NHS Confederation

Putting money where our mouth is?

Exploring health inequalities funding across systems

In partnership with

CLARITY
Making Change Happen

Research partner

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About us

NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

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About this report

This report has been produced using research commissioned by the NHS Confederation, in partnership with the Care Quality Commission and Clarity Consulting, conducted by Leeds Beckett University in 2023.

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Key points

- When integrated care system (ICS) leaders were surveyed in 2023, tackling inequalities ranked as the primary ambition leaders would like to have achieved in five years' time. Yet one in five ICSs stated that they did not feel confident in their ability to tackle inequalities, and none were 'very confident'.

- In response, the NHS Confederation, in partnership with the Care Quality Commission, Clarity Consulting and Leeds Beckett University, undertook a project to understand how systems are approaching efforts to tackle inequalities.

- The project focused on how the ringfenced health inequalities allocation was spent. Informed by interviews with health inequalities (HI) leads across England, the project explored how HI funding was allocated, the decision-making processes involved and the barriers and enablers of change.

- HI leads offered reflections on the activities the ringfenced funding has been used for and insights on the role of data and evidence as part of decision-making. They identified critical enablers of progress in tackling health inequalities, which included leadership, governance and relationships. Indeed, strong leadership was seen as a more important driver for change than ringfencing. As such, an ongoing commitment to recurrent funding in the baseline (ie not ringfenced) is helpful.

- Tackling health inequalities is a long-standing and complex challenge. Based on the insights from HI leads across the country, this report puts forward a number of recommendations – nationally and locally – to support further progress. It is accompanied by a practical toolkit, developed for system leaders across England, on how to implement high-impact changes to address health inequalities.

Background

Statutory integrated care systems (ICSs) were established in July 2022 to fulfil four core purposes, including to tackle inequalities in outcomes, experience and access. When ICS leaders were surveyed in 2023,[1] this ranked as the primary ambition system leaders would like to have achieved in five years' time. However, one in five ICSs stated that they did not feel confident in their ability to tackle inequalities, and none were 'very confident'.

To respond to this the NHS Confederation, in partnership with the Care Quality Commission, Clarity Consulting and Leeds Beckett University, undertook a project to understand how systems are approaching this purpose and to share key principles of effective working. Representatives from 36 ICSs (86 per cent of systems) volunteered to take part, and a sample of 20 were selected for interview. Discussions explored three areas:

- allocation of funding
- decision-making processes
- enablers, barriers and how to overcome challenges.

See the appendix for more information on the methodology.

This report aims to support ICSs to understand effective principles for allocating health inequalities funding, based on systems' experiences of developing strategies and plans to address inequalities. It also reflects key external obstacles in allocating funding and makes recommendations on how these can be overcome locally and at a national scale. The report is accompanied by a practical toolkit, developed for system leaders across England, on how to implement high-impact changes to address health inequalities.

This work uses the additional £200 million health inequalities allocation in 2022/23 and 2023/24[2] as a way to explore systems' approaches to addressing health inequalities. As of 2023/24, the funding for tackling healthcare inequalities was included in the NHS baseline budget.[3] As such it will increase in line with inflation but will not be ringfenced in budget allocations to systems.

While this report focuses on the £200 million funding to integrated care boards (ICBs), health inequalities is one of the factors taken into account when determining the total ICB budget allocation. The focus on this £200 million provides an insight into how ICBs approach tackling health inequalities.

This project was instigated after independent analysis of the three ICSs in Yorkshire showed significantly different approaches to how this funding was used in 2022/23.[4] These ranged from supporting a range of strategic place-level programmes through to using all the funding to meet general financial challenges in the ICS. This analysis was presented to the NHS Confederation's ICS Health Inequalities Reference Group, which requested a review to understand the approaches taken across the whole of England.

It is important that local health systems are able to learn from each other

It was considered probable that the variation in approaches identified in Yorkshire was replicated across England. If action on health inequalities is to be sustained and have a significant impact, it is important that local health systems are able to learn from other systems how funding can be used most effectively.

As spending is the responsibility of the ICB, this project interviewed health inequalities leads from integrated care boards and focuses on the role of the ICB. This happens in tandem with integrated care partnership (ICP), local authority and place and neighbourhood level activity, all of which is crucial to addressing health inequalities.

To explore the role of the ICP further, please see Integrated Care Partnerships: Driving the Future Vision for Health and Care.

For insights on the relationship between local public health teams and ICBs, please read NHS England's Delivering a Quality Public Health Function in Integrated Care Boards.

Context

It is important to recognise the following factors when considering how ICBs are responding to the challenge of improving the way in which health and care systems take action to address health inequalities.

