NIHR Policy Research Unit in Health and Social Care Systems and Commissioning

Tackling health inequalities: the role and potential impact of Integrated Care Systems

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Executive Summary

Introduction

The Health and Care Act (2022) introduced Integrated Care Systems (ICS) into the English NHS on a statutory basis from 1st July 2022. ICSs are made up of partnerships of organisations including: healthcare commissioners; providers; local government; and voluntary and charitable sector organisations. ICSs comprise of different geographical spatial levels including System, Place (usually aligned to Local Authority boundaries) and Neighbourhoods (Primary Care Networks). Each ICS has an Integrated Care Board (ICB) formally responsible for meeting the health care needs of their local population and an Integrated Care Partnership (ICP) responsible for creating the strategy for the ICB to deliver.

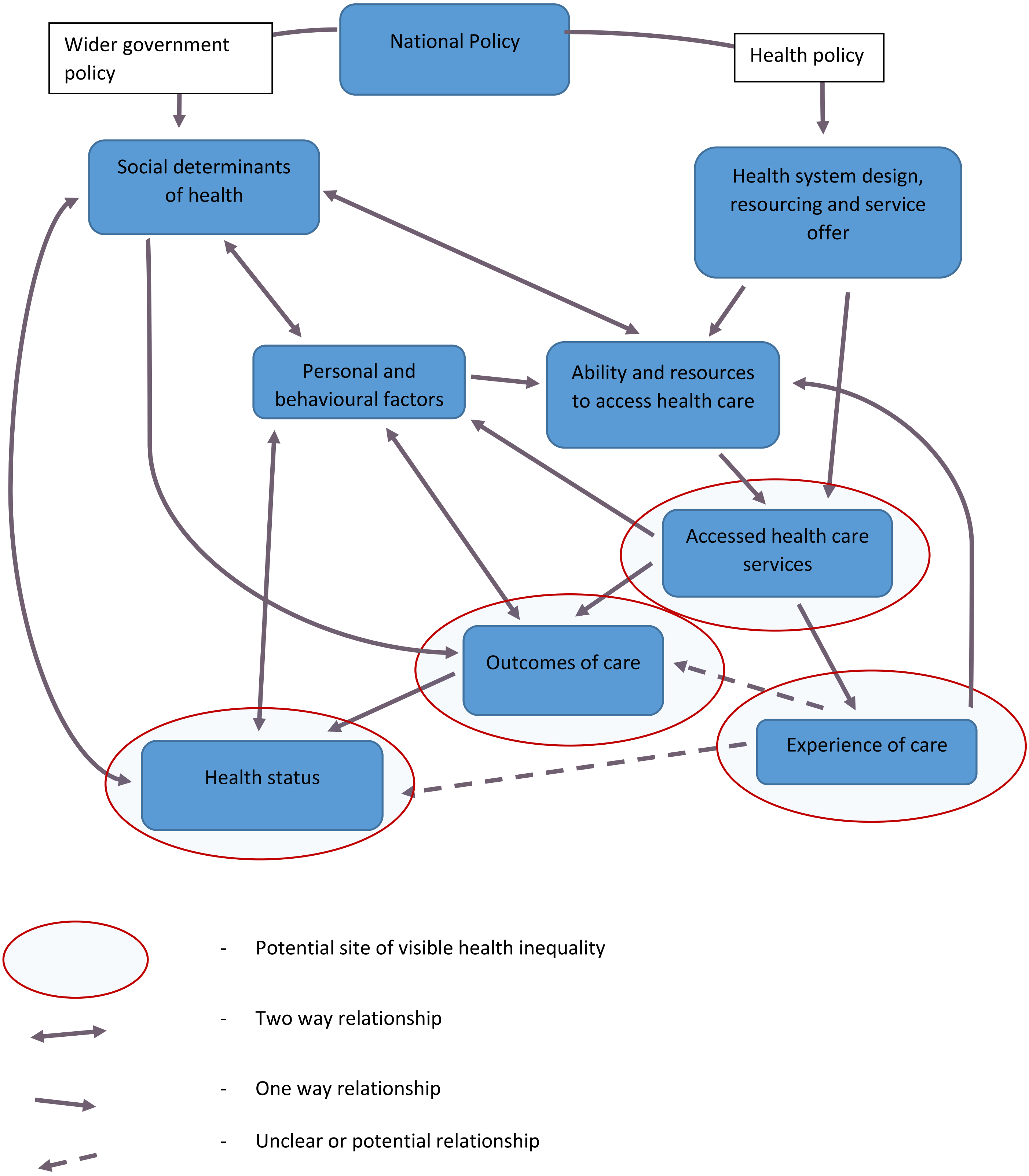
ICBs have a number of formal responsibilities, and two of these explicitly focus upon health inequalities, with ICBs required to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, access and experience

The responsibility to tackle health inequalities is a statutory one, formalised in the Health and Care Act 2022. This is not new; the Health and Social Care Act (2012), also placed a statutory duty on newly forming Clinical Commissioning Groups (CCGs) to tackle health inequalities, although research demonstrated that progress in this regard was limited (Warwick-Giles et. al. 2017).

There is a significant academic literature devoted to health inequalities, with much of the literature focussing on the broader societal factors that shape health on an individual or group level (Marmot 2010). In exploring the role of ICSs in tackling health inequalities, we drew upon a synthesis of the literature which emphasises the interlinkages between underlying causes of inequalities and the different ways in which inequalities might be manifest (figure (i)). This was used to shape project design and data analysis, supporting clarity around where and how ICSs might be expected to be able to influence particular types of inequalities. In addition, we considered the different geographies and priority groups which might be selected for focus.

Figure (i): Schematic representation of possible relationships between different factors influencing health inequalities and different types of inequalities



Aims, Objectives and Research Questions

Aim:

To provide evidence to inform policy makers as they design policies and mechanisms to support ICSs respond to their statutory duty to address health inequalities.

Research objectives:

1. to characterise approaches to tackling health inequalities in developing ICSs and identify what information ICSs use to guide their inequalities work
2. to understand the factors affecting how health inequalities are perceived, including national policies (including targets and standards), internal ICS organisation and governance, the role of individuals and relationships with Local Authorities
3. to explore how perceptions of important health inequalities are translated into plans of action, and the factors affecting this
4. to investigate what progress ICSs might be expected to make in short-term indicators of addressing inequalities, including budgets and access and establish potential indicators for routine monitoring in the longer term.
5. to consider how national policy might best support ICS action on health inequalities

Research Questions:

1. *Understanding health inequalities:*

a) How are health inequalities defined within national policy, and how is it intended that the new system will support action in this regard?
b) How do local ICSs perceive health inequalities within their local area?
c) What factors have affected the framing of health inequalities in case study sites, including micro (personal), meso (local/regional) and macro (national policy) level influences?
d) How has this framing translated into plans of action, and what factors have influenced this?

2. *Learning and longer-term prospects:*

a) How might progress in tackling health inequalities by ICSs be monitored in the future?
b) How could changes to funding allocation mechanisms be used in supporting action to tackle health inequalities?
c) How can national policy support local action to tackle health inequalities?

Methods

We undertook a study to bring together national level interviews with policy makers, a national survey of ICS leads and in-depth qualitative case studies across three ICS areas.

National level interviews and analysis

Analysis of national policy and guidance documentation was undertaken in order to understand the national policy context and guidance provided to ICSs. Documents included:

- The NHS Long Term Plan 2019
- Establishing ICSs White Paper
- The ICS Design Framework

- The Core20PLUS5 Framework
- NHS Operational Planning Guidance

We also undertook eight semi-structured interviews with national leaders responsible for the policy development and/or policy implementation relating to health inequalities. Interviews were undertaken to explore:

- How health inequalities were conceptualised nationally
- The wider national policy context and the embedded incentives within the policy

National survey of ICS Leads

This work package was intended to provide evidence about approaches to health inequalities across England. Working with the NHS Confederation, a survey was designed and distributed to all ICS Directors of Strategy that were also NHS Confederation members. The survey included questions focused on:

- Their current understanding of inequality and the important health inequalities in their areas
- Their top three priorities in tackling these inequalities
- The mechanisms they are adopting
- Their approaches to monitoring outcomes
- The top three challenges they face in delivering their plans

The survey was distributed twice—initially in March 2023, and then in May 2023. Unfortunately, the response rate was poor, with only four completed responses, and therefore the survey data is not included in the results.

Qualitative case studies of 3 ICSs

Three ICS case study sites were identified and selected to account for geographical location, size and population demographics which could potentially influence and shape local health inequalities strategies.

Fifty-four semi-structured interviews with key stakeholders at System (covering a geography of between 1-2 million people) and Place (Local Authority areas) level were undertaken. Interviewees were selected because they were responsible for leading the ICS or health inequalities programmes of work across health and Local Authority organisations. Interviews addressed how health inequalities were being conceptualised and tackled across the three ICS spatial levels.

Data from all case study sites was analysed together using a thematic approach which drew upon our conceptualisation of the interlinked causes and manifestations of health inequalities. An account of understandings about—and actions to—tackle health inequalities in each case study was constructed, and cross case comparison undertaken.

Findings

Policy Documents & National interviews

We explored the claims made in policy documents about how the development of ICSs would enable health inequalities to be tackled. The mechanisms outlined in the documents include:

- Provision of preventative services for particular diseases
- Better adjustment of funding formulae for need

- Services will be better designed to meet the needs of disadvantaged groups
- Partnership working will support action on the social determinants of health and facilitate transfer of resources
- Place-level structures will enable local action
- Provider collaboratives will improve patient experience which will reduce inequalities
- GP practices will be incentivised to reduce inequalities in their local area
- Core20PLUS5 will support the identification of disadvantaged groups and populations and allow targeted action, focusing upon priority diseases

Overall, we found that:

- Tackling health inequalities is an important element of current policy.
- The terminology used in the policy documents was inconsistent, oscillating between health inequalities and healthcare inequalities and not always fully defining what type of inequality was being addressed.
- The proposed mechanisms by which the various policies would address inequalities remain under-specified.
- Our conceptual framework provides a useful way of clarifying what is meant by inequalities in any given context.

National interviews highlighted the importance afforded to tackling inequalities and emphasised the complexities of achieving this in practice. National leaders suggested that the Core20PLUS5 framework developed by NHS England provides an importance focus in this regard, and discussed their understanding of the need to monitor progress.

Case study findings

<u>ICS conceptualisation of health inequalities</u>

Senior staff in our case study sites articulated a range of perceptions and views about the nature of health inequalities and the most appropriate approach to tackling them. However, we were able to identify a number of key themes and tensions:

- All of our case study sites were clear at System, organisational and individual level that tackling health inequalities is an important part of their role. This is a significant change from previous research about CCGs, with the Covid-19 pandemic having provided stark illustration of the impact of inequalities
- Systems identified their developing collaborative ethos as important in enabling action around inequalities
- The complexity of health inequalities was highlighted, with some interviewees suggesting that it could be paralysing. Identifying a priority and focusing upon it was seen as a way through this complexity
- The Core20PLUS5 framework was described as a useful tool in support Systems to choose areas of work to focus on and to generate local discussions about health inequalities, although some described it as a rather medical approach to the problem.

<u>Programmes of work</u>

We explored how health inequalities were considered in the work of our ICS case study sites. We found that the approaches adopted locally was strongly influenced by national policy and local factors, including:

- Funding allocations
- The Core20PLUS5 framework
- A lack of a national monitoring schemes for inequalities
- The role of Public Health
- History and relationships

ICSs were undertaking many programmes of work to address inequalities, we found that there were three main themes of work, including: capacity building; addressing the social determinants of health via partnership working; and tackling inequalities in healthcare delivery. Some Systems have employed internal Public Health staff. Managing this in future will require clear lines of communication with public health staff employed in local authorities.

Table (i): Summary of the different types of programmes of work initiated by case study ICSs

Health inequalities conceptualisation or approach	**Focus**	**Examples of programmes of work**	**Classification according to Buzelli et al (2022)**
Capacity building	To ensure that staff were educated and trained about health inequalities. With an aim of ensuring that staff could apply their learning and address inequalities in their professional roles.	• Introducing training across the workforce to ensure staff understand health inequalities and how to address them through their professional roles. • Opportunities for staff to develop small programmes of work related to their professional roles to address inequalities.	Implementation approach – focus upon skilling staff
Wider Determinants of Health	Addressing inequalities via partnership working with system partners or ensuring that the work undertaken by the NHS contributes to the health inequalities agenda.	• Housing quality-working with system partners to address housing issues which impact on health i.e., asthma. • Provision of information in clinical settings to help support the population suffering from poverty i.e., foodbank information. • Targeting children who suffer from poor sleep via education • Climate change-adjusting prescribing attitudes and preferences • Anchor institutions-ensuring that NHS organisations consider their impact as an organisation on their local populations.	Population level, NHS in partnership Individual level, NHS in partnership Individual level, in partnership Population/individual level, NHS alone Population level, NHS alone
Healthcare inequalities	Addressing inequalities in access and experience of care.	• Working with specific population groups to meet their healthcare needs i.e., asylum seekers/frail population • Addressing waiting lists based on population need.	Population/Individual level, NHS alone Population/Individual level, NHS alone

		• Core20PLUS5	Not an intervention
		• Alcohol harm	Individual level, NHS alone
		• Suicide prevention	Individual level, NHS alone
		• Maternity equity	Individual level, NHS alone
		• Obesity	Individual level, NHS alone

Cross-cutting issues

A number of cross-cutting themes were identified:

- We found some tension between traditional *Public Health* approaches to health inequalities, and newer, more medically and data driven *Population Health Management* approaches. The former focuses upon wider societal issues and the social determinants of health affecting populations, whilst the latter focuses upon the identification of individuals and groups at higher risk using data-driven approaches. This tension is, to some extent, inherent in the Core20PLUS5 approach (which includes material deprivation alongside a medical focus on particular diseases), and may be exacerbated by the structural division between Public Health as a Local Authority responsibility and Population Health Management as an NHS-driven approach. These two different approaches are not mutually incompatible, but differences in approach need to be acknowledged and considered.
- The adjustment of national funding streams to account for inequalities is currently partial, with an aspiration in the future that funding will more closely follow need. Internally, we found some ICSs distributing significant funding to Place level, with some adjustment for population need. Other ICSs have taken a more cautious approach, asking Places to bid for additional funding to tackle inequalities or suggesting that Places might 'earn' greater financial autonomy.
- All ICSs in the study have established internal structures such as population health committees to consider inequalities. Action included a combination of ICS-level interventions, largely focused upon capacity building, and more local programmes of work. A collective narrative about the nature and extent of local inequalities was suggested as being helpful. ICSs serving very heterogeneous or uniformly deprived populations face significant challenges
- At the time of data collection, inequalities did not form part of the formal oversight of ICSs by NHS England, and this was highlighted as being a problem. Since the study finished, a monitoring regime has been introduced and this is to be welcomed. Internal monitoring of local progress is also important.

Discussion

What this study adds

- Integrated Care Systems take their obligations with regard to health inequalities seriously, with significant improvement since similar research in Clinical Commissioning Groups.
- Systems have put in place a range of work programmes directed at tackling inequalities.
- However, current guidance and policy aspirations are confused, with a lack of clarity around what types of inequality are being targeted and confusion as to how far ICSs might be expected to influence different types of underlying causes of inequalities. This confusion is

reflected in ICS approaches to inequalities, with considerable variability in ICS leaders' conceptualisations of their role in tackling inequalities.
- Our conceptual framework provides a potential approach to provide greater clarity, distinguishing actions required to tackle underlying causes from mitigating actions focused upon issues in the direct control of ICSs
- There is potential for tension between traditional public health approaches focusing upon the social determinants of health and current programmes focusing upon data-driven population health management. The relationship between Local Authority employed public health staff and their NHS colleagues could usefully be clarified.
- Ongoing monitoring of performance with respect to inequalities will be important in maintaining focus and progress.
- The best approach to adjusting funding allocations to mitigate health inequalities remains unclear.

The table below highlights the mechanisms by which policy documents proposed that the creation of ICSs would address health inequalities, and summarises our findings for each.

Table (ii): Summary of evidence relevant to the mechanisms identified in policy documents by which ICSs are expected to tackle health inequalities

Mechanism in policy documents	**Evidence from case studies**
Provision of preventative services for particular diseases	Systems addressing these clinical priorities, with some local schemes addressing priority groups. No large scale initiatives
Better adjustment of funding formulae for need	Awaiting national decisions re ICS funding. Some systems allocating some funds internally according to dimensions of inequality
Services designed to meet the needs of disadvantaged groups	Some local attention to redesign particular services for particular under-served groups
Partnership working will support action on the social determinants of health and facilitate transfer of resources	Systems are optimistic that partnership working will support action. Limited evidence so far. Relationship with Public Health important.
Place-level structures will enable local action	Some systems prioritising delegation of funding and responsibility to Place, others less advanced in this regard
Provider collaboratives will improve patient experience which will reduce inequalities	Limited evidence to date
GP practices will be incentivised to reduce inequalities in their local area	Incentive scheme had limited impact to date
Core20PLUS5 will support the identification of disadvantaged groups and populations and allow targeted action, focusing upon priority diseases	Core20PLUS5 welcomed, but difficult to operationalise in Systems serving the most deprived populations

The Core20PLUS5 approach has provided a framework within which programmes of work are being developed, and it has generally been welcomed, but in general we found that policy aspirations reflected in guidance documents do not necessarily reflect the realities faced by Systems, with limited evidence so far that the mechanisms suggested will generate the progress intended.

Implications for ICSs

- ICSs could usefully spend time clarifying their collective perception of which types of inequalities they wish to focus upon within which populations, the likely causes of those inequalities and the type of action which might be useful. Potential targets for action could be classified as to the extent to which they are amenable to NHS action and the extent to which action should be individual or population focused (as per Buzelli et al. (2022), and metrics identified which could be used to track progress. Our simplified schematic linking the different types of observed inequality to proximate causes could be useful here (see figure i). Systems should formally identify their targets for interventions, including specifying:
    - populations deemed to be at a disadvantage over which geographies
    - type of inequality to be addressed
    - potentially modifiable causes underlying observed inequalities.
- Where good local relationships exist, it is likely that such structured conversations around tackling health inequalities could be relatively easily achieved. Where relationships are less well developed there may be a role for NHSE in facilitating engagement.
- Where an ICS has employed in-house Public Health staff, attention should be paid to their role and their interface with Local Authority Public Health teams. Clear roles and responsibilities, and appropriate collaborative structures and governance are required.
- The internal distribution of funding according to need is an important potential mechanism by which inequalities might be tackled. However, this is unlikely to be easy to achieve, not least because of the fixed nature of much current spending. We recommend that ICSs should explicitly consider and document:
    - The extent to which core spend is delegated to Place level – ICSs vary considerably in their approach to this, and lack of delegation may inhibit local action due to a lack of control over decision-making.
    - The approach taken with any additional funding. Options include: distribution according to some measure of need and allowing local spending decisions; ICS-wide activity (such as staff training), alongside a degree of delegation; or central decision making, with local areas bidding for funding for particular projects.
    - The development of appropriate local decision-making structures for health inequalities work, with associated oversight and internal monitoring arrangements.
    - The length of any funding. Short term funding is unlikely to address fundamental long term structural issues, but may be appropriate on occasion for such things as catch-up vaccination programmes etc.

Implications for national policy

- Current guidance lacks clarity with confusion as to what types of inequality could be addressed by which type of action.
- National policy could be clearer in distinguishing between: population-focused interventions directed towards more upstream underlying causes of observable inequalities, which may require national policy change e.g. in welfare policy; and population health management approaches which focus upon identifying individuals or groups of individuals with particular risk factors. Our proposed conceptual framework (see figure i) could be used to support this.
- The Core20PLUS5 framework has been useful in supporting ICSs to choose which populations to target. However, greater clarity in national guidance around the fact that the size of geography over which populations are identified will affect which groups are chosen for focus would be helpful, as well as greater clarity around the types of inequalities which can and should be addressed by different types of intervention. This could be achieved by expanding the Core20PLUS5 framework to provide Systems with a matrix, within which they

could identify the population to be addressed, the geography over which action is to be taken, the type of inequality and the potential intervention target.

- There is an official policy intention to adjust national funding formulae to better account for inequalities. However, we have highlighted the complexities around this, including the fact that the use in the core allocation of measures of previous service use can fail to account for unmet need amongst some populations. Furthermore, current approaches to funding allocations do not take account of the fact that providing services to particular populations may be more costly.
- NHS England currently provides some guidance to support internal allocation according to need, but this remains difficult, because much resource use, particularly in the acute sector, is driven by contracts which require payment for activity. Sectors using block contracts (such as community and mental health services) will be disadvantaged by this. Appropriate internal allocation to mitigate inequalities will require access to robust data about local populations and appropriate analytical capacity to understand the data.
- Progress in tackling health inequalities will probably require some form of external performance monitoring and management, and it is to be welcomed that a monitoring framework is now being developed by NHS England. We have highlighted some of the attributes to be considered in choosing metrics to monitor.

Contents

1 Introduction

1.1 *Policy Background*

The Health and Care Bill and latterly the Health and Care Act (2022) introduced Integrated Care Systems (ICS) into the English NHS on a statutory basis from 1st July 2022. ICSs are made up of partnerships of organisations including: healthcare commissioners; providers; local government; and voluntary and charitable sector organisations. The policy outlines that ICSs are intended to work together to develop and deliver a local plan to meet the healthcare needs of their local population. ICSs are presented in the policy documentation as operating over three different geographical spatial levels: System, Place and Neighbourhood. There is an expectation that integrated working and care should be undertaken across all three levels of the system (see table 1).

	Population Size
System	1-3 million
Place	250,000-500,000
Neighbourhood	30-50,000

Table 1: Population size across ICS geographical spatial levels

At *System* level, it is expected that work should be undertaken at scale to create efficiencies across the system. Strategic planning is to take place at this level to ensure that the healthcare needs of the population are being accounted for and addressed across the ICS footprint. ICSs are expected to put in place appropriate structures to meet these aims. The policy is generally permissive, outlining a minimum set of structures for each area, with ICSs expected to develop locally-specific delivery mechanisms at each level. All ICSs are expected to have an Integrated Care Board (ICB) and Integrated Care Partnership (ICP). The ICB is the statutory organisation, which holds the budget for the ICS and is accountable to NHS England for addressing the healthcare needs of the local population. System funding allocated to all ICSs is linked to population need, with the national funding formula being weighted for deprivation.

The ICP has a much broader membership, with membership being locally driven. Representatives on this committee are expected to have a key interest in improving the care and wellbeing of the local population. Each ICP is tasked with developing and writing the local Integrated Care Strategy, with the purpose of outlining population health needs to the ICB. This will be developed from Joint Strategic Needs Assessments (local analysis and documentation to highlight evidence-based priorities for commissioning organisations) drawing on data from each Place within the System, to ensure that the strategy is relevant to local needs. This approach replicates historical work that was carried out by Clinical Commissioning Groups (CCGs), Health and Wellbeing Boards and Local Authorities. It is then the responsibility of the ICB to deliver the strategy for their system.

Each ICS was required to identify its local *Places,* which are assumed to be the level at which most operational delivery of services would occur. Places are typically aligned to Local Authority boundaries or to historical CCG footprints (CCGs were historical commissioning bodies that were abolished with the introduction of ICSs). The size of Places is variable across ICSs, but most ICSs include a number of Places, which often, but not always, map onto previous administrative units. There is little detail within the current policy about the work that should be undertaken at Place level and how Place fits within wider system working, beyond a general expectation that ICBs will seek to delegate a significant proportion of their funding and decision-making to Place level. Each Place is required to nominate a local *Place Leader*, and policy documents suggest that Place-based partnerships will be developed; however, their role, purpose and accountability relationships are not currently specified, with policy guidance suggesting that ICBs will have the freedom to develop these sub-Board structures as they wish. As a result, it is likely that there will be significant variation in the structures through which ICBs discharge their responsibilities.

Neighbourhoods within each system are much smaller, and are assumed to be local meaningful geographical entities across which primary care and community services are delivered to populations of between 30-50,000. As with Places, Neighbourhoods have no statutory existence, but it is suggested in policy documents that integration between primary, community and other services (e.g. voluntary and community enterprises) will occur at Neighbourhood level to deliver joined up care to patients. To facilitate this integration, the contract by which GP practices deliver primary care services was altered in 2019 to incentivise practices to work together in larger groups known as Primary Care Networks (PCNs) (NHS England, 2019). In addition to the mutual support assumed to flow from networked models of service delivery, PCNs were also intended by policy makers to be large enough to work effectively with other service providers in Neighbourhoods and to represent primary care at ICB level (Checkland, 2020). A review of PCNs in 2022 suggested that future policy should focus upon the development of Integrated Neighbourhood Teams, bringing together primary, community, social and voluntary sectors organisations to deliver seamless care outside hospitals (Fuller, 2022).

Alongside these geographically-based new structures, policy guidance associated with the Health and Care Act 2022 also envisaged the establishment of Provider Collaboratives. These represent partnership arrangements between large scale NHS trusts, working together over multiple Places to try and ensure resilience across the healthcare system and address unwarranted health variation (NHS England, 2021c). How such large-scale collaborations will work with local Places is not specified in policy, and raises questions as where strategic decision-making about local service delivery will be made (Sanderson, 2021). It is, for example, possible to envisage a situation in which a large-scale Provider Collaborative wished to make changes to services which went against the wishes of a local Place-based partnership. These complexities remain to be resolved at the time of this research.

The rationale for this large-scale reorganisation of the NHS in England is said to be a recognition of the importance of integration between all of the organisations providing health and social care services to local populations (NHS England, 2020). Policy documents argue that modern health care requires different organisations to work closely together, downgrading the importance of competition and highlighting the value of co-operation. This is argued to be particularly important in challenging and eliminating the inequalities in access, experience and outcomes that were clearly highlighted during the Covid-19 pandemic (NHS England, 2021). It is acknowledged within the documentation that tackling health inequalities is complex and unlikely to be achieved through siloed organisational working, and the White Paper which set out the shape of the new system argues strongly that a more joined up approach at both System and Place level is required to reduce health inequalities.

ICBs have a number of formal responsibilities, and two of these explicitly focus upon health inequalities, with ICBs required to: improve outcomes in population health and healthcare; and tackle inequalities in outcomes, access and experience. The responsibility to tackle health inequalities is a statutory one, formally vested by the Health and Care Act in the ICB, but policy acknowledges that delivery will depend upon work by all system partners across the different geographical spatial levels within ICSs. This statutory requirement to tackle health inequalities is not new; the Health and Social Care Act (2012), also placed a statutory duty on newly forming CCGs to tackle health inequalities. At the time, this was regarded as being surprising, as prior policy initiatives had recognised that the role of healthcare services in tackling health inequalities was often minimal (Exworthy et al., 2003). Research exploring the impact of this statutory duty on the work of CCGs highlighted a lack of clarity over what it meant and how it could be achieved, with limited evidence of progress (Warwick-Giles et al., 2017). Indeed, the most recent Care Quality Commission report on the state of the health and care system (Care Quality Commission 2021 p68-9 (Care Quality Commission, 2021)) states:

'We have found that most systems had some understanding that inequalities in health and social care existed in their areas before the pandemic, and how they had worsened or changed due to the pandemic. But tackling inequalities was often not a main priority for systems, or strategies to identify and tackle health inequalities across some systems were not yet well established…. Overall, across all our provider collaboration reviews, we highlight the strong need for leaders in local systems to work hard to understand the inequalities that exist in their areas, and to develop strategies to specifically address them.'

Current policy aims to tackle these difficulties, raising the profile and priority afforded to reducing health inequalities, supported by the explicit commitment to partnership working embodied in the Act. Policy documents highlight three types of inequalities that ICSs are expected to influence: inequalities in access; inequalities in experience of services; and inequalities in outcomes (NHS England, 2021b). In the next section we highlight the complexities underlying these apparently straightforward concepts.

1.2 Health Inequalities

Health inequalities are not a new phenomenon; they have been documented within politics, health care and the academic literature for decades. The concept of health inequalities is a slippery one which is used across many different disciplines and which has multiple meanings for those using it. The various different understandings of the nature of health inequalities has implications for not only how the problem is understood but also how it might be tackled. McCartney et al (2019) examined existing definitions of health and health inequalities by undertaking a literature review. They argued that it is important to clarify what is meant by health and health inequalities, as assumptions and values associated with understanding the problem will have implications for research, policy and practice. Therefore, differing conceptualisations of health inequalities will naturally lead to a different policy approaches to addressing the problem.

