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**A cure for everything and nothing?
Local cross-sector collaboration and health inequalities in England**

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National policies supported local partnerships to emerge in various contexts studied (see section on external context)^{105,103,100,95,89,78}—though some studies also noted that national government policies mandating local collaboration may reflect an underlying lack of motivation for joint working among local agencies, and could create conditions for future conflict.^{76,105} Commitment to collaboration from local leaders and staff was commonly thought to be needed for partnerships to work effectively.^{86,87,88,96,98,80,81,83,84,85}

Relationships and cultures

Multiple studies described how collaboration was more likely to be successful if partners trust each other^{105,72,74,88,89,101,104,83,84} and have positive relationships.^{72,75,87,91,93,96,98,99,101,103,83} For example, Davies et al identified lack of trust between health care staff and care homes as a barrier to integrated working.¹⁰⁴ Historic relationships between agencies—present or absent; good or bad—shaped how local partnerships developed and functioned.^{105,72,86,93,96,80,81,82,84,85}

Relationships were also affected by cultural and professional differences between agencies and staff within them—often identified as barriers to collaboration.^{105,72,76,86,95,96,97,99,83,84} In some cases, shared values could bring local agencies together—for example, united by a commitment to good governance or reducing health inequalities.^{89,101} But differences in values could also fundamentally undermine collaboration efforts. Williams, for example, found that philosophical differences between health and social care and criminal justice agencies—between ‘care and control’ sectors—contributed to various structural and procedural challenges experienced among crime prevention and reduction partnerships in England.⁷⁶

Clarity on roles and responsibilities of different agencies was thought to help collaborations make decisions, implement programs, and function effectively.^{72,105,89,93,95,97,81,83,82,86,94} Lack of clarity could lead to protectionism, concerns about loss of power, and underuse of particular skills or services within the partnership.^{72,75,94} For example, Green et al described how lack of understanding of aboriginal health workers among public service agencies contributed to their underutilization within partnerships to improve care for indigenous children.⁹⁴ Developing clear frameworks and processes for collaboration^{72,75,87} and joint training for staff between agencies⁸⁶ (see section on resources and capabilities) were both identified as mechanisms that could help improve clarity on organizational roles. Yet role clarity may not be needed for all kinds of partnerships, or at all levels within them. Corbin et al noted that flexibility on roles may help partnerships be more inclusive and garner increased resources.⁸⁵ And, at a service level—for example, for staff delivering programs within the partnership—flexibility may be needed to support multidisciplinary teams to function.⁷²

How and when partners communicate was widely thought to affect how collaborations work.^{105,71,72,76,86,87,88,89,91,93,94,95,78,96,97,98,103,81,82,83,84,85} The simple interpretation from the literature is that good communication helps, while poor communication makes things harder. Good communication

<p>Winters et al (2016). Cross-sector provision in health and social care: an umbrella review</p>	<ul style="list-style-type: none"> - Partnerships between health care and social services - Studies focused on services for school-aged children, adults with comorbidity, adults living with a disability, veterans, nursing/care home patients, people living with HIV, primary care populations 	<ul style="list-style-type: none"> - Cross-sector service provision. defined as 'independent, yet interconnected sectors working together to better meet the needs of consumers and improve the quality and effectiveness of service provision'
<p>Zakocs and Edwards (2006). What explains community coalition effectiveness? A review of the literature</p>	<ul style="list-style-type: none"> - Community coalitions in the US focused on population-level health improvement - Coalitions targeting US 'neighborhoods, towns, cities, or counties'. Coalitions covering larger geographical areas ('state, national, or international') were excluded - Studies focused on coalitions targeting substance misuse, older people's health, cancer, tobacco control, teen pregnancy, cardiovascular disease, alcohol use, and other health issues and risk factors 	<ul style="list-style-type: none"> - Community coalitions, with coalitions defined as 'inter-organizational, cooperative, and synergistic working alliances'

