Evaluation of Buckinghamshire, Oxfordshire and Berkshire West Health Inequalities and Prevention Funding – Year One Report

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Thank you: We would like to thank all the staff and public partners who took time to talk to us throughout this year one evaluation.

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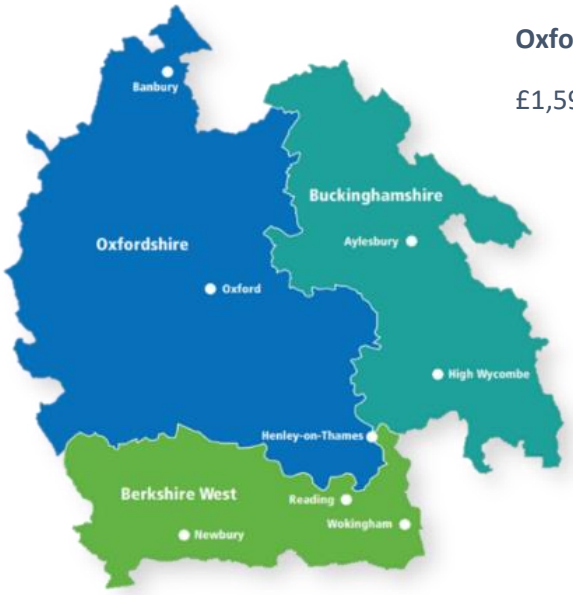
Introduction

There has been a long-standing focus in public health around reducing inequalities and improving equity in health. In January 2019, the NHS Long Term Plan was published setting out key actions the NHS would take to strengthen its contribution to reducing healthcare inequalities. As a result the National Healthcare Inequalities Improvement Programme (HiQiP) was established in January 2021 and is responsible for setting the direction for tackling healthcare inequalities. These are set out in the CORE20PLUS5 approach introduced by NHSE on the 1st November 2021. Despite this, the inequalities gap is widening (The Kings Fund, June, 2022). The challenge for systems is to find a balance between delivering mainstream services accessible to all, including personal choice and offering equity (The Kings Fund, Sept 2022).

In January 2023 Buckinghamshire, Oxfordshire, and Berkshire West (BOB), Integrated Care Board (ICB) received £8 million funding from NHS England (NHSE) to be used for health inequalities and prevention activities over a 2-year period. After three months of consultation the final resource document published in March 2023[1] focused the funding on a simple split between Place (Buckinghamshire, Oxfordshire and Berkshire West). The funding was agreed to be given annually 2023-2024 and 2024-2025 (Figure 1).

Figure 1: Place and funding allocation of BOB Integrated Care System



Oxfordshire

£1,595,302.67 (39.88%)

Buckinghamshire

£1,103,449.86 (27.59%)

Berkshire West

£1,301,536.59 (32.54%)

In August 2023, Health Innovation Oxford and Thames Valley were asked to undertake an independent evaluation of the funding. The initial scoping report[2] demonstrated that funding was encouraging partners to think about ways to align the monies to Place-based priorities and a focus on Core20PLUS5.

[1] BOB System prevention and inequalities resources allocation of targeted approaches to addressing health inequalities and improving prevention. Steve Goldensmith, March 2023

[2] Evaluation of Berkshire West, Oxfordshire and Buckinghamshire Health Inequalities and Prevention Funding, Scoping Report

In December 2023, BOB Integrated Care System (ICS), forecast a system deficit of £44.4million, which has since worsened by a further £19million. Difficult decisions have been made to develop a plan for longer term sustainability. These included re-absorbing uncommitted health inequalities funds back into the system and reducing the overall funding by approximately £1million (£8million reduced to £7million). There remains a commitment to review recurrent health inequalities funding through the 2025/2026 planning process.

This report sets out evaluation findings for year one.

Evaluation approach for year one

Evaluation questions

The evaluation plan and scoping report (January 2024) describe the collaboratively designed questions for this system-wide evaluation (Table 1).

Table 1: Evaluation themes and questions

Theme	Evaluation question
Theme One: Resource Allocation	1) How has this funding changed the way in which health inequalities and prevention activities are designed and delivered?
	2) Has this funding improved the sustainability of these activities?
	3) What can we learn about how best to allocate resources for health inequalities and prevention across the system?
Theme Two: Focus	4) What can we learn from the approaches to health inequalities and prevention activities being used by system and place?
	5) To what extent are local communities involved, and how?
	6) Are there approaches, or key ingredients for success which we can highlight for the future?
Theme Three: Leadership and Culture	7) Over the lifetime of this investment, have there been changes in culture, knowledge, attitudes and behaviours regarding health inequality and prevention?
	8) Is there any evidence that changes in leadership or culture could be attributed to the investment?
	9) Are decisions about health inequalities being made in the most appropriate parts of the system?
	10) Are decisions involving the right people?

Methods

To address these questions in year one, a series of mixed method evaluation activities took place between February 2024 and September 2024 across the BOB ICS region. The methods were co-designed and agreed between Health Innovation Oxford and Thames Valley (HIOTV), and BOB Integrated Care Board, and are set out in the Evaluation Plan (Appendix 1). The evaluation involved senior leaders, programme and project leads, and public partners from within BOB ICS. Professional participants were identified by BOB ICB and Place-based colleagues. Public partners were identified by HIOTV. Introductions were made via electronic mailing. All identified were offered to participate in interviews, surveys and focus groups.

Table 2: Breakdown of attendees/invitees by area

Area	Leadership thinking space	Interviews	Focus groups
Integrated Care Board	6/9	6/6	NA
Berkshire West	3/10	8/8	12/14
Oxfordshire	5/7	5/5	14/14
Buckinghamshire	2/4	4/4	5/6 8/11
Public Partner	None	2/2	None
Other	2/2	None	None
Total	18/32	25/25	39/45

Leadership thinking space: To enable findings and actions to be explored, senior leaders from across BOB Integrated Care System were identified by BOB ICB and invited to attend a face-to-face three-hour session. An external facilitator led the session in May 2024 using a modified Delphi technique where participants were encouraged to think through specific questions posed (Appendix 2). Thirty-two attendees were invited, 21 attendees agreed to participate and 18 were present at the session (Table 2).

Interviews: Interviews took place in July and August 2024, and data was collected through semi-structured interviews (Appendix 3) with senior leaders and programme managers within BOB ICS. Interviews took place virtually and were conducted by three individual interviewers. Twenty-five individuals including two public partners were invited to interview, 25 responded and were interviewed (Table 2).

Focus groups: Four on-line focus groups were undertaken in September 2024, one per Place location (Bucks had two to accommodate personnel). Project leads were identified by the Place programme lead and invited to attend. A voluntary sector representative was invited to attend each focus group session. The groups were led by two facilitators and used a co-designed set of questions (Appendix 4).

Survey: The leadership survey was sent out in May 2024 to 40 senior leaders and programme managers within BOB ICS. The initial survey (Appendix 5) received 5 responses. After discussion with BOB ICB Head of Inequalities, an agreed shorter survey (Appendix 6) was designed. The surveys were open for 6 weeks and received a total of 15 responses (15/40 = 37.5% response rate, Table 3).

Table 3: Leadership survey response by organisation

Integrated Care Board	Hospital	Public Health	Primary Care Network
40%	27%	27%	6%

The focus group survey (Appendix 7) was sent out to each focus group attendee prior to the focus group with a response rate of 67% (30/45).

Document review: Agendas and minutes were requested and reviewed from BOB ICB prevention, population health and reducing health inequalities group, and each Place-based governance group.

Observation: Observation at BOB ICB and Place governance groups was requested and undertaken where permission was granted (Table 4)

Table 4: Attendance to regional health inequalities governance groups

Area	Meeting	Date attended
Integrated Care Board	Prevention, Population Health and reducing health inequalities group	25th April 2024 25th July 2024
Berkshire West	CWO Quarterly Meeting Wokingham Local Integration board	8th August & 18th September 2024 17th September 2024
Oxfordshire	Prevention and Health Inequalities Forum	16th October 2024
Buckinghamshire	Health Inequalities Forum	Not attended to date

Analysis: Interviews were transcribed and reviewed using thematic analysis. Notes from the focus groups were taken and reviewed using thematic analysis. Two reviewers undertook the analysis.

Data sharing: All interviews and focus groups were confidential. All notes and transcripts were anonymised, stored on a secure drive, and deleted after the final report agreed (October 2025).

