Rapid Evidence Assessment

Care Quality Commission

Feb - May 2024

National Voices

The **Point of Care** Foundation

Contents

Introduction

This Rapid Evidence Assessment (REA) report is the first part of a wider research and development project commissioned by The Care Quality Commission. The purpose of this REA is to explore what evidence is available to help us understand any existing models and practice that may be in use to inform the overall project aim which is:

■ **Assessing Integrated Care System performance in understanding and responding to the health and care needs and experiences of people most likely to experience poorer care and inequalities.**

This report provides summary insights of light-touch rapid evidence assessment. This will inform the specific project aim of supporting ICSs and ICBs to develop a rigorous consistent framework (and a suite of learning products and activities) for tracking and demonstrating their progress (assessing, reporting on and driving improvement) in these areas:

■ **How ICSs are performing in relation to their People and Communities strategies; and**
■ **How ICSs are performing in acting on people's needs and experiences to reduce inequalities in health and care provision.**

1.1.   Aims

The review aims to explore current practice in:

1. **Measuring progress** against People and Communities Strategies; and
2. **Understanding** the experiences and needs of people more likely to experience poor care;
3. **Acting on** the experiences and needs of people more likely to experience poor care.
4. **Measuring** the outcomes of 2. and 3. above.

Once promising practice was identified we then carried out 16 stakeholder interviews across 4 systems to conduct a deep dive into how this was playing out in a real world environment.

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The broad questions we are seeking to explore are:

1. How are ICSs currently measuring progress against their P&C Strategies?
2. How are ICSs currently **identifying** the populations who are more likely to experience poor care?
3. How are ICSs currently **taking action** to improve outcomes for populations experiencing poor care?
4. How are ICSs currently **measuring** improved outcomes for populations experiencing poor care?
5. How has all this activity changed over the time ICSs have formally been operating?

For each of these we have looked for:

- **Key themes** of assessment or improvement approaches / domains / indicators.
- **Examples/case studies** where tangible improvements have been evidenced in experiences of care or health outcomes.
- **Models:** Examples of continuous engagement approaches or ongoing feedback mechanisms to improve care.
- **Data:** Data sets that might help inform the work.

We have explored evidence across the following **sectors**:

- ICSs
- Local Authorities
- VCSFE
- National organisations such as Think Tanks or charities

1.2. Review method

We identified potentially relevant UK-based evidence via three main approaches:

- searches of academic literature via Google Scholar;
- searches of grey literature (including briefs, policies, strategies, and social research reports) via Google search; and
- through networks and existing relationships, to provide relevant unpublished or pre-publication documents.

These searches informed a longlist of 48 potential sources, which were sifted according to relevance (using abstracts or executive summaries) to create a shortlist of sources. Shortlisted items were then thoroughly reviewed to create this literature review report.

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Stakeholder interviews were then conducted with four ICS areas to explore how existing frameworks etc were being used in practice.

1.3.   Limitations and context

This review was undertaken through the lens of the NHS system, particularly the English health system. It should be acknowledged that literature considering community engagement and outcomes more broadly (including globally) is extensive but was not covered by this review.

It is also worth considering that the current availability of engagement toolkits in the health service is extensive, largely due to a lack of coordination and prioritisation. A review in 2022 found **536 toolkits for public involvement in the NHS**, with an average of two per week being published.[1] This background should be considered before undertaking work that might duplicate existing resources.

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[1] The Toolkits Mountain, Patient Experience Library.

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Existing literature
1. Measuring progress against strategy

The following literature explores how ICSs are measuring progress against their People and Community Strategies through asking the question:

- How are ICSs measuring progress against People and Communities Strategies?

Working in Partnership with People and Communities

NHSE & DHSC, Statutory Guidance

What is this and who does it apply to?

- Developed by NHSE with partners including LGA in response to The Health and Care Act 2022.
- Used by some ICSs as the main structure/guidance for their People and Communities Strategies.
- **Applies to:** This is statutory guidance for Integrated Care Boards (ICBs), NHS trusts and foundation trusts, and adopted as policy by NHSE, but "relevant to the entire health and care system."
- Considered 'good practice' for ICS partners not under a statutory duty.

Key things to know

- Structured around 10 Principles, which include:
- (1) Ensure people and communities have an active role in decision-making and governance;
- (3) Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working; and
- (4) Build relationships based on trust, especially with marginalised groups and those affected by inequalities.

How might it relate to this work?

- Each of these ten principles has around 5-8 good practice suggestions underneath it.
- There is no detailed framework to assess/audit or self-assess progress, but a framework could be mapped against these **ten principles** and their associated guidelines.

Link

- Working in Partnership with People and Communities
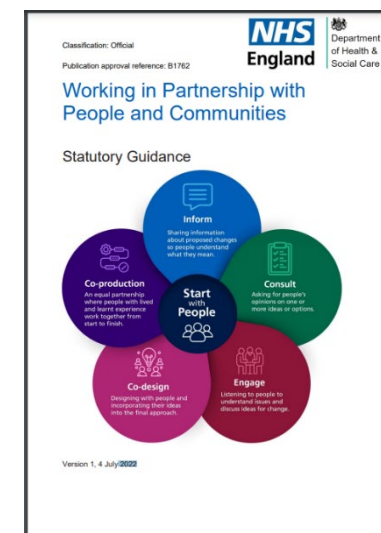
What is this and who does it apply to?

- This NHSE document provides an overview of ICB progress against their P&C Strategies, based on feedback from ICBs after their first year of delivery.
- The document aim is to support ICBs with good practice and general feedback about progress nationally.
- It also highlights where future national support can support ICBs.

Key things to know

- Key enablers to delivering engagement ambitions provide a useful framework / set of domains.

How might it relate to this work?

- The key enablers identified provide a set of domains that may be useful to consider when developing a framework.

Findings:
Key enablers to delivering P&C Strategy ambitions:

- Taking a collaborative and co-ordinated approach across the system
- Clarity in Place / System governance and reporting
- Collaborative leadership
- System leadership visibility and support
- Strengthening partnerships across the ICS
- Sharing insight across the system
- Resourcing
- Developing a culture of engagement
- Understanding communities and recognising diversity

Link

- This document is not published.

What is this and who does it apply to?

- This guide is designed to support the assessment of ICBs' performance on their public involvement duties, as required under section 14Z59 of the NHS Act; the audiences are NHSE and ICBs.

Key things to know

- This is around assurance rather than measurement.
- NHSE requires yearly assurance for ICBs around their statutory duties, which should align with their P&C Strategies.

How might it relate to this work?

- An understanding of the assurance process is helpful to avoid duplication.
- The ten domains are a useful framework.

Link

- This document is not published.

Assurance domains/questions:

The guidance provides a framework which maps to the ten principles in the statutory guidance *Working in Partnership with People and Communities*:

1. The ICB ensures people and communities have an active role in decision-making and governance.
2. The ICB involves people and communities at every stage of its work and feeds back to them about how it has influenced activities and decisions.
3. The ICB understands its communities' needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working
4. The ICB builds relationships based on trust, especially with marginalised groups and those affected by inequalities.
5. The ICB works with Healthwatch and the VCSE sector as key partners.
6. The ICB provides clear and accessible public information
7. The ICB uses community-centred approaches that empower people and communities, making connections to what works already.
8. The ICB has a range of ways for people and communities to take part in health and care services.
9. The ICB addresses system priorities and service reconfiguration in partnership with people and communities.
10. The ICB learns from what works and build on the assets of all health and care partners – networks, relationships and activity in local places.

