Health Innovation
Oxford & Thames Valley

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

"Health Inequalities is not an add on anymore"*

An evaluation of a two year funded health inequalities programme in Buckinghamshire, Oxfordshire, and Berkshire West

"Eighteen months ago, we arrived in tribes defending our spaces. Now we are a big tribe, and defend everyone's space."
Focus group participant

Katie Lean

October 2025

*Focus group participant

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Executive Summary

Over the past two years, the Buckinghamshire, Oxfordshire, and Berkshire West (BOB) Integrated Care System (ICS) Health Inequalities, and Prevention Programme has supported a wide range of locally driven initiatives across each Place. Funded around a Core20PLUS5 approach, these projects have aimed to prevent or reduce health inequalities for underserved populations. While some have delivered outcomes at a local level, system-wide transformation remains limited.

This evaluation highlights the diversity of the funded programmes. Flexibility at Place level has enabled tailored responses to local need but has made it difficult to assess collective impact.

This evaluation sought to learn about what helped or hindered the delivery of funded programmes. It found that:

- flexible, and equitable funding enabled local innovation, but led to variation in how impact and outcomes were understood across the system.
- trusting relationships were essential, took time to build, and were often disrupted by external changes outside the control of the programme.
- data collection was extensive, yet translating activity data into outcome focused insights proved challenging.
- community engagement, and local nuance generated valuable learning, though translating this into regional/system-level impact was difficult.
- good practice, and shared learning emerged in pockets, with a consensus for the need to break down organisational silos, and share more widely.
- facilitated reflection, and discussion was valued amidst fast-paced delivery.
- system-wide knowledge and skills on health inequalities is growing, but staff would benefit from more opportunities for learning and development.
- each Place-based governance structure is inclusive, growing, and forward thinking. There is an opportunity for BOB ICB to restructure its health inequalities forum to be more strategic, and decision based, with key Place-based leaders.

Looking ahead, BOB ICS has an opportunity to align more closely with the NHS 10 Year Health Plan [6] by embedding prevention and equity into strategic planning and investing in neighbourhood level delivery. The recommendations from the evaluation include:

Strengthening strategic commissioning: decide whether reducing health inequalities is a long-term priority. If so, funding should be embedded across all services. Commissioning should be guided by data, and co-designed with senior Place leaders.

Shift from activity to outcomes: future programmes should prioritise outcome-focused evaluation. This includes providing support to turn data into insights enabling a clearer understanding of what works for whom and why.

Foster trust through transparent processes: rebuild confidence in commissioning through transparency, continuity, and shared decision-making. Understand that budget uncertainty can undermine outcomes.

Build equity into system design: when one Place has demonstrated improved sustained outcomes, ensure there is the capacity to spread and adopt the innovation across the system.

Create space for collective wisdom: establish structured opportunities for cross-regional learning such as thematic learning sets, shared digital platforms, and regular reflection sessions.

Reshape governance: learn from thriving Place-based governance to re-form a central senior membership group with senior Place-based leaders, focused on decision making.

Align with neighbourhood level change: in line with the NHS 10 Year Health Plan [6], future efforts should be focused on neighbourhoods as foundation for prevention. Resource local teams to lead, with strategic support across the system.

Introduction

Addressing health inequalities is one of the four core principles of Integrated Care Systems (ICS)[1]. In 2022, NHS England announced extra funding to support systems address health inequalities, including the implementation of the Core20PLUS5 approach. This two year independent evaluation report commissioned by Buckinghamshire, Oxfordshire, and Berkshire West (BOB) Integrated Care Board (ICB), and undertaken by Health Innovation Oxford, and Thames Valley (HIOTV) focuses around understanding the learning, and change that has occurred over the system as a whole rather than individual projects. The evaluation plan focused on three main themes:

- resource allocation: has the funding changed the way health inequalities, and prevention activities are designed, and delivered.
- focus: what learning can be gleaned from approaches taken by Place, and system.
- leadership and culture: have any changes occurred in culture, knowledge, attitudes and behaviours.

This report builds on the year one findings which were completed in October 2024[2]. They demonstrated that the funding to date had started to facilitate the building of relationships between health, and Local Authority staff. Governance structures were mixed across the region with some established, and others in infancy. Programmes, and projects were beginning to move forward, with some small projects already completed. Key recommendations were around implementing decision based governance structures, sustained funding, and access to regional data to support improvement.

Background

Health inequalities in England represent one of the most persistent, and pressing challenges facing the NHS. These inequalities defined as avoidable, and unfair, are often rooted in broader social, and economic disparities. Factors such as income, education, housing, ethnicity, disability, and geography influence both the likelihood of experiencing poor health, and the ability to access appropriate care. [1] [2]

The Health Foundation projects that by 2040, the burden of major illness will rise significantly, particularly in deprived communities, impacting individuals, and placing increased pressure on primary care, and the NHS workforce. [3] [4]

National policy and frameworks

The Marmot Review 10 years on, underscores the need to address the social determinants of health as a foundation for reducing health inequalities. It revealed that life expectancy improvements have stalled, and the gap between rich and poor has widened. [5] Marmot's Framework advocates for change across five domains: early childhood development, education, employment, income, and healthy environments.

[1] Building strong integrated care systems everywhere, 2021
[2] Year 1, BOB ICS health inequalities evaluation report, Oct 2024

Building on this, NHS England's Core20PLUS5 provides a targeted operational approach to tackling healthcare inequalities. It identifies the most deprived 20% of the population (Core20), locally defined underserved groups (PLUS), and five clinical areas requiring accelerated improvement: maternity care, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension management. [4] [5]

NHS England acknowledges that while many determinants of health lie outside the health system, the NHS has a critical role to play in reducing inequalities through inclusive service delivery, targeted prevention, and equitable resource allocation. [1] [2]

The NHS 10 Year Health Plan: Fit for the future, raises the profile around health inequalities, and calls for a modernised, equitable health system. It commits to shifting resources, and services towards communities with the lowest healthy life expectancy, including deindustrialised towns, and coastal areas. [6]

The plan outlines three major shifts, all of which are designed to reduce disparities in access, and outcomes. [6]

- moving care from hospitals to communities.
- embracing digital transformation.
- prioritising prevention over treatment.

Specific measures include:

- publishing waiting list data by deprivation, and ethnicity.
- investing in neighbourhood health centres in underserved areas.
- wider access to NHS roles for those not currently employed.
- encouragement to promote patient/public power, and agency.
- support for community strengthening.
- the abolition of NHS England, and a move away from central micromanagement of the NHS.

These efforts are underpinned by a broader ambition to align NHS action with social, and economic development, recognising that health is shaped by far more than healthcare alone, [6] and to align the NHS with wider work across government, particularly the broader devolution agenda. [7]

Integrated care boards

During this two-year evaluation period the system has faced, and continues to face both challenges, and opportunities through these substantial on-going changes in policy, and structure.

Since their formal establishment under the Health and Care Act 2022 [8], Integrated Care Boards have undergone significant transformation in response to evolving NHS priorities. Initially tasked with commissioning services, and leading system-wide collaboration, ICBs have increasingly been positioned as strategic commissioners, responsible for

setting long-term population health strategies, and maximising value from available resources. [9] NHS England has issued annual assessments to evaluate ICBs' performance across key domains including leadership, tackling inequalities, productivity, and contribution to broader social and economic development. [10]

In 2025, a major restructuring initiative was launched through the draft Model ICB Blueprint. This anticipated the NHS 10 Year Health Plan, and suggested updated roles for ICBs, mapped functions across the system, and introduced a national commissioning development programme to build strategic capabilities. [9] A key requirement was a 50% reduction in administrative costs by Q3 2025/26, with ICBs expected to spend no more than £18.76 per head of population. [9] With the creation of Strategic Authorities [7], the long term role of the ICBs is likely to evolve over time.