Findings

The evaluation found a wide variety of views about how or even "if" a system can work together to reduce and prevent health and healthcare inequalities. Common areas of exploration included shared purpose, approaches to address health inequalities, relationships, governance, community involvement, decision making, financial sustainability and skills development.

Shared purpose

Introduction

It was generally felt that the funding to date had not facilitated a shared purpose across the Integrated Care System. However, there is evidence to suggest that it has supported an emerging sense of shared purpose at Place, with local authorities, hospitals, voluntary sector and Place-based BOB ICB representatives identifying some shared commitments.

One survey respondent described a desirable situation where there is:

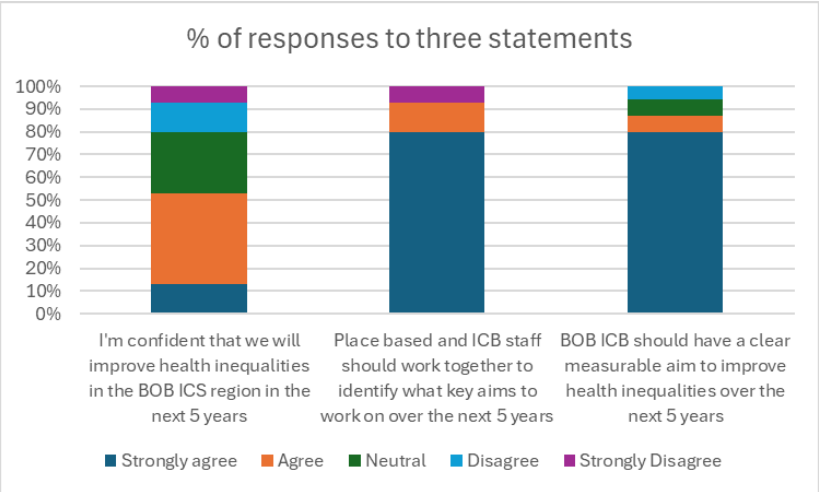
> *"A joint commitment to cede organisational sovereignty in order to better serve and achieve equity for our population" Survey respondent*

Integrated care system leadership

The leadership thinking space demonstrated that most attendees did not know each other well, and there was a limited sense of common goals about which inequalities should be prioritised, and how they should be approached.

Senior leaders were also asked to respond to survey statements regarding their perception of health inequalities in BOB ICS over the next five years. The majority strongly agreed that the ICB and Place should work together and have key measurable aims (80% = 12/15). However, only 53% (8/15) agreed or strongly agreed that they were confident that health inequalities would improve over the next 5 years.

Figure 2 - % of responses to three statements around working together to improve health inequalities



Place-based

Among Place-based participants, there was diversity of thought about the extent to which BOB ICB could or should develop this sense of shared purpose. Some felt that a co-designed approach with an overall steer from BOB ICB would help to shape their local priorities. It was suggested that BOB ICS could co-produce a shared vision around certain topics which could then be implemented at Place. These topics might include, for example:

- Improving health, with homeless, asylum seekers, gypsy, Roma, and travellers
- Improving access to health services for vulnerable groups
- Commissioning more services in the community rather than in the acute setting.

It was suggested that once the area to collaborate on was agreed then it would be for Place to decided how to implement that with their local population. One focus group discussed proportionate universalism as a principal for delivering resources at scale whilst being informed of the inequalities within each area.

"At the moment we are making every service bespoke for a group or race, we need to move away from one big hub into smaller hubs for all"
Focus group participant

However, other Place-based participants felt that their current approaches worked well and did not require this higher level of input. Survey responses provided insights about the conditions which would need to be in place to develop this sense of shared purpose at either Place or system level. Notable responses included:

- Producing accurate data
- Creating equity in access to NHS services
- Reorientating the health system away from domination by acute hospitals to one built on public health, self-care, primary health and social care end to end pathways
- Common priorities
- Knowing each other's role
- Supporting, equal and equitable experience and outcomes for all in "our" community despite deprivation, and protected characteristics.

Differing approaches to health inequalities

A tension was noted between NHS health services, commissioned to focus on Core20PLUS5 and Local Authorities who have a broader responsibility around the wider determinants of health. Currently these two approaches do not overlap well.

Participants in the leadership thinking space explored this issue, noting that there was a lack of clarity from NHSE about whether the NHS should be focusing on the results of health inequalities (e.g. ensuring better access to services for disadvantaged groups) or focusing on the causes of health inequalities (poverty, housing etc.) or both.

There was consensus about the importance of access to population health management data to understand the greatest need and then to focus the funding around those areas with communities at the centre of the design and implementation. Public health colleagues shared that health inequalities are their "bread and butter", and data is central to understanding the demographics and need of the population they serve. Most already have established relationships with a wide variety of communities, voluntary groups, health and social care.

"We know that 20% of inequalities is Health services and 80% is Local Authority services. There is a difference, Health inequalities is not a piece of work to be centralised"
Senior leader place

"The problem is the way the money flows down from NHS England, requires a focus on Core20 PLUS5. Central government needs to offer a really clear alignment and direction on the issue of Core20PLUS5 vs wider determinants of health. If we want to further the prevention agenda that will be the only way to do it"
Senior leader board

"BOB is also constrained to Core20PLUS5. I don't think that addresses social inequalities and wider determinants and that prevents BOB from addressing the real inequalities"
Senior leader place

Most participants noted that working at system level was complex and that each Place area was diverse and needed bespoke interventions. Survey responses confirmed that there was no consensus about which health inequality issues should be prioritised. The survey did highlight that respondents agreed around who should focus on what:

- 100% (15/15) suggested that the ICB and hospitals should focus on Inequalities around access to NHS services and outcomes of NHS services, and
- 93% (14/15) noted that public health should focus on wider determinants of health e.g. poverty, housing, transport.

"We need to take a step back and look at services in their entirety to be as effective as possible" Senior leader, BOB ICB

"The ICS has amalgamated five areas that are systematically quite different. You can't have a one size fits all. There are some things we can do at system level but mostly it needs to be targeted and Place based" Senior leader, Place

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Relationships and partnership working

Introduction

There was consensus that relationships are key to build trust and grow a vision where all key partners in addressing health inequalities can be heard. This includes relationships with communities as well as between organisations at system and Place level. At present people are still too focused on working within organisational boundaries:

"There is far more that unites them (organisations within BOB ICS) than separates them, the boundaries are porous" Senior leader, BOB ICB

Between BOB ICB and Place

It was clear that the introduction of Place directors was thought to be a positive step by most, bridging the gap between ICB and established organisations within the ICS. Participants did however tend to feel that these working relationships were currently over-reliant on one or two individuals, posing a risk should one of these individuals depart. Some indicated that there had not yet been enough time to cultivate relationships further, but with consistency it was felt that these would develop organically.

"It's been a dream working with our Place director, but they cannot change the system" Senior leader, Place

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Whilst some change had been noted across organisations, it was felt that there is a long way to go for trusted, empowered relationships to grow between BOB ICB and Place. This was multifaceted but factors thought to support trusted relationships included, blended ways of working (NHS and LA), financial consistency, having the right people in the room, partnership working, listening, and considerate understanding. It was felt by several that partnership needed to be acted out rather than just used as a label.

ICB participants recognised that relationships with public health colleagues was key and recognised the need to build on these. This included listening and learning from their expert knowledge around health inequalities. Survey and interview participants noted that this work is challenging, especially as the system is still "forming and storming" (*Survey respondent*).

"It's been really hard to build relationships against this financial backdrop. Trust has been key and will be good foundations for the future".

Senior leader, BOB ICB

"One of the solutions is about meaningful partnership working, there is no malintent to the way they (ICB) work, but they are an institution (NHS) in a (set) way of working"
Senior leader, Place

""Relationships with public health is probably not strong enough and needs to be better".

Senior leader, BOB ICB

Between Place and community

Place-based participants were clear that this funding has helped to build relationships, and trust between NHS, local authority and voluntary sector organisations at Place. The evaluation encountered numerous examples of positive developments because of partnership working, along with a sense of positivity about what could be achieved with these new-found opportunities.

> *"We [PCN respondent] realised that people have funding for white goods, and we didn't know about it. There's a lot of that stuff that primary care don't know about because they are not exposed to the right conversations. So having that exposure and knowing what services are out there has been hugely helpful"*
> *Focus group participant*

Focus groups participants talked about a "seachange", and the transformative nature of putting funding directly in the hands of voluntary sector. One Place highlighted that it had supported the growth of partners working together at scale whereas in the past small bids encouraged disparate working. Whilst they noted that this had been difficult, they were unanimous that it was worth the time taken (6 months) to establish this.