NHS leadership competency framework for board members

NHSE

What is this and who does it apply to?

- The framework for NHS leaders describes specific core elements of competence, which all directors should be able to meet and against which they can be assessed.
- This framework is for chairs, chief executives and all board members in NHS systems and providers.

Key things to know

- The individual competencies are expressed as 'I' statements.

How might it relate to this work?

- Domains 3 and 6 align to this work and provide a strong case for leaders understanding communities in order to reduce inequalities.
- The use of 'I' statements could be framed as "We" statements for this type of work for systems.
- The appendix links to the NHS Values and summary of the duty of the Health and Care Act which would be useful framing for the next stage of work.

Link

- NHS Leadership Competency Framework

Assurance domains/questions:

The six leadership competency domains:

1. Driving high-quality and sustainable outcomes
2. Setting strategy and delivering long-term transformation
3. Promoting equality and inclusion, and reducing health and workforce inequalities
4. Providing robust governance and assurance
5. Creating a compassionate, just and positive culture
6. Building a trusted relationship with partners and communities

Domain 6 is described in detail as: "The need to collaborate, consult and co-produce with colleagues in neighbouring teams, providers and systems, people using services, our communities, and our workforce. Strengthening relationships and developing collaborative behaviours are key to the integrated care environment."

1. Measuring progress against strategy:

How are ICSs measuring progress against People and Communities Strategies?

Summary:

- The **key guidance** for P&C Strategies is the NHSE and DHSC Working in Partnership with People and Communities Statutory Guidance. This sets out how ICSs should be engaging with communities.
- NHSE **reviewed the ICSs P&C Strategies** after their first year, and identified **key enablers** for delivering the strategies, including strong leadership and partnerships and embedding a culture of engagement.
- NHSE assesses ICB's P&C Strategies and engagement activities as part of its **assurance function**. A framework for this assurance is based around ten areas, including ongoing involvement with people and communities, understanding the community's needs and working with the VCSE sector. This framework is clear and question based.
- The **NHS Leadership Competency framework** for board members that will be available in detail for self-assessment from November 2024 stipulates clear areas of community engagement and addressing health inequalities. This is again based around a framework of questions and "I" statements.

Key themes in domains for 1. Measuring Progress:

- **Community participation and decision-making:** ensuring active involvement of people and communities in decision-making processes and governance structures.
- **Understanding community needs and experiences**: engaging with communities to understand their needs, experiences, and aspirations for health and care services.
- **Building trust and relationships:** establishing trust-based relationships, particularly with marginalised groups and those affected by inequalities.
- **Partnerships and collaboration:** working closely with key partners including the VCSE sector to foster collaboration and co-production.
- **Communication and accessibility:** providing clear and accessible public information to communities about health and care services.
- **Empowerment and learning:** using community-centred approaches to empower people and communities, while also learning from successful practices and building on existing assets within the health and care system.

2. Identifying Populations

The following literature explores how ICSs might understand the experiences and needs of people more likely to experience poor care through asking the question:

- How are ICSs currently identifying the populations who are more likely to experience poor care?

What is this and who does it apply to?

- Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level.
- The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.
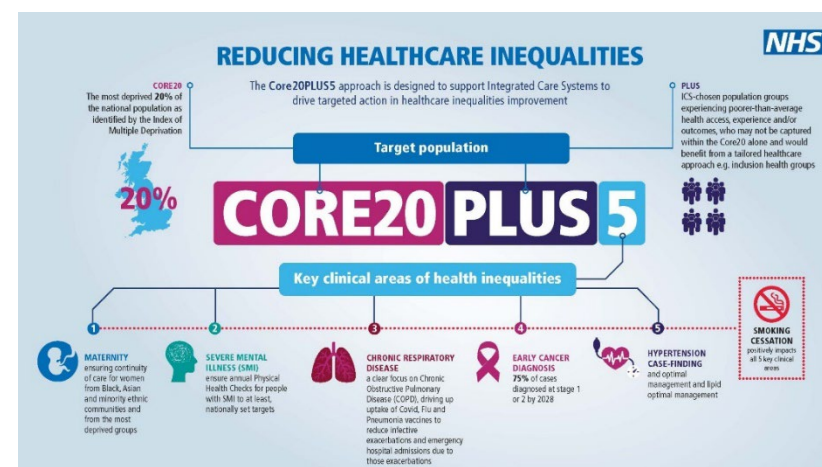
Key things to know

- **The Core20** are the most deprived 20% of the population as identified by the national Index of Multiple Deprivation (IMD), which has seven domains with indicators accounting for wider determinants of health.
- **PLUS** population groups should be identified at a local level.
- **5** are:
  1. Maternity
  2. Severe mental illness
  3. Chronic respiratory disease
  4. Early cancer diagnosis
  5. Hypertension.

How might it relate to this work?

- Core20PLUS5 is useful to consider how NHSE are defining healthcare inequalities at a population level.
- This could provide a useful structure for data sets for identifying inequalities.

Link

- Core 20 Plus 5

Approaches to Improving Quality of Data Relating to Health Inequalities 2022

Moorthie et al, Public Health journal

What is this?

- Review of approaches within the healthcare (global) context to improve the quality of data for the identification and monitoring of health inequalities and describe the evidence base on the effectiveness of such approaches or recommendations.

Key things to know

- This global study looked at how different healthcare systems approached capturing quality data for addressing inequalities.
- It developed four categories of factors that enabled healthcare systems to capture inequalities data.

How might it relate to this work?

- This review may be of interest when looking at the wider issue of capturing and recording inequalities data consistently across systems.
- The issue of data quality may be peripheral to this piece of work, but one finding was that engaging the community was important in ensuring that data was relevant and meaningful for equalities issues. For example, many systems may only now be introducing categories for non-binary gender identification.

Findings

This review found that enablers could be themed into four categories of factors:

- Distal factors (e.g. national, or 'upstream' of data collection and analysis), such as national mandates and legislation.
- Wider actions to enable improvements in data collection (Preparing for data collection), such as achieving senior-level buy-in in organisations involved in data collection.
- Data collection instruments, systems, and standardisation (Data collection), such as creating standardised definitions and coding practices across organisations.
- Methodological approaches to improve data quality and accuracy (data analysis), such as linking with other data sources.

Link

- [Approaches to improving quality of data](#)

Other tools and data sets to be aware of:

The following tools and data sets may be used by systems to identity population groups. Consideration should be given to which of these are likely to remain relevant and centrally updated. (Note: Many of these tools are restricted.)

Model Health System (NHSE)

- Building on the Model Hospital dashboard, which provided provider-level benchmarking for health services, the **Model Health System** is a data-driven improvement tool that enables NHS health systems and trusts to benchmark quality and productivity.
- By identifying opportunities for improvement, the Model Health System empowers NHS teams to continuously improve care for patients.
- **Link:** Model Health System

Health Equity Assessment Tool – HEAT (Public Health)

- Resources and e-learning to support systematic action on health inequalities and equalities.
- This was driven by requests from across the system for a practical framework that could be used with a range of stakeholders to identify and support local action.
- A need was identified for a resource to enable professionals to systematically address inequalities and equity in programmes and services to drive change and generate improvements.
- **Link:** **HEAT Tool**

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Actionable Insights tool (NHSE)

- Using statistical models, the tool identifies significant inequalities and presents these clearly as written statements (in a narrative form). The easy to understand sentences summarise information and include information on the proportion of affected patients. They also make comparisons, give a ranking against other systems and predicted outcomes if improvements were made.
- Maps are available which highlight where patients are most negatively impacted within the user's ICS.
- Link: **Actionable Insights Tool** (Restricted access)

Healthcare Inequalities Improvement Dashboard (NHSE)

- The Healthcare Inequalities Improvement Dashboard provides key strategic indicators relating to healthcare inequalities all in one place.
- The dashboard measures, monitors, and informs actionable insight to make improvements to narrow health inequalities.
- It covers the five priority areas for narrowing healthcare inequalities in the 2021-22 planning guidance and the five clinical areas of the Core20PLUS5 approach.
- **Link:** Healthcare Inequalities Improvement Dashboard

2. Identifying Populations: How are ICSs currently identifying the populations who are more likely to experience poor care and inequalities?