First, as the Institute of Health Equity notes in its 2020 report, since 2010, life expectancy in England has stalled and inequalities in life expectancy have increased. Among women in the most deprived decile, life expectancy fell between 2010-12 and 2016-18. Inequalities in healthy life expectancy also fell, meaning that people in more deprived areas spend more of their shorter lives in ill health. Large government funding cuts have affected the social determinants of health across the whole of England, but more deprived areas experienced larger cuts.[5]

Second, ICSs are comparatively new. They were legally established in July 2022, with reducing health inequalities as one of their four statutory purposes. While many ICSs have been able to build on the relationships developed by previous structures, others have been less able to do this. This has particular implications for work on health inequalities as long-term trusted relationships with communities and places experiencing health inequalities are particularly important with regard to building and maintaining momentum.[6]

Third, in 2022/23 the NHS faced significant short- and long-term financial pressures against the backdrop of recovering from the impact of the COVID-19 pandemic. Other very challenging issues continue, including ongoing industrial action.

Fourth, in ICS's second year there have been further pressures, including the announcement of a 30 per cent reduction in running costs allowances commencing in the financial year 2023/24,[7] followed by a letter in November 2023 requiring ICBs to achieve balance for that financial year.[8] This reduction in management funding combined with resulting organisational changes created further challenges with regard to the use of funds, such as the health inequalities funding allocations, and other funds such as the winter social care fund, for their original purposes.

Finally, consideration of actions taken by ICBs to address inequalities needs to recognise not just the complexity of addressing this wicked issue[9] but also that the NHS is operating in an environment where there has not been a cross-government health inequalities strategy since 2010.[10] The impact of this has been compounded by constrained funding, which has impacted particularly on local government, but also on the NHS itself by increasing demand exacerbated by people's declining living and working conditions across society.[11] A government white paper on health disparities was due for publication in 2022, before being shelved in 2023, and replaced by the major conditions strategy, due for publication in 2024. Health inequalities is expected to feature as an underpinning issue in the major conditions strategy, but is not the strategy's core focus.

There has not been a cross-government health inequalities strategy since 2010

Insights from health inequalities leads

Allocation of funding

Interviewees were asked the following questions:

On what theoretical, conceptual or other basis were decisions about the allocation of health inequalities funding made?

- What is the ambition behind them?
- Was a theory of change or conceptual framework used?
- What was the evidence behind the decision?

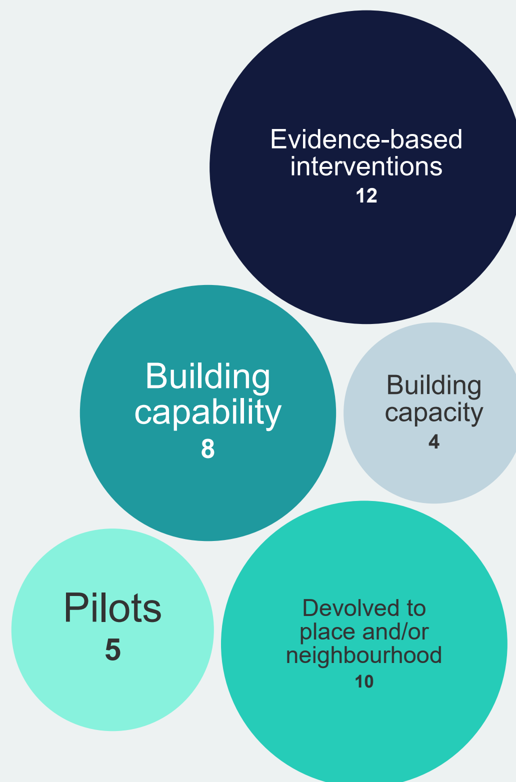
The interviews revealed wide variation in how the share of the £200 million health inequalities funding was used by systems (see figure 1), with some systems setting out principles around how they would use the money:

> "We've defined a set of principles around what this money is for. It's not for core service delivery: it's for catalytic innovation around quality improvement around certain things."
>
> Health inequalities lead; large, more rural system

This is not surprising. Guidance to support the development of ICBs' Joint Forward Plans (JFPs) was produced by NHS England in December 2022[12] – four months after ICBs were legally established. JFPs are the overarching plans that set out each ICB's priorities and actions. NHS England's guidance was released in December with the expectation that inaugural JFPs would be produced by 1 April 2023, outlining ICBs' plans for 2023/24.

In effect this meant that each new ICB was working without an explicit forward plan for the financial year 2022/23, while undertaking work to create one. As such they were basing decisions on existing data and plans, such as those developed by sustainability and transformation partnerships or clinical commissioning groups and local health and wellbeing boards.

Figure 1: What activities did systems spend their health inequalities allocations on?



*Figures denote number of systems

Pilots

A number of interviewees described how they had used some of the health inequalities funding to commission pilot programmes. These tended to be focused on issues faced by specific services or community groups. For some systems, funding pilots resulted in further funding being secured. For example, when pilots generated evaluation data, this was used to present the case for further funding.

Examples of ICB-commissioned pilots using ringfenced health inequalities funding

- **Large mixed (urban and rural) system**: Improving attendance at general practice diabetes clinics in areas with culturally diverse communities. Piloting approaches that are sensitised to different cultures.

- **Large mixed (urban and rural) system**: Working with Barnardo's and the Institute for Health Equity on the mental health and wellbeing of children. Speaking with 300 young people to make sure that their experience informs the work with a focus on emotional wellbeing and self-harm.