> *"The money is a flagship to bring partners together. We blasted through perceptions that different organisations had of each other" Senior leader, Place*

The survey responses built on these themes concerning strong relationships noting that these should be built on trust, empathy, partnership, and a willingness to work in different ways.

Governance

Allocation of funding

There was a degree of positivity around the decision to allocate funding at Place, with some Place leaders noting that it had felt like a clear and transparent process. There were minor concerns about delays in key groups hearing about the work (e.g. maternity services), but the overall structure, transparency and equity of the funding was viewed either positively or at least not negatively by most. There were some question marks about the purpose of the funding which has been held back by BOB ICB, so more clarity and transparency on this may be of value.

Decision-making

A diversity of thinking was noted when exploring how decisions around health inequalities are made. Generally, all noted that finances were finite, local autonomy was needed within a strategic framework, and addressing health inequalities was a long-term vision. However, there remains uncertainty about where key funding, and programme of work decisions should

be made. When asked about where "real" decisions about health inequalities get made and should be made participants had several views to share.

Place leaders tended to have a strong instinct that decisions should be led by the community. They were able to offer examples of this approach working well. A smaller proportion acknowledged the complexity of this, indicating that strategic decisions are also key. In general, they felt that more strategic decisions should be made at Place. A small number of Place leaders could see the value of the ICB making strategic decisions around health inequalities. Where this was the case, it was felt that the ICB's ability to scan data across the ICS was useful in setting policy priorities. However, even so, there were several participants who were concerned about an over-reliance on data without more nuanced engagement with communities. The issue of pockets of wealth masking inequalities within wards or neighbourhoods was highlighted by several as a concern, especially regarding allocation of resource using population health management approaches.

Other participants felt that decision-making should be held at Health and Wellbeing Boards, with communities inputting via community of practice style representation groups.

"It doesn't give Place the ownership if it still needs to be rubber stamped by the ICB. It undermines the journey that place is going through" Leader, BOB ICB

System leaders recognised the importance of community-led decisions, but also noted that good insight sits within services and teams. However, a more unified set of views suggested that strategic choices must be made in partnership by the Integrated Care System, underpinned by data, evidence, and financial support. For example, the ICS strategic decision could be made around a theme (e.g. waiting list targets, equitable access to healthcare, homelessness, asylum seekers etc.) and the individual outworking of this taking place at Place/neighbourhood level co-designed with local communities and third-party sectors.

"Use system level public health data where they have it (to identify need) then Place negotiate with local communities to try to work in these areas"
Public partner

Discussions in the Leadership Thinking Space indicated a willingness for these cross-system conversations to be taken through existing or modified system governance processes to agree system wide goals, priorities, role, responsibilities, actions and indicators for addressing health inequalities across BOB ICS.

"It's not just the investment that will make a difference, it's how we work as partners across the system"

Senior leader, Place

"System can help to tackle small scale deprivation/areas e.g. learning disabilities – easier to do that specialist work at system than Place but most other stuff is easier at Place". Senior leader, Place

"If we continue to stay in our lanes the needs will be overtaking us"

Senior leader, Place

Monitoring and oversight

A wide variety of opinions were observed around how to measure the success of a health inequalities reduction and prevention programme for the ICS. Some thoughts included data identified key areas to focus on and measure these over time (smoking, hypertension etc.) as well as case studies. The survey demonstrated a consensus forming around reducing the gap between healthy life expectancy and social groups, or the gap between richest and poorest. One survey respondent noted the complexity of this issue and highlighted the importance of including qualitative measures, as well as those which explore system maturity, and shift in culture.

It was suggested that oversight of any programmes should be through the BOB Health Inequalities and Prevention Group. However, there are mixed views about the effectiveness of the group. Some believe it is a crucial forum for learning and relationship building, others do not believe it understands the local context, involves communities enough, and has not sufficiently been action focused. There was a general feeling that there should be more time for discourse to grapple with complex ideas which would feed into the overall strategy, however little time was given for meaningful discussion. The group has a membership of 46 people and on both observations 39% (18/46) of those members attended, the majority being BOB ICB based. There was limited time for in-depth discussion, with the meeting finishing 50 minutes early on one occasion. It was noted that the patient voice on this group is currently represented by Healthwatch rather than a public member.

The Place based governance groups were chaired to time and had a more holistic approach with all members having time to openly discuss agenda items. One group had a core membership of 15 with an 80% attendance.

Impact and sustainability of the work

Impact

Although the funding is officially into its second year of delivery, most projects and programmes are in their infancy. So far, the funding has clearly enabled the development of new relationships in the community and a fostering of trust. Time has been allocated to working with communities to find out what is important to them. It has brought health inequalities higher on the agenda for the NHS, where this has remained central to the local authority. Several participants shared that rather than starting something new, the funding has enabled them to develop and extend services that they had already started.

"I don't think these (projects) would have happened without the additional money. This opportunity has allowed people (access to) the practical benefits of health inequality initiatives" Senior leader, anchor institution

"Most of the funding used to support worthy but small projects locally, most do good things but probably don't really move the dial and not really data driven" Senior leader, BOB ICB

Each Place is evaluating local impacts and outcomes arising from the funding. Each Place will monitor these results, but all noted that meaningful health outcomes are unlikely to occur within the timeframe for this funding.

Financial sustainability

There was consensus that ongoing funding for health inequalities work will be difficult. Whilst some are working hard to make a business case to secure future funding, there remains pessimism that this would be forthcoming. There were concerns raised about the current funding cuts and the extent to which projects will be cut and relationships/goodwill strained. One person felt that the cut in services was not just disappointing, but it was damaging and widened the health inequalities gap further. Most felt that recurrent funding was critical to building trust, capacity and continued work within communities.

"We need to have 3/5/10 year ripple effect to demonstrate change. I'm concerned that this will be a nice to have that is easy to be dropped"

Senior leader, Place

"£8m over 2 years geolocated over BOB ICS's populous of 4.3 million doesn't go far. It is very short termism, what happens after this, is it going to be dropped there is nothing about the long term. You can't improve things by a bit of work, then pause, then another bit of work" Public Partner

Participants (particularly at Place) shared a clear view that much more could be achieved if longer term funding is available.

"We MUST hold our nerve and invest for longer – that's why we're failing to tackle health inequalities – we're decommissioning promising efforts too early" Senior leader, Place

It was notable that local leaders are familiar with a pattern of short-term funding and used to "making the most" of it. Voluntary groups talked about being "ready with the data" to make sure they could get going quickly when the funding arrived, and others who were combining pots of funding to ensure best results. Concerns are present around projects not sustaining but again there was agreement that it has enabled partnerships to develop around health inequalities.

Community involvement

Communities have been closely involved in all three places. The models of involvement have varied, and local evaluation reports will be undertaken to glean insights about the impact and learning.

Summary of the three approaches[3]

- Berkshire West have focused on a programme of health checks. This programme has connected the expertise and focus of primary care network colleagues with voluntary sector capacity to reach into communities and encourage engagement. In comparison with Buckinghamshire and Oxfordshire, the approach here has been relatively standardised, providing opportunity to observe how several different communities react to this universal programme of support. The voluntary and community sector is closely involved in delivering the work and had some involvement in designing the approach.
- Buckinghamshire have connected their approach to the Opportunity Bucks partnership programme. This focuses on the ten most deprived wards in the county and builds on several existing initiatives, e.g. Making Every Adult Matter, and the Council's pre-existing commitments under the Start Well and Live Well strategies. As a result, the voluntary and community sector is involved, but possibly to a lesser extent that the other two places.
- Oxfordshire has distributed the funding through a mixture of pre-existing activities (e.g. Move Together Programme) and encouraged the community to lead the creation of new solutions through a programme of community grants. These have been focused on priorities identified by Oxfordshire and aligned to Core20plus5 principles.

Oxfordshire, and Buckinghamshire spoke positively about local community involvement activities that the funding had supported them to initiate and nurture. Berkshire West also had positive community engagement, however, did not feel that this was the result of the £8million funding as they had already developed good relationships.

For joined up working and true partnership it was thought that integration with ICB, public health, voluntary, community and social enterprise (VCSE) organisations, community researchers and anchor organisations was essential. One region approached community involvement by identifying gaps in service provision and reaching out to the community for co-designed solutions.

