Integrated care systems

The poor care that some people receive – and the problems that many people face in getting access to care – is often influenced or caused by services not being joined up, or not working well together. But we do know that people get better care when local services work together.

Integrated care systems (ICSs) have a responsibility to make sure services work together to meet people's health and care needs. In 2022/23, CQC was tasked with a new responsibility to provide meaningful and independent assessments of the provision of health and adult social care services within each ICS area. This work has begun with pilot assessments, and we are working with government and local systems to refine the way we will report on what we see locally.

Part of our new role is to find out how different parts of local care systems are working together to meet the needs of their local populations. This includes understanding how local authorities fulfil some aspects of their Care Act duties and inspecting to find out how well integrated care systems (ICSs) are functioning to meet the needs of local populations – this includes understanding what matters to people in local communities.

In September 2024, we published an update on plans for developing an engagement and health inequalities improvement framework for ICSs.

Challenges and planning

In 2023/24, we piloted our new methodology framework for integrated care system assessments and learned from 2 completed pilot assessments. Following on from this, we have focused on the following 3 things to help us understand at what level systems have a shared vision:

- published integrated care system strategies
- joint forward plans (JFPs)
- local health and wellbeing strategies.

This focused work is in advance of our formal assessments of ICSs, which were planned to start over 2024/25. Our ICS assessment methodology will be updated for the Secretary of State for Health and Social Care to approve the final approach for our assessments, as required by the Health and Care Act 2022.

We set out to review ICSs' visions for their services – how they align at system and place levels, and if joint plans demonstrate how improvements will be delivered and implemented over the next 5 years.

Systems must update their joint forward plans annually. We wanted to understand any synergies among England's 42 ICS strategies, joint forward plans, and in health and wellbeing plans for specific system delivery areas where we previously identified that people often experienced poor quality of care.

NHS South, Central and West Commissioning Support Unit carried out an audit of the 42 system strategies in 2024, which was focused on actions taken to tackle health and healthcare inequalities. This work was a 'baseline audit' and identified that vision statements were focused on ensuring that populations and communities experience longer, healthier lives, using life expectancy and healthy life as the key metrics to track impact.

All systems used a 'life course' approach, ensuring that people have a 'best start in life, can live well and age well'. They all used the Core20PLUS approach. The audit also supported themes in research by CQC and NHS Confederation conducted in 2023 into exploring health inequalities funding across systems.

We can see 3 main challenges:

- finance
- joint forward planning
- workforce.

Finance

This is identified as the main challenge. Our baseline audit supported research by CQC and NHS Confederation into exploring health inequalities funding across systems, indicating finances as the main challenge to tackling health inequalities. This report in 2023 highlighted that leaders ranked tackling inequalities as the primary ambition they would like to have achieved in 5 years. In our latest review, 1 in 5 ICSs were 'not' confident in their ability to tackle inequalities and none were 'very' confident in doing so.

Our review shows that several ICSs were planning significant investment for improved urgent and emergency care, better system flow, and tackling 18-week waits. ICSs that are looking at capital investment to improve waiting times are considering new surgical theatre suites, surgical hubs, and improved information technology systems. Some systems have identified digital transformation as a key factor in allowing health and care organisations to make the most of the information they hold and to work together.

As a minimum, plans of integrated care boards (ICBs) should set out how they, and partner trusts, will provide NHS services to meet local needs.

Joint forward plans

As well as finance, a key challenge demonstrated by the review – and in line with the audit – is that the joint forward plans lacked synergy across health and wellbeing board strategies, and ICS and integrated care strategies.

