How to embed action on health inequalities into integrated care systems

A practical guide to inform spending on health inequalities

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Introduction

Produced in partnership with:

CLARITY
Making Change Happen

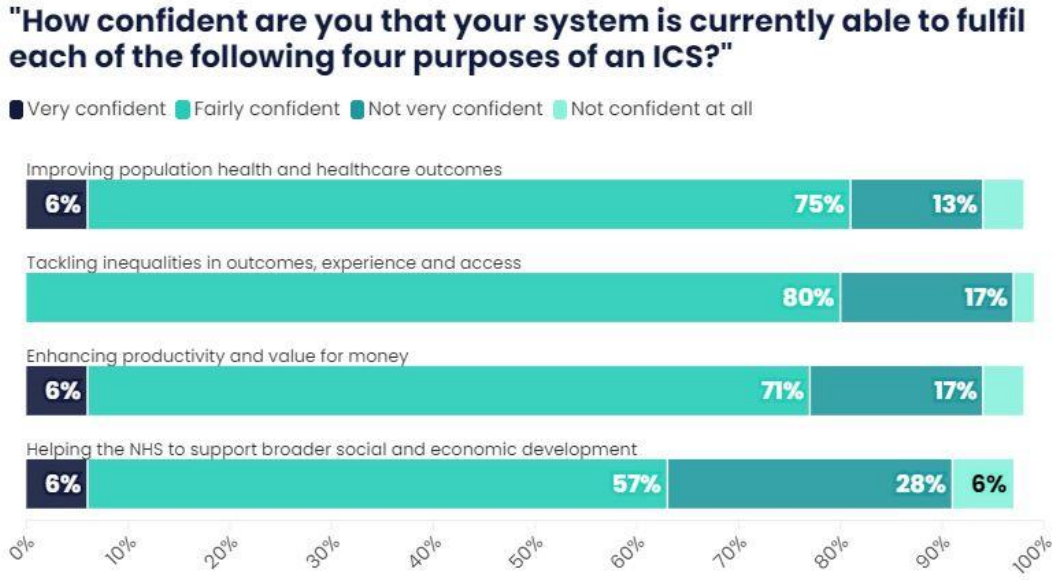
This toolkit is a practical guide for system leaders that will help to inform future spending on health inequalities (HI) and support implementation of high-impact changes within integrated care boards (ICBs) to address HI. It aims to build system leaders' confidence in their ability to tackle inequalities in their organisations and is accompanied by a research report that looks at the approaches systems took to spending health inequalities money.

This project was carried out in response to the NHS Confederation's State of ICSs report, which asked ICB leaders how confident they are in their ability to fulfil their four statutory purposes.

The four core purposes of integrated care systems

- To improve population health and healthcare outcomes.
- To tackle inequalities in outcomes, experience and access.
- To enhance productivity and value for money.
- To support broader social and economic development.

While ICBs in the survey reported feeling ‘very confident’ in three of the core purposes of an ICS, no systems reported feeling ‘very confident’ in their ability to tackle inequalities in outcomes, experience and access, and 20 per cent of systems responding were ‘not very confident’ or ‘not confident at all’.



Source: NHS Confederation - State of Integrated Care Systems Survey
Sorted by most very confident-confident responses - n=

Toolkit development

The toolkit is informed by a series of interviews and workshops with ICB health inequalities leads and a review of available resources.

Information was gathered from discussions that centred on three key questions:

- How did you decide where to invest HI resources?
- Which tools did you use to help you?
- How do you know/will you know if the approach has been successful?

The four main stages of quality improvement methods (plain text) +

The project used the additional health inequalities allocation from NHS England in 2022/23 and 2023/24 as a case study through which to explore systems' approaches to addressing health inequalities. This was an allocation of £200 million, distributed to ICBs. Spending is the responsibility of the ICB, therefore this project interviewed health inequalities leads from ICBs and focused on the role of the ICB. This happened in tandem with integrated care partnership (ICP), local authority, and place- and neighbourhood-level activity, all of which are crucial to addressing health inequalities.

You can find out more about the ICP role in Integrated Care Partnerships: Driving the Future Vision for Health and Care, and see Delivering A Quality Public Health Function in ICBs for more detail on the relationship between local public health teams and ICBs.