[3] See Scoping Report January 2024 for more detail

"Our area is working on developing communities rather than developing services, if you don't go to the community and learn from them, you'll fail"

Leader, BOB ICB

" I would like to see asset-based work so that it's leaving a legacy of community development"

Leader, BOB ICB

There is clear and consistent praise for the value of community engagement and the professionalism with which voluntary sector organisations have responded and enabled this process. One concern relates to the increased demand which this engagement creates and effective ways for statutory services to respond.

Skills development

"A key factor is training awareness across the system to enable staff to be more confident in addressing health inequalities" Leadership survey respondent

Focus groups with Place-based project and programme leads explored the extent to which people felt they (or the system) had grown in skills, knowledge and behaviours concerning health inequalities and prevention over the last year. Responses here were muted. Some noted improved knowledge of their local communities, and of the support available - especially via the voluntary sector. GP and PCN colleagues found pro-active community engagement especially valuable, articulating the benefits of being proactive with patients, taking the care out into the community.

Both the leadership and focus group surveys asked respondents about further training needs. There was an appetite to learn more around health inequalities from subject matter experts. Respondents preferred a mix of formal and informal training settings with 60% favouring workshop style learning. Case studies were also thought to be a valued way of sharing learning. Topics of interest included data analysis, co-production, engagement of different communities as well a range noted in Appendix 8.

Discussion

When the NHS was founded in 1948 its vision was to improve health and tackle health inequalities. These primary goals have not changed over the last 76 years. Throughout this time the inverse care law was described by Julian Tudor Hart as people who most need healthcare are least likely to receive it (The Health Foundation, 2022). Government policy has sought to address this longstanding injustice, yet the inequalities gap continues to widen (The King's Fund, June 2022). The government is expected to set out a new 10-year health plan in Spring 2025 which will set out a long-term vision for the NHS to address this salient challenge. Part of this vision will require collective action from systems, places, sectors and organisations (The King's Fund, Sept. 2024). This vision will require financial support through all healthcare funding i.e. the inclusion of health inequalities in all NHS spending and not just monies explicitly labelled as "inequalities monies".

During these year one activities we have been able to gain partial information in response to the evaluation questions, as set out below.

Theme One: Resource Allocation

Evaluation findings to date provide evidence that the funding has changed the way in which health inequalities and prevention are designed and delivered. Participants cited numerous examples of projects which would not have occurred had small amounts of Place funding not been passed to VCSEs. These responses were particularly strong in relation to the development of partnerships for tackling health inequalities. If the system remains stable these relationships should continue in the long run.

The approach to allocating resources has been largely well received, however the allocation of funding that is time limited may well have set things up that cannot sustain. People may have felt the funding approach was fair and transparent, but the inevitable fall out is that many do not know how their projects will continue. If funding is non-recurrent, sustainability may only be achieved by working to create agency and VCSE led and delivered services.

None of the individual projects we encountered have yet secured on-going funding, so it is likely that a large proportion of the activities will reduce or cease when this funding ends. There is a clear message from participants that any healthcare inequalities work should be funded on an on-going basis to allow (at least 5 years) (a) time to set up the project and for outcomes to be observed (b) security of tenure for staff appointed to the project and (c) opportunity for partnerships to establish.

Theme Two: Focus

Each of the three Places have approached their health inequality and prevention projects differently and have involved communities to a greater or lesser extent. It is too early to determine whether any of these approaches have merit over each other. However, we can make the following observations:

- There was positivity about the Oxfordshire approach, which builds on some strong community relationships and wider partnership working which appear to have been in development for some time. Combining clearly articulated purpose with the ability

for communities to co-create their own solutions appears to have been well-received. It is too early to note whether this positive start brings longer term change.

- In Berkshire West, not all partners were entirely satisfied with the decision to focus on health checks. However, in theory this structured approach to increasing health checks has the potential to make notable improvements in the overall health of the population. It is too early to note how the outcomes from this more structured approach compare with results being observed in other Places.
- By building on pre-existing programmes, Buckinghamshire is taking a different approach. By investing more deeply in existing evidenced programmes (e.g. Making Every Adult Matter) it is logical to conclude that more robust outcomes could emerge.

Whilst it remains early days, some key ingredients for success are emerging. They appear to be:

- Commitment to making investments over longer time frames (e.g. five years)
- The ability for health and voluntary sector colleagues to collaborate more directly
- Building bridges between Local Authorities and NHS
- Harnessing as many networks and partnerships as possible within the programme. Where other agendas (e.g. integrated neighbourhood teams) emerge, it is important to include them within the programme of work so as not to dilute existing or future work.

Theme Three: Leadership and Culture

It is too early to describe whether there have been any lasting changes in leadership and culture around health inequalities. Most participants have cited that partnership working has improved which has facilitated some change in behaviours between organisations. Where this has occurred, trust and growth are in their infancy as they start to collaborate. Public health colleagues have a wealth of knowledge to draw upon and it will take full commitment from all agencies to draw together to prioritise funding around an agreed plan.

There was an appetite to gain more knowledge and skills from those with expertise. Running a variety of sessions on popular health inequality topics may support individuals and the system to grow, learn and deliver a unified approach.

It is complicated to describe how and where decisions about health inequalities and prevention should get made within BOB ICS. However, we can make the following observations:

- The Health Inequalities and Prevention Group is valued as an opportunity for senior leaders to demonstrate their commitment. However, the group is large and there is are concerns that the meeting agenda does not always enable meaningful discussion and decision-making around health inequality and prevention strategy.
- There is a strong recognition that communities must be involved in decision-making and clarity that good quality responses to health inequalities and prevention cannot

be made without their input. Some processes are in place for this to happen, but need to be developed, embedded and built upon, with a particular focus on ensuring that senior leaders can access this insight

- Opinions about decisions which should lie at Place and decisions which should lie at ICB level tend to vary according to respondent. All participants recognise the value of Place-based decisions. However, colleagues located at Place find it more difficult to articulate which elements of decision-making are best held at ICB level. Several participants note the value of the ICB in setting strategic priorities.

Recommendations

The upcoming leadership thinking space provides opportunity for ICS leaders to reflect on the initial findings from this evaluation. There is a lot of promising work underway and an opportunity for BOB ICS to grow in this area: recommended areas for consideration are:

Accept the long-term challenge

It is currently difficult to provide clear evidence that health inequalities and prevention programmes are having an impact. Much of the short-term evidence is qualitative, and longer-term evidence requires evaluators to demonstrate the reduction of a concern: this requires a consistent plan and process. The consideration of the following activities could enable BOB ICS to grow and mature a long-term vision:

- The ICB board should agree and state that reducing health inequalities is one of its primary goals
- Key leaders (NHS, LA, VCSEs etc.) across the region should set an agreed joint ambition e.g. reduce inequalities in (healthy) expectation of life and infant mortality by 10% over 10 years
- The oversight and accountability of these aims and ambitions should be delegated to a named Director who should chair the Health Inequalities Prevention Group (reporting bi-annually to the ICB board)
- Funding should be integral to every funded service and a proportion for addressing health inequalities allocated from that budget (not be an individualised budget)
- A process to facilitate that all spending decisions should take account of the implications for inequalities (social justice), as well as the implications of individuals (choice, personalisation) and value as measured by population health gain (proportionate universalism)
- Places should have the freedom to identify the issues that matter most in their communities and where they believe they can have the greatest impact on making progress to the overall ICS joint ambition
- Work should continue to build on the progress all have made in strengthening relationships with partners and communities

- Provide a more visible leadership which demonstrates to communities that BOB ICB leaders are keen to listen and understand more about the barriers which prevent people from accessing healthcare services and the wider barriers which limit their ability to lead healthy lives.

Grow in knowledge and skills

- Design and deliver regular training and workshops around health and healthcare inequalities to build individual confidence and system-wide foundations
- Facilitate the production and sharing of data for places, partners and the ICS that relate to inequality
- Consider how BOB ICS can understand and monitor the extent to which NHS healthcare services are affected by the inverse care law.

For the evaluation in year two:

- *Prioritise liaison with place-based evaluations:* The year two evaluation report will ideally be more grounded in the findings which each Place is uncovering. It will be useful to align report timings to ensure that local evaluation feedback can be incorporated in the year-two report for this system-wide evaluation
- *Focus on qualitative engagement:* The richest insights from this year-one report have come from qualitative engagement. Several survey approaches have been attempted, but they tend to be complicated surveys which are open to differing interpretations and secure limited responses. We recommend diverting this resource to gather wider feedback through interviews and focus groups
- *Increase community insight:* The scoping report and year-one report included modest input from community members. This insight was useful, so greater focus on gathering insight from community members with a good understanding of they way in which BOB ICS functions would be useful.