Summary:

- Identifying populations who are more likely to experience poor care and inequalities is a key challenge and is the first step in addressing the issue.
- It is essential to make sure we agree on clear definitions of key terms and concepts. This includes the key populations, what we mean by health inequalities and inequalities, how we look at outcomes and experience, and which inequality groups we should consider.
- NHSE terminology is currently tending towards: "health inequalities in access, experience and outcome."
- It is also essential to ensure that nationally agreed definitions - where these exist - need to be clearly communicated so that ICSs understand what these are.
- There is an assortment of tools for identifying data sets of populations from NHSE and Public Health England/Office for Health Improvement and Disparities: it is hard to distinguish these and guidance about which is the most appropriate or updated would be helpful.
- Overall, the CORE20Plus5 approach appears to be the most recent, but may be difficult to convey to wider stakeholders who are not familiar with the model.

Key themes in domains for 2. Identifying populations:

- Equalities can be considered from various perspectives, including the protected groups under the Equality Act 2010, and also the wider determinants of health, including education, economic and areas of deprivation.
- Many additional groups can be included, such as carers, veterans, homelessness and the digitally excluded.

The CORE20Plus5 model:

- **The Core20** are the most deprived 20% of the population as identified by the national Index of Multiple Deprivation (IMD), which has seven domains with indicators accounting for wider determinants of health.
- **PLUS** population groups should be identified at a local level.
- **5** are: 1. Maternity. 2. Severe mental illness. 3. Chronic respiratory disease. 4. Early cancer diagnosis. 4. Hypertension.

Existing literature
3. Taking action

The following literature explores how ICSs act on the experiences and needs of people more likely to experience poor care, through asking the question:

- How are ICSs currently taking action to improve outcomes for populations experiencing poor care?

Equality Delivery System (EDS) 2022

NHS England, Equality Framework

What is this and who does it apply to?

- 'The EDS is the foundation of equality improvement within the NHS.'
- The framework helps NHS and partners, in discussion with local populations, review, score and improve their performance for communities with protected characteristics, to help meet their duties under the Equality Act 2010.
- Applies to: NHS commissioners and providers, local authority and other partners. Can be completed at ICB level.

Key things to know

- The EDS comprises eleven outcomes spread across three Domains, which are: 1) Services; 2) Workforce health and well-being; and 1) Inclusive leadership.
- The outcomes are evaluated and scored using evidence and data, and graded as Undeveloped, Developing, Achieving or Excelling.
- This is captured in a standard template which all NHS providers and commissioners need to publish. This is a self-assessment that should be done with the local community, particularly groups representing protected characteristics.

Link

- Equality Delivery System 2022

How might it relate to this work?

- Standard template provides a self/community-assessment system.
- The guidance suggests sources for data including the local Joint Strategic Needs Assessment, Healthwatch reports, Workforce Disability Equality Standard and Workforce Race Equality Standard.

Domains in the Equality Delivery System 2022:

Domain 1: Commissioned or provided services:
- Patients have required levels of access to the service.
- Individual patients' health needs are met
- When patients use the service, they are free from harm.
- Patients report positive experiences of the service.

Domain 3: Inclusive leadership:
- Leaders routinely demonstrate their understanding of, and commitment to, equality and health inequalities.
- Board/Committee papers identify equality and health inequalities related impacts and mitigations.
- Leaders ensure levers are in place to manage performance and monitor progress with staff and patients.

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Rapid literature review: Health inequalities within a local area

RSM UK Consulting LLP & Professor Rosalind Raine, UCL

What is this?

- RSM looked at good examples of how ICSs are thinking about, supporting and meeting the needs of people who might not have equal access, experience, or outcomes from healthcare.

Key things to know

This work covers the themes:

1. What are effective ways of identifying local health inequalities or potential health inequalities?
2. What is the evidence-based approaches that work to address health inequalities within a local area?
3. What does successful engagement with local people and communities look like?

How might it relate to this work?

- This work aimed to help CQC with their development of assessment criteria for ICSs and how they address inequalities, so is extremely pertinent to this work.

Link

- Health inequalities in a local area

Highlighted findings/key domains:

This work highlighted the following learnings for CQC for developing a framework for assessment:

- **Leadership**
  - Vision and understanding of the system
  - Collective ownership
  - Whole pathway framework
- **Integration**
  - Length and amount of funding
  - Partnership / joint working
  - Commissioning arrangements / contracting
  - Wider determinants of health
  - Community assets
  - Population profile
- **Quality and safety**
  - Information governance and data sharing
  - Use of data and data quality
  - Co-production of services
  - Engagement with communities
  - Feedback from communities
  - Engagement with populations at risk of inequality.

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Listening, learning and taking action with people and communities: Development tool, 2023
NHSE Derbyshire, Tool

What is this and who does it apply to?

- Joined Up Care Derbyshire (JUCD) wanted an approach to working with people and communities that felt different, and community led, with a widely owned shared vision and purpose, and the citizens voice built into 'Place' decision making on a continuous basis.
- This Insight Framework looks at how the ICS can identify and make better use of insight that is already available in local communities.
- All components of this framework have been, or are currently being co-produced with a wide range of system partners.

Key things to know

- The framework looks at 3 levels within 5 domains (right):
1. Level 1 is focused on personal commitment and consideration of what is required – I have considered
2. Level 2 moves into active mode – I am / we are
3. Level 3 is when a change or action has been completed – We have done

How might it relate to this work?

- This is a pertinent framework for considering ICS engagement.

Link

- Development and Support tool

Highlighted findings/key domains:

The tool uses five areas:

- **1. Understanding Power:** To achieve meaningful relationships with the community, to build trust and develop and share the importance of an accurate and deep understanding of community experiences, needs, ideas and ambitions.
- **2. Enable Social Action:** So that change can be led by the community. Exploring what people want to talk about, change and influence, and understanding how they want to do this.
- **3. Building a picture of community experiences, needs, ideas and ambitions:** So that accurate and deep community led insights can be understood and shared.
- **4. Connecting community and the integrated care system:** So that community led insights can shape solutions and services.
- **Making a difference together:** To address health inequalities and improve services and health outcomes by translating community led insight into action.

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Tackling Inequality Commission Report

2024

Diabetes UK

What is this and who does it apply to?

- This research looks at inequalities in diabetes care across healthcare.
- This user-led research included the voices of people alongside the data on inequalities in diabetes care.
- Diabetes UK produced calls to action across seven areas, with anti-racism as the number one area.

Key things to know

- When developing this work, Diabetes UK ran a workshop with the King's Fund, exploring different frameworks, which helped them structure their calls for action.
- The research looks at inequalities and produces calls to action as a values-led framework for measuring progress.