TABLE 2: study quality assessments

Study	Study design	AMSTAR 2 assessment for reviews reporting evidence on collaboration outcomes [†]	CASP checklist for studies only reporting evidence on factors influencing collaboration [‡]	How authors assessed risk of bias for studies included in their review
Anderson et al (2015). Community coalition-driven interventions to reduce health disparities among racial and ethnic minority populations	- Systematic review - 58 studies included	High	NA	- Assessed using Cochrane risk of bias tool for RCTs and Effective Practice and Organization of Care (EPOC) risk of bias tool for other studies - Overall, studies included showed ‘moderate to high risk of bias’, particularly in relation to selection bias
Andersson et al (2011). Organizational approaches to collaboration in vocational rehabilitation-an international literature review	- Review - 62 studies included	NA	1,2	- No formal quality assessment
Auschra C (2018). Barriers to the integration of care in inter-organisational settings: a literature review	- Systematic review - 40 studies included	NA	1,5	- No formal quality assessment

[†] We assessed studies against the 16 items in the AMSTAR 2 instrument. Item 2—having a protocol registered before commencement of the review—was not deemed a critical domain when constructing the overall ratings, given that papers were included from a wide range of disciplines where this would not necessarily be expected.

[‡] We assessed studies against the first 5 items in the CASP instrument. The five items are: (1) Did the review have a clearly focused question? (2) Did the authors look for the right kind of papers? (3) Do you think all the important, relevant studies were included? (4) Did the review’s authors do enough to assess quality of the included studies? (5) If the results of the review have been combined, was it reasonable to do so? For item 5, we scored papers as meeting this criterion if the findings of individual studies were clearly displayed or described, or if the paper clearly illustrated the presence or absence of review findings or themes between the studies included. Given there is no overall rating in the CASP instrument, we include the number 1-5 for each paper only if it was deemed to fully meet the corresponding criterion.

Bagnall et al (2019). Whole systems approaches to obesity and other complex public health challenges: a systematic review	<ul style="list-style-type: none"> - Systematic review - 35 studies included 	Low	NA	<ul style="list-style-type: none"> - Assessed using checklists adapted from the National Institute for Health and Care Excellence Public Health methods guidance, and the Critical Skills Appraisal Programme (CASP)
Baxter et al (2018). The effects of integrated care: a systematic review of UK and international evidence	<ul style="list-style-type: none"> - Systematic review - 167 studies included 	High	NA	<ul style="list-style-type: none"> - Quality assessment using a variety of checklists depending on study type, including Cochrane criteria and National Institutes of Health checklists - Evidence assessments for each outcome category (see table 3)
Cameron et al (2014). Factors that promote and hinder joint and integrated working between health and social care services: a review of research literature	<ul style="list-style-type: none"> - Review - 46 papers, reporting on 30 studies 	Critically low	NA	<ul style="list-style-type: none"> - No formal quality assessment - Authors note that the evidence had several limitations, including small scale studies and few with comparative design
Cooper et al (2016). Interagency collaboration in children and young people's mental health: a systematic review of outcomes, facilitating factors and inhibiting factors	<ul style="list-style-type: none"> - Systematic review - 33 studies included 	Critically low	NA	<ul style="list-style-type: none"> - Assessed using CASP checklists - Quantitative studies: assessed as being 'suitable' for the investigations conducted—though studies used correlational designs and assessment of outcomes at follow-up was limited - Qualitative studies: 10 assessed as 'valuable', 10 'fairly valuable', one 'not valuable'

Corbin (2016). What makes intersectoral partnerships for health promotion work? A review of the international literature	- Review - 26 studies included	NA	1,2	- No formal quality assessment used - Authors note that few studies comprehensively assess partnership processes, factors, or their interaction
Davies et al (2011). A systematic review of integrated working between care homes and health care services	- Systematic review - 17 studies included	Critically low	NA	- Assessed using checklists based on the Cochrane Collaboration risk of bias tool and Spencer et al's quality assessment checklist for qualitative studies
Dowling et al (2004). Conceptualising successful partnerships	- Review - 36 studies included	Critically low	NA	- No formal quality assessment - Authors describe weaknesses in evidence
Errecaborde et al (2019). Factors that enable effective one health collaborations: a scoping review of the literature	- Review - 50 studies included	Critically low	NA	- No formal quality assessment
Foster-Fishman et al (2001). Building collaborative capacity in community coalitions: a review and integrative framework	- Review - 80 studies included	NA	-	- No formal quality assessment
Gannon-Leary et al (2006). Collaboration and partnership: A review and reflections on a national project to join up local services in England	- Narrative review - Studies included not defined	NA	-	- No formal quality assessment