Terms such as equality and equity are often used when discussing health inequalities. Equality takes as its starting point the need to ensure that everyone within a given population has equal access to services and interventions, whilst equity acknowledges that peoples' capacities to benefit from any given intervention are likely to differ, suggesting that if everyone is to have a fair opportunity to reach their full health potential differential interventions may be required (Dahlgren & Whitehead, 1992).

There is a significant academic literature devoted to conceptualising the complexity of health inequalities. Within this work, there is recognition that the NHS contributes little to tackling health inequalities (Exworthy et al., 2003). This leads to a focus within much of the literature on the broader societal factors that shape health on an individual or group level (Marmot, 2010).

These factors are often called the ‘social determinants of health’, and research has explored in depth the different ways in which societal factors may influence an individual’s experience of ill health. Researchers and commentators have drawn these together into a wide variety of explanatory models, with differing emphases often driven by different political views. For example, the observation that poorer members of society experience poorer health is linked by some to behavioural issues such as greater propensity to engage in risky behaviours such as smoking and unhealthy eating, whilst others have emphasised the fact that deprivation is multifactorial, with societal structures limiting the choices and opportunities of those without material wealth, such that so-called ‘behavioural factors’ in fact represent the end point of cycles of deprivation and limited opportunity.

These approaches discuss particular aspects of society and their influence an individual’s health. Researchers have tried to draw together the multiple understandings of the problem of health inequalities by suggesting that inequalities in health outcomes arise out of factors which accumulate over time and across different aspects of peoples’ lives. This is known as the life course approach, and highlights the extent to which childhood experiences of poverty or ill treatment, educational experiences, housing, job opportunities, societal prejudice and discrimination and access to resources within families and communities interact with personal and biological characteristics and service provision and access to determine how any individual will experience ill health across their lifetime (Bartley, 2004). This approach highlights the importance of culture, economics and social position in shaping health outcomes.

Dahlgren and Whitehead (1992) developed a framework that accounts for the numerous different factors that have an association with health inequalities, referred to as the social determinants of health model (see figure 1). This model accounts for the biological, individual and societal factors that shape peoples experiences of health. This model identifies the micro and macro factors that shape health, demonstrating that many influences on an individual’s health, are often beyond the control of an individual. This model demonstrates the complexity and multiple contributing factors that shape and influence health.

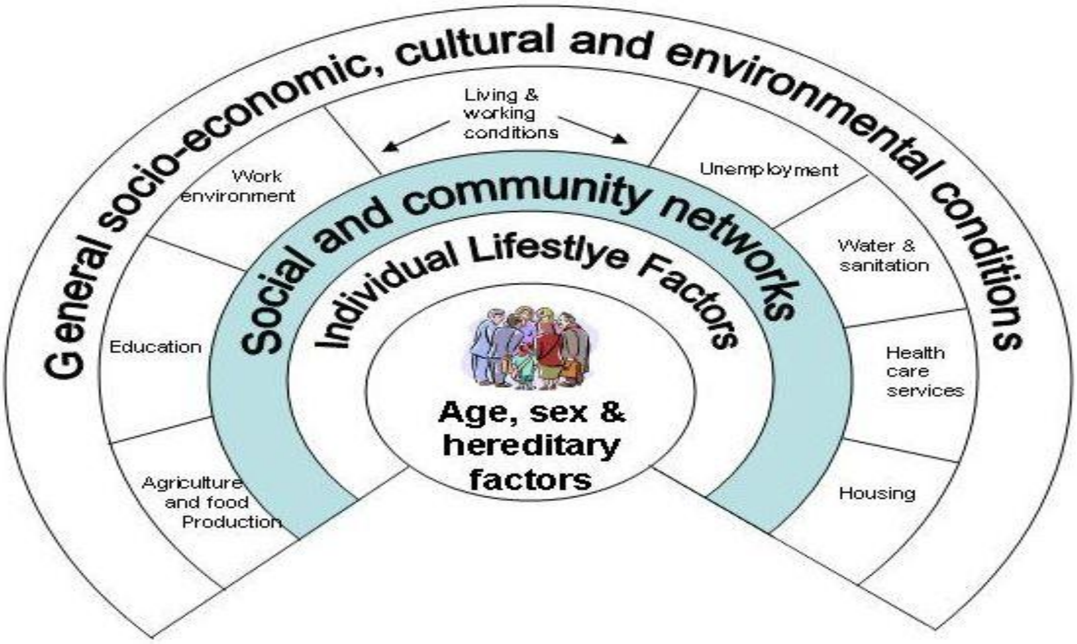


Figure 1: The main determinants of health European strategies for tackling social inequities in health: Levelling up Part 2 (who.int) (Dahlgren, 2000)

Against this complex background it is easy to understand why research has found that health care services contribute in a limited way to the development and alleviation of inequalities in health outcomes (Exworthy et al., 2003). Pons-Vigués et al. (2014) when undertaking a scoping review found that 44% of interventions implemented to tackle inequalities focused on addressing individual health behaviours, not the broader societal factors that are discussed at length within the literature. Nevertheless, there is evidence that the provision of health care is also driven by the same factors driving individuals' experiences across their lifetimes. The so-called 'inverse care law' highlights the fact that health care services are worst in areas of greatest need (Tudor Hart, 1971), and this pattern of service provision has proved remarkably resistant to initiatives designed to change it (Fisher, 2022), with the Covid-19 pandemic clearly demonstrating the fact that communities affected by social deprivation also often receive poorer services (Fisher, 2022). Research has repeatedly demonstrated that those from lower socio-economic groups are less likely to receive relevant treatments (Chaturvedi & Ben-Shlomo, 1995), with these things affecting outcomes. This suggests that, whilst tackling the social determinants of health inequalities must be the primary focus of any policy in this area, there remain issues which may be amenable to changes in health care delivery, and which could potentially be influenced by the work of ICSs. However, there remain significant complexities. Whilst inequalities in access to care might seem to be relatively straightforward to tackle by systematically considering and changing what services are provided where, societal factors also come into play, with issues around transport, the availability of accommodation for services, the way in which funding is allocated to populations, and peoples' differing capacities to take advantage of services all being important. In addition, whilst improving access to care may alleviate some inequalities, peoples' ability to benefit from care will also be affected by the underlying social factors, rendering the benefits of any changes difficult to predict. Thus, changes to health care provision may not straightforwardly translate into improvements in outcomes or health status.

In 2010, The Marmot Review: Fair Society and Lives was published (Marmot, 2010). The review highlighted that health inequalities were still prevalent. Within the review the social gradient of health is discussed, whereby the lower an individual's social position the poorer their health is. Marmot suggests that effort should not be concentrated on specific disadvantaged groups to address inequalities, instead the approach of proportionate universalism should be enacted, focussing on the gradient of health. Thus, the intensity in which the inequality is tackled is based upon the disadvantage across the gradient. The review suggested six policy objectives, to address inequalities:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention.

In 2020, the Health Foundation commissioned Marmot to undertake a review of health inequalities, 10 years on since the publication of Fair Society and Lives, assessing inequalities across the six policy objectives outlined in the original report (Marmot, 2020). The evidence suggests that some communities have effectively managed to address some local inequalities. However, the review found that life expectancy had stalled within England and that the national funding cuts had affected the social determinants of health, further disadvantaging existing deprived areas and populations located outside of London. The report highlights that the Government had not prioritised addressing inequalities within their policy and policy moving forward should benefit areas of the North of

England to ensure that they can have the same levels of good health enjoyed by people living in affluent areas in the South of England.

When designing research and interventions to tackle inequalities, it is important to account for the social constructed nature of inequalities. Mackenzie et al. (2017) used seven different discourses of health inequalities with both policy makers and health practitioners within one health system, to understand their approaches to tackling and mitigating against health inequalities. It was agreed that targeting the most deprived and attempting to reduce the gap in health was ineffective. Overall, the socially patterned nature of inequalities often failed to account for the policy and politics, and the significant role they play in influencing inequalities. Furthermore, Nutbeam (2004) suggested that there is a vast amount of evidence that describes health inequalities within the UK, but there is little evidence to help inform policy. Therefore, it is important to support research that is overtly directed at informing policy.

This brief account of the varied approaches to and understandings of health inequalities demonstrates the multidimensional and complex nature of the issue. This is important, because how Systems choose to tackle inequalities will naturally be shaped by their understanding of the problem. In exploring the approach taken by ICSs in meeting their statutory duties around health inequalities it is therefore important to understand how they think about the problem, as this will determine not only what they decide to do but also what they decide to measure in monitoring their performance.

1.3 Funding allocation

Addressing health inequalities requires an approach to the appropriate allocation of resources. In this section we briefly set out the current situation with regards to adjustment of funding formulae to account for inequalities.

Allocations to ICBs are based on weighted capitations (NHS England, 2020), following the same approach previously used for distributing resources to Health Authorities, PCTs and CCGs. Funding formulae were introduced for the first time in 1976 by the Resource Allocation Working Party, and have since evolved to serve evolving institutional settings and objectives, and reflecting methodological innovations or data availability (Buck., 2013; Smith, 2008).

The ICB funding model is made of three distinct formulae: Core services, Primary Medical Care and Specialised Commissioning. Specialised Commissioning currently remains centralised, and Primary Care resources remain allocated to GP practices, either directly or via co-commissioning based on a dedicated formula (Gardiner, 2016). Each formula defines an equitable target, which compared with the allocation of the previous year determines the speed of convergence (pace of change) for ICBs which are under-target.

The Core services is made up of seven segments including one for each of five funding streams (General and Acute, Maternity, Mental Health, Community Services and Prescribing), one for unavoidable costs of delivery and an adjustment for health inequalities. For each of the five funding streams need is estimated based on current utilisation patterns adjusted for differences in supply (utilisation models) using linked person-level records from relevant administrative data. Need estimates are averaged at the GP practice level to serve as a population weight within each segment. Weighted populations are calculated based on GP practice registration for each segment and aggregated with a relative weight determined by the patterns of spending in previous years. For example, in the 2023/24 allocations, the adjustment for health inequalities and unmet needs was attributed a weight of 10.2% compared with a weight of 89.8% of the utilisation models. The adjustment for unavoidable costs differences accounts for market forces factors, transports in rural areas, inefficiently small hospitals and historic private contracts in trusts.

A health inequalities adjustment was used for the first time in 2001/02 allocations to PCTs (Smith, 2008), and has been object of research (Orr et al., 2010). The health inequalities and unmet need adjustment in its current form, was introduced in 2013/14 allocations (NHS England, 2022), with the objective of reducing inequalities in access to NHS funded health care, and support NHS organisations in their duty to reduce inequalities in outcomes from health care. A recent review commissioned by the Advisory Committee on Resource Allocation (ACRA) (NHS England, 2022), recommended using avoidable mortality rates instead of the previously used Standardised Mortality Ratio for those aged under 75 years (SMR<75). The change was made in 2022/23 allocations and the weighting of the adjustment increased from 10% to 10.2% in 2023/24. Extra funding was made available for health inequalities and distributed according to this adjustment, presented as recurrent budget, and not a one-off project, in 2022/23 allocations, but then re-included in the core budget in subsequent years.

The review of the health inequality adjustment included a number of additional considerations which may be relevant for distributing resources to ICBs, but also for ICBs in planning their activities and resource use. The review considered adjustments for populations known to experience poor health outcomes and that may be under-represented in GP practice registration. It didn’t recommend their implementation because of the small impact they would have, but recommended further research in the area and continuing to review related data availability. The review also highlighted that mortality based measures may not best capture inequalities in mental health, for which a better measure should be used in the future. The review made additional recommendations to improve the current approach: i) separating adjustments for unmet needs and health inequalities, and for primary care and community services (out-of-hospital services) versus hospital services; ii) accounting for the differential cost of services for disadvantaged groups and ii) promoting collection and use of better data including specific population groups particularly affected by inequalities.

The review provides a definition of health inequalities, limiting the scope for funding adjustments. *“Health inequalities are avoidable differences in health across the population and between different groups within society, that are amenable to healthcare and preventative activities (and therefore can be avoided with the appropriate provision of healthcare and prevention that is in the scope of the bodies we are funding).”* There is also a definition of preventive actions in relation to the NHS context, which exclude interventions, for example on the social determinants of health, which are more naturally funded though other sectors: *“Disparities in healthcare access, experience and outcomes are avoidable and do not occur randomly or by chance but are determined by circumstances largely beyond an individual’s control. Focused action on tackling health inequalities in the scope of the bodies we are funding seeks to bridge these differences in order to ensure equitable access, excellent experience and optimal outcomes with the aim of putting in place prerequisites to reduce health inequalities that are amenable to healthcare.”* Overall, this clarifies that adjustment for fundings remain confined to activities within the remit of organisations that are NHS funded.

Options to separate the adjustments for unmet need and for health inequality are under consideration (Barr, 2020). There tends to be an agreement that adjustment for unmet need may relate to correcting funding allocations to better account for need for current services which may be under or overestimated where the formula may fail to account for needs of individuals who don’t use or under use services. Adjusting funding for health inequalities may require *“(i) identification of effective health-care interventions designed to reduce the health inequality; (ii) identification of disadvantaged groups at which the intervention will be directed; (iii) identification of the areas where* *such groups live; (iv) allocation of resources according to the group composition of an area*". This may involve the identification of new services or services which are currently not covered by the formulae, either because they are not provided nationally, or because good enough data are not available yet. As better information becomes available about groups affected by health inequalities and services specifically targeting them are implementable, resources should be distributed with a view to support their implementation in the places and forms which would benefit disadvantaged populations.

It has been noted that resources allocated to commissioners, should be spent "appropriately on disadvantaged groups and the necessary interventions" (Smith, 2008). Formulae allocating funding to ICBs, or CCGs in the past, have tended to be agnostic to this. Formulae serve to create a playing level field and organisations who best know the needs of their population should spend in the most effective, equitable and efficient way. However, recent research has shown that CCGs exhibited different patterns of spending for general and acute and mental health care, with some appearing to best align the distribution of resources and care to population need (L. Anselmi, Urwin, Sean., Lau, Yiu-Shing., Mentzakis, Emmanouil & Sutton, Matthew, 2023). Systematic evidence on how resources are spent within ICBs (or CCGs in the past) is missing. However, the variation is spending patterns suggests that either some form of performance monitoring or some incentives may be introduced in the allocation process, to help breaking undesirable patterns and ensure that resources reach the intended populations. These elements remain for consideration either at the national or local level

NHS England has made available a Place Based Tool to support ICBs in distributing their resources (NHS England, 2023b). The tool essentially provides the weights and weighted populations for the five core funding streams, health inequalities and Primary Medical Care. The weights are the same ones used in the national formula, but are provided for Places within ICBs based on ICB rather than national standardisation, and for Places that can be flexibly defined, based on combinations of GP practices. The tools does not provide information on differential costing, nor convergence rate. Therefore, the tool can essentially support the definition and measurement of patterns of need within ICBs. NHS England does not provide further indication on how resources should be allocated within ICBs and the tool is meant to only support the process. ICBs still have to make decisions on how their funding is allocated to match or meet these needs, and to tackle health inequalities. Discussions with ICBs have revealed that some are effectively using the tool to distribute resources and more specifically some of the funding allocated for health inequalities. However, a systematic approach to allocating resources to promote the reduction of health inequalities within ICBs is currently missing (L. Anselmi, Heppolette, W., Lake, T., Outhwaite, L., Ross, H., Puts, H., Bentley, C., Barr, B., Kypridemos, C., Anosova, O., Urwin, S., Sanderson, M., Surgey, M., Galbraith, G., Chandler, D., Webb, J., Spence, M., Mott, L., Ferguson, J., Liu, A., 2023).

It should be considered that national funding formulae tend to adopt a universal definition of need across England. This means that services provided in some systems but not others, are not accounted for. It also means that costs are assumed to be equal across England, when in reality providing the care which meets the needs of specific populations and in specific circumstances may require different amounts of resources. ICBs will have to take into account those differential and population specific costs in addressing health inequalities.

ICBs currently face a fragmented funding landscape both in terms of resources, and constraints decision making related to spending decision, due to current pressures on the system and funding hypothecation, for example from the mental health investment standard. Combined with a limited increase in the overall budget, these may constrain opportunities to effectively change current patterns of spending and resource provision.

2 Design and Methodology

2.1 Theoretical Framework

In pulling together this complex literature, we suggest that it is possible to think about inequalities in terms of inputs – access to resources, services or opportunities – and outcomes, with peoples' health status arising out of complex interactions between inputs such as their social situation, behaviours, individual biology and the care they receive. Furthermore, the outcomes of the healthcare that people receive will contribute to their overall experience of health, but this will also be affected by other factors. Policy and commentary regarding health inequalities often tends to elide these different concepts, with the umbrella term 'health inequalities' used to refer to many different aspects of the problem. As we will see in the next section, current guidance suggests that ICSs should think about inequalities in terms of inequalities in: health care access; experience; and outcomes. In our formulation, these represent both input inequalities and inequalities in an intermediate outcome. Figure 2 provides a schematic representation of some of the ways in which these different aspects of inequalities can relate to one another.

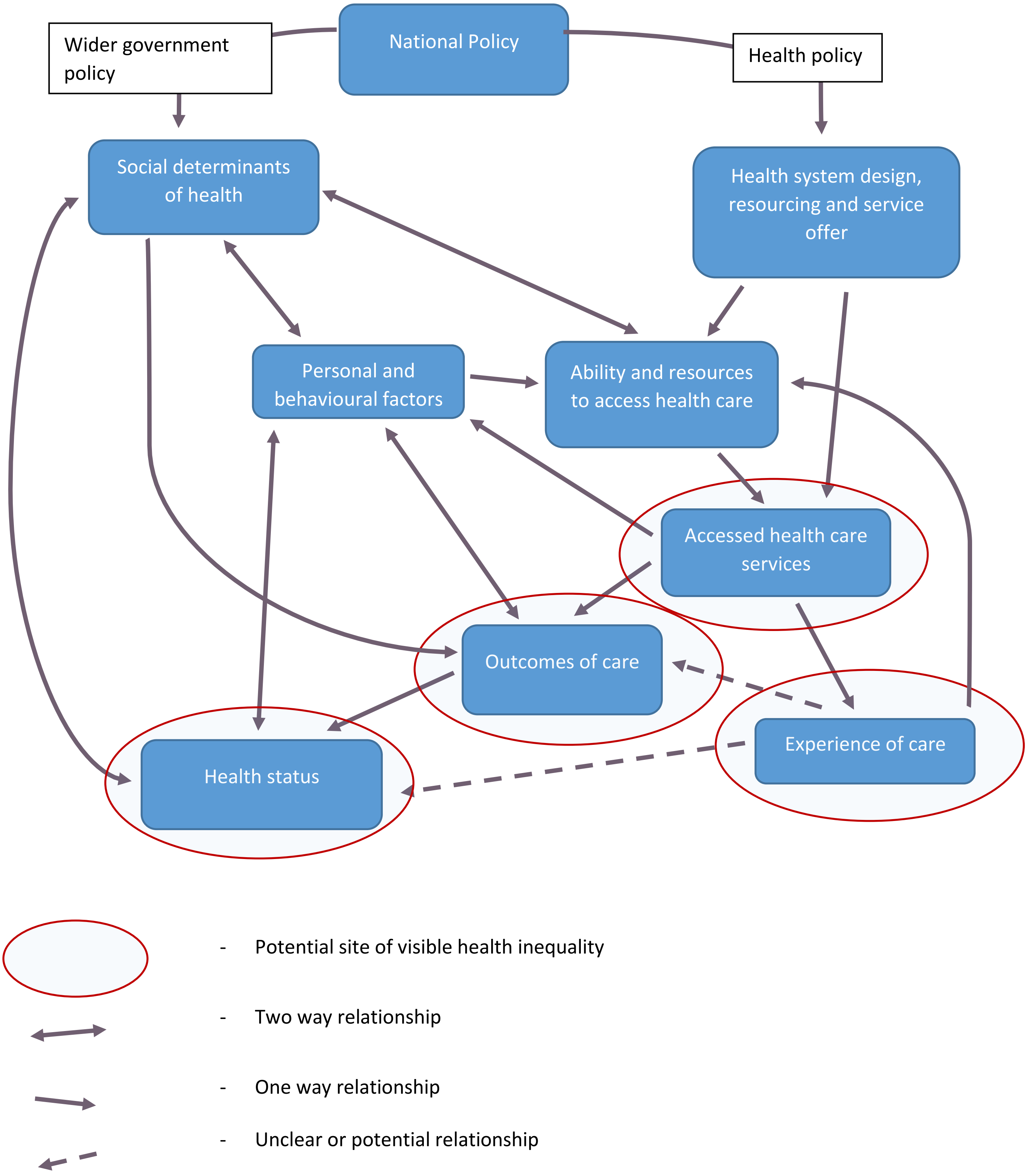


Figure 2: Schematic representation of possible relationships between different factors influencing health inequalities and different types of inequalities

This way of thinking about inequalities is necessarily a simplification, but it allows a clear distinction to be made between the different types of inequalities which might be targeted. The umbrella term 'health inequalities' can be confusing, with little clarity over whether any specific use of the term refers to inequalities in health status, access to services, outcomes of service provision or experience of care. Alongside ambiguities and variation in how inequalities are conceptualised, ambiguities in what type of inequalities are being targeted may hamper efforts to address the problem. Our model highlights the fact that the different types of visible inequalities – in access, experience etc. – are affected by different aspects of both the system and wider society, and so will require different solutions as well as different metrics for monitoring. It also makes clear the fact that, whilst distinction is sometimes made between health care inequalities and those not amenable to health care intervention, in reality health care inequalities are inextricably linked to the wider social determinants of health, and optimisation of services will not necessarily straightforwardly lead to measurable improvements.

Finally, it is important to note that the term 'inequalities' implies a comparison between groups – one group is doing less well in some way than another. Which groups are chosen to make the comparison will affect who is seen as suffering detriment, and within the literature and in policy there are many ways of defining inequalities. This is particularly evident if relative deprivation is chosen as a measure. There are a number of metrics which seek to measure deprivation; one of the most commonly used is the Index of Multiple Deprivation which combines measures to rank geographical areas in terms of their population's experience of different forms of deprivation. However, the size of the geographical population over which such measures are applied will lead to different populations being identified. Thus, for example, ranking by deprivation of areas within the geographical area of Greater Manchester according to the latest census (https://www.ons.gov.uk/census/maps/choropleth/population/household-deprivation/hh-deprivation/household-is-deprived-in-four-dimensions?lad=E08000007) shows that Stockport ranks in the middle, more deprived than some areas but less than others. However, at a lower level of geography, the Middle Super Output Area, it is clear that Stockport contains some very deprived areas, and down at Output Area (the smallest area defined in the census), Stockport has some of the most deprived streets in Greater Manchester. Both the extent of measurable inequalities and the potential action required to target them will depend upon how these comparisons are being made across which geographies. Beyond geography, some discussions of health inequalities group people on other characteristics, such as race and ethnicity, sexual orientation, experience of homelessness or learning disabilities. Such groups are sometimes called 'inclusion groups', and have been identified as suffering poorer health than the general population. There will be overlaps between groups identified in this way and those identified by geography or deprivation, but these will vary across populations and across characteristics. In summary, the term 'health inequalities' is complex and capable of a number of different interpretations, with measurable inequalities influenced by multiple factors including how the measurement was done.

Previous research confirms that tackling health inequalities at a local level is not straightforward. Warwick-Giles et al. (2017) undertook a study on CCGs and found that those involved in commissioning often did not have a shared understanding of the nature of health inequalities, leading difficulties in agreeing programmes of work to address the problem. Local perceptions of health inequalities and how they were tackled were strongly influenced by the wider relationships with local Public Health teams.

A recent meta-ethnography analysis by (McMahon, 2023), undertaken to understand what shapes local health system actors' thinking and action to tackle health inequalities, found that healthcare professionals tend to have their own individual interpretations of health inequalities. Furthermore, these conceptualisations are shaped and influenced by the organisations in which they work, and are often influenced by the organisational governance arrangements in place, and the criteria by which organisations are held accountable. For example, funding over and above core allocations within the NHS tends to be short term and project specific, which restricts the ability of organisations to take a more long-term approach to tackle health inequalities. Health inequalities are one focus of work within the healthcare sector and can sometimes be eclipsed by other apparently more pressing statutory duties. Interestingly, the paper suggests that all of the studies (n11) found that local areas tend to have a shared overall perception of the nature of important inequalities in their population. The focus was often based on geography or concerns about a specific cohort of people, and tended to be driven by the influence of particular individuals. As a result, the wider determinants of health were often described as being ‘out of scope’, with a focus being placed on equity of access rather than attempting to tackle more fundamental problems. Overall, McMahon (2023) suggests that the concept of health inequalities within healthcare organisations is moulded by powerful, influential discourses which align existing pre-conceptions about health inequalities with institutional practices.

This literature, therefore suggests that in considering health system action to tackle health inequalities account needs to be taken of the initial framing of the problem, as well as individual conceptualisations and priorities, local institutional constraints and national policy drivers which influence action. Importantly, this brief overview of the literature highlights the fact that the term ‘health inequalities’ can itself be a source of confusion, with lack of clarity over what is being referred to in any given context. This is important because action to alleviate inequalities depend crucially upon being clear as to what it is that is being addressed.

Drawing these issues together, the approach taken to addressing health inequalities within any health system will depend upon how the problem is conceptualised. This in turn will be driven by a complex mix of factors including national policy, individual disciplinary backgrounds and experiences, and the structures established locally to address the problem. Our study therefore set out to explore the national policy discourse around health inequalities, and to understand how local health systems were going about the task of tackling their duty to reduce them. We used our simplified schematic setting out the ways in which different proximate causes might be linked to observable inequalities as a sensitising device within which to make sense of what we found.

2.2 *Aim, objectives, and research questions*

Aim: This work was commissioned by the Department of Health and Social Care (DHSC) to provide evidence about the approaches that ICSs are taking to their duty to address health inequalities to inform policy makers, both within DHSC and NHSE, as they design policies and mechanisms to support this process. To provide a baseline understanding of appropriate approaches to monitoring and evaluating progress against ICS responsibilities.

2.2.1 Research objectives:

1. to characterise approaches to tackling health inequalities in developing ICSs and identify what information ICSs use to guide their inequalities work
2. to understand the factors affecting how health inequalities are perceived, including national policies (including targets and standards), internal ICS organisation and governance, the role of individuals and relationships with Local Authorities
3. to explore how perceptions of important health inequalities are translated into plans of action, and the factors affecting this

4. to investigate what progress ICS might be expected to make in short-term indicators of addressing inequalities, including budgets and access and establish potential indicators for routine monitoring in the longer term.
5. to consider how national policy might best support ICS action on health inequalities

2.2.2 Research Questions (RQs):

1) *Understanding health inequalities:*
    a. How are health inequalities defined within national policy, and how is it intended that the new system will support action in this regard?
    b. How do local ICSs perceive health inequalities within their local area?
    c. What factors have affected the framing of health inequalities in case study sites, including micro (personal), meso (local/regional) and macro (national policy) level influences?
    d. How has this framing translated into plans of action, and what factors have influenced this?

2) *Learning and longer-term prospects*
    a. How might progress in tackling health inequalities by ICSs be monitored in the future?
    b. How could changes to funding allocation mechanisms be used in supporting action to tackle health inequalities?
    c. How can national policy support local action to tackle health inequalities?

2.3 Work Packages

We undertook a qualitative study across three work packages to bring together national level interviews with policy makers, a national survey of ICS leads and in-depth qualitative case studies across three ICS areas. In addition, we considered potential approaches to monitoring outcomes. This approach was to enable us to understand national policy development, national objectives and oversight of the inequalities agenda at a national level. Whilst complementing it with local level research to explore how ICSs were interpreting the policy and implementing ways to both tackle and monitor local inequalities. This allowed us to see how national objectives were/or were not being implemented locally and why. Qualitative case studies and interview methods were selected due to our previous success of using such methods to explore policy implementation (Moran et al., 2017);(Checkland, 2020);(Warwick-Giles, 2014).