How might it relate to this work?

- A discussion about frameworks may be a useful starting point for coproducing the outputs of this work.
- The 'calls to action' lens is both pro-active, familiar and assertive.
- Leading with an anti-racist approach offers a robust challenge to addressing health inequalities in diabetes.

Link

- Tackling Inequality Commission Report

Highlighted findings/key domains:

The 7 'call to action' areas are as follows:

1. Anti-racism – be bold
2. Address deprivation – be proactive
3. Environments – be supportive
4. Data and insights – be specific
5. Representation – be diverse
6. Co-creation – be inclusive
7. Sustainability – be persistent

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Integrated care systems and equity: prospects and plans
Maria Goddard, Journal of Integrated Care

What is this and who does it apply to?

- This research explores how the integrated approach of ICSs may help to facilitate progress on equalities.
- It looks at the content of the 23 overarching ICS plans in order to explore how they focus on health inequalities and the strategies they intend to employ to make progress.

Key things to know

- Findings include that ICS plans differentiate between process outcomes (access to services) and health and wellbeing outcomes (including mortality).
- The role of health behaviours (obesity/physical activity) is also key as are the wider determinants of health.

How might it relate to this work?

- This paper describes the role of ICSs in reducing inequalities very clearly and this narrative may be very useful in shaping the messaging for the engagement sessions in subsequent project stages.

Link

- Integrated care systems and equity: prospects and plans

Highlighted findings/key domains:

- The research highlights that inequalities in ICS plans are usually expressed in terms of health and well-being outcomes, or in terms of process outcomes, such as access to health and care services.
- The paper draws attention to the limitations in addressing equalities through a 'clinical lens' and the need for whole-system working to address the wider determinants of health, including education, housing and economic factors.
- The role of the NHS as 'anchor organisations' within their own communities is also highlighted.

Understanding integration: How to listen to and learn from people and communities
Thorstensen-Woll, Wellings and Crump, The Kings Fund – Guide

What is this and who does it apply to?

- A practical guide for partners working in ICSs about how ICSs can listen to and learn from people and communities, with ideas on how they might go about this.

Key things to know

- The guide, created by The King's Fund and Picker on behalf of NHS England and NHS Improvement, has been developed with input from ICSs, patient leaders, and engagement and experience experts.

How might it relate to this work?

- As a coproduced piece of work, this is useful and includes Ten principles for engagement and a visual Roadmap to understanding people's experiences of integrated care.

Link

- How to listen to and learn from people and communities

Highlighted findings/key domains:

Ten principles are:
1. Build a shared purpose for this work across systems
2. Place this work at the heart of your organisations
3. Set the right culture
4. Place this work on an equal footing with other data and information gathered at a system level
5. Be clear that this work is everyone's business
6. Build on the resource that exists locally
7. Ensure you have the right skills, capacity and resource in place
8. Ask the right questions
9. Who you hear from matters
10. Turn understanding into action

Roadmap:

What is the aim of the project?

Who needs to be involved?

What do we want to find out?

What is already known?

Who do we need to hear from?

Which approaches are most appropriate?

How do we collect and interpret what we hear?

How do we turn data into action?

Where are we now?

Tackling inequalities in healthcare access, experience, and outcomes
Yorkshire and Humber Academic Health Science Network for the Health Foundation/ NHS England

What is this and who does it apply to?

- This supports NHS systems in reducing healthcare inequalities and complements the Healthcare Inequalities Improvement Dashboard and Actionable Insights tool.

Key things to know

- Based on analysis of 32 case study examples for tackling inequalities in healthcare, four themes emerged (right), which are proposed as necessary foundations for sustained service level action.
- Under each of these themes there is a framework in the form of a checklist for: ICS system leaders, ICPs, provider collaboratives and within NHS bodies to consider whether they are creating the necessary conditions for improvement.
- The framework is also suggested for service teams to assess whether they are working within an enabling context (and could be extended to wider system partners, such as VCSE).

How might it relate to this work?

- The framework might be good to test with the VCSE.

Link

- [Tackling inequalities in healthcare access, experience, and outcomes](#)

Highlighted findings/key domains:

Four themes that are needed to create sustained action. Under each theme and sub-theme are a set of questions.

1. **Creating an enabling system context**
   1.1 Systems leadership
   1.2 Governance and resourcing
2. **Building clear and shared understanding**
   2.1 Start with the data
   2.2 Test the data with lived experience
3. **Maintaining a sense of urgency and commitment to act**
   3.1 Raise awareness
   3.2 Engage leadership on the issue
   3.3 Engage hearts as well as minds
   3.4 Commitment of resource
4. **Focusing on implementation, impact and evaluation**
   4.1 Using a logic model
   4.2 Have an orientation towards action
   4.3 Action, test and learn

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Review of the Mayor of London's Health Inequalities Test

Gainsbury S and Hutchings R for the Nuffield Trust.

What is this and who does it apply to?

- The Nuffield Trust was commissioned to undertake a review of the Mayor of London's health inequalities test: the first of six 'tests' expected to be met when considering major health care reconfigurations in the capital.
- This analysis reviewed recent evidence of health care inequalities in the NHS in England and highlights ways the tests can acknowledge a changing understanding of the way inequalities arise within the NHS and health care more widely following the pandemic.

Key things to know

- The overarching aim of the review was to develop recommendations for the future of the test as it is applied to major health care reconfigurations in London.

How might it relate to this work?

- The review differentiates between health inequalities and health care inequalities, which may be useful framing for this project.

Link

- Review of the Mayor of London's Health Inequalities Test

Highlighted findings/key domains:

- The review notes that work around healthcare inequalities is dominated by the "protected characteristic" framework of the Equality Act, which excludes socio-economic deprivation and as such, is poorly suited to capturing the way structural inequalities intersect.

The recommended new test is worded as follows:

- 'The proposed changes make best use of the opportunities available to the health system to reduce health and health care inequalities which have been set out transparently together with an evidenced plan for further action. The plans clearly set out proposed action to prevent ill health, including targeting action and resources to improve the healthy life expectancies of the worst off, including groups who experience wider structural inequalities.'

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3. Taking action: How are ICSs currently taking action to improve outcomes for populations experiencing poor care?

Summary:

- The **Equality Delivery System 2022** is a framework that NHS systems and organisations are contractually obliged to complete, in discussion with local partners and local populations, review, score and improve their performance for communities with protected characteristics, to help meet their duties under the Equality Act 2010.
- There are many examples of **approaches, frameworks and tools** that have been developed in different areas for listening, learning and taking action from community engagement. There are also tools and guides that have been developed nationally, such as the guide included here from the King's Fund. These contain a wealth of advice and domains that highlight enablers in this area.
- In 2023 the CQC commissioned a Rapid literature review, looking at **local approaches to address health inequalities**. This work aimed to help CQC with their development of assessment criteria for ICSs and how they address inequalities, so is extremely pertinent to this work.

Key themes in domains for 3. Taking action:

- **Leadership and vision:** Effective leadership with a clear vision and understanding of the system, coupled with collective ownership and a whole pathway framework.
- **Integration and partnership:** Integration of services, appropriate funding, collaboration, and understanding and addressing the wider determinants of health.
- **Data and governance:** Embedding effective governance and using data effectively.
- **Co-production:** Defining problems and enablers with key communities, understanding power dynamics, enabling social action, building deep community understanding, and connecting communities with the system.
- **Equity-focused actions:** Anti-racism, proactive measures to address deprivation, supportive environments, diverse representation, and inclusive co-creation.
- **Implementation, impact, and evaluation:** establishing an enabling system context, building shared understanding, maintaining urgency and commitment, and focusing on implementation, impact, and evaluation.