Culture, leadership and governance

If you can crack the culture and leadership piece, the rest will follow…

Health inequalities lead, toolkit development workshop, December 2023

Research findings

Leadership at the top of the organisation is an important enabler of change.

Interviewees stated the importance of:

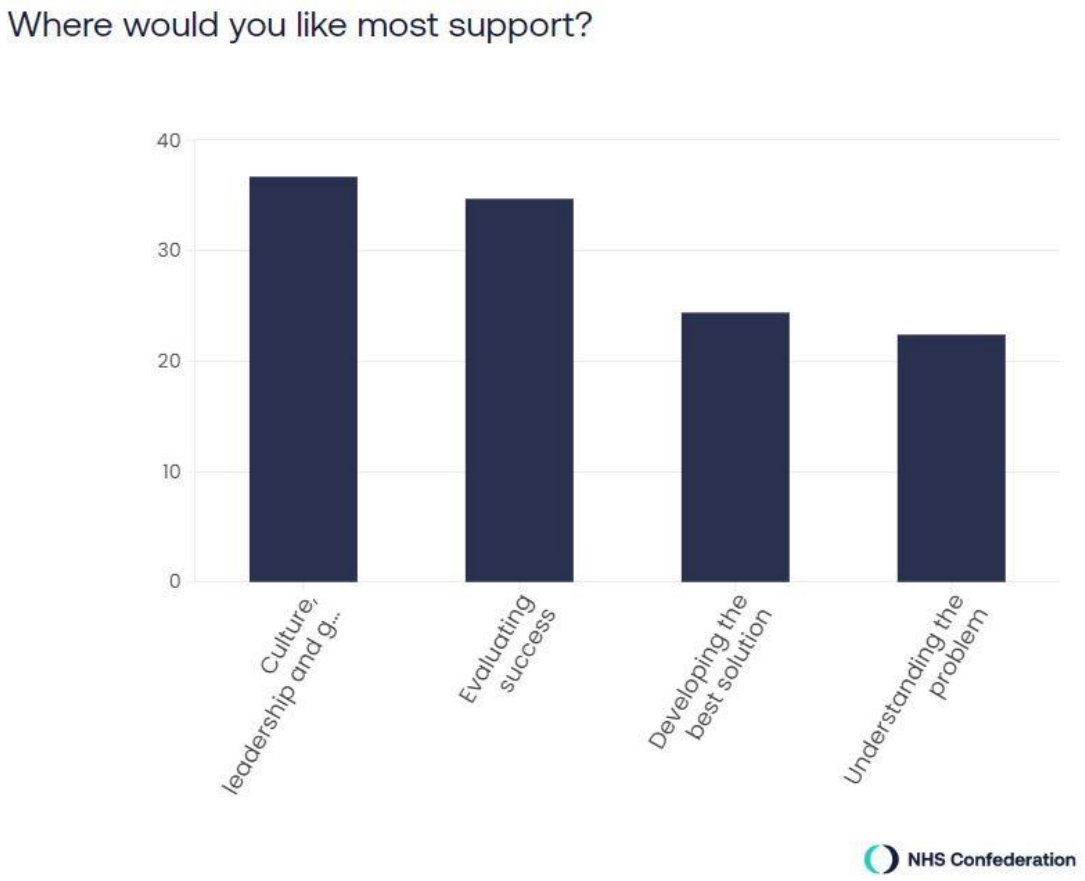
- **cultural change** to place health inequalities more centrally within the governance structures of the ICB. If health inequalities is everybody's business then attention and investment should focus on building capacity and capability across the health system and mainstreaming strategic actions.

- **The creation of specific committees and work groups** to take responsibility for developing strategic approaches for addressing inequalities, with direct lines of reporting into the board. These structures are important because they are not just concerned with receiving and endorsing reports, but provide a place for members to develop a shared analysis, discuss tactical approaches for change and gain support for action. In many cases these structures were chaired by a director or a non-executive director (NED) of the ICB.

- The **value of bringing the ICP into these committees**: most of these committees had a membership that included representation from local authorities, usually the director of public health.

There is widespread recognition that creating the right culture, engaging and demonstrating strong leadership and building a robust governance framework are critical to reducing inequalities in health.

In a poll asking ICB HI leads to rate where they would most like support, culture, leadership and governance was ranked first.