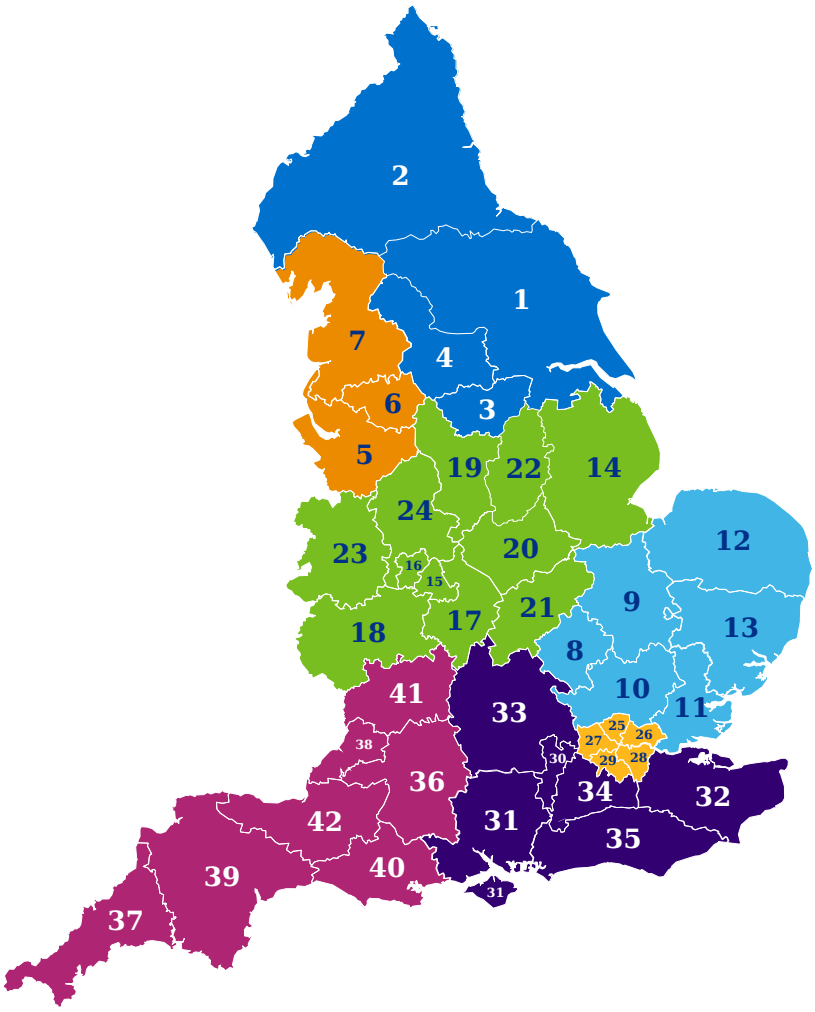
Only a minority of ICSs have developed detailed strategies with measurable key performance indicators (KPIs) for urgent and emergency care and system flow, dental care, children and young people, and dementia care. The KPIs rarely showed a localised approach to match inequalities and needs – without these indicators, people will not be able to assess annual progress.

Workforce

The third key challenge is workforce. ICSs provide the opportunity to take a 'whole system' view of the longstanding workforce challenges – and the strategies and plans recognise that the right workforce is key to achieving objectives. We found that most ICSs saw the importance of reducing their spend on temporary staff, and they have clear plans for improving recruitment, as well as staff retention.

However, along with upskilling a highly skilled and complementary skilled workforce to deliver new models of care, systems are still experiencing challenges related to culturally competent workforces. Culture, equality, diversity and inclusion and the workforce race equality standard are a key focus in ICS plans for the workforce.

Figure 21: Integrated care systems in England



North East and Yorkshire

1 Humber and North Yorkshire Health and Care Partnership
2 North East and North Cumbria Integrated Care System
3 South Yorkshire Integrated Care System
4 West Yorkshire Health and Care Partnership

North West

5 Cheshire and Merseyside Integrated Care System
6 Greater Manchester Integrated Care Partnership
7 Lancashire and South Cumbria Integrated Care System

East of England

8 Bedfordshire, Luton and Mid Milton Keynes Integrated Care System
9 Cambridgeshire and Peterborough Integrated Care System
10 Hertfordshire and West Essex Integrated Care System
11 Mid and South Essex Integrated Care System
12 Norfolk and Waveney Integrated Care System
13 Suffolk and North East Essex Integrated Care System

Midlands

14 Better Lives Lincolnshire
15 Birmingham and Solihull Integrated Care System
16 Black Country Integrated Care System
17 Coventry and Warwickshire Integrated Care System
18 Herefordshire and Worcestershire Integrated Care System
19 Joined Up Care Derbyshire
20 Leicester, Leicestershire and Rutland Integrated Care System
21 Northamptonshire Integrated Care System
22 Nottingham and Nottinghamshire Integrated Care System
23 Shropshire, Telford and Wrekin Integrated Care System
24 Staffordshire and Stoke-on-Trent Integrated Care System

London

25 North Central London Integrated Care System
26 North East London Health and Care Partnership
27 North West London Integrated Care System
28 South East London Integrated Care System
29 South West London Integrated Care System

South East

30 Frimley Health and Care
31 Hampshire and Isle of Wight Integrated Care System
32 Kent and Medway Integrated Care System
33 Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System
34 Surrey Heartlands Health and Care Partnership
35 Sussex Integrated Care System

South West

36 Bath and North East Somerset, Swindon and Wiltshire Together
37 Cornwall and the Isles of Scilly Integrated Care System
38 Healthier Together: BNSSG Integrated Care System
39 One Devon
40 Our Dorset Health and Care System
41 One Gloucestershire
42 Somerset Integrated Care System

Source: Map shared with the permission of NHS England.