This financial reset has prompted redesigns of internal structures, including reviews of committees, and governance. NHS England has emphasised the importance of aligning ICB changes with the NHS 10 Year Health Plan. [6] [9]

Funding of Buckinghamshire, Oxfordshire and Berkshire West two year health inequalities programme

In January 2023, NHS England released £8 million to Buckinghamshire, Oxfordshire, and Berkshire West (BOB) Integrated Care Board (ICB). The focus of this spend was to improve health inequalities, and prevention over a fixed two year period. Funding was split according to populations (using an NHS health inequalities formula, and unmet need adjustment based on age-standardised avoidable mortality) in each Place: Buckinghamshire (27.59%), Oxfordshire (39.87%), and Berkshire West (32.54%).

In December 2023, BOB Integrated Care Board, forecast a system deficit of £44.4million, which since worsened by a further £19million. Difficult decisions were 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 (£8m to £7m). Following this, partners at Place were informed that any underspend in the financial year would not be carried forward. In March 2025, a pause on all spending, and a weekly review of all spend greater than £5,000 was instigated by BOB ICB. This included all previously allocated monies, including those for health inequality, and prevention. The continued funding of projects was agreed in May 2025.

Evaluation approach

Evaluation questions

The evaluation plan and scoping report[3] (January 2024) describe the collaboratively designed approach and questions for this system-wide evaluation (Appendix one). These were agreed with BOB ICB. This evaluation focuses on understanding the extent to which the system has used, adapted, and responded to this funding. Each Place has commissioned a more detailed evaluation of each intervention's process and impact.

Methods

A mixed method approach to the evaluation took place between February 2024 – September 2025. The evaluation involved senior leaders, programme, and project leads, and public members from within BOB Integrated Care System (ICS). Participants were identified by BOB ICB, and Place-based colleagues. Introductions were made via email, and people were invited to participate in either an interview, a survey or a focus group. There was a high response rate with exception to the leadership survey.

Table one: Breakdown of attendees/invitees by area

Area	Interviews		Place-based focus groups		Place-based survey	
	Year 1	Year 2	Year 1	Year 2	Year 1	Year 2
Integrated Care Board	6/6	7/7	NA	NA	30/45	26/41
Berkshire West	8/8	6/7	12/14	14/15		
Oxfordshire	5/5	6/6	14/14	8/13		
Buckinghamshire	4/4	4/4	13/17	12/13		
Public member	2/2	2/2	NA	NA	NA	NA
Total	**100%**	**96%**	**87%**	**83%**	**67%**	**63%**

Leadership thinking space: To explore thoughts and findings, senior leaders from across BOB ICS were identified by BOB ICB, and invited to attend a face-to-face three-hour session (May 2024 and December 2024). An external facilitator led the sessions where participants were encouraged to think through specific questions posed (Appendix two, and three). In May 2024, thirty-two attendees were invited, and 18 attended. In December 2024, twenty-seven attendees were invited, and 21 attended. The intent was to have the same people attend both sessions, but due to the turnover of staff around a third of attendees were different.

Interviews: Interviews took place June - August 2024 and 2025. Data was collected through semi-structured interviews with senior leaders, and programme managers within BOB ICS. Interviews took place virtually, and were conducted by three individual interviewers. Twenty-five individuals were interviewed in 2024 and 2025 (Table one). The

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

original plan was to conduct baseline interviews, and follow up one year later. Due to staff turnover around a third of interviewees were different in the second year.

Focus groups: Three on-line focus groups were undertaken in September 2024, and September 2025, one per Place location (six in total). Project/programme 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 facilitated, and used a co-designed set of questions. The original intention was to speak to the same group of people one year apart to understand any progression of thought or action. Due to the variety of projects, some had already completed. Around a quarter of focus group attendees were different in year two.

Survey: A leadership survey was undertaken in 2024 with a 37% (15/40) response rate. The intention was to understand if there was an appetite for strategic working. Due to low engagement and limited analysis, it was agreed not to repeat this survey in year two.

A survey focused for project/programme leads at Place was sent to all focus group invitees one week prior to the group in September 2024 and 2025. The response rate was 67% and 63% respectively (Table one). This survey explored how health inequalities are addressed, and understood at Place level. The intent was to highlight any changes in insight over the two year period.

Document review: A desktop review was undertaken of each Place's evaluations to date, to review any short or long-term outcomes.

Observation: Observation at BOB ICB, and Place health inequalities, and prevention forums was undertaken between April 2024 - October 2025. Observations included facilitation, member participation, and decision-making.

Analysis: Interviews were transcribed, and reviewed using thematic analysis. Focus groups were recorded, transcribed, and notes were taken. These were reviewed using thematic analysis. Two reviewers undertook the analysis. An independent consultant gathered themes from the desktop review, and analysed the surveys.

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

The findings are built on the evidence supplied at the time of writing (September 2025).

Findings

This section sets out the key themes over the two-year evaluation. The journey of each Place has been different with a variance of programme approach, evaluation, and impact. Each section introduces the background to the topic, and the evolution of findings from year one.

Resource Allocation: Funding and programme approach

This section sets out the findings around the funding delegation. It covers the diversity of approach to programme design, and evaluation by each Place.

Funding allocation

In the first year, it was felt that funding allocations of the inequalities budget had been relatively transparent, however this feeling changed at the start of the second year due to the pause on ICB spending. Many felt a lack of transparency, and were uncertain whether they would receive any funding in the second year. As a result, this had an impact on their projects which lost momentum, community leads, and sometimes key staff.

"Not hearing about the funding until May 2025 put a big strain on the projects, but also the staffing, and therefore delivery. We lost quite a bit of staff because of it." *Focus group attendee*

"Biggest plea is the certainty of funding. It should not be every year are we going to get the funding or not." *Senior leader, BOB ICS*

Alongside the impact that Places were feeling around the funding, ICB leaders were managing the shift around financial pressures.

"We have been knocked sideways by the NHS reform agenda, and all funding envelopes need to be agreed weekly as a survival measure." *Senior leader, BOB ICB*

"The last two years of continuous reorganisation in a challenging financial climate make it difficult to do the innovative things we'd like to." *Senior leader, BOB ICB*

One interviewee noted that there are always health inequalities to be addressed, and always limited resources.

"Decisions about health inequalities are made across the health, and care system every hour, every week, every year. You will always have a limited resource. There are multiple opportunities about decisions around health inequalities, and I think we are getting better." *Senior leader, BOB ICB*

The overall way the funding was set up (two-year fixed term, stop-start nature, late notice extensions), were perceived to be detrimental to achieving the desired outcomes.

Programme approach

The evaluation plan and scoping report[4] highlighted that partners were encouraged to align the monies to Place-based priorities with a focus on Core20PLUS5. This led to a wide variety of approaches between, and within each Place.

Summary of the three approaches:

Berkshire West focused on a programme of health checks. This programme connected the expertise, and focus of primary care network colleagues with voluntary sector capacity to reach into communities, and encourage engagement. The approach has been relatively standardised, providing opportunity to observe how several different communities (including low indices of deprivation, and health inclusion) react to this universal programme of support.

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.

Oxfordshire 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 approach.

