included in the scoping review by two independent reviewers using a data extraction tool developed by the reviewers, based on JBI recommendations (online supplemental appendix 2). The data extracted will include details about the source, target population, approach and outcomes. It will also record details of context to account for the potentially diverse locations of intervention delivery. The draft data extraction tool will be modified and revised as necessary during the process of extracting data from each included paper. Modifications will be detailed in the full scoping review. Any disagreements that arise between the reviewers will be resolved through discussion, or with a third reviewer. Authors of papers will be contacted to request missing or additional data, where required.

Data analysis and presentation
Study findings will be presented in tabular form detailing the interventions identified in the literature and the corresponding outcomes. If appropriate, a diagrammatic chart will be used to describe themes derived from the literature. Possible themes could explore type of inequality for example, access and/or outcome; or type of intervention, for example, support provision and/or educational. Data will be presented alongside a narrative summary of the findings. Expert methodological advice and input will be sought if necessary.

Patient and public involvement
This study is a review of the literature and there are no study participants. Patients and public are not involved in this research.

Ethics and dissemination
This study is a synthesis of published literature and does not involve identifiable information, patients or members of staff, therefore, no ethical review is required. The results of this scoping review will be submitted for publication in a peer-reviewed journal and scientific meetings and conferences. The findings will be used to inform best practice guidelines for addressing health inequalities to be used by Children’s Hospitals in the UK.

Contributors LB has developed the research question, study methods and lead on drafting and editing the final manuscript. RI and LB aided in developing the research question and study methods, contributed to the drafting and editing and approved the final manuscript. JL, FE, DPS and PP aided in developing the research question, search methodology and approved the final manuscript.

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