Urgent and emergency care and system flow

Most systems had identified significant challenges with a high demand for services and shortages in the workforce, and there was a need to improve urgent and emergency care and system flow. Productive patient flows are those that support a patient's journey through the department so that they receive appropriate care in a timely way and are kept well informed during this process. However, not all system plans identified the improvements as a priority and the details in plans varied.

In our 2022/23 State of Care report, we described plans from government and the NHS to boost capacity and speed up hospital discharges. This points to the importance of system-wide co-ordination for changes and improvements to keep people safe and improve care.

Joint forward plans now show a broad understanding of the importance of supporting emergency departments through improved access to GP services, hospital at home or virtual ward services, mental health services, and improved hospital discharge pathways. Several plans identified targets for tackling inequalities and improving patient outcomes, and many identified ways to improve system flow, citing working with local ambulance services or identifying the key stakeholders to help, including local authorities and people who use services.

Some ICSs have ambitious plans, including developing system-wide step-up models, which could play a key role in managing the level of demand for urgent care and building capability in the community to safely support people outside of a hospital setting.

However, many plans lacked a clear ambition to improve services. Mostly, there was a lack of cohesiveness between some joint forward plans and the integrated care strategies. And most local authority health and wellbeing strategies did not reference improving access to urgent and emergency services or improving patient flow.

ICS improvement strategies must be inclusive of local authorities to ensure there are pathways enabling patient flow through the system.

Plans from the Department of Health and Social Care and NHS England also referred to scaling up intermediate care to relieve pressure on hospitals and move people somewhere that is better for their needs. Looking at 2023 data, the Health Foundation estimated that 125,000 people are entering intermediate care each month. And as described earlier in our spotlight on intermediate care, 1 in 5 people who have been in hospital for more than 14 days are delayed because of waits for a rehabilitation bed in a bedded setting, such as a care home or community hospital.

All 42 systems referred to intermediate care – their plans vary in content and description of how this care should be provided. Some plans also referenced neighbourhood-level integration in line with the Fuller Report and national targets.

There is a combined effort to strengthen intermediate care services with a strong emphasis on collaboration across integrated community and social care networks. Plans include the expansion of virtual wards to manage patients effectively as their care transitions – and to reduce unnecessary hospital admissions. It is anticipated that staff and stakeholders will learn more about the benefits of prompt discharge and community-based care solutions.

Most ICSs recognise the need for a sustainable integrated care model – they include plans to help people recover and increase their independence after a hospital stay, illness or operation, to help reduce repeat visits to urgent and emergency care services as well as taking pressure off GPs.

Good intermediate care relies on enhanced stakeholder engagement and partnership working with social care. There is evidence of this in some systems where discussions are focused on providing intermediate care.

For others, there are challenges in scaling up services and addressing strategic gaps effectively. However, ICSs are actively pursuing integrated approaches to intermediate care, focusing on collaboration, reducing hospital stays, promoting preventative care, and engaging stakeholders.

In one example, there was clear indication from South Yorkshire ICS about its intention to improve the flow of hospitals through intermediate care – working with integrated community services, including social care, to ensure sufficient capacity and maximising the use of virtual wards. The Rochdale Borough Locality Plan 2020-24 shares how working with partners has enabled them to commission a successful intermediate care service whose design moves away from a previous focus on activity/numbers and key performance indicators in care settings, to delivery of care in local care organisations.

18-week waits

Systems are demonstrating a commitment to reducing waiting times for people who need different kinds of care. But there is variation in descriptions of how ICSs are planning to tackle waiting lists.

Most ICSs have objectives to reduce waiting times and increase capacity to meet demand, but some are lacking in detail or direction on how the system will achieve those objectives. And few have a short-term plan to achieve the NHS Constitution statement that: patients should wait no longer than 18 weeks from GP referral to treatment.