The purpose of the case study work was to understand how ICSs conceptualise and pursue tackling health inequalities within their area, exploring mechanisms by which a shared understanding has been reached and adopted action to tackle health inequalities. This approach was chosen to allow us to explore the impact of national policy drivers and incentives and local institutional arrangements. Therefore, to take into account these contextual factors, an in-depth approach was required. Thus, a qualitative case study approach was adopted loosely based on the work of Yin (Yin, 2003). Ethical approval was received from The University of Manchester Proportionate Ethics Committee: 2022-14973-24814.

2.3.1 Work package 1: policy analysis

(RQ1 a—d and 2c)

Analysis of national policy and guidance documentation was undertaken in order to understand the national policy context and guidance provided to ICSs. We undertook policy programme analysis to construct an initial programme theory (Weiss, 1998) to comprehend how ICSs were expected to tackle health inequalities. Documents included:

- The NHS Long Term Plan 2019
- Establishing ICSs White Paper
- The ICS Design Framework
- The Core20PLUS5 Framework
- NHS Operational Planning Guidance

Documents were selected based on the timings of their publication-relating specifically to ICS development and health inequalities. We examined the policy documents and the underlying programme theories (Weiss, 1998), that they embody in order to try to understand what the policy targets are and what mechanisms are expected to be activated to address those targets. All documents were read multiple times, specifically looking for information about health inequalities. All information regarding health inequalities and responsibilities or duties relating to ICSs and inequalities were captured. The analysis undertaken focussed on understanding the specified policy objective, outlined mechanisms to address the problem and expected policy outcomes. This enabled us to understand the policy objectives and goals in more detail and provided us with information that could be explored further via interviews with national policy makers.

To complement the policy programme theory analysis, we also undertook eight semi-structured interviews with purposefully sampled national leaders responsible for the policy development and/or policy implementation relating to health inequalities. Interviews were undertaken to explore in more detail: how health inequalities were conceptualised nationally, and the wider national policy context and the embedded incentives within the policy. Interviewees were identified and selected based on a consultation with Department of Health and Social Care policy colleagues, and included interviewees from Department of Health and Social Care, NHS England and The Office for Health Improvement and Disparities. All interviewees were closely associated with health inequalities policy development or implementation. Interviews were audio recorded and took place via Microsoft Teams. Interview data was analysed together with the policy content analysis to develop the programme theory behind the national inequalities policy. Data was thematically analysed (Braun & Clarke, 2006), focussing on how health inequalities were conceptualised by policy makers and within the policy documents; mechanisms to help ICSs address inequalities; and associated factors that could support policy implementation-such as financial incentives and accountability structures. These key themes were selected based on previous findings and work undertaken by Warwick-Giles et al 2017 and McMahon 2023.

2.3.2 Work package 2: Initial national survey of ICS leads

(RQ 1a)

This work package was intended to provide evidence about approaches to health inequalities across England, focussing on local level implementation to help understand how ICSs were interpreting national guidance. Working with the NHS Confederation, an eight-item survey was designed and distributed online to all ICS Directors of Strategy that were also NHS Confederation members. As the NHS Confederation distributed the survey to their members on our behalf, we were not provided with final numbers of who received the survey. Directors of Strategy were emailed a link to the survey and the survey link was also included in the NHS Confederation newsletter. Membership to the NHS Confederation is voluntary and therefore not all ICSs are necessarily members of the NHS Confederation. The survey included questions focused on:

- Their current understanding of inequality and the important health inequalities in their areas
- Their top three priorities in tackling these inequalities
- The mechanisms they are adopting
- Their approaches to monitoring outcomes
- The top three challenges they face in delivering their plans

The design of the survey was informed by previous research, exploring the importance of the conceptualisation of health inequalities and its influence on how inequalities are addressed (Warwick-Giles et al., 2017, {McMahon, 2023 #797), the policy documentation and analysis from work package one, a lack of clarity on monitoring mechanisms.

The survey was distributed twice, by the NHS Confederation—initially in March 2023, and then in May 2023. This approach was selected after consultation with the NHS Confederation. It was suggested that due to the amount of work that ICS staff were undertaking at the time of the research study, a concise survey was the best approach to collect data from ICSs. Unfortunately, the response rate was poor, with only four completed responses, and therefore the survey data is not included in the results. Appendix 1 contains a copy of the survey.

2.3.3 Work Package 3: Qualitative case studies of 3 ICSs

(RQ 1a-d and 2a-c)

To understand local level policy implementation further, three ICS case study sites (A-C) were identified and selected to account for a maximum variety over multiple domains which could potentially influence and shape local health inequalities strategies: geographical location, population demographics (including deprivation levels, coastal geography and rurality), and the number of Local Authorities within the ICS footprint and the coherence of those boundaries with the system. Data collection took place between October 2022 and June 2023. Table 2 below sets out the characteristics of these sites according to select dimensions of difference (with consideration of the need to preserve site anonymity).

	Integrated Care System case study site		
	A	**B**	**C**
NHS England geographical region	North East and Yorkshire	North West	South East
Approximate population size	Between 2-3 million	Between 2-3 million	Between 1-2 million
Deprivation level	Deprived	Mixed (pockets of high levels of deprivation)	Mixed (pockets of high levels of deprivation)

Table 2: Integrated Care System case study sites (A-C) by NHS England geographical region, population size, and deprivation level.

Data collection within each case study site involved semi-structured interviews with key stakeholders responsible for leading the ICS or health inequalities programmes of work across health and Local Authority organisations. Fifty-four interviews were conducted by LWG, DB, SB, and JH with staff working at either System or Place level within each of the three ICS sites (see Table 3 for additional detail). Views were sought from the different levels within ICSs to capture how health inequalities were being conceptualised and tackled across these levels, enabling us to explore whether there was a consistent approach within a system or whether there are any key differences across the system levels and why. Interviews also addressed questions relating to the monitoring of progress and opinions on the potential for adjustment of funding allocations to reflect inequalities.

Interviewees were recruited across a wide range of roles including: ICS Chief Executives; Clinicians; Place based lead; Commissioners and Providers; local Public Health Consultants and Local Authority representatives. Initial contact was made with an individual contact within each ICS, we then identified the key stakeholders and approached them for interview, using snowball sampling to enable broader recruitment via these interviewees.

	Integrated Care System case study site			**Total**
	A	**B**	**C**	
Number of interviews conducted	15	17	22	54
System level interviews	11	10	19	40
Place level interviews	4	7	3	14

Table 3: Number of interviews conducted per Integrated Care System site.

Interviews were audio recorded and professionally transcribed. Transcripts were imported into NVivo 12 software. Analysis was undertaken following a framework analysis approach (Gale et al., 2013). An initial coding frame was developed collaboratively by all members of the research team, focusing on codes that reflected the research questions, previous evidence and the need to capture how perceptions of health inequalities may be influenced by personal, local institutional, and national policy contexts. This was then refined and developed inductively by LWG, DB, and SB as they conducted the analysis. Data from all case study sites was analysed together using a thematic approach. This allowed for cross referencing and the concurrent development of codes, themes and analytic memos. Data collection and analysis were conducted in parallel to allow emerging findings to inform the on-going data collection process. An account of understandings about—and actions to—tackle health inequalities in each case study was constructed, and cross case comparison undertaken. This provided scope to tease out common or recurring factors both locally and nationally which influenced the approach taken. From previous research we knew that different relationships between NHS managers and local authority-employed public health staff could have an important impact on the way in which commissioners approached health inequalities. We therefore included a previously-developed typology of approaches to public health into our analysis. . In our case studies, we found that ICSs articulated many different large and small scale programmes of work directed at tackling inequalities. In order to make sense of these we utilised a previously developed framework by Buzelli et al (2022) to categorise the different types of initiatives. A final cross-case analysis allowed us to address research question 2c, considering how policy might usefully support action to tackle inequalities.

2.3.4 Dissemination and next steps

The target audience for this research was policy makers and those responsible for providing guidance to ICSs as they developed their plans in this important area. The research team convened meetings with the relevant policy makers during the research to feedback emerging findings, and at the end of the study to report the final analysis. Important topics raised in the early meetings included lack of clarity in policy documents as to exactly what type of inequalities were to be targeted, and the lack of any formal oversight and monitoring mechanisms. This draft final report is to be shared widely with DHSC and NHS England policy teams, and associated meetings have been convened to discuss the findings. In addition, ICSs taking part in the research are offered access to the report and Executive Summary, and given the opportunity to receive in person feedback if this would be helpful.

3 Findings

3.1 Policy document analysis

The first phase of the study was to explore the relevant policy documents in order to understand how ICSs are expected to approach their statutory duty to address health inequalities. A specific policy document focusing on health inequalities was scheduled to be published in Spring 2022, but this was cancelled, with focus instead upon a wider strategy relating to people suffering from Multiple Long-Term Conditions, with inequalities framed as an important aspect of this. In the absence of a specific policy document, we focus here upon the documents relevant to the design and implementation of ICSs.

In undertaking our analysis of the relevant policy documents, we refer back to the schema in Figure 2, seeking to identify in each case which types of inequalities are being addressed and which mechanisms are identified as underpinning suggested action, as well as highlighting ambiguities when they occur. Our overall objective in this analysis was to explicate the policy context within which individual ICSs are developing their policies in this area and to highlight the fact that different ways of conceptualising inequalities lead to different targets for action.

Analysis of the policy documents highlighted the fact that the need to tackle health inequalities is prominent within all of the major documents assessed. This underlines the increasing policy salience of inequalities generally, and demonstrates the importance which current policy places upon action in this area. However, the documents do demonstrate a general lack of clarity over how inequalities are conceptualised and defined, with some ambiguities as to how policy objectives will be achieved. This is perhaps unsurprising, given the complexities which we have highlighted, and these documents should be seen as setting an initial framing for ICSs which will likely be further developed over time.

Table 4 sets out the framing of health inequalities present in each document, and explores the mechanisms by which policy is intended to generate action to alleviate inequalities.

Table 4: Policy approaches to tackling health inequalities

Document	Type of inequalities referenced	Framing of the problem	Mechanism(s) to tackle inequalities	Issues arising
NHS Long Term Plan (NHS England, 2019)	Inequalities not always fully defined. References multiple types of inequalities, including health status, access to services and outcomes	People in deprived areas more likely to suffer from ischaemic heart disease, Chronic Obstructive Pulmonary Disease, liver disease, diabetes etc. Prevention of these diseases will reduce inequalities	Roll out further programmes of preventative care, including: • Smoking cessation • Weight management • Alcohol & drug treatment • Hypertension screening and management • Diabetes Prevention Programme	To address inequalities effectively, such programmes would need to be targeted at specific populations
		People in deprived areas do not access services at the same rate as people in more affluent areas.	Target funding at areas of maximum need by adjusting funding formulae to account for need to address local health inequalities, specifically focussing on inequalities in access and outcomes.	Which dimensions of need are included in the formula will affect which areas receive additional funding. Impact on inequalities will depend upon ICSs distributing funding internally according to need
		Specific groups in society are disadvantaged compared with others, including those suffering homelessness, minoritised groups, people with learning disabilities etc	Services should be designed for and targeted at these groups	A clear rationale is required as to which groups will be targeted in any given area. If no additional resources are available, targeting in this way may require funding to be moved from other services
White Paper- Integration and Innovation: working together to improve health and social care for all (Department of Health and Social Care, 2021)	References inequalities in health status most prominently	Health inequalities arise out of the social determinants of health and cannot be tackled by the NHS alone	The creation of ICSs will support better integration between health services and local authorities. The resulting partnership working will enable activity to tackle the social determinants of health and therefore will reduce inequalities	The importance of Local Authority engagement is emphasised, but there is less reference to the role of public health. Local Authorities area in a challenging financial position, which may impact partnership working. Previous approaches to improving partnerships between health and other sectors have found it to be difficult, with limited impact on inequalities
ICS Design Framework (NHS England, 2021b)	Inequalities not always fully defined. References multiple types of inequalities, including health status, access to services and outcomes	The people living in deprived areas who have the greatest health needs are not getting the care that they need	Funding should be adjusted for need, and strong partnerships will facilitate the transfer of resources within ICSs to the areas of greatest needs	Different definitions of ‘need’ will generate different approaches – clarity is required, alongside appropriate skills in analysing and interpreting data. In the absence of additional funding, targeting specific groups may require internal redistribution of resources. ICSs serving heterogenous populations may have particular difficulties.

		Inequalities are driven by the social determinants of health	Strong place-level partnerships will enable action to tackle the wider determinants of health. These local partnerships will be able to feed data and intelligence up to the ICS to support them to tackle inequalities.	This mechanism places strong emphasis on local use of data to understand local population health needs. The role of local public health teams will be important here. Focus on partnership working to facilitate approaches to tackling the wider determinants of health is a longstanding aspiration, although good evidence as to how this can be achieved is lacking.
		Health inequalities are driven by unequal access to services	The linking of large scale providers into provider collaboratives will support providers to work together and thereby tackle unwarranted variations in access. Provider Collaboratives will improve patient experience, and this will tackle variations in patient experience. The collection of good data across Provider Collaboratives will allow them to target disadvantaged population groups.	There are a number of ambiguities in this approach. Tackling unwarranted variations in access may result in increased access overall, and this would need to be accounted for in funding mechanisms. How Provider Collaboratives will improve patient experience is not currently clear, and expectations of joint working such as this must operate alongside providers' individual statutory duties.
		Inequalities arise because services are not responsive to the needs of particular populations	Groups of GP practices working together as Primary Care Networks will provide intelligence about local needs to support ICS action on inequalities.	Research to date has shown that Primary Care Networks do not have capability to undertake population health analyses (Checkland et al., 2023). Support from public health may be required.
		Primary care services, like all services, have not been responsive enough to need. If local inequalities are tackled this will scale up to ensure inequalities tackled throughout ICS population	Action to tackle health inequalities will be directly incentivised via requirements for Primary Care Networks to set up programmes of work on inequalities.	Research to date has shown that PCNs find this difficult, and that action so far has been small scale (Warwick-Giles et al., 2023).
Core20PLUS5-An approach to reducing health inequalities (NHS England, 2021a)	Type of inequalities not defined	Socio-economic deprivation is a driver of inequalities	ICSs should target action towards the most deprived 20% of their population	The geographies over which populations are identified will affect which areas are chosen.
		Particular groups in society are particularly likely to suffer from inequalities	ICSs should identify the important inclusion groups in their local area.	Mechanisms for choosing which groups to focus upon will be required. Public health support will be important in identifying key groups in each area.
		Inequalities in outcomes are driven by inequalities in the incidence of specific diseases	Action should target the prevention of the 5 disease areas identified as a national priority.	Whether such action reduces inequalities will depend upon the extent to which preventative services are targeted at those most in need.

2023/24 Priorities and Operational Planning Guidance (NHS England, 2023a)	Prioritises tackling inequalities in access, experience and outcomes	Specific diseases can be managed better to help prevent inequalities	Increase the number of patients receiving specific treatments and monitoring, in line with NICE guidance. • Hypertension patients • CVD risk score register	Requires providers to be aware of local population needs
		Specific population groups suffer more inequalities in comparison to the wider population.	Create action plans for maternity services for people from BAME communities or living in deprived communities. Improve care for people with learning disabilities, autism, etc.	Introduces specific priorities for all ICSs to follow. May cut across local priorities.
		Delivering the Core20PLUS5 programme will tackle health inequalities	Using the framework that NHS England have developed will address inequalities	The Core20PLUS5 approach identifies those in need. It does not define the action required.

3.1.1 Summary

We have identified various conceptualisations of health inequalities within NHS policy documents and guidance. To understand this further we also identified the mechanisms required to tackle each problem and potential issues that may be experienced by ICSs when trying to implement action to tackle health inequalities.

Taken as a whole, the policy documents make it clear that tackling health inequalities is an important element of current policy. However, we found that the terminology used in the documents was somewhat inconsistent, oscillating between 'health inequalities' and 'healthcare inequalities', and the proposed mechanisms by which the various policies would address inequalities remain under-specified. Returning to our framework set out in figure 2, we found that the various policy documents are not always clear as to which type of observable inequality is being targeted (access, health status, outcomes of care etc), and approaches to tackling these do not clearly identify the underlying drivers of inequalities that are being addressed. Some policy prescriptions – such as the aspiration to adjust funding mechanisms to account for inequalities – implies a focus upon equalising access by improving provision in underserved areas, whilst others suggest a wider hope that partnership working will help to tackle underlying social determinants of health. The Core20PLUS5 approach promulgated by NHS England focuses upon identifying the population to be targeted by ICSs, leaving Systems to decide which types of inequality they wish to tackle within the identified populations and which underlying drivers of inequality to address. The approach is broad, highlighting deprivation, specific drivers of inequality such as membership of minoritised groups or disadvantages such as learning disabilities, and groups suffering particular diseases. The geographical scale over which these groups are to be identified is also left to Systems to decide.

Overall, this analysis demonstrates the importance afforded to health inequalities by current policy but also the complexity that policy makers and local systems face. The analysis highlights the fact that different definitions of the problem to be tackled will naturally influence the approaches that are adopted, and identifies the potential challenges that may be faced when implementing strategies locally. In keeping with the overall complexity of the topic, the documents do not set out any concrete targets for ICSs to meet, and do not specify measurement or monitoring procedures. Looking across the mechanisms set out in the documents, the importance of strong Public Health programmes stands out, alongside the need for good intelligence about population health and health needs.

3.2 Policy Maker Interviews

Eight interviews were conducted with policy makers and staff within the Department of Health and Social Care (DHSC) and NHS England.

The main purpose of the interviews was to understand the national policy context and embedded incentives in more detail. The main themes that were explored throughout the interviews were how health inequalities were framed, policy initiatives intended to address health inequalities and the monitoring processes in place to capture progress.

3.2.1 Conceptualisations of health inequalities (research question 1a)

Policy maker interviews reflected the complexity of the topic, with different individuals framing inequalities in different ways. One DHSC member of staff explained that this plurality of approach is to be expected, but suggested that a consistent approach needs to be adopted, implemented, and monitored over time.

> *…From my perspective, kind of whatever floats your boat. There's so many ways of coming at it. I think they can spend a lot of time arguing about the right one. Just do something and be boringly consistent and repeat it, for everyone's fed up with it, and don't keep reinventing it every five minutes. And I do think there's still, at a policy level, you'll gather…well, you know, the government and its frame on what it means…Because we all have different interpretations of that, haven't we, and we're meant to be seeing how that resettles….. the levelling up agenda, probably points more towards your kind of geographically based distributive views of levelling up. Whereas others might almost view it as your kind of individualised opportunity take on levelling up. [P0002xl_081122_LWG]*

Individual approaches to health inequalities were shaped by professional background and the organisation in which interviewees worked, replicating the findings of McMahon (2022). In 2021, a function of Public Health England was transferred into DHSC and named the Office for Health Improvement and Disparities (OHID). This Public Health background shaped how policy makers in OHID saw the problem:

> *So, I guess it's the, as we've talked about for the last hour, it's understanding the differences and the variation between places, and trying to understand what will make a difference to addressing those inequalities and enabling an environment, or facilitating an environment, that makes it possible for those interventions to be effective. But they're not all with…well, most of them aren't within the gift at a place level, there are things that need to happen at a macro level. So, it's using the…whether it be the influence, or the relationships, or the responsibility, to be able to try and inform, at a macro level, the decisions that could be made that would also influence this. [P003tq_141122_LWG]*
>
> *Well, it's the traditional public health model with the Dahlgren and the social determinants, it goes like the social audit determinants goes down to community, environmental and then goes into lifestyle and then goes into individual risk factor, and then you go to the individual person. [P001cg_031122_LWG]*
>
> *In my national role I did a lot of work to conceptualise health inequalities, and I think where I personally landed is contextual and compositional stratifiers. So contextual being geographical, and compositional being more about personal identifiers. So it's power inequities distributed across community identities versus geographic communities. [P004cr_021222_LWG]*

DHSC staff who did not work in OHID acknowledged that the wider backgrounds of staff in that organisation led to a more pluralistic understanding:

> *I'm not sure there's any such thing as the department's conceptualisation of anything. I think there are people in it who think about things and then some of those thoughts dominate over others and they ebb and flow. [P005wx_051222_LWG]*

Within NHS England, by contrast, there was more consistency, reflecting the Core20PLUS5 approach. This conceptualisation of the problem focussed on healthcare inequalities, with reference to inequalities in access, outcomes and experience.

> *And in our team we talk…we tend to talk about…our vision is about ensuring equitable…excellent healthcare for all through equitable access, excellent experiences and optimal outcomes. That's the vision statement. [P006rq_061222_LWG]*

NHS England has established a National Healthcare Inequalities Improvement Programme. The team are responsible for setting the strategy and vision for the NHS and their approaches to tackle health inequalities.

> *'My programme's role is to set strategic direction, to clarify the vision, to set out key priorities for tackling health inequalities and to help NHS England nationally, and integrated care systems to develop an accountability framework for tackling health inequalities. [P008qh_270123_LWG]*

Interviewees reported that they see NHS England as having a responsibility via their strategy to try and demystify inequalities. The sheer scale and complexity of the problem can often be paralysing, and they explained that they wanted to provide some clarity in order to support collective action. However, they acknowledged that wider government policy on the issue was less clear.

> *so I stick to the script because I feel like we've got an agreed NHS position on how we're doing this. So, I think if I was speaking publicly I would always use our public vision and our public definitions… I do think that…look, there is no kind of national Government description, is there, is the thing. So, I think that's the…that's in some ways the elephant in the room. [P006rq_061222_LWG]*

The NHS England conceptualisation of health inequalities directly informed the framework that has been developed for local ICSs to tackle health inequalities set out in the policy documents analysed above. This approach focusses on healthcare inequalities, situating the NHS as being best suited to tackle healthcare inequalities- specifically focussing on access, experience and outcomes of healthcare. However, interviewees also told us that they felt that the NHS had a broader role in supporting other system partners in addressing the wider determinants of health through their role as an employer and a large institution located within many communities. One interviewee described the NHS as being able to address health inequalities across four different dimensions.

> *However, healthcare inequalities as it relates to people's access to their experiences of and their outcomes from healthcare services, we consider to be within the remit of NHS England, the NHS and ICBs more broadly…And so we've described the role of the NHS in tackling health inequalities as being in four dimensions. First of all, the NHS as a commissioner and provider of healthcare services has direct responsibility and accountability for tackling healthcare inequalities. Secondly, the NHS as an employer is able to address health inequalities affecting its 1.4 million staff, who are a microcosm of the wider population. Thirdly, we also say that the NHS as an anchor institution, can play a significant role, particularly looking through the three lenses that I've talked about, employment, procurement and use of estate. Finally, we talk about the NHS…as a significant ally within the integrated care system is able, in collaboration with other partners in the ICS, to make significant contribution to addressing the social determinants that drive health inequality. So that's the four dimensions that we think the NHS can make a significant contribution to tackling health inequalities. [P008qy_270123_LWG]*

3.2.2 Health inequalities programmes of work (research question 1a)

Health inequalities are only one of multiple duties placed upon ICSs. For example, the triple aim outlined in the NHS Long Term Plan (2019) stated that commissioners and providers had a duty to promote: better health for everyone; better care for all patients; and sustainability, both for their local NHS system and for the wider NHS (NHS England, 2019). This takes a broader view of the purpose of the healthcare system, without a sole focus on treating ill health. Policy makers told us that they felt that including inequalities in these duties was important in focusing attention and effort, providing NHS England with levers that they could use in their interactions with ICSs.

> *there's a sort of, web of duties and the, you know, inequalities is certainly part of it and there's also the triple aim, which I think you'll be aware of, which touches on this as well, which also gets you to the population health point. And again, the thinking behind the triple aim, which...and if you think NHS England were very, very keen on...actually, we were quite keen on as well, was to get all players in the system to think, not just about one or other aspect of what they were doing…And it gives NHS England a bit of a hook with them, although I shouldn't think about these things in terms of hooks because again, hooks are not very motivating and the point of this is energy and motivation nearly. But it does at least allow NHS England to provide support and to push this agenda because there is that legislative recognition, as I say, to use a more neutral term there. So, that I think was quite an important part of the framework, now I come to remember it. [P005wx_051222_LWG]*

The Core20PLUS5 programme was described in policy as: *'the NHS contribution to a wider system effort by Local Authorities, communities and VCSE sector to tackling healthcare inequalities'(p2)(NHS England, 2021a).* The focus of the scheme is on healthcare inequalities, focussing mainly on specific clinical areas, with some local discretion and flexibility to ensure that local population concerns are not overlooked.

> *And then Core20PLUS5 is the core 20 most deprived, defined at a national level. The plus cohorts are all defined locally by ICSs, so that's trying to make sure that the communities need to be advocated for are advocated for. And then the five clinical areas are the maternity, mental health, blood pressure, cancer diagnosis, and COPD. So yeah, there are the kind of agreed priorities. And through all the funding guidance and everything that is what the ICSs are supposed to be focusing on. [P007yu_081222_LWG]*

The Core20PLUS5 agenda was welcomed by DHSC staff who were interviewed, however there were some concerns about its narrow focus. One of the core elements of the programme is a 'dashboard', through which ICSs can check their progress. However, this is not without its issues. One regional member of staff from OHID said that defining dashboard indicators nationally could make it less useful for local systems.

> *I think it's useful but it's so…it's just the fact focus is very narrow. So, in XXX there's a lot of different datasets and ICS have their own datasets, so I think it's helpful to have a dashboard where you can click and go further down into the different geographical areas. But I think if you're narrowing it to indicators that's been measured it kind of removes the utility of the potential of that whole data and system. So, I think recently XXX is developing integrated data anyway and how that will manifest it will come in time. And also, because I think there is supposed to be flexibility, isn't there, about what each local area does? I personally don't know how that's factored into the dashboard or whether it can be. And without having a lot of flexibility with what you report in the dashboard and what's shown then you limit the ability for the local areas to do their own monitoring. [P001cg_031122_LWG]*

Many of those working in OHID have a Public Health background, and were thus keen for an approach which brings the social determinants of health to the foreground. However, this programme was not introduced to address all aspects of health inequalities. Rather, it was seen as a way to get some action around healthcare inequalities started, providing a platform on which to build in the future.

> *And it's not to say that other areas aren't in very much need of addressing, but it was the concept is kind of, what we say, focus, traction and impact, so it was really just trying to build a very strategic focus nationally and all through the country, and then really get that message out and get that traction in the system, and then actually have an impact. Because looking at the data we know health inequalities have been a major problem for decades and decades, probably since the founding of the NHS, but all the successive work hasn't managed to shift the dial. And so that's kind of why the sort of priorities were taken out and really addressed. But you'll see that the sort of cohort is actually really large, so we're talking about 20 per cent most deprived and plus communities. So it's to try and change tack, so to stop looking at sort of general population and then hoping things will trickle out to the fringes, but to sort of start at the most vulnerable, most needy and then work in. So it's kind of trying to change around the population-health-management approach, almost. [P007yu_081222_LWG]*

However, this approach is somewhat at odds with that advocated by Marmot in his reports of 2010 and 2020, which favoured an approach known as proportionate universalism, which suggests that to address inequalities you cannot just focus on disadvantaged population groups alone.

Inevitably around a topic as complex as inequalities, policy makers were aware of tensions between national and local priorities, suggesting that it is important to balance both. Local ICSs should not be solely seen as a delivery agent for national programmes of work, they have their own priorities that should not be overshadowed by a national agenda.

> *I definitely think there's a recognition that there needs to be some balance between national or local priorities and that you can't just expect ICSs, just as you can't expect local government to be purely a delivery agent of specific national priorities. You've got to allow some ripple, but kind of quite where that aligns in reality is always an interesting one, isn't it? [P002xl_081122_LWG]*

DHSC staff recognised the Core20PLUS5 programme as a good starting point to focus people's minds on the health inequalities agenda. As discussed earlier, there was some concern about the level of geography being used to capture the Core20. Dependent at what scale the Core20 measure is captured (System, Place, or Neighbourhood), there is a risk that some inequalities may be hidden.