Programme categories

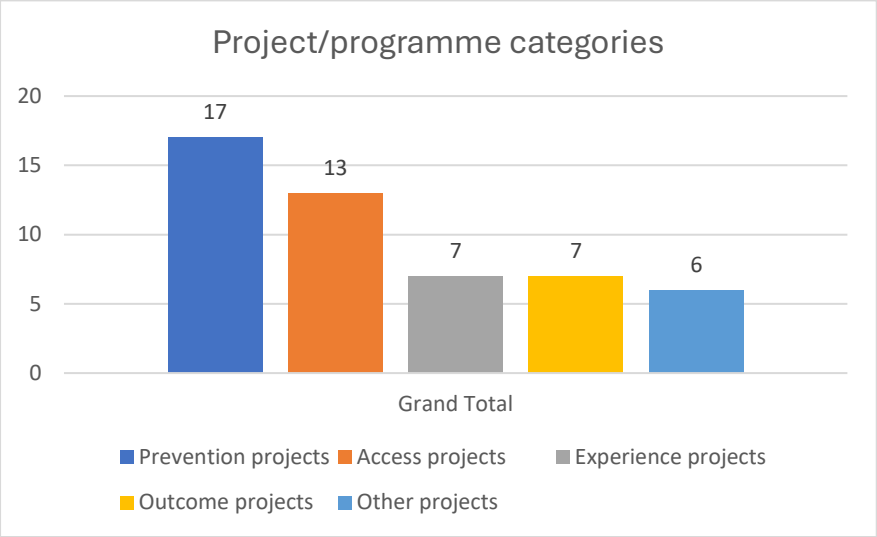
The flexibility of approach has led to each Place leading either one large programme (Berkshire West), several larger projects (Buckinghamshire) or a mix of larger projects, and multiple (~130) small grass roots projects (Oxfordshire).

Based on the information available, projects/programmes were broadly categorised around whether they were aiming to reduce health inequalities through prevention, access, experience or outcomes (figure one and two).

In total, twenty-four projects were categorised, but some belonged to more than one category e.g. prevention and access. Most projects were ultimately likely to be seeking to improve outcomes, but for some the link was more explicit than others. All of the projects categorised as 'outcomes' also had at least one other classification e.g. improving surgery outcomes through increasing physical activity was also classified as prevention.

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

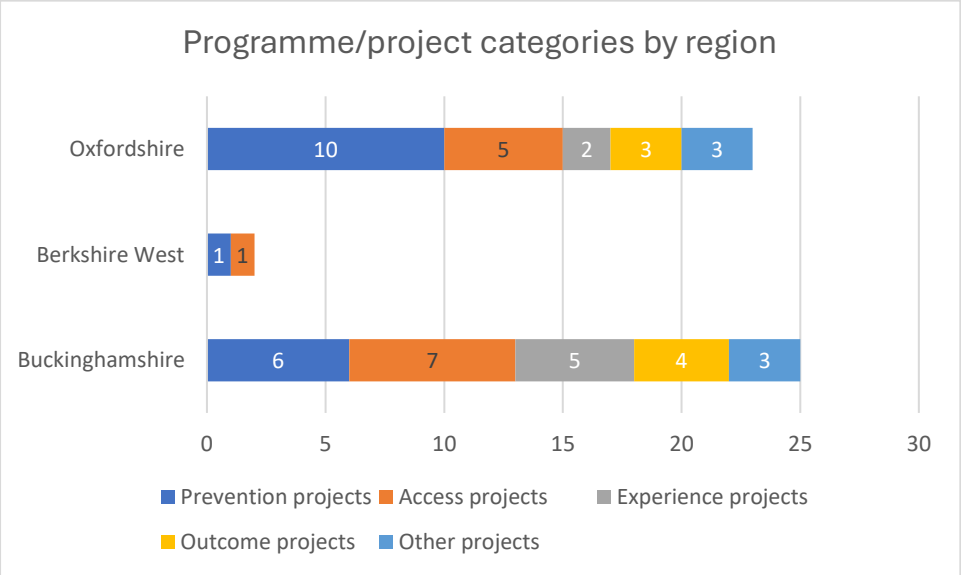
Figure one: Breakdown of programmes/projects by category



The core emphasis was on prevention e.g. getting people active, reducing social isolation, and access e.g. signposting, health checks, support. Projects classified as experience typically sought to change the way services were provided e.g. by providing training to healthcare professionals. The data to date cannot determine whether or not increased access necessarily led to improved outcomes or indeed whether signposting, and health checks led to further interventions.

'Other' projects included ones designed to map services, and research to understand what communities felt they needed to support them.

Figure two: Breakdown of programme/projects by category and region



Due to missing data, it was not possible to accurately link project categories to allocated funding spend.

Evaluation approach

At the outset, there was an expectation that projects, and programmes would be evaluated at Place. However, there was no specific guidance around how evaluations should be undertaken.

"I would want to see evaluation built in from the get-go, and a strategic approach with aligned funding that goes beyond the earmarked monies." Senior leader, BOB ICS

Due to the diversity, and set up of projects in each Place, some evaluations are now complete, and others still underway. The most ambitious evaluations are seeking to use outcome data from NHS records, and these are taking longer to produce. Each Place has worked with organisations to support their evaluations including academic institutions and innovation networks. Due to the variance of the projects some evaluations are in the form of a report from the funded organisation, and others a formal academic evaluation.

Whilst there is diversity in approach there was consensus about the importance of robust evaluation. The projects appreciated the flexibility to select the right evaluation for their interventions, but would have valued more guidance as a starting point and to reduce unnecessary variation.

"We can't manage these things year on year. We need a robust evaluation to make strong recommendations." Senior leader, BOB ICS

Focus: Learning about what works

Over the course of the two-year funding there are key insights that have supported or hindered the work moving forward. This section sets out themes around collaborative working, shared learning, the importance of understanding data, as well as the pros, and cons of variation vs standardisation.

The value of collaboration

"We cannot continue to work in silos, (we have) got to get out of organisational shackles. Partnership takes time, effort, energy, trust, and transparency."
Senior leader, BOB ICS

At the beginning of the funding, the BOB ICB programme team for health inequalities were new in post, and over the two years there have been several organisational restructures.

"I feel like we are on the back foot from the start, we were a new team building new relationships, and there have been three restructures." Senior leader, BOB ICB

Over the two-year funded period, staff changes have echoed across BOB ICB, and the Local Authorities. BOB ICB has replaced their Chief executive, medical, nursing, and financial officers. Place Directors that were one per Place, reduced to one over all three Places with the support of an executive lead per Place. Across the region there have been

multiple changes in Public Health Directors, Public Health Consultants, and Directors of Strategy.

Partnerships that had taken time to form, and build trust were interrupted, and new relationships needed to be built. Trust, and partnership working between the ICB, and Place was cautious within the first year of funding. For these to grow it was cited that evidence of blended ways of working, financial consistency, listening, and considerate understanding were important. In some areas these appear to have weakened but in others progress continues to be made.

"The interface between ICB, and Public Health is key in this space, and that relationship is strengthening. The organisational barriers have not helped in recent times." Senior leader, BOB ICB

Despite the change in personnel at Place, there is a growing sense of programmes joining up, and information being shared. The focus groups held for Place project/programme leads reflected that the funding has encouraged organisations to problem solve towards a shared objective.

Where working together was successful:

- organisations moved from being defensive to collaborative. Sharing what worked well or not, building trust, and confidence. This enabled them to challenge each other which led to improvements in the projects.
- teams worked through problems together with confidence to start, stop or adapt.
- people networked on similar problems from different perspectives.
- the funding impact was magnified by developing a more integrated approach, e.g. by enabling cross-referrals between different projects/programmes.
- local areas utilised the expertise, and knowledge of local communities.
- local GPs had greater buy-in.

"Last year it felt like we were working more on individual plans, now we are working as a joined-up programme." Focus group attendee

Moving from data to insight

Over the duration of the funding, project teams developed a better understanding of what data they needed. One focus group attendee described the lack of data as "operating blind", whereas others described experiencing data overload. There was a general consensus among senior leaders about the need to have access to regional data to ensure work is focused on the greatest need, and impact can be demonstrated over time.

"You need an organisation that can analyse all the available data, and how we spend our money with the greatest impact." Senior leader, BOB ICB

This subject of the importance of data was also echoed throughout the surveys, citing the need to amalgamate quantitative data with the voices of those with lived experience. Participants thought it was important to create a story around regional or national metrics, and that combining qualitative, and quantitative data was one way to do this.