Green et al (2014). Cross-sector collaborations in Aboriginal and Torres Strait Islander childhood disability: A systematic integrative review and theory-based synthesis	- Systematic review - 31 studies included	NA	1,2,3,4	- Assessed using multiple checklists depending on study design, including Kitto et al's quality assessment tool for qualitative studies, the STROBE checklist for observational studies, AMSTAR for review articles, the MMAT for mixed methods studies, and the TREND checklist for non-randomized intervention studies
Guglielmin et al (2018). A scoping review of the implementation of health in all policies at the local level	- Review - 27 studies included	NA	1.5	- No formal quality assessment
Hayes et al (2012). Collaboration between local health and local government agencies for health improvement	- Systematic review and meta-analysis - 16 studies included - 11 studies used for meta-analysis	High	NA	- Assessed using EPOC data collection checklist - RCTs: one low risk of bias, one medium of risk of bias, two high risk of bias - Non-randomized studies: one medium risk of bias, others high risk of bias
Herdiana et al (2018). Intersectoral collaboration for the prevention and control of vector borne diseases to support the implementation of a global strategy: a systematic review	- Systematic review - 50 articles included	Low	NA	- Assessed using Cochrane handbook - Quantitative studies: 10 rated 'strong', 9 'moderate', 31 'poor' - Qualitative studies: not reported
Liljas et al (2019). Impact of integrated care on patient-related	- Systematic review	Low	NA	- Assessed using checklists developed by the Swedish Agency for Health Technology

outcomes among older people: a systematic review	- 12 studies included			Assessment and Assessment of Social Services - Six studies low risk of bias, five studies moderate risk of bias
Lopez-Carmen et al (2019). Working together to improve the mental health of indigenous children: A systematic review	- Systematic review - 11 studies included	Critically low	NA	- No formal quality assessment (though quality ratings are described in discussion) - Authors note that most studies were descriptive accounts of service integration, with few impact evaluations
Mackie and Darvill (2016). Factors enabling implementation of integrated health and social care: a systematic review	- Systematic review - 7 studies included	NA	1,4,5	- Assessed using CASP checklist for systematic reviews - Overall, quality of studies assessed as low
Martin-Misener et al (2012). Strengthening Primary Health Care through Public Health and Primary Care Collaborations Team. A scoping literature review of collaboration between primary care and public health	- Review - 114 studies included	Critically low	NA	- No formal quality assessment - Authors note that a large proportion of the articles were descriptive accounts of collaboration, and 75% used qualitative, mixed methods, or cross-sectional design
Mason et al (2015). Integrating funds for health and social care: an evidence review	- Review - 122 studies included, reporting on 38 initiatives	Critically low	NA	- No formal quality assessment

Ndumbe-Eyoh and Moffat (2013). Intersectoral action for health equity: a systematic review	- Systematic review - 17 articles included	Low	NA	- Assessed using three different tools (for systematic reviews, qualitative and quantitative studies) - Systematic review: strong - Quantitative studies: one strong, five moderate, eight weak - Qualitative studies: no overall rating
Ogbonnaya and Keeney (2018). A systematic review of the effectiveness of interagency and cross-system collaborations in the United States to improve child welfare outcomes	- Systematic review and meta-analysis - 11 studies included	Critically low	NA	- Assessed using National Institute for Health (NIH)/National Heart, Lung, and Blood Institute (NHLBI) tools—one assessment for experimental studies and one for quasi-experimental studies - Narrative overview of study quality: study quality varied, with limited information to assess experimental studies
Perkins et al (2010). ‘What counts is what works’? New Labour and partnerships in public health	- Systematic review - 31 studies included	NA	1,2,4,5	- See Smith et al (2009)
Rantala et al (2014). Intersectoral action: local governments promoting health	- Review - Studies included not defined (but 25 case studies identified)	NA	1,5	- No formal quality assessment
Roussos and Fawcett (2000). A review of collaborative partnerships	- Review	Critically low	NA	- No formal quality assessment

