



**HEALTH
INEQUALITIES:
IMPROVING
ACCOUNTABILITY
IN THE NHS**

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EXECUTIVE SUMMARY

This report examines current and past mechanisms and levers that enable and hinder accountability for health inequalities and analyses whether they are sufficient to reduce health inequalities. It provides proposals to improve accountability for health inequalities across Integrated Care Systems (ICSs). Better accountability mechanisms to reduce inequalities are within reach, it is up to NHS England to take this opportunity.

In order to establish 'off the record' views about accountability for health inequalities, 18 semi-structured interviews with people in senior NHS management roles and/or held academic posts, who have experience and expertise in health inequalities, were conducted between October and November 2022. Policy documents and relevant grey and academic publications were also reviewed to inform assessment of past and current accountability mechanisms.

KEY THEMES

Robust accountability systems are an essential part of reducing health inequalities. Without these there is a risk health inequality will be disregarded as other priorities with clear and stringent accountability mechanisms take precedence.

Since 2010 accountability for health inequalities in the NHS has been weak and health inequalities have widened. In 2020 a national team on health inequalities with a Task and Finish group was created as part of the 2020 COVID-19 pandemic response. In 2021 further action was taken and a health inequalities programme team and national director were created. In addition, there was a welcome strategic and policy focus on health inequalities for ICSs, however, accountability mechanisms to drive actions in the NHS remain insufficient to drive appropriate investment and action on health inequalities and their causes.

Interviewees agreed that they should be held accountable for reducing health inequalities. The planning requirements, the Board Leadership Tool for health inequalities, Health Inequalities Improvement Dashboard and CORE20plus5 are welcome tools for local systems. However, whilst these tools will increase actions on healthcare inequalities they do not increase accountabilities.

A number of themes arose suggesting how to improve accountability mechanisms to address health inequalities.

DEVELOPING ACCOUNTABILITY FOR REDUCING HEALTH INEQUALITIES

- The requirement to have health inequalities in the ICS strategies has prompted a considerable focus on health inequalities and many interviewees said it could be a useful mechanism to improve accountability.
- No single approach or target will guarantee improvements in accountability.

PERFORMANCE MONITORING

- Many interviewees said performance monitoring measures were needed however, they warned that these could be easily manipulated, as such targets and goals should not be punitive, nor blunt national targets.
- Performance accountability mechanisms should focus on supporting systems to identify where their actions are being effective and where they need to take different approaches.
- Two-way performance measures are a useful mechanism, with consistent exchanges between local systems and NHS England (regionally or centrally), and fostering relationships that facilitate achievement and do not act punitively.
- Performance measures should be appropriate to the health of the local population and consider local, social and economic contexts.

FUNDING AS A TOOL TO IMPROVE ACCOUNTABILITY

- Central NHS systems could track funding to assess outcomes and activities related to inequalities however, current funding systems impede accountability in relation to health inequalities.
- The dependence on short-term funding is not effective and does not follow the copious evidence demonstrating long-term approaches with longer-term funding are needed to reduce inequalities.
- Funding should be longer-term and ring-fenced. Respondents stated ring-fenced funding for reducing health inequalities is essential to improve accountability.

LOCAL SYSTEMS

- NHS England should work with local systems to identify how to improve policy support and policy implementation – local systems do not want another strategy or plan stating systems should address inequalities.
- Local systems requested in 2023 NHS England provide them with the mechanisms to evaluate current inequalities policies which would enable them to feedback to their own local systems.
- Local systems reported they wanted NHS England to take a leadership role and:
 - > Continue to thread health inequalities in NHS policies.
 - > Develop a national strategy on health inequalities.
 - > Work with the Care Quality Commission to integrate actions on inequalities into their accountability mechanisms.
 - > Reach out to local systems to identify support and training needed to improve actions on inequalities and the mechanisms needed to improve accountability.
 - > Lead discussions on health inequalities and accountability across government departments and to filter this information back to local systems.

MONITORING HEALTH INEQUALITIES FOR GREATER ACCOUNTABILITY ON HEALTH INEQUALITIES

- The NHS in England is a global leader in health data however, data is currently not being used to hold systems to account for health inequalities. There are opportunities to use data more effectively to enable local systems to identify inequalities and monitor actions on inequalities to strengthen accountability for health inequalities.
- NHS England can work more consistently with local systems to identify how Fingertips and other central data sources can supply more useful information on inequalities and progress on reducing inequalities.
- No interviewees discussed the new health inequalities improvement dashboard, regardless, the dashboard should be made available to non-NHS stakeholders.

THE LIMITS OF ACCOUNTABILITY TO REDUCE INEQUALITIES

- Many areas are taking their own actions to address inequalities that go beyond NHS requirements and expectations. They are leaders in the field, regardless of the accountability mechanisms and policies coming from NHS England. However, leaving actions to local leadership is not sufficient, and can risk some areas taking effective action and others not.
- There is a limit to what accountability systems to reduce health inequalities can achieve as the NHS does not have all the levers to address the causes of health inequalities found outside the health system.
- As stated, improving accountability mechanisms in the NHS to reduce inequalities is only part of the story and more effective action for health inequalities also involves increased investment and policy implementation and a broad, cross-sector approach to reduce inequalities in the social determinants of health.

Key components of a stronger accountability system

- Better guidance and support and training
- Listening to and trusting local systems
- Mainstreaming accountability and inequalities in national strategies
- Realistic funding structures and long-term funding
- Improving performance measures
- Data to support accountability
- Shift to bottom-up approaches

RECOMMENDATIONS

CHANGING SYSTEMS, PROVIDING THE TOOLS TO SUCCEED

- NHS England and its mandates, constitution and funding and allocation arrangements, monitoring and data-sharing procedures should all strengthen accountability mechanisms to reduce inequalities.
- NHS England should publish a national strategy on health inequalities, developed in partnership with local systems.
- All accountability mechanisms should aim to impact in the longer-term, at least five years.
- Develop mechanisms to strengthen accountability between health systems (ICBs) and non-NHS partners, such as local government, the voluntary sector and other public services – that can influence the social determinants – are needed.
- Work in partnership with the Care Quality Commission to integrate actions on inequalities into their accountability mechanisms.
- NHS England should commission 3–5-year pilots with local systems to identify accountability mechanisms able to hold local systems to account.

GUIDANCE, SUPPORT AND LEADERSHIP

- NHS England should provide stronger leadership to create the organisational contexts to deliver new policies and approaches, such as the current enhanced focus on reducing inequalities in ICSs.
- Include reducing health inequalities in future NHS long-term plans, annual strategies and operational planning guidance to give local places the tools to work with staff – at board level and those delivering services – to show inequalities should be part of their everyday work and practice.
- Work with local systems to identify support, training and mechanisms needed to improve accountability related to health inequalities.
- NHS England should lead discussions on health inequalities and accountability across government departments and filter this information back to local systems.

PERFORMANCE MANAGEMENT

- Develop multi-faceted and long-term approaches to accountability. Short-term targets are likely to be ‘gamed’ as the current additional funding for health inequalities shows.
- Punitive performance measures are not wanted, instead systems want implementation support.
- A heavy-handed set of targets will not work. Targets that facilitate and support local actions based on national parameters are recommended.

DATA AND MONITORING

- Enhance data to enable ICSs to better identify where inequalities are, the actions needed and how to measure the impact of their actions. This type of data can improve local accountability to their ICBs and local communities.
- Make the NHS inequalities dashboard available to non-NHS stakeholders.
- NHS England, NHS Digital and OHID should work with local systems to identify data needed.
- Develop targets and monitoring in partnership with local systems.

FUNDING

- Funding should be for long term. Health inequalities will not be reduced if the dependence on short-term pots of funding continues. Policies will fail.
- Funding should be ring-fenced.

1 INTRODUCTION

The NHS has a significant and underdeveloped role in reducing health inequalities and addressing the causes of these health inequalities. There is greater potential for the NHS to take action in the NHS including: the development of national strategies and policies, through the workforce and through provider organisations and primary care. These approaches have been set out previously by the Institute of Health Equity (1) (2) (3) (4).

Robust accountability systems are an essential part of delivering health equity. Without robust accountability mechanisms focussed on reducing health inequalities, actions on health inequalities are at risk of being disregarded as other priorities with clear and demanding accountability mechanisms take precedence (5). Strong accountability frameworks have been shown to drive behaviour, improve quality and value for money (6).

In 2020 the IHE Ten Years On report showed life expectancy in England had stalled (5). Three-year averages in life expectancy for females between 2018 to 2020 were 82.9 years, no improvement compared to 2015 to 2017. For males, life expectancy returned to 2012 to 2014 levels, the first decline since the series began in the early 1980s (7). The effects of the pandemic in England have exacerbated these poor outcomes and the cost of living crisis will damage health and widen health inequalities. The need for effective action to reduce health inequalities is even more pressing and must be supported by NHS England through provision of tools and support to improve accountability for health inequalities.

This analysis was commissioned by NHS England to examine factors that affected accountability in relation to health inequalities, with a focus on the role of Integrated Care Systems (ICSs) and it seeks to provide a practical set of proposals to improve accountability for health inequalities. It examines current and past mechanisms and levers that enable and hinder accountability and analyses whether they are sufficient to reduce health inequalities. The report examines if the current legislation and guidance is clear and achievable and if NHS staff believe it gives them the capability to translate this legislation and guidance into action.

This research is based on a review of key policy documents and academic publications and 18 semi-structured interviews conducted between October and November 2022. We analysed documents provided by the NHS England team, primarily England health inequalities policies, as well as published research examining what drives accountability in government policies and policy implementation. We draw on this research throughout the report.

THE NHS' ROLE IN REDUCING INEQUALITIES

The most important influences on health and health inequalities are beyond health systems, as such, there is a limit to what can be achieved in health systems alone as most of the drivers of poor health lie outside of health care. Essential partnerships between many sectors, such as early years, businesses, education, work, social protection, environment, housing and social care are needed to support action on health inequalities. However, healthcare systems have an important role in providing equitable access to services and adopting an inequalities informed approach to improving the experience of and outcomes from healthcare services to reduce health inequalities. Delivering the Core20PLUS5 approach and secondary prevention interventions at pace and scale can have a rapid impact on health inequalities.

In addition, healthcare systems can do far more to support actions on improving the social determinants of health. For example, NHS Trusts and primary care can improve partnerships with non-health stakeholders to improve their role as anchors in local economies. The NHS Confederation states supporting social and economic development by adopting anchor approaches is 'perhaps the most significant chance...to bring the NHS's role in addressing the inequalities agenda more to the fore' (8).

NHS services can provide direct access to support and information for housing, debt and benefit entitlements and employment within their own walls, and indirect support through effective social prescribing services targeted at populations to reduce inequalities. The healthcare workforce can take action on the social determinants of health by improving their education and training and focussing on the social determinants of health; better sharing and integrating data information systems; maintaining effective partnerships and multi-disciplinary teams with organisations that broadly influence health outcomes, including organisations with remit outside healthcare services, such as housing, education and social care and focus on supporting (and developing) services in deprived areas to meet their needs (4) (9).

The size and scope of ICSs should lead to longer-term planning and partnerships with key stakeholders to better support actions and policies to reduce health inequalities. ICSs do not yet have the accountability mechanisms to understand the impact of their actions to address health inequalities as accountability mechanisms set nationally have, in the past, prioritised reducing response times and not wider assessments of the impact of policies on inequalities.

DEFINING ACCOUNTABILITY

Numerous academics have outlined the difficulty of defining accountability in healthcare systems. A study of seven national healthcare systems found many accountability mechanisms were not carefully designed but emerged through a mix of historical accidents and political expediency (10). Andrew Hudson, former Head of the Health Team in the Treasury, suggests the following are key components of an integrated approach to accountability in health systems:

- An overall framework for planning and monitoring, with the national elements set for the length of a parliament, and the local elements for a local authority term.
- A single set of outcome indicators, covering health care, public health and social care; this should comprise some key national indicators, plus a set of local indicators agreed by the relevant parties.
- A coordinated approach between providers and commissioners of health and care to planning at local level, including how planning and monitoring for individual organisations fits within this strategic, place-based approach.
- A high-level financial plan also agreed at local level, as part of the process of setting service plans, which provides the framework for commissioning decisions.
- A common database for headline performance measures that is available to the public, which spans health and care, quality and finance.
- Fully coordinated inspection regimes (6).