> *I think, you know, you can pick holes in anything, but I think it's a pretty good place to, you know… There is an element about which Core20 and of what level you do your geographies, which is an issue for us as well. You know, if you're looking at kind of, you know, deprivation level data and inequalities, the level at which you look at it, you end up with a very different geographic picture. You know, if you look upper-tier deprivation versus lower super output area deprivation, you get a very, very different… I think the potential risk is, if you just look at top level, you'll end up with a large part of the country thinking it's nothing to do with them. [P002xl_081122_LWG]*

In addition to Core20PLUS5 there were additional policy approaches for ICSs to engage with the health inequalities agenda. These included the Core20 Community Connectors (NHS England »

Core20PLUS5 Community Connectors) and Ambassadors programmes (NHS England » Core20PLUS ambassadors).

The purpose of the Core20 Community Connectors programme is to fund ICSs and Place based initiatives to recruit community connectors to reduce inequalities in their area. ICSs had to apply for this programme, developing a programme to suit a specific population need. Two pilot waves have been introduced. ICSs have to focus on one of the 5 areas outlined in Core20PLUS5 and target different population groups. This programme is utilising some of the learning from Covid19 and the importance of community agents to bridge the gap between experience and services.

> *So, there're lots of different community centred roles and approaches of course out there that try to achieve different things. But I think the kind of the purpose for Core20PLUS5 Connectors is to say, well if we recognise that one of the things about driving change in some of these big areas that we've talked about, like engagement with case finding, and so on, is the way in which we connect with the communities, recognise their lived experience, shape services in ways that relate to them, overcome barriers to access, do things which make experiences better so that the word gets spread, have trusted voices, then you really need people from communities to be doing some of that business. So, that's the premise of the programme. [P006rq_061222_LWG]*

The Ambassadors programme is also linked to the Core20PLUS5 programme, whereby the National Healthcare Inequalities team have recruited staff across the NHS who are committed to reducing healthcare inequalities. The programme is to provide ambassadors with support and opportunities and a platform to voice the health inequalities agenda.

> *And then also I've set up the Ambassadors' Programme, so this is a clinical…we've got 130 clinicians who are trained professionals, so they can be managers or pharmacists, or physiotherapists or GPs, and they're spread across all the 42 ICSs, we have two or three in nearly every single ICS. But we recruited them recently, and we tried to do it through the ICSs and that gave a great insight into how the ICSs were handling healthcare inequalities. [P007yu_081222_LWG]*

Overall, the Core20PLUS5 programme was welcomed and viewed as an opportunity to reframe the responsibility of healthcare to tackle health inequalities using a particular framework to guide the work and ensure that the NHS was contributing to the wider agenda. Beyond this, interviewees also highlighted the fact that many aspects of current policies will, if implemented appropriately, also have an impact on inequalities.

> *So, how can you get a system, a health and care system which is naturally oriented towards the immediate and the urgent, you know, the kind of, access pressures that we're currently seeing, and we'll always see to some degree. …….. You'll never prevent your way entirely out of the need for A&E, or for cancer treatment, or whatever it might be but prevention, the investment in those people and those areas and those issues where we know there's a lot of health gain which gets you into inequalities pretty quickly…But the...so I think that our framing was, perhaps, less explicitly in terms of inequalities but we certainly thought about, kind of, that element of it. And part of the point of the framing that we came up with was that so that the different players in a system have to, as I were, sit around the table and look at each other a bit more, and think a bit more about the population they serve, as a population not just as a set of services that they run and own. [P005wx_051222_LWG]*

This suggests an aspiration for ICSs to consider inequalities in all that they do. In addition, the need for broader action on the social determinants of health was also highlighted.

3.2.3 Finance

There were a number of unresolved issues when policy makers spoke about finances and health inequalities. All funding to ICSs is adjusted for health inequalities, one policy maker said that this accounted for 10% of ICB funding allocation. The methods used to account for inequalities provides additional financial resources to areas with higher levels of deprivation.

> *I mean the essence of it is there's an adjustment for health inequalities in the ICB funding, which is equivalent to about 10 per cent of total ICB funding. It's weighted according to needs, so particularly according to deprivation, so more deprived areas you get more of that share. [P006rq_061222_LWG]*

Although the formula accounts for health inequalities, one policy maker suggested that the weighting approach could potentially be improved. Whilst the current formula tries to ensure that money is allocated in a way that is fair for all, the approach does not necessarily provide the flexibility that is required to address local health inequalities.

> *So I guess the funding formula is sort of still a work in progress in terms of tackling healthcare inequalities. And I think everybody admits that it's not right yet. And so I guess the funding formula is trying to make sure that everything is allocated in a fair way and that the demographic is taken into account. But it doesn't allow the sort of flexibility that, for example, we've got in the PLUS population of Core20PLUS5 where you can identify yourself the needs of the community. And we know that the funding formula hasn't accommodated the extra mileage that NHS has to go to address healthcare inequalities. So for example, in hepatitis C treatment we know that hepatitis C can be completely fully treated, fully eradicated, but that requires people to turn up at a clinic, have lots of injections, or tablets, and have tests, blood tests, follow up, and have a specialist nurse. And so a lot of the community that have hepatitis C may be from minority ethnic communities or from inclusion health groups including living on the streets or people experiencing homelessness, or people using intravenous drugs. So there's huge, huge economic burdens and problems with actually working with those communities effectively that are in no way allocated for in the funding formula. [P007yu_081222_LWG]*

To address health inequalities £200 million of System funding was badged as health inequalities funding to all of the 42 ICSs. Although this money was allocated for health inequalities, the money was not ring fenced. This has implications locally as the money does not necessarily have to be utilised to tackle health inequalities. This allocation of resources has led to varied approaches being adopted by ICSs.

> *This financial year we've provided an additional allocation of £200 million which has been distributed to ICSs, you know, in recognition of the kind of health inequalities issues, but that money's not technically ringfenced, and next financial year it will be subsumed into the ICB baseline funding. So, the major challenge…a tension I perceive is that you can't actually ringfence any programme money for action on health inequalities. It relies on making a local case which is accepted, particularly by, say, finance directors, that, you know, they should release funds to spend on health inequalities related issues. And in some quarters that £200 million this year people have sort of treated it like a ringfenced pie pot and the money's been*

> *dedicated to different health inequalities related initiatives. In other areas it's just been subsumed and people who are doing work on health inequalities has had no joy in accessing any of that money. So, it's a real practical challenge that you don't have ringfenced money for the kind of cost cutting work on health inequalities that you might do. So, I think that's one thing. [P006rq_061222_LWG]*

The assurance process for understanding how the health inequalities monies are being utilised is both complex and challenging. At present, no mechanisms have been put in place to require Systems to report how their allocation has been used. Furthermore, with no ring fencing in place, the money can be spent in any way that ICSs deem appropriate, which may include things other than inequalities. Some interviewees raised further concerns about the funding mechanisms, expressing concern that the weighted allocation for ICSs to address inequalities would go straight into the ICS baseline from next year onwards, meaning that it would be harder to identify and trace how money allocated for health inequalities is being utilised.

3.2.4 Accountability

There are formal mechanisms in place to monitor the performance of ICSs. However, when interviewing staff at DHSC and NHS England it was clear that there was some uncertainty around monitoring the health inequalities agenda. There were no accountability or performance metrics associated with health inequalities, unlike other critical areas of focus. The assurance process for health inequalities seemed to lack clarity. One policy maker suggested that work for health inequalities was incentivised to try and ensure that systems challenged the agenda.

> *It would be a challenging thing where the reality would be we'd be having lots of frank and escalating conversations, I would say, with senior leaders to understand what are the issues and how we turn it around. So, I mean I think in practice…I'm trying to think what could the penalties be. I think we've got lots of incentives but fair few disincentives in that instance. I mean the only other thing is of course given the legal framework, you know, there is a risk of legal challenge that the ICB would face, which I'm sure you…we'd be pressing on them. So, you know, one would hope that any senior leader in that position would recognise that risk and act accordingly. But, yeah, I think that's probably our strongest lever. [P006rq_061222_LWG]*

There are numerous resources and tools available to ICSs to help inform them about their local inequalities, enabling them to compare themselves with their peers. These tools highlight the issues of health inequalities and suggest approaches for reducing inequalities. However, an approach for monitoring performance against inequalities seems to be lacking.

> *I mentioned the health inequalities improvement dashboard, it's actually a health inequalities improvement work space that we've built. And it contains three tools, one is the dashboard. There is also an actionable insight dashboard, which enables ICSs to compare themselves with their peers across a whole range of parameters. It also contains the workspace called Priorities Ward Dashboard, which enables them to see emergency admissions for ambulatory care sensitive conditions, which can be managed in primary care or community services. How the emergency admissions for ambulatory care conditions compares with their peers. And that's the Priorities Ward Dashboard. So that workspace contains those three tools. The other thing we've done is we've worked with the Health Foundation and the Yorkshire Academic Health Science Network through an expert reference group, to develop the actionable insight guidance, which*

> *sets out principles, approaches and case studies for ICSs to use in their effort to tackle health inequalities. [P008qh_270123_LWG]*

Interviewees spoke about tensions between the focus of the programme, where responsibility lies and issues with monitoring/ supporting health inequalities, especially regarding the national and regional roles of NHS England.

> *Because we talk about obvious tensions at local level, at regional level, but potentially at times if you've got a different agenda… Or what your starting point on an agenda is a better way to describe it. How has that come together nationally when developing this policy? [P002XL_081122_LWG]*
>
> *Then the way that NHS England works is that the relationship with ICSs is managed generally through regional teams. So, regional teams will have at least quarterly kind of catchups but they will be meeting probably on a monthly basis with integrated care systems to discuss a whole raft of issues, including how they're doing on their health inequalities plans. Then at a national level we do a quarterly stock take with each regional team where the regional team account for what they've done but also seek information from ICSs to give us assurance about the delivery on the different priorities that we set. Then annually ICSs are required to write an annual report, and as part of that annual report process regional teams will be reviewing and providing an assessment of ICB performance on a whole range of issues, including on health inequalities. [P006rq_061222_LWG]*

The NHS England health inequalities agenda and programme of work have been designed and developed centrally by the National Health Inequalities Team. The national team has formal oversight of the health inequalities programme, however they do not themselves work directly with ICSs. The national teams monitor ICS returns and can monitor whether any of the work that is being carried out locally is impacting on the national health inequalities priorities and targets. There is no oversight at present around locally chosen inequalities targets or programmes of work. When ICSs wrote their initial plans, the national team examined all of the plans to monitor how health inequalities were being spoken about.

> *But we have been involved in making sure that all ICS plans as they changed into ICBs in July this year, we've been involved in reviewing all their plans on how they actually approach healthcare inequalities. So we've reviewed every single of the 42 ICSs' plans on how they will tackle healthcare inequalities, and given feedback. And that's like a mandatory part of their planning. But we do offer a lot of support to them for that planning. And that support is sort of multi-fold: so we have our health inequalities improvement dashboard; we have our health inequalities future NHS platform, which is kind of the way we have spread best practice and case studies, but also connect people to the latest sort of guidance for that. Yes, so that's kind of the main way that we've been feeding into the ICSs in terms of their formal reporting of healthcare inequalities. [P007yu_081222_LWG]*

It was apparent from this work that there was significant variability across the 42 ICSs regarding their plans, with an acceptance that the majority of ICSs have been unable to focus on the health inequalities agenda because of the current pressures the NHS is facing.

> *And so I would say there are a few ICSs that are very progressive and advanced in terms of addressing healthcare inequalities, but the norm is that it's, sort of, either they're*

> *overwhelmed with all the other pressures and health inequalities doesn't seem to be woven in yet in all other programmes. [P007yu_081222_LWG]*

The NHS England relationship with ICSs is managed through the regional NHS England teams, where local oversight of ICSs takes place. The regional teams meet on a quarterly basis with all ICSs (following the historical monitoring process that was in place for CCGs). This is where health inequalities can be discussed. If an ICS was performing poorly with regards to inequalities, it would be discussed with the regional team and potentially escalated to the national team if it was deemed necessary.

> *So, I think it sits mainly at a regional level to be managing that relationship. It would definitely be escalated up to a national level for us to be aware if there were kind of particular concerns. So, look, there are formal mechanisms for kind of, you know, critical lack of performance in an ICS. I don't necessarily think that the kind of…if I'm honest the failure on health inequalities or, you know, a kind of belligerence, some…on the agenda would fall into that category, would it? It would be a challenging thing where the reality would be we'd be having lots of frank and escalating conversations, I would say, with senior leaders to understand what are the issues and how we turn it around. [P006rq_061223_LWG]*

However, it was acknowledged that the system is not in a place whereby any ICS could be penalised for not addressing health inequalities. There is no formal regulation in place to address concerns about local health inequalities work. Although health inequalities are stated as an NHS priority, without formal mechanisms to monitor progress, prioritisation of inequalities is unlikely to happen. Particularly when ICSs will be formally monitored across other indicators.

> *And so the kind of structures and the networks are very immature in most places. And so in July, for example, we contacted the ICSs around the time that we were reviewing the plans, and they weren't able to identify the health inequalities lead in a lot of cases; in fact the vast majority were not able to identify the lead on healthcare inequalities. And so I would say there are a few ICSs that are very progressive and advanced in terms of addressing healthcare inequalities, but the norm is that it's, sort of, either they're overwhelmed with all the other pressures and health inequalities doesn't seem to be woven in yet in all other programmes. [P007yu_081222_LWG]*

3.2.5 Success

When designing and implementing policy it is important to understand the aim of the policy. We therefore asked interviewees what they felt 'success' would look like with regards to tackling health inequalities.

All interviewees commented that defining health inequalities policy success was challenging and that it would be difficult to define a specific target or approach that ICBs need to deliver to be deemed successful. One interviewee commented that success is all about perspective, success can be characterised differently depending on what aspect of the health inequalities agenda you are referring to. There was a tension between what would potentially be deemed as a policy success nationally, which may not be appropriate or helpful to local geographies and populations. Success can be measured at different levels of the System and be measured differently depending on which aspect of inequality a particular programme of work is targeting. This makes measuring success challenging. The multiple conceptualisations of health inequalities, alongside the national vs local policy implementation mean that a single definition of success is unlikely to be achieved.

When thinking about policy success interviewees told us that it would take time and the measure of success would need to take this into account.

> *So, I think there's a cultural challenge for us, I mean, the way I would frame it and try to frame it to people here is, that there is not one way of being and ICS, we haven't worked out the perfect ICS that everyone can just be, and even if we had it probably wouldn't work for different geographies, nor are there 42 ways, probably, it seems very unlikely there'd be 42 models…So, what we will see in the next few years, if this works well, and if they are willing to learn from each other, is, sort of, pursuit of, if you like, five or six ideal type models, probably shaped by geography and social demography, by and large. So, you'll get a, I don't know, coastal ones with old people, you know, urban ones with working age populations dominating and so on. And we'll start to see some of that reflected in the service models and the kind of, areas where working closely together matter more than in other, other types let's say. And so, you know, and within those different models we would want and expect to see, you know, the good outcomes that everyone ideally should be getting [P005wx_051222_LWG]*

In the short term, several of the interviewees believed that success would be demonstrated by ICSs having a shared understanding of what health inequalities are and being able to use that understanding to drive changes in outcomes.

> *…Well, I think short-term success would be visibility on, you know, inequalities in your planning, in your commitment. It's that point about do you understand, yes, is there evidence of building a shared understanding, is there evidence of building a shared commitment. It's probably your initial phase, isn't it? And then over time, you would look and see, well, how has that impacted on outcomes. Acknowledging that that's going to need to be a mix of national and local outcome priorities, rather than just the ones at any particular moment]that a] politician or anybody else thinks is the important one. So, we're going to have to accept that progress and inequalities might match a local frame of what progress and inequalities means rather than necessarily just a national frame of what that progress means. And there's always a tension there. [P002xl_081122_LWG]*

An NHS England member of staff articulated something similar, arguing that success would be ICSs being able to effectively communicate about health inequalities, understand how they affect their populations and have plans in place to try and address those issues. In the longer term, understandings of health inequalities need to be embedded so that everyone is aware of the problem across the whole of the NHS.

> *I would think policy success would be again around those three things that weren't quite there when we look at the ICS plan. So policy success would be that people would actually be able to articulate the challenges around healthcare inequalities and what they were going to do, and then they would be able to sort of understand how to identify the community at risk and then measure improvements in the outcomes or impact….So it's when we get everybody in the NHS kind of caring about healthcare inequalities, because I think policy success would be like when healthcare inequalities are business as usual, because the more we look the more I realise, gosh, actually healthcare inequalities are a problem in every single aspect of the NHS. [P007yu_081222_LWG]*

This idea of heath inequalities being part of business as usual was important for regional members of staff who suggested that they are often an afterthought in policy development. Health inequalities success would be their inclusion in all policies from their development to their implementation.

> *I think it's health inequality in every policy from start to finish. I think unfortunately what happens quite a lot of the time is policies are developed and health inequalities are an afterthought, and it's very much are we going to negatively impact people here. It's not how are we proactively going to make this a more equitable process or have more equitable outcomes. I think there's something to be said for improved data but also methodologies behind monitoring. [P004cr_021222_LWG]*

It is clear from the history of the NHS that health inequalities are a 'wicked problem' (Stewart, 1990) which will take time to address. Interestingly, one respondent acknowledged that they can never be truly eradicated, instead success has to be about reducing 'the gap'. They were concerned that the current economic climate would negatively impact on the more disadvantaged groups in society, potentially increasing the current health inequalities gap.

> *I mean ultimately, you're going to have to wait years, basically the gap, for example, life expectancy and even in possibly access. Health inequalities will always exist, they will never go away, it's just narrowing the gap and whichever gap you want to look at. And that won't narrow in the next few years, I don't think, if anything it might potentially increase. [P001cg_031122_LWG]*

Success in the short term was described as people being able to articulate what health inequalities are, how they plan to challenge them and outlining the interventions of how they would tackle them.

3.2.6 Summary

In summary, there are a number of different programmes and frameworks that have been introduced to help support and enable ICSs to tackle health inequalities. The Covid-19 pandemic illuminated the consequences of health inequalities and provided the impetus for policy makers to try and address the issue. There is a clear acknowledgement of the importance of health inequalities. The policy documents place responsibility on health services to address health inequalities through a number of different mechanisms. However, when speaking to policy makers the main mechanism to tackle health inequalities was perceived to be the Core20PLUS5 programme. There was recognition that tackling health inequalities was unachievable by the NHS alone and that work with wider system partners was required to address the wider determinants of health. Some policy makers referenced the role of NHS organisations as local 'anchor institutions', using their role as employers to strengthen local economies, thereby contributing to reducing inequalities.

Within national teams, it was accepted in DHSC that there is no shared conceptualisation of health inequalities, in part because with their wider responsibilities they are very aware of the role of the social determinants of health which largely lie out of the purview of the NHS. However, NHS England have adopted an agreed framework which was articulated by policy makers and is visible in NHS England policy documents. The publications from NHS England and their national programmes for tackling health inequalities have used a health*care* inequalities lens to shape the work that is required of ICSs. This approach, although narrow, was described as taking a more population health management approach, focussing on what services and health risks are most amenable to change through the NHS. This national strategy to tackle health inequalities is interesting as it takes an alternative approach to that suggested by Marmot et al 2010, 2020, and adopted locally by many

Public Health professionals. ICSs have received a proportion of their funding weighted for inequalities, but this is not ring fenced, and there is a danger that as resources are constrained the money will be spent on ‘business as usual’ rather than specifically to address inequalities.

Those interviewed acknowledged that tracking and judging the success of policy in this area is challenging, and that there is a danger that without specific monitoring and accountability progress will be difficult to achieve or demonstrate. Regional NHS England Teams play an important role in their oversight of ICSs. Success is acknowledged to be complex and contingent, with most suggesting that embedding health inequalities in the work of the ICS as an acknowledged and important issue that is considered within all decisions would be the most important indicator of success.

4 Case study analysis

4.1 The Conceptualisation of Health inequalities (research question 1b-c)

How health inequalities are perceived, conceptualised and framed is fundamental to the way that they are viewed and tackled by the ICSs in fulfilling their policy mandate as described in Section 3. In this section we explore how the interviewees within our case study sites thought about and framed the problem of health inequalities. Interviewees were asked how they conceptualise health inequalities at different levels within their Systems and what factors shaped this conceptualisation.

4.1.1 Health inequalities – an urgent problem (research question 1c)

The Covid-19 pandemic both exacerbated and highlighted what health inequalities are and their impact. The consequences of health inequalities were visible to all and received much media attention at the time.

> *'And then obviously in 2019/2020 the COVID came and inequalities became really big thing.'. N012pu*

Kingdon's model of policy windows suggests that parallel streams (problem recognition, policy proposals and political process) need to come together for a policy window to be opened (Kingdon, 2003). Although there has been ample evidence that health inequalities existed prior to the pandemic (Acheson, 1998; Marmot, 2010; Marmot, 2020; Townsend & Davidson, 2002), it became clear that the issue could not be ignored during the pandemic and the problem was recognised by all. Politically the consequences of the pandemic could not be ignored as experts were coming forward and speaking publicly and using the media to highlight the impact that the pandemic was having on specific population groups. This provided an impetus to ensure that inequalities were being addressed. Policy proposals started to place the health inequalities agenda as one of the main priorities for healthcare organisations to address when delivering their services.

> *'I suppose just in terms of bringing it to the fore, I think COVIDs really shone a harsh light on inequalities, hasn't it really? And prior to that, I suppose we used to talk about it quite a lot, and we used to do some things, but actually I certainly noticed both, well in my previous role certainly, how the NHS became much more focused on health inequalities and really how COVID shot a spotlight on that through various programmes. Whether that was like a COVID vaccination programme, an uptake in vaccinations to uptake in other health services. So just really obvious differences and differences in communities. So I think we're all trying to respond to that now'. N011mr*

The reality of what was experienced throughout the pandemic has framed how health inequalities are discussed and helped shape the health inequalities agenda. All of the interviewees we spoke to, both nationally and locally all spoke about the importance of tackling health inequalities and that it is everyone's responsibility to do something about them, including the wider political system.

> *Yeah, so every individual who works, certainly in commissioning, but even if you're a healthcare assistant in A&E or in an outpatient clinic, you've got a role to play in challenging where you see inequalities happening. So, every individual, but then when you get to individuals who are in commissioning roles, like we are in the ICS, the responsibility becomes a million times greater. And then the responsibility of organisations, so hospital trusts, GP practices, et cetera, all have a responsibility. But ultimately, we all work in the environment that the politicians set out for us, so it's the choices that they make that influence how much we can do to tackle inequalities. But*

> *there are things we can do to tackle inequalities without any funding, so that is within our gift, but really you'd have to lay it at the government, it's a political choice, we're getting into politics now, don't get me started. N014ax*

Whilst previous commissioning organisations CCGs had a similar statutory duty to address health inequalities, previous research found that the health inequalities agenda was rarely discussed, with limited understanding or acknowledgement of where the responsibility lay. Local approaches were significantly affected by the way in which CCGs engaged with Public Health colleagues, with other staff unsure as to whether or not inequalities should feature in their work (Warwick-Giles, et al 2017). By contrast, the ICS staff that we interviewed across our case study sites all showed an awareness of their responsibilities in this regard, and an appreciation of the importance of the issue.

National policy framing was helpful, with interviewees highlighting the fact that the Core20PLUS5 framework had been useful. It was seen as providing a tangible framework to help shape and focus their approaches to tackle health inequalities. Historically there has been an expectation that commissioning organisations should tackle health inequalities, without any formal guidance of how to do so (Warwick-Giles et al., 2017). The lack of formal guidance potentially enabled health inequalities to be overlooked because of other competing policy and local system demands. The Core20PLUS5 framework provides a collective approach of how Systems can choose their target populations with regard to inequalities. The approach does allow some scope for local areas to choose their areas of focus, but it also includes the significant national clinical areas of focus, ensuring that the national agenda is reflected in local action. It was seen as providing a useful focus and shared language with which to discuss and plan action.

> *It will be really interesting. I mean, some of these concepts, like the Core20PLUS5, are useful because they give us a common language around it as well and they help people who it's maybe new to them. It gives us something concrete to see, oh, I see, so these areas, there's definitely evidence behind, we need to work on them, and we'll have some that arrive. N006sl*
>
> *And the other thing that's probably worth in terms of name dropping, one of the things nationally that does I think, or has helped us and given us something to rally around is the Core20PLUS5, which I don't know how familiar you are with it. But that of course identifies populations and then certain disease areas. All of those we have included within our programme priorities and we've got teams who are working on implementing those, and the children's one, children's Core20PLUS5 has come out in the last couple of weeks. And we're already realigning our plans around that. And they include metrics within them. So they are really helpful. N018xx*

4.1.2 General overview – what are health inequalities? (research question 1b)

We found that health inequalities are conceptualised in a variety of different ways by individuals and organisations within and across each participating ICS site, with many differentiating between healthcare inequalities (i.e. access to care) and the wider social factors contributing to health status. There is confusion around the term, with 'inequalities' meaning different things to different people and frequent slippage between 'health inequalities' and 'healthcare inequalities'. Invariably, the ways in which health inequalities are conceptualised or articulated could be described as different but not wrong.

> *'Because it can be a bit nebulous, can't it, if you just say health inequalities? It really sort of drills down to what could really make the difference? And it helps our whole ICS,*

> *we're all part of the ICS, we've got some work to do on making people realise that, but that's another conversation.'* (N006sl_ DB)

Interviewees highlighted the breadth of the agenda, and suggested that the sheer scale of the problem could be inhibiting.

> '*And also, translate it in a way that…because health inequalities is such a ridiculous term, like what does it mean, it's really confusing, it's jargony? Like when people tell me I'm the lead for health inequalities, I want to have a panic attack, I'm just like, oh…it's like how can anyone do that.'* (N034hm_LWG)

This interviewee recognised the fact that even a defined framework such as the Core20PLUS5 could be problematic, as the extent of disadvantaged groups could be overwhelming. The solution, it is suggested, is to focus on something – anything – and do it well.

> *'So, I certainly wouldn't say that there's any that is crystal clear. I think that point you make though is that the downside, sometimes, of the conversation about inequalities, is it becomes a bit of a never-ending loop, because you don't…because people can explode it out forever. And you get this classic tension, we had it in our team, which is great, to some extent. We had the people who are conscious of how, in any conversation, you want to make sure you don't miss out, potentially, an equality or a potential group that isn't being…that it could be more effective, and keep going and keep going until you've covered it all, versus the, we've got to pick a lane and do something, and proven we can do something, otherwise, we're never going to do anything. And that constant sliding scale is, I sometimes think, where we…where the tension comes in.'* (N043xj _LWG)

The word holistic was often used to describe the desire to ensure that health inequalities were conceptualised as being a consequence of a multitude of factors, including the wider determinants of inequalities such as social factors, economic, environment, education, housing, learning disability, in contributing to health inequalities.

> *'So you can look at socioeconomic, that's a huge driver of health inequality. But you can also look at…and these are all intersectional. But you can also look at educational attainment, employment, obesity levels, age, et cetera. And all of those things in some way or other map onto measurably different outcomes in people's life healthcare outcomes.' (N028oe_SB)*

When asked, a number of interviewees asked the interviewer to clarify the question as to whether we were asking for their personal conceptualisation or that of their organisation and in many instances, responded with what they perceive as their personal thoughts and ideas. However, the discussions were blurred such that it was difficult to discern where organisational, personal or other conceptualisations are conflated.

Personal, disciplinary or other background could be influential. One Public Health Consultant split their conceptualisation of health inequalities into two domains. The first focused on the wider determinants of health, using the principles set out by Marmot et al (2010, 2020). This framing has been very influential in Public Health since 2010 and was discussed by a number of Public Health interviewees (N013vv, N033il) who saw this as a core part of their role. The second domain focussed more on the clinical aspects of inequalities that the NHS are able to tackle. This is an interesting understanding of the problem, as the two main ways of conceptualising inequalities will require different mechanisms and come under the purview of different public sector organisations.

> *'I suppose in a very pragmatic sense, I would…the way I visualise this…that agenda would be broadly to split it into wider determinants, so upstream wider determinants. Housing, greenspaces, fair employment, you know, all that…fair work for all, all that kind of stuff that would fall under Marmot. And then the more NHS-facing clinical priorities that are embodied within Core20PLUS 5 Adult and Children's Frameworks. So I suppose together, I would…and obviously, there's a layer of interpretation and adaptation of that to match it with local priorities as well.'* (N038fb_DB)

Understanding the experiences and needs of their population, both at Neighbourhood and Place level, was also cited as informing some participants' conceptualisations. Being embedded in a local community and working with and alongside, community members was a way of appreciating and understanding health inequalities.