- **Very large urban system**: Allocating funding so that GPs can offer some longer health check appointments, to provide a more in-depth opportunity to explore the issues that are causing people concern about their health.

- **Very large urban system**: Giving community pharmacies additional funding for families who are below the statutory thresholds access to free prescriptions.

- **Large mixed (urban and rural) system**: Giving some funding to places to create warm spaces during cold weather. Warm spaces are there for people to keep warm and also act as a hub where attendees can be referred to mental health and cost-of-living support.

While some systems embraced the opportunity to test novel approaches to targeting funds at specific issues, other interviewees noted that following engagement with local communities, they had decided against trialing pilots.

> "We're not going to do a six-month project because our community tell us time and time again we need longer-term [projects] and if not, at least something different aligned to our key health inequality areas."
>
> Health inequalities lead; large urban system

Building capacity and capability

It is often said that health inequalities is, or ought to be, a golden thread throughout all activities of an ICS. A number of ICBs identified that if health inequalities is to be 'everyone's business',[13] then at this stage of system maturity, attention and investment need to focus on building **capacity** and **capability** within the system.

Systems that took this approach focused on building the capacity of the health inequalities team within the ICB, and/or building health inequalities capability (the understanding and skills) of colleagues from across the ICS.

1. Capacity of ICB health inequalities team

Examples of capacity-building activity included investing between 8 and 15 per cent of the ringfenced funding to employ more central staff to monitor and support health inequalities actions across all aspects of the system's activity, as outlined in their Joint Forward Plan (from 2023/24 onwards), with a particular focus on areas where more development was possible, such as the acute sector, and new areas of responsibility, such as dentistry, pharmacy and optometry.

Other examples included building capacity to improve data management and analysis across the health and care system with regard to health inequalities.

2. Capability in the system

It was clear that there is variation in how health inequalities is interpreted within ICBs.[14] Generally, the Core20PLUS5 framework is considered to be helpful.

For example:

- Is the ICB primarily concerned with health service provision, quality and access with regard to health inequalities?
- Does good practice involve considering how health system activity is integrated with wider prevention activity?
- Are there areas where the ICB has a direct responsibility for prevention?

While strategies for change are system specific, it would be worth considering which actions and strategies are necessary or are the most impactful to action on health inequality in systems. There were different views about where the focus should be: on healthcare inequalities or on health inequalities more generally. While the NHS Core20PLUS5 framework was considered "medical, and that's OK because it is healthcare inequalities and it says what is on the tin", as one health inequalities lead put it, some ICBs felt that greater attention needed to be given to the social determinants of health and on working with system partners to address health inequalities in a broader sense. Systems that focused on addressing health inequalities in a broader sense tended to devolve the funding to place through initiatives such as warm hubs.

A number of interviewees were concerned that health inequalities could not be a golden thread across the system because the system did not have a shared understanding of health inequalities, in terms of what actions health services could take. To address this, many made a decision to invest in establishing learning networks to build capability and understanding, in effect creating a cadre of experts in different parts of the health and care system. Some of these pre date the ringfenced health inequalities funds, so the investment was used to develop the existing offer.

These expert and peer learning structures included:

- **The development (and in some cases development and evaluation) of a system health equity strategy**, using funding to collaborate with external experts such as universities, the Institute for Healthcare Improvement, the King's Fund, 'deep end' networks and the Institute of Health Equity. This supports health inequalities leads and relevant colleagues in the ICS to learn from and work with external experts to build their own capability.

- **Strengthening the primary care offer through establishing and supporting 'deep end' networks to do research into their own impact on health inequalities and lobby for additional support and resources**. 'Deep end' is a term used to denote the primary care practices that serve 'areas of blanket deprivation with high proportions of patients living in the 15 per cent most deprived local areas'.[15] This research activity was sometimes linked with local health innovation networks[16] to strengthen evaluation and demonstrate return on investment.

- **Establishing a population health academy**[17,18,19] to support staff to learn about health inequalities and the role of system partners, such as those in the voluntary, community and social enterprise (VCSE) sector. Some academies or learning networks targeted the intake at specific parts of the health and care system such as the VCSE, primary care, nursing staff or managers.

- **Establishing leadership development programmes to support the career development of ethnically diverse staff within the system**.[20]

Devolving to place and neighbourhood

Many ICBs devolved all or the majority of the health inequalities funding to place, and some ICBs devolved the funding to primary care or neighbourhood level (local authorities, primary care and the VCSE sector). In some systems, dividing the funding between places in the system's footprint was done according to a formula which sought to take account of deprivation and population size, and in other cases the funding was shared equally across all places.

Once the funding was devolved to place, it was often then devolved further. Approaches to enable access to the funding varied from competitive bidding rounds to allocating funds to specific groups or organisations.