Hudson's definition shows accountability in health systems is a complex issue, a succinct and easy definition fails to reflect the range of issues to consider in addressing accountability.

No single target or approach will guarantee improvements in accountability – a single mechanism can both enable and inhibit accountability for health inequalities. Bamba reviewed five global examples of national strategies to reduce health inequalities: the Nordic social democratic welfare states from the 1950s to the 1970s; the Civil Rights Acts and War on Poverty in 1960s USA; democratisation in Brazil in the 1980s; German reunification in the 1990s; and the English health inequalities strategy in the 2000s. She reiterates there is no single, 'silver-bullet' intervention that will reduce health inequalities and argues academics and policy-makers need to examine accountability-related issues and 'focus more on the implementation and evaluation of wide-ranging, long-term policy programmes that simultaneously target multiple social determinants of health. This will help to develop more effective post-pandemic public health policy programmes' (11).

CURRENT EVIDENCE OF ACCOUNTABILITY MECHANISMS FOR HEALTH INEQUALITIES

England is not the only country seeking to improve accountability systems. Analysis of health inequalities policies in 10 European countries, including England, found a ‘low rate of accountability and evaluation systems related to strategies’ and that this reflected ‘poor intelligence systems... low efforts in term of resources’. They also found an ‘implementation gap’ between good intentions, policies and actions in terms of tackling health inequities in European Countries (12).

Since 2010 accountability for health inequality in England has been weak. There was a change in direction in 2020 with the appointment of a national team on health inequalities with a Task and Finish group created as part of the 2020 COVID-19 pandemic response. In 2021 further action was taken and a health inequalities programme team and National Director were created (5). Since 2019 NHS guidance and plans have sought to include more specific mechanisms to address health inequalities. Health inequalities were prominent in the 2019 NHS *Long Term Plan* with the plan outlining a ‘more concerted and systematic approach to reducing health inequalities’ (13). However, Ford et al. argue the 2019 plan and related supporting documents ‘failed to outline how local and national systems could systematically approach health inequalities with an expectation that local healthcare systems would each develop their own approaches’. They state ‘this is challenging for local systems, resulting in local plans being vague and lacking a systematic or joined-up approach’ (14).

Accountability systems are also weak in public health. Between 2011 and 2019 there were no public health white papers. The 2012 Health and Social Care Act transferred many public health functions to local government. The IHE *Ten Years On* report stated it was right to shift public health to local government where they were better placed to take action on the social determinants but that the move to local government coincided with austerity and cuts to public health budgets, limiting their ability to take action on health inequalities and worsening outcomes in the social determinants (5). In addition, local government accountability ‘is much weaker [than the NHS]...there is a reliance on sector-led improvement, whereby councils review and support each other’s performance’ (15). As such, public health’s move to local government has weakened accountability in relation to health inequalities and it is more difficult to understand the impact of actions from the health care system on reducing inequalities and the social determinants of health.

The 2020 reorganisation of the NHS, which introduced ICSs, had a strong and more focussed approach to health

inequalities. ICSs have four core purposes, one of which includes reducing health inequalities:

- Improving outcomes in population health and healthcare;
- Tackling inequalities in outcomes, experience and access;
- Enhancing productivity and value for money;
- Supporting broader social and economic development.

Despite the integration of inequalities into ICSs’ core purpose, the Local Government Association (LGA) warns as ICSs structures are not required to be accountable to public health and local authorities, their effectiveness will be limited. They argue: ‘ICSs need to be accountable and inclusive of local place-based leaders – whether or not they are put on a statutory footing. Also, having a solitary local authority representative on an ICS board is not sufficient to ensure full local authority involvement, especially in areas where the ICS footprints spans several local authorities’. The LGA proposes a ‘reciprocal “duty of collaboration” which would ‘require ICSs to ensure meaningful involvement and an equal partnership with local government, with a ‘place by default’ approach’ (16).

The 2022 *Health and Care Act* introduced new obligations to Integrated Care Boards (ICBs). In their general duties, ICBs must ‘in the exercise of its functions, have regard to the need to reduce inequalities between persons with respect to their ability to access health services, and reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services’ (17). Whilst this definition emphasises the differences between individuals, it fails to look at the differences between social groups. However, as part of their duty to have regard for the wider effects of their decisions, ICBs also have a duty to consider their decisions in relation to health inequalities. Whether this occurs or not is unclear, as there are no requirements to document or measure if health inequalities have been considered. It is also unclear whether these relate to the social determinants of health which drive most of the inequalities in health. ICBs are currently developing their interim strategies where they are required to ‘set out how to address unwarranted variations in population health, and disparities in access, and outcomes’ (18).

Integrated care partnerships (ICPs) have a broad focus and will address public health, including health inequalities, social care and wider issues. The Department of Health and Social Care (DHSC) state ICPs should coordinate local services and as a result, improve population health and

reduce health inequalities (19). However, the ICPs strategies currently under development are unlikely to improve accountability related to health inequalities as the National Audit Office (NAO) have stated 'there is no requirement for any of the bodies that must have regard to the ICP strategy to report their progress against it' (20).

The 2022/23 *Operational Planning Guidance* requires the NHS to 'continue to develop our approach to population health management, prevent ill-health and address health inequalities' and requests systems to use the Core20PLUS5 approach to tackle health inequalities and improve data systems. In the section on prevention the guidance states 'it is particularly important to focus preventative services on these groups' (21). Again, there is no requirement to focus on prevention activities on a particular group (i.e. those living in places with greater deprivation), it is only noted it is important to 'focus' services. It is hoped that a stronger focus on prevention will occur as a result of the Operational Guidance 2023/24 as one of the NHS' national objectives is to continue to address health inequalities and deliver the Core20PLUS5 approach. The NHS Confederation have stated signaling the importance of inequalities and prevention is 'helpful' (22).

Core20PLUS5

The Core20PLUS5 approach is part of NHS England's actions to address health equity. It seeks to improve equity of access, experience and outcomes for the most deprived 20% of the population in England in five clinical areas and has an additional focus on particular communities, which is defined at the local level by ICSs. The Core20PLUS5 approach targets the most deprived quintile of the population and does not work across the social gradient, as such there will be parts of the population in need who will miss out on support offered by this programme. In addition, as the approach only focuses on five clinical areas and not on the causes of ill-health, its impact may be limited as it does not address the social determinants of health. This targeted approach provides additional resources and actions in some communities and areas with higher levels of deprivation. The Core20PLUS5 targeted approach is one aspect of what is needed to adopt a proportionate universalist approach. For information on how local systems are implementing CORE20PLUS5, see: <https://www.england.nhs.uk/about/equality/equality-hub/case-studies/>

This new policy focus on integrating health inequalities into NHS structures and annual guidance is welcome. However, a number of voices have raised concerns that these new approaches do not include adequate accountability mechanisms.

- The NAO state their concern of a high risk to good governance and accountability in the ICB system. They state that ICBs are accountable for delivering NHS priorities and the strategies developed by ICPs yet the organisations delivering many of these actions, such as local authorities and NHS trusts, are not accountable to ICBs but remain accountable for their own statutory responsibilities (20).
- In their analysis of the Vanguard programme, Coleman et al. found that as the Vanguard programme was not evaluated or monitored, it was not clear what worked and what did not, and they expressed concern that ICSs could end up in a similar position as Vanguards. They show how approaches from the centre impeded accountability processes and concluded 'a slower paced and more critically evaluated programme might have mitigated these issues; however, there were other political pressures at work requiring rapid demonstration of progress...this needs for visible success and the increasing requirement to demonstrate this according to narrowly defined metrics may have discouraged initiatives that would take time to demonstrate effectiveness' (23).
- In 2018 the Institute of Health Equity report *Reducing Health Inequalities Through New Models of Care: A Resource for New Care Models* also expressed similar concerns. Whilst the Vanguard models had a strong focus on integration, partnerships and multidisciplinary teams the different operational targets, outcome frameworks, budgets, operational cultures, professional practices, data and information systems did not enable accountability but instead were a risk to operationalising this integrated approach (4).

Whilst the new approaches in ICSs to address health inequalities are welcome, the current accountability mechanisms do not appear to be sufficient. The interviews with NHS staff and policy experts in Section 3 further outlines the shortcomings in current accountability mechanisms.

PREVIOUS HEALTH INEQUALITIES STRATEGIES IN ENGLAND

England has been without a national health inequality strategy since *Tackling Health Inequalities: A Programme for Action*, which ran from 2003 to 2010. The Spearhead approach was a part of the previous Labour government’s health inequalities approach. The Health Inequalities National Support Team worked in Spearhead areas, the most deprived 70 local authorities in England, seeking to reduce inequalities compared to the national (England) average. Spearheads ran from 2006 until 2010. A member of the advisory group that we interviewed spoke of their experience of the programme.

We gave (local NHS services) our appraisal and we said ‘this is where your strengths are and this is where you need to build’. This was the first time someone had said to them ‘this is what you are good at’... We weren’t performance management, not reporting back to centre, it was change management...It worked because you had to do it – it was a national requirement, a manifesto pledge to reduce the inequalities gap. We demystified what to do, people wanted to take action but didn’t know what to do.

In addition to the Spearheads, a number of other cross-government strategies contributed to addressing the social determinants of health: funding formulas redistributed services and power to poorer areas, regeneration and area-based initiatives were introduced in many areas of deprivation (Health Action Zones and New Deal for Communities), Sure Start centres were introduced in 1998 and the national minimum wage and tax and benefit changes sought to reduce child poverty (14) (24). One of the advisory group explained why the Spearhead programme would not be successful now “because there isn’t a coherent national approach”, such as the programmes above which all contributed to the impact of the Spearhead approach.

Figure 1 shows the impact of these inequalities’ strategies. There were positive changes until 2013 but then widening health inequalities between 2013 and 2015 after the Spearhead approach ended (25) and inequalities have continued to widen since 2015 (5). Barr et al.’s analysis of the inequalities strategy argued that the cross-government strategy that increased social investment proportionately in more deprived areas and population groups, as these approaches sought to do, reduced health inequalities. They stated there remains much to be learnt from the 2003-10 health inequalities strategy (25).

Figure 1. Trend in the gap in life expectancy between the most deprived local authorities in England and the rest of the country by sex, before, during and after the strategy, months, 1983-2015



Source: Barr et al. (25)

There have been independent evaluations of the Spearhead strategy to understand its impact. One assessment of the policies identified a number of areas of weakness. The Spearhead strategy:

- lacked attention to the structural determinants of health and relied on lifestyle choices targeting individual behaviours.
- shifted to downstream, individualised policies.
- failed to shift resources from secondary and tertiary services to prevention, early diagnosis and treatment in primary care.
- lacked performance management and lacked specific, relevant measures.
- did not target the gradient in health and focused only on the most deprived fifth of local authorities and included only a small number of drivers of health inequalities (26) (27).

Other research has argued that as the Spearhead life expectancy target focussed only on the most deprived fifth of local authorities, and did not tackle the gradient in health outcomes, and as only a small number of drivers of health inequalities were included, its impact was limited (28).

NHS England and ICSs should be mindful of these criticisms of the Spearhead programme, as they could be applied to the current ICS inequality duties and policies such as Core20PLUS5, which focus on inequalities related to access and treatment outcomes and in the case of

Core20PLUS5, focus on changing individual behaviours and downstream policies. These approaches are likely to have limited impacts on inequalities unless they are broadened out to address the social gradient and address the upstream causes of inequalities.

Whilst there have been no overall national strategies on health inequalities since 2010, inequalities have been addressed in other NHS Acts, such as the Health and Care Act 2022. The 2010 Public Health White Paper was based on the 2010 Marmot Review and accepted 5 of the 6 recommendations (except 'ensuring a healthy standard of living for all') (29). The current public health outcome indicators incorporate these social determinants of health (30). In 2012 the *Health and Social Care Act* placed duties on NHS England and Clinical Commissioning Groups (CCGs) to have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved, similar to what the current ICSs are expected to focus on. The *Public Health Outcomes Framework 2013-2016* included indicators related to the social determinants of health, but there has not yet been an assessment of the impact of the indicators and whether or not they increased activity and improved outcomes related to health inequalities. In 2015 NHS England published guidance for NHS commissioners on equality and health inequalities legal duties (31). This paper emphasised the need for CCGs to have 'due regard' to health inequalities issues but lacked any performance management or tools to evaluate or monitor how this due regard was being done or the impact it had on reducing health inequalities.