In the ICSs with detailed plans, there was a focus on reducing significant backlogs and eliminating 52, 65, and 104-week waits for treatment. A small number identified a target date to achieve no waits longer than 18 weeks. And those systems that did share initiatives to reduce waiting times set out plans for improved access to diagnostic services in the community, working with cardiac networks, improving waiting list management and service productivity.

Most forward plans did not show how ICSs sought views from the public or input from voluntary, community and social enterprise organisations (VCSEs). But there were examples where VCSEs and other partners gathered local people's voices on which initiatives would work best in their communities – and with measurable outcomes. One initiative was to work with the VCSE to reduce drivers of ill health.

Dental care

In October 2023, we reported on the problems that people faced when trying to access NHS dental care. People told us how they resorted to spending thousands of pounds on private dental treatment because they were in pain but could not see an NHS dentist. And the Health and Social Care Committee's report on NHS dentistry in 2023 was clear that NHS dentistry needs 'urgent and fundamental reform' to ensure people get the care they need.

The NHS Confederation's early adopters report points to challenges including the national contract, access to data, workforce, and governance.

NHS England has delegated its responsibility for commissioning dental services to integrated care boards (along with pharmacy and optometry). We reviewed plans across all 42 ICS areas and found there were differing approaches to dental services. Some had clear strategies and acknowledged challenges with access to dental services, but others were not as explicit and did not provide details about their work.

There is recognition across ICSs of a need for increased investment in dental services – resources to tackle treatment delays and improve access. Several highlighted a strain on primary care, and we can see how some communities are actively involved in identifying access issues and influencing the focus of dental strategies. A few ICSs had published plans to expand dental services for their communities, including some innovative service delivery models.

We can see that health services for children are a significant priority and are focused on preventative measures, particularly for children under 5 years. One county in the North East and North Cumbria ICS (NENC ICS) has a comprehensive oral health strategy with proactive measures towards better outcomes for people. These strategies should include clear recommendations and objectives within a set timeframe.

Feedback from stakeholders and NHS guidance will play pivotal roles in shaping annual updates and refining commissioning arrangements within ICSs for dental services – and partners such as Healthwatch have shared observations. Collaborations with local authorities and public health leaders are underway in some systems to evaluate and enhance oral health provision, demonstrating a combined effort to address inequalities through targeted interventions and strategic partnerships.

Dementia health inequalities

There is significant variability in the way ICSs plan to address health inequalities relating to dementia, particularly in terms of early diagnosis, access to care, and treatment strategies. Many ICSs acknowledge the prevalence of dementia and propose various initiatives.

Health and care services for people with dementia is one of our regulatory priorities – we want to influence and drive improvement in the provision of services, models of care and the quality of services for people living with dementia. We are looking at how we can use our role to achieve this – for people with dementia and for their carers.

The establishment of formal dementia strategies with clear timelines and performance metrics is still in progress for many systems. In their first year while ICSs have been establishing demographic data, one common ambition is to create dementia-friendly communities.

Plans emphasise community engagement initiatives to encourage support networks, andhealth and wellbeing boards are collaborating to prioritise dementia care. Dementia initiatives reviewed in these plans include:

- implementing proactive dementia models
- developing anticipatory care models that focus on independence and quality of life
- actions identified in local care partnerships to enhance service provision with a focus on community wellbeing.

Emphasising the benefits of community interaction, these plans manage dementia through local engagement and support.

The intention is to reduce waiting times for memory assessment services with community-based initiatives to upskill local teams for early-stage support. This would free specialist resources for more complex cases. The strategies involve partnerships with stakeholders, engaging dementia advocacy groups and care providers to ensure support and feedback.

Systems acknowledge that in areas of high deprivation, ensuring equitable access to dementia services for rural and marginalised communities remains a significant challenge. There is also limited involvement from a broad range of stakeholders, such as community organisations, educational institutions, and businesses, which weakens the implementation of dementia-friendly initiatives.

Local authorities have a crucial role in systems for raising awareness of place-based partnerships and local neighbourhood models to support improved dementia care with better care pathways. Our review of published plans showed the need for more consistent and comprehensive approaches across all ICSs to ensure equitable and effective dementia care. Three ICSs showed clear alignment to health and wellbeing boards, tailoring models of engagement to enable genuine co-production and personalised care tailored to local needs and preferences of individual people, along with a strong reliance on social research and insight to inform decision-making. Examples included establishing dementia-friendly communities, improving access to early diagnosis, integrated care hubs and community engagement in managing dementia.