> "What we're planning is that the work we want to focus on will be very much about that very local community work. It will be informed by the data – deprivation, areas of geography where we know there are people who are more at risk of hypertension. We're looking to work with workplaces and employers that we know employ people that are in lower socioeconomic groups, like the migrant worker population. We're tying it up with our resettlement programme as well."
>
> Health inequalities lead; small, more rural system

ICBs that devolved the funds varied with regard to the requirements they placed on where the funding should be targeted and how recipients should report back about their use of the funds. Some of the characteristics (these are not mutually exclusive) that describe their approach included:

- Placing no specific requirements except that it should be used to **build on existing health inequalities priorities**, as set nationally, or by the system or place. For example, some systems indicated that the funding needed to be used in accordance with the Core20PLUS5 approach (national health inequalities priorities).
- **Involving directors of public health** in the decision-making.
- **Targeting the most deprived communities** specifically. In some cases this was through the local authority/ies, in others, this was by making funding available to the primary care networks (PCNs) serving the most disadvantaged communities. In others this was through ensuring that 'Core20' communities (the most deprived 20 per cent of the national population according to the Index of Multiple Deprivation) received 80 per cent of the funding, with the remaining 20 per cent made available for bids from local stakeholders including PCNs and the VCSE.
- **Prioritising funding the VCSE sector**.

It was recognised that in some cases this funding was used to cover gaps in existing services for the most vulnerable groups at risk of poor health (for example homelessness) rather than innovation (such as creating new services).

Some felt that one of the significant benefits of devolving the funding to place or neighbourhood level was to build relationships and facilitate partnerships with system partners, in particular local authorities and the VCSE sector. This was seen as particularly

important given that ICSs are recent structures that rely on meaningful relationships between all of the organisations that form the system. Using the funding in this way was seen as helping to promote dialogue through establishing critical friend relationships (rather than performance management), bringing the learning and discussion into the ICB.

> "The idea was that the money was transformational. It brought people together. It gave you a more holistic view of what the challenge was, made partners work together, broke some barriers down, brought people together."
>
> Health inequalities lead; large, more rural system

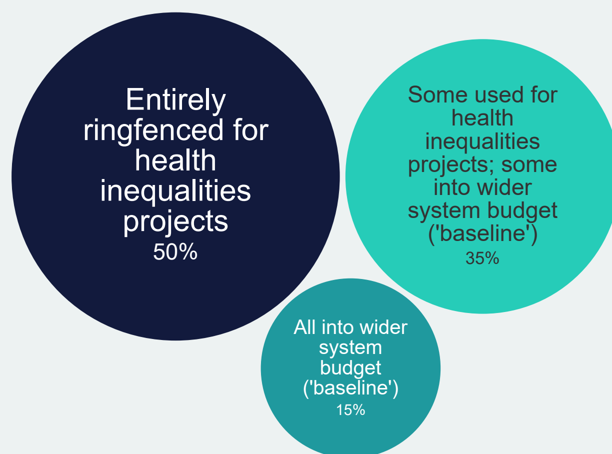
Devolving health inequalities funding to place was associated with a focus on the social determinants of health, rather than medical or healthcare interventions. For example, an ICB described how it had invested in a warm hub initiative in one of its local authority areas:

> "The place stuff, by working with communities and things, gives the opportunity for the NHS to realise its medical model does not work for most of what drives the improvement in health outcomes… It needs to work with others on that wider social model if it's really going to improve health outcomes and create and sustain the ability for the health services to cope with what is coming through the door in terms of health."
>
> Health inequalities lead; large, more rural system

Ringfencing

Almost all ICBs used all or some of the health inequalities (HI) allocation for its intended purpose (see figure 2), with half of systems interviewed ringfencing the allocation in its entirety. Seven systems put some of the allocation into health inequalities projects and some into the wider system budget, and three systems put all of the allocation into the wider system budget (this was referred to as the 'baseline').

Figure 2: Was the health inequalities funding allocation ringfenced by systems?



*Figures denote percentage of systems that identified that option

In 2022/23, the health inequalities allocation was officially a ringfenced funding allocation of £200 million, divided between systems using the health inequalities and unmet need adjustment.[21] From 2023/4, this funding was included in the NHS baseline budget allocations, which means that it will increase in line with inflation but will not be ringfenced in the allocations to systems.[22] In practice, ten ICBs interviewed treated this funding as ringfenced in 2022/23 and have continued to do so in subsequent years, while other systems did not.

> “We’ve done quite well at not getting it raided in the way some systems have, I’ll put it that way.”
>
> Health inequalities lead; large, more rural system

> “I came in and half [of the ring-fenced funding] was essentially taken into the baseline.”
>
> Health inequalities lead; large, more rural system

While in most cases the health inequalities lead was aware of the funding allocation and actively involved in how it was used, a small number of HI leads were not aware of the allocation, its size or how it was to be used. There were some cases where the HI lead had not been involved in the decision to use the funding to address deficits elsewhere in the system – usually acute or elective hospital care. This may reflect the short time that ICSs have been in existence and/or the date that some health inequalities posts were established, which may have resulted in limited opportunities to engage in decision-making when the HI funding was first announced. Generally, health inequalities leads noted that this decision was made within the context of ICBs facing significant financial pressures.