Creating the right culture

The culture of an organisation or system shapes the behaviour of everyone in it, the quality of care it provides and its overall performance. It is the norms, rituals, expected behaviours and unwritten rules that underpin practice.

HI leads shared the need to create the right culture. This includes:

gaining the support and commitment of senior leaders within the organisation, including the CEO and director of finance, and having a dedicated non-executive director (NED)

a specific and tailored training programme for staff, such as a health equity academy, to embed understanding and encourage managers at all tiers to address the systemic and structural issues that can exacerbate inequalities

overcoming the dominance of the medical model to focus on the upstream, preventative support needed to reduce many causes of health inequality.

- In **Cheshire and Merseyside**, an NHS prevention pledge has been developed and signed by health, local authority and third sector organisations to set out and confirm a shared commitment to addressing health inequalities.

- In **Dorset,** the system is working with partners to ensure that they are focused on making the very best use of resources to deliver equitable outcomes. A whole-system partnership brings together the NHS; local government; voluntary and community sectors; academia and blue light services to tackle both the direct and wider determinants of health, improving access, experience and outcomes from healthcare services by addressing the root causes of what gets in the way of good health.

- In **Herefordshire and Worcestershire**, board papers require health inequalities to be a considered in every discussion. Training and developing the workforce and NEDs in the issues and challenges of health inequalities is an organisational priority.

- In **Coventry and Warwickshire**, Coventry has been declared a Marmot city. This has led to a widespread understanding of

the issues and a determination by NHS organisations, the council and other partners to follow the six Marmot principles.

- **North East London ICB** is building a Health Equity Academy to increase understanding and embed this within routine operational practice.

- **NHS Hampshire and the Isle of Wight ICB** is incorporating health equity within the curriculum of its Population Health Academy.

Embedding appropriate governance

Part of creating the right culture is ensuring that governance structures enable and support the values and priorities of the organisation. Some ICBs have refined committee structures and decision-making processes to ensure that health inequalities are acknowledged, prioritised and reflected in the roles and responsibilities of individuals and groups.

- in **Dorset,** health inequalities are considered by a dedicated committee. This ensures that the approach to governance gives equal oversight and assurance of actions to address variation in health outcomes, as it does to other important priorities such as finance.

- In **Coventry and Warwickshire**, a NED has been given responsibility for leading the ICB's response to HI. A strategic group is responsible for aligning work to address HI and the wider determinants of health among partners. A delivery group is in place to manage the operational implementation of plans.

Plans and strategies

For some systems, HI is a golden thread that links all strategic documents. Where resources are even tighter, or systems are in special measures, this is considered even more important as solutions have to be found that address the causal factors more creatively.

- **Coventry and Warwickshire ICB** has a Health Inequalities Strategic Plan and a supporting delivery plan to guide implementation.
- The Joint Forward Plan of **North East London ICB** fully captures the needs and ambitions of the HI agenda and describes how it will be delivered as part of every planned improvement programme. The expected benefits are detailed along with the anticipated impact on the inequality gap.
- The health inequalities agenda is woven through the **Hampshire and the Isle of Wight** Care Plan and is a core theme within the Joint Forward Plan

Key questions on culture, leadership and governance

These questions will help prompt discussion among different groups of ICB leaders.

Questions for non-executive diretors

- How do our governance structures explicitly address health inequalities, and how can we enhance their effectiveness? Are

health inequalities treated with equal attention and focus as our other obligations, such as system finance and operational performance?

- What specific actions have we taken to ensure our commitment to HI leadership is reflected in impacts within the diverse communities we serve, via our plans and monitoring?

- How are we assured that all NEDs and executives are appropriately addressing this agenda?

- How are we embedding health inequality considerations into all our decision-making processes? Can we evidence this?

Questions for health inequalities leads

- How are we fostering a culture within the organisation that prioritises addressing health inequalities?

- Does everyone in our system understand our current position, the areas of focus to improve HI and the actions we have put in place?

- What measures have we put in place to ensure accountability for health inequality initiatives?

- How are we engaging with wider system stakeholders to inform our approach to health inequalities?

Questions for system partners

- Do we have a clear understanding of the health and healthcare inequalities in our system or place? How do we know?

- How can we contribute to building a culture that acknowledges and addresses health inequalities?