4.1.3 Influence of organisational roles and geographical scale (research question 1c)

Whilst we found general agreement that inequalities are important and that ICSs have a significant role in addressing them, the complexities around the definition of inequalities that we highlighted in our introduction were mirrored in our case study sites. We found considerable variation within and between sites, with some highlighting the importance of considering inequalities in everything they do, whilst others saw inequalities as a separate area of work. This Local Authority participant encapsulates some of this succinctly by suggesting;

> *'I feel as though the NHS in our system really understands the inequalities agenda. It isn't unusual for us with the chair of the ICS to have a conversation about wider determinants. There is a lot of conversations…I think sometimes they've had quite a focus recently on inequalities, which again is another element of inequality. So, yeah, I think we probably all have the same narrative**, I guess maybe there's just different emphasis on different building blocks potentially**.* (N033il_LWG)

Again, as the above quote alludes to, the way health inequalities are conceptualised is potentially dependent upon where you sit organisationally within the ICS. Those employed in the NHS and following the Core20PLUS5 framework will have different conceptualisations of it than those working in Local Authority Public Health. However, the collaborative ethos within newly created ICSs was highlighted as having the potential to support a wider shift in approach to inequalities.

> *'Brilliant buy-in, I have to say lots of really good energy and enthusiasm from different parts of the system to…everyone's talking about inequalities and prevention, which is brilliant and it's all happening grassroots in different parts of the system. It's just this idea of having an ICS framework or conceptualisation of inequalities and coordinating that and leading it is maturing. So I'd say I don't think I could confidently just say, yes, that's how everyone else sees inequalities because I think everyone probably sees it differently but there's this work now to get everybody on the same page with how we see inequalities and what…where we fit in that jigsaw. So no, I don't think we've all got the same vision at the moment. I think there's lots of brilliant work happening and now we're working to try and get everyone on the same page so we can see how we're working together as a system more.* (N038fb_DB)

However, respondents acknowledged that there remained work to be done, because the needs of individual organisations might be at odds with the needs of the wider system.

> *'And then when you get down into organisations, I think, I think we probably haven't percolated it down that far yet, we still get cost shunting and we still get decisions made that will impact adversely in another organisation which will mean we probably won't get the best outcomes for people, and that won't help you address the inequalities, so how do you push that down.'* (N017ou_JH)

Interviewees recognised the need to address inequalities across the different system levels. For example, this GP stated; *'should be a thread through everything we do, for everybody, if you like. It's one of those ones that's key to everyone, isn't it?* (N006sl_DB)

Others highlighted the need to generate a shared understanding across the different levels, and to commit to something.

> *'I think definition and language is always really interesting. So, inequalities, inequities, disparities, differences, let's be clear on what it is we're talking about, let's define the problem, let's look at the data, let's look at the evidence base and let's commit to doing something about it.' (N022nl_LWG)*

In this regard, population health data were seen as an important tool in informing strategic programmes for tackling health inequalities across all of our sites. Such data, along with the use of health inequality indicators and dashboards, can illuminate differences and unseen inequalities across Place and System level. However, how data are aggregated across which geographical footprint, and how the population is segmented will affect how the problem of inequalities is considered and addressed. This is particularly complicated for systems where there are wide variations within a single geographical area.

> *'Our population is so diverse in terms of the types and whilst we are a predominantly white county there are still pockets of very different populations in different areas. So it's hard to [have an overarching view]. I think the thing that does pull it together which is used quite often is that difference in life expectancy between our most deprived and most affluent areas which is something like 20 years, which is staggering and criminal. And that gets talked about quite a lot.'* (N41oj_LWG)

Consistency and shared definitions were said to be important:

> *'And then you're into sort of the vertical levels of governance that each of those organisations will have. They're all doing their own thing there as well. So, I suppose the question is, how do you bring it all together so that you have, as a system, one holistic view that you can all sign up to? And either the other bits go away, or they are aligned with what you have to do. So, I guess it's aligning the system so that everybody can commit to that one holistic view of what health inequality is.' (N001fw_SB)*

This highlights the importance of simple and compelling messaging which Systems needed to galvanise action.

4.1.4 Philosophical issues: Medical Model vs Wider Determinants (research question 1c)

Many participants considered the Core20PLUS5 a useful and helpful framework and frame of reference, providing a common language and standardised definition round which to coalesce, as well as setting direction for tackling health inequalities. However, there was some criticism from

Public Health colleagues across the case study sites that the concept is a blunt tool, focussing too narrowly on specific population groups.

> *'There's a slight anxiety for me that we've got Core20PLUS5 because again the Core20 is 20 per cent, which isn't progressive universalism as Marmot suggests. Marmot says, yes, do that 20 per cent, but you need to have a system that goes across, not just target the 20 per cent.'* (N013vv_LWG)

> *'I think the tension comes when…the biggest thing that's cause the tension is Core20PLUS5, because I think what it…and it's perfectly welcome and we have to tackle all aspects of inequalities, but what it's done is it's distracted the rest of the system from the whole discussion about the wider determinants, and getting people to think more broadly, and focus people on thinking that that's the only thing we need to do to tackle health inequalities*. (N033il_LWG)

It was also criticised for focusing upon health*care* inequalities.

> *'And then you've for the Core20PLUS5 piece also, the only problem it's in a useful framing but the only problem is even in the framing rather belatedly I noticed in the heading itself is the clue, it's in the NHS England website itself it's labelled as healthcare inequalities framework. So it is not the full picture, it's almost that 20 per cent, speaking to that 20 per cent.* (N003zo_SB)

Other interviewees identified problematic tensions between the medical model perceived as underpinning the Core20PLUS5 model of health(care) inequalities and wider ideas about the social determinants of health. There was an acknowledgement that focus solely on one aspect is insufficient to tackling health inequalities as the following quotes suggest;

> *'Because the health services on their own…NHS Core20PLUS5 isn't going to solve health inequalities on it's own, is it?'* (N007aw_LWG)

> *'And two, it's very much, as I said, as great as that framework is, it is still a medical model…And that would restrict our ambition and outside the box thinking. So, we've purposely kept the two separate, so that we can do exactly what we need to do in CORE20PLUS5, but we can still have than innovation and ambition within the health inequalities network. And then we have different streams of work that come off that, if and when they're needed.* (N019qv_LWG)

In keeping with this, there were a number of discussions about managing different perspectives and conceptualisations. For example, some interviewees suggested that it is the job of the NHS to manage the burden of poor health and that of the Local Authority to manage causes of poor health. It was emphasised that both parties need to understand their roles in addressing the problem and work together not in contradiction.

Again, there were comments around the lack of understanding of the term from the healthcare side when viewed from a Public Health perspective.

> *'And it's interesting from the health side; people talk about inequalities and then when you say, so, you know, what…how do you deal with that, I don't think people quite know.'*(N010xh_SB)

> *'There's something about the journey that the NHS needs to go on here, and I am thinking about local but also national as well. The NHS hasn't quite got its house in order yet. So, I think probably the NHS going into wider determinants of health right now possibly isn't the right approach, they need to focus on some of the basics.'*
> *(N022nl_LWG)*

In the main the Core20PLUS5 conceptualisation has been influential in shaping work programmes detailed by interviewees in our study. One ICB member said they have given them something to rally around and are included in their programme priorities, finding the metrics particularly helpful. Some suggested that the clinical focus is complimentary to other conceptualisations of health inequalities, highlighting the important cross-fertilisation that was happening as organisations from different sectors started to work together.

Whilst some senior leaders – notably those from NHS England – highlighted the differences between healthcare inequalities (i.e. those arising out of inequalities of care provision) and the wider concept of health inequalities, interviewees in our case study sites often demonstrated a good understanding about the ways that these were linked, highlighting the fact that social deprivation could influence the ability to access services.

> *'Well, I suppose for me basically health inequalities are unexplained and, what's the word I'm looking for…not unequal, what is the word I'm looking for…well unfair really, differences in health outcomes between different groups, or access to health services, you know, experience and outcomes for different groupings of people. And often the route of that is inequalities in the wider determinants of health, that brings about inequalities in health outcomes. But also there can be inequalities in terms of access to health services as well, or inequalities in people's experience of health services, when they do access them.'*
> *(*N040lr_LWG)

4.1.5 Summary – identifying and defining the problem

Overall, we found that perceptions of health inequalities within our case study sites mirrored the complexities that we have identified more generally, with interviewees from all sites and all levels within sites articulating a wide range of views and perceptions about what health inequalities are and how they should be tackled. However, despite this complexity of views, it is possible to identify a number of key themes and tensions. Firstly, our case study sites were all clear that health inequalities were a very important part of their role. The Covid-19 pandemic provided a stark illustration of the impact of inequalities, and the development and dissemination of national policy in this area – including the Core20PLUS5 framework - has been helpful in emphasising the importance of inequalities and in shaping local conversations. Many interviewees told us that they felt that the collaborative ethos developing within their ICS was important in supporting action on inequalities, although we found some differences between those who saw the health inequalities agenda as pervading all that they did, and others who saw tackling health inequalities as a separate stream of work. Secondly, interviewees often articulated the fact that the sheer breadth of the agenda and the multiple different axes and dimensions across which inequalities may be found could be paralysing, with many suggesting that it was important for ICSs to pick something – anything – as a focus in order to avoid that paralysis, with consistency of definitions and understandings within a system seen as being important. The Core20PLUS5 framework was felt to be useful in supporting Systems in choosing their areas of focus. However, this tied in with our third overarching theme. We found something of a fundamental tension between those – often from a Public Health background – who emphasised the importance of the social determinants of health and the need for wide action to tackle poverty, housing need, educational provision etc, and those who took a more limited view focusing upon action within the healthcare system. The Core20PLUS5 framework was felt by some to be linked to this narrower approach, although others suggested that setting more limited goals in areas where the NHS has a clear role and potential to act would be a useful start, with wider action seen as the responsibility of the wider partnerships within the system.

Our data was collected in the early stages of ICS development, and it is therefore not surprising that, as yet, many Systems have not yet come to a shared understanding of the nature and scope of inequalities within their geographical area. The need for such shared understandings was clear amongst our interviewees, but our findings suggest that Systems will need to consider not only which groups across which geographies facing which sorts of disadvantages they wish to focus upon (as set out in the Core20PLUS5 framework) but also find a shared language between those from a Public Health background and those taking a more health care focused approach.

4.2 Inequalities in the work of Integrated Care Systems (research question 1c and d)

4.2.1 Introduction

In this section we explore how our case study ICSs are addressing inequalities within their work. We explore: approaches to operationalising the Core20PLUS5 framework, and the issues that arose; the influence of previous relationships and legacy work programmes; the impact of performance management regimes; the role of local Public Health teams; and the approach taken to the distribution of funding. We finish by setting out some of the types of work programmes which have been initiated under the broad heading of tackling health inequalities.

4.2.2 Operationalising the Core20PLUS5 framework

As highlighted above, the Core20PLUS5 framework was welcomed as providing Systems with a shared language and framework within which to think about how they might approach the task of tackling inequalities. However, as with any models or approaches, the Core20PLUS5 framework does have some limitations. Local Authority Public Health staff were concerned that the framework had adopted a biomedical approach to understanding and tackling health inequalities, failing to take into account the wider determinants of health, arguing that this approach does not address the root causes of the problem.

> *There's a slight anxiety for me that we've got Core20PLUS5 because again the Core20 is 20 per cent, which isn't progressive universalism as Marmot suggests. Marmot says, yes, do that 20 per cent, but you need to have a system that goes across, not just target the 20 per cent. So they've not listened to Marmot principles in the way they've set that Core20. Then the PLUS5 is again getting us down a group aspect rather than a progressive universalism approach. So again it's, let's target these groups, which is good in one way, but it's not the complete picture. Then the PLUS is we can maybe pick one or two things to do, so we haven't actually got a lot of flexibility really. I feel it's quite nationally set, some of it. N013vv*

Furthermore, one of our interviewees commented on the Core20 aspect of the framework, arguing that focussing on the outlined target population was not particularly helpful for all ICS areas. ICSs serving largely deprived communities would have the majority of their population situated within the most 20% deprived population. Thus, making it hard for ICSs to target those populations without any adequate remuneration.

> *Being blunt, I find it useful because it's a national direction. The NHS does what it's told. So, I…so, you know obviously, the five areas are the five areas, a lot of the things that you need to do around some of your population health challenges, the upstream activity, if you get the upstream activity right it'll impact on a load of other programmes as well. So, in a sense it doesn't massively matter, you know maybe kind of maternity is different, but it allows a focus, so it's good. The interesting thing for me about the Core20 is, just going back to what I said about XXX population, 60 per cent of our population is in the Core20. So, if you're saying the Core20 is a priority, then straightaway, to me, I go into resource allocation and say, well okay what does that mean for the 60 per cent of XXX population that's in the Core20, what are you actually going to do about it, where…you know, put your money where your mouth is, type stuff. So, it's a good hook and it's a good, you know, direction but I think we need to see what that means. N022nl*

Other ICSs in a similar situation have tried to overcome the Core20 issue by focussing on smaller groups of their most deprived population. Such local amendments to the framework allowed the ICS to still address inequalities in the way that had been nationally defined, but focusing upon a narrower segment of the income scale. Unless these disparities are recognised nationally through funding models there is a danger that the inverse care law could be further reinforced, with ICSs serving more deprived populations having a more difficult task than their more affluent counterparts.

> *I mean, I think first thing to say, [ICS area] we agreed it would be the Core10PLUS5 because just the 20 was such a big proportion of our population, it wasn't targeted enough, so we've done that. N023ks*

In addition, the way the framework sets out to segment the population is likely to encourage ICSs to adopt smaller more targeted pieces of work rather than taking a more strategic whole system approach to resource allocation to reduce inequalities.

4.2.3 History and previous relationships

The framework within which ICSs developed was deliberately permissive, with local Systems given considerable leeway to develop structures and ways of working which were congruent with their local histories and geographies. Some ICSs had the benefit of pre-existing good relationships and a history of working together, whilst others were newly formed based on new groupings of organisations. These factors can be very important in shaping what action is taken (Coleman et al., 2010). One of our ICS sites had worked together for a number of years, with their ICS footprint mapping onto longstanding geographical commissioning footprints. This provided continuity both across and within the system. Leadership roles at both System and Place level remained the same, with CCG and Sustainability and Transformation Partnerships (the forerunners to ICSs) staff continuing to work within the ICS. Trust and ways of working were well established which enabled the ICS to delegate both decision making and finances to Places, with the aim of ensuring that healthcare commissioning decisions were being made closer to smaller population groups. This delegation significantly shaped the health inequalities agenda, with senior leaders emphasising the fact that meaningful action on inequalities would take place within local communities at Place level.

> *And that comes back to those mission statements of an ICB in terms of reducing those inequalities, but it's about, actually, it's about the culture of working together as a*

> *partnership, recognising where we're having that right data, recognising we've all got the right...that we've the same, so we're all coming from the same data. Recognise that it is about partnership working, but recognise that it is about what goes on in our communities and in our places and that's where it's most important. N026pk*

Historical ways of working and strong existing relationships enabled this ICS to develop a fairly advanced approach to governance, with a nuanced understanding of when local action was required and when an ICS-wide approach might be more appropriate.

> *So, we will always look for where we can add value by doing something at system. Where something might be a particular challenge, so it's better for us to put our heads together and look at it as a system, or where resource demands mean it makes sense for us to do something collaboratively…So, we're not duplicating, we're not doing things beyond our scope, and what we're doing is supporting things to happen closer to home for people in neighbourhoods and localities at Place. N019qv*

However, longstanding relationships are not always helpful; ossified leadership and relationships could potentially make it harder for new approaches to be adopted across the System.

These longstanding relationships and ways of working were not evident across all of our case study sites. At the time of data collection, one of the Systems was still working on its internal relationships whilst trying to build a leadership team. There were concerns that there was considerable heterogeneity across the ICS geography, with high levels of affluence and of deprivation. There were many discussions of how the System would need to understand the different challenges and how they need to be addressed. This highlights the difficulties associated with addressing inequalities in heterogeneous Systems.

> *Yeah, it's much harder, isn't it? So I think that's why some people had not wanted us to be part of xxx ICS, to be honest. They wanted xxx with its own ICS…We need to work really hard to understand each other across xxx and across xxx. The same thing goes the other way as well. I'm not sure in xxx we've really realised just the mammoth task for people in, say, the middle of xxx, to try and provide for their population and how difficult it is and what the challenges are. N006sl*

When exploring health inequalities local programmes of work, it was evident that some programmes had been in existence prior to the establishment of ICSs, with historical working practices shaping the health inequalities agenda. In one case study site, a programme of work had been developed and introduced by Public Health colleagues prior to the introduction of the ICS and was then adopted by the ICS.

> *Yes. What we've agreed as a system is that the work that we did with Marmot and the [inequalities] report is going to be at the heart of the work that we do. What we've done at each place level, at each borough level, is our place plans are going to incorporate the Marmot work so that our outcomes will be around tackling health inequalities. That's what's driving us all really at xxx is tackling health inequalities. N032yh*

In this case, the formation of the ICS did not set the direction of the health inequalities work. Rather, this programme had been established and led by Public Health staff who worked across multiple Local Authorities. This is of particular importance for this ICS because the System was in its early establishment and did not have any history of working together. The existence of a well-developed programme of work on inequalities was helpful, as it provided something for the ICS to adopt and focus upon whilst the longer-term complexities of working together were considered and addressed.

4.2.4 The role of Public Health

The example discussed above illustrates the importance of the role of Public Health in shaping how ICSs have incorporated inequalities into their work. The Public Health profession has a responsibility to improve health and to tackle health inequalities. The Public Health England Strategy 2020-2025 (Public Health England, 2019) outlined the priorities for Public Health to ensure that they are protecting and improving the health of the population, whilst also tackling health inequalities. Since 2012, Public Health has been situated within Local Authorities, a policy move that was welcomed, at the time, by many (Kingsnorth, 2013). Since Public Health services moved away from the NHS and into Local Authorities, it is natural that the relationship with healthcare services changed. Early research by (Warwick-Giles et al., 2016) demonstrated that local Public Health teams and their defined roles influenced the local health inequalities agenda, via their relationships and links with healthcare organisations. The role of Public Health was shaped by existing relationships with healthcare organisations and the prioritisation of the Public Health agenda.

The current legislation placed statutory duties on ICSs to tackle health inequalities and work in partnership to meet the healthcare needs of their population. When considering local organisations to tackle health inequalities, the responsibility and skill set of Public Health teams was acknowledged as being crucial for addressing health inequalities. Public Health had a role within all of our three case study sites. However, the role, responsibilities and the presence of Public Health varied across and within each site. The central policy guidance did not clearly define the role of Public Health within ICSs, instead Local Authorities were spoken about more broadly. A lack of defined role for Public Health may lead to variation in how Public Health expertise is utilised by ICSs. There are multiple examples of how Public Health were involved with their respective ICS and the health inequalities agenda. Some staff praised the data analytic skills of Public Health colleagues.

> *And the way I know it is…no, for me, it is all based on working with the public health teams and the data we get from them. XXX in particular public health team has published data across all of our [XXX] partnerships and is brilliant in the way it produces its information, and can be drilled down into, and things like that. So that's been really useful. And then at the more PCN level is that population health management programme that's ongoing. N049vd*

In some cases, joint working across healthcare organisations and Public Health was visible. There was a sense of pride that NHS strategies were being developed with Public Health to ensure that the wider needs of the population were being accounted for.

> *I feel positive that through the joint work with colleagues in Public Health like [PHC 1 & 2], our directors of Public Health, that we have absolutely predicated our strategy on the Robert Johnson Wood model, which you will know is around the wider determinants. This isn't a strategy about healthcare, it is about the wider determinants. N027so*

It was recognised by some, that Public Health expertise skills were not only required to identify population challenges but also to outline how ICSs could ensure that the needs of the population were being met. The expertise of Public Health provides a different perspective for healthcare organisations to consider when planning services and challenging health inequalities.

> *Yeah. I mean, I think the director of public health is really important because I think their public health annual report is their chance to kind of set out having looked at the health*

> *needs and done the JSNA and everything that comes with that, what is it we want you as health deliverers, health partners, to focus on. So I think they have a very important role in setting out what they want us to focus on from that population health perspective. So I think they've got that. N005yp*

In one of our sites, one ICB member of staff explained that Public Health have specific areas of work to focus on, accounting for the wider determinants of health. It was felt that the System as a whole worked well with Public Health colleagues ensuring that they were a fundamental part of the ICS, with representation within key leadership groups as well as not only being a part of, but in some cases leading health inequalities programmes of work, on behalf of the System.

> *So Public Health is very much around the health, you know, Healthy Behaviour and making sure that the people are living in the environment where they can have a healthy life. So very much around the wider determinants, plus the healthy life behaviours and working on obesity and smoking and all that and promoting the healthy lifestyles. We work very well with the… All the directors of Public Health, they are an integral part of the leadership groups. In the ICB, ICS, they are also, they helped us in creating the strategy for Core20PLUS5. N012pu*

To understand the role of Public Health in ICSs further, we used a Public Health typology that was developed by Warwick-Giles et al (2016) to explore the role of Public Health in shaping the local health inequalities agenda in newly forming CCGs. Warwick-Giles et al. found that there were three identifiable roles that Public Health staff were undertaking when working with CCGs (see table 5).

Table 5: The role of Public Health in CCGs

Role	**Definition**
Service Provider	This is a transactional relationship defined by roles, structures and rules. The relationship can take two forms, whereby Public Health offers a list of services that they can provide to healthcare organisations or where healthcare organisations can request that Public Health undertake some work on their behalf.
Critical friend	Public Health is not necessarily involved with the development of plans with healthcare. They are able to operate in a similar way as the service provider model. However, the relationship has developed further with Public Health being able to off comments and critique to partner organisations, influencing the agenda.
Co-owner	Public Health are a co-owner of the public health agenda alongside healthcare organisations. Often having voting rights and being able to be part of the decision making with healthcare.

We found all of these roles identifiable within ICSs. However, whilst in the original research, Warwick-Giles et al. found that each CCG had a relatively cohesive and standard approach to working with Public Health, in ICSs we found greater variety, with several types of relationship manifest within a single site. This may simply reflect the larger size of ICSs compared with CCGs, as well as the fact that each ICS contains within it, multiple Public Health teams situated within each Local Authority. However, we found that the typology was still useful in helping to unpick the nature of the Public Health role(s) in each site.

4.2.4.1 Public Health as a Service Provider

In one of our Systems, Public Health staff were provided with a seat at both System and Place level committees, however these seats did not come with any voting rights. Thus, they were unable to directly shape the work of the ICS, instead their role was perceived to be there to build relationships and ensure that Public Health and healthcare work was aligned.

> *So it's to provide Public Health advice to the board and representation on that. It is a non-voting position and I think, yeah, I think it's really good, actually it really adds a lot of engagement, prior to that, around should…you know, everyone wanted to join the Integrated Care Board, didn't they? And we had to be mindful that it actually was really important we had local authority representation on there as well…We could have been invited to come along if we had topics to take there, but the fact that we have a standard invite, I think is a positive thing and we are a part around that table to discuss*. *N007aq*

The importance of Public Health intelligence and data were apparent across all of the case study sites. Public Health data was essential for ICSs to understand their local demography and in turn help shape programmes of work and services that the NHS introduce.

> *I think there is an area in the middle where they come together. If I think about the role that the ICB has obviously working in close partnership with our partners in xxx Council and xxx Council. We obviously developed the Integrated Care Partnership and we are really drawing on the public health data to help us to really understand what the demography is of the different parts of xxx and where there is variation across our communities and our populations. N027so*

Public Health insight was seen as crucial for helping to develop local inequalities programmes of work. Across the sites Public Health intelligence had been used to develop their work in response to the Core20PLUS5 framework. Across the systems, Public Health staff were asked to lead specific programmes of work, where their expertise was seen to be useful, on behalf of the ICS. This is a good example of the service provider model, whereby Public Health is conducting work on the behalf of the ICS.

> *…we opened in November, and since then we've also had our public health team from our local council have provided vaccination services. N45dq*

4.2.4.2 Critical Friend

This role provides services to healthcare organisations but with an added ability to offer more comment and critique of work that is being undertaken. This was evident with the Core20PLUS5 framework. Although, the model itself was deemed as a useful tool to enable conversations about health inequalities, the focus was seen by Public Health colleagues as too biomedical with centrally pre-defined goal. The approach taken to develop the Core20PLUS5 framework was viewed to be in potential conflict with how Public Health operates.

> *And everyone goes, and we've got another one, Core20PLUS5 for children. You've got nought-to-19 programmes, nought-to-25 programmes. You create an architecture and an infrastructure which is about producer capture. And you know what I'm talking about with that. …… Oh, Core20PLUS5 for children. What the heck are health visitors or school nurses meant to be doing in that space? But again, it's how you use those kind of things, and how you lever it, and whether you use it as an opportunity and just accept people are putting resource in there, and you can either do a King Canute or you can say, okay, how best can we actually align that initiative into other things that we want? N048fx*

There was some evident tension regarding where Public Health should be situated, either with the Local Authority or the NHS. In one of our case study sites, the ICS had employed their own Public Health team to work on behalf of the NHS. In some cases, the additional Public Health resource was seen as a positive, particularly with the central reduction of funds allocated to Local Authorities and the reduction of the Public Health grant. However, in this site, it created problems with ownership of specific programmes of work. One of the Local Authority Public Health staff explained that they felt that staff in the NHS should focus on the things which they could influence, rather than encroaching on the wider Public Health agenda.

> *And I know you made that comment about the NHS has little role in tackling inequalities in its broadest sense, I agree with that. But I also think it's almost like why try and do everything when you could just do the things you can influence, which is healthcare public health, which is what is your inequality of access to these services, what is the inequalities in outcomes of your interventions, and how do you make sure that we're preventing some of these things N025cf*

One Public Health Consultant commented that one of the major frustrations for Public Health staff is that they often have limited access to funding, therefore their ability to design and deliver services is limited. This is particularly challenging when they are expected to reduce health inequalities. The limiting lack of funding means that often the role of Public Health is about influencing rather than doing. This is where the role of critical friend is important and potentially influential.

> *…it's another one of my huge frustrations about health inequalities and public health is that we're often influencing. But to make real change, you need to get your hands on the commissioning money, you know, to commission services differently. So my initial vision for it was, it would be a commissioning lead that would work to get all the budgets from the various places and either working sort of…some places might say brilliant, we don't want to do the commissioning, have our budget. Other places, probably a big place like xxx and xxx would be like, over our dead bodies, we've been doing this for years, you're not taking it off us. So…but the idea was it would be a real job and not just kind of like, oh, let's talk to people about how they can do better with refugees and asylum seekers, which won't result in anything. N034hm*

4.2.4.3 Co-owner

It was evident when discussing the health inequalities agenda that Public Health did have some co-ownership of the programmes across the ICS areas. As mentioned earlier, one of the programmes of work had been developed by local Public Health staff, prior to the introduction of the ICS. This meant that the health inequalities strategy was co-owned by both the NHS and Public Health as the ICS adopted it and wanted to deliver against the programme's goals.

> *So I think…having the Marmot report [named report] there is really helpful, because a lot of the pre-work's been done. But we need to work really hard to get the*

> *infrastructure behind it. Our local authorities from a public health perspective have a lot of that. Again, one of the real strengths in xxx and xxx has been the xxx local authorities for several years have worked really closely together on some work programmes…And they all put money in to fund a single team who do some of that central infrastructure work around the shared work programmes they have. And that's where the Altogether Fairer work is being led out from. And then obviously in our places they have more localised plans as to how they will implement the priorities in those 22 beacon indicators that you've clearly already had a look at. N018xx*

One of the ICSs when developing their System strategy did so alongside Public Health colleagues, ensuring that the strategy was not a healthcare one but in fact accounted for the wider determinants of health. Public Health knowledge was utilised alongside healthcare commissioners to ensure that they developed a strategy that encapsulated different organisational expertise to meet population needs.

> *I feel positive that through the joint work with colleagues in Public Health like xxx and xxx, our directors of Public Health, that we have absolutely predicated our strategy on the Robert Johnson Wood model, which you will know is around the wider determinants. This isn't a strategy about healthcare, it is about the wider determinants. N027so*

Co-ownership of the ICS and programmes of work was also visible when Public Health staff were given committee roles that had voting rights. This ensured that their expertise was utilised in decision-making. The role of Public Health was included within the system rather than being there as an observer of the work being undertaken.