as a strategy for improving community health	- 34 studies included, reporting on 252 partnerships			- Authors describe several limitations of the evidence ('weak outcomes, contradictory results, or null effects were found in the more methodologically rigorous studies')
Savic et al (2017). Strategies to facilitate integrated care for people with alcohol and other drug problems: a systematic review	- Systematic review - 14 studies included	NA	1,2	- No formal quality assessment
Seaton et al (2018). Factors that impact the success of interorganizational health promotion collaborations: a scoping review	- Systematic review - 25 studies included	NA	1,2,4,5	- Assessed using tool adapted from Harden et al.
Sloper, P (2004). Facilitators and barriers for co-ordinated multi-agency services	- Review - Studies included not defined	Critically low	NA	- No formal quality assessment
Smith et al (2009). A systematic review of the impact of organizational partnerships on public health outcomes in England between 1997 and 2008	- Systematic review - 15 studies included	Low	NA	- Assessed against critical appraisal criteria, adapted from two instruments - Authors note that the evidence had several limitations, such as short follow-up and potential contamination between control and intervention groups
Whiteford et al (2014). System-level intersectoral linkages between the mental health and non-clinical	- Systematic review - 40 studies included	Critically low	NA	- Assessed using National Health and Medical Research Councils (Australia)

support sectors: A qualitative systematic review				<ul style="list-style-type: none"> - Studies assessed from level 1 (highest quality) to level 4 (lowest quality) - 10 studies level 2, 14 studies level 3, 16 studies level 4
Wildridge et al (2004). How to create successful partnerships: a review of the literature	<ul style="list-style-type: none"> - Review - Studies included not defined 	NA	-	- No formal quality assessment
Williams I (2009). Offender health and social care: a review of the evidence on inter-agency collaboration	<ul style="list-style-type: none"> - Narrative review - Studies included not defined 	NA	1	- No formal quality assessment
Winters et al (2016). Cross-sector provision in health and social care: an umbrella review	<ul style="list-style-type: none"> - Umbrella review - 16 studies included 	Critically low	NA	- Assessed using Joanna Briggs Critical Appraisal Checklist (but several low rated articles were included due to relevance)
Zakocs and Edwards (2006). What explains community coalition effectiveness? A review of the literature	<ul style="list-style-type: none"> - Review - 26 articles included 	NA	1,2,5	- No formal quality assessment

TABLE 3: summary of evidence on collaboration impacts

Paper	Outcomes studied	Collaboration impacts			
		Health outcomes	Service use and quality	Resource use and spending	Process impacts
Hayes et al (2012). Collaboration between local health and local government agencies for health improvement *	<ul style="list-style-type: none"> - Measures of improved health, health status, survival, or health-related lifestyle factors - Studies included with any measure of mortality, morbidity, or behaviour change 	<ul style="list-style-type: none"> - Overall, little or no reliable evidence of health benefits - Meta-analysis of three studies investigating impact on mortality found no effect (pooled relative risk = 1.04 in favour of control, 95% CI 0.92 to 1.17) and no heterogeneity ($I^2 = 0\%$) - Meta-analysis of five studies investigating impact on mental health found a small effect favouring the intervention (standardized mean difference = -0.28, 95% CI -0.52 to -0.04) with evidence of heterogeneity ($I^2 = 87\%$) - Meta-analysis of two studies investigating 	NA	<ul style="list-style-type: none"> - Some studies reported additional costs associated with partnership interventions 	NA

		<p>impact on function found a small improvement in the global assessment of function symptoms score scale (pooled mean difference [on a scale of 1-100] = -2.63, 95% CI -5.16 to -0.10) and no heterogeneity ($I^2 = 0\%$)</p> <p>- Meta-analysis of five studies investigating impact on physical health found no evidence of improved physical health (standardized mean difference = -0.01, 95% CI -0.10 to 0.07) and little evidence of heterogeneity ($I^2 = 16\%$)</p> <p>- Meta-analysis of three studies investigating impact on quality of life found no significant difference in quality of life (standardized mean difference = -0.08, 95% CI</p>			
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		-0.44 to 0.27) with evidence of heterogeneity (I ² = 83%)			
Baxter et al (2018). The effects of integrated care: a systematic review of UK and international evidence *	- Service delivery outcomes, including effectiveness, efficiency, or quality, and/or the effect on patients and staff	NA	- Stronger evidence for improvements in patient satisfaction, improvements in perceived quality of care, and improvements in access to some services - Inconsistent evidence related to number of clinician contacts, number of GP appointments, length of stay, unscheduled admissions, number of admissions, re-admissions, attendance at accident and emergency, quality of care standards, staff work experience, community care activity, secondary care activity, overall healthcare utilization	- Inconsistent evidence related to cost of provision	NA