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Glossary – Integrated care systems explained

Integrated Care System (ICS) - Integrated care systems (ICSs) are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. There are 42 ICSs across England. They have existed since 2016 but following the release of the 2022 Health and Care Act, ICSs were formalised as legal entities with statutory powers and responsibilities. Statutory ICSs comprise two key components:

- **integrated care boards (ICBs):** statutory bodies that are responsible for planning and funding most NHS services in the area
- **integrated care partnerships (ICPs):** statutory committees that bring together a broad set of system partners (including local government, the voluntary, community and social enterprise sector (VCSE), NHS organisations and others) to develop a health and care strategy for the area.

Integrated care boards (ICBs) - The role of the ICB is to allocate the NHS budget and commission services for the population. The ICB is directly accountable to NHS England for NHS spend and performance within the system. ICBs may choose to exercise their functions through delegating them to place-based committees but the ICB remains formally accountable.

Integrated care partnerships (ICPs) - The ICP is a statutory joint committee of the ICB and local authorities in the area. It brings together a broad set of system partners to support partnership working and develop an 'integrated care strategy', a plan to address the wider health care, public health and social care needs of the population. This strategy must build on local joint strategic needs assessments and health and wellbeing strategies and must be developed with the involvement of local communities and Healthwatch. The ICB is required to have regard to this plan when making decisions.

Working through their ICB and ICP, ICSs have four key aims:

Improving outcomes in population health and health care; tackling inequalities in outcomes, experience and access, enhancing productivity and value for money, helping the NHS to support broader social and economic development.

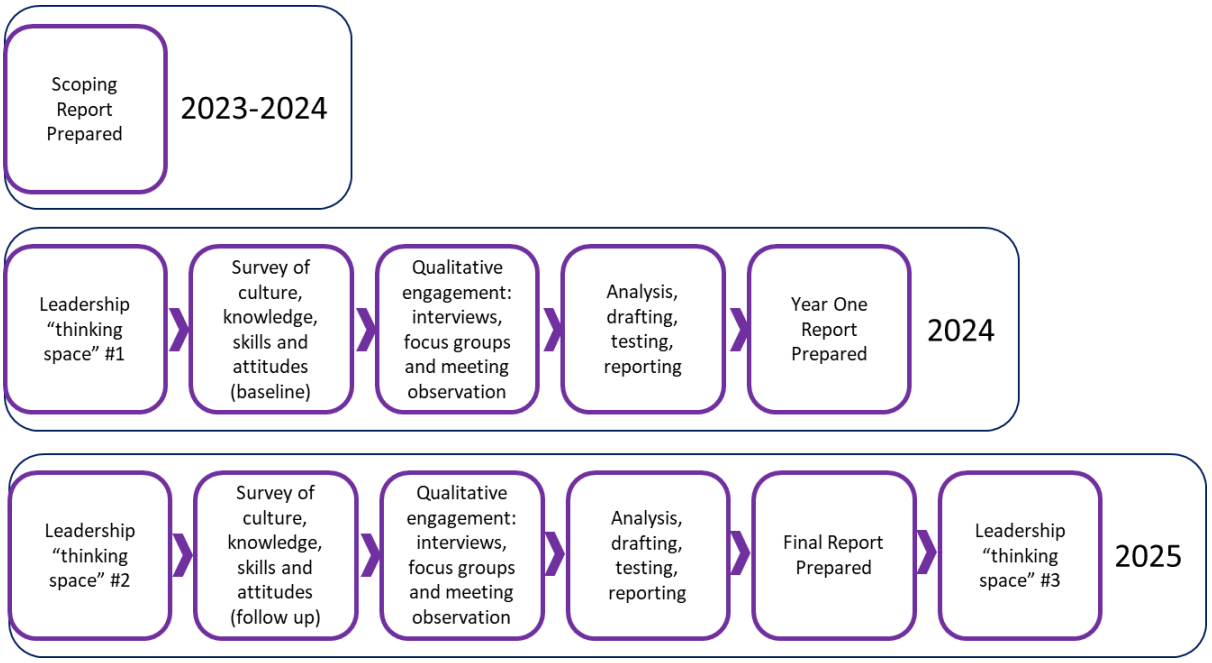
An overview of neighbourhoods, places and systems

Neighbourhoods (covering populations of around 30,000 to 50,000 people): where groups of GP practices work with NHS community services, social care and other providers to deliver more co-ordinated and proactive care, including through the formation of primary care networks (PCNs) and multi-agency neighbourhood teams.

Places (covering populations of around 250,000 to 500,000 people): where partnerships of health and care organisations in a town or district – including local government, NHS providers, VCSE organisations, social care providers and others – come together to join up the planning and delivery of services, redesign care pathways, engage with local communities and address health inequalities and the social and economic determinants of health. In many (but not all) cases, place footprints are based on local authority boundaries.

Systems (covering populations of around 500,000 to 3 million people): where health and care partners come together at scale to set overall system strategy, manage resources and performance, plan specialist services, and drive strategic improvements in areas such as workforce planning, digital infrastructure and estates.

Appendix One – Proposed methods of evaluation plan



Appendix Two – Leadership thinking space report

Background

1. The first of three facilitated Leadership Thinking Spaces that brought together people in System leadership roles from across Buckinghamshire, Oxfordshire and Berkshire West was held on 7 May 2024.

Purpose

2. The purposes of the "Thinking Spaces" was to provide busy leaders with a chance to:

a) reflect safely on complex inequality related issues including the nature of inequalities, the best way to tackle them, priorities, inequality related roles and responsibilities for their organisation and the ICS
b) build or deepen relationships with colleagues in other organisations
c) develop a shared understanding of purpose and a way of working together to tackle complex and challenging issues related to health inequalities.

Method

3. Prior to the meeting attendees were sent and asked to read recently published BMJ paper by Hugh Alderwick et al. Solving poverty or tackling healthcare inequalities? Qualitative study exploring local interpretations of national policy on health inequalities under new NHS reforms in England | BMJ Open

4. The meeting was run using Chatham House rules ie points made and conclusions reached could be reported externally but without attribution to either the organisation or the person making specific points.

5. Stakeholders were asked to sit on tables with people from other organisations and/or people they didn't know well and then asked to consider and discuss four questions using a modified Delphi technique ie stakeholders initially considered and wrote answers to the questions by themselves before sharing and discussing answers on their tables and then in plenary. Notes of the meeting were taken and all the written answers and flip charts were collected and photographed for record and for later analysis.

6. The questions posed were:

A) One of the national policy objectives for integrated care Systems is to reduce health inequalities.
   a. How have you interpreted this objective?
   b. What types of inequalities are you aiming to reduce? (e.g. health care, health outcomes)?
   c. Are there key goals or measures that you're aiming for?

B) What do you think the top three inequalities priorities should be for…
   a. the Integrated Care SYSTEM?
   b. the Integrated Care BOARD?
   c. your organisation?

C) Thinking of the top priorities you have suggested for the ICS and ICB, how can they best be addressed? Which of these actions are best undertaken
   i) locally?
   ii) at BOB level?
   iii) nationally?

D) Thinking about your organisation's roles and responsibilities what could it do to deliver….
   a. its own inequalities priorities?
   b. ICB and ICS inequalities priorities?
   c. what help / contribution might your organisation want from other organisations?

For questions A) and B) stakeholders were asked to respond as themselves drawing on their personal values, skills, and knowledge.

For questions C) and D) stakeholders were asked to respond in ways that reflected their understanding of their employing organisations. and as leaders of those organisations.

Headline Results

7. The main results from each of the questions were as follows:

Question A. There was consensus among stakeholders that

a) health inequalities are manifest in multiple ways
b) where those inequalities were avoidable, they represent unfairness that there was a moral imperative to work to minimise them
c) there was lack of clarity from NHS England about whether the NHS should be tackling the results of health inequalities (ie arranging services to reflect that there was more illness among disadvantaged groups) or tackle the causes of health inequalities (e.g. poverty, broad determinants of health) or both. Most people thought that local agencies should be doing both with the ultimate goal of reducing inequalities in health outcomes between different groups in society.
d) Whilst recognising that the inverse care law still applied in most services, few people were able to identify specific inequalities that their organisation was specifically working to reduce, saying that the ask of them and their organisations was unclear.