- How are we ensuring that our day-to-day work aligns with the system's health inequality goals?

- What challenges do we face in embedding health inequality considerations? Do we know how to raise issues, propose solutions and address challenges?

Understanding the problem

Research findings

Strategic Needs Assessments, developed by local authorities, and/or new analysis coming from strengthening and expanding data sets. This includes population-level data on health conditions, service use, deprivation and other relevant metrics. It is critical that a range of data sources are drawn upon to ensure that the problem is fully understood at a sufficient level of granularity.

Spending time exploring the challenges is more likely to result in an effective solution.

When HI leads were questioned on areas of strength within their organisation, ‘understanding of the problem’ topped the survey and was the area in which they felt they needed the least support. The main issue in this area is being able to use more granular information to identify the specific individuals who are most vulnerable, and understanding the interventions most likely to change the course of their health trajectories.

Using frameworks

When choosing an approach to inform actions to reduce healthcare inequalities, Core20PLUS5 is the most commonly used assessment framework.

However, in addition to Core20PLUS5, some systems have developed their own frameworks. **Coventry and Warwickshire ICB** has a bespoke maturity matrix that enables a more detailed understanding of the challenges in elective, primary and urgent and emergency care.

Defining the problem and scope

It's important to define at the outset whether you are looking to address **health** inequalities, or **healthcare** inequalities. The scope of problem will be very different if the remit is health (covering the wider determinants of health) rather than healthcare (focused on access to health interventions).

Being clear about the problem that needs to be resolved is the most critical element of any change programme, but this stage is often skipped over in improvement work as many stakeholders come with ideas for solutions and plans that they are keen to implement.

Given the challenges of evaluating outcomes, applying robust programme and project management techniques, including a clear problem statement, could help to mitigate any challenges at later stages of implementation.

Investing resource in this stage is critical to ensure key questions can be answered and captured in a project charter:

Key questions

- What is the problem?
- Why do we need to address this?
- What are our goals?
- Over what time period are we expecting the work to take place/goals to be achieved?
- What's in scope and out of scope?

Measuring and understanding

Measuring the scale and characteristics of the problem is essential not only for quantifying the current position and knowing where to focus, but also for being able to monitor and track progress.

Both quantitative and qualitative data should be used to ensure that a complete and comprehensive appraisal is undertaken.

Qualitiative data

HI leads have highlighted the risk of failing to sufficiently collect and use qualitative data to understand the problem and identify the best solutions. If qualitative information is not used as well as it should be, it creates a risk of exacerbating HI as decisions are made on the basis of limited and partial data.

Although it can be more costly to collect and analyse, qualitative data it is vital for triangulating findings and deepening awareness.

Quantitative data

A wealth of quantitative data is available to start developing a picture of health inequalities:

- Joint Strategic Needs Assessments, developed by local authorities.
- The Midlands and Lancashire CSU planned care tool (fee payable).
- Mosaic - allowing population analysis and segmentation (fee payable).
- Acorn - providing geodemographic segmentation (fee payable).
- Spotlight – Public Health England's data dissemination platform that collates and presents key statistics related to the public health outcomes of inclusion health groups across the themes of access to and utilisation of health care; preventative care; health outcomes; and wider determinants of health.
- OHID Health Inequalities Dashboard - evidence of health inequalities in England. Measures of inequality are provided for key indicators to monitor progress on reducing inequalities within England. For some indicators, inequality measures are also provided within regions and upper-tier local authorities. More local level measures will be added to the dashboard over time.

- OHID Segment Tool - providing information on the causes of death and age groups that are driving inequalities in life expectancy at local area level

- OHID- Fingertips - a significant collection of public health data, organised within themes.

- The global burden of disease - a comprehensive picture of mortality and disability across countries, time, age, and sex. It quantifies health loss from hundreds of diseases, injuries and risk factors.

Many systems combine high-level data from national datasets with that gleaned from local systems and partners, to drill down and build a more granular picture of the problem within the communities they serve.

- **Herefordshire and Worcestershire ICB** has developed local dashboards that marry local and high-level data, using EMIS data from primary care, system-wide data and national sources.

- **NHS Hampshire and the Isle of Wight ICB** uses data from GP practices and place-level information to build a comprehensive view of the problem it is trying to solve.