> *So, I am the director of public health for xxx Council, but I am also the nominated director of public health into the integrated care board for xxx. So essentially it is a formalised role in that I applied, I don't think I've got a contract as such, but essentially I've applied and I am their representative on their board from a public health perspective. My understanding is that I am a formal board member, so an executive board member that represents public health. So, if there was to be a vote, I would have a vote. N025cf*

4.2.4.4 Internal vs external Public Health expertise

We have demonstrated the different roles of Public Health within ICSs using the Warwick-Giles et al. typology. Public Health staff were found to be working hard within ICSs, influencing and seeking to steer the work of ICSs, particularly around inequalities. The latest Health and Care Act establishing ICSs left Public Health as a responsibility for Local Authorities, as determined in the Health and Social Care Act 2012. However, we found that it is increasingly common for NHS organisations to employ their own Public Health staff. This created tension in some cases between healthcare Public Health staff and Local Authority Public Health staff, with concerns that the NHS were trying to lead on an area that was not within their portfolio of work.

> *So, from a… Did people welcome that as an option with open arms? There was a bit of a sensitivity in local government in the early days. And I think that sensitivity and was public health, the functions of public health are a local authority responsibility. So why would the NHS want to appoint somebody who's a consultant in public health? And is this a takeover bid really? And this was probably about four or five years ago we had this conversation. N039vg*

One Public Health member of staff saw having Public Health resource situated both within and outside of the ICS as an advantage, as it served to amplify the Public Health perspective.

> *But also, the wider xxx system, so the DsPH and the consultants in public health from xxx that that post can be calling on to do work together on healthcare, public health. So, I guess, if that…I know that again, was an outpouring, but we've got a voice both inside and formally and also outside and informally. And we use that influence to try and shape what the priorities are and where the energy goes, where the focus of effort goes. No22nl*

Public Health teams situated within the NHS were seen to have access to funding which enabled them to lead programmes of work and decide where money should be allocated. This was visible across two of the ICS sites, whereby NHS Public Health staff were deciding which local programmes of work should be funded.

> *And we also have the population health programme board which is a [System] programme board, and that is particularly looking at things like health inequalities, so that tends to set a bit of a tone about areas of focus and what the priorities are. I'm not part of that board, but it's been quite important in sometimes distributing some of the small amounts of money that come into the system and so on. N023ks*

This was particularly challenging for Public Health staff working within the Local Authority who are operating within a climate of shrinking budgets. It is too early to understand what the impact will be of employing Public Health staff within ICSs. In the short term there were concerns that having two different Public Health teams within an ICS could lead to duplication of work, and that without any mechanisms to bring them together the teams may be working towards different goals. There were also some concerns for the future of the Public Health Profession within Local Authorities, with some suggesting that Public Health experts might choose to work in the NHS as they could be paid more and have greater access to resources to deliver programmes of work.

4.2.5 The allocation of funding

As set out in Section 1.3, each ICS receives an allocated amount of central funding. Once the funding has been allocated to each ICS, it is then their responsibility to decide how the funding is allocated locally. However, it is important to be aware that much of the internal distribution of funding is driven by obligate spending, for example the cost of hospital appointments and procedures, with discretionary spending representing a small proportion of overall funding.

Within this overall framework, we found that the distribution of funds and local governance arrangements at ICS level is complex and varied across the three ICS case study sites. There were two main funding sources that were discussed by ICS staff, including the central allocation and the health inequalities allocation. The money allocated to tackle health inequalities was not new money; rather, it was a ring fencing of a proportion of the existing budget to be spent on health inequalities work. This ring fencing was short term, lasting only for the first year, with subsequent annual financial allocations wrapping the money into the total budget. The amount nominally allocated was seen as a relatively small proportion of the overall ICS allocation.

> *So we have a very small allocation that comes down to…which is particularly for health inequalities and we make sure that is spent on it. N041oj*

The 'small' amount of money allocated for health inequalities had implications for how health inequalities programmes of work could be developed. A number of the interviewees spoke of their frustrations about the health inequalities agenda being consistently funded via small amounts of money, often with short term time frames. This was said to be very limiting for ICSs, as they were unable to invest in programmes that required longer term financing, which led to them focussing on small scale interventions.

> *But the issue with CorePLUS5 for me, and I know it's just probably like a national issue, is that it's one-year funding at the moment. So I know it will probably be…probably continue but, I mean, it is quite funny because you just think we're trying to like solve intractable health inequalities in the most deprived communities, in a cost of living crisis and all the rest of it. How can you possibly do that with only one-year fund…you know, a one-year funding decision? N034hm*

The one-year ring-fencing of the budget for health inequalities was particularly felt to be a problem because leaders were aware that once the money nominally allocated to health inequalities was wrapped up in the core budget it would be very difficult to extract it to make sure it was spent to alleviate inequalities. Having ring-fenced money for a year led to a drive to allocate it quickly to schemes which could be got up and running quickly. Once the ring-fencing ended it would be hard to extract the money from pressing needs elsewhere.

> *It helps if you knew that that was always going to be the case, and what you weren't going to get is a year later, well, it's in your core budget, and it's that lack of certainty that means what you do is you give the money to people who can take it quickly, because you have no guarantee it'll come next year, and if they say it's in your core budget, well it won't get spent on that though, it'll go……because the core funding is under such pressure. N023ks*

Thus, our respondents told us that to really bring about change and impact on health inequalities, there needs to be an adjustment to the whole of the ICS allocation, with the amount of money allocated more closely reflecting the level of deprivation within the population. However, this would be very difficult to achieve in practice, as without a significant uplift in overall funding such an adjustment would lead to some areas losing funding, which would have had further knock on effects on the core ICS task of reducing waiting lists.

One of the largest challenges for ICSs is the expectation that they need to end the financial year in financial balance. This was felt to be particularly challenging because systems are continuing to deal with the consequences of the Covid-19 pandemic and the austerity of the previous years. Ultimately, it was felt that there is not enough money to meet local demand. This has consequences for investment into new schemes, particularly the prevention agenda. Outcomes will only be visible over the longer term and therefore the financial challenges and annual monitoring framework restricts the work that systems are able to undertake. The operation of the NHS impacts on how funding is allocated and spent. The System is demand led which does not allow for money to be easily reallocated to address inequalities.

> *But that's not to say it's not right, people can't get an appointment with the GP. It's just the demand for services post pandemic is just huge. And we don't have any workforce to expand because everyone's retiring as quickly as they can because they've realised it's just not worth slogging yourself to the grave almost, being slightly depressing. We are seeing that across many of our professions that people are getting out as soon as they can because they're burnt out. So I'm painting a bleak picture, I'm sure we'll come onto some of the positives as we go through the questions. N018xx*

Beyond the overall allocation of funding to ICSs, the approach to tackling inequalities within each ICS will be influenced by how that core allocation is distributed internally. This in turn will depend upon local internal governance arrangements. These varied considerably across the three ICS case study sites with regard to decision making and funding distribution. This is important because where the budget is held and by whom naturally shapes the responsibility of who it is to lead and tackle health inequalities. One of our sites had delegated the majority of the funding directly to Place whilst other sites chose to delegate specific amounts and in one case, at the time of data collection, ICS funding was being held at ICB level. As discussed in Chapter 2, the geography over which inequalities are defined will affect which populations are targeted.

In site A, the System decided that they wanted to allocate funding in a way which took account of the differing needs of Place populations. However, they acknowledged that their ability to do this was relatively limited. Once the money had been allocated decision making and responsibility was held at Place level.

> *The one thing that we did do is we tried to keep alive the sense of distance from target based on the ACRA formula, not only at an ICB level because NHS England did that because they had something called the convergence factor instead of your above or below target based on your population health needs. We extended that because we could see all the data at a practice and place level. So we said we're not only going to look at it for xxx, we'll say, well what's the target allocation for each of our xxx places and what's the money that's actually going out into our xxx places, and we could see where some places were getting more money than their target and some were getting less. We put in place our own local convergence factor which was fairly limited but we wanted to at least acknowledge the fact that our population health needs at a place level were different……Our xxx place, which was really unusual because xxx as a place have always spent far less money than their target…The latest numbers actually said they were spending more than their target would suggest. So they had £3 million taken off them, xxx had £1 million taken off them and that £4 million was recycled and put into xxx and into xxx…So we, sort of, tried to keep alive the sense of population health to a very limited extent, but at least to have a bit of a nod to it really. N021hz*

In one site, Places had to bid for the earmarked health inequalities funding, submitting applications to the ICB which outlined the work they wanted to undertake. These different models of working impact on how work is undertaken and who is involved with the decision making. If a Place receives a weighted allocation of the core budget, then local decision-making around commissioning and planning services will be required, with the option of potentially moving funding between sectors or geographical areas to tackle inequalities. If, on the other hand, Places must bid for specific funding for discrete initiatives, the potential impact will be less. Some Systems employed an earned autonomy approach with their respective Places, with Places allocated small amounts of money which would be increased over time once they had demonstrated their capabilities.

> *So the creation of the ICB has led to the centralisation of all the monies into one body, to the ICB. So far we've devolved back out to each place has 25 per cent of that money, and the intention is to maximise that devolvement to place. And it's essentially an earned autonomy approach in terms of places need to demonstrate that they have got the capability, the capacity to manage what are quite considerable amounts of public funds. So once they're up and running, seven months old now, so they're not that well matured, we'll be devolving more. No31ox*

In some sites, a proportion of the funding was retained at System level to employ staff to oversee the population health agenda and to run programmes of work that were required scale.

> *We've done bespoke research and insight work projects. But when CORE20PLUS5 came out a decision was made that we would keep some of the funding at system to create an inclusion health unit for [System]. So, and that's the examples of where were not stepping on Places toes, actually what they're said to us is, we could do with system help on this because we know that we've got to do something for this community. But it's not the right use of our resources to setup bespoke services because of numbers. N019qv*

In one system the delegation of health inequalities funding was based on population need. This meant that some Places lost out on the funding that they would have expected to receive. Although challenging on relationships, it was seen as the right thing to do.

> *So this being the first year, we've got xxx million for xxx, which you could argue is not a lot, but it's something. But each Place got their chunk based on their deprivation, which again was brilliant…xxx only got about £xxx million. I think xxx did better than xxx, because xxx haven't actually got that much deprivation…But they didn't. So xxx only gets like £xxx million out of £xxx million. xxx gets £xxx million. Now, xxx population is only twice the size of xxx, but they've got three and a half times much money and that's based on Core10. Which is good, and it's right. N020yc*

This short overview demonstrates how the central allocation of funding is one aspect of the funding story; how money is allocated within the System is also important and has the potential to support the reduction in health inequalities. We found a variety of approaches within ICSs, from the delegation of virtually all ICS funding to Place level, through the allocation of ring-fenced inequalities funding, to a much more limited approach of requiring Places to bid for funding. Clearly each of these different approaches will have different impacts, with a particular significance for where decisions are made. However, the NHS allocation alone is not the only issue Systems face. Reductions to the Public Health grant and Local Authority funding all impact on the prevention agenda and on action regarding the wider determinants of health. Small short term NHS health inequalities income streams will not be able to deliver new programmes of work whilst bolstering the gaps in the wider system.

4.2.6 Performance management

ICSs are statutorily accountable to NHS England, with a variety of metrics to be monitored set out in the Annual Operating Model. Although there is a statutory duty for ICSs to tackle health inequalities, our national interviews highlighted the fact that there were no metrics in place to monitor progress (see section 3.2). Staff across all ICSs acknowledged that there was no formal way of monitoring health inequalities. One respondent recognised that there is a real difficulty in translating a statutory duty into something meaningful on the ground when trying to monitor local health inequalities. However, there was some scepticism that appropriate monitoring had not been implemented because the severity of the problem would be visible.

> *How do you translate that statutory duty, written down in a document, into real-life, and in everything that you do? That's the difficulty. I think one way of doing it would be to mandate ICSs to publish health inequalities' data, like waiting times, ethnicity. Every performance measure that we look at, if we broke it down by ethnicity and deprivation as a matter of course, then you'd start to build a much richer picture wouldn't you? Well, I suppose it's, you know, I was going to say habit, but we are very driven by what NHS England instructs us to do, and performance targets in terms of raw numbers, our headline numbers. And I suppose another cynical way of looking at it, is perhaps somebody doesn't want us to do that, because it's not going to paint us in a very good light, if we do start reporting all of that. N014ax*

There was some additional money provided to ICSs in the form of the elective recovery fund, post Covid. This money was to be targeted to address inequalities in waiting times. It was outlined by NHS England that for ICSs to receive the funding that they must segment their waiting lists to address inequalities. This represents a small aspect of work within ICSs that has been monitored to account for inequalities.

> *In the elective recovery funding set up arrangements for this year, 2022/23, I think there was something that said in order to get access to that money, you've got to segment your waiting lists. And I presume segment them and then use them in some way. In my position, it's not visible to me, but I'm not sure because I've just not seen it. It may have happened. I'm not sure what follow through there was on that in the same way there was a follow on in terms of, you know, 78-week waiters, and two year waiters and that sort of thing, but there might have been. N021hz*

Health inequalities indicators were not perceived to be a priority area for NHS England. Other indicators such as waiting times or aspects of service provision that had immediate consequences for care delivery, such as strike action, were understood to be of more importance to national monitoring targets.

> *Not…hasn't really appeared. Having said that, it doesn't…it's not the main focus of NHS England's attention, so it's not one of those…it's not the kinds of measures that you will get, you would feel under acute and really big pressure from, it just doesn't feel like that yet. And I think particularly with the latest government, it definitely doesn't feel like that's the most important thing. One – well, one is the direction of resource and energy, so where your attention is focused, you're never called into a meeting about health inequalities, but the strikes, you'd be called into ten meetings in three days, because it's all about the immediate, and I can sort of see why, but that is very clear. N023ks*

At the time of undertaking fieldwork, the NHS was facing many competing delivery demands as a consequence of the Covid-19 pandemic. In addition, ICSs were expected to deliver services from a position of financial pressure. These factors, alongside meeting numerous statutory duties, impacted on local health inequalities discussions and programmes of work e.g. work focussed on meeting financial balance will require a very different approach to what is needed to address inequalities.

> *And then the second area is when it comes to finance, because in theory…the best places to spend this money …. in changing and altering health inequalities are not in Acute Trusts or in Community Trusts or even in Mental Health Trusts to be honest, it's hugely in community-type work and maybe at the edge of general practice. But you have a statutory duty to balance the NHS bit of the system, and with elective recovery and some of the demands around that, that's where the money will go, and therefore trying to get…I think we're facing a £120m gap next year in xxx, forecast gap in the NHS [inaudible 41:43] council, trying to find even £5m to put into really innovative schemes to improve health inequalities is incredibly difficult. And so it's those kinds of decisions that are often limited by, you know, the rhetoric is limited in its effect. N023ks*

Locally ICS staff wanted more formal processes in place to monitor health inequalities. The quarterly monitoring meetings with NHS England Regional Teams did require ICSs to provide an update on the health inequalities work that was being undertaken by the system. However, it was felt that there was a lack of information about what impact of this work was achieving.

> *At the moment, what happens is, quarterly, we are asked to give an update to the regional health inequalities, NHS England Health Inequalities Team, the Regional Team, on what we're doing around Core20PLUS5, which is fine. But actually, what we could do with is some proper measures, or what they could go with, is some proper measures across the piece, so that they can see how this activity is having an impact at that level? But hey, what do I know? I just want to make a difference…N040lr*

When discussing accountability, many ICS staff member's recognised that Systems were unlikely to be penalised or staff lose their jobs for not tackling health inequalities.

> *And space to do this stuff because like you say, the thing that'll get you the sack, if you're a chief exec of an ICB is how you're doing on ambulances? How are you doing on elective recovery? And frankly no one's ever got sacked because inequalities have got wider. N039vg*

Although central policy has placed a statutory duty on ICSs to tackle health inequalities, delivering this agenda locally is not particularly straightforward. ICSs have a large and varied portfolio of work to deliver, with health inequalities only being one aspect of this. Without any formal monitoring of the health inequalities agenda, it is likely to be overlooked. Other System priorities are given more prominence via the NHS England assurance process with direct monitoring mechanisms in place between ICSs and NHS England. To ensure that health inequalities is as visible as other ICS work it would be beneficial for more formal monitoring processes to be developed.

4.2.7 Internal accountability and monitoring

Although data relating to health inequalities was not collected by NHS England, each ICS had their own local monitoring arrangements for local schemes of work. Governance arrangements across the three case study sites were understandably different however, all three Systems had introduced Population Health Boards. Responsibilities included focussing and tackling health inequalities in their broadest sense and working with Public Health and Local Authority colleagues.

> *In terms of how we monitor it, I touched on earlier, we have something we call Population Health Board, which is chaired by a director of public health who's actually the [Local Authority area] director of public health, [XXX]. And that group oversees delivery of this programme. N018xx*

One System had introduced a health inequalities group that was separate from the Population Health Board that also sat at System level. This was a historical group that had formed prior to the introduction of the ICS. The purpose of this group was to provide a space for people to come together and discuss inequalities and mechanisms to address them. Membership was voluntary and although a well-respected group, there was no mechanism in place where this group had any formal roles and responsibilities to meet any of the ICS targets, regarding inequalities. The main purpose of this group was centred around capacity, capability and intelligence building within the System.

> *'So Health Inequalities [group]…So how we do it, we do a deep dive. So every Health Inequality [group], there is a deep dive session. So we did things like inequalities in end of life care, inequalities in access to care, housing and health, children, mental health. So there are different deep dives where we invite... So people put themselves forward that I have this thing and I want to discuss in the network, share learning with different places or I want to develop the network through different people, things like that. So that is the main agenda item. So we gave about one and half hour for that. And then we have standing items, so updates… [N012pu]*

Some sites also adopted a Core20PLUS5 committee that sat at System level. This fed directly into the ICB. The purpose of this group was to help support Places deliver the Core20PLUS5 policy locally. This was described as a key programme of work to address inequalities; oversight of the agenda was kept separately from local pieces of work. A commitment to tackle health inequalities was also visible at Place level, with Place Based Partnerships expected to tackle health inequalities. Place level Partnerships were accountable to their respective Systems, reporting their work and progress to System level boards/committees.

Each ICS had to write a strategy, outlining how they would meet the healthcare needs of their population. Respondents spoke about the key ambitions or targets that were outlined in the strategy and how there were indicators that were measured locally to ensure that they were meeting their locally defined objectives.

> *Yeah, so for each of the xxx ambitions we've got metrics that we track. And we expect… I mean the main thing is that we expect places to describe through their forward plans how they're delivering against our ten ambitions because they've sat around a table and they've engaged on them and they've said they're important to them. And we can track those things. N039vg*

The biggest issue for Systems when trying to track local programmes of work was data availability. There seemed to be issues with data quality, the time frame in which data was available and the way in which data was utilised to measure health inequalities programmes of work.

> *But I think it's that sort of concept, we need the right data. We need to use that data well and we need to build networks across places so we can understand how each other is doing. Rather than use it as a way of performance manage change on something. The other problem we've got is that the data…two linked problems on that is that the data on health inequalities and outcomes is much slower than hospital waiting times and ambulance response times. So, you've got that issue. N039vg*

Some health inequalities targets were less amenable to short term monitoring.

> *So, at the moment, it's got, I think one of the things that's challenging with health inequalities is that in terms of actually, so, for example, we've got a 10-year gap in life expectancy within borough. That's true of both of our boroughs actually. Weirdly, pretty much exactly the same. And it's going to take time, isn't it, to impact something like that in terms of outcome measures? So, a lot of the things that we're reporting at the moment are, these are the things that we've said that we will do in order to help us to impact that metric. So, some of it is more of an output rather than an outcome measure at this point, but that will change as time goes on. Just because some of those metrics take a long time to be able to impact, that you can see in the figures. So, it's kind of a combination I would say at the moment. [N045dq]*

Overall, accountability both externally and internally for the health inequalities agenda was in its infancy at the time of data collection. Although policy documents and local ICS strategies all spoke of the importance of addressing inequalities, and interviewees discussed many programmes of work that were introduced to tackle local inequalities, there seemed to be a lack of means of monitoring the schemes of work, partly due to data issues and partly because some approaches were seen as less amenable to monitoring in the short term. The fact that progress on health inequalities was not part of the overall performance management of ICSs also had an impact.

4.2.8 Local health inequalities work programmes (research question 1d)

In a recent report, Buzelli et al. provide a framework within which to think about the possible actions that an ICS might take to tackle health inequalities (figure 3) (Buzelli et al., 2022).

	Individual level	Population level
Within the NHS	**Adapt NHS care to account for patients' social needs** Eg use data on patients' housing conditions to inform treatment and medication decisions	**Use NHS resources to improve social conditions in the community** Eg widen access to high quality employment in the NHS for more deprived groups
NHS in partnership	**Connect patients with resources to address social needs** Eg link patients to food banks or advice about benefits if they are experiencing food insecurity	**Align local resources to improve population health** Eg joint planning between the NHS and local partners to identify and respond to local needs
	Implementation depends on a mix of system-level changes, such as data collection on social needs, community involvement, staff capacity and training	

Figure 3: framework for understanding NHS approaches to social needs. Taken from (Buzelli et al., 2022)

We asked each ICS about the programmes of work they were undertaking to try and tackle health inequalities locally. In this section we discuss these programmes, and consider where they sit within this framework.

ICSs were undertaking a numerous and varied programmes of work to tackle local health inequalities, demonstrating that approaches to tackle inequalities were being implemented across the three different ICS spatial levels; including System, Place and Neighbourhood. The scale of the programmes of work varied, with some schemes concentrating specifically at Neighbourhood level for example the PCN Health Inequalities Service Specification, whilst others operated across the whole of the System. For example, when specific population groups were targeted with at scale programmes to ensure that they were receiving a consistent offer of care, no matter where they resided within the System i.e., asylum seekers. The programmes of work can be grouped and linked to three broad conceptualisations of health inequalities. These include: capacity building; wider determinants of health and healthcare inequalities (see table 6).

Table 6: Programmes of work and health inequality conceptualisations

Health inequalities conceptualisation or approach	**Focus**	**Examples of programmes of work**	**Classification according to Buzelli et al (2022)**
Capacity building	To ensure that staff were educated and trained about health inequalities, with an aim of ensuring that staff could apply their learning and address inequalities in their professional roles.	• Introducing training across the workforce to ensure staff understand health inequalities and how to address them through their professional roles. • Opportunities for staff to develop small programmes of work related to their professional roles to address inequalities.	Implementation approach – focus upon upskilling staff
Wider Determinants of Health	Addressing inequalities via partnership working with system partners or ensuring that the work undertaken by the NHS contributes to the health inequalities agenda.	• Housing quality-working with system partners to address housing issues which impact on health i.e., asthma. • Provision of information in clinical settings to help support the population suffering from poverty i.e., foodbank information. • Targeting children who suffer from poor sleep via education • Climate change-adjusting prescribing attitudes and preferences • Anchor institutions-ensuring that NHS organisations consider their impact as an organisation on their local populations.	Population level, NHS in partnership Individual level, NHS in partnership Individual level, in partnership Population/individual level, NHS alone Population level, NHS alone
Healthcare inequalities	Addressing inequalities in access and experience of care.	• Working with specific population groups to meet their healthcare needs i.e., asylum seekers/frail population • Addressing waiting lists based on population need. • Core20PLUS5 • Alcohol harm • Suicide prevention • Maternity equity • Obesity	Population/Individual level, NHS alone Population/Individual level, NHS alone Not an intervention Individual level, NHS alone Individual level, NHS alone Individual level, NHS alone Individual level, NHS alone

Programmes of work were chosen and implemented for many different reasons across the ICS case study sites. Partnership working was evident for a number of a schemes that were being implemented by Systems. In some cases, the health inequalities agenda was being driven by Local Authority Public Heath staff, with system partners pooling budgets to try and address the problem. For example, Public Health expertise and knowledge were used to lead the programme of work to address obesity.

> *So, we have, it's a whole systems approach to obesity, it's public health, what was Public Health England programme that we're following across xxx. So, again, each of the public health teams in xxx will have responsibility for their own areas…So, the way we've handled that is, we've got an over-arching group, which takes an over-arching view across xxx. And then, each of the areas are basically running their programmes in parallel. So, they're following the same programme just at slightly different stages. So, you've got to just kind of work with it. And then, what we've got is, we've got a co-ordinator in each of the health and care partnerships to essentially chunk down the*

> *whole xxx system into smaller areas that are easier to work with to get that close-space view and to be able to work locally with the stakeholders there. N001fw*

One System had a longstanding issue with GP recruitment which was in turn affecting access to services for their local population groups. To try and address this, the ICS had undertaken some work with the Local Authority to try and increase GP recruitment and retention into the area.

> *So…and also then there's…with the practices that want to take part in this programme is that we provide some funding to [backfill 07:04] the GP to effectively create a really good learning environment for the GP coming to xxx…So, what we've done is, the attraction package is around mentoring support. So, it'll be, kind of, releasing a senior GP in practice to be able to provide mentoring for the new GP coming in. There's some funding for the GP that's coming in to work in that area. We're working with the councils that will provide information to people coming to live within Kent and Medway on, kind of, housing, schools, other, it might be, kind of, other employment opportunities for their family members. So, just trying to see if we can just put that package together…and HR support as well. So, it's just making sure that we, kind of, help and, kind of, what they might need, to make sure they can settle. N002sn*

Other national drivers shaped the local programmes of work that were being introduced to tackle health inequalities. The national PCN contract introduced a service specification which required GP practices to work together on a project relevant to health inequalities.

> *…there's a Primary Care Networks Health and Equalities requirements. So, what each Primary Care Network had to do was identify an area of focus. So, we've got that. So, each PCN have reported back to us what their areas of focus are going to be. And that's part of the Directed Enhanced Services requirement. So, what we would be doing is just seeking some assurance that they've all got that, and if there's any opportunity that we can link them in. N002sn*

Another ICS site spoke about trying to address fuel poverty within their area and how useful the NICE guidance had been for really demonstrating how the NHS can help contribute to the wider social determinants of health agenda by adopting an 'every contact counts' approach.

> *So I mean, I think actually that the NICE guidance on fuel poverty was really, really helpful. So the fact that that was an evidence base, this is what NHS colleagues can do to help tackle fuel poverty… So we are making sure that we're using that kind of making every contact count methodology. So that whenever you are seeing somebody from the front line, that you are asking those questions, you know, what are you worried about, if it is heating, if it is eating, this is where you can go. So what we have done is used some of the money that we were going to direct more into some of our other priorities, we've diverted – it's not a lot of money, but it is to some people - £50,000 into a much more locally coordinated single point of access for our population to phone if they have any worries. N005yp*

The Core20PLUS5 framework had also helped to shape the local health inequalities programmes of work, with one System appointing Core20PLUS5 local leaders to focus on the clinical areas of work and bring together System partners to collate the work that was already being undertaken and share learning to help the ICS deliver the Core20 targets.

> *So people like xxx, and you might know some of these people and mainly place based leads for Core20 implementation. And then the ICS what we are… So for the next six months what we have agreed with the leadership group, that we will be taking, you know, each of the five priority areas of the framework and we will be doing the sessions around that…And that is to bring, because there are programmes across ICS. So there is, for example, Respiratory Network across ICS, and they are doing a lot of work on COPD vaccination, flu vaccination and COPD diagnosis. That is essentially the clinical indicator of Core20PLUS5. Then Places are planning their plans to implement. So it's how we link the Places with each other and with the ICS networks. N012pu*

There were also local initiatives that had been implemented prior to the introduction of ICSs which shaped local work that had been undertaken, we were able to identify this at both System and Place level. As mentioned in section 4.2.3 one ICS had adopted a Public Health programme of work to address inequalities that had been developed prior to the introduction of the ICS. In another ICS, one Place based programme was introduced in 2019, adopting a partnership approach to addressing inequalities. The lead clinician on the programme felt passionate about inequalities and scaled the programme up to lead a Network for tackling health inequalities at ICS level.