Children and young people

There are some transformation plans in place for children and young people's services, where systems are looking to improve outcomes for people who use the services. In those systems, the plans are linked to the integrated care strategies and joint forward plans. Some ICSs also have children and young people scrutiny boards to provide governance and monitor the planned implementation.

Among positive signs, the Coventry and Warwickshire ICS Health and Social Care Delivery Plan identifies an integrated approach to the transformation of services for children and young people. There was similar focus in both South Yorkshire and Gloucestershire.

The first year for many ICSs was about understanding how and where health inequalities were affecting children locally and acting to reduce any barriers to care. There is evidence of assessments to understand demographics and strategic needs to inform their planning – we saw how at least one system, Nottingham and Nottinghamshire, was making digital improvements to collect outcomes and using the THRIVE model.

In last year's State of Care, we reported on long waiting times for mental health and community therapy services. Demand was growing exponentially during and after the Covid pandemic, and ICSs continue to report these challenges in their plans. In Northamptonshire, we are aware of the ICB's work with local partners and residents to develop a 2023/24 transformation plan for children and young people's mental health services.

Some ICSs are struggling to deliver both initial health assessments and the review health assessments for children in care within a statutory timeframe. Waiting times for services remain a problem and the main challenge is demand versus supply – a significant increase in requests at the same time as workforce shortages. For example, it was clear in one locality that waits for children and young people's community services were largely driven by an increased demand for speech and language therapy – but this is also a national problem.

Only a minority of published joint forward plans gave information on COVID-19 impact assessments – these were done to assess the impact on children and young people and helped to shape priorities, such as the prevalence of diabetes in young children or children's mental health and wellbeing.

Planned priorities emphasised the importance of children's early years - the first 1,001 days is commonly cited. Priorities included increasing universal antenatal and postnatal support, establishing new parents' groups, and reducing stillbirths. National priorities were articulated in published plans about asthma, diabetes, epilepsy, and mental health. Very few published plans reflected the priorities for oral health for children – and where they did, it was for children under 5 years.

Examples of priorities published included reducing the proportion of children who are overweight or obese, increasing support for children with diabetes who are transitioning to adult services and, in particular, priorities relating to children and young people's mental health.

There was some variation or lack of clarity in published plans about intended outcomes. But some had examples of action already taken; one Midlands ICS described its virtual wards for children, which had supported more than 1,150 children.

There were some good examples of systems with high aspirations. Gloucestershire Integrated Care Board's leadership includes an executive lead for children and young people, and for special educational needs and disabilities. There are 2 system-wide transformation programmes that are particularly focused on the needs of children, covering physical and mental health and clearly identifying collaborative system partners. Our review of plans found evidence that ICSs had engaged with young people and their carers, as well as with Healthwatch and the voluntary sector to inform strategies and make plans. We also saw an example in Northamptonshire of engagement with VCSEs where people had their say on new ways of delivering activities and respite, such as short breaks, for disabled children. The Humber and North Yorkshire system had evidence of a strong commitment to partnership working between the NHS and VCSEs, which focused on children-centred approaches and maximising community engagement. There were similar examples in South West and South East London.

From our inspections of providers, we saw examples where specialist services for children and families with complex needs were often pivotal in leading multi-agency working and sharing learning. For example, in West Yorkshire the local authority developed several programmes with neighbouring local authorities and the VCSE sector to encourage healthy childhoods.

Communication between parents, carers and the local area partnerships, and between agencies, often needed to be strengthened. Poor communication had affected parents, as they were unable to access the right support or having to repeat their story. Between agencies, this meant that services were not always kept informed of actions and support for children. But consistent good multi-agency attendance and information-sharing was supporting and protecting children.

In some areas, leaders across the local authority and the ICB have worked together to identify, support and plan to meet needs. This meant there was oversight of the issues affecting families, and they were better placed to begin to address these issues.

Addressing inequalities at a system level

One of our core strategic ambitions is tackling inequalities in people's access, experiences and outcomes when using health and social care services.

This year, before we have begun formally reporting ICS assessments as part of our new role, we carried out a survey with the Nuffield Trust to begin to understand a baseline context from which ICSs are operating – the challenges they face and the opportunities ahead.

In 2023, we could see that most ICSs demonstrated a commitment to engaging with people living in their area; most systems publicly recognised the importance of equality, diversity, and inclusion, and addressing health inequalities and equity in access to care services.