2 METHODS

Semi-structured interviews with the advisory group and senior personnel in the NHS sought to identify understandings of accountability in the NHS and in relation to health inequalities and the factors that can improve or obstruct accountability. Semi-structured interviews provide a flexible structure, allowing for further exploratory questions when appropriate (32).

Interviews with experts increase understanding of how complex environments, such as the NHS, function and how policy influences these structures (33). Interview questions were developed in partnership with NHS England and the Institute of Health Equity. The interview topic guide followed these questions and provided a flexible structure in the interviews (Box 1).

Box 1. Interview topic guide

1. What does accountability in the NHS mean to you? Who are you/do you feel accountable to?
2. Does it matter if you have a clear definition and adoption of accountability for health inequalities – is a definition helpful?
3. What drives change in the NHS? What drives change in health inequalities?
4. What good examples can you point to where the accountability arrangements supported change or good practice in the NHS?
5. If you do not implement policies related to health inequalities – what are the repercussions?
6. If you were developing the accountability mechanisms to address health inequalities in the NHS – what would you recommend?
7. Does current NHS guidance (or policies or mechanisms) improve or strengthen accountability? Have they in the past?
8. Does guidance acknowledge the complexity of reducing health inequalities?
9. Are statutory partners (e.g. local authorities, schools, prison and probation services), accountable for driving actions on health inequalities?
10. Thoughts on the role of agencies such as Care Quality Commission (CQC) and Audit Commission in improving accountability in health inequalities.
11. Any other comments.

The sample was purposive, we selected people with expertise and experience related to accountability and health inequalities (34). These interviewees were selected based on the Institute of Health Equity's contacts and contacts provided by NHS England. We also used snowballing techniques and asked interviewees if they would recommend colleagues to be included (Table 1).

Table 1. Job description of interviewees

Title	# Interviewed
Policy experts	4
Chief executive	3
Chief Medical Officer	2
ICS Director / Senior	2
Population Health lead	3
Health inequalities lead ICB (various job titles)	4
Total	18

Table 2. Regions of interviewees

Region	# Interviewed
East of England	1
London	2
Midlands	2
North East and Yorkshire	3
North West	3
South East	2
South West	1
Total	14

3 FINDINGS

3A. VIEWS ON CURRENT HEALTH INEQUALITIES ACCOUNTABILITY MECHANISMS

A study of local leaders in 2016 in the NHS found they understood accountability as something that is felt, rather than procedural mechanisms, such as imposed performance management mechanisms (35). Interviews revealed this to still be true. Interviewees spoke of being personally accountable to a range of stakeholders – their managers, the public, NHS England, their Boards. Almost all did not mention or identify targets or performance measures when asked how they felt accountable in relation to health inequalities.

When asked what inequalities meant in relation to accountability, all interviewees stated they had problems and concerns with current NHS approaches, stating accountability in relation to health inequalities was “pretty patchy, pretty uneven”. Others stated that accountability tools and levers related to inequalities are currently non-existent.

There’s a fake rhetoric around accountability now – we need to hold each other to account. We need to call out all that kind of stuff that are usually fake signals that people are raising a particular standard of accountability. The tools and levers are not in place for that.

I don’t think there is accountability on health inequalities. If you look at our ICS, there is a Prevention and Inequalities board. It’s not even one of the main (area wide) boards. It sits a few levels down, so where is the accountability?

We just seem to have made a complex system even more complex and lacking in clarity.

The 2022/23 *NHS Oversight Framework* mentions inequalities 4 times, twice in the context of ICBs and finally in terms of what the NHS England team will do:

The NHS England regional team will conduct the annual assessment, drawing on national expertise as required and having regard to relevant guidance. We will, in particular, consider how successfully the ICB has, in relation to its statutory functions...reducing inequalities (21)

The approach to inequalities in the 2022/23 *Oversight Framework* appears to have had an early impact on local NHS actions. The 2022/23 guidance is based on the 2021/22 guidance (36) and that required the NHS to address inequalities in waiting lists and reduce inequalities in access. In all interviews the NHS professionals stated they were addressing both inequalities in waiting lists and inequalities in access – suggesting that including these two issues in the Oversight Framework has influenced practice in the NHS.

ICS INTERIM STRATEGIES

All interviewees welcomed the requirement to have health inequalities in the ICS interim strategies and the inclusion of health inequalities as one of the four objectives of ICSs. They stated this has prompted a different approach to health inequalities and many said it could be a useful mechanism to improve accountability, though they warned these were only useful if other mechanisms continued to encourage accountability.

Having (inequalities) in (the core strategy) is absolutely fantastic and now we just need to live that rather than just have it as a piece of paper and then spend all the time worrying about performance assurance... They’re only a few months old and they’re kind of establishing themselves.

It is important that the NHS holds itself to account around inequalities.... we can't take the inequalities agenda and put it in the 'not now' bucket. It has to be core to what we're delivering as an ICS.

As a public health consultant, there's a part of me that jumps for joy that so many people have got on board and understand and appreciate the impact of wider determinants. But actually I also hear a lot of NHS colleagues thinking that leads them to wanting to just park their tanks on other people's lawns. By that I mean they've decided that the biggest factor is housing, etc. So we'll be getting on the Council's back as to why it's not sorting out housing rather than dealing with unwarranted variation and atrociously unwelcoming cultures within our organisations.

There was also concern that the words in ICS strategies would not translate into actions.

Now we're in this world of the ICS's. I'd love it if we said we hope that we'll see different models and experiences coming from different parts of the country...In 10 years' time we want you to show us that you have tried to do different things in smaller clumps of the population rather than try and micromanage 55 million people's experience. That would be quite liberating. Maybe there is an opportunity to take a liberated perspective to this going forwards because it's complex, adaptive longer term, multiple dimensions and local people might just have a better idea of what to prioritise going forwards.

Now you go in and they say, oh, yeah, inequalities are most important, most important and then it's about eighth down on the agenda list because they're still worrying about deficits and activity and waiting times.

People working in health systems have experience of policies making great commitments, but little real action occurring. When CCGs were asked to set local equity indicators as part of their five-year plan, there was little action. Research found most CCGs failed to set the indicators, and for those who did, the commitments did not lead to actions and the lack of quality accountability mechanisms meant 'it was easy to rely on one or two projects as evidence of their work on inequalities' (26) (37).

HEALTH AND WELLBEING BOARDS

Similar to the learning that could've been provided by Spearheads, the lack of research on the impact of Health and Wellbeing Boards (HWBBs) is a missed opportunity to understand which accountability mechanisms could be useful. A 2021 LGA survey of 59 HWBBs reported that they felt the HWBBs had a good understanding of health inequalities and the partnerships and data needed to address inequalities. However, there was no analysis as to whether this led to effective actions to reduce inequalities (38). Perkins et al studied five HWBBs and concluded: 'in the majority of study sites there was a clear lack of evidenced outcomes. Insufficient accountability, lack of strategic focus and weak or non-existent monitoring were cited as key factors. Instead, process issues were largely cited as outcomes' (39). Few interviewees discussed HWBBs; one interviewee, a member of the advisory group, stated that the new ICS structures needed to have better accountability mechanisms than HWBBs.

(Health and Wellbeing Boards) weren't held to account for doing anything...They were talking shops in the main. The joint and health well-being strategies, the one tangible thing they had to hold anyone to account, they were often just ignored or just didn't seem to register in the system...at the end of the day, it didn't matter. It just disappeared into the ether and no one, no one picked them up on it... They were just lists of what people thought they should be doing.

A study in 2019/20 of 13 responses to the 2019 *Long Term Plan* found a 'high level of commitment to the notion of tackling health inequalities, but lack of commitment to take action. This was demonstrated through a lack of concrete and accountable targets or actions' (40).

There is a similar lack of accountability mechanisms in other health strategies. A study of 14 obesity strategies in England published between 1992 and 2020 found few strategies had accountability measures: 24% of obesity policies had any details of a monitoring or evaluation plan and only 9% offered

any details about cost or included an allocated budget. 13 of the 14 strategies studied explicitly stated the need to reduce health inequalities yet 19% of all the policies proposed were likely to be effective in reducing inequalities, the authors suggest this is 'of great concern and... may explain why efforts to reduce health inequalities have also widely failed'. The authors conclude that strategies and policies need targets to be implemented, 'No matter how well-intended and evidence-informed a policy is, if it is nebulously written without a clear target, it makes implementation difficult, and it is unlikely the policy will be deemed successful' (41).

PERFORMANCE MONITORING: REFLECTING COMPLEXITY

Within the NHS what gets measured gets done.

An analysis of health inequalities policies in 10 European countries found 'clear targets and a system of impact assessment to demonstrate the quality and results of the actions and interventions are often missing' (12).

The NHS tracks performance to enable local and national systems to examine and compare their performance. Whilst the UK has some of the most robust health systems data - measuring activity, outcomes and processes - on its own this data is not sufficient to improve accountability or drive change. The European Observatory on Health Systems states 'performance measurement needs to be aligned with other aspects of system design such as financing, market structure, governance arrangements and regulation'. They provide examples of indicators to measure performance related to health equity: utilisation measures; rates of access; use-needs ratios; spending thresholds and disaggregated health outcome measures (42).

One of the advisory group, who has been involved in developing monitoring frameworks and indicators related to health inequalities, stated the NHS had only once included an inequalities indicator into its usual monitoring frameworks.

They've been lax to having inequalities built into NHS outcomes or other monitoring frameworks. Richard Cookson managed to get one indicator in - but then (NHS) dropped it, it was emergency readmissions for a particular condition. One could think of others that were distal, that was a very proximal indicator.

Many interviewees with years of experience addressing health inequalities said targets and performance measures were needed.

All the quality improvement work we do starts with big aims, the aims are supposed to be measurable. It feels difficult but you're not really doing it if it's straightforward. I like targets and data when they're about these sorts of objectives. It's very easy to say that but it is much harder to do.

It needs to be a bit of muscle in the system to back it up, whether that's through some sort of tracking policy tracking system, either regionally or nationally, probably regionally might be better, that needs to be part of the mix as well, rather than a lying wholly on what might happen at the local level.

Setting targets is sometimes a bit controversial, but does setting targets get people to do things? Not always, but it's important to set the target so that actually we're all driving in the one way and we get direction in one way. Setting targets at ICS level that looks at our overall population and then allowing the differences in the work to actually take place is important. I don't see why central targets are not a weapon. A stick to keep us to accountable - it only needs to be a few.

A Director of Population Health stated the current culture and approach to accountability in the NHS was not helpful.

The whole performance management culture of targets, accountability for target performance and sackings that that comes from a very flawed management theory called new public management.

Most interviewees supported targets of some form but stated clearly that targets could be easily manipulated, as such these measures needed to be more nuanced rather than blunt national targets.

If you tried to performance manage out of this, you would improve the performance and change nothing on the ground....(NHS England) need to say this isn't a nice add-on...there's so much to do, with waiting lists and A&E, it's a really good reason to do it. That might sound really naïve but I promise you the other way, performance way, we can all do that. We can all make that data go in the right direction without actually touching anything, it's really easy. You just clean the data up. It's so easy.

Metrics...need to be a balance of things that are achievable and aspirational.

It's a big stick, top down and performance management...There's a lot of game playing and plotting and scheming and lot of effort put into a complete waste of time to show that things are better than they were.

Look at the current state, you've got 4 hour A&E target, you've got ambulance standards, you've got cancer standards. If every Chief Exec was sacked for non-delivery of those, there wouldn't be any Chief Execs. So what are you now accountable for? At the moment, we would judge on improvement getting back to a standard.