Decision-making processes

Interviewees were asked the following questions:

What were the decision-making processes involved in the allocation of the health inequalities funding for 2022-2024?

- What were/are the processes involved in decision-making?
- Who was/is involved?
- How transparent are these processes? How accountable?

- Are decisions made by individuals or boards? What is the role of the ICB/ICS in this process?
- How are the decisions then implemented? What is that process? How transparent is it?
- What did you measure (including impact on health inequalities)?

Evidence and data

Most interviewees talked about the role that evidence had played in decision-making around the allocation of health inequalities funding. These fell into three main categories:

- use of existing population-level data to inform allocation according to need

- drawing on existing evidence of what works to reduce health inequalities and/or improve health for those in the poorest health

- developing new evidence as part of pilot studies or experiments where the allocation of health inequalities funding was either given to new interventions or used to evaluate existing interventions.

1. Use of data to inform decision-making

Interviewees mentioned using existing data to make some commissioning decisions, or work to strengthen and broaden data sets. This included population-level data on health conditions, service use, deprivation and other relevant metrics, which was used to inform decisions about how to allocate health inequalities funding.

> "We're working on a data hub that will provide valuable insights because some of it could be population health level, but some of it we actually need to drill down to

> primary care data as to who people are and where we will find them, support and improve those outcomes and to be able to reach, with interventions and access, health and care service."
>
> Health inequalities lead; large, more rural system

Some used existing data analysis such as Joint Strategic Needs Assessments[23] to inform the decision-making process, while others developed new datasets and dashboards. These datasets and dashboards were created by putting resource into external partnerships with universities and other organisations. These tools were then used to monitor impact and evaluate effectiveness of the funding. Others used the health inequalities funding to put extra resource into data functions, creating posts for statisticians and data analysts, and training staff and other stakeholders to use these effectively.

> "One of the indicators based on household poverty isn't collected nationally anymore. So one of the tasks I've set is 'can we get some more sort of proxy indicators like; what can we measure a little bit more frequently?' [To see] if we're on the right lines, on the right way to make a shift in the [...] indicators that we've got. So that's how we're going to measure kind of success. But as you know, changing inequalities doesn't happen overnight."
>
> Health inequalities lead; very large, more urban system

A few participants mentioned their ICB having used NHS England's place-based allocation tool to determine how the HI funding was allocated.[24] In some ICBs, data on needs and preferences of the public was also collected as a complementary part of this process, using stakeholder surveys and, less often, community outreach and participation to gather views.

> “And then we’ve also got some data now from [redacted]. So we’ve got a programme where we’re gathering insights from communities into a data bank. [...] We’re doing that through community connectors, having conversations with people in communities.”
>
> Health inequalities lead; large, more rural system

2. Drawing on existing evidence of what works

Most ICBs had processes for determining what kinds of interventions might work to reduce health inequalities, although these processes were not uniform and not always transparent to wider stakeholders and the public. Evidence from Prof Sir 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.

Guidance on what works also came from learning networks with other ICBs, primary care organisations and places that had tackled similar issues.

> “So I’m I think there’s something interesting there about making better use of our places like [redacted place names] – developing a better relationship with [them] and doing a lot more work with them, with primary care, which is really interesting. Particularly trying to invest in the health inequalities fellowships programmes and really trying to think about that like drawing on lots of work the whole system have done.”
>
> Health inequalities lead; large, more rural system

3. Developing new evidence

New evidence was generated in the form of routine data monitoring or evaluations of new projects supported by the HI funding, either carried out by the ICB or contracted out to external partners. Some ICBs invested in staff training on how to conduct evaluations and monitor impact, and some carried out community outreach.

Evaluation was also carried out on the impact of the funding as a whole for the system, whether this was towards projects and interventions or towards building capacity or strengthening relationships at place or system level.

> “We’ve identified a pot of money as part of the health inequalities fund to support evaluation. But that’s evaluation of the fund itself. So how is the fund itself having an impact on health inequalities? Does the process support what we need to in relation to having that impact on health inequalities? How do we have a framework for evaluating going forwards as well as the evaluation of the individual schemes themselves? We hope there’s been learning about the process itself. How do we give people enough time to have the conversations that they need to across the system, but then also to build in the co-production element.”
>
> Health inequalities lead; large mixed (urban and rural) system

Many of those interviewed saw this first year as a pilot stage in terms of their approach to tackling health inequalities, and built in evaluation and monitoring of their activities to inform the system’s future allocation of larger amounts of funding to tackle health inequalities. They were of the view that it was as important to learn about what did not work as much as what did work. This was sometimes referred to as a quality improvement approach.

> “Health inequality, it’s about testing, learning, experimentation, exploration, learning. There’s no failure. It’s about what did we learn from that, what we’ll do next time and so on, and adaptation and reflection.”
>
> Health inequalities lead; large, more rural system

Some noted that it was 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 it tries to measure long-term outcomes in a short timeframe.