In 2024, we reached out to ICSs, which have responsibility for planning health services for local populations. Again, we have focused on the theme of inequalities. We commissioned the Nuffield Trust to conduct an independent survey of progress on health inequalities across systems. The survey was targeted at individuals working on health inequalities in all 42 ICSs in England and more than half (29) took part, to whom we are grateful.

This year, our approach was to understand what ICSs perceive as the main challenges or barriers to addressing healthcare inequality, recognising various stakeholder views, including the NHS Providers point that "national leaders will rely upon [ICSs] to bring different parts of the system together to address [health inequalities]".

This work with the Nuffield Trust in 2024 was shaped by the importance of understanding a viewpoint from the ICSs themselves about their progress and challenges. This is before we start our formal assessment work with systems.

Central to our survey is a focus on the 5 priority clinical areas, nationally defined as the CORE20PLUS5. Our findings are presented in 3 parts, describing the key viewpoints about systems and inequalities:

1. Progress on health inequalities
2. Barriers and challenges
3. Key themes from free text responses

Progress on health inequalities

The Nuffield Trust survey asked about progress on health inequalities in 3 parts:

- addressing social determinants of poor health (for example, unfit housing or poor diet)
- addressing unequal burden of disease
- addressing people's access, experience and outcomes

On these areas of health inequalities, respondents to the survey perceived that the least progress had been made around addressing the social determinants of poor health: 15% of respondents said no progress had been made.

A further 41% said very little progress was made, while more positively, 45% also answered that moderate or significant progress had been made.

Respondents were more positive about the progress made in addressing inequalities in access to health care: 66% felt there was moderate or significant progress.

In addressing the unequal burden of disease, 65% felt moderate or significant progress was made.

Population groups targeted

The survey asked which population groups, or segments, systems were targeting to address these 3 key areas of health inequalities. The pattern of answers was broadly similar across all 3 areas.

Of the 5 options presented, respondents most frequently said they were targeting socio-economically deprived groups or small geographic areas, as defined in the national Index of Multiple Deprivation, to address inequalities in healthcare access or outcome (93% of respondents), the unequal burden of disease (90% of respondents), or the social determinants of poor health (86% of respondents).

This was closely followed by targeting actions among people in ethnic minority groups to address inequalities in healthcare access or outcome (83% of respondents), the unequal burden of disease (83% of respondents), or the social determinants of poor health (69% of respondents).

Respondents also targeted actions among locally defined 'inclusion' groups, such as homeless people, ex-offenders, or sex workers. This was to address inequalities in healthcare access or outcome (69% of respondents), the unequal burden of disease (69% of respondents), or the social determinants of poor health (79% of respondents).

Approximately half of the survey respondents said they had prioritised other groups with protected equality characteristics across inequalities in access, burden of disease and social determinants. A small number of respondents highlighted other communities they were targeting, such as people with a learning disability.

A very small number of respondents answered that they were not targeting any of these groups.

Progress on national priorities and inequalities

There are 5 priority clinical areas, nationally defined as the CORE20PLUS5. The survey asked about the extent to which survey respondents thought that their ICS had made progress towards addressing inequalities in these clinical priorities and in smoking cessation.

Most respondents tended to 'agree' or 'strongly agree' that their ICS had made progress across all priority categories. Slightly more respondents strongly agreed to having made progress in addressing inequalities in maternity (18%) and cancer (18%).

No respondents strongly disagreed or disagreed that their ICS has made progress on smoking cessation, although 21% of respondents were neutral.

Around a third of respondents were neutral about whether their ICS had made progress on chronic respiratory disease (37%) and cancer (32%).

Respondents most strongly disagreed that progress had been made around chronic respiratory disease (7%) and mental illness (7%). It is important to note that due to the very small numbers of this survey, any additional responses could change this weighting significantly and so this must be interpreted with caution.

Challenges, barriers and opportunities

We wanted to identify where respondents felt their ICS faced the most significant barriers or challenge to progress in health inequalities, and where they saw opportunities for progress.

Respondents were presented with a series of statements about their ICS's data infrastructure, governance, and capacity and capability. They were asked to state the extent to which they agreed with the statement.

Comments were allowed in free text boxes, but the survey grouped statements into 3 broad areas:

- Data and analysis skills
- Governance and accountability
- System capacity and capability

Data and skills

Overall, responses suggest that access to analytical capability is a significant challenge shared across many ICSs, alongside accessing the right types of data to support analysis of population needs.