Sharing data

Data protection arrangements can be a barrier to sharing data across organisations. However, there are examples of where the issues have been overcome:

- The **Dorset** Intelligence and Insight Service (DIIS) is leading work to combine health and social care datasets to inform health inequalities interventions.

- **North East London ICB** has built a platform that all partners are able to access and draw on. It includes detailed population health profiles and prevalence patterns.

Data protection arrangements can be seen as a barrier to sharing data across organisations. General Data Protection Regulations (GDPR) provide a framework for data sharing and the NHS has developed data sharing agreements to document and govern the process. This can be used to manage data sharing between NHS and private organisations.

Collating resources

Public Health England's Health Equity Assessment tool helps systematically assess health inequalities and can also be used to set out plans for improvement as well as the means by which the investment will be evaluated.

Key questions on understanding the problem

Questions for non-executive diretors

- Is the problem we need to address sufficiently defined and based on a robust analysis that draws on a range of sources?

- To what extent are we really listening to people in our places who are most vulnerable to the identified health inequalities?

- Are we balancing the national priorities with a focus on the specific needs of our population?

- Have we drawn on the experience and advice that the regional team can offer?

Questions for health inequalities leads

- Can I be confident that our understanding of the problem is based on a complete and full picture of need, from both qualitative and quantitative sources?

- Are we successfully combining high-level data with local data so that we have a comprehensive view, with an appropriate level of granularity?

- Are we collating the data in a way that enables decision-makers and partners to really understand the problem and the priorities?

- Are we confident in the quality of the underpinning data?

- Has the emerging picture been shared with partners to validate and confirm the findings and conclusions being reached?

Questions for system partners

- Do we have data that we could share (without breaking any confidentiality or GDPR rules) that could improve understanding of the challenges?

Developing the best solution

Research findings

Most ICBs have processes for determining which kinds of interventions might work to reduce health inequalities. Evidence from Michael Marmot's reports and the Institute of Health Equity was referred to several times by participants whose ICBs had taken into account the social determinants of health as well as healthcare needs, and often was associated with a focus on children and young people, and on communities, neighbourhoods and the VCSE sector, as recommended in the Marmot evidence.

Solutions were also inspired by:

- learning networks with places, primary care networks and other ICBs that had tackled similar issues
- using existing, or creating new, population-level data on health conditions, service use, deprivation and other relevant metrics to inform decisions
- relationships and learning from the integrated care partnership, communities and the voluntary sector.

With the problem defined and understood and clear metrics that will demonstrate improvement, how do you design the right solutions for the target populations and how do you ensure the best return, helping the most people for the lowest cost?

These ten design principles from NHS Digital provide a helpful prompt:

Ten principles for designing the best solution

- Put people at the heart of everything you do.
- Design for the outcome you want to achieve.
- Be inclusive.
- Design for context.
- Design for trust.
- Test your assumptions.
- Make, learn, iterate.
- Do the hard work to make it simple.
- Make things open. It makes things better.
- Design to protect the environment.

Solution frameworks

The population intervention triangle looks at three clusters of interventions to inform place-based plans.

- civic-level interventions
- community-centred interventions
- service-based interventions.

It highlights the factors critical to the success of any place-based solution including:

- quality characteristics, such as strong leadership

- effective partnership
- a joint vision and credible strategies
- the need to drive measurable change, bringing the impact of the individual segments together.

As a framework, it also recognises the potential to enhance impact by focusing on the interfaces or ‘seams’ between the segments. With creative working across the system, the whole can become greater than just the sum of the parts.

- In **Dorset**, logic models were used to develop and test the combination of actions that might be required to deliver our system ambitions.
- **Midlands and Lancashire CSU** has developed a comprehensive guide to developing logic models, offering both training material and frameworks to capture thinking.
- In **Nottingham and Nottinghamshire**, solutions emerged by the application of a quality improvement methodology, adapted to address specific health inequalities issues.

Working with partners and peers

Many systems have drawn in peers and partners**,** including local communities, to work with them on developing the right response and reference.

- In **Herefordshire and Worcestershire**, the ICB engaged peers and partners to generate solutions and a number were managed through primary care networks. These were allocated funding after a rigorous test of the underpinning evidence base and projected impact. Other schemes are being delivered at place level, working with housing departments and the VCSE.