Insights are key to understand this complex arena, and to ensure disparities are not widened through decision making.

Some key highlights that were observed around data insight in projects were:

- quantitative data gathered locally tended to be about number of attendees to a service rather than overall impact/outcome on health. The case studies behind these numbers were thought to be essential to note the benefit to individuals.
- getting data about outcomes takes time, and multiple iterations in a project. Whilst survey data can gather numbers, it fails to link the data to further health outcomes. Gathering patient linked data often involves a form of ethics which can be time consuming.
- data flows, and linking into health records takes time but learning around this can now be spread to other outreach activities.
- the development of joint evaluation frameworks was seen as valuable. Other areas believed they could adapt, and adopt frameworks if not too restrictive.

There remains a tension between ICB, and Place which was highlighted in year one. This is around the need for strategic planning to be made in partnership with the Integrated Care System underpinned by data, and evidence. It was highlighted that whilst regional data is vital, Place level data often offers a greater depth of understanding around the population.

Impact: Growing awareness of local versus system impact

> *"We allowed variation to flourish, and this was in competition with ICB wanting standardisation."*
> *Senior leader, BOB ICB*

The impact of the projects, and programmes funded are diverse, with evidence ranging from case studies to qualitative, and quantitative research. This diversity may lead to less strategic learning, and regional adoption.

There is a general sense that the funding has been used to build on existing work or start smaller innovative ideas. It has been complex to unpick the 'why' behind projects, and what theory of change was used for either continuing or starting the work. Many of the interviewees noted the importance of a strategic approach to planning, and data driven commissioning to ensure there is system impact. They also highlighted that it takes time to evidence impact/outcomes in a pressured commissioning environment. In contrast, people involved in the delivery of the projects highlighted the importance of a "bottom-up" approach, listening to local communities to understand what they need.

Many of the projects operated within the prevention space, which moves towards one of the aims of the NHS 10 Year Health Plan (2025). Over time, these preventative activities should lead to improved health outcomes e.g. the broad implementation of health checks may over time reduce cardiovascular incidents. It was identified that once outcomes are realised, the learning could be adapted, and adopted across the system. However, due to the diversity of projects funded over the two-years, these outcomes may prove challenging to evidence.

"We are not very good at understanding the outcomes from work in local organisations, and applying them on mass." Senior leader, BOB ICS

In general, most projects have had some impact to either individuals or system working. The majority of case studies reflect positive stories of individual lives changed through one or several interventions. Whilst these are powerful, the learning around how to sustain them including addressing structural issues (other than funding) was part of the puzzle that was often missing.

Project, and programme leads in the focus groups talked about impacts they had achieved. Whilst it is not a systematic list, the following reflect what was foremost in people's minds. These included:

- the funding has enabled stronger relationships, and increased trust.
- benefits to working in a more joined up way rather than silo working.
- a legacy of connections between partners, and communities which may springboard future work.
- investment in training for health care professionals who are now better equipped to consider health inequalities in their day to day work.
- many impacts at individual level, from increased activity to reduced need for healthcare services (resulting in cost savings for the NHS).

"Eighteen months ago, we arrived in tribes defending our spaces. Now we are a big tribe, and defend everyone's space." Focus group attendee

These impacts have sought to heighten the profile of health inequalities across the region for patients, healthcare, and public health teams. At this time there is no evidence of a reduction in health inequalities, but realistically the timeline was too short to see significant changes in ingrained issues, and interviewees were hopeful that over time this evidence base may evolve.

"A variety of initiatives have landed well which have been supported at Place level – I'm not convinced we have made major strides in (addressing) health inequalities." Senior leader, BOB ICB

Collective wisdom: Learning together

There is evidence of signposting of good practice, and some areas have shared learning with BOB ICB, or a national platform. However, there was limited evidence of this sharing within BOB ICS, and many of the focus group attendees were unsure as to projects

undertaken or learning other than their own. Some evaluations noted learnings around the time taken to onboard people, room to flex initial criteria set as the project evolved, and the importance of a system of safety for lone workers. Learnings such as these may already exist in the system, and could be shared to foster new knowledge.

"We could do better at showcasing the good stuff, and drawing out the learning from success."
Senior leader, BOB ICB

It was felt that some of the learning that has evolved over the last two years may be transferable into the neighbourhood approach introduced by the government in 2025. [11]

"A lot of the model, and good work will help inform our neighbourhood work, we can use the data to help inform going forward." *Focus group attendee*

Making space to breathe, and thinking creatively

Several of the interviewees, and focus group attendees noted the benefit of time to think. It was felt that in the midst of change, time is often pressured, and focused on driving agendas forward. This may miss opportunities to re-think, and adapt along the improvement journey. Facilitated discussion groups or space in meeting agendas was thought to be of benefit.

"The open-ended nature of the focus group is valuable, and quite rare. Most meetings have heavily packed agendas." *Focus group attendee*

"There is such a lot of pressure in the system, people don't have the headspace."
Senior leader, BOB ICS

"Good conversation, and it's helped me to think about things that I could take forward."
Senior leader, BOB ICS

Leadership and culture: developing unity and knowledge

This section explores the governance structures, and changes in knowledge, attitudes, and behaviours over the two year funding period.

"Currently there seems to be a lack of leadership, and lack of a proper health (as opposed to healthcare) strategies at BOB ICB, and at Place."
Senior leader, BOB ICS

Governance, and focus

When the funding was allocated, BOB ICB convened a health inequalities, and prevention group where discussions around health inequalities, and prevention take place including the projects undertaken within the two-year funding umbrella. Year one highlighted the need to restructure this forum to have more time for in-depth discussions. Whilst this group has had a change of leadership in the second year, there remains a consensus that it remains "a bit up in the air" *(Senior leader BOB ICB)*.

"ICB health inequalities prevention forum struggles for purpose, and focus – how do they influence, and report to the board." Senior leader, BOB ICS

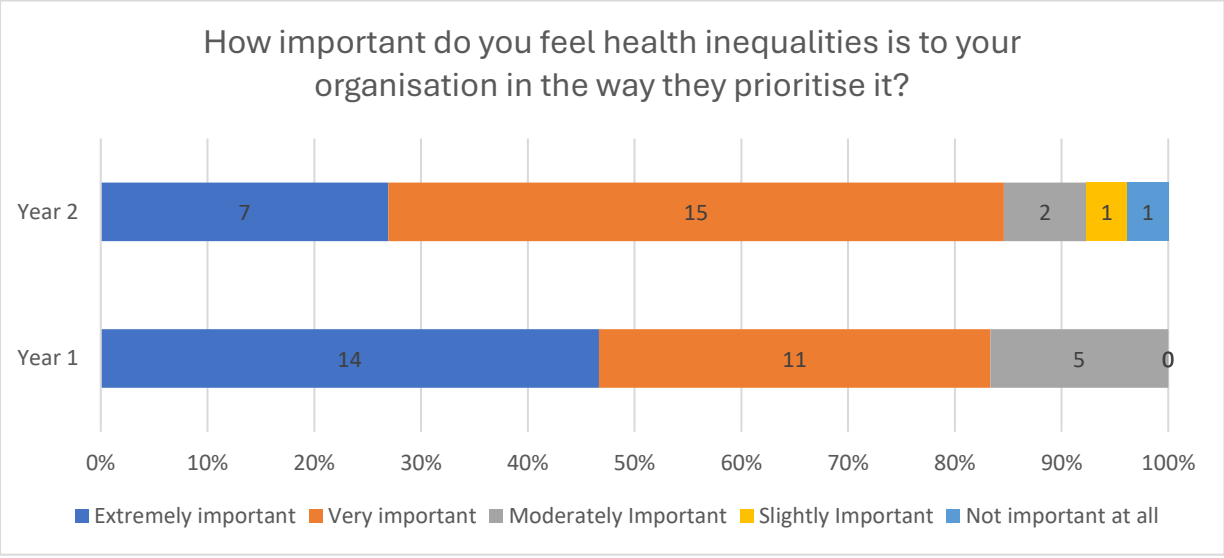
The membership remains large with sporadic attendance, and some members have disengaged due to the lack of apparent decision making. One interviewee suggested that the papers which are often 100 pages should be streamlined, and sent out with time to allow consideration.