			- Limited evidence on prescribing rates, access to resources, time spent in accident and emergency department, number of incidents/complaints, identification of unmet need		
Anderson et al (2015). Community coalition-driven interventions to reduce health disparities among racial and ethnic minority populations *	- Measures of mortality (eg all-cause death within period of study), morbidity (eg quality of life), and health-behaviors (eg smoking and alcohol consumption) - Also focused on costs of interventions	- Broad-scale community system level change strategies led to little or no difference in measures of health behavior or health status - Broad health and social care system level strategies led to small beneficial changes in measures of health behavior or health status in large samples of community residents - Lay community health outreach worker interventions led to beneficial changes in health behavior measures	NA	- Financial data on interventions not reported	NA

		<p>of moderate magnitude in large samples of community residents</p> <ul style="list-style-type: none"> - Lay community health outreach worker interventions may lead to beneficial changes in health status measures in large samples of community residents; however, results were not consistent across studies - Group-based health education led by professional staff resulted in moderate improvement in measures of health behavior - Adverse outcomes of community coalition-led interventions not reported - Moderate to substantial heterogeneity ($I^2 > 50\%$). in effects across studies 			
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<p>Smith et al (2009). A systematic review of the impact of organizational partnerships on public health outcomes in England between 1997 and 2008 ‡</p>	<ul style="list-style-type: none"> - Public health outcomes, defined as ‘health improvement and/or a reduction in health inequalities’ - Impact could be direct (eg by improving self-reported health) or indirect (eg by raising profile of health inequalities) 	<ul style="list-style-type: none"> - Quantitative studies found no intervention effect (two studies found no improvements compared to other areas) or mixed effects (one study found improvements on some indicators but worse performance on others) on health outcomes, such as morbidity and mortality - One mixed methods study found that people had been supported to adopt healthier lifestyles 	<p>NA</p>	<p>NA</p>	<ul style="list-style-type: none"> - Qualitative studies found that partnership initiatives had helped embed or increase focus on health inequalities
<p>Liljas et al (2019). Impact of integrated care on patient-related outcomes among older people: a systematic review ‡</p>	<ul style="list-style-type: none"> - Patient satisfaction, hospital admission, length of hospital stay, hospital readmission, mortality 	<ul style="list-style-type: none"> - No studies examining mortality reported significant changes in mortality rates 	<ul style="list-style-type: none"> - Mixed impacts on hospital admissions, readmissions, and length of stay - Mixed impacts on patient satisfaction 	<p>NA</p>	<p>NA</p>
<p>Ndumbe-Eyoh and Moffat (2013). Intersectoral action for health equity: a systematic review ‡</p>	<ul style="list-style-type: none"> - Impact on health equity or social determinants of health, such as housing or employment, for deprived groups 	<ul style="list-style-type: none"> - Mixed impacts on health outcomes - Limited evidence on equity impacts 	<ul style="list-style-type: none"> - More downstream interventions ‘moderately effective’ in increasing access to services for marginalized groups 	<p>NA</p>	<p>NA</p>

<p>Bagnall et al (2019). Whole systems approaches to obesity and other complex public health challenges: a systematic review ‡</p>	<p>- Focused broadly on evidence of effectiveness and cost-effectiveness of whole systems approaches</p>	<p>- Most studies reported some positive effects, including on health behaviors and BMI - Some studies reported positive effects on wider public health outcomes, including on smoking rates, exercise, and diet</p>	<p>NA</p>	<p>- Limited evidence on cost-effectiveness</p>	<p>NA</p>
<p>Herdiana et al (2018). Intersectoral collaboration for the prevention and control of vector borne diseases to support the implementation of a global strategy: a systematic review ‡</p>	<p>- Outcomes related to the prevention and control of vector borne diseases, such as disease incidence or prevalence</p>	<p>- Most studies measuring disease indicators reported positive effects, such as reduction of cases</p>	<p>- Most studies measuring vector variables (adult density, pupae or larval indices) reported declining vector indices - Improvements in access to intervention and treatment</p>	<p>NA</p>	<p>NA</p>
<p>Davies et al (2011). A systematic review of integrated working between care homes and health care services §</p>	<p>- Health and wellbeing (eg health status, quality of life), service use (eg hospital admissions), cost savings, process-related outcomes (eg quality of care and staff satisfaction)</p>	<p>- Some improvements in outcomes reported, but the majority of studies found that the intervention had mixed effects or no effect</p>	<p>- Some improvements in outcomes reported, but the majority of studies found that the intervention had mixed effects or no effect</p>	<p>- Insufficient evidence on costs</p>	<p>NA</p>