> *One thing was because we had this xxx Programme, we started in 2019, so it was… xxx has so many inequalities anyway, so we need to do something about it. So it was quite, it was like thinking evolved from the xxx Programme that how can we do more and how can we keep the momentum going in inequalities. And then when we were creating the CCG shifting towards, we thought it was a good idea to create a small team of people whose day job is to think about inequalities and how they can help everyone. So initially it was a team of three/four people. I was quite keen to replicate what we had xxx, a director who is a Public Health consultant. N012pu*

The health inequalities network meets at ICS level on a regular basis, and has grown to employ its own Public Health staff, introducing System wide initiatives. The network is trying to embed health inequalities capacity building into the system, developing health inequalities knowledge and expertise across the workforce. This approach is trying to ensure that staff are aware of what health inequalities are and how they can address them in their jobs.

> *The first thing the Health Inequalities Academy did was actually train – I'm not saying this is brilliant but on paper it looked great - a health inequalities lead in every PCN, and I thought that was good. It didn't have to be a clinician. It needed to be somebody reasonable. It didn't have to be a GP, sorry. But they actually had a proper course – this is a couple of years ago now – of at least showing what health inequalities were, how to look for them, how to analyse data, how to pick stuff out, and they needed to sit within the leadership of the PCN. N020yc*
>
> *The other successes, there's xxx fellows now that have been trained in the public health foundation course, bespoke training around trauma, they've had additional training around inequalities, they've had a mentor for 12 months, and they've delivered a robust project. So, they're champions now, within the system, to continue conversations around inequalities and how important they are. N019qv*

Local programmes of work were influenced by both national policy and existing local priorities. Overall, all work undertaken focussed on either developing capacity and capability within the workforce or addressing inequalities for specific population needs.

4.2.9 Summary

In this section we have explored how inequalities featured and were considered in the work of our case study ICSs. We found that the approach taken locally was strongly influenced by national policy, including approaches to funding allocations, the centrality of the Core20PLUS5 framework and the fact that health inequalities are not yet included in national monitoring regimes. We also found local influences, with our case study ICSs taking very different approaches to how they devolved responsibility and funding for health inequalities work within their ICS. Funding is particularly important, with a general sense that short term funding within constrained budgets tended to limit what any ICS could do to tackle local inequalities. In the next section we look across the case studies to pull out a number of cross cutting themes.

5 Cross-cutting issues and themes (research question 1c and d)

5.1 Introduction

As we have shown, health inequalities is a complex topic, and ICSs are new organisations in very different states of development. As a result, whilst it is clear that there has been a step change in the importance given to health inequalities within the health system, there is considerable variation and heterogeneity around what is happening on the ground. In this section we look across our case studies to try to tease out the factors which can be identified as offering potential avenues for intervention or where further clarity may be required.

5.2 'Population Health Management' vs Public (population) Health

As identified in our initial section exploring how Systems conceptualised health inequalities, we found something of a fundamental tension between a medical model approach to inequalities and the wider Public Health approach. This was exemplified across our case study sites in a distinction which was sometimes explicit but often not between techniques of Population Health Management and a wider concern with Public (or Population) Health. Exploring these differences is useful, firstly, because it offers insights into different ways of conceptualising and measuring health inequalities, which in turn shapes different views on how best to target interventions towards their amelioration. Secondly, the differences between the two, which can appear subtle in abstraction, can be consequential for the organisational arrangements assembled around them. This has implications for working collaboratively across boundaries and for system complexity, which are important matters to consider in policy designed to enable integration.

This section begins by looking at the different conceptualisations around Public Health and Population Health Management, subsequently looking at how these differences play out in approaches taken to tackle health inequalities, in relationships between NHS and Local Authority stakeholders, and in system design.

5.2.1 Conceptualising Population Health Management

Public Health (often referred to as population Health in our interviews) and Population Health Management were often used interchangeably, and even when explicitly asked about their differences, some did not see an important distinction in principle.

> *Well, you could apply a population health management approach to anything but conceptually population health management…because there's very little that separates at least core public health from population health management, it seems to be similar. N003zo*

Relatedly, many emphasised the overlaps between the approaches based upon their shared population focus.

> *I mean, one of the aims of population health is to reduce health inequalities, so we really see a massive overlap, or at least a very significant overlap between the two. N040lr*

Notwithstanding this broadly shared agenda, one area made attempts to explicitly define the difference between the two approaches, citing the confusion that might otherwise result from their interchangeable use.

> *It should be clear because we did agree a definition pre-pandemic with the NHS when we were in PHE about the difference between population health and population health management. The latter being a subset of the former. But they get used interchangeably*

> *with different meanings and that causes confusion if you use them inappropriately or you think someone is using them appropriately, actually they are not. N046xy*

The conceptual distinctions drawn out by such processes revolved around specific differences in how population is understood. Population Health Management was often referred to in terms of population 'segmentation' or 'stratification'. This differed from a Public Health or population health approach which was seen as more 'holistic'.

> *Population health is a really holistic approach to understanding the needs of the population and the range of interventions that you would make to improve their health. So that would include the wider determinants, et cetera, et cetera. Whereas population health management is much more looking at data at an individual level. Stratifying for risk, identifying cohorts that you might say, oh, those people haven't had their blood pressure checked in the last five years. Let us track them down and do the necessary. It is a different kind of approach. N046xy*

As suggested in the above, the segmentation approach leads to interventions which are 'risk' or 'disease' focussed, while the broader Public Health attempt is associated with building a more contextualised understanding of health determinants.

> *Some of the principles that they use aren't the ones that I would advocate as a DPH, from my understanding of being in the field of public health for quite a while... I understand when people use certain terms what they're trying to say, and I don't say that I'm an expert because I'm not, but I will always then look at a broader perspective. You get some evangelists who just…and it's got to be population, but they don't know what they're talking about. And they might have been on a King's Fund course and had their eyes opened up a little bit, so they might know a little bit more. But when it comes to implementation, they get stuck because they forget that they're dealing with all of the [factors], but where do these people live, what roles have they got in society, what jobs do they do? N048fx*

The frustration evident here signals some of the complexity in balancing the attention and resources directed towards each approach. The more rationalised approach of Population Health Management was seen as a means of getting funding moving through the system – a means of formalising the more nebulous language of health inequalities around concrete problems, offering a 'quick win' in comparison to approaches driven by wider determinants.

5.2.2 NHS vs Local Authorities

Some saw the difference between Public Health and Population Health Management as an institutional one, with Public Health being Local Authority driven and Population Health Management being health service driven. The following quote refers to the Robert Woods Johnson model of health inequalities, which estimates that only 20% of the factors determining health inequalities can be influenced by the health service.

> *I think the distinction is on two fronts, one is that that is predominantly focussed on healthcare setting, so it is what you can do within the confines of primary care, in particular, which is very important actually. But also within community health and acute and primary, secondary, tertiary, that whole thing, care, but it is health focussed so it doesn't actually cover the things which…you know the other 80 per cent, so it attends to that 20 per cent but not the 80 per cent. N003zo*

For some the distinction highlighted a necessary move from within the NHS towards a more population sensitive approach (N042xk). This view was reflected in several of the respondents' comments, and was generally viewed favourably, as important for collaboration, or pragmatically as a way of ‘getting the NHS to the table’. However, it also signalled the presence of historical and continuing differences and tensions between the ‘two sides’ of the system. An implicit tension here is in the potential for the attempt to bring the NHS into efforts to address inequalities to result in a more medicalised Public Health approach (LANTZ, 2019) which could occur if the perceived practicality of Population Health Management gives it a ‘foundational’ place in emergent systems designed to tackle health inequalities.

> *So we’re actually putting in a proposal to get some funding to further develop that tool that we’re developing to help our system actually. It’s to give those, the kind of underpinning sort of…oh, what’s the word…oh…the kind of the foundation blocks that we need, the building blocks that we need for population health. N040lr*

This also signals the potential for the two approaches to contradict rather than complement each other. This derives from the opposing styles of intervention represented by the two approaches, which means they can both start with a shared ‘population’ agenda, but the way in which they represent and intervene with this population is quite different, one approach which seeks to tackle health inequalities through increased rationalisation: data is used to segment a population according to risks, and in this way direct resource allocation to at need groups (Checkland et al. 2021). The other approach seeks to understand the wider determinants of health inequalities, and is driven by a relational approach which treats the population as a whole, intersected by interdependencies (i.e. between health, housing, education etc). This envisages a more radical overhaul in how health and care resources are allocated.

One of the ways in which respondents worked through the two approaches was through discussions of data. The recent popularity of Population Health Management is partly due to the more widespread availability of ‘big data’ (Checkland, 2021), in which heterogeneous datasets are combined together, enabling the identification of new patterns and associations. Local Authority Public Health teams were widely seen as an important source of data intelligence, as suggested earlier in the report, and Population Health Management was often described as the vehicle through which this could be delivered.

> *We have developed a population health management programme which we are rolling out across the county, again working with Public Health really closely. Part of that Population Health Management system is about how we develop the tools to support our partners on the ground to do something then with the data. Just one example for me would be if you look at general practice or our primary care networks, for example. We need to be able to know at a neighbourhood level what the determinants are looking like across that neighbourhood to identify those parts of the community or population where there might be greater risk. I think that approach to doing some re-stratification enables us to target some of the resources and interventions that we need to develop in order to meet the needs of the populations that live in our communities. N027so*

Data is seen as an important resource for helping to break down or ‘segment’ the population. This then drives the allocation of resources, and shapes the ‘population health’ approach as a whole.

Some respondents indicated how Population Health Management might provide a way in to thinking about population, which could then be broadened and contextualised to take in a more community-oriented approach.

> *I don't think we've really scratched the surface around what people call population health management. Just to give you one little example, [Acute] Foundation Trust and this is a hospital getting interested in health inequalities did some work about where people from [Town] live when they're being bluelighted into their hospital. And what they found is there's certain communities and certain streets actually within [Town] where you can have somebody who's a vulnerable person who's got a chaotic lifestyle and every second week there's an ambulance taking them into hospital. And that's, A, not good for the individual, and B, it costs a lot of money. And so, there's a real…I think really doing the work to understand patterns of utilisation across different communities, across different geographies. And the nature of that utilisation, so is it all unplanned? Is it all blue lights? And then trying to design service around those communities. I think there's a huge value in that. And I think what you probably find is that if you can work with VCSE partners, if you've got really responsive integrated primary care, and you build relationships with these people and their families, then you can hopefully end up in a situation where you're delivering a much better, more integrated service and saving quite a lot of money...it's how you use the data to understand how people are utilising services and how that's impacting on their wellbeing and working with them and communities to try and reshape services more around them really. N039vg*

This description suggests how a Population Health Management approach, which begins with the identification of risk and is driven by a focus upon activity and costs, could nevertheless take a more socialised approach to health inequalities by understanding ‘patterns of utilisation’, and using this as a basis for developing relationships with communities. Although offering a more integrated idea of a combined Population Health Management/Public Health approach, the focus here is still upon health service utilisation and the ‘chaotic’ behaviour of individuals, and it isn’t clear from this quite how the leap would then be made from this to ‘reshaping’ services around communities. This demonstrates a danger of coupling Population Health Management with data and Public Health with relationships, rather than seeing them both as data driven approaches which use data in different ways.

5.2.3 Health and Care System Structures

Combining the two approaches is therefore complicated in practice, requiring an effective means of structuring relationships between groups, such that ongoing tensions between different world views can be given sufficient space within, but also effectively contained by, decision making. A key concern here is that the structure of ICB and ICP does not go far enough in enabling collaborative decision making.

> *So, for me the bit in the middle is okay there is data on the one side, there is addressing inequalities work on the other side. But in the middle, it is how do we use that local intelligence to drive what we are doing? Drive our planning, drive our development of services, but also drive some of our commissioning decisions. Obviously for the Integrated Care Board we still have a statutory responsibility to do that commissioning work of health services. But actually, the opportunities to drive commissioning as joint commissioning between health and care that is absolutely focused on what are the measurable outcomes that we would achieve through this is where I think there are opportunities for us to get*

> *better traction. Both in a positive way but also in a negative way because it may mean that we need to do some service reconfiguration or drive some planning around transformations of models of care and services in order to do that. N027so*

This separation imposes pragmatic limits upon the extent to which the more radical resource allocation envisaged by holistic Public Health approaches could be realised. It also generates system complexity, with a Population Health Management function sitting within an ICB hierarchy shaped by the statutory responsibility to deliver health services, and a Public Health function operating in conjunction with this, but not within the same hierarchy and with different accountabilities. As the Local Authority are formal partners in the ICB, individuals can occupy responsible roles within the ICB hierarchy. However, the ambiguity regarding the potential conflict between two sets of statutory obligations remains. Furthermore, we know from decades of research on individuals occupying 'boundary spanning' positions, that their effectiveness derives from the degree to which they are effectively socialised into both 'sides' of their role. How different systems go about this might have a decisive impact upon their ability to balance their agendas.

5.2.4 Summary

In this section we have expanded upon the tension which we highlighted earlier between traditional Public Health approaches to health inequalities and newer, perhaps more medically and data driven approaches to Population Health Management. We have highlighted how the two different approaches can be complementary, but can also be problematic, with language differences reflecting potentially more fundamentally different understandings of the nature of the problem being addressed. In particular, Population Health Management can take a more individualistic approach to inequalities, locating problems in individuals and their behaviour, which can be at odds with Public Health focus on relationships, communities and the wider factors influencing that behaviour. This tension is, to some extent, inherent in the Core20PLUS5 approach (which includes material deprivation alongside a medical focus on particular diseases), and may be exacerbated by the structural division between Public Health as a Local Authority responsibility and Population Health Management as an NHS-driven approach. The fact that some ICSs are now appointing Public Health-qualified staff suggests that the complexities are not yet fully worked out, and that good communication across organisational and institutional boundaries will be required, alongside a clear sense of what is to be targeted by which means in order to reduce inequalities.

5.3 Structures and decision-making (research question 1d)

We have highlighted significant differences in the approach taken to operationalising commitments to reducing health inequalities within our case study sites. These differences arise out of their different contexts and different populations, but are also heavily influenced by the previous history within local areas, including past experiences of working together and the maturity of relationships between organisations. This was particularly evident in differences in relationships between ICSs and local Public Health teams. In areas where these relationships were longstanding and well-established, ICSs were able to adopt and continue joint programmes of work. Where these relationships were less well established, the role of public health was seen as more distant.

ICSs were introduced with minimal guidance as to how they should be organised internally, beyond the specification of the establishment of an ICB to carry out executive functions and a wider ICP to bring together the broad group of organisations in the local area with health and care responsibilities and interests. In response to the increasing salience of health inequalities, many systems have established committees with responsibility for overseeing work in this area, but it was also evident that Systems were keen that inequalities were seen to be 'everybody's business'.

Although there was local variation in governance structures, it is important to note that interviewees were able to discuss different aspects of the ICS structures and how they related to health inequalities, demonstrating how health inequalities were part of ICS business.

The ICB makes strategic decisions as to how funding and responsibilities are to be distributed, with most Systems having established subsidiary structures at Place level. However, there are considerable differences as to the role of these local structures, with some granted considerable autonomy, whilst others are limited in what they can do or decide.

This heterogeneity makes it difficult to draw general conclusions about how work to tackle health inequalities should be organised within ICSs. Our data collection took place in the early stages of ICS establishment, when structures and functions were still developing in most systems. It may be some time before schemes of delegation and approaches to decision-making around health inequalities are fully worked out and established. Nevertheless, despite this complexity and lack of definitive organisational structure and function, we found that, in comparison to the approach taken by CCGs to their similar statutory duty (Warwick-Giles et al., 2017), our case study ICSs had succeeded in inculcating a sense that health inequalities were a core responsibility at all levels. Looking across the case studies we can highlight a number of relevant issues related to how a System is organised.

Firstly, action on health inequalities generally combined a number of discrete initiatives and programmes with broader attempts to train staff and appoint 'champions' to promulgate the importance of health inequalities in all decisions. This points to the need for action across the levels within a system, with a strong central infrastructure supporting local appropriately targeted action, along with clarity as to the extent of decision-making powers which sit at each level.

Secondly, as might be expected given the large size of most ICSs, we found considerable diversity in how inequalities were conceptualised within each case study site. Many interviewees acknowledged this diversity, and highlighted the fact that the sheer complexity of the topic could be paralysing. Others told us that action – any action – could help cut through this complexity, as collective action could generate collective vision and goals. Our initial summary of the breadth of the topic of health inequalities highlights the fact that there can be no single 'right way' to think about them. However, it may be that Systems could usefully establish an internal collective narrative about the approach to be taken, potentially using a simplified schema such as that presented in our theoretical framework to encourage dialogue and decision making as to priorities for action at each level. The Core20PLUS5 framework encourages Systems to identify particular disadvantaged populations; our study suggests that they could also usefully identify which types of inequality they wish to initially prioritise, alongside consideration of what are likely to be the main causes of the observed inequalities to be targeted.

Finally, the extent of heterogeneity of the population covered by any given ICS is a significant issue, particularly with respect to the socio-economic drivers of inequalities. Good knowledge of their local population, and relationships that will support differential investment in different populations will be important.

5.4 Funding (research question 2b)

The NHS and Local Authorities are currently operating in an environment of extremely constrained funding. Our analysis of national policy documents highlighted an ambition to adjust ICS funding allocations to account for deprivation, but this can be difficult to achieve in a resource constrained environment, with adjustments to allocations within a fixed funding envelope inevitably resulting in winners and losers. Historically the NHS has done this by establishing a funding target, with incremental moves towards the target applied each year within any overall increase in resources, thereby minimising any drops in funding. As discussed in Section 1.2, the exact make up of any formula used to derive target funding is determined at national level, and the weighting given to particular measures of disadvantage will significantly affect the outcome for different Systems. During our study period there were no significant changes to existing funding formulae, although our case study Systems were aware that adjustments may come over future years.

Whatever funding adjustments are made at System level to account for local disadvantages, the extent to which funding changes will contribute to addressing local inequalities will depend crucially upon decisions as to the internal allocation of funding. Within national funding allocations, for one year only, a proportion of the funding had been ring fenced to be used to tackle inequalities. These monies will not be separately identified in subsequent years.

Within our case study sites we observed different approaches to the distribution of these funds. One site took an approach based on the delegation of most of the core allocation and ear-marked inequalities funding to Place level committees, with additional adjustment of inequalities funding between areas to take account of deprivation, whilst another took a more centralised approach, with spending directed centrally whilst inviting local places to bid for funding for projects addressing local inequalities. Others talked about ‘earned autonomy’, requiring local Places to demonstrate their ability to make spending decisions before substantive delegation of funding would be considered. These different approaches will clearly generate very different results, and any consideration of how best to tackle local health inequalities will need to include approaches to distributing funding.

A number of other issues arise from our case study work, beyond these significant differences in approaches to delegation. Firstly, many interviewees highlighted the short-term nature of much funding allocated to tackle inequalities, exemplified by the decision to ring fence money within the core budget for a single year. This was felt to be problematic, as the problems which need to be addressed if inequalities are to be addressed are generally longstanding and deeply entrenched. Approaches which encourage bidding for short-term ring-fenced amounts of funding are unlikely to be able to accomplish much in this context, with many interviewees arguing for longer term and sustained approaches to moving funding to areas of disadvantage.

Secondly, the heterogeneity with regard to material disadvantage present within many Systems leads to the need for explicit consideration of the geographies over which allocations are to be made, and the level at which decision making will take place. Ideally a mature System, with good relationships between representatives of different sectors and organisations, would be able to agree collectively the need for differential investment in disadvantaged communities. Whether or not this is possible will be a key test of ICSs in the longer term, and will require strong trusting relationships and clearly understood shared goals.

Finally, we found an implicit tension between the conceptualisation of health inequalities as something which could or should be addressed via discrete projects versus an approach which saw addressing inequalities as a core activity within all decision-making processes. We saw both of these in action, but current approaches to funding distribution and arguably the Core20PLUS5 approach (which singles out groups for attention) tend to incentivise discrete projects rather than a more holistic approach.

5.5 Monitoring and accountability (research question 2a)

Our case study work highlights the importance of both internal and external monitoring. At present, whilst Systems have access to various ‘dashboards’ which track a number of metrics relevant to inequalities, progress in reducing health inequalities was not part of the formal monitoring process for ICSs at the time the study took place. In part this reflects the complexities which we have highlighted; the multiple ways in which inequalities can be conceptualised and defined makes it difficult to choose metrics which could be usefully monitored. Discussions of inequalities (including in the policy documents which we analysed) often focus upon headline differences in health status such as mortality rates or healthy life expectancy. However, as we have discussed, the potential for health services to impact on these measures is relatively limited. In interviews, senior policy staff from NHS England highlighted the difference between *health* inequalities and *healthcare* inequalities. However, as we have discussed, this distinction is not necessarily completely clear in practice, with social deprivation of all kinds tending to feed into inequalities in access to services and to outcomes of treatment. Notwithstanding these difficulties, it seems clear that progress in tackling inequalities may be more likely to be achieved if some sort of external monitoring were to be introduced although operationalising this may be difficult.

WP1, WP2, and WP3 in line with other studies (Olivera, 2022) revealed that there is not yet an emerging agreed conceptualisation of health inequalities grounded on an established framework, beyond the common reference to the Core20PLUS5 framework, for which monitoring indicators are being developed NHS England » The Healthcare Inequalities Improvement Dashboard. This makes approaches to monitoring progress more difficult to develop. Amongst all potential indicators, those relative to access to health services, experience of care, outcomes of care, and ultimately health status, appear to be most relevant for health inequalities, as highlighted in our framework (see figure 2). The number of indicators may be quite large, but can be reduced by focusing on the most prominent inequalities or those recognised as a priority within a system.

Measuring progress in inequalities requires (Schlotheuber & Hosseinpoor, 2022):

- A unit (individuals or groups of individuals): these may be for example patients or groups of patients, for which data are available (for example patients registered with a GP practice).
- A measure for the indicator of interest, this may be health status, but also a set of measures that relate to resources, service delivery, access, quality and experiences that may contribute to change the ultimate outcome of interest.
- A dimension of inequality, typically socio-demographic characteristics, such as age, gender, ethnicity, deprivation, or geography, or a mix of circumstances that define a specific group.
- An adjustment for variations which would be legitimate (for example age and gender standardisation or a measure of service need if the focus is on resources or access to services)
- An index to provide a summary measure of inequality, these include measures such as gaps or descriptions of the distribution.

For example, if an ICB decided to reduce health inequalities through primary care, monitoring should cover distribution of resources, access to services throughout improved health indicators. For example, existing indicators (Fatimah et al., 2023) may allow to monitor:

- Inputs measured by workforce GP headcount (per 100,000 registered patients) capturing resources;
- Access measured by the percentage of patients able to get same day appointment;
- Quality measured by the Quality of Outcomes Framework (QOF) score (out of 100);
- Experience measured by overall patient satisfaction with GP services (% of patient satisfied)

- Health outcomes measured by self-assessed health, mortality, or more broadly capacity to live a heath life.

Inequalities may be measured for example by socio-economic status or by ethnicity, or by geography. Because socio-economic status is a continuous measure that can be meaningfully ranked, summary measures can account for the whole distribution on the population organised by socio economic status. For ethnic groups inequalities are better summarised as the differences between the group of interest and a reference group, and the same can be done with socio-economic status grouping individuals. Geographic inequalities are better represented through maps or differences between the most and least disadvantaged. GP practices can be compared with different list compositions by demographic and socio-economic characteristics, and outcomes can be standardised. For example, GP head count may need adjusting not only by registered populations, but also by the disease prevalence of the population, and the number of resources and care that each disease required, or by the capacity to benefit of its population. It may also need adjusting by differential resources required for providing services to populations with different socio-economic and ethnic profiles. Of course, measuring and standardising each indicator correctly would require careful research but we hope that we provided an illustration of the complexities and potential issues associated with monitoring inequalities.

In spite of the importance of monitoring in order to support the allocation of resources and to assess progress, there is still remarkably little evidence on how services are actually used by different populations. Ongoing research using person-level data covering secondary care services, including mental health, provided by the NHS (L. Anselmi, Urwin, Sean., Lau, Yiu-Shing., Mentzakis, Emmanouil & Sutton, Matthew, 2023), has shown that there was huge variation in inequalities between and within CCGs and that it is affected by the summary measure of inequality chosen (Anselmi). This is important, because the outcome of any monitoring process may be different if different measures are chosen.

Internally, Systems told us that they were keen to track metrics to monitor local progress, but that this could be difficult to achieve due to data availability as well as the difficulties we have described above. Furthermore, when assessing inequalities in health care it is also important to consider between and within which units is being monitored. For example, inequality between GP practices can be measured within ICBs, within and between defined places (for example old CCGs which have remained to identify places), or within and between groups such as PCNs or Neighbourhoods (when large enough) which may be more relevant to the funding and delivery of services specifically relevant to tackle health inequalities. All of these factors would need to be taken into account in devising monitoring regimes.

Data availability affects inequality measurement and monitoring. It is important to collect data related to interventions aimed at reducing inequalities, and their cost; currently this is rarely done. It is also important to start exploiting the rich and linkable NHS person-level data to capture inequalities more precisely and whenever possible to integrate information on GP practice registration with characteristics which may be key indicators for inequality monitoring, for example language or religion, which are not routinely collected. Finally, clarity within ICSs as to what types of inequality are being targeted is important, alongside investment in data analytic expertise within Systems.

5.6 Summary

In this section we have looked across our case study findings to draw out a number of cross-cutting themes and issues. We have highlighted the complexities of reconciling traditional Public Health Approaches with more recent data-driven approaches to Population Health Management, and teased out the complexities surrounding decision-making structures, funding allocations within Systems and approaches to monitoring outcomes. In the next section we return to our research questions in order to summarise our findings.

6 Discussion

6.1 Summary of findings – research questions

Our research questions asked:

1) *Understanding health inequalities:*
   a. How are health inequalities defined within national policy, and how is it intended that the new system will support action in this regard?
   b. How do local ICSs perceive health inequalities within their local area?
   c. What factors have affected the framing of health inequalities in case study sites, including micro (personal), meso (local/regional) and macro (national policy) level influences?
   d. How has this framing translated into plans of action, and what factors have influenced this?

2) *Learning and longer-term prospects*

   a. How might progress in tackling health inequalities by ICSs be monitored in the future?
   b. How could changes to funding allocation mechanisms be used in supporting action to tackle health inequalities?
   c. How can national policy support local action to tackle health inequalities?

Our first group of research questions (1a-d) sought to explore how health inequalities were being understood within ICSs. Our initial analysis of policy documents (RQ1a) (Section 3.1) highlighted the salience given to inequalities within these documents, but also identified an overall lack of clarity, with documents shifting between different definitions of both type of inequality being addressed and relevant populations to be targeted. Table 7 below highlights the mechanisms by which policy documents proposed that the creation of ICSs would address health inequalities, and summarises our findings for each.

Table 7: Evidence relating to the mechanisms by which policy intends ICSs will be able to tackle inequalities

Mechanism in policy documents	Evidence from case studies
Provision of preventative services for particular diseases	Systems addressing these clinical priorities, with some local schemes addressing priority groups. No large scale initiatives
Better adjustment of funding formulae for need	Awaiting national decisions re ICS funding. Some systems allocating some funds internally according to dimensions of inequality
Services designed to meet the needs of disadvantaged groups	Some local attention to redesign particular services for particular under-served groups
Partnership working will support action on the social determinants of health and facilitate transfer of resources	Systems are optimistic that partnership working will support action. Limited evidence so far. Relationship with Public Health important.
Place-level structures will enable local action	Some systems prioritising delegation of funding and responsibility to Place, others less advanced in this regard
Provider collaboratives will improve patient experience which will reduce inequalities	Limited evidence to date
GP practices will be incentivised to reduce inequalities in their local area	Incentive scheme had limited impact to date
Core20PLUS5 will support the identification of disadvantaged groups and populations and allow targeted action, focusing upon priority diseases	Core20PLUS5 welcomed, but difficult to operationalise in Systems serving the most deprived populations

These policy documents set the scene for the work being done within ICSs, with the Core20PLUS5 framework for identifying relevant target groups developed by NHS England being particularly influential. Our interviews with senior policy makers (Section 3.2) also emphasised the importance of tackling inequalities within current policy. NHS England, as the oversight body for ICSs has developed an agreed focus upon *healthcare* inequalities (i.e. those perceived to be amenable to NHS action), and put in place a support programme which has included feedback on health inequalities strategies, access to a data dashboard and an online workspace for sharing best practice.