Health inequalities targets need to be regarded with the same status as other targets, which means adequate funding and support from NHS England to address inequalities and time to understand if targets are being met, and if not, provided with guidance and funding to achieve these targets. An assessment of health inequalities in the USA found some evidence targeted policies were successfully reducing inequalities but also suggested good policy planning and effective programming could also be responsible for these successes (43).

The targets need to be followed by the funding and the consequence of not achieving them. if you said population health outcomes includes reduction of inequalities of whatever because currently improve population health outcomes hasn't even got any targets, it's just what the ICS is asked to do. What are your targets actually? Does that mean you're going to increase life expectancy?

We need sanctions but don't start with (punitive measures), look at the whole system, building relationships.

We could do with some meaningful targets around the things that we have influence over... I'm not opposed to targets but I just don't think they are necessarily always the answer, particularly at the minute in such tough times... It's partly a cultural shift...It can't be in isolation and (a single) health inequalities target.

Interviewees did not suggest specific targets to be measured, but they did discuss the difficulty in setting national targets.

How would we judge accountability for health inequalities? Would it be about healthier life expectancy? Would it be about core mortality rates? Would it be about smoking cessation rates? What would we be accountable for? Or would it be having a very articulate action plan responding to Core20PLUS5 where the NHS is able to say, this is what we need to do and other partners are able to say, this is what we need to do. It's a judgment accountability to a partnership.

Targets do help to focus the mind. There probably is a need for more demanding targets, reporting and also sharing of best practice. Building on the evidence base of what actually works in addressing inequalities rather than it all being a little bit of people's pet projects.

There's still a mismatch between the aspiration and the actual way in which people are monitored and held to account. The feeling is still that people are being judged against the quick wins and the quick fixes which come all too easy, they have a place but they're not the answer, they're not the solution, they are part of the package, the part of a sweeter list of interventions...Unless (people in the NHS) they think there's going to be real change to the way they're going to be held to account or held against the strategy for delivery of it, they're going to continue behaving the way that I've always done because they sense that things have not really changed that much. The structures have changed, but the actual culture remains pretty much the same.

What the national people do is they set targets of various lengths of time, but then they micromanage and they micro-specify. If they were to say 'in 10 years' time, we want you to have done X in relation to healthy life expectancy and Y in terms of reducing the gap between your most deprived life expectancies', then you begin to see action over a longer period of time. But what they cannot stop themselves from saying is 'you must measure these inputs in cancer services and children, and you must do this, this and this and then we want to report'. That's the bit that is exhausting the service, this drains people and it's lacking in trust.

The risk with targets is they get trumped by delivery targets that NHS England produces.

What you could be held accountable to is: having a plan using an evidence base being an effective partner, using information and publishing information in the public domain and listening to your communities and their perspectives on what makes health or what action would be timely and you could be accountable for your part in delivering a plan of action that came from that - that's all very tangible.

Interviewees wanted to be held accountable, for NHS England to come back and see what they have done. Interviewees frequently stated NHS England did not ask them about inequalities.

Very, very rarely does anyone ask you 'What's happening in the data? What do you understand that to mean and what does that mean for the next steps?' That's a really rare conversation.

All interviewees but one said there were no repercussions if they did not act on health inequalities.

There's no consequence to not doing this at the minute... There should be a consequence.

There needs to be something about how the Integrated Care Strategies are really going to be used by the ICB... It's unclear where responsibility lies. The mechanism of the strategy could be a way of bringing those different bits together and then ensuring there's action taken or if there isn't, why not?

Over-optimism in policy development

The NAO studied public policy and stated the ‘tendency to be overly optimistic leads public bodies to underestimate the delivery challenges of what are often complex projects’. Complexity in projects is defined as: having multiple stakeholders, being interlinked or relate to other major projects, and dependent on organisational or citizen behavioural changes (44) – all factors relevant to reducing health inequalities.

Factors contributing to over-optimism:

- 1. Complexity** – Underestimating the challenges in delivering projects and incorrectly assuming local ability to deliver (both in terms of skills and capability). Policies not set in context of local realities.
- 2. Weakness in evidence** – Poor data and modelling techniques and lack of independent/ expert review and no or little data/experience from similar projects.
- 3. Failure to involve stakeholders** – It takes time to identify, align and engage local stakeholders particularly when the topic is complex or involves new ways of working, such as with health inequalities. Whilst the NHS has no powers of accountability over external organisations such as local authorities, the voluntary sector and businesses, it is important to have formal partnerships with these key stakeholders and develop actions where appropriate.
- 4. Lack of independent challenge and accountability** – The NHS, at national, regional and local levels, has carried out internal evaluations of health inequalities and these reports should be made publicly available to increase transparency.

Central government can be ‘over-optimistic’ in expecting local systems to change and as such, accountability mechanisms should consider the complexity of policies. A study of experts from four countries concluded assumptions that the policy process is a simple linear progression is ‘not appropriate. It is not effective for governments to simply establish a particular agenda or policy intention, develop a policy response and expect policy to be implemented’ (45). Despite the number of times academics state ‘health systems are complex’ policy too often continues to fail to reflect complexity. Failing to reflect complexity affects the ability of organisations to achieve policy outcomes (45). Reducing health inequalities requires cross-government and cross-sector collaboration, which will differ in each area in England. Hunter and Bengoa argue ‘this demands a new emphasis on how to change, not just what to change and should be at the core of strengthening policy capacity’ (46).

FUNDING AS A TOOL TO IMPROVE ACCOUNTABILITY FOR HEALTH INEQUALITIES

The World Health Organisation state financial accountability can be used to reduce health inequalities (47). By tracking how funds are dispersed, central NHS systems could use funding systems to monitor outcomes and activities related to inequalities. However, the current NHS funding systems impede accountability in relation to health inequalities. The dependence on short-term funding is in contradiction to the copious evidence demonstrating long-term approaches with longer-term funding is needed to reduce inequalities (5). Interviewees spoke of their frustration that the DHSC persists

in depending on short-term funding. Their plea echoes others, who, for many years, and across government departments, have asked and implored central government to shift from short-term funding programmes to longer-term approaches.

Maddening flurry of short-term funding, for which we are invited to bid with next to no notice for paradigms that often make no sense.

The NHS have a lot of data, they know what a lot of the issues they are, they can see across all of the systems what the problems are. They could give a specific amount to spend on a specific thing rather than creating the last-minute requests as we do.

As stated earlier, the NAO have stated short-term funding pots fail to address the planning needed to address complex problems, such as health inequalities, and also contribute to over-optimism amongst those making policy (44).

We've got various bits of funny money coming in at different points all the time at the moment. It's a bollocks approach to health creation. It's like supermarket sweep, you've got a minute to run around the supermarket – that's not going to promote accountability that's going to promote irrational knee jerk actions... That doesn't lead to any systemic actions, it just leads to initiatives. You can create accountability for your little initiative but you're not doing anything in depth.

I cannot help but feel we're in a silly game, I can only think short term funding is there for Ministers to look good so they can announce they've put eggs into a particular scheme, by the time it's broken down, scattered across the systems, it achieves very little. It's often underpinned with a paradigm that ties you into a way of working or a way of viewing the world that might not suit or might be just wider than the mark, that's just replete across the system.

The fact that funding is not recurrent and is so dependent on short-term pots means it cannot be used as a tool for accountability.

If (funding for health inequalities) survives the budget, it's not enormous, not loads, but it's not nothing. If it was recurrent, we'd really have to go, right why are we spending there?

Interviewees wanted consistent and longer-term funding that would enable them to shift from project-based interventions to funding core infrastructure to better address inequalities.

What we need is core infrastructure funding... It is fairly classic in the NHS that money arrives sort of out of the blue for something you weren't quite expecting and you have to rally round and put something in place fairly rapidly or you're going to lose the money.

Previous funding approaches have sought to shift from short-term pots and adopting sustainable funding formulas.

You need proportionate universalism...a lot of countries are not good at that but the NHS, in terms of resource allocation, can be. A project led by Richard Murray (with) additional funding and premiums paid by the NHS to areas to health authorities. We spent a lot of time developing this formula for extra funding (but) what went wrong? Scale and intensity – there wasn't enough money to shift the problem. NHS resource allocation used to have an inequalities element but it has been eroded, undermined by other factors.

The following ICS lead on health inequalities, with many years of experience, illustrated the effect of this approach:

That pace of 'here's a funding opportunity' - some of it's nonsense. For example... Nice approved guidance for an intervention that was going to reduce health inequalities but, by and large, it took you down a of a pharmaceutical intervention route that most people weren't looking at that (approach). Then you end up with mealy mouthed interventions, pretending black and white are grey. The relationships and the dialogues are really ineffective and immature.

One interviewee stated that when funding streams specifically tackled health inequalities, it was a tool for staff to show their colleagues the NHS was taking the issue seriously.

Money makes a difference, even small amounts of money. Saying we're going to fund a health inequalities program, who wants to bid for it? It also draws attention and shifts the culture about the things that are important because these are the things that we're funding and we're asking you to think about.

RING-FENCING FUNDING – A BETTER MECHANISM?

Proportionately increased funding in more deprived areas has been found to be associated with reduced health inequalities (48) (49). NHS England adjusts its allocation formula as part of its commitment to reduce health inequalities and adjust for unmet need. The weighted funding formula is 15% for primary care allocations and 10% for ICB core allocations. The unmet need allocation is under review and alternative methods for calculating it will be published in 2023 (50). In April 2022, NHS England announced a further £200 million was allocated to each ICS as part of their health inequalities allocation. There were no requirements on how to spend the funding but the briefing stated the funding should 'help systems to maintain work to reduce health inequalities, such as the Core20PLUS5 approach, while achieving financial balance and elective recovery' (51). The briefing states the funding will be recurrent, however, none of the interviewees understood this. The funding is recurrent and has been incorporated into the ICB baseline (which has the benefit of being uprated each year and not fixed at £200M). In the 2023/24 online allocation spreadsheets for ICBs, it is identified as HI funding available.

Many interviewees referred to this additional funding as an example of the absence of funding-related accountability mechanisms. Of the eight areas interviewed, representing roughly one in five of the ICSs in England, none had spent this funding solely on health inequalities.

What was really unhelpful was the pressure to spend it fast which meant that we didn't get to engage. It wasn't that much money, but the spirit that it could have engaged - we could have come around as new ICP partners and gone 'Right, these are our ideas' and sharing would have been much greater than the actual amount, but instead what happened was there's a certain amount of money you've got to spend it by yesterday. We find something to spend it on, we went out and found some stuff that was already there that matched health inequalities, it wasn't disingenuous. It was health inequality stuff, but it's just a bunch of bitty little stuff.

We received £2.1 million. I made a proposal we hold it within my health inequalities group and that we come up means of using the money. We managed to hold on to £600,000 and the rest of it went straight into filling the black hole. Now I can barely access the £600,000 and anything that hasn't already been committed is going into the black hole... We end up with scant resource in the pot for dealing with health inequalities, despite having £2.1 million. ... (It's) positive that the money was made available, but it seems to be widely accepted and understood that it will be raided to deal with the financial pressures.

Most of the interviewees did not know the funding was coming, this affected what they did as the short notice meant they were not able to identify how the money could be best spent.

That's got to be an accountability issue - that (DHSC) can say they've given this money... Maybe what we should have done is we should have just looked at that money and seen where it went because that would tell the story of health inequalities - *what it wasn't spent on*.

There's a natural progression that's to take place before a really smart use of that funding could take place...we're still in the forming, norming, storming stages of getting to a point where we can really, intelligently take that money and do some clever things with it, I suppose it comes back to the accountability question...the local authority grants around public health was ring-fenced for a number of years and but still inevitably got sucked into social care and other things. So we're kind of going through that same process.

For a senior lead new in post and with little experience of inequalities but years of experience in quality improvement, they were unsure what to do with the funding and thought they would have to give money back if not spent on inequalities, as they would have to do for other issues.

(DHSC) could easily call for it back, what they have to see is what they get for the money... Going forward I think that it is really important we think about how we demonstrate we've addressed health inequalities. I think you have to have a common methodology; I've been working in quality improvement for many years. I think you have to have a common methodology across the whole system that everybody is engaged in the same way.