Respondents answered more positively to these statements:

> "My ICS has access to the expertise needed to understand key drivers of inequalities."

(45% agreed, 28% strongly agreed)

> "My ICS is actively using data to understand population needs."

(45% agreed, 14% strongly agreed)

Answers were positive overall for this statement, with some negativity for:

> "My ICS has access to the right data to understand population needs."

(41% agreed, 14% strongly agreed, 17% disagreed, 3% strongly disagreed)

There was a clear difference in the pattern of response to this statement:

> "My ICS has the right analytical capability to analyse complex data and make decisions."

A relative majority of respondents answered more negatively (24% disagreed, 21% strongly disagreed) and a smaller proportion was positive (24% agreed, 10% strongly agreed).

All respondents chose an answer for this question, none chose 'unsure/not applicable'.

Governance, leadership and strategy

Most respondents said they agreed with statements related to governance, leadership and strategy.

Statements on leadership and accountability were especially positive: 45% of respondents agreed and 34% strongly agreed that their ICS has a dedicated leadership to drive progress on health inequalities, and only a small number disagreed with this statement (none strongly disagreed).

Furthermore, 39% of respondents agreed while 43% strongly agreed that it was clear who is accountable for leading work on health inequalities in their ICS, with a small percentage of disagreement (15% disagreed or strongly disagreed). It is possible that some responses may be biased towards the roles of people who responded to the survey, many of whom are in leadership positions and accountable for health inequalities themselves.

There was more moderate agreement on statements related to having a shared understanding of priorities across local partners, the ability to balance competing national and local priorities, and having a clear and achievable plan to reduce inequalities in access, experience, and outcomes.

Around a third of respondents (34%) were neutral about the statements: “My ICS is able to balance competing national and local priorities to make progress on health inequalities,” and, “My ICS has a clear and achievable plan to reduce inequalities in access, experience and outcomes across pathways of care.” However, there was stronger disagreement with the latter statement, with 24% disagreeing or strongly disagreeing.

Respondents had a much more negative perception on the degree to which local partners within their ICSs agreed over how best to shift resources to prioritise reducing health inequalities. Over half (51%) either disagreed or strongly disagreed with the statement.

It was important to note that some responses may have been biased towards the roles of people who responded to the survey, many of whom are in leadership positions and accountable for health inequalities work programmes themselves.

System capability and capacity

There was less positivity around system capability and capacity.

The proportion of people who selected ‘agree’ or ‘strongly agree’ was not more than 50% in reply to any of the statements.

There was particular disagreement about ICSs having sufficient resources (time and money) to prioritise health inequalities, as 42% disagreed and 19% strongly disagreed.

A smaller proportion of respondents disagreed that their ICS has sufficient operational capacity to deliver on plans to reduce health inequalities (28% disagreed, 10% strongly disagreed), or buy-in to deliver plans and ensure they meet the needs of underserved communities (24% disagreed, 7% strongly disagreed).

The proportion who responded neutrally to the statements on capability and capacity is relatively large across all the questions, ranging from 23% for "My ICS has sufficient resource (time and money) to prioritise health inequalities,", to 45% for "My ICS has the cultural competence and understanding of underserved communities necessary to address health inequalities".

There was more agreement for statements about influencing social determinants of health and cultural competence around underserved communities.

Just under half (46%) of respondents agreed or strongly agreed that their ICS was able to influence wider socioeconomic determinants that drive health inequalities. Only 18% disagreed and no respondents strongly disagreed.

Barriers and enablers

Several themes have emerged from the Nuffield Trust survey that point to some of the main things that might make a difference for systems as they look to tackle local health inequalities.

Respondents were asked to provide additional comments on what they judged to be the biggest barrier in challenge areas, including data and skills, governance, leadership and strategy, and system capability and capacity. Fourteen respondents provided comments, their answers are perceptions rather than a representative indication.

- Financial pressures and competing priorities
- Relationships
- Challenges in getting the most out of existing data
- Power dynamics and influence

Respondents expressed concerns that financial pressures were adversely affecting ICSs' ability to make progress on inequalities: 11 out of 14 pointed to this, while 3 of the 11 pointed to the challenges of managing competing national and local priorities.

A further 5 of these 11 respondents expressed a frustration that, despite often having a strategy that commits to community or 'upstream investment' (addressing the root causes of poor health), in reality the system pressures meant that acute services continued to be prioritised.