- In **Hampshire and the Isle of Wight**, the ICB is working closely with the Voluntary Sector Alliance – Hampshire and Isle of Wight VCSE Health and Care Alliance - to deliver improvement.

Identifying the best option

Identifying the best option is inherently context specific. Broad themes for using health inequalities funding, identified in the research, included:

- devolving funding to place and/or neighbourhood
- evidence-based interventions
- building capability
- commissioning pilots
- building capacity.

Devolving to place and/or neighbourhood

- **Coventry and Warwickshire ICB**, allocated funding to places based on a formula that quantified and ranked the level of need within the system. While this favoured the north of the geography, stakeholders recognised why it was important and the right thing

to do. As well as prioritising allocations to different communities, Coventry and Warwickshire has also taken steps to weight the waiting list for elective care, based on health inequalities factors.

Building capacity

- **Hereford and Worcestershire ICB** has linked recruitment to health inequalities, targeting campaigns to people in specific postcodes to target wider inequalities issues.

Key questions on developing the best solution

Questions for non-executive diretors

- Does the solution align to the agreed problem and priorities for the system?
- Are the people we serve at the heart of the solution?
- Has the solution been developed with the engagement and support of partners from across the system?
- Do we have interventions that address civic-level needs, community needs and service needs?

Questions for health inequalities leads

- Do the solutions being implemented align to the priority areas agreed as part of the work to define and articulate the problem?

- Is there a clear project charter that explains the interventions we are implementing/planning to implement?
- Do we have the right people in the right places to implement the solutions?
- Have we identified solutions that need a tactical investment to leverage significant gains?
- Are there enabling works that we should support?

Questions for system partners

- Do the interventions proposed build upon and add to existing resources?
- How can we support and contribute to the success of the scheme/package of interventions being implemented?

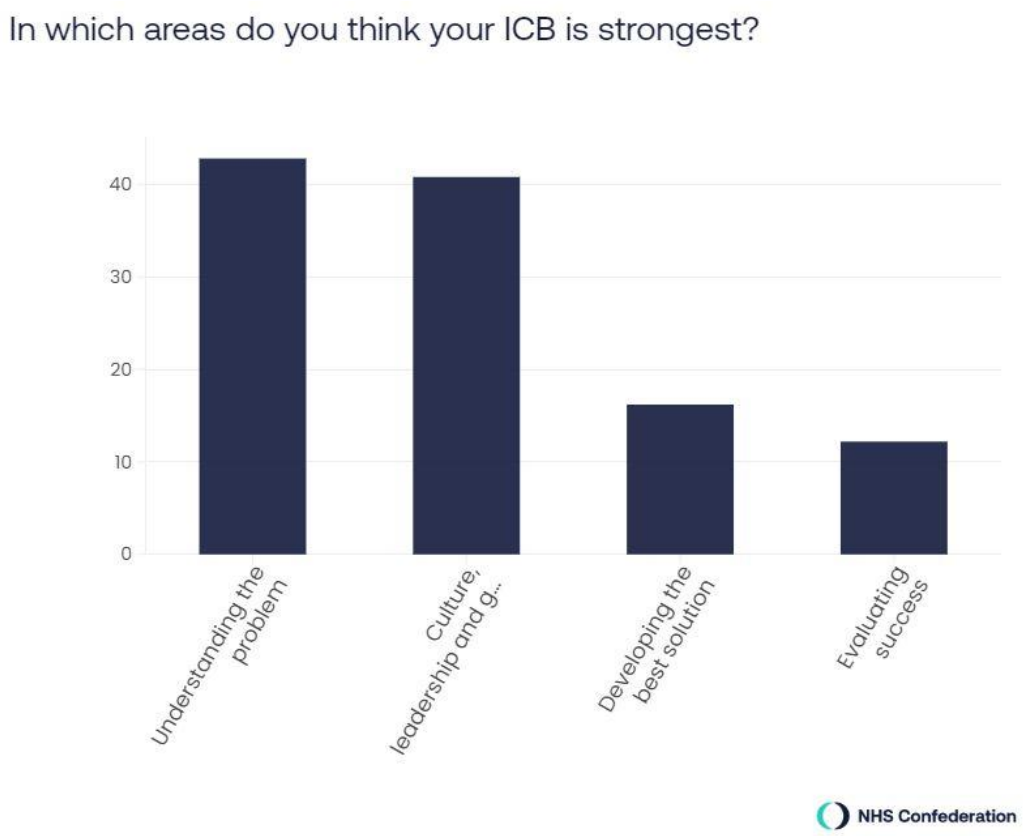
Evaluating success

“Health inequality, it's about testing, learning, experimentation, exploration, learning. There's no failure. It's about asking what did we learn from that, what we'll do next time and so on. And adaptation and reflection.”