4. Measuring outcomes

The following literature explores how ICSs are measuring the outcomes of understanding and acting on the experiences and needs of people more likely to experience poor care, through asking the question:

- How are ICSs currently measuring improved outcomes for populations experiencing poor care?

Evaluating and evidencing asset-based approaches and co-production in health inequalities: measuring the unmeasurable?   2018

Andrade & Angelova, Critical Public Health

What is this?

■ An Assets Model was applied to develop and implement a co-produced methodological evaluation framework – *Asset-Based Indicator Framework* – measuring impacts of creative community engagement on health and inequalities.

Key things to know

■ Working with communities, this research developed a framework for evaluating the impact of engagement on different inequalities indicators.

■ The framework uses a Who? Why? What? And How? Approach to articulating the engagement approach.

■ The framework uses challenging questions, such as "What if the community wants something different to what you want?"

Link

■ Asset-based indicator framework

■ A useful training pack on the Asset-Based Indicator Frameworks is here.

Health inequalities, improving accountability in the NHS

Institute of Health Equity
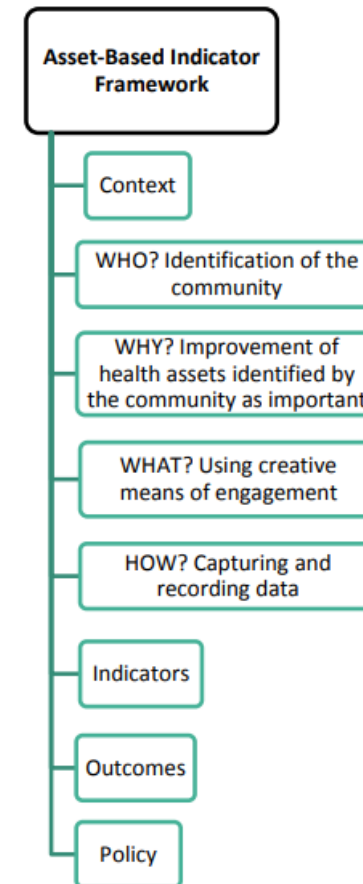
What is this and who does it apply to?

- This report looks at mechanisms and levers that enable and hinder accountability for health inequalities, and analyses whether these processes are sufficient to reduce health inequalities.
- The report provides proposals to improve accountability for health inequalities across ICSs.
- As well as policy documents, this review included 18 semi-structured ("off the record") interviews with people in senior NHS management roles and/or held academic posts.

Key things to know

Key components of a stronger accountability system were identified As:

- 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

How might it relate to this work?

- This work emphasised that there was a strong need for central data, guidance and advice for addressing inequalities.
- The work emphasised the role that transparent data systems can play in allowing communities and other stakeholders to play a part in accountability.
- It noted that many data sources and IT systems that pertain to inequalities are currently not available for non-NHS stakeholders.

Link

- [Health inequalities: Improving accountability in the NHS](link) (link downloads file)

Rapid literature review: Strategy assurance indicators   **2023**

CQC/RSM UK Consulting LLP

What is this and who does it apply to?

- This research looks at how regulatory and oversight organisations evidence the impact of their strategies and how this is monitored and communicated.

Key things to know

The most cited benefits of the measures and/or indicators currently in place across CQC and other regulatory or oversight bodies included:

1. Simplicity and ease of use/understanding
2. Identification of areas of high or poor performance against overarching strategic objectives
3. Providing strategic direction and focus
4. Measuring tangible impact
5. Raising awareness and promoting positive impact.

How might it relate to this work?

- While not directly relating to this topic area, some high-level findings may be helpful in considering the particular benefits of outcome indicators, and suggested next steps may be of interest.

Link

- Strategy Assurance Indicators

Highlighted findings/key domains:

For regulatory and oversight bodies to leverage the findings of this research, we suggest that they consider the following next steps:

- A simplified logic model and theory of change that could add value and showcase the high-level causal linkages.
- Proportionality and pragmatism in terms of allowing impact to be captured (for example, balancing how the data will be used versus the time and resources required to set-up, collect and analyse).
- Translating indicators of impact and strategy effectiveness into a story or narrative.
- Clear ownership of indicators (including a senior responsible owner with ultimate oversight and accountability) would improve accountability and streamline the monitoring process.

4. Measuring outcomes: How are ICSs currently measuring improved outcomes for populations experiencing poor care?

Summary:

- The challenge of measuring the outcomes of community engagement is one of the hardest ones to tackle.
- The majority of engagement evaluation centres on process and the impacts on individuals who take part, rather than wider outcomes for communities as a result. This is often because of the complexity of the contexts and issues within which engagement takes place: engagement is likely one of many factors that influence population outcomes at any given time.
- While there is a lot of work measuring inequalities, there is very little in the way of measuring improved population outcomes. This may be partly due to the definition of those outcomes being clinical indicators, and those indicators being something that cannot be usefully measured in short or medium-term timescales.
- This was the area where there was the least evidence of systems in use across ICS. However, this may not be surprising as they are still in the early stages of this work, or may not have published their approaches.

Key themes in domains for 4. Measuring improved outcomes:

- If there is to be co-created evaluation, then evaluation frameworks based on community goal-setting is a good approach.
- Involving communities in evaluation requires data that is accessible for non-system stakeholders, and this is often another challenge as data systems are often inaccessible to non-health partners.
- Involvement of communities requires simple communication and models to empower people to get involved in the process.
- It will be more useful/feasible for ICS to evaluate their processes and measure the impact public engagement makes to people, services and/or teams/cultures in the short-to-medium term, than try and directly link it to changes in wider population outcomes that are simultaneously affected by many other factors. However, shorter-term changes should be accompanied by clear, logical arguments that link how they are then anticipated to contribute to longer-term changes in population outcomes.

5.   Stakeholder Interviews

The following insights were gathered through discussions with leaders within the NHS and the VCSE sector.

The conversations explored how ICSs showing promise in this space are actually finding the process of tackling inequalities by working with their communities.

To ensure that participants could speak freely, including offering perspectives on what was not working well, we agreed that the insights shared would not be traceable to individuals, or to specific Systems except where necessary to understand the messages.

5. Stakeholder Interviews: How is promising practice playing out in a real world environment?

Summary of findings:

- It is really early days still for the ICSs, and so the emphasis from the emerging best practice is very much on the word emerging.
- Each of the frameworks and tools that have been developed have been designed with a specific purpose in mind – sometimes to give boards oversight, other times to give engagement teams a mechanism for highlighting their work.
- Existing tools are often being used in parts of systems – so at Place level, or within specific providers, or pathways – not across systems.
- Some tools have undergone significant redesign post their "first contact" with the real world to ensure they are fit for purpose, as a result they are not yet embedded.
- There isn't necessarily cross over between tools that support engagement and those that support work to tackle inequalities.
- Leadership support for this work is being squeezed.

- The tools that seem to be working best are those which have been designed to align with the wider strategic priorities of the ICS.
- Awareness of tools among local VCSE organisations and communities themselves is low. This is unsurprising given the early stages of this work.
- Stakeholders questioned whether, given the variation within systems and the diversity of their communities, it is even possible to make a statement about how well an ICS is doing at engaging people at the system level.