"Maybe the BOB Health Inequalities group needs a reset as it becomes Thames Valley. Devolve to a level closer to neighbourhoods. At the moment it's dysfunctional." Senior leader, BOB ICS

Contrary to this, governance structures at each Place are thriving. Oxfordshire was already running an effective forum in the first year of funding. Buckinghamshire, and Berkshire West have now created a space for discussions around health inequalities. All three Place-based governance structures are well run, effective, collaborative, and well attended. Inclusive discussion is welcomed by each chair.

The perceived focus around health inequalities as a high priority varied between project/programme lead, and their organisation. Whilst survey (Table One) respondents continued to believe that it is extremely important for them to address health inequalities in their work, the number, and percentage who believe it to be an 'extremely important' organisational priority has halved (Figure three**Error! Reference source not found.**). This m ight suggest that health inequalities has become a lower priority for the organisations the respondents work for in 2025.

Figure three: Importance of health inequalities for organisation

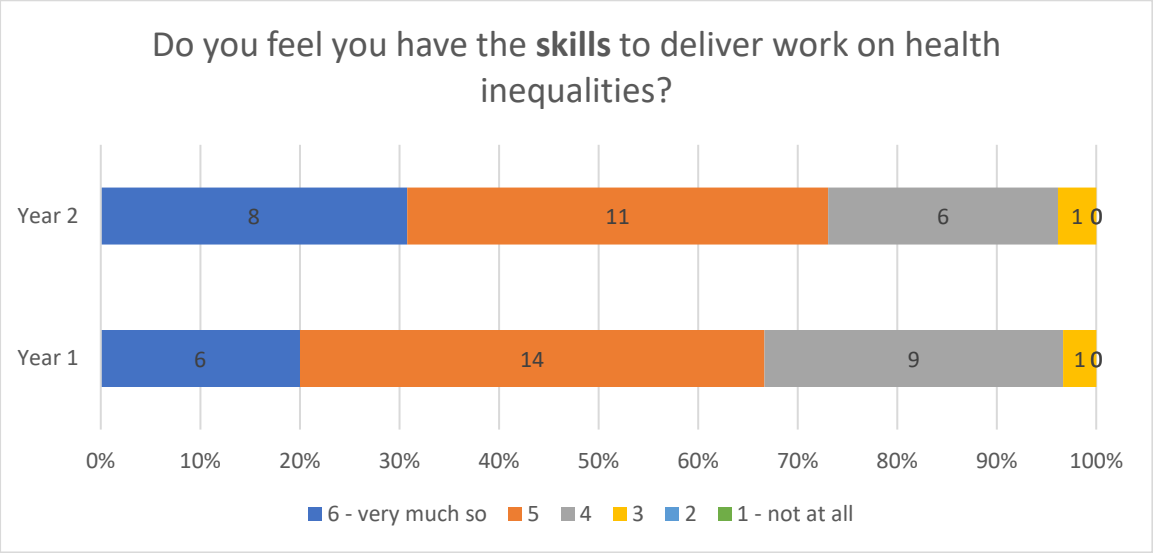


Growing in skills, and knowledge

The project/programme leads who responded to the survey (Table one) answered questions around knowledge, and skills. It demonstrated that that individually there been an increase in focus around health inequalities, and there is a continued appetite to continue learning.

This year, respondents reported that they have a good understanding of health inequalities, and were more likely to report having the skills they require, compared with the previous survey (Figure four).

Figure four: Personal skills around health inequalities



The qualitative feedback appears to have moved on from year one where there was more discussion about the need to understand where individual projects would fit into the bigger picture, and an emphasis on creating a shared understanding of health inequalities across the system. Year two focused around being able to evaluate impact, demonstrate outcomes, secure support to implement structural changes, and the need for additional training around health inequalities.

This is also reflected in the areas respondents said they would like to build their understanding, and knowledge. This year, on average participants listed 6.7 areas they would like more understanding, compared with 5.6 last year (Appendix four). The greatest appetite continues to be for knowledge, and understanding of evidence-based interventions.

Leaving a legacy: Moving towards sustainable change

Whilst legacy from the projects/programmes undertaken in the two-year funding period is important, consensus about wider commissioning was thought to be vital for health inequalities to be strategically addressed in the long term. Both local, and strategic legacy learnings are discussed below.

> *"A model of healthcare where there aren't health inequalities, and you could argue that truly effective strategic commissioning should ensure that."*
> *Senior leader, BOB ICB*

Throughout this evaluation it became evident that the profile around health inequalities was raised. A member of the public with a wealth of healthcare experience, noted that

they have "seen more conversations at a combined Trust board on health inequalities (this year) than in the 30 years previously."

There was a consensus of thought that over the last two years, key ingredients for future strategic planning, and commissioning have emerged. These included the need for strategic decisions to be informed by data, resource to be allocated in accordance with the greatest need, consistency of funding, equitable offer across the system, and for each Place to flex to their population based on community conversations.

"I think we need to be a little more objective, and dispassionate, and that our approach is not about who shouts the loudest. I think health inequalities needs to be through every programme." *Senior leader, BOB ICB*

"One of the things we are trying to do with neighbourhood going forward is trying to get some consistency. If you look across a certain level (system) - it's not equitable as Place prioritised different things - often it's personal enthusiasm rather than evidence." *Senior leader, BOB ICB*

"Sometimes we lost sight around outcomes, and parameters – maybe be more directive in the commissioning space" *Senior leader, BOB ICS*

There was some thought around a topic focused approach i.e. prison service, smoking, homeless, and focusing down on the 'hard to shift areas.' Others had an instinct to work with a public health management approach about focusing on an issue, identifying a population, and choosing an evidence-based intervention. Whilst others felt that health inequalities should be addressed in every commissioned service.

Alongside these strategic insights which may inform future system health inequalities work, there were a number of local legacies from the investment. These include:

- **relationships:** new, and improved working relationships between NHS, Local Authority, and Voluntary Organisations particularly within the Place setting.
- **skills and knowledge:** these have developed among staff which will support future work.
- **structure:** prevention, and health inequalities forums have grown at Place promoting trust, and transparency.
- **systems:** work around digital integration has supported connected care where learning can flow into other work streams.
- **individuals:** for the individuals who have participated in the funded activities, some are already demonstrating better health outcomes e.g. reduced need for NHS services, and others have adopted new behaviours likely to lead to better long term outcomes.

Year one project findings identified no evidence of sustainability of impact/outcomes. Year two has demonstrated that there are several local learnings, some of which could be tested further, adapted, and adopted across the system. One example per place has been highlighted below.

Berkshire West: Digital integration

A key strength of the Community Wellness Outreach programme is its digital integration. Practices can identify eligible patient cohorts for health checks using Connected Care. Health check providers upload the results directly into primary care clinical systems - improving accuracy, and reducing duplication.

Three different platforms are currently used across the areas:

- Wokingham: JoyApp
- Reading: Whzan and JoyApp
- West Berkshire: IHS System

Although the systems vary, this approach demonstrates how digital connectivity can work across multiple providers. With most areas already using the JoyApp through social prescribing, there is strong potential for future outreach programmes to link in the same way, making the model scalable and sustainable. A substantial amount of time, and energy was required to install Whzan across multiple systems.

Evaluation data will also help determine the funding and clinical impact across all three localities.

Buckinghamshire: Developing knowledge and skills

Buckinghamshire focused on two new initiatives to grow and develop staff skill, and share learning across the region. These were a Deep End Network (DEN) for GP Practices, and Health Inequalities Communities of Practice (CoP) for front-line staff, and volunteers.