> "Despite verbal commitment to reducing inequalities, the ICB leadership have no practical commitment to this aim, choosing instead to prioritise acute secondary care in a traditional manner, which serves only to increase existing inequalities..."

> "...our senior leaders are driven by financial priorities and [the] front door of A&E. They use wonderful rhetoric, but they are not creating the fundamental conditions to create a generational difference."

Three respondents specifically highlighted the importance of positive working relationships between partners in the ICS when making progress on health inequalities. One of them highlighted the importance of good joint working with voluntary, community and social enterprises (VCSEs).

When it comes to getting the best from existing data, limited capacity or capability for data analysis or interpretation emerged as themes in survey comments. Five respondents said their ICS either lacked the data to fully understand their under-served populations or had insufficient analytical capacity to make use of data.

However, 2 respondents mentioned positive efforts to better understand or use data, such as by establishing a specific population health intelligence unit. One respondent mentioned the challenges of attempting to procure a new data platform.

Power dynamics also appear to be an issue in these early years for ICSs. Two respondents expressed concern that ICSs and the local structures lack 'powers, resource and influence' to make a tangible difference. They suggested that financial inequalities needed to be addressed across sectors.

> "...whilst local structures such as the integrated care partnership or health and wellbeing boards have good strategies, everyone knows they lack power, resources and influence. We have deep inequity here reflected in major disparities in life expectancy and health lives. We need a major step change and not tinkering around the edges."

Prioritisation

The survey also asked respondents to select which of these 3 main areas – data and skills; governance, leadership and strategy; or system capability and capacity – posed the biggest challenge to progress. The aim was to get more clarity on where systems need most support. When asked which of the 3 broad areas posed the biggest challenge to progress:

- 59% of respondents selected system capability and capacity
- 17% of respondents chose data and skills in their ICS
- 7% chose governance, leadership and strategy
- 17% opted for 'other'.

Respondents who chose 'other' could provide their own answers. These included themes such as the lack of prioritisation of prevention, insufficient place/locality-level working, and insufficient national levers, for example legislation and target-setting, as the biggest barriers preventing progress on health inequalities.

Those who answered 'system capability and capacity' as their greatest challenge area selected insufficient resource (time or money) to deliver on plans as the most significant barrier. Other answers highlighted challenges around operational capacity or buy-in, and a combination of operational capacity and financial resource.

Of the 17% who identified data and skills as the biggest challenge, most said their ICS did not have access to the right data to understand population needs. One respondent said their ICS did not have the right analytical capability to analyse complex data and make decisions, and one said their ICS was not actively using data to understand population needs.

This contrasts with 45% of respondents who disagreed or strongly disagreed that they had the analytical capability to analyse complex data and make decisions. It might suggest that while analytical capability is perceived to be insufficient, other barriers pose a greater hindrance to progress.

All the respondents who chose governance, leadership and strategy as the biggest challenge specifically identified the biggest issue as local partners in their ICS not agreeing on how best to shift resources to prioritise reducing health inequalities.

Only a small number of respondents said what they thought was the biggest barrier in each challenge area, so the answers should be seen as individual perceptions of the biggest barrier to addressing health inequalities, rather than a representative indication.

Final thoughts on challenges

Survey respondents had the opportunity to elaborate and comment freely about their chosen most significant challenges in addressing health inequalities. The 2 main themes here were financial pressures and the scope of power and influence of systems.

Of 19 responses, 13 mentioned a difficult financial context – issues around prioritisation of acute services, too little resource, time or energy for enabling change in inequalities. Some said there was genuine commitment for change, but an inability to 'shift funding flows' and make a difference. Two respondents cited concerns about short-term funding and risks for small VCSE organisations because of unstable funding:

> "If we are serious about shifting resources and focus, this entails changing funding flows and making difficult decisions about where we prioritise spending. This requires join up from acute players who may see this as a lose/lose choice, and for finance colleagues who are pressurised to focus on year end – the wider system does not support longer term strategic decision-making."

Some ICSs say they doubt their ability to 'move the dial' on the root causes of health inequalities. Three respondents flagged this as a major challenge, saying that local organisations have little ability to resolve this. They mention issues around housing and financial stress. One of the 3 also highlighted the complexity of accountability:

> "The reality of the current working environment doesn't create much time/energy or leave much resource available to focus on reducing inequality. In addition, some of the areas covered in your survey [such as poor housing] are not really within the remit of NHS partners in the ICS to lead on, and as a 'two-tier' local government area this sits with 13 districts/boroughs, for example."