Caveats:

- These headlines are drawn from 16 interviews across 4 ICS sites identified through the rapid review of emerging practice. They are therefore only a snapshot, and can only provide a partial understanding.

Key things to be aware of:

The stakeholder conversations highlighted a few key things to consider as we move into testing the framework and tools:

- We need to meet systems where they are to ensure tools are pitched at the right level, recognising that many of them are building from a low baseline.
- Given the pressures on budgets and time, the process of completing the framework should be light touch.
- Due to the variation between different ICSs the framework needs to avoid a one-size-fits-all approach – leaving space for systems to build on existing strengths and structures, recognising that these operate at different levels and in different places within each system and are owned by different organisations.
- Whether the aim of the tool is to drive the creation of new ongoing mechanisms for engagement, or specific engagement exercises. The latter may be easier to define and measure, but the former will create more meaningful outcomes.

Possible areas to explore through the domains:

- **Exploring leadership** – Board-level champions and empowered leaders within ICBs were clearly critical.
- **Exploring process** – Thinking about where and how community insight is built into "business as usual" structures e.g. data dashboards / businesses cases
- **Understanding which communities** – Understanding which are the communities that need to be engaged and why. It was clear that some systems are prioritising insight from "the community" as a whole and are starting where the energy is while others are seeking community insight primarily from groups whose voices may not otherwise be heard.
- **Avoiding duplication** – There is a significant risk that any tool creates an incentive to do more engagement work, to the detriment of drawing on existing expertise and insight in the community. It will be important that the tool supports the use of different forms of community insight including tapping into the knowledge held within VCSE organisations. **Using data** – It will be important to think about how the tool can capture how community insight is used to drive action, and how it could define and encourage robust processes for bringing community insight into decision making processes. Understanding the extent to which there are feedback loops back into communities will also be important.

6. Conclusion

Conclusion

In examining how Integrated Care Systems (ICSs) might approach the addressing health inequalities and improving outcomes for populations experiencing poor care, several key themes emerge.

Firstly, assessment frameworks for measuring progress against People and Communities Strategies are essential, with an emphasis on empowering communities, community participation, understanding community needs, building trust, fostering partnerships, and ensuring accessible communication.

Secondly, identifying populations at risk of inequalities involves clear definitions and data sets, utilising various tools for data analysis, and adopting models like the CORE20Plus5 approach.

Thirdly, taking action requires strong leadership across the system, equity-focused actions, and appropriately resourced implementation, impact, and evaluation mechanisms.

Lastly, measuring outcomes should entail co-created evaluation frameworks that focus on both what changes for people involved and what changes for people, teams/cultures and/or services as a result of engagement, accessible data for non-health partners, and simple communication models to empower communities.

Overall, these findings underscore the importance of collaborative, community-centred approaches underpinned by clear leadership, data-driven decision-making, and a commitment to equity to effectively tackle health inequalities within health systems.

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Long list of sources

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Appendix 2: Stakeholder Interviews

About the interviews

This appendix sets out insights elicited through discussions with leaders within the NHS and voluntary, community and social enterprise (VCSE) sector organisations within Integrated Care Systems (ICSs) which had been identified as having promising practice to share in relation to the use of community insights to inform work on health inequalities.

Some of the sites were selected from the desk review and others were identified through contacts at NHS England.

In total, 16 stakeholders were engaged across four systems. These included systems covering a mix of rural, urban and coastal areas, and were selecting from different regions across the country. The sites populations also reflect a mixed picture of deprivation.

In addition to speaking to lead members of staff of Integrated Care Boards (ICBs) in the four Systems, we also spoke to a handful of key stakeholders who had been involved in insight work. Some of these were suggested by the NHS contacts, others were proactively approached by National Voices. They included local Healthwatch organisations, charities and community groups.

To ensure that participants could speak freely, including offering perspectives on what was not working well, we agreed that the insights shared would not be traceable to individuals, or to specific Systems.

Key Insights

The importance of leadership

Participants in all the Systems we approached identified individual leaders – usually Board Chairs and / or CEOs - as playing a central role in creating a space for community insight across their Systems. Staff were clear that community insight and / or health inequalities work was being taken seriously because Board members had championed it.

Board champions were important in giving credence to community insight and in ensuring that the need to engage communities was taken seriously at Board level. This brought resources to these agenda, and created more opportunities for staff working on these agenda to share insights with senior staff.

"I've been invited to speak at lots of different strategic places in the System, including by the chair. So I think the impact is, it is starting to see people change their view and ask, how do we do this? How do we embed this in our work and what do we need to be doing differently?"

The other key people in these Systems were the individuals who led community insight / engagement functions within the ICBs (i.e. the NHS staff members to whom we spoke). It was notable that these were often individuals that had joined the ICB from outside the NHS – either from local authority Public Health functions, Healthwatch or VCSE organisations. These leaders were described by other participants as vital champions and advocates for working with communities and as providing support and creating routes in for those working within communities to engage with the System – e.g. inviting them to speak at events etc.

However, concerningly, we heard from participants in several Systems that work on community insight was being squeezed out by national priorities and pressing financial concerns. This meant that Board level leaders were now less focused on this agenda, teams leading this work were being cut back and restructured, and budgets for community insight work reduced.

The importance of relationships

Another common theme across all participants was the role of positive and longstanding relationships in supporting effective community engagement and insight work.

Many of the community insight systems and teams had been built on existing infrastructure and relationships that pre-dated the establishment of the ICB. These functions had often "come across" to the ICB from non-NHS parts of the System. Participants emphasised the critical importance of trusting relationships between those in the NHS and communities, and of working through trusted intermediaries.

"I think the good practice is hard won and long term and we benefit in the city because there's been long-term investment from the council in community development support that then ICS and health have come in and so they reap the benefits of that long-term investment"

Another aspect of relationship-building that emerged as critical was the emphasis teams within ICBs placed on developing communities of practice among those involved in community insight work. Several Systems had set up, or were setting up, groups which brought together those working to gather community insight in different areas / communities / parts of the System. These offered peer support to those engaged in working with communities, emboldening them to continue their work, which could otherwise feel like an uphill struggle against prevailing power structures.

The role of tools

The primary focus of this investigation was to uncover insight around the use of tools to support the evaluation of the use of community insight to inform work to address health inequalities. While these were discussed, it was notable that they came relatively low down on people's lists of things that had made the difference to their System's approach to community insight.

Two Systems in our samples had developed bespoke tools for this purpose. The tool in ICS A was explicitly designed to support evaluation and reporting on community insight work whereas the tool in ICS B was more of a self-assessment tool for those involved in the work.

Some important insights into their status emerged during the process of these discussions:

- The original version of the ICS A tool is no longer in use. It was considered "clunky" and had not proved to work in practice. A slimmed down version of the tool more closely aligned with the ICBs existing priorities, and less reliant on bespoke data collection had since been developed. However, this new tool remained largely untested as the ICB had entered a restructure that had drawn staff time and resource away.

- The ICS B tool was not being used systematically across the system – but was being used on a voluntary basis by early adopters.

As such insights on the use of the tool in practice were limited. However, a few key points emerged:

Insights from ICS A

- The tool was developed to ensure that work on community insight was understood and given legitimacy at the Board level – making this work measurable was seen as an important way to secure its position within the ICB.