<p>Mason et al (2015). Integrating funds for health and social care: an evidence review §</p>	<p>- Focused broadly on effectiveness or cost-effectiveness, including a range of health and service level outcomes</p>	<p>- Most studies assessing health outcomes (including health-related quality of life, physical functioning, depression and anxiety, mortality, carer burden) found no significant difference from usual care. Findings from other studies were mixed</p>	<p>- Impact on secondary care utilization was mixed - Impact on quality of care and user experience was mixed</p>	<p>- Impact on secondary care costs was mixed</p>	<p>- Some studies found unintended consequences, such as 'upcoding'</p>
<p>Ogbonnaya and Keeney (2018). A systematic review of the effectiveness of interagency and cross-system collaborations in the United States to improve child welfare outcomes §</p>	<p>- Outcomes related to 'safety, permanency, and well-being for child welfare involved families'</p>	<p>NA</p>	<p>- Family drug treatment court (FDTC) collaboration intervention positively associated with treatment entry (odds ratio [OR] = 2.94, 95% CI 1.50 to 5.75, with evidence of heterogeneity $I^2 = 86\%$) and completion (OR = 2.07, 95% CI 1.26 to 3.41, with evidence of heterogeneity $I^2 = 84\%$) of substance use services - FDTC (OR = 2.40, 95% CI 1.75 to 3.29, with evidence of heterogeneity $I^2 = 71\%$)</p>	<p>NA</p>	<p>NA</p>

			<p>and recovery coaches (OR = 1.52, 95% CI 1.17 to 1.99, with little evidence of heterogeneity $I^2 = 30\%$) were positively associated with likelihood of reunification</p> <ul style="list-style-type: none"> - Relationship between FDTC and days to reunification less positive across studies (standardized mean difference = 0.47, 95% CI 0.25, 0.69, with some evidence of heterogeneity $I^2 = 48\%$). 		
<p>Lopez-Carmen et al (2019) Working together to improve the mental health of indigenous children: A systematic review §</p>	<ul style="list-style-type: none"> - Effects of integrated mental health services for indigenous children, including children's mental health outcomes 	<ul style="list-style-type: none"> - Improvements in children's psychosocial functioning, stress management, and individual 'empowerment' - 'Empowerment' of families and communities 	<ul style="list-style-type: none"> - Improved access to services, utilization 	<p>NA</p>	<ul style="list-style-type: none"> - Greater collaboration between health and non-health services and 'strengthened organizational capacity'

<p>Whiteford et al (2014). System-level intersectoral linkages between the mental health and non-clinical support sectors: A qualitative systematic review §</p>	<p>- Focused broadly on outcomes for services or clients from intersectoral linkages between clinical and non-clinical mental health services</p>	<p>NA</p>	<p>- Improved accommodation stability, reduced child foster placements, reduced recidivism and involvement with the juvenile justice system, improved employment related outcomes - Studies of one program to address homelessness among people with severe mental illness did not lead to improved outcomes</p>	<p>- Improved efficiency, though also examples of cost shifting</p>	<p>- Improvements in interagency communication, mutual understanding of services</p>
<p>Martin-Misener et al (2012). Strengthening Primary Health Care through Public Health and Primary Care Collaborations Team. A scoping literature review of collaboration between primary care and public health §</p>	<p>- Focused broadly on outcomes of primary care and public health collaborations, including outcomes related to individuals and populations, health professionals, and health service delivery</p>	<p>- Improvements in chronic disease management, disease control, maternal and child health</p>	<p>- Improvements in access to care, immunization rates, and care processes, such as needs assessments</p>	<p>NA</p>	<p>- Financial incentives for health promotion may skew priorities away from efforts to reduce health inequities - Concerns among primary care staff about reduced time for medical care</p>