Both initiatives were aimed at those involved in supporting people, including teams (GPs, social workers, religious leaders etc.) who work with people in the most deprived wards in Buckinghamshire.

Both have yielded significant progress in terms of increasing awareness of health inequalities, and strengthening collaboration between organisations. Some of these key learnings include:

- deepening awareness of barriers, and community realities.
- applying learning to practice.
- increasing confidence to address health inequalities.
- shared learning, and collaborative working.

Through increased knowledge, connections, and awareness patients can be signposted, and referred to more personalised, and appropriate services within the region to support their need. They have also supported the workforce in their sense of connectedness, and resilience when working in areas of greater need, and lower GP funding.

"One person can go out for a couple of hours, and come back with all that knowledge and share it." DEN member

Oxfordshire: Homeless inclusion team

The Oxfordshire Health & Homelessness Inclusion Team is a partnership between Health, Housing, Care and Third Sector providers. Working with people aged 18 and over who are experiencing, or at risk of, homelessness or rough sleeping. Its aims are to:

- support **safe and timely discharges from hospital** – avoiding discharges to street whilst generating patient flow and capacity.
- increase access to community-based services and treatment – reducing health and other inequalities and **preventing non-elective admissions to hospital**.
- prevent rough sleeping, and homelessness.

In 2024-25 they supported over 280 hospital discharges, identifying move on options, connecting people with community-based services, and Primary Care, reducing hospital bed days, and preventing discharge to street, and associated readmissions.

The community-based services worked with 300 people to maintain their accommodation, build their networks of support, and personal resilience, and avoid admission to hospital – breaking cycles of readmission.

Highlights to date:

- Emergency department attendances reduced by 56% (2023-24, for people accessing Step Down).
- Patients stranded in mental health wards due to housing barriers reduced from 16 to 1, contributing to 89% reduction in bed days (year one of project).
- 95% reduction in people returning to rough sleeping from hospital (2023-24, for people accessing Step Down).

Discussion

> *"A model of healthcare where there aren't health inequalities, and you could argue that truly effective strategic commissioning should ensure that."*
> *Senior leader, BOB ICB*

Over the past two years, BOB ICS health inequalities, and prevention two-year funding has enabled a diverse range of programmes across Buckinghamshire, Oxfordshire, and Berkshire West. Anchored in the Core20PLUS5 approach, these initiatives have largely focused on improving prevention, and access, with many delivering meaningful short-term outcomes at a local level. However, while individual stories of impact are evident, there is a long way to go for the system to establish a business as usual approach to addressing health inequalities.

Business as usual could include:

- understanding the health situation of the system.
- understanding the population of the system.
- consistent funding to support the agreed BOB ICS health inequality aims.
- embedding outcome-based evaluation into all programmes.

A key theme emerging from this evaluation is around the variety of projects undertaken. This diversity reflects the flexibility given to each Place to respond to local need, but it also makes it challenging to assess collective impact. Many projects are still in early stages, and others are too context-specific to draw broad conclusions. To scale what works, there is a need to move beyond activity reporting, and towards understanding outcomes, and sustainability. A shift from data to insight.

Collaboration has grown at Place level, with stronger relationships between delivery partners. However, trust in the commissioning processes has been strained, in part due to ongoing funding deficit, and organisational changes. This has affected continuity, and confidence in longer term planning, and delivery. Despite this, the value of shared thinking time has been consistently highlighted. Stakeholders appreciate opportunities to reflect together, rather than being driven by short-term deadlines, and reactive funding cycles.

Future commissioning should be strategic, data-informed, with a long-term lens applied. It should bring key players around the table to co-design solutions that are sustainable, and scalable, not just temporary fixes. The importance of co-design with senior Place leaders, and commissioners cannot be overstated. Both insights are essential to ensure that future programmes are aligned with system ambitions while rooted in local realities. This approach fosters ownership, relevance, and sustainability.

There is a shift in thought from localised delivery to system-level learning. While some insights have been shared across regions, many teams remain unaware of work

happening outside their immediate area. To unlock the potential of collective wisdom, there should be mechanisms for cross-regional learning, and strategic alignment. Crucially, there must be a focus on equity of offer across the BOB system. Without this, there is a risk that health inequalities could be inadvertently widened, with some communities benefiting more than others depending on local capacity or priorities.

Looking ahead, BOB ICS has an opportunity to align more closely with the NHS 10 Year Health Plan [6], which emphasises addressing health inequalities through integrated care, and a stronger focus on neighbourhood-level delivery. By embedding prevention, and equity into strategic planning, and by investing in neighbourhoods as part of the foundation, BOB ICS could move to a more coherent, system-wide approach.

While most projects expressed a need for continued funding, it is worth reflecting on the original scope: a two-year funded programme. A more prescriptive focus from the system may have helped shape more focused, time-bound interventions, with a clear route to sustained impact beyond the programme end. Going forward, it is important to balance ambition with realism, ensuring that future programmes are designed with both outcomes, and sustainability in mind. In some cases, the legacy was intended to be learning about what works, and evidence that prevention activities achieve value for money by reducing the need for care. However, so far, the evidence is too anecdotal to make such evidence-based investment decisions.

With strengthened collaboration, data-driven insights, Place informed strategic commissioning, and evaluation, it is likely that BOB ICS would have embedded health inequality activities which could be measured over time. By working together across each Place, and with communities, BOB ICS could move from promising local initiatives to lasting system-wide change.

Recommendations

This is a pivotal moment. As BOB ICB undergoes system changes, there is an opportunity to reset, and refocus. With the right leadership, collaboration, and strategic focus, BOB ICS could position itself to become a model for other ICSs, around tackling health inequalities, not just through isolated projects, but through a unified, system-wide response.

Strengthen strategic commissioning

If the ICB would like to make reducing health inequalities over time one of their core priorities, funding should be woven through every service. Commissioning should be underpinned by a long-term vision, informed by data, and co-designed with senior Place leaders. This approach will ensure programmes are both locally relevant, and system-aligned, fostering sustainability beyond short-term funding cycles.

Shift from activity to outcomes

Future programmes should prioritise outcome-focused evaluation over activity reporting. This means investing in tools and frameworks, and providing support to translate data into

actionable insight, enabling a clearer understanding of what works, for whom, and why. Whilst some of the funded projects have started to put in place the data infrastructure to do this, the next step will be to ensure a more systematic use across the region.

Foster trust through transparent processes

To rebuild confidence in commissioning, BOB ICB should prioritise transparency, continuity, and shared decision-making. This includes clear communication around funding timelines, criteria, and expectations. While sometimes unavoidable, it should be noted that budget uncertainty is not without costs. A pause in funding may impact the final return on investment that could be achieved.

Build equity into system design

Equity of offer should be a guiding principle e.g. if Oxfordshire has a move together programme that demonstrates sustained improved health outcomes, then this should be adopted across the system. BOB ICB should develop mechanisms to monitor, and address variation in access, capacity, and outcomes across Place, ensuring that no community is left behind due to local constraints.

Create space for collective wisdom

To unlock the full value of collective wisdom, BOB ICS should establish structured opportunities for cross-regional learning. This could include thematic learning sets, shared digital platforms, or regular system-wide reflection sessions to ensure learning is available to all.

Invest and expand workforce capability

The growth in skills, and knowledge around health inequalities is a major asset. Continued investment in workforce development, including training, peer learning, and leadership support will be essential to maintain momentum, and embed equity into everyday practice. Projects have demonstrated it is possible to engage healthcare workers from across the system with the right combination of opportunities, and incentives. It will be important to build on these learnings.

Reshape governance

Governance at Place is thriving. Based on the interviews and findings, the system-wide group needs reforming with a focus on:

- senior leadership membership.
- the power to make decisions.
- place-based leaders involved in strategic commissioning.