> “I think there’s a risk there in terms of the evaluation always with these kind of pieces of work, that actually the timescales for the funding are too short have the impact we’d like to see on population health.”
>
> Health inequalities lead; very large, more urban system

Enablers, barriers and how to overcome challenges

Interviewees were asked the following questions:

What facilitating factors have enabled ICSs to progress action on health inequalities?

- What factors have held ICSs back?
- And how have they overcome these barriers?

The responses can be broadly categorised into leadership, governance, subsidiarity and relationships.

Leadership

The importance of strong and engaged leadership at the top of the organisation was highlighted by many interviewees. One of the challenges identified by many s was how to move the health inequalities agenda into mainstream strategic actions in the ICB. Many interviewees mentioned the importance of leadership at the top of the ICB to achieve this, with key players being the chief executive, deputy chief executive, finance director and chair. This leadership gave health inequalities leads the mandate to raise the profile of actions on health inequalities within the ICB and was linked to longer-term commitments to health inequalities interventions.

In the same vein, a smaller number of interviewees noted that when the finance director was not supportive, this was a barrier to accessing the health inequalities funding.

> "There is something fairly powerful about the visibility of inequalities in our system. Our chief executive calls it the 'north star' all the time."
>
> Health inequalities lead; very large, more rural system

> "It's really helpful having the director of finance sitting on the population health transformation board; we've had many conversations."
>
> Health inequalities lead; small, more rural system

Governance

Many ICBs have created new structures focused on health inequalities as part of the governance of the system and these were generally considered to be a helpful mechanism to raise the agenda of health inequalities with the ICB and ICP leadership.

Committees that were specifically responsible for health inequalities strategy and actions were mentioned often in the interviews. Examples included health inequalities committees, population health and integration committees, health and equalities boards, and prevention, population health management and health inequalities groups. Most had a membership that included representation from the integrated care partnership, for example local authorities, usually the director of public health. In many cases these structures were chaired by a director or a non-executive director (NED) of the ICB, with a reporting line direct to the ICB board.

> "The governance within the ICB is that there are committees that have been set up to provide that assurance and health inequalities fits under a health inequalities prevention committee."
>
> Health inequalities lead; very large, mixed (urban and rural) system

As part of the work to establish ICBs' new governance structures since their establishment, most have created structures that enable them to develop and take forward system-level actions to address health inequalities specifically.

Addressing health inequalities requires strategic whole-system action, and a number of interviewees noted the importance of cultural change that placed health inequalities more centrally within the governance structures of the ICB. The creation of specific committees and work groups responsible for developing

strategic approaches for addressing inequalities, with direct lines of reporting into the board, was a key enabler to action on health inequalities. 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.

Relationships within the ICS and with communities

Several interviewees described how they used their influencing and negotiating skills within their networks and with senior officers to influence for change.

> "It's a system leadership executive… the director of finance, our chief executive, our place-based leads because that's the highest group… I had numerous one-to-one discussions with everyone to make sure that they were on board. So when it went to the executive group it was really easy: a ten-minute discussion and it's passed. But that's what we mean with the system leadership executive system – leadership!"
>
> Health inequalities lead; very large, more urban system

As well as relationship building within the ICB, some interviewees described work to strengthen the voice of people and communities experiencing health inequalities. Examples included:

Large mixed (urban and rural) system: Working with Barnardo's and the Institute for Health Equity on the mental health and wellbeing of children. Speaking with 300 young people to make sure that their experience informs the work with a focus on emotional wellbeing and self-harm.

Very large more urban system: The creation of an inequalities and involvement committee as part of the ICB that aims to bring the voice of marginalised communities into discussion and planning.

> "How do we give people enough time to have the conversations they need to across the system, but then also to build in the co-production element?"
>
> Health inequalities lead; large mixed (urban and rural) system

The role of the national health and care policy

A number of interviewees highlighted the dissonance between NHS England's 'must do' priorities and local system work on their statutory purpose of tackling health inequalities. They reported feeling that NHS England's 'must do' priorities favour short-term operational issues such as achieving financial balance and reducing waiting times, at the expense of longer-term strategic goals such as tackling health inequalities. It should be noted, however, that these priorities are ultimately decided by targets set by the government.

This is perhaps due to the broader political context. While national policies seem to be moving in the direction of giving more weight to locally set priorities (as confirmed in the government's response to the Hewitt review),[25] in practice NHS England's oversight of systems remains focused on the short-term and acute issues. Each year, the government sets a mandate to NHS England which sets

out key objectives for the service to deliver that year. In line with the recommendations of the Hewitt review,[26] the mandate set in 2023[27] contained a reduced number of nationally-set targets,[28] with the intention of allowing local systems the freedom and flexibility to deliver their statutory purposes (including tackling inequalities) according to the local context. There was also a positive move in the planning guidance signalling the importance of inequalities work.[29]

Despite this, in practice, the pressure on NHS England to report on performance and operational improvement from the government exchanges between the centre and ICS leaders remain overwhelmingly focused on short-term priorities. One example of this is a letter sent to systems in November 2023 by NHS England's chief financial officer, interim chief operating officer, national medical director and chief nursing officer, asking systems to complete a 'rapid two-week exercise' to outline their plan to achieve financial balance by the end of the financial year.[30] This led to some ICBs reporting that they felt it was a fight to keep health inequalities as a priority against the focus given by NHS England on short-term operational issues.