This funding process hindered what could have led to ICBs developing mechanisms for better partnerships, identifying and creating local structures needed for a more engaged and integrated way of working to better address health inequalities. NHS England provided funding, which was welcome, yet its funding structure did not appear to consider accountability as part of the process. As such, local systems stated they received funding, but much of the funding ended up spent in other parts of the NHS. Without any accountability structures, the funding is meaningless. For one health inequalities lead, this health inequalities funding might as well not have been given.

It would be easier if we could just collectively get the money, be allowed to spend it rather than you come towards the end of the year and you can have 100 here and 80 there...(the funding) is just not helpful...when you're in a situation as we are now with the inception of the ICP's - we're trying to get some structures and some kind of assemblance of order in place.... You're frowned upon if you don't go for the money.

Reflecting on the process of applying for this funding, interviewees stated ring-fencing would improve financial accountabilities in health inequalities.

(In addition to funding) what was missing was following through and guidance - what's the point of giving them money? What would they spend it on? You need to say, here's money, and make it ring-fenced for addressing health inequity, effective interventions on health inequality amid a portfolio of upstream and downstream activities...You need funding and you need some guidance on how to spend the funding and you then need to monitor.

For the people who set the principles, the policy and the drive - we need your help in terms of determining that drive and ring-fencing and devolved budgets that purely look at health inequalities. The argument will be 'we've done this' and 'we've done that'. (But) it's peanuts.

At the minute (health inequalities) money is not even ring-fenced. It goes into the bottom line. It needs to be ring-fenced into a bigger pot with the local authority to prioritise one or two key areas.

Giving local systems the tools and time they want

The short-term notice to spend funding linked to health inequalities frustrated many interviewees. Many stated they “felt forced” to fund small projects they would not have chosen to fund had they had more time to decide what to do.

- “One of (our) first jobs is to distribute this money and figure out how the hell do you address health inequalities? But given the culture, there’s no kind of a method, no kind of a building up that system...There’s a bit of this a bit of cart before horse.”
- “It came unannounced with no caveats on its usage or requirements which makes it even easier for colleagues to take it to use it to shore up the funding gap. Not knowing it was coming means you can’t prepare for it and set up things in place so you’re immediately on the back foot.”
- “I was unaware until money arrived in the ICB’s bank account that there was an allocation for health inequalities. I would have thought someone locally would have cascaded it if it was known. As far as I can tell, I there’s no guidance. It’s not rocket science, if the NHS is talking about a framework of Core20PLUS5 and it’s just given us (amount) you’re going to expect to see something out of that funding that impacts on Core20PLUS5. You’d be a fool not to join up those dots but it’s not stated, not made explicit.”

The funding appeared to let local systems decide what to do locally to address inequalities however, many felt obliged to fund only actions related to Core20PLUS5. They wanted to address health inequalities within the NHS but also to use funding to address the causes of these inequalities but felt the short-term nature of the funding did not allow for these actions to be funded. Others referred to allowing systems time and providing guidance to find approaches to implement Core20PLUS5.

- “Core20PLUS5...people went ‘Alright, now I know what I need to focus on’. But not really. Because whether it’s cardiovascular disease, maternity or mental health, whatever it is, end of the day there are a number of determinants of inequality and we need to address them, and we need to address them with other partners. We can never do this on our own.”

LEADERSHIP CREATING THE CONTEXT FOR CHANGE

The NHS Leadership Academy states holding individuals and teams to account is important because it focuses ‘people’s energy, give(s) them the freedom to self-manage within the demands of their job, and deliver(s) improving standards of care and service delivery’ (52). When introducing new policies and approaches, such as an enhanced focus on inequalities, leadership is ‘essential for creating an organisational context conducive to change’ (53). Interviewees stated strong leadership was an important part of gaining support for new policies, but they were also clear that this could not be the only accountability mechanism used to encourage and inspire their staff.

You can’t just rely on strong leadership.

You need (leadership) but it can’t be the only thing you rely on.

We can’t rely on (leadership) solely. It needs to be a bit of muscle in the system to back it up.

They stated that it was important to have more than leadership because otherwise politics and personal agendas could influence actions on health inequalities.

There is a real risk that looking at inequalities has been seen as worthy.... Making the economic case, that in order to reduce waiting lists, in order to get capacity in the NHS we need to tackle the inequalities in our society, that is how we will solve this problem. Trying to speak to the motives of some of the decision makers in government.

(Health) is a political football. See what catches the headlines, people not getting cancer treatment? Or more money being pumped into living conditions for local people? (We need to) prove if you concentrated more upstream you're going to get less cancer patients coming in and you're going to get less cardiovascular disease.

The lack of a defined role for public health professionals was discussed by interviewees as a potential barrier to accountability. Many referred to finding ways to include their public health colleagues as despite their expertise, they were not part of the NHS' existing health inequalities accountability mechanisms.

It doesn't work from an accountability standpoint because the health system is not, cannot be held responsible for solving this problem. Public health actors really should be accountable for ensuring the public health and the equity of public health in their catchment area.

Public health people are having a real identity crisis, my goodness, population health is now everybody's business. There is definitely tension around about who does what bit, what are the wider determinants of health, because we thought we all knew what they are. But now we've got different dialogues developing depending on whether or not you're speaking to public health.

In one of the areas, public health consultants were jointly appointed and jointly funded by the ICB and local authority.

Those posts are just brilliant because they straddle, they're part of the senior leadership team of the ICB and the local authorities. So they do a lot of that knitting that perhaps is missing elsewhere.

DATA: THE SHIFT FROM DESCRIBING TO EXPLAINING AND EXPLORING

In their analysis of how data can help the NHS to better address key issues, the Health Foundation argue better data linkages and new ways of analysing data can 'can help NHS commissioners and providers measure inequalities, understand their causes and allocate resources more equitably' (54). The 2022 DHSC policy paper *Data saves lives* also emphasised the potential of data-sharing and linkages to hold systems to account for their actions to reduce health inequalities (55).

The *Health and Care Act 2022* includes the requirements to publish inequalities data for ICBs, Trusts and Foundation Trusts. In addition, NHS England is required to: 'publish a statement about use of information on inequalities in access and outcomes, setting out the powers available to bodies to collect, analyse and publish such information, and views about how the powers should be exercised' and 'NHS bodies should publish annual reports describing the extent to which NHS England steers on inequalities information have been addressed' (17).

Interviewees stated using data differently and more intelligently was a key tool to improve accountability on health inequalities.

I think there's a belief in NHS England that one of the big problems is an absence of data - they're wrong, from top to bottom. The belief that goes with the thing about data is if there were more data, there'd be some magic data that would give you a solution and we would show you a problem you don't know about. By and large the problem isn't data - it's what you do with them.

Public Health England... have all the data...they know what is going on in places, but they never used it to help people tackle those issues. There's the evidence base - NICE, LGA are doing all this stuff, but they're not joined up in a way that can then focus on what needs to be done.

The NHS collects a lot of data that we use for reporting on performance managing contracts, sorting out payments, etcetera, but we don't consistently use that data to understand our business and to understand who's coming in, who's not, and what point are they coming in.

Throughout the interviews, local areas showed they were analysing local data to take actions to reduce inequalities in the NHS, without guidance or support from NHS England.

We just did a basic piece of work with one of our analysts in the Trust which was 'can you tell me the rates for patients not attending appointments - the so-called DNA?' The average Trust rate at the time was about 9%. Because we collect demographic information about patients we then said, right, give me a gender split, give me ethnicity split and then can you give that to me by deprivation deciles. When we played back the data your average DNA rate is about between 9.5% and 10%. When you look at that by socioeconomic status, DNA's in your most affluent areas is 4.3% and DNA is in some of your most deprived communities is almost 18-20%. You play that back to colleagues and they're like 'oh right, well, we'd never looked at it that way'. I think one of our highest DNA rates was about 28% for one of the paediatric pathways. Kids do not DNA, so what drives that? How can we get to understand that? Is it about how we are structuring services?

Interviewees did not discuss or reference the new health inequalities improvement dashboard.

Interviewees spoke of Public Health England's (OHID's) approach in relation to data, which could hold local systems to account, but not by reprimanding or punishing systems.

Public Health England had the data but it never held local authorities to account in a way that might have been useful not in a punitive way, but simply to demonstrate where things were happening that were interesting and where things were not happening and why. But they didn't do that.

PARTNERSHIPS, INEQUALITIES AND ACCOUNTABILITY

Reductions in health inequalities need to be achieved in partnership, yet policies and accountability mechanisms rarely address this problem. For more than a decade, researchers have argued that the NHS' accountability systems need to acknowledge the role of external organisations: 'only when all sectors are held accountable for their contribution towards these targets can population-wide approaches to public health be suitably valued' (56). If many stakeholders are responsible for addressing inequalities, then who is to be held accountable? One member of the Advisory Group stated the ICB should be accountable, in their coordinating role.

The accountability should be about the whole system, not by individual agencies being held to account, the whole system being held to account, which is the ICB board. Then the different partners have to play their part in implementing or committing to those bits that they can contribute to. People are still caught in a lot of tunnel vision around individual agencies being held to account rather than whole system held to account, that's going to be time to break out of that mindset.

The difficulty of holding external bodies to account to address health inequalities was a common theme in interviews. The NHS did not have the levers to address the causes of health inequalities the health system was treating.

We are not accountable for the poverty and poor living conditions in our communities. That's where your push and drive and visioning fall down because we're not accountable for the fact that, for example, in our travelling communities, average life expectancy is 60. As an Integrated Board we should be accountable. The fact families are living in damp conditions, damp housing – we know at some point one of these families will come into one of our hospitals with a respiratory condition or a cardiovascular condition – we know that. The fast foods and crap sold in our communities has an integral effect on health and wellbeing of our population but we're not accountable for that. The local authorities hold some accountability, opening kebab shops instead of fruit and veg.... we need to be made more accountable in terms of living conditions and people's lives.

A Director of Population Health with many years of management experience discussed how accountability related to health inequalities was difficult because it involved the considering the causes of health inequalities.

That old analogy of people falling into the river and having to be rescued – it was one of the first things I was ever taught about public health/population health. The NHS is rescuing people out of the river when they're sick and hasn't moved upstream to find out why they've been falling into the river in the first place. It's a really powerful metaphor for what we're doing to prevent and anticipate and deal with people who've got disease. I wonder how we apply the accountability word to that analogy? Do we need to be accountable for rescuing people in an effective and efficient way? Yes, we do. There is an accountability for the delivery of high quality, safe and affordable services. That's the downstream bit that most NHS chief execs would accept. What's the accountability for stopping people falling in to the river? The bridge builder? The lifeguard? The first responder? When some of those reasons people fall in are linked to background, ethnicity, education, employment, the analogy doesn't help us does it?... I think there is a little bit more about that accountability upstream.

You can't hold organisations outside of NHS to account.

There's lots of rhetoric around ICSs... a lot of other parts of the system have accountability lines that run elsewhere. We have this murky ground, in relation to health inequalities, to care more widely but what would be appropriate accountability for the NHS? Making it a requirement of health providers or the wider ICS partnership? What jurisdiction does NHS England have to place on other parts of the ICS partnership?

Interviews with health and social care professionals in North England in 2019 and 2020 found the cuts to the social determinants of health prevented their ability to reduce inequalities poverty and these budget cuts also hindered the ability of local organisations to work together (57).

If we really want to address health inequalities, we need to operate on a number of fronts, different timelines, different time horizons. In the short term, we might look at unwarranted variation and the culture of system provision that is one-size-fits-all, which exacerbates people's access and experience and hence, their outcomes. We say that's only part of the inequalities agenda and if we were to really be looking at addressing health inequalities we need to look at those wider determinants.

The NHS itself acknowledges the difficulties of adopting collaborative approaches. A review of leadership in the NHS in 2022 concluded collaboration was ‘the bedrock of effective system outcomes’ yet these approaches ‘are not always encouraged or rewarded in a system which still relies heavily on siloed personal and organisational accountability’ (58).

It’s not a single intervention, it’s working together, it’s not that the community needs lots of monies repurposing it, but having groups of people across sectors to come together. There is nothing that supports that...that is the problem, policies that support the coming together – that would be great and that funding that needs to go with it.

A member of the advisory group suggested what was needed to improve accountability in partnerships.