Align with neighbourhood level change

In line with the NHS 10 Year Health Plan [6], future efforts should focus on neighbourhoods as the foundation for delivering prevention, and equity. This means resourcing local teams to lead, while ensuring strategic support, and consistency across the system.

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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 commissioning 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.

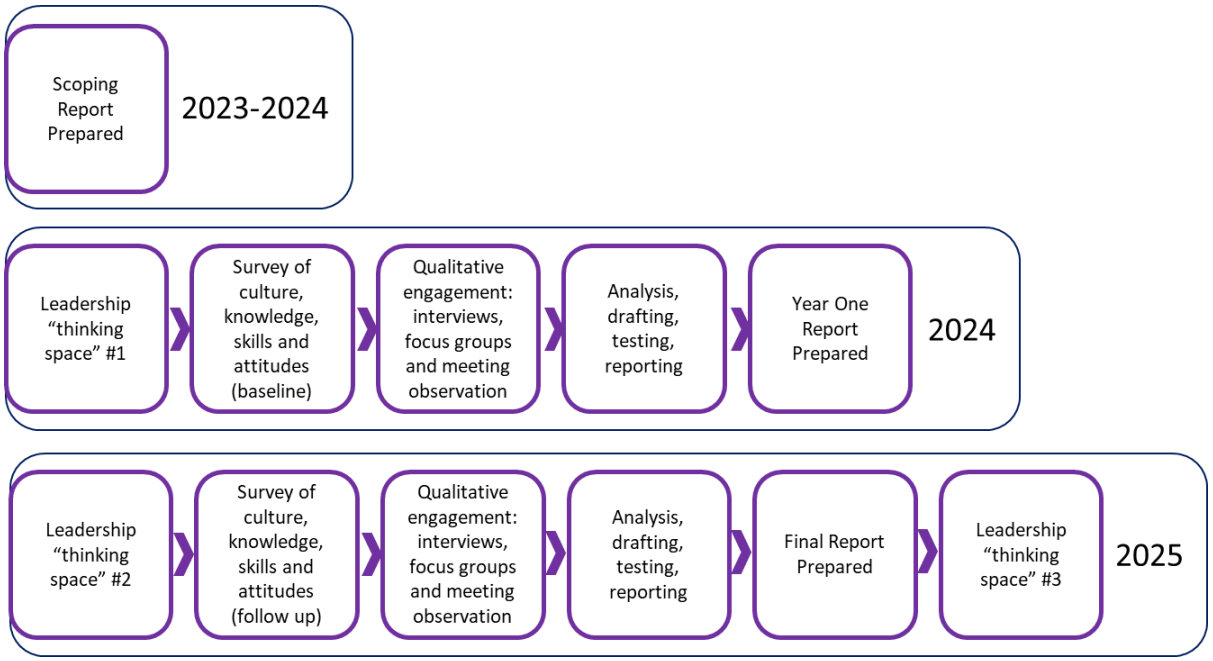
An overview of neighbourhoods, places and systems

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 – Evaluation approach, 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?

Appendix Two – Leadership thinking space report (May 2024)

Leadership Thinking Space 1: Health Inequalities
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. Participants 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 participants 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) participants were asked to respond as themselves drawing on their personal values, skills, and knowledge.

For questions C) and D) participants 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 participants 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 participants 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: Participants 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.

Participants were able to identify multiple specific things they might do to increase the impact of health inequalities.
Comments and reflections

8. Participants 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 organisations.

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, participants 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 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 – Leadership thinking space report (Dec 2024)

Leadership Thinking Space 2: Health Inequalities

Background

1. The second of three facilitated Leadership Thinking Spaces that brought together people in system leadership roles from across Buckinghamshire, Oxfordshire and Berkshire West (BOB) was held in Oxford on 10 December 2024.

Purpose

2. The purposes of the "Thinking Spaces" is to provide busy leaders with a chance and safe space to:

a) to 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 Integrated Care Systems (ICS)
b) to build or deepen relationships with colleagues in other organisations
c) to 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 the report of Year 1 Evaluation of the Buckinghamshire, Oxfordshire and Berkshire West Health Inequalities work.

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

5. Participants were asked to sit on tables with people from other organisations and/or people they didn't know well. Katie Lean, Senior Programme Manager Health Innovation Oxford and Thames Valley presented the Year 1 Evaluation Report and Steve Goldensmith, Associate Director, Prevention and Health Inequalities, BOB presented on the work of BOB System Planning and Leadership Group. Nick Hicks (evaluation team) facilitated the plenary and table top discussions. Notes of the meeting were taken, and all the written answers and flip charts were collected and photographed for record and for later analysis.

Results

1. There was broad support of the recommendations of the Year 1 evaluation:
    - That leaders should agree a shared ambition for tackling health inequalities
    - That 'Places' have freedom to address those ambitions in ways which best addressed their understanding of local need
    - That a named Director should have oversight and accountability for the inequalities work and its impact at both place and system level.
    - That partnerships were crucial to delivery and that the involvement of the voluntary sector should be increased
    - That active efforts should be made to place work in places of greatest need.
    - That this work should be supported by ongoing training, opportunities for shared learning and the spreading of good practice, and some dedicated funding.

2. There was also support for the work of the BOB System Planning and Leadership Group. In particular

    - Agreed £4m ring fenced ICB funds for inequalities for 2025/2026.

- Funds will be allocated to Places in a similar manner to prior allocations.
- It will be down to Place Partnerships to consider how best to deliver these outcomes.
- Inequalities work and use of the ring fence monies will be monitored through Integrated Care Board (ICB) governance and assurance processes:
    a. Place

Each Place will have their own local governance structure that is made up of representative membership of ICB, Primary Care, Secondary Care & Mental Health Services, Public Health & Local Authority, voluntary, faith & community organisations, patient representative groups such as Health Watch.

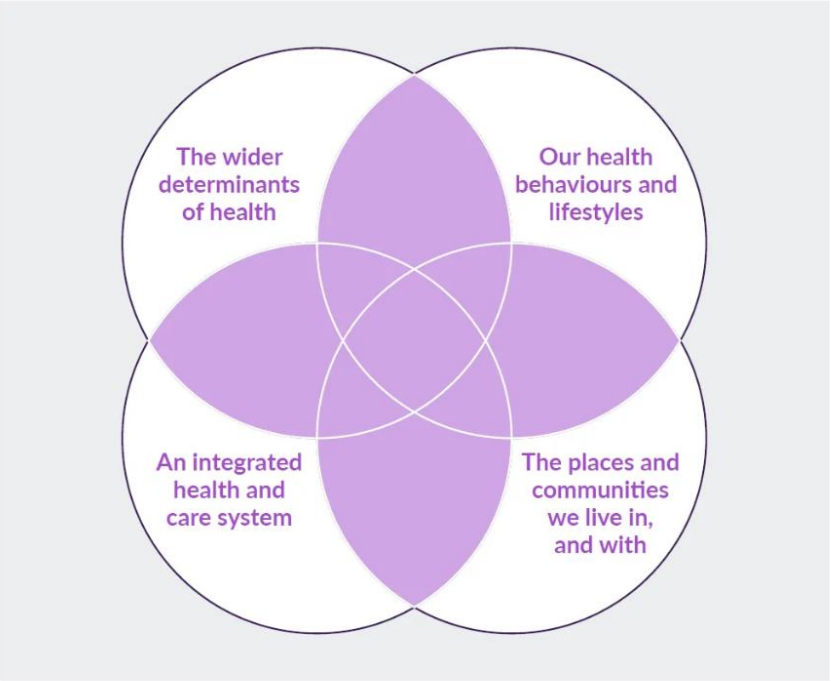
b. Integrated Care Board

Report from Place-based Governance to The Prevention, Population Health & Health Inequalities Group on a quarterly basis and up into the Population Health Management and Patient Experience Committee as well as providing update via this route to Executive management Committee

3. There was then discussion and debate about how to tackle inequalities and the use of the ear-marked inequalities funding noting that tackling health inequalities is a core goal and the ringfenced spending is a very small % of the total ICB spend.