Question B. There was considerable agreement among stakeholders about the topics they wanted to see as widely adopted priorities across the ICB and ICS. These were:

e) Reducing inequalities between rich and poor in expectation of life and expectation of health life

f) Reducing inequalities in smoking rates between different groups in society
g) Working to make sure that all children received a good start in life
h) Reducing inequalities in cardiovascular disease
i) Tackling inequalities in mental health and access to support for mental health
In addition
j) The NHS (as opposed to the ICS) should work to reduce inequalities in access, quality, and experience of care so that, for equal level of need, there should be equal access to care of equal quality for all communities across all relevant services). This was seen as an NHS responsibility…'getting its own house in order' and simultaneously recognising that the NHS can and should work more broadly to do its bit in tackling the core determinants of health and drivers of ill-health that poor communities are more exposed to than others

There was a view that once the ICS and ICB had agreed overall goals and priorities, then individual organisations would find it easier to be able to articulate what their specific contribution to achieving those goals could and would be.

Discussing the results the general view was that tackling inequalities would not be achieved just by using 'inequalities monied' to fund specific anti-inequalities projects. Instead, the general view was that all policies and services should be provided in a way that considers inequalities …for example, the NHS elective recovery work should take account of the socio-economic distribution of those waiting, making sure that waiting times for people in equal need were equal across social groups. The same applies to the access to all services.

Questions C and D: Stakeholders struggled to differentiate actions from roles and responsibilities best undertaken at different levels of the overall System. From the discussion, the general view was as follows:

k) National agencies including Government and NHS England have a role in articulating the importance of health inequalities and setting the national ambitions and mission. As health and health inequalities are influenced by decisions in every sector, the national agencies have a role in putting health inequalities high on the agenda of every sector in society including education, environment, housing, transport, welfare and more. This should be complemented by legislation, regulation, resourcing and performance management to match the narrative
l) Regional agencies and integrated are Systems have both executive and convening roles. They should exercise those roles in line with national priorities. They also have a role in bringing together local Systems to support the process of developing shared ambitions that contribute to the national ambitions. As part of their executive roles they should commission data Systems and analyses to enable local Systems and organisations to understand how their inputs and processes are contributing to tackling inequalities.

m) Locally, organisations should make sure that all their operations are undertaken with an eye to their impact on inequalities, paying a particular attention to their contribution to the long term ambition and mission and agreed ICS priorities.

Stakeholders were able to identify multiple specific things they might do to increase the impact of health inequalities.

Comments and reflections

8. Stakeholders came from different disciplines, different organisations different sectors, and different counties. Most did not know each other well. Unsurprisingly, they started the afternoon with very little obvious common ground about which inequalities they should be tackling and how they should be tackled. Nevertheless, over the course of an afternoon they were able to agree broadly on:

a) The nature of health inequalities
b) The priorities for tackling them
c) The sorts of actions their organisation could take to address inequalities – including things that only their organisation could do
d) The things other organisations could do to help and the things they could do to help other organiations.

9. This created a sense of optimism. Although the thinking space has no official status and is not part of a formal process for working about the priorities of any organisation or of committing any organisational resource to any particular action, stakeholders recognise that it did illustrate the sort of cross System conversation that could be taken through existing and potentially slightly modified System governance processes to agree System wide goals, priorities, roles, responsibilities, actions and indicators for tackling health inequalities across BOB. As leaders they and their colleagues shape and control process, so a next step should be to set out and agree the governance processes and time required to generate formal answers to the sorts of questions that were tackled at the Thinking Space.

An illustration of the sorts of statements of mission and priority that might be used across the System

10. Below is an illustration of the sorts statements of mission and priority that might be used and useful across the System. The detail is based on the conversations at the Thinking Space and is provided as illustration only. A formal governance process may result in something that looks very different.

Overall, Missions

To reduce absolute inequalities in (healthy) expectation of life at birth between the richest 20% and the poorest 20% of wards by 2035.

To reduce absolute inequalities years spent living with mental and/or physical disability between richest 20% and the poorest 20% of wards by 2035.

System Priorities for achieving the missions

To reduce absolute inequalities years in cardiovascular disease between the richest 20% and the poorest 20% of wards by 2030.

To reduce absolute inequalities years in school readiness between the richest 20% and the poorest 20% of wards by 2035.

Organisational plans and targets

All organisations asked to identify (with support of public health teams):

- the actions they can take that would accelerate the delivery of any of the mission or priorities listed above
- the support /help they would like from other organisations
- the support/help they can offer other organisations
- how they would like the delivery of their contributions to be measured / judged

And, on the basis of the above, record intentions in System and organisational plans.

Nick Hicks

June 2024

V1.0

Appendix Three– Interview questions

Questions for interviews with senior leaders

Introduction

Thank you for taking part in this evaluation. It explores the difference which is being made by the investment of £8million for Health Inequality and Prevention across BOB ICS. In each Place (Berkshire West, Oxfordshire, and Buckinghamshire) evaluations of individual health inequality initiatives are taking place. The purpose of **this** evaluation is to explore the ways in which the System is responding and changing to focus on health inequality and prevention.

This interview will inform the year one report (along with a document review and analysis from a range of qualitative research activities which are underway at present).

We want to keep your contribution confidential so that you feel free to speak frankly – that's when the most useful information emerges. As a result, your name will not appear next to any quotes or material which appears in the report.

Does this sound ok? Do you have any questions before we proceed?

Questions
Introductions
1. Please could you confirm your role and say a few words about how your role relates to health inequality and prevention within BOB ICS?
Research theme 1: Resource allocation
2. Has this funding influenced the way in which health inequalities and prevention activities are designed and delivered? If so, how? • What can be learnt from this? • Has it made a difference to the sustainability of these activities? • Can you point to any examples or evidence to support your answer? • Is there any learning which has emerged from the way in which these resources have been allocated?
3. To what extent has the funding enabled you to work with local communities • Can you share with me how they are involved?
Research theme two: Focus
4. Thinking about the Place-based health inequality and prevention activities which are being funded. • Are there approaches or key ingredients for success which we can highlight for the future?

Questions
• Any key aims/measures being used in the work?
Research theme three: Leadership and culture
5. Thinking about collaboration between ICS organisations (e.g. hospitals, community groups, local authorities). • What do you think has helped in their efforts to work collaboratively to reduce health inequalities? • And then thinking about barriers, what do you think has hindered their efforts to collaboratively reduce health inequalities?
6. Since the introduction of this investment and shared focus on inequalities, have you noticed changes in the way leaders, managers, workers and / or the community think about health inequality and prevention? • What sort of changes? • Among which sorts of people? • (If positive change observed) Can you see any connection between the investment of £8million and these changes in knowledge, skills, and behaviours?
7. Where do the real decisions about health inequalities and prevention get made? Within BOB ICB? At Place? In communities? • Who leads these decisions? • Do you feel empowered to make decisions? • To what extent do you think decisions are being made in the right place and involving the right people? • (If changes observed) Can you see any connection between the investment of £8million and these changes in decision-making approaches?
8. Thank you for your time. Is there anything else you would have expected me to ask me, or which you feel it would be useful to explain?

Appendix Four – Focus group questions

BOB ICB: Evaluation of health inequality system change Year one evaluation (23-24)

Questions for focus groups with operational staff and VCSE

Introduction

Cover key focus group protocols:

Open discussion hands to share just so that everyone has an opportunity. It's ok to disagree, respectfully and politely. In fact, that can be very useful, so please do say if you have a different point of view to share.

- *Introductions and thank you for taking part*
- *Brief warm-up / ice-breaker activity*
- *Explain purpose of the conversation: This is part of an evaluation which explores the difference which is being made by the investment of £8million for Health Inequality and Prevention across BOB ICS. In each Place (Berkshire West, Oxfordshire and Buckinghamshire) evaluations of individual health inequality initiatives are taking place. The purpose of **this** evaluation is to explore the ways in which the system is responding and changing to focus on health inequality and prevention. Today's discussion will inform the year one report (along with a document review and analysis from a range of qualitative research activities which are underway at present).*
- *Confirm anonymity and agree protocol that no one will share anything which was said outside of the room.*
- *Does this sound ok? Do you have any questions before we proceed?*

Questions
Research theme 1[4]: Resource allocation
1. To what extent are you aware that new funding has been made available to support health inequalities and prevention within BOB ICS? 2. (For those who are aware): Do you feel it has been allocated in a useful / fair way? Do you think it has potential to increase the sustainability of health inequality and prevention initiatives locally? 3. (For those who are not aware) If funding was to come again (no expectation at present of future funding, what do you think would be a useful / fair way to allocate this type of funding?

[4] The System Level Evaluation Plan (January 2024) outlines the three themes which this evaluation seeks to explore.