Tools, resources and the ability to bring people together and demand accountability, to make a plan that says ‘transportation you need to X, then you need to Y and you need to do Z. The NHS (needs) to say ‘in 6 months I want to see how you’ve spent the money and what your preliminary outcomes are?’ The NHS (should) have not only a convening role, but a role to really crack heads if outcomes aren’t achieved.

Others were unsure what to suggest, but all agreed, the current mechanisms did not facilitate or encourage accountability in partnerships.

For example, improving mental health in young people...(NHS) can help...by making sure the waiting times for being seen are shorter, that will contribute positively, but it doesn’t really tackle all of the determinants that will impact on somebody’s mental health. It’s a really complicated notion of accountability... What is the contribution that the NHS could make that will help progress this?

There is a danger that the NHS can jump in and start tinkering with housing policy and economic development when in actual fact they don’t have the levers for that.

Many interviewees were clear – the reason why health inequalities were not reducing was not due to issues related to accountability but to the failure of policies to address the causes of health inequalities.

The question of who is responsible for solving the problem of health inequalities and making local systems accountable... it’s actually very problematic because health inequalities are the result of a really wide variety of factors in society and the economy and the political system over which local health systems have virtually no control...Local health systems cannot solve the problem of health inequality because they are fundamentally not about health care. The extent that political leadership is asking local health systems to solve the problem of health inequalities is, in a very real way, passing the buck, national political systems passing it on to local and regional health systems...This is not a uniquely English problem at all. There is no way for the actors who you’ve made responsible for this problem to solve them. These are problems that have to be solved by national level political leadership.

Other interviewees were as bold, stating health inequalities policies were bound to fail because those responsible for delivery policies were not accountable in current health system structures.

Health systems are going to fail because the health system that they have made accountable for solving this problem do not have control over the policy levers that we know create the bulk of inequalities in health and well-being.

Accountability for achieving what or doing what? What are we going to do to address health inequalities when many of the major levers for change are held nationally?

Nordic approaches

In Sweden, an intersectoral approach has been adopted to reduce health inequalities. This approach includes schools, social services, elderly care, and health and care working together. Interviews with policy-makers finds they accept that to reduce health inequalities, they must adopt horizontal integration. Their monitoring involves a series of indicators that directly or indirectly affect health and the social determinants of health (59). For example, indicators they have used and their related successes:

- Self-assessed health – aged 16–84 has increased by at least 3 percentage points and differences between different socio-economic groups have decreased.
- Sedentary leisure time – aged 16–84 has decreased by at least 5 percentage points and differences between different socio-economic groups have decreased (46).

In the early 2000s Norway adopted national and local (municipal) approaches to address the social determinants of health and social inequities in health. These policies are situated in the lens of 20 years of national policies improving equity, solidarity and universal services. Researchers analysed whether local teams were the actors implementing the national policies and they found the different national and municipal political agendas and priorities hampered multi-level action for health equity (60).

Cross-government approaches improving physical activity

The National Audit Office (NAO) reviewed government approaches to encourage grassroots sport and physical activity and their findings provide many similarities to health inequalities. Physical activity rates have increased but not in the target groups that Sport England have sought to improve; people from lower socio-economic groups and women aged 16–60.

Policies to improve physical activity are found across government departments yet when collaborations happen, they tend to focus on specific strategies and are not general collaborative approaches such as joint – policy making / implementation. In addition, the NAO stated funding was not reflecting need. Despite plans to fund areas of high deprivation ‘the share of local grants awarded to the most deprived local authorities was less in the five years from 2016-17 the previous five years. The NAO stated that evaluation and monitoring processes were needed yet in June 2022 ‘the Department and Sport England (had) yet to produce a robust plan for monitoring and evaluating the effectiveness of their approaches for the future.’

Many of the recommendations in this report on physical activity are also relevant for NHS England to improve accountability in its work on health inequalities, as highlighted in the recommendations below. The NAO recommend Sport England:

- ‘Set out how it will lead delivery of the objectives and outcomes for sport and physical activity that it shares with other departments. The Department should clarify its plans for leading and influencing cross-government efforts designed to sustain its objectives and ensure better whole-system working. This should include, for example, establishing with the Department for Levelling Up, Housing & Communities how to tackle the challenges facing public sector facilities.’
- ‘Check that its distribution of funding supports its objective to target lower socio-economic groups. Given Sport England’s aim to reach lower socio economic groups as part of its objective to tackle inactivity, it should review whether its mechanisms for allocation and distribution of funding fully support this aim.’
- ‘Exploit its networks to identify and share findings, themes and learning from its work that could accelerate greater collaboration across the sector. Sport England should use its insight from its research and evaluation, including its learning from the COVID-19 pandemic, to highlight common challenges whereby organisations it funds can learn from each other, such as approaches to reaching deprived communities and tackling inequality (61).’

SHORT-TERMISM AND ITS IMPACT ON ACCOUNTABILITY

Systems are expected to be held accountable yet, as Hudson et al. point out, politicians ‘tend not to be held accountable for the outcomes of their policy initiatives’ (62). They point out politicians move on to other positions or move out of politics, as such, they tend to like policies that lead to short-term results instead of dealing with more complex problems, such as health inequalities (62). A study of the NHS inequalities targets found the pressure to demonstrate rapid improvements led to actions that led to short-term ‘quick wins’, mostly targeted pharmacological treatment for ‘at risk’ population groups, rather than more comprehensive system-wide approaches (63). Interviewees said that the use of targets that emphasise short-term impacts will continue to see the use of interventions that are ‘quick fixes’ such as social prescribers.

Health checks and social prescribing are often seen as quick fixes, and then we can get NHS England off our back, that’s breathing down our necks.

The NHS is a large, complex organisation. Policy-makers need to consider that making changes takes time, there are substantial organisational change complexities and each area in England is different. Each local authorities will have a slightly different starting points for apply an inequalities lens to their services (64).

The problem is that different places are at different levels, even within one ICS. In terms of maturity and accountability, one place is different from another place...Care and services are provided at the level of neighbourhood and built around individual communities, rather than what would be usual at the NHS - building huge systems and then expecting communities to go to the systems we’ve built. We’re trying to think about how do we base (health inequalities) at a level of neighbourhood and place.

With health inequalities we’re going to struggle to have meaningful metrics that we can track in the short terms. We don’t really know which levers to do in the short term.

Taking generational action as well as taking action in the very short cycles of change - that has a bit of an impact on accountability. Some of the CORE20PLUS5 work needs to be tracked over 10 years. People still refer to Wanless, that’s 20 years ago this year, but I bet nobody really tracked what actually happened off the back of it.

Some interviewees were optimistic that ICSs could improve accountability in relation to health inequalities, though they were all clear, time was needed to see if the approach would be effective.

The monitoring system used by the NHS and NHS England focuses very much on acute care and not really on issues around health and equality. The Integrated Care System should be aware of changing that mindset, but whether it will or not, I think it’s still early days.

Weaker mechanisms driving accountability

The 2012 *Health and Social Care Act* introduced legal duties for Commissioning Boards and CCGs to have regard to the need to reduce inequalities, in terms of access and health outcomes of patients. Two legal requirements are also legal duties and act as accountability mechanisms related to health inequalities, the 2010 Equality Act and 2012 Public Services (Social Value) Act. The Equality Act 2010 states that public sector bodies 'must, when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage' (65). These duties, however, were not mentioned by interviewees as accountability mechanisms in relation to health inequalities. Nonetheless, these two Acts influence ICSs. For example, the themes in the Social Value Act are reflected in many of the actions to improve the NHS' role as an anchor institution.

Another mechanism infrequently mentioned in the interviews were health equity in all policies approaches. Only two members of the advisory group suggested it could be a valuable tool for accountability but it was not discussed by the other interviewees.

- "Health in all policies...as well-intentioned as this may be, ultimately it often devolves back to asking the health system to do things, particularly at the local level, with insufficient resources and insufficient policy levers, because the big Ministries - Finance Treasury - are never asked to do their job. So, sure, you'll ask Transport, you'll ask Housing, you'll ask Environment to engage in health in all policies, and call that a political commitment to reducing health inequalities. But if you're not willing to get the Treasury or Finance in them, in on the act, then you're not going to achieve your goals."

Another member of the advisory group stated health equity impact assessments have limited value and they:

- "Have to be used by people who have the right mindset to think about how they can be used in a context of a whole system".

3B. THE TOOLS TO SUCCEED

If you want me to succeed, let me have the tools to succeed.

One senior manager with little direct experience of reducing health inequalities said it was their own personal responsibility to be accountable for their staff to address this issue.

To be honest, it's me building the conviction amongst my team and amongst the people I came in with and getting that working right across all system. The most important thing for me is not a carrot or a stick, it's actually seeing the impact on our local residents. I think there's a lot of people that I've got working with me that are really committed to making a difference for our residents.

However, other senior managers, with more experience in health inequalities stated specific accountability mechanisms were needed otherwise it was too easy to demonstrate accountability without it actually being useful accountability.

When people say accountability for financial management, what they really mean is don't overspend. When you're accountable for inequality - what? What do they mean? The right culture? Learning? Organisation? I think often the thing about accountabilities is it's just a big phrase.

Currently they ask 'do you do anything'? It might be as big as that on inequalities. We've got policies and all sorts in the Trust, so we can always show them those. It needs to be more specific about what they're looking for.

Health inequalities is such a broad and varied area - the accountability must be defined specifically and passed to the system in a specific way. Otherwise, it's too easy to say it's happening.

At the moment there's been a definite attempt within the health inequalities area to lighten load on us locally, reduce the monitoring burden, they created templates and pre-populated them for us...I'm not sure it adds up. We're not really being very rigorous in the monitoring. We're ticking boxes and counting activity, but not in a very robust way measuring impact. I'm quite happy to join in the delusion because it's less burdensome.

BETTER GUIDANCE AND SUPPORT AND TRAINING

Interviewees were clear that the NHS was accountable for reducing differences in outcomes to reduce health inequalities. They agreed this was a key priority arising out of the ICS objectives, however, they did not yet have the tools to do this immediately. Local systems were in the process of identifying inequalities and analysing data.

They wanted guidance from NHS England or other NHS bodies on how to reduce the inequalities and variations and budgets to address these inequalities. They did not want another plan telling them to address inequalities, instead, they wanted support to reduce these inequalities and mechanisms to ensure these actions were taken and funding spent on inequalities.

Improving or trying to address health inequality, that's the bit that often isn't spelt out.

I do not see how addressing unwarranted variation is consistent with chasing numbers and reducing waiting lists. We have a delivery model that is set up on numbers and quantity of service and if we want to address unwarranted variation as a contribution to health inequalities, I cannot see how we do that without there being a hit on efficiency and even greater pressure on waiting lists because we would be acknowledging some people need more time.

For the centre, why not have a period of engagement and conversation about what do we mean by addressing health inequalities? What could we help, meaningfully do at the centre? What should we be asking of you locally; we need a more adult conversation around this. It would be time well spent and invested in. Part of the focus would be the specifics of health inequalities and part would be a cultural exploration and journey about how we might work together better.

It's like health inequalities, we're going to do something about making somebody live longer in 20 years' time - it's not real enough. (NHS England) can come up with valid enough proxies to measure, to repeat, that sequence of personalisation in order to reduce the burden of navigation, to reduce the burden of access and burden of use of services in order to impact health inequalities.

Accountability for inequalities has to be around guidance and minimum standards which we've not had.

Where's inequalities in the NHS System Oversight Framework 2021/22? If you're in category 1, you're left alone, if in category 4 can't do anything without permission, I don't think there's anything about inequalities in that.

Better policy implementation in the NHS is part of improving accountability in the NHS. Implementing evidence-based policies is not a simple, linear process and a number of factors influence whether or not they are implemented:

- Middle managers play a key role, in particular, deciding which staff should undergo training in the new policies. A review of evidence-based policy implementation found lack of training and development were key barriers to implementation success (53).
- Not giving staff time to implement new evidence-based policies and instead continuing to deliver what has already been done. New policies require the time needed to adapt working practices (64).

The review of obesity strategies suggested that to 'increase the likelihood of policies being implemented, governments should accompany policy proposals with information ensuring they can readily lead to implementation, such as a clearly identified responsible agent, evaluation plan, and time frame' (41).