4. The general view was that Places should aim to be addressing inequalities by influencing behaviour in each of the four circles of the Kings Fund population health model (Fig 1):

Fig 1: Kings Fund Population Health Model



Source: Buck et al 2018

5. Most participants wanted to work towards achieving an explicit understanding in their places and systems around:

- **Tackling inequalities is a core task and duty of every organisation service** – Processes need to be designed and implemented to make sure that every NHS decision regarding care and expenditure takes account of inequalities

- **The inverse care law** (NHS) still applies, and every service has a duty to understand how it applies to them and to take steps to reduce it. This may mean moving resources or changing the way services are offered. This work should become part of 'business as usual' and undertaken with mainstream funding
- **Addressing the wider determinants of health** – engaging with local people, local government, voluntary sectors is an essential task for the NHS as well as local government and Voluntary Community Social Enterprise (VCSE).

6. Participants discussed ways in which the modest ringfenced inequalities funding could be used. Effective approaches included:

- Direct service provision to disadvantaged groups, especially via support for VCSEs where it was acknowledged that small sums of money in the hands of committed local people can generate large amounts of local benefit. This was seen as especially true when the approach included creating the agency of local people and community organisations.

- Engaging with local communities

- Training and staff development: to increase the understanding and agency of staff in tackling inequalities, strengthen individual networks

- Organisational development: e.g. developing, implementing and evaluating processes that will make the aspiration that inequalities should be considered in all decisions that commit resources; strengthen inter organisational relationship and partnerships

- Accessing external support: e.g. becoming a Marmot community.

- Investing in new data collections, analyses and their use.

7. In relation to tackling the **inverse care law**, actions participants wanted to see included:
    a. Greater weighting for inequality in national funding formula
    b. A shift of focus from the short to the longer term supported by a commitment to longer term funding.
    c. Greater investment in primary care serving disadvantaged communities e.g. by modification of the Carr-Hill formula (as some other ICBs have done)
    d. Better engagement and more co-design with people living with disadvantage
    e. Better use of data (including sharing of analyses with front-line staff and local communities)
    f. Inequality analyses of services associated with priority national targets e.g. Inequality analyses of waiting lists, urgent care etc.
    g. Proactive efforts to tackle digital exclusion, because, as services and access to them becomes more digital, if digital exclusion is not tackled access to services is likely to become more unequal.
    h. Be more prepared to
        i. move services to where people can access them "hard to reach" just implies a service is poorly designed to meet core target users
        ii. Adjust service times so they can be accessed without people losing money or education by missing work or missing school.

8. Participants reconsidered that they **shared values** and that they had a **collective commitment** to helping their organisations tackle inequalities effectively. They know that their **personal leadership** and **daily championing of this agenda** can make a

difference. They **aspire to being brave** individually and collectively. Creating a culture in which inequalities matter will be important. **Language is the data of culture – by changing conversations, participants can change culture**.

Reflection and Next steps

Three things stood out:

a) There was a shared commitment among participants to the importance of tackling the inequality agenda. This commitment was felt both personally and on behalf of their organisations.

b) There was a growing sense of a shared understanding of **how** inequalities can be tackled and a belief that it's important to work in ways that
    a. Support individual projects
    b. With partners, address both the inverse care law and the core determinants of health
    c. Strengthen processes so that all spending takes account of inequalities
    d. Support a shift of focus, planning and action from the short to the longer term. This includes a commitment to longer term funding.

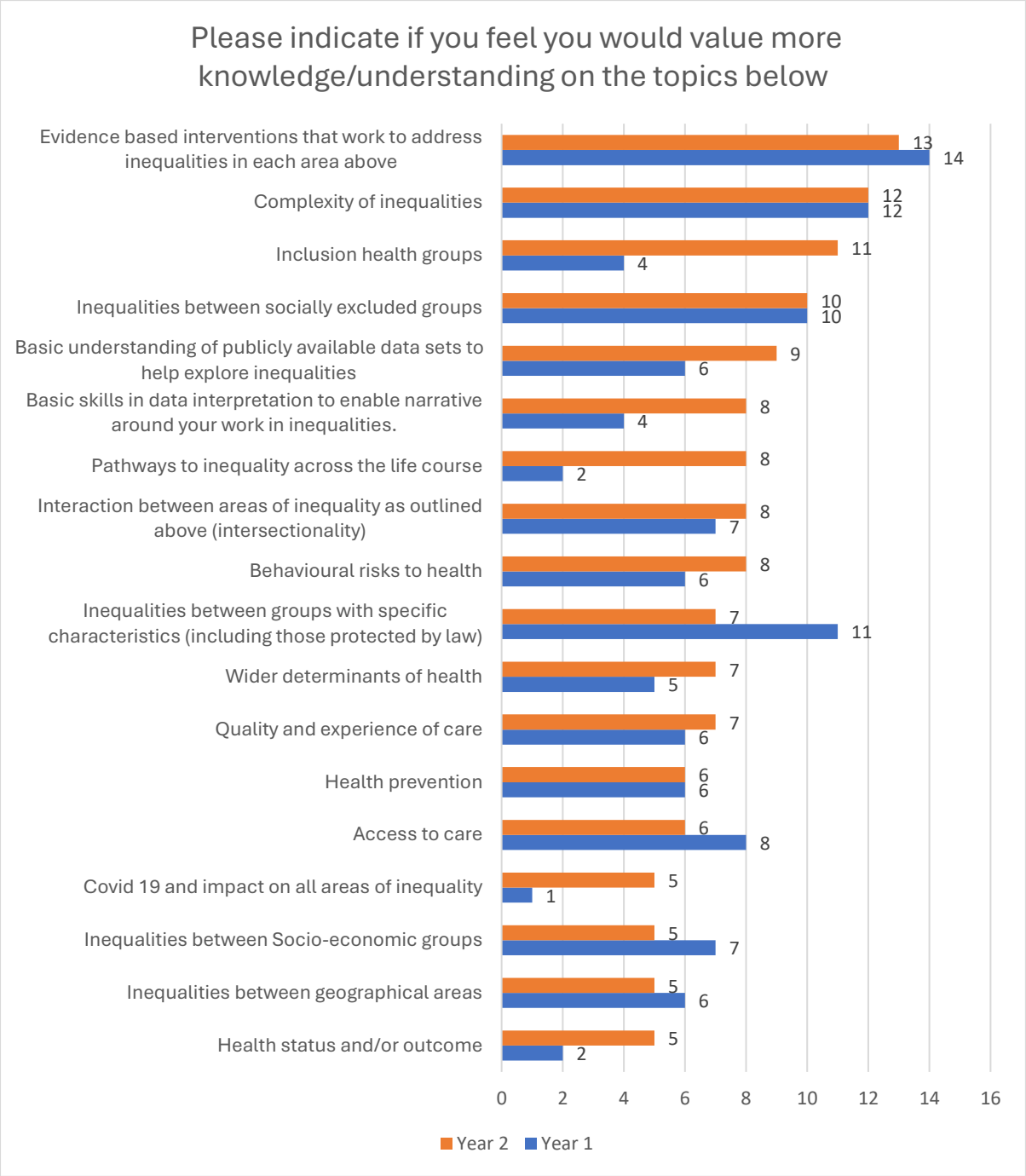
c) Participants shared an ambition to be brave leaders and recognised that their behaviours can make a difference.

Next steps

1) Participants resolved to take the conclusions of this conversation into their daily work
2) Most but not all participants felt it would be helpful to continue meeting for mutual support, shared learning as a way to helping turn the aspiration of brave leadership into practical action.

Nick Hicks
January 2025
V1.1

Appendix Four – Skills and knowledge based interests



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