- The original tool had proved too complex and required too much bespoke data to use in practice. The new version had been revised to create a much clearer alignment between the tool and the overarching System priorities and targets.

- The new version was designed to support those undertaking community insight work to identify at the outset what they wanted to achieve and how they would know they had achieved this – there was more emphasis on using data that could be collected along the way (e.g. saying we want to reach x communities, and then being able to report later that this happened).

- There was little awareness of the tool outside the NHS. Participants outside the NHS did not see this tool as driving the work that they were doing.

Insights from ICS B

"The tool has helped people to mostly grow in confidence to do the thing that they were intuitively wanting to do"

- The tool was primarily intended to support self-assessment and self-reflection by organisations undertaking work on community insight.

- Those who were aware of the tool had primarily found it useful in validating and reinforcing their understanding of best practice in community insight. Some described using it as a springboard for creative conversations.

- The tool was seen as helpful in giving legitimacy and credence to those seeking to "disrupt" systems and to make the case for community insight.

- There was recognition that the tool encompassed both very broad concepts which were essentially about organisational culture – in particular the focus on power – and narrower concepts around the use of data. Separating these out into guidance on best practice and culture change and a tool on data and insight was being considered for future iterations.

- System staff recognised that the tool worked best for those who already had some understanding of, and commitment to working with communities and with the narratives around coproduction and sharing power.

- In contrast those less familiar stakeholders found the tool was "a lot of words" and that it needed to be brought to life with worked examples

- These staff also were increasingly finding that the assessment tool did not start from a low enough base – many using the tool couldn't recognise their practice even at the lowest levels

- Stakeholders told us the tool only covered part of the job needed to drive meaningful community engagement – the current tool covers the "how" of gathering insight and working with communities, but not the "how" of this insight can inform practice within the NHS where it needs to "compete" against other priorities

"[Focus is now needed on] the messy middle bit where you go from intelligence and insight and views and feelings and all of that stuff into commissioners and the shape of services and the way in which things are delivered and they're planned."

"What's the process and how do you turn that insight into what does it look like and how then do you describe that to people or how do you know that's made any difference in a year's time?"

Insight from ICS C and D

- ICS C (North East London) did not have an evaluation tool for its community insight work, but in many ways its community insight work seemed to be the most systematised and mature of the Systems engaged with (although it is important to note that this exercise only offered a very limited snapshot of practice in each System).

- Desk research had identified that the HEAT (Health Equity Assessment Tool) tool may be relevant to this project. From the conversations with NHS England, ICS D was identified as one of a number of ICSs now using this tool to address inequalities. However, upon further conversation and investigation it was clear that community insight data was not yet being used as one of the data sources to inform the HEAT analysis.

General insights

Across all areas participants reflected a view that tools came second to culture and individual commitment in driving action on community insight and / or health inequalities. However, participants (especially those within the NHS) recognised that they could be helpful in bringing new people into the conversation around community insight work

"Having an insight framework as part of the engagement strategy of the Integrated Care System has been a hook to put all this on. And that's been absolutely key because we can keep going back to, well you said you want to put this at the heart of everyone's work."

"Because there is a mandate and a tool now it feels much easier than it ever has."

Community insight and health inequalities

While the focus of this project is on utilising community insight to inform work to address health inequalities, it was notable that the link this project makes between these agenda was not evident in all Systems to which we spoke.

In one System we heard that the main focus of the community insight work within the ICB had been on encouraging health system and leaders and clinicians to share power with people in general, rather than taking forward targeted work to tap into community insight to uncover or address health inequalities. Some participants expressed some concern that this could, in practice, exacerbate inequalities by amplifying "louder" voices over and above those of people experiencing health inequalities.

In another System we heard from NHS staff that the focus of community engagement was led by Core20Plus5 priorities and understanding of inclusion health groups etc. However, several other participants in this area told us they felt engagement work was less data driven and more influenced by which communities were "in fashion".

Other participants in the same areas attributed their engagement work to their own proactive approach in finding routes to engage with their ICB.

"So you have to be proactively try and engage with them to get them to engage with you."

Another key insight was that, even in apparently leading systems, community engagement processes are not yet embedded right across all Systems and at all levels. In most Systems the community insight team was being invited to work on specific projects or programmes, or in specific geographies – standing up engagement processes and gathering community insights to inform individual programmes. Teams were cognisant that other decisions were being made without community insight or engagement.

It was notable that, at system-level, community insight was not necessarily informing the big strategic decisions. Participants also reflected that the pattern seemed to be one in which community engagement processes were stood up in relation to individual programmes rather than standing mechanisms being created.

"It feels like if we could get a two or three year funding, then you could look at the data year on year. So instead of snapshots, we could actually say, 'Well, this is what it looks like now. This is what it looks like in three years time. And what are the trends?'"

Where there were some standing mechanisms being created these were generally in localities – at place or neighbourhood level. For example, in one System a small number of local health forums were being established around trailblazer integrated neighbourhood teams.

More generally there was a sense that System-wide community insight was not meaningful, due to the massive diversity of the communities encompassed within Systems. And while our contacts within the NHS were operating at ICB it was clear that most of the "action" was taking place at Place level, with organisations engaged with Place Based Partnerships rather than the ICB as a whole.

The exception to the lack of a System-level approach was North East London (NEL), which had commissioned a Community Insight System from a local VCSE organisation (formerly a provider of local Healthwatch) which operated across the System and which appeared to be building an approach to community insight into System-wide processes. For example, we heard that there was now a requirement for emerging businesses cases to include information around what community insight had been accessed and community insight was being incorporated into system dashboards and reports alongside financial and clinical data. This parity of prominence was considered to be important in ensuring the community insight was taken seriously and was helping to bring community insights onto the radar of a wider audience.

Participants in NEL emphasised that having quantitative as well as qualitative insights – and being able to bring together qualitative insights in a robust way – had been critical to ensuring that community insight could be taken seriously.

Community Insight Databases

While North East London (NEL) had the most established Community Insight database, other areas were also developing these.

Participants in NEL emphasised two key features of their insights system that they believed were vital to its success. The first was the strong emphasis placed on gathering demographic data alongside insights so that there was a robust sense of where they came from. The second was the work put into coding data so that it could be crosscut by issue, place etc. Staff leading the Community Insight System emphasised that it had initially had to prove its worth to the ICB, by showing that accurate data could be quickly accessed. They had also tried to always be open about the limitations of data and to encourage clinicians and others to corroborate community insight data with other sources and that this had helped build confidence.

In all Systems community insights databases were intended to be repositories of insight gathered from a range of sources, including the VCSE and Healthwatch as well as data directly

gathered by the NHS through exercises it led or commissioned. In practice, however, it was not clear that insight from the VCSE was feeding in. Indeed, we heard from several participants that the NHS was missing out on the insights and expertise held within VCSE organisations and it was noticeable across all Systems the structures for community insight operated separately to those designed to support VCSE input to ICS.

There was some sense that the NHS did not trust existing insight – and was reluctant to gather insights from VCSE organisations, preferring to establish their own "fresh" consultation exercises:

"I think there's quite an uphill battle in some sectors more than others where although the need for consultation and co-production I think is now being appreciated, there's a lot of protectiveness over everybody having their own consultation service and what insight we are gaining within our service with our service users."

Participants in NEL were confident that their Community Insights System was being used consistently to tap into existing insights around different communities and that as a result bespoke data collection exercises were being used appropriately to address gaps in understanding.