What we want (NHS England) to do is make our life a bit easier by doing some really radical things that reduce that over time - because the NHS isn't going to change quickly.

LISTENING TO AND TRUSTING LOCAL SYSTEMS

Interviewees pointed out only examining how accountability was implemented did not address the causes of poor accountability.

You realise, don't you that you're opening up bigger things than just accountability here. I wonder whether what's going on here is to get to accountability, you need to address issues of complexity and trust, time and scale. If someone wants to keep the answer to this question narrow, it's a very different answer they'll get than if they're prepared to consider some of these things in a broad scope.

Interviewees stated accountability should be part of the process of working with local systems to improve outcomes.

If the accountability is showing great levels of deficiency and inability to be held to account because things aren't happening, then accountability is not leading to any accountability... you've then got to ask, why is that so? Accountability is only a way of opening the door, opening the window to what's happening.

The issue of trusting local systems, ran throughout the interviews. The most consistent plea from interviewees was to create trust and feedback loops so that NHS England can consistently be in communication with those on the ground.

Do (NHS England) talk to a culture of trust or control? I think they talk to one of complete overcontrol. I find it really sad, there's all of this talk of empowerment and systems... There's the rhetoric of empowerment and enabling and just an overwhelming cascade of stuff that we are required to do.

The system is under so much pressure that we've got to have an element of trust and partnership, otherwise we will all fail.

Whatever the national level policy is, people implementing it need to be talking to each other on the ground level to make sure that it all makes sense together. You need to have feedback loops from them going back up to the national government. What I see happening is local boards, local actors are being held responsible for producing these results but there's no mechanism for them to give feedback back up to the national level to say 'we really can't do what you're asking us to do because the supply of housing is insufficient or wages too low and we cannot solve the problem of low wages'.... The problem is not going to be solved if there are no feedback mechanisms back to the national level.

Trust is really fundamental in getting this agenda progressed. Someone mentioned something which had never had before, but it's stuck with me – trust arrives on a tortoise and leaves on a horse, it takes time to build trust, you will get there. But destroying it – it can be away in a flash.

The centre doesn't have the level of trust so seeks to control, that might be a bit of an old fashioned and oversimplistic paradigm but it does seem to fit. NHS England doesn't seem able to truly trust so it then starts looking to control and prescribe and then say locally what told to do from the centre. I've come to a point at the end of my career that this feels like there's even more top-down pressure than I've ever seen before.

Having high levels of trust in workplace relationships improves motivation, performance and quality of care (66).

MAINSTREAMING ACCOUNTABILITY AND INEQUALITIES IN NATIONAL STRATEGIES

Whilst local systems might be criticised for lack of accountability on health inequalities, many national strategies also do not include accountability requirements, and thus, it's unclear if local systems or national policies are to blame for the lack of accountability.

Interviewees were clear, health inequalities need to be given the freedom to set local strategies, but also be included in the NHS's national strategies. These expectations must be clearly defined and measured.

(Health inequalities) has got to be a requirement, if it's not an absolute must do, it doesn't get done...I've heard it so many times, organisations say if it's not an absolute must do, it doesn't get done.

Strategies need to be properly thought through documents that have deliverables that are clearly feasible with the timeline attached, and then you revisit that from time to time. If agencies outside the NHS have come together to support something like a (health inequalities) strategy, they need to have a strategy. That's what they're being held to account for delivering on. You do a good local strategy, that's doable, not just a wish list of good intentions but a really nailed down strategy in terms of deliverables and you're held accountable against those deliverables.

Without a national strategy you'll have variability and it won't add up to anything nationally. Some places will do well, some places won't do well. I know already, from places that I'm involved in directly, one is doing really nicely in many ways and other one is completely floundering, they're working in the same framework but they haven't got the right structures. They've got more complicated make-up in terms of places; they've got more of a deficit to start with. One of them has got a fab top team leadership and the other one, you don't know who is in charge.

We need to step back or persuade people to address health inequalities. But there is no funding. There are no policies on population health or inequalities. One of my non-exec directors said 'You want to do this with discretionary effort? Where is the formal project? Where is the formal ICB support that says this is a priority?' I say, it's not there.

Having the objective of addressing health inequalities would be a very good thing to be a core objective and what should an ICB be doing and what should a Trust be doing.

Interviewees used phrases such as 'threading' and 'mainstreaming' inequalities in NHS England and DHSC policies and guidance and operational plans. By encouraging NHS staff to literally see inequalities in the documents they use to organise their services, they said more NHS staff would then regard health inequalities as something 'to do', instead of something 'nice to do'.

Build inequalities into the normal performance processes with organisations, all the time, not just 'we're going to have a keynote speaker on it and then we'll move on to the money', it needs to be threaded through everything.

The five priorities of our ICP – children and young people, digital, mental health, prevention and workforce - if there was an inequalities thread in all their priority areas, then that would start to prompt people to think, 'How do I focus on those and what do I need to do?' Even embedding it in each of the ICS priorities is a start. I think if there is a common area across multiple ICSs, those areas could be areas of focus, for the next period to see what people are doing. what policies work, what sort of evidence-base is there to the interventions we might want to adopt? Do we need to evaluate it ourselves? If we can show benefits to wider health, it gives it more impetus to do so.

REALISTIC AND USEFUL FUNDING STRUCTURES

Interviewees offered a number of suggestions on improving funding approaches to improve accountability. An ICS health inequalities lead stated without additional, ring-fenced funding, allowing staff to have the capacity to address inequalities and not do in addition to their usual work, then questions of accountability were irrelevant.

We've all got excited and passionate which is great, but this change agenda requires a lot of resources and time and the stark reality is the raising of interest in health inequalities is all well and good but people are swamped by the pressure of keeping services running and dealing with financial challenges and staffing issues, etcetera. We're raising understanding and awareness but we also arrive at a point where we're poorly placed to carve out the time and space and resources to do the work.

These funding pots - short-term and often asking systems to do what they do not think is best practice - can impact on accountability, as systems are not adequately funded to address inequalities. Interviewees stated they wanted guidance from NHS England and others on how to adopt current funding to better address inequalities and also, tools to ensure their local systems can account for funding spent on inequalities.

We want to take advantage of a window we have with our chief executive at the ICS who sees health inequalities as the North Star of our ICS, which is a great opportunity with him and others to look at our £4.5 billion budget overall as a way to think about health inequalities, not our £6.2 million health inequalities pot. How do we focus on some program work but then play a much broader system role and developing that accountability towards thinking about health inequalities from a whole systems perspective?

IMPROVING PERFORMANCE MEASURES

Performance measures traditionally use a 'one-way' tracking process whereas a 'two-way' process could encourage better results. A two-way process could include:

- Reports from national and regional NHS England teams and to local bodies and the reverse.
- NHS England to support problem-solving and policy implementation. This could be a similar approach as adopted in the Spearheads, and involve field visits. Hudson et al. point out, local NHS staff managers and professionals, 'know more about the challenges of delivery than national policy-makers' as such, they suggest implementation support is recruited from NHS to support others (62).
- Proportionate primary and secondary targets with timelines developed in partnership with local NHS organisations.
- Separating monitoring, regulating and inspecting roles from support mechanisms.
- Having 'realistic expectations of what constitutes "success" (62).

Many interviewees suggested ways for NHS England to better support local areas to improve accountability in health inequalities.

If I were ICS chief executive, I would want to be held to account for longer term planning, very high-quality partnerships that could demonstrate very high quality and really strong community engagement and community leadership, very explicit use of high quality data to inform my evidence based decision making. That's what I'd want to be held to account for, because I would be then describing the capabilities of an organisation that was good at population health. It doesn't sound like I'm describing an NHS treatment organisation, does it?

I think NHS England are probably locked into a medical care model ... We talk about population health, we talk about inequality, we talk about places but you go into the room with NHS England and within 20 seconds they start talking about waiting lists and A&E times and why are you doing this? Why are you doing that? The mindset is completely wrong for the task. Until it changes, we're going to be coming back to these same issues time and time again.

Interviewees were clear, they did not want a prescriptive set of targets instead they wanted a system that was facilitating, enabling and supportive.

(NHS England) should provide implementation support, helping people deliver on the agenda, not just holding them to account, which is a bit passive in a way, but something more active and engaging.

Performance management can assist if it's done right and in capturing the frontline making a difference. (NHS England) can share good practice more effectively, it can facilitate that. But that's not performance management. It is a managing of performance.

Let's talk about the fact that it wouldn't be appropriate for the centre to set detailed metrics for performance and mapping out inequalities because that might not fit with what's happening regionally or locally, but it needs to. The centre needs to address the issue of how it can monitor progress by using (NHS England) regional teams and its own assessment of the ICBs, because the NHS executive has to do an annual assessment of ICBs. Those channels could be a mechanism for identifying where there are gaps, where they're good, things happening, where they're problems, where there is need for support. Then they can trigger good local support. It's not rocket science. I don't think people are thinking in those terms.

Consistently interviewees stated they were eager for information on what to do to reduce health inequalities.

DATA TO SUPPORT ACCOUNTABILITY

Leaders said NHS England can help local data teams to show how to tell the story of inequalities in local areas and argued this will improve leadership and understanding.

I have a lot of colleagues or people that knock on my door, they are really interested and passionate about health inequalities and they don't know what to do next. That's fine. I say, well, we can help you with support. You're doing HEAT workshops or similar and we'll take you on a sort of structured voyage, but you need to know where inequalities are in your service, you need to have data. You see people glaze over and they don't know if they have local data, they probably have but there's quite a disconnect between the parts of the system and their access to information and how they explore and use it. We talked quite a lot about board level reporting and trusts around inequalities, but actually we also need to empower the frontline teams to understand better what the inequalities are that they are generating or creating in the service.

We need to use the data intelligently. The minute you get into RAG rated boxed (red, amber and green) on data one is good and one is bad, you're on the wrong track...The problem isn't data, The trick is whether you've got a method to use the data.

NHS Digital could offer better alignment of Fingertips with NHS small area data. They've got some NHS data but not at small area levels – more support is needed for people producing Fingertips – Fingertips could be improved. It does require NHS England and DHSC to talk to each other... All sorts of governance issues stand in the way of NHS Digital trying to be more helpful. (NHS England) need to better link the wider determinants of health part of Fingertips with NHS utilisation and outcome data and may need more small area data. Maybe Fingertips is the concept but the actual delivery mechanism is more sophisticated. It might need more powerful geographical mapping.

The data tools developed to increase accountability in health inequalities should be available to all relevant stakeholders. The current health inequalities dashboard developed by NHS England to track progress on health care inequalities is currently not available to external partners (67).

THE ROLE OF OHID AND THE CQC

The role of external regulators, such as the National Audit Office and NHS regulatory bodies (e.g. the Care Quality Commission), were discussed by a small number of interviewees as possible mechanisms to improve accountability in the NHS. Ford et al. state that currently, equity perspectives are 'rarely considered in healthcare quality improvement programmes, clinical audits, service evaluation or adverse event investigations' (14).

OHID could have a role, certainly at the regional level, being a kind of independent auditor almost in the way the Audit Commission used to operate.

Regulators, they've got a role to play in this and the National Audit Office, one could argue, has got a role to play. We know that when those organisations make recommendations, those things get done...But I think they'll bring useful checks and balances that ensure that there is consistency in an approach and that people know that this is a serious agenda.

Locate (health inequalities) activities in the home of an actor who is accountable, and should be responsible for ensuring public health outcomes, that would be OHID and local public health officials.

ACCOUNTABILITY MECHANISMS AND THE SHIFT TO BOTTOM-UP APPROACHES

A member of the advisory group warned that the top-down nature of the NHS could inhibit the success of ICSs adopting new accountability mechanisms.

If there's too much top down prescription on what ICSs should be doing, that's going to limit their ability to attend to local needs and priorities, which will confuse the picture even more in terms of local accountability because it will be seen to be upwards rather than downwards...if it's too top down prescriptive it'll be seen to be not taking local people with you but will just be seen to be playing to the tune of NHS England or whoever is monitoring them nationally and not what is needed for good policy locally.