Questions
Research theme two: Focus
Thinking about the Place-based health inequality and prevention activities which are being funded: 4. are there approaches or key ingredients for success which we can highlight for the future? 5. To what extent are local communities involved, and how? (are there vulnerable/disadvantaged groups in that)
Research theme three: Leadership and culture
6. Thinking about collaboration between Integrated Care System organisations (e.g. hospitals, community groups, local authorities), what do you think has helped and hindered their efforts to collaboratively reduce health inequalities?
7. Is there anything that would not have happened if this funding had not been in place.
8. Have you grown in health inequalities knowledge, skills or the way you approach health inequalities over the last year? (If so how? If not what could support you?)
9. Where do decisions about health inequalities and prevention get made? Within BOB ICB? At Place? In communities? Who leads these decisions? What is the overall balance of power? (What do you think would work)
10. What would collaborative working around health inequalities look like in 3-5 years and what would it take to get there?
11. Thank you for your time. Is there anything else you would have expected me to ask me, or which you feel it would be useful to explain?

Appendix Five – Survey questions (longer version)

Introduction page of the survey

Health Innovation Oxford and Thames Valley are working in partnership with Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board to understand and evaluate how the Place-Based Health Inequalities and Prevention funding has been used. As part of the evaluation, we will aim to capture thoughts and insights into current understanding around what "tackling health inequalities" means to individuals and place. Some questions will relate to health inequalities and some to "wider inequalities". Also, some questions will relate to the Integrated Care System and some to the Integrated Care Board. This is so that we can capture thoughts and understanding around all aspects of regional work.

It is hoped that these findings may support and strengthen future co-designed work around health inequalities within the region. The following questions have been designed from informal interviews undertaken with colleagues in the scoping phase of this evaluation. We are keen to capture different opinions about what is working well or could work better in the future through this survey which has 27 questions that may take up to 35 minutes to complete so please do set aside the time.

The information we collect from this survey is anonymous and no responses will be attributed to individuals. If you have any questions, please email katie.lean@healthinnovationoxford.org. Once the survey has closed, the information will be aggregated into an anonymised report which will be shared in the phase one report, October 2024.

1. The funding being evaluated is to reduce/prevent Health Inequalities. Please share in the box below what you understand by the term "Health Inequalities" to mean. (open text)

2. Can you summarise what a shared vision of tackling Health Inequalities means to you? (open text)

3. What 3 words currently describe how you feel about addressing health inequalities (free text)

4. Do you know if BOB **ICS** have a Health Inequalities strategy or similar document Y/N
   If yes, can you summarise the key themes within the strategy (open text)

5. If there is not one that you know of, should there be one? Y/N

6. Are you aware of any collective key ICS initiatives to reduce or prevent health inequalities in BOB ICS Y/N
   If yes, can you summarise them below (open text)

7. What sort of inequalities should the **Integrated Care SYSTEM** be tackling as a priority? Please rate on a scale of 1-6 (1= should not be prioritising, 6 = should definitely be prioritising)

    a. Inequalities in access to NHS services
    b. Inequalities in access to other services
    c. Inequalities in outcome of NHS services
    d. Creating specific services for particular groups of disadvantaged people
    e. Investing relatively more in services serving disadvantaged people and communities, than services serving more privileged people and communities
    f. Influencing core determinants of (e.g. poverty, housing, transport, employment etc) health beyond the NHS
    g. Other (free text)

8. What sort of inequalities should the **Integrated Care BOARD** be tackling as a priority? Please rate each statement on a scale of 1-6 (1= should not be prioritising, 6 = should definitely be prioritising)

    a. Inequalities in access to NHS services
    b. Inequalities in access to other services
    c. Inequalities in outcome of NHS services
    d. Creating specific services for particular groups of disadvantaged people
    e. Investing relatively more in services serving disadvantaged people and communities, than services serving more privileged people and communities
    f. Influencing core determinants of (e.g. poverty, housing, transport, employment etc) health beyond the NHS
    g. Other (free text)

9. What do you think the shared vision of the **ICS** should be around reducing and preventing health inequalities?
   (free text)

10. What role should **your organisation** have in contributing to the achievement of the ICS vision for tackling health inequalities? (free text)

11. How would you measure the success of the IC's work on tackling health inequalities? (free text – don't want to constrict to one thing or another)

12. Do you have access to sufficient data to help you understand current health inequalities in your region? Y/N

13. What data access (if any) is missing to help you understand current health inequalities in your region? you.
    (Open text)

14. What 3 inequality issues do you think should be the top priorities for Trusts?

15. What 3 inequality issues do you think should be the top priorities for Place?

16. What 3 inequality issues do you think should be the top priorities for the ICB?

17. What 3 inequality issues do you think should be the top priorities for the ICS?

Understanding what skills you have and what might support your going forward (Skills/culture/behaviours)

18. What skills do you believe you have which could support your organisation/region to reduce health inequalities?
    (free text)

19. What do you see as the skills available to your organisation that need enhancing to support your organisation/region to improve its ability to tackle health inequalities?
    (free text or give examples?)

20. What learning methods are best for you/your organisation to grow in skills addressing health inequalities
    Options: online webinars, online workshops, face to face workshops, seminars, action learning sets, drop-in sessions, case studies etc. Please mark on a scale of 1-4 with the learning style you most prefer (1=least preferred and 4 = most preferred).

21. Would you prefer learning sessions to be formal or informal?

22. What would make you proud of a regional collaboration to reduce health inequalities?
    (free text)

23. What do you think it will take for leaders to work together to reduce/prevent health inequalities in the region
    (free text)

24. Please indicate the extent to which you agree or disagree with the following 3 statements:
    (Strongly agree, agree, neutral, disagree, strongly disagree)

    - I'm confident that we will improve health inequalities in the BOB **ICS** region in the next 5 years
    - BOB **ICB** should have a clear measurable aim to improve health inequalities over the next 5 years
    - Place based and ICB staff should work together to identify what key aims to work on over the next 5 years

25. Is there anything else that you would like to add (free text)

26. **Please select the area you work in**

- Local Authority -public health
- Local Authority – Other
- Integrated Care Board
- Acute Trust
- Primary Care
- Other (Please specify)

27. Please select what region are you mostly aligned to

- Buckinghamshire
- Oxfordshire
- Berkshire West
- ICS
- Other (Please specify)

Thank you for taking the time to complete this survey.
Your time and continued support to reduce inequalities throughout the region is very much valued.

Survey End

Appendix Six – Survey questions (shorter version)

Introduction page of the survey

Health Innovation Oxford and Thames Valley are working in partnership with BOB Integrated Care Board to understand and evaluate how the Place-Based Health Inequalities and Prevention funding has been used. As part of the evaluation, we will aim to capture thoughts and insights into current understanding around what "tackling health inequalities" means to individuals and place. Some questions will relate to the ICS and some the ICB and some to Local Authority and Acute Providers.

It is hoped that these findings may support and strengthen future co-designed work around health inequalities within the region. The following questions have been designed from informal interviews undertaken with colleagues in the scoping phase of this evaluation.

The information we collect from this survey is anonymous and no responses will be attributed to individuals. If you have any questions, please email katie.lean@healthinnovationoxford.org. Once the survey has closed, the information will be aggregated into an anonymised report which will be shared in the phase one report, October 2024.

Understanding Inequalities and Health Inequalities

One of the overall national policy objectives for integrated care Systems is to reduce health inequalities.