However, in other areas it was not yet clear that this was the case and we heard concern that duplicative exercises were being carried out. For example, in one area we heard of a charity which had been funded to deliver two separate engagement exercises with their service users on different aspects of NHS delivery, with many of the insights gathered duplicated across both exercises.

"We always seem to start from the beginning of engagement, asking similar questions instead of perhaps coming in and saying, 'This is what we learnt. Here is this learning, can we move forward with that learning or have we missed something? Can you give us more details about that?' But we start from ground zero again and that's such a waste of resources and it's also disenfranchising to people because it reflects back that you haven't listened."

"We've got huge amount of data anyway. We collect data about people's health needs already. We have got years' worth of data that we could track of the homeless population of this part of [county…]. So we're, I hate to say 'chasing the money' sometimes that in order to get money to deliver the services we need to deliver, we're having to constantly plough through and do the same thing over and over again for a different audience."

Across all Systems, participants spoke about real concerns around consultation and engagement fatigue – recognising that multiple engagement exercises were underway with communities beyond those led across the ICB (for example

processes linked to charitably funded initiatives, and university research etc).

"I think the stop start nature of health funding is really detrimental to those projects and that you can't maintain a relationship because it's tiny bits of funding. I think that's where the consultation fatigue comes in, that you do a report, you go, what do you think about this? Let's get some insight. There's no feedback loop because it's slow to make the action and because those are funded as individual projects and not general, we're going to work with the community on different issues."

"The jading part of it, the people. So lots of our clients have been in and out of homelessness services for years. They may have answered similar questions many times over a number of years, but they don't see anything change. And I think that's where it gets difficult"

Funding Community Insight work

There were very mixed approaches to how community insight work was being funded across the Systems we spoke to.

One area had a small grants programme to fund pieces of community insight work. In some areas contracts were being issued for place-based insight work. Others were commissioning community insight work out of the budgets relating to specific projects. Others were piggybacking on existing structures and processes.

The impact of community insight

Most of the leaders we spoke to were clear that it was too early to be certain about whether and how the insight gathered from communities would be used to inform action.

"I don't think we're quite at that point to see the actions that come from the data, but it's good that they're working with partners to gather the data."

A strong theme across all our conversations was how "young" the processes for gathering community insight were across ICBs – reflecting the relative youth of the organisations themselves. Participants were generally hopeful that their input would be used to make change, however several of the VCSE organisations we spoke to told us they did not know what had happened to the insights they had shared and there were concerns around a lack of mechanisms for feedback to communities.

We also heard concern that budget challenges would impact the extent to which services could respond to community insight. In one case we heard from one participant that it had recently become clear that no action would be taken in response to community insight on a particular service, because the budgets for that programme had been slashed subsequent to the engagement process. Unfortunately, another participant, whose organisation had supported the engagement, was not yet aware of this reality.

This reflected a broader theme around the challenges of engaging with communities around addressing inequalities in a context where budgets were so tight and little could be done. In one area we heard that this had led to a creative process in which the community was being brought into working together with multiple agencies too pool budgets for reaching underserved communities to achieve shared goals. However, this was not a common story.

Challenges for community insight

We also heard that there were ongoing challenges in building meaningful community engagement into structures like ICBs because of the very different drivers. Participants emphasised the need for building trust when working with communities, and how this created challenges for organisations which tended to work on the basis of short-term funding, with considerable staff churn.

"I would say the ICB struggles to take a long-term view of communities. It's a political organisation, it goes in cycles, it's top down, these are things that it can't help. These are facts of our life that is not what works in communities. So if you look at what works isn't a tool, it's about a set of relationships that you can lean into make stuff happen."

Although some participants argued that a concern around reputational damage and maintaining public buy in was potentially creating a driver towards greater community engagement.

Participants also pointed out that the complexity of Integrated Care Systems meant that it was very difficult to establish an approach right across a System.

"The will is absolutely there and the culture and mindset seems to be on board with this 100%, but actually doing things then in a different way is a very different matter"

Testing the emerging framework

We asked participants whether they agreed that three key questions for assessing community insight work would be "Do we know who we need to talk to?"; "Do we talk to them?"; and "What do we do with what they tell us?" Most agreed these questions made sense.

It was clear, however, that in most System areas there was not a clear and systematic approach being used to address the first question. In relation to the second question, most areas were able to assess who they were talking to in terms of their direct engagements with residents. However, this potentially meant that there was an over-emphasis on bespoke data collection to the detriment of tapping into existing sources of expertise. There were major gaps in relation to the third question – in most places it was simply too early to make this

assessment, but also there was a lack of clear mechanisms for systematically converting community insight into plans for action and then providing feedback to communities to provide confidence.

Challenges for creating tools

When discussing the potential for new tools to be created it the majority of stakeholders expressed some concern about how these could be made to be sufficiently flexible to fit different local circumstances. In particular stakeholders emphasised the need to create tools which encouraged systems to build on existing strengths and structures and the need for flexibility around different localities.

"When people start talking about toolkits and one size fits all, that's where my heartbeats because it just doesn't work. You've got to build on what you've got and the strengths of the communities that you are working in and in different areas the lessons need to go much more high level. Where is the leadership? Where is the trust? Who has the networks? Are they open networks, are they inclusive networks?"

Key considerations

As we move into developing a tool, a few key considerations emerge from these conversations, including:

- The need to meet systems where they are – it will be important to ensure tools are pitched at the right level recognising the low base from which many systems are building

- The need to keep processes light touch – given the pressures on budgets and cuts to teams it will be important to ensure that any evaluation does not rely on bespoke data collection

- The need for alignment – the tools that seemed to be working best were aligned to the wider strategic priorities of the Systems in which they operated – linking to priorities held more widely across the System. This will obviously be challenging for a tool at national level given the wide variation across Systems in terms of how priorities are structured and expressed

- The need to avoid one-size-fits-all – any tool should leave space for Systems to build on existing strengths and structures, recognising that these operate at different levels and in different places within each System and are "owned" by different organisations

Possible directions

This exercise has uncovered some potential areas into which a future tool may need to speak, in order to support Systems in developing robust structures. These include:

- **Exploring leadership** – Board-level champions and empowered leaders within ICBs were clearly critical. "Heroic leadership" may not be the ideal model, but having champions clearly makes a difference

- **Exploring process** – Thinking about where and how community insight is built into "business as usual" structures e.g. data dashboards / businesses cases feels important

- **Understanding which communities** – Understanding which are the communities that need to be engaged and why will be important. It was clear that some Systems are prioritising insight from "the community" as a whole and are starting where the energy is while others are seeking community insight primarily from groups whose voices may not otherwise be heard. It will be important to be clear what aspects of engagement with communities this tool covers

- **Considering timelines** – It will be worth considering whether the tool is intended to drive the creation of standing mechanisms or specific engagement exercises – the latter may be easier to define and measure, but the former may create more meaningful engagement

- **Avoiding duplication** – There is a significant risk that any tool creates an incentive to do more engagement work, to the detriment of drawing on existing expertise and insight in the community. It will be important that the tool supports the use of different forms of community insight including tapping into the knowledge held within VCSE organisations

- **Structures and systems** – It will be worth considering how the tool would capture the development and use of community insight databases and systems. Thinking about how these could encompass data from a wide range of sources will also be important.

- **Using data** – It will be important to think about how the tool can capture how community insight is used to drive action, and how it could define and encourage robust processes for bringing community insight into decision making processes. Understanding the extent to which there are feedback loops back into communities will also be important.