Interviewees were clear, NHS England needed to respect that ICSs are required to have a more bottom-up approach and that any new accountability mechanisms needed to reflect this shift.

There are things that need to be done at the policy level but there is something about respecting that interaction that happens at place and avoiding some of those things that can easily take away the trust that we have taken a long time to build.

There's a bit of a challenge within the ICS – when does it come to the point for us to say to the centre 'no, that's not the way we're doing it because that does not meet the needs of our population' because our population is a very, very diverse population, from an ethnicity point of view, from a deprivation point of view, from an intersectionality point of view. That means we have to maybe adapt, think, tweak, share and support each other and how we actually address those inequalities.

Implementation support in the Care Act 2014

The Care Act 2014 used a different approach to implementation through policy tracking and implementation support helping people address the problems that they were facing rather than holding them to account and then blaming them for not performing well. Hunter et al. analysed the implementation of this Act and the reasons for its success was the national team, before the policy was introduced, worked with key stakeholders and with those in managerial and professional roles to identify and address the problems they anticipated in the new policy. They identified the implementation support in the Act was a useful tool and recommended developing a team of 'experienced and trusted 'implementation brokers' to offer support tailored to local contexts' offering implementation support where it is needed or requested in order to develop sustainable implementation skills and knowledge (68).

3C. THE ROLE OF NHS ENGLAND

The role of NHS England was mentioned throughout the interviews. When interviewees made suggestions to improve accountability in relation to health inequalities, they were prompted to discuss who could implement these. NHS England was the most common response to who should be leading on these actions. One interviewee imagined what a good overall accountability framework for inequalities would look like.

NHS England is tasked with keeping an eye on minimum indicators and minimum standards and the Care Quality Commission has a set of tick boxes when they visit, they should have a role in inequalities as they do in other areas of guidance and minimum standards. It has to run through the entire culture... How resources are allocated, what guidance is given when money is allocated, what standards are set for Trusts and units within Trusts. Then you monitor that they are following guidance – which is about the CQC inspecting standards... indicators need to cover upstream and downstream.

Interviewees responded to the question about what they were doing to improve accountability for health inequalities and instead asked what NHS England were doing to improve accountability mechanisms.

NHS England have got to be held to account too, as the central team.

The framing about your question about accountability for this – you could almost ask that the other way around. Who would (NHS England) trust to do this?

When my regional director rings me up and asks me what I'm doing about employing more people from disadvantaged backgrounds or working on inequalities and population, then I'll know that NHS England are really taking this seriously. We get asked to report on the ambulance waiting times, COVID vaccination uptake, they never ask about inequalities, ever. At least this year they say inequalities featured in the planning guidance, which I think was the first time. I think these things are starting to come through the normal mechanisms.

I spent half my career not in the NHS and one of the things I found is that there is a slight culture of waiting for permission on a lot of things and people assuming that they won't be allowed to do something rather than assuming that I'd rather ask for forgiveness than permission kind of culture. I quite often find myself saying to people if you got a brilliant idea, just do it, don't go round asking permission from 20 people because you'll eventually find someone that says no. It's cultural. People think they have to be very brave and actually most of the time either people won't particularly notice or they won't care or they'll think, wow, that was amazing, well done! It's rare that people come forward and say you shouldn't have done that.

One Chief Executive challenged NHS England to be more honest about addressing inequalities.

I'd really like (NHS England) to decide whether they mean this with their hearts as well as their heads. Inequalities are absent from every single thing that's coming out of the moment about operational pressures – A&E, ambulances, waiting lists. Yet most of those things are operating on inverse care law principles. Straight up slap bang in front of your face and you can see it. It's blindingly obvious. There is joining up to be done that could make a lot of difference. It's a bit like when NHS England talk about staff wellbeing, it's like an add on tick, they know it's got to be there but it doesn't come through in the way they operate. It's barn door obvious. Everyone can see it. That's the biggest challenge, that coherence.

EVALUATE INEQUALITIES POLICIES AND CURRENT ACCOUNTABILITY MECHANISM NOW

The lack of NHS clarity and information about the potential effectiveness, implementation, and cost of its own policies may be further compounded by an apparent aversion to conducting high-quality, independent evaluations (which risk demonstrating failure, as well as success), which may also reduce the NHS' ability to learn lessons from its past policies. However, the NHS does not have a good track record in evaluating its own policies. An analysis of evaluations of England's public health policies found they were either tightly controlled in order to minimise criticism, were not conducted at all, or were conducted in a way that made lessons for future policymaking ambiguous (41). Ford et al. also found detailed and independent evaluation was not embedded or undertaken of the Spearhead approach and concluded that learning 'which contributed to the observed narrowing inequalities gap remain unknown' (14).

SUPPORT AND TRAINING

Interviewees had many suggestions of the support NHS England could be providing to them.

What's the support and the help that could come from the centre that permits us locally to work with them in a slightly different way? Be cleverer about how to set targets locally, some places are further behind.

Helping every Trust have a method for thinking about improvement, how do you use data and who do you use it with?

What is the balance between health creation and sickness treatment in our model of healthcare? Answering that question for the latter part of this decade and the early part of the next decade would be really good. And helping to promote the use of a new funding formula, to incentivise longer-term action.

Good practice examples are good because they inspire, and they help, people stay in a 'can-do' mindset rather than 'it's too difficult' mindset.

A Director of Population Health stated training on inequalities for early career managers would be useful.

If I'd been as informed and as literate about some of these issues 25 years ago, I would have probably been a more effective manager. There's something about health inequalities literacy – it should become a core capability for clinical professionals and managerial professionals going forwards.

Another interviewee stated NHS England could be providing training to NHS staff.

I can't understand why they're not geared up for training because they haven't had a history of being geared up for that kind of thinking. If they can't do it themselves, they ought to be able to point people in the direction of who can.

LEADING CROSS-DEPARTMENTAL APPROACHES

NHS England have the institutional connections to develop and sustain relationships with key cross-government departments. Interviewees wanted NHS England to take a more pro-active approach to present the case for tackling health inequalities and demand actions and accountability from other government departments.

There is a big need to change the Treasury thinking about the NHS and health. That's the biggest challenge - asking the Treasury 'what do you need to see from health for the inequalities agenda to be a priority for you?'

(NHS England) should be doing serious political lobbying.

(NHS England) are going to have to be working cross government nationally, but also vertically in relation to local government and OHID regional offices and so on. There's a big role, but it needs to be joined up at different points in the system.

4

CONCLUSION AND RECOMMENDATIONS

There are ample opportunities to improve the accountability mechanisms in the NHS focussed on reducing health inequalities. The interviews and document analysis find current accountability mechanisms in the NHS related to health inequalities are weak to non-existent: current levers are insufficient to ensure effective accountability to tackle health inequalities and the root causes of health inequalities. Past levers in the NHS have also not provided local systems with the capacity and influence they needed.

Interviewees were eager to provide suggestions on how to improve local accountability mechanisms in the NHS; they want the tools to achieve a reduction in health inequalities, to improve the health and wellbeing of their patients and to reduce the pressure on the NHS. They want to be held accountable, and they want NHS England to be held accountable as well.

Section 3B explores the many opportunities for NHS England to better support local systems to improve accountability in relation to health inequalities, this involves: more proactive support on the policies and guidance to address inequalities and the social determinants in the NHS and changing the funding structures so systems can implement longer-term policies.

For NHS England local systems want to see you and to improve relationships so that together you can improve accountability mechanisms. Part of this involves more frequent local visits but also establishing feedback systems from the local to NHS England.

CHANGING SYSTEMS, PROVIDING THE TOOLS TO SUCCEED



- NHS England and its mandates, constitution and funding and allocation arrangements, monitoring and data-sharing procedures should all strengthen accountability mechanisms to reduce inequalities.
- NHS England should publish a national strategy on health inequalities, developed in partnership with local systems.
- All accountability mechanisms should aim to impact in the longer-term, at least five years.
- Develop mechanisms to strengthen accountability between health systems (ICBs) and non-NHS partners, such as local government, the voluntary sector and other public services - that can influence the social determinants - are needed.
- Work in partnership with the Care Quality Commission to integrate actions on inequalities into their accountability mechanisms.
- NHS England should commission 3-5-year pilots with local systems to identify accountability mechanisms able to hold local systems to account.

GUIDANCE, SUPPORT AND LEADERSHIP

- NHS England should provide stronger leadership to create the organisational contexts to deliver new policies and approaches, such as the current enhanced focus on reducing inequalities in ICSs.
- Include reducing health inequalities in future NHS long-term plans, annual strategies and operational planning guidance to give local places the tools to work with staff – at board level and those delivering services – to show inequalities should be part of their everyday work and practice.
- Work with local systems to identify support, training and mechanisms needed to improve accountability related to health inequalities.
- NHS England should lead discussions on health inequalities and accountability across government departments and filter this information back to local systems.

PERFORMANCE MANAGEMENT

- Develop multi-faceted and long-term approaches to accountability. Short-term targets are likely to be 'gamed' as the current additional funding for health inequalities shows.
- Punitive performance measures are not wanted, instead systems want implementation support.
- A heavy-handed set of targets will not work. Targets that facilitate and support local actions based on national parameters are recommended.

DATA AND MONITORING

- Enhance data to enable ICSs to better identify where inequalities are, the actions needed and how to measure the impact of their actions. This type of data can improve local accountability to their ICBs and local communities.
- Make the NHS inequalities dashboard available to non-NHS stakeholders.
- NHS England, NHS Digital and OHID should work with local systems to identify data needed.
- Develop targets and monitoring in partnership with local systems.

FUNDING

- Funding should be for long term. Health inequalities will not be reduced if the dependence on short-term pots of funding continues. Policies will fail.
- Funding should be ring-fenced.

This report echoes suggestions to improve accountability that have appeared in previous reports. Our own 2020 Institute of Health Equity *Ten Years On* report recommended:

Clear political accountability for improving population health and reducing health inequalities (be) established, with the Government taking responsibility for reducing health inequalities... New targets should be developed and these should include reducing regional and socioeconomic inequalities in health and inequalities in key social determinants. The health inequalities duties under the *Health and Social Care Act*, described earlier, should be enforced and relevant organisations held to account for their progress on reducing inequalities. There should be high level and public reporting of actions and outcomes through regular monitoring of health inequalities and their social determinants, discussed further under implementation (5).

The words ‘should be enforced’ are not a recommendation for a severe performance management approach – nor are legal frameworks are needed. The expectations of ICSs to address inequalities has helped to push inequalities up the agenda, as such, local systems are keen to address inequalities. Instead, local systems want the right support and leadership from NHS England, such as: mutually agreed targets (i.e. between NHS England and local systems) and longer targets (i.e. not annual); two-way communication channels with more clearly defined expectations in regards to health inequalities; ring-fenced funding; longer-term funding; support for and trust of local leaders – these will give local systems the tools to improve local accountability mechanisms enabling them to better address health inequalities.

Whilst the NHS is capturing a great deal of data on inequalities, local systems stated the current data does not give them the information needed to tell the story of health inequalities in their areas. They need data that is more timely and enables them to better identify where inequalities are, the actions needed and then how to measure the impact of their actions to reduce inequalities. This type of data can improve their local accountability to their ICBs and to local communities.

Andrew Hudson, former Head of the Health Team in the Treasury, suggested national level accountability regimes in the NHS ‘should be set for a five-year horizon...with a single light-touch mid-term review. In between these major reviews, policymakers should resist the temptation to make changes’ (6).

The Hewitt Review, announced in November 2022, is set to analyse similar themes as this paper, to “explore how to empower local leaders to focus on improving outcomes for their populations” and to review the scope for national targets and other performance measures. And the February 2022 *Joining up care for people, places and populations* white paper described DHSC’s plans to develop new outcomes, accountability, and regulatory and financial reforms. It intends to begin trialling these reforms by spring 2023. They include a shared outcomes framework focused on improving population health and reducing health inequalities, and a single person accountable for delivering shared outcomes at place level across both health and social care (20).

This report, the Hewitt review and the *Joining up care for people, places and populations* white paper – three documents in one year about improving accountability in the NHS. Better accountability mechanisms to reduce health inequalities are within the grasp of NHS England, it is up to the organisation to take this opportunity.

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