These short-term issues, particularly when enforced through rapid 'must do' letters, were felt to cut across and unbalance the ICB work to address health inequalities. Several interviewees stated that work on addressing health inequalities is complex and long term, and this does not fit with government, and by extension NHS England's, requirements to make short-term financial decisions to balance budgets before year end.

Embedding addressing inequalities as a golden thread in everything the system does would mean moving away from seeing these priorities in siloes and instead tackling waiting times (for example), through the lens of inequalities.

> "I think the challenge we have is how do you ensure that it doesn't get diluted or it doesn't get overridden by the here and now issues which the NHS is very good at; that command and control. 'Can you tell me how many ambulances are waiting outside the hospital? How many people are waiting for hip operations?' So it's trying to break into that and say absolutely we need to do that, but while we're doing that, let's be mindful that the people who are more likely to not access services, more likely to receive poor care, are people from the deprived, disadvantaged communities."
>
> Health inequalities lead; very large, mixed (urban and rural) system

While the dominant narrative in NHS England is focused on short-term operational issues including service performance and financial balance, interviewees recognised and appreciated the work of the NHS England National Healthcare Inequalities Improvement Programme, and particularly the Core20PLUS5 approach. It was widely recognised by ICBs that the health inequalities fund from NHS England was a useful lever that helped to "mobilise conversations around health inequalities" (health inequalities lead, large mixed [urban and rural] system).

However, there was concern that other NHS England initiatives needed to go further to embed health inequalities.

> "Can we make sure that the health inequalities agenda is actually embedded within the NHS IMPACT approach? Otherwise again, we'll lose all this great learning that we've got. We're stuck in 'pilot-itis' is how I call it. We have great examples but they never become mainstreamed."
>
> Health inequalities lead; large, more urban system

NHS IMPACT (Improving Patient Care Together) was launched in April 2023 as a national initiative intended to be a 'single, shared NHS improvement approach'.[31] This interviewee identifies the opportunity presented here to mainstream action on health inequalities through ensuring that it is embedded in central policies. Currently, the approach outlined by NHS IMPACT does not explicitly mention health inequalities.

Conclusion and recommendations

This research took place between September and November 2023 when ICBs were still relatively new, having to make running cost allowance savings and working within a health and care system under immense pressure. It focused primarily on how the ringfenced health inequalities allocation was spent in this first year. This was a moment in time and represents a starting point for further action in future years. Year one was particularly turbulent, not least as the first Joint Forward Plan was only produced for the subsequent year. For those initiatives that were commissioned in year one and in year two, it is far too early to test whether they had an impact on population health inequalities. However, it has provided useful insights into the approaches that ICBs are taking to addressing health inequalities.

Although some health inequalities leads indicated that a ringfenced health inequalities budget would be helpful, it is clear from our research that the ringfence put in place in the first year of health inequalities funding was not the crucial enabler for a significant number of ICBs (and there are cumulative drawbacks of centrally ringfencing funds to ICSs). Other factors such as pressure to achieve financial balance coming from NHS England oversight can take precedence over even ringfenced funds.

Strong leadership seems to be a more important driver than ringfencing

In addition, when there was a visionary leadership commitment to tackling inequalities within the ICB, this funding was more likely to be used for its original purpose and commitments made for future years. This strong leadership seems to be a more important driver than ringfencing. As such, the ongoing commitment to recurrent funding to address health inequalities in the baseline

(not ringfenced) is helpful. A number of ICB health inequalities leads indicated that they had been able to use this to commit to programmes that were longer than one financial year.

This research found that **leadership**, **governance** and **relationships** were enablers for success in health inequalities. The biggest barrier that systems reported overcoming was balancing long-term strategic priorities with short-term operational must-dos.

The health inequalities leads we spoke to were determined to develop meaningful programmes of action to address health inequalities in ICSs. Addressing health inequalities coherently is challenging both because of its complexity and because this is an area that successive governments have been reluctant to address explicitly.

Recommendations

For government

Tackling health inequalities is a long-standing and complex challenge that is in significant part affected by government socio-economic policies: 80 per cent of what affects our health outcomes comes from outside of the health system. This means that local health and care systems are working to determine what they can reasonably do to reduce health inequalities within a wider context, where there has not been a cross-government health inequalities strategy since 2010.

To support the work of local health and care systems in tackling health inequalities, central government should:

- **lead the development of a cross-government strategy to reduce health inequalities**. We are calling for this alongside the 250 other members of the Inequalities in Health Alliance, convened by the Royal College of Physicians.

- **lead a cross-government national mission for health improvement**, led by the Prime Minister, and set up a sub-cabinet committee responsible for this mission. The government should introduce new criteria in the Treasury's green book assessing the impact of spending decisions on the health of the nation. This will ensure that the physical and mental health implications of all government policy are undertaken as part of the broader impact assessment process.