Unfortunately, our intended survey of ICS leads to explore their understanding of inequalities and priorities for action proved impossible to operationalise, despite support from the NHS Confederation. We are therefore unable to provide evidence as to the general approaches being taken across ICSs. In our case study sites we found that health inequalities are seen as an important part of the role and responsibilities of ICSs (RQ 1b). This marks a step change from the approach seen in the early days of CCGs. In terms of considering the factors which had influenced the framing of inequalities within ICSs, we found that the Core20PLUS5 approach has provided an important framework within which programmes of work are being developed, and it has generally been welcomed. However, our research has also highlighted a number of important issues:

- There is a general lack of clarity over which types of inequalities were being addressed over which geographies in both policy documents and ICS programmes of work. In particular, we found some confusion with regards to how far ICSs might be able to tackle the wider social determinants of health, and how far they should instead focus upon inequalities that are more directly attributable to the provision of health services. The sheer scale of the problem can be paralysing, but many respondents told us that identifying an important local issue and focusing upon it could be helpful in generating momentum and change.
- We found some tension between a Public Health view of inequalities, focused upon the social determinants of health and a proportionate universal approach to tackling them, and a more medical individually focused approach, using techniques of population health management to identify and target individuals at risk. The role of Public Health professionals within Local Authorities is important in how the issue is framed, and we found evidence of extensive engagement between Public Health staff and their local ICS. At the same time, some ICSs are appointing their own Public Health staff. This could cause confusion, and will require the development of clear roles and responsibilities.
- More generally, all interviewees agreed that strong cross-sector relationships will be required if existing inequalities are to be addressed. Current financial pressures in the NHS and Local Authorities can put a strain on these relationships, and we found evidence that those Systems which have been working together for a while and developed good relationships have some advantages compared to more newly configured partnerships, with greater clarity over the nature of health inequalities in the local area and around roles and responsibilities in tackling them.
- At present, action to tackle inequalities within ICSs is relatively small scale, focused upon local projects. Alongside this, many ICSs are also seeking to develop staff skills, training staff to understand inequalities and providing small amounts of resource for them to undertake projects within their local services. In this way it is hoped that addressing health inequalities will become embedded as an important priority across all services. We did not find a clear linkage between the overall conceptualisation of inequalities within the System and the approach taken to tackling them.

For our second set of research questions (2a-b), we focused upon learning and the longer-term prospects for progress on inequalities. we found that:

- Progress in tackling inequalities is not currently part of the formal monitoring process for ICSs, and this affects how they are addressed. Each ICS does have access to a 'dashboard' to support their internal priority setting processes, but progress on inequalities did not, at the time of writing, play a part in NHSE's assessment of ICS performance. This brings with it the danger that pressing high profile issues such as elective care backlogs and the need to maintain financial balance will over-shadow attempts to address inequalities. We have used our theoretical framing around the different types of inequalities to suggest how indicators for monitoring might be chosen, and highlighted the complexities, including choosing comparators, the fact that outcomes of monitoring may vary according to the choice of indicators used and the need for a good understanding of available data sources.
- A national aspiration to adjust funding to account for inequalities requires clarity over which types of inequality are to be included in any formula. Within ICSs we found wide variation in approaches to the internal distribution of funding, and some concern that the lack of longer-term ring fencing for inequalities funding. Historically, funding to tackle inequalities in the NHS has tended to be short term, and this is perceived as a problem. Adjusting the internal distribution of funding to account for observed inequalities is a complex undertaking and is constrained by obligate spending driven by service activity.

Our final research question (2c) sought to draw more general lessons for policy, and these are addressed in section 6.6 below. Overall, we found that there had been significant progress in comparison with previous research on Clinical commissioning Groups, in that ICSs have clearly taken on board their obligation to address their local health inequalities, but we have also highlighted important issues which need to be addressed. In the following sections we consider the utility of our conceptual framework, address our findings in relation to the existing literature, and present some implications for ICS development and for wider national policy. We finish with a consideration of the strengths and weaknesses of this study.

6.2 Conceptual framework

In addition to our specific findings relevant to ongoing policy development, we also developed a conceptual framework which tries to bring clarity to the profusion of definitions and mechanisms present in both policy documents and to some extent the research literature. It is our contention that ICSs cannot be expected to make progress in meeting their duty to tackle health inequalities without an initial rigorous analysis of what the problem is and, most importantly, where they might be able to intervene. The lack of conceptual clarity in policy documents and discussions is a significant problem, because without a clear sense of what can and should be targeted it is likely that efforts will be diffused and unfocused and therefore unlikely to succeed. Figure 2 is an attempt to provide a clear and logical framework within which policy makers and managers alike can interrogate their local context and clarify where and how they might have the best chance of making a difference. The framework is, of necessity, simplified, and does not attempt to address the complex web of societal factors which underpin concepts such as the social determinants of health. It is not, therefore, a blueprint for activism or social change. Rather, it is an attempt to support those required to introduce practical programmes to tackle health inequalities to focus their efforts within their current context, distinguishing issues amenable to their action from those requiring wider social change.

6.3 Recent policy developments

Since we completed data collection with our ICS case study sites, NHS England have published a statement on health inequalities (NHS England, 2023c). This statement outlines that ICBs and NHS Trusts and Foundation Trusts have a duty to report within their annual reports information on health inequalities. Data is to be reported over a number of indicators (including the Core20PLUS5 framework, diabetes, smoking cessation and more). The purpose of this exercise is to ensure that NHS organisations are using data to inform service improvements and address health inequalities locally. This has been described as a phased approach and organisations are able to include additional local data that is pertinent to local population issues. This new statement provides a formal monitoring process that was identified as lacking within our research. However, collecting data at System or Trust level could potentially mask some inequalities that would be identified if data was extracted at Place or Neighbourhood level. The policy drive to collect, report and monitor data does not define how health inequalities will be addressed. This is something that will need to be monitored over time.

6.4 Comparison with existing literature

In this section we focus upon literature relating to current UK health policy and consider how our findings relate to this wider body of work. We started by building our study upon the review carried out by McMahon et al (2023) (Section 2.1), which identified the fact that the very complexity of the topic of health inequalities means that individuals within the system will have very different conceptualisations as to what constitutes an important inequality and the means by which they should be addressed. These authors argued that individual perceptions and beliefs are shaped by institutional factors, both within local organisations and within other groupings such as professional traditions etc. In our study we found that, compared with CCGs, ICSs have moved some way towards a more cohesive approach to addressing health inequalities, and that this has been driven by public discourse arising out of the pandemic as well as by national policy focused around the Core20PLUS5 framework. However, there remain confusions and competing approaches, with a specific tension between Public Health approaches focusing upon the wider social factors shaping society and a more medically driven approach.

More widely, in keeping with our findings, Ford et al. (2019) highlighted the lack of conceptual clarity with regards to health inequalities in the NHS Long Term Plan, and Olivera et al. (2022) identified ‘vagueness’, ‘variation’ and a failure to clearly conceptualise the type of inequality to be targeted in the plans that Sustainability and Transformation Partnerships (the forerunners to ICSs) had produced in response to the Plan. Capper et al. (2023) examined policy documents, including the NHS Operational Planning Guidance analysed for this report, and highlighted the disconnect that we have identified between a Public Health approach, based upon proportionate universalism and a focus upon the structural drivers of the social determinants of health, and an NHS approach which tends to drift towards a focus upon identifying ‘at risk’ individuals and targeting interventions at specific demographics and personal risk factors and behaviours. This mirrors the tension that we have identified between Public Health and Population Health Management approaches. Capper et al also suggest that current policy does not delegate sufficient power and resource to local areas to allow them to truly address the factors driving observed inequalities. Our study has identified the fact that the design of Integrated Care Systems could provide a vehicle for a degree of such local delegation, at least with respect to the delegation of NHS funding to local Places, but that at present this is not occurring everywhere, with existing spending patterns making significant shifts in funding difficult to achieve. Goddard (2023) concurs, analysing ICS plans and suggesting that these demonstrate the potential for Place-based planning and activity to address local inequalities. However, Goddard also identifies many of the same issues identified in our study, including: the need for good local relationships; the need for clarity as to which types of inequalities for which populations are being targeted; the difficulties associated with shifting expenditure to areas of greatest need; and the fact that different ICSs cover very different populations, and so face very different challenges.

In keeping with our evidence as to the current lack of formal monitoring of ICS progress, Bambra et al. (2023) suggest that specific targets should be put in place across government in order to focus social policy attention. Their designated indicators include: Life Expectancy (LE); Healthy Life Expectancy (HLE); Infant Mortality Rate (IMR); Overweight and obesity; Anxiety and Depression; and Suicide rates. These indicators focus upon what we have called inequalities in health status, and represent the eventual outcome of a wide range of potential societal and health system actions. As we highlighted in our discussion of how potential indicators might be chosen (section 5.5), this approach may have some advantages, but it also fails to take account of the limited ability of any given health system to address entrenched issues of poverty and deprivation. It may be that more proximate outcomes around access to care may be helpful as interim targets which could plausibly be addressed by health services within a reasonable time frame.

Finally, in an editorial focusing upon approaches to health inequalities, Ford (2023) highlight the need for clarity and precision. In keeping with many of those we interviewed, Ford et al argue that progress in tackling inequalities is most likely to be achieved if those responsible pick a problem, define it precisely and focus attention and resources upon it. Many of our interviewees echoed this, highlighting the potential paralysing effect that the complexity of the issue can have and suggesting that progress was most likely when agreement could be reached about a specific problem to be addressed. Our conceptual framework provides one approach that could be used to achieve this clarity.

6.5 Implications for ICSs

Our study and existing literature highlight the fact that, whilst current policy has increased the focus within the health system on tackling health inequalities, and the Core20PLUS5 framework has gone some way in supporting the development of action plans, there remains considerable confusion around the conceptualisation of health inequalities and the role that ICSs could and should play in addressing them. We would therefore recommend that ICSs could usefully spend time clarifying their collective perception of which types of inequalities they wish to focus upon within which populations, the likely causes of those inequalities and the type of action which might be useful. Potential targets for action could be classified as to the extent to which they are amenable to NHS action and the extent to which action should be individual or population focused (as per Buzelli et al. (2022), and metrics identified which could be used to track progress. We would argue that our simplified schematic linking the different types of observed inequality to proximate causes could be useful here (see figure 2). Whilst such a model remains an idealised depiction of complex and inter-related issues, it would facilitate dialogue and discussion, and prompt Systems to formally identify their targets for interventions, including specifying: populations deemed to be at a disadvantage over which geographies; type of inequality to be addressed; and potentially modifiable causes underlying observed inequalities. Such an approach would also support the identification of those situations in which modifiable causal factors amenable to NHS or wider system action do not exist, preventing wasted effort. This approach would also stimulate discussion as to where a wider public health focused approach led by non-NHS organisations is required (directed at such things as inequalities in housing, education, pollution etc) and where a more medically focused population health management approach is more appropriate. Where good local relationships exist, it is likely that such structured conversations around tackling health inequalities could be relatively easily achieved. Where relationships are less well developed there may be a role for NHSE in facilitating engagement.

Our study also suggests that:

- Where an ICS has employed in-house Public Health staff, attention should be paid to their role and their interface with Local Authority Public Health teams. Clear roles and responsibilities, and appropriate collaborative structures and governance are required.
- The internal distribution of funding according to need is an important potential mechanism by which inequalities might be tackled. However, this is unlikely to be easy to achieve, not least because of the fixed nature of much current spending. We recommend that ICSs should explicitly consider and document:
  - The extent to which core spend is delegated to Place level – ICSs vary considerably in their approach to this, and lack of delegation may inhibit local action due to a lack of control over decision-making.
  - The approach taken with any additional funding. Options include: distribution according to some measure of need and allowing local spending decisions; ICS-wide activity (such as staff training), alongside a degree of delegation; or central decision making, with local areas bidding for funding for particular projects.
  - The development of appropriate local decision-making structures for health inequalities work, with associated oversight and internal monitoring arrangements.
  - The length of any funding. Short term funding is unlikely to address fundamental long term structural issues, but may be appropriate on occasion for such things as catch-up vaccination programmes etc.

6.6 Implications for national policy (research question 2c)

Our study suggests that the Core20PLUS5 framework has been useful in supporting ICSs to choose which populations to target. However, a key finding of our study is that unclear guidance feeds lack of clarity at local level as to what needs to be done, by whom. Our study suggests that greater clarity in national guidance is required, including clarity around: what type of inequalities exist and can be targeted; where ICS action is most likely to be useful; and how different targets for intervention interact with one another. There is also currently a lack of clarity in the Core20PLUS5 framework around the fact that the size of geography over which populations are identified will affect which groups are chosen for focus. Our conceptual model may be helpful here, providing a framework to underpin more structured guidance. As set out in table 7, current guidance does not clearly identify the specific mechanisms by which ICS action can support improvements, with many statements appearing aspirational rather than rooted in evidence. Our framework could support a more explicit approach to identifying these mechanisms. We would also recommend that the Core20PLUS5 framework is expanded to provide Systems with a matrix, within which they could be guided to identify the population to be addressed, the geography over which action is to be taken, the type of inequality, the potential intervention target and associated monitoring metrics. This could support a targeted action plan which could be monitored.

More generally, we would concur with Capper et al. (2023) that national policy could be clearer in distinguishing between: population-focused interventions directed towards more upstream underlying causes of observable inequalities, which may require national policy change e.g. in welfare policy; local whole population interventions, e.g. transport, housing or local health promotion approaches, in which an ICS might collaborate in a programme of work led by Local Authority Public Health and other teams; and ICS-led population health management approaches which focus upon identifying individuals or groups of individuals with particular risk factors and targeting interventions to support them. Given the importance of inequalities within policy and in the formal responsibilities of ICSs, it may be that further specific policy attention (such as a White Paper) would be useful in supporting this clarification.

There is an official policy intention to adjust national funding formulae to better account for inequalities. However, we have highlighted the complexities around this, including the fact that the use in the core allocation of measures of previous service use can fail to account for unmet need amongst some populations. Furthermore, current approaches to funding allocations do not take account of the fact that providing services to particular populations may be more costly. One of our case study ICSs had identified the fact that a majority of their resident population live within the 'core 20' most deprived areas nationally. Other ICSs have very different population profiles. These differences will have a significant impact on the work of the ICS, and should be recognised in funding. More research is needed to understand in detail what the impact of better adjustment for different measures of population need would have on Systems, and work needs to be done with Systems to identify the advantages and disadvantages of different approaches.

Within ICSs, NHS England currently provides some guidance to support internal allocation according to need, but this remains difficult, because much resource use, particularly in the acute sector, is driven by contracts which require payment for activity. Sectors using block contracts (such as community and mental health services) will be disadvantaged by this. Appropriate internal allocation to mitigate inequalities will require access to robust data about local populations and appropriate analytical capacity to understand the data.

Finally, our study suggests that real progress in tackling health inequalities will probably require some form of external performance monitoring and management, and it is to be welcomed that a monitoring framework is now being developed by NHS England. However, we have also highlighted the complexities associated with the choice of indicators and comparator populations, and further research is required to support decision making in this regard alongside better use of the rich data sets currently available to the NHS. We have highlighted some of the attributes to be considered in choosing metrics to monitor.

6.7 Strengths and weaknesses

The purpose of this work was to specifically focus on the organisations within the English NHS in order to understand how they were interpreting the national health inequalities policy guidance and what local action or policies they were introducing to tackle inequalities. The strength of the study lies in its detailed analysis of policy documents, and in the use of an explicit conceptual framework within which to make sense of the varied and shifting interpretations of health inequalities that we found both in policy and on the ground. This explicit framework has wider utility beyond the study, providing a practical approach for policy makers and local system managers. In addition, our qualitative case studies allowed us to collect rich and nuanced data about local contexts and approaches to health inequalities. It was our original intention to undertake a survey of ICS leads in order to obtain some national information about approaches to tackling inequalities which would have provided a wider context for our qualitative work. A survey was designed and distributed on our behalf by the NHS Confederation ICS Network, but unfortunately only four responses were received. In future it may be better to use an interview approach to obtain such information. Due to the project timelines, ethical permissions and funding, we were unable to introduce a different methodology to capture national ICS data. A lack of national data from the ICS survey does impact on the generalisability of these findings. However, the rich information about many aspects of ICS health inequalities work obtained from our case studies allowed us to explore in depth the complex issues around health inequalities. We were able to compare data from ICSs which have taken quite different approaches to aspects of their work, including their approach to delegation of responsibility and funding, finding that, notwithstanding their different approaches, there was considerable commonality around the issues that arose. We therefore believe that the findings from this project provide useful information for policy makers and for ICSs.

The research was undertaken to address specific policy needs from DHSC, and as such focused upon ICS respondents rather than considering the views of those suffering as a result of health inequalities. Whilst such public voices would have been interesting, they would not have helped us to address our core research questions in a timely manner, as members of the public are unlikely to know how and why ICSs are responding to national guidance. It is undoubtedly true that there are important research questions to be answered around the views of the public on priorities in tackling health inequalities, as well as ICS approaches to engaging with the public, but that would require a different research design and therefore falls out of scope of this report. To improve the work, it would have been useful to interview staff from the voluntary and community sector organisations working with local ICSs to capture their understanding of local action to address inequalities, and this omission is a weakness of the research that could usefully be addressed in subsequent studies.

We had initially hoped to be able to undertake some new quantitative analyses that might provide some evidence as to the extent of progress in addressing health inequalities. However, it was quickly clear from this and our other ongoing research that ICSs were still in the early stages of their organisational development, and that progress in dealing with inequalities could not yet be expected. We therefore focused our quantitative work on considering what metrics might prove to be useful in monitoring ICS progress, and in exploring how funding formulae might be adjusted to take account of deprivation and other drivers of population need.

The study design and development did not include any specific patient and public engagement or involvement, and this is a weakness. The genesis of the study – in response to policy maker requests for support in this area – led us to focus our initial engagement on those within DHSC and NHSE with a specific remit to support activity around health inequalities. During the design of the project we spoke to a number of policy makers and received feedback on our research aims, objectives and research questions. It was in response to policy maker feedback that we included the online survey, which in practice proved difficult to operationalise. Future research in this area could usefully include convening a broadly-based advisory group to support the work and ensure that public voices are heard.

6.8 Conclusions and next steps

The duty to address health inequalities is one of the most important roles of newly created ICSs. We have shown that this duty is being taken very seriously by ICSs, but that there are considerable issues which need to be addressed if progress is to be made. Our study suggests that greater clarity is required over the types of inequality being addressed, the extent and identification of affected populations and the nature of the potentially amenable causes which are to be targeted by interventions. We have provided a simplified schematic framework which may support policy makers and Systems in developing their plans and programmes, explored how funding formulae might be modified and suggested potential metrics for ongoing monitoring. Future research will be required to measure progress and to explore which approaches to tackling health inequalities have been most successful. The findings from this work have been reported back to DHSC and NHSE policy makers. Further engagement will take place on publication of the report with a public engagement event planned to obtain public feedback on the findings. A lay summary will be available. Papers will also be submitted to academic journals, and we will engage with the NHS Confederation Integrated Care System Network to provide practical feedback to Systems.

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Appendices

7.1 Appendix 1: Survey questions

ICS Leaders Survey 1

Start of Block: Default Question Block

Q1 **Tackling health inequalities: the role and impact of Integrated Care Systems**
Online Survey

You are being invited to take part in a research study that aims to inform policy makers as they design mechanisms to support Integrated Care Systems to tackle health inequalities. We aim to understand how health inequalities are characterised and how they are being tackled locally. Before you decide whether to take part, it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully before deciding whether to take part. Thank you for taking the time to read this.

Who will conduct the research?

The research is being carried out by the PRUComm (Policy Research Unit in Commissioning and the Healthcare System) team, which includes the Health Organisation, Policy and Economics (HOPE) research group at The University of Manchester, and colleagues from London School of Hygiene & Tropical Medicine and the University of Kent.

What is the purpose of the research?

This mixed-methods project is focused on Integrated Care Systems (ICSs), exploring how health inequalities are perceived and how these perceptions are translated into plans to tackle health inequalities. We are recruiting ICS Leaders to complete a short online survey to understand how ICSs are thinking about and responding to their duty to tackle health inequalities. Data collected will be fed back to The Department of Health and Social Care to help inform policy makers as they design policies and mechanisms to support ICSs to tackle health inequalities.

Will the outcomes of the research be published?

Our findings will be published in a final report, which will be shared with all participants, who agree to be contacted with the findings. We will also publish in academic journals and present our findings at conferences. Any quotations from the survey will be anonymised in any of our publications. All of our publications from this research project can also be found on our unit's website Home - Policy Research Unit in Commissioning and the Healthcare System (prucomm.ac.uk).

What would I be asked to do if I took part?

The survey questions will take you approximately 30 minutes to complete. There are no specific risks or benefits associated with taking part, although your involvement will be valuable in allowing us to develop informed findings to present to policy makers.

Will I be compensated for taking part?

There will be no compensation for taking part in this research.

What happens if I do not want to take part or if I change my mind?

It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time without giving a reason and without detriment to yourself. Should you withdraw, you can request that your survey data be withdrawn from the study, by contacting Lynsey Warwick-Giles lynsey.warwick-giles@manchester.ac.uk, although this will not be possible if it has been used, in an anonymous form, in a published output before your request. This does not affect your data protection rights. If you decide not to take part you do not need to do anything further.

What information will you collect about me?

In order to participate in this research project we will need to collect information that could identify you, called "personal identifiable information". Specifically we will need to collect:

- Your contact details (so we can keep in touch whilst you are in the study)

- Your job role

Under what legal basis are you collecting this information?

We are collecting and storing this personal identifiable information in accordance with UK data protection law which protect your rights. These state that we must have a legal basis (specific reason) for collecting your data. For this study, the specific reason is that it is “a public interest task” and “a process necessary for research purposes”.

What are my rights in relation to the information you will collect about me?

You have a number of rights under data protection law regarding your personal information. For example, you can request a copy of the information we hold about you, including audio recordings. If you would like to know more about your different rights or the way we use your personal information to ensure we follow the law, please consult our Privacy Notice for Research.

Will my participation in the study be confidential and my personal identifiable information be protected?

In accordance with data protection law, The University of Manchester is the Data Controller for this project. This means that we are responsible for making sure your personal information is kept secure, confidential and used only in the way you have been told it will be used.

All researchers are trained with this in mind, and your data will be looked after in the following way:
- Survey responses will be stored on The University of Manchester’s secure servers. All survey responses will be pseudonymised so your name and other identifying information will be removed and replaced with an ID number. Only the research team will have access to the key that links this ID number to your personal information.
- All findings will be reported anonymously, without individuals being identified. We will endeavour to maintain to maintain anonymity when writing papers and reports by referring to participants with vague job titles such as ‘manager’ or ‘clinician’.
- Please also note that individuals from The University of Manchester or regulatory authorities may need to look at the data collected for this study to make sure the project is being carried out as planned. This may involve looking at identifiable data. All individuals involved in auditing and monitoring the study will have a strict duty of confidentiality to you as a research participant.

If you have any queries about the study, please contact the researcher: • DR LYNSEY WARWICK-GILES Email: lynsey.warwick-giles@manchester.ac.uk

Page Break

Q2 I understand the purpose of this research, the risks and benefits of this survey and consent to providing my information for the stated use.

○ Yes (1)

Page Break

Q2 Which Integrated Care System do you work for?

____

____

____

____

____

Q4 What is your job title?

____

Q5 Please provide your email address so that we can share the findings from this research project (you may choose not to leave your email address if you are happy not to receive information regarding the findings of the study).

____

Page Break

Q6 We know that many health outcomes are unequal across society. Thinking about people living in the areas covered by your ICS, what do you think are the most important causes of those unequal outcomes? (List in order of priority by dragging the answers into your desired order)

_______ Poor/unequal access to healthcare (community care) (1)
_______ Poor/unequal access to healthcare (primary care) (2)
_______ Poor/unequal access to healthcare (secondary care) (3)
_______ Poor/unequal access to healthcare (mental health care) (4)
_______ Poor/unequal access to healthcare (specialised services) (5)
_______ Poor/unequal access to social care (6)
_______ Poor/unequal access to prevention (7)
_______ Poor/unequal environmental and social determinants of health (please state what these are) (8)

Page Break

Q7 Has the CORE20PLUS5 programme guided the ICSs approach to tackle health inequalities?

○ Yes (1)

○ Maybe (2)

○ No (3)

Page Break

Q8 What are the ICSs three top priority areas for tackling health inequalities? (Please include the information below)

○ Priority area 1 (1) ____

○ Priority area 2 (2) ____

○ Priority area 3 (3) ____

Page Break

Q9 Thinking of the three priorities you have outlined, is each a new priority or a continuation of previous work?

	New (1)	Continuation of previous work (2)
Priority One (1)	○	○
Priority Two (2)	○	○
Priority Three (3)	○	○

Q10 Does your ICS have any other health inequality priorities that are important to the area you serve? (Please provide your answer in the box below)

____

Q11 Which members of the ICS (NHS or other organisations) are leading work in each of the priority areas you have outlined? Please comment next to each priority.

○ Priority One (1) ____

○ Priority Two (2) ____

○ Priority Three (3) ____

Page Break

Q12 Thinking about your ICS structure and processes: what structures do you have in place to address inequalities? Please select all that apply.

☐ A named health inequalities lead. (If yes, please provide their job title below) (1) ____

☐ Health inequalities committee/group at ICS level (If yes, please provide the job titles of the membership below) (2) ____

☐ Health inequalities committee/group at Place level (3)

☐ Health inequalities as a standing item on the ICB agenda (4)

☐ Health inequalities representatives on ICB committees/delegated bodies e.g., Place committees (5)

☐ Other (please specify) (6) ____

Page Break

Q13 How are local Public Health specialists represented in your ICS structure? (Please select all that apply)

☐ Member of the ICB (if yes: specify in text box DPH/deputy DPH/other) (1) ____

☐ Member of the ICP (if yes: specify in text box from one local authority or from multiple local authorities) (2) ____

☐ Local authority employed Public Health specialist a voting member of 1 or more ICS committees (please specify which committees in the text box) (3) ____

☐ Local authority employed Public Health specialist a non-voting/observer of 1 or more ICS committees (please specify which committees in the text box) (4) ____

☐ One or more Public Health specialists employed by the ICS (5)

☐ Other (please specify in the text box) (6) ____

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Q14 What are the main constraints to address health inequalities in your ICB? (List in order of priority by dragging the answers into your desired order)

_______ Lack of resources (specify resources: financial, staff) (1)
_______ Lack of identified priorities (2)
_______ Too many competing priorities (3)
_______ Lack of mechanisms to channel resources where needed (please provide examples) (4)
_______ Weak inter-sectoral collaborations (to tackle social determinants of health) (5)
_______ Others (specify) (6)

Page Break

Q15 Funding allocated by NHS England to ICBs are based on a formula which includes an adjustment for differences in unmet need and health inequalities. Do you plan specific financial arrangements to address inequalities?

○ Yes (1)

○ No (2)

Q16 If yes, which financial arrangements are you planning to use to address inequalities?

☐ Use NHS ICB Place Based Allocation Tool (this is already inclusive of an adjustment for health inequality and unmet need). Please specify how Place is defined. (1) ____

☐ Adapt NHS ICB Place Based Allocation Tool or use an alternative approach to redistribute resources to Places to tackle inequalities. (2)

☐ Allocate ring-fenced resources for inequalities in addition to national allocation. If yes, to whom? e.g. Places, Other. (3) ____

☐ Other (Please explain) (4) ____

Q17 If you have no plans to use specific arrangements to address inequalities please can you explain why?

____

Page Break

Q18 How are you planning to monitor health inequalities progress? (Please select one option)

- ○ Using the CORE20PLUS5 dashboard alone? (1)
- ○ Using the CORE20PLUS5 dashboard alongside locally developed indicators? (2)
- ○ Using locally developed indicators alone? (3)

Q19 Where are health inequality indicators being monitored? (Please select one answer)

- ○ at ICB level alone? (1)
- ○ at ICB level and at Place level? (2)
- ○ at Place level alone? (3)
- ○ Other? (Please specify) (4) ____

Page Break

Q20 Is there anything else you you would like to add that has not been covered in the survey but you think is pertinent to the research?

____

____

____

____

____

End of Block: Default Question Block