Research findings

Reflecting on the extent to which expected benefits have been achieved is critical for the learning process and informing future action. Should the approach or project be scaled up and implemented more widely or does it require refinement in order to meet the objectives agreed? Baselines must be set and the approach to evaluation agreed at the start of the project to ensure that an objective and fair assessment can be undertaken.

The poll of HI leads showed that evaluating success came second when asked where support would be most welcomed. It was ranked last in response to ‘in which areas do you think your ICB is strongest’.



This reflects three key messages that emerged from HI leads:

- Many organisations lack the capacity and capability to undertake robust evaluation.

- It can be challenging to understand cause and effect. Evaluation is not always simple. It can be better to look at the overarching system metrics rather than the granular detail.

- There is a tendency for organisations to take a light-touch approach, partially in response to the first two points but also because of the cost implications.

The research highlighted that it is important to be aware of potential challenges associated with evaluation, such as the burden it creates in terms of time and resource spent, or that it might give the wrong answers if trying to measure long-term outcomes in a short timeframe.

Establishing a framework for evaluation

In the absence of a standardised and consistent national NHS evaluation approach, there are a number of other sources that can provide guidance on creating the right evaluation framework:

Evaluation, What to Consider - a useful summary from the Health Foundation paper on how to approach an appraisal.

Planning an evaluation: evaluation in health and wellbeing – government guidance covering similar areas.

Better Evaluation - a knowledge platform containing a library of evaluation guidance and tools.

- **Herefordshire and Worcestershire ICB** is actively using existing measures to track the impact of interventions across the system.

- **North East London** has invested in support to establish the right framework and build understanding of ‘what works’.

- **NHS Hampshire and the Isle of Wight ICB** is developing a health inequalities outcomes framework, building on the NHS England core health inequalities data set.

Monitoring

Measuring success is a core element of all transformation and change methodologies, including the NHS England Change Model. It is essential if leaders are to be able to prioritise investment and be accountable for the results.

While many measures collected and used at a national level offer a helpful perspective, in many situations there will be a need to establish and agree indicators of success at a project level. This must be done at the outset so that a baseline is established.

This will allow two questions to be asked:

Two questions to establish success

- Are we seeing the outcomes we forecast in our project charter?
- If not, why is this?

HI leads recommended short feedback loops to enable close observation and in-depth learning about the pace and extent of the impact.

Learning

Reflecting on the outcomes achieved is necessary if interventions are to evolve and improve. It is also vital where there is an intention to expand their reach over a greater geographical area, or by expanding the target population.

As part of closing any project or programme, leaders and stakeholders should consider what has been learned through the course of implementation so that lessons can be noted and plans adjusted accordingly.

Some systems are using cost benefit analysis or benefits realisation tools to inform learning.

Key questions on evaluating success

Questions for non-executive diretors

- Do the outcomes we see align to what we expected to see from our project charter?
- If we're not seeing the benefits we expected, why is this?

- Are the timescales during which we should expect to see improvement reasonable?
- Do we need to engage partners in the process of evaluation?
- How are we using the lessons learned to inform future plans?

Questions for health inequalities leads

- Do we have the capacity and capability we need to evaluate interventions?
- Are we confident that we have an evaluation approach that will allow us to understand whether the investment is adding value?
- Do the outcomes we're seeing align to what we expected to see, from the project charter
- If we’re not seeing the benefits expected, why is this?
- Can we use existing metrics to support evaluation work?
- Are we testing progress at the right level?
- Are the timescales during which we should expect to see improvement reasonable?
- Do we need to engage partners in the process of evaluation?
- How are we using the lesson learned to inform future plans?

Questions for system partners

- How can we support the evaluation process?

- Can we offer useful insights from our experience?

Contacts for more information

Contact details for more information on the examples featured on this resource.

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