- **have a view to the longer-term vision of integrated care when setting national targets to the health service**, and therefore ensure that national priorities and targets are aligned with all four core purposes of integrated care systems.

For national regulators

This research has shown how central oversight can destabilise the work of systems when it is not aligned with all four core purposes of integrated care systems. National regulators, including the Care Quality Commission (CQC) and NHS England, can play a key role in this, by:

- **ensuring that oversight of integrated care systems incentivises systems to focus on reducing health inequalities**, as one of their four core purposes. This would realise the Hewitt review recommendation that the CQC considers, as part of its assessment of ICSs, 'how far the system is making progress in shifting resources towards prevention, population health and tackling health inequalities'.

- **supporting the sharing of good practice** by emphasising areas of progress towards tackling health inequalities in assessment reports and publications, including the CQC's annual State of Care report.

For NHS England

Embed health inequalities in all activities, by:

- **ensuring that executive team requests of systems are compatible with the long-term strategic vision** for systems of improving population health and tackling inequalities
- **ensuring that central initiatives, such as NHS IMPACT, align with the statutory purposes of ICSs**, including tackling inequalities
- **continuing the work of NHS England's National Healthcare Inequalities Improvement Programme** and embedding the inequalities approach across all NHS England activity.

For integrated care systems

- **Use our toolkit**: This report was created as a response to ICS leaders requesting the opportunity to learn from each other's approaches to tackling inequalities. To support them to embed the learning from this report we have developed a toolkit: How to embed action on health inequalities into integrated care systems is available on the NHS Confederation website and draws upon the research and interviews. It outlines a quality improvement approach to embedding addressing inequalities into system working and has been coproduced with 36 ICSs.
- **Access peer support**: There is a significant amount of good practice emerging within ICBs. Going forward it will be important to continue to provide spaces where systems and partners have an opportunity to share concerns and successes and for these to be used to drive further development. The NHS Confederation convenes a number of peer-support forums, which include:

- NHS Confederation's ICS Health Inequalities Reference Group (bi-monthly meetings of a closed group of ICS chief executives, chairs, non-executive directors and system health inequalities leads).
- NHS Confederation's EDI Reference Group (quarterly meetings of a closed group of chief executives and chairs of NHS trusts, systems and national bodies).
- the NHS Confederation, Local Government Association and Association of Directors of Public Health's Public Health and Integrated Care Systems Forum, bringing together national and local public health functions.

These networks, with their specific focus on inequalities and EDI, also connect with a wider range of networks that include those for ICB non-executive directors, ICB chairs, place leaders, ICP chairs and system improvement leads.

Please get in touch with office.icsnetwork@nhsconfed.org if you would like to learn more or get involved with these forums.

Appendix: methodology

Leeds Beckett University's Centre for Health Promotion Research undertook a qualitative review based on 20 hour-long, semi-structured interviews with nominated ICB health inequalities leads from a purposive maximum variation sample of 20 systems. This report is based on analysis of the transcripts of these interviews, which took place from September to November 2023.

The research aimed to answer the following research questions:

1. On what theoretical, conceptual or other basis were decisions about allocation of the health inequalities funding made?

- What is the ambition behind them?
- Was a theory of change or conceptual framework used?
- What was the evidence behind the decision?

2. What were the decision-making processes involved in the allocation of the health inequalities funding for 2022-24?

- What were/are the processes involved in decision making?
- Who was/is involved (to include social care and the VCS)?
- How transparent are these processes? How accountable?
- Are decisions made by individuals or boards? What is the role of the ICB/ICS in this process?
- How are the decisions then implemented? What is that process? How transparent etc.?
- What did you measure (including impact on health inequalities)?

3. What facilitating factors have enabled ICSs to progress action on health inequalities, what factors have held them back, and how have they overcome these barriers?

The research was approved by the Leeds Beckett University (LBU) research ethics coordinator.

Recruitment was coordinated via the NHS Confederation, which invited all ICS health inequalities leads or senior responsible officers to take part in an online or telephone interview with the LBU research team. Participant information sheets were distributed by email as part of this process.

Representatives from 36 ICS (86 per cent) volunteered to take part, and a purposive maximum variation sample of 20 were selected for interview, using a sampling frame based on geographic region[32]; population size[33]; number of local authorities[34]; Health Index Aggregated and Avoidable Mortality scores; inequalities ranking[35]; NHS System Oversight Framework[36] (SOF) ranking; and whether areas were urban, rural or coastal.

Semi-structured interview schedules were developed that aligned to the research questions. Selected ICS participants were contacted by the LBU researchers and informed consent collected. The LBU researcher read the existing Joint Forward Plan before carrying out the interviews. Semi-structured online interviews were carried out, recorded and transcribed using MS Teams. Transcripts were checked for accuracy by the research team, and thematic analysis (Braun and Clarke, 2006[37]) was carried out using NVivo software. This involved line-by-line coding, generation and refinement of a coding framework and thematic categories by discussion.

Interim findings were presented and discussed at four online workshops, with invitations extended to all ICBs. The workshops were used to test and broaden the initial findings from the interviews.

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