Cameron et al (2014). Factors that promote and hinder joint and integrated working between health and social care services: a review of research literature §	- Focused broadly on evidence of ‘effectiveness’	- Some studies reported improvements in quality of life, but no or marginal improvements in studies with comparative designs	- Some studies of particular service models (eg intermediate care) found potential reductions in inappropriate admissions to institutional settings	- Most studies did not find cost savings	NA
Winters et al (2016). Cross-sector provision in health and social care: an umbrella review §	- Focused broadly on ‘impacts related to cross-sector service provision and service delivery’	- Majority of studies did not report positive impacts on outcomes (outcomes were weakly defined)	- Majority of studies did not report positive impacts on outcomes (outcomes were weakly defined) - Four reviews reported positive impacts, including improvements in access and potential reductions in length of stay and readmissions to institutional settings	NA	NA
Roussos and Fawcett (2000). A review of collaborative partnerships as a strategy for improving community health §	- Population-level health outcomes and behaviors (eg smoking or physical activity)	- Insufficient evidence related to population level outcomes - Collaborative practice can contribute to change in community health behaviors	NA	NA	NA

Cooper et al (2016). Interagency collaboration in children and young people's mental health: a systematic review of outcomes, facilitating factors and inhibiting factors §	- Focused broadly on outcomes of interagency collaboration across children and young people's mental health services, such as health status and service use	- One study found a positive association between collaboration and mental health status	- Mixed impacts, including on access and quality of services (with some studies reporting positive impacts and access and its equitable provision, but others reporting negative impacts on access and quality) - Collaboration generally viewed positively by staff, patients, carers	NA	- Five studies reported positive attitudes to collaboration from staff, but one study found that staff reported increased time burden, management difficulties, challenges to professional identities, and other issues
Sloper, P (2004). Facilitators and barriers for co-ordinated multi-agency services §	- Focused broadly on 'outcomes for service users', such as quality of life and service use	- Limited evidence	- Limited evidence	NA	NA
Errecaborde et al (2019). Factors that enable effective one health collaborations: a scoping review of the literature §	- Focused broadly on the outcomes and effectiveness of collaborations around health events	- Vast majority of studies did not report on outcomes - Impacts reported include decreased mortality (one study), reduction in MRSA cases (one study), improved safety	NA	- Vast majority of studies did not report on outcomes - One study reported reductions in cost	- Process impacts reported were increased stakeholder buy-in and professional development opportunities
Dowling et al (2004). Conceptualising successful partnerships §	- Impacts related to 'service provision to users and carers, or to the	- No clear or consistent evidence of improvements	- No clear or consistent evidence of improvements	NA	NA

	wider interface of health and social care'				
<i>AMSTAR 2 overall confidence assessment:</i> * High † Medium ‡ Low § Critically low					

TABLE 4: summary of evidence on factors influencing collaboration functioning

Paper	Factors influencing collaboration functioning
<i>Studies reporting on generic factors</i>	
Andersson et al (2011) Organizational approaches to collaboration in vocational rehabilitation-an international literature review	<ul style="list-style-type: none"> - Communication (eg lack of communication can be a barrier) - Trust (eg trust can support collaboration) - ‘Territoriality’ (eg competition between agencies can be a barrier) - Shared aims (eg shared goals for collaboration can support collaboration) - Commitment (eg lack of involvement from key actors can be a barrier) - Rules and regulations (eg different rules on confidentiality can be a barrier) - Leadership (eg leaders who can overcome organizational barriers can support collaboration)
Cameron et al (2014). Factors that promote and hinder joint and integrated working between health and social care services: a review of research literature	<p><i>Organizational</i></p> <ul style="list-style-type: none"> - Aims and objectives (eg shared aims can support collaboration) - Roles and responsibilities (eg lack of understanding of other agencies’ roles can be a barrier) - Flexibility (eg flexibility for staff to work together can support collaboration) - Organisational ‘difference’ (eg conflicting agendas can be a barrier) - Communication and information sharing (eg effective communication can support collaboration) - Co-location (eg co-located teams can support collaboration) - Strong management and ‘appropriate’ professional support (eg different management structures can be a barrier) - History of joint working