1. Can you summarise what a shared vision of tackling Health Inequalities means to you?
   (open text)

2. What sort of inequalities should the **Integrated Care SYSTEM** be tackling as a priority?
   Please rate on a scale of 1-6 (1= should not be prioritising, 6 = should definitely be prioritising)

   a. Inequalities in access to NHS services
   b. Inequalities in access to other services
   c. Inequalities in outcome of NHS services
   d. Creating specific services for particular groups of disadvantaged people
   e. Investing relatively more in services serving disadvantaged people and communities, than services serving more privileged people and communities
   f. Influencing core determinants of (e.g. poverty, housing, transport, employment etc) health beyond the NHS
   g. Other (free text)

3. What sort of inequalities should the **Integrated Care BOARD** be tackling as a priority? Please rate on a scale of 1-6 (1= should not be prioritising, 6 = should definitely be prioritising)

   h. Inequalities in access to NHS services
   i. Inequalities in access to other services
   j. Inequalities in outcome of NHS services
   k. Creating specific services for particular groups of disadvantaged people
   l. Investing relatively more in services serving disadvantaged people and communities, than services serving more privileged people and communities
   m. Influencing core determinants of (e.g. poverty, housing, transport, employment etc) health beyond the NHS
   n. Other (free text)

4. What sort of inequalities should the **Acute Trusts b**e tackling as a priority? Please rate on a scale of 1-6 (1= should not be prioritising, 6 = should definitely be prioritising)

   o. Inequalities in access to NHS services
   p. Inequalities in access to other services
   q. Inequalities in outcome of NHS services
   r. Creating specific services for particular groups of disadvantaged people
   s. Investing relatively more in services serving disadvantaged people and communities, than services serving more privileged people and communities
   t. Influencing core determinants of (e.g. poverty, housing, transport, employment etc) health beyond the NHS
   u. Other (free text)

5. What sort of inequalities should public health & Local Authority **b**e tackling as a priority? Please rate on a scale of 1-6 (1= should not be prioritising, 6 = should definitely be prioritising)

   v. Inequalities in access to NHS services
   w. Inequalities in access to other services
   x. Inequalities in outcome of NHS services
   y. Creating specific services for particular groups of disadvantaged people
   z. Investing relatively more in services serving disadvantaged people and communities, than services serving more privileged people and communities
   aa. Influencing core determinants of (e.g. poverty, housing, transport, employment etc) health beyond the NHS
   bb. Other (free text)

6. What do you think the common goal of the **ICS** around reducing and preventing health inequalities should be? (free text)

7. How would you measure the success of the ICS's work on tackling health inequalities?

8. What 3 inequality issues do you think should be the top priorities for Trusts?

9. What 3 inequality issues do you think should be the top priorities for Place?

10. What 3 inequality issues do you think should be the top priorities for the ICB?

11. What 3 inequality issues do you think should be the top priorities for the ICS?

Understanding what skills you have and what might support your going forward (Skills/culture/behaviours)

12. What would make you proud of a regional collaboration to reduce health inequalities?

13. What do you think it will take for leaders to work together to reduce/prevent health inequalities in the region
(free text)

14. Please indicate the extent to which you agree or disagree with the following 3 statements:
(Strongly agree, agree, neutral, disagree, strongly disagree)

- I'm confident that we will improve health inequalities in the BOB **ICS** region in the next 5 years
- BOB **ICB** should have a clear measurable aim to improve health inequalities over the next 5 years
- Place based and ICB staff should work together to identify what key aims to work on over the next 5 years

15. Is there anything else that you would like to add (free text)

16. **Please select the area you work in**

- Local Authority -public health
- Local Authority – Other
- Integrated Care Board
- Acute Trust
- Primary Care
- Other (Please specify)

17. **Please select what region are you mostly aligned to**

- Buckinghamshire
- Oxfordshire
- Berkshire West

- ICS
- Other (Please specify)

Thank you for taking the time to complete this survey.
Your time and continued support to reduce inequalities throughout the region is very much valued.

Survey End

Appendix Seven – Survey questions focus group

BOB ICB:

Evaluation of health inequality system change Year one evaluation (23-24)

Survey prior to focus groups with operational staff and VCSE

Introduction

Health Innovation Oxford and Thames Valley have been asked to undertake an evaluation around the current BOB Integrated Care Board funding of Health Inequalities at Place. We are particularly focusing on knowledge and understanding of health inequalities and how the Integrated Care System can grow together in this arena. All survey responses are confidential. This survey has 10 questions and should take between 5-7 minutes. If you have any questions, please contact Katie Lean katie.lean@healthinnovationoxford.org.

Questions
Personal Information
12. Please can you confirm which area you are currently working a) Buckinghamshire b) Oxfordshire c) Berkshire West
Attitudes/Culture
13. Within the last 6 months, how regularly has your work required consideration of health inequalities a) Every day b) A few times a week c) About once a week d) A few times a month e) Once a month f) Less than once a month 14. Has the focus on health inequalities in your work changed over the last 12 months? (increased, decreased, stayed the same) 15. How important is it **to you** to address health inequalities in your work? (Not important at all, slightly important, moderately important, very important, extremely important) 16. Many say that health inequalities are important – How important do you feel health inequalities is to **your organisation** in the way they prioritise it?

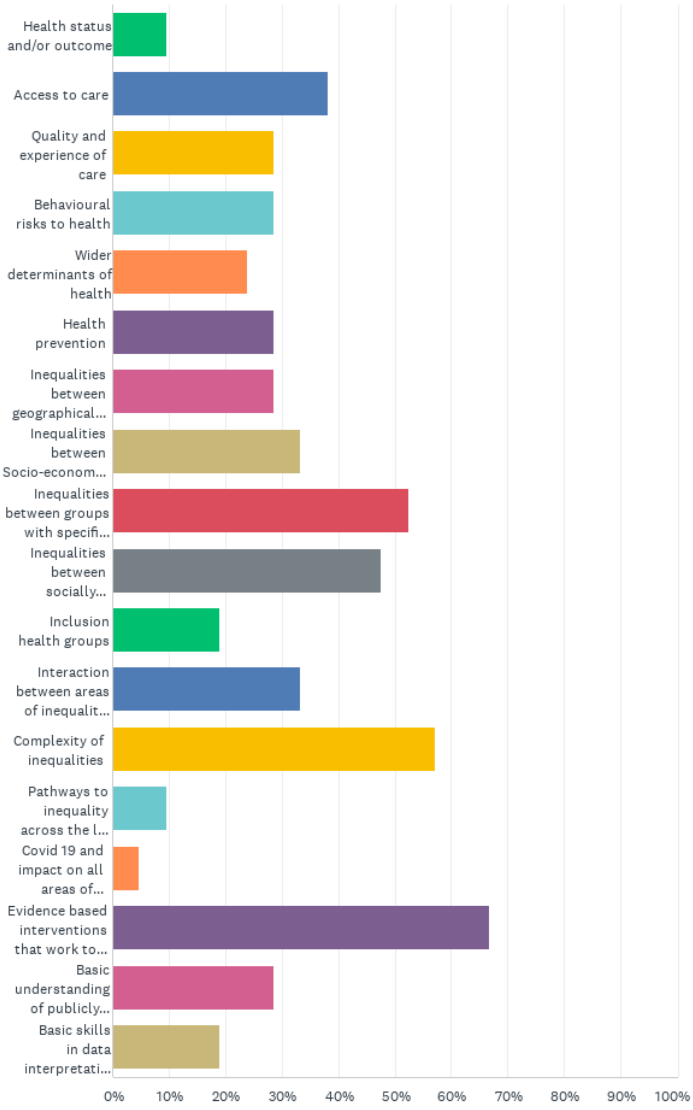
Questions
(Not important at all, slightly important, moderately important, very important, extremely important) 17. Do you get the support that you need from your manager to address health inequalities in your work? Y/N a. if no what support would help you? (Free text)
Knowledge – Do they know enough to do what they need to do
On a scale of 1-6 (1 = not at all, 6 = very much so) 18. Do you feel like you have a good understanding of health inequalities that allow you to undertake your work?
Skills – what skills are needed to do HI well
On a scale of 1-6 (1 = not at all, 6 = very much so) a) Do you feel you have the skills to deliver work on health inequalities? b) What (if anything) would help you to feel more confident to address health inequalities in your work? (Free text) c) Addressing health inequalities is multi-faceted. If you feel you would value more knowledge/understanding on the topics below, please indicate by selecting the relevant check boxes. (multiple select). **Inequalities in what?** d) Health status and/or outcome e) Access to care f) Quality and experience of care g) Behavioural risks to health h) Wider determinants of health i) Health prevention **Inequalities between who?** j) Inequalities between geographical areas k) Inequalities between socio-economic groups l) Inequalities between groups with specific characteristics (including those protected by law) m) Inequalities between socially excluded groups n) Inclusion health groups

Questions
o) Interaction between areas of inequality as outlined above (intersectionality) p) Complexity of inequalities q) Pathways to inequality across the life course r) Covid 19 and impact on all areas of inequality s) Evidence based interventions that work to address inequalities in each area above t) Basic understanding of publicly available data sets to help explore inequalities u) Basic skills in data interpretation to enable narrative around your work in inequalities.
Thank you for your time in completing this survey. We look forward to welcoming you to the focus group in September.

https://www.surveymonkey.com/r/2YSRBPY

Appendix Eight – Survey response to training needs

Q10 Addressing health inequalities is multi-faceted. If you feel you would value more knowledge/understanding on the topics below, please indicate by selecting the relevant check boxes. (please tick all that apply - you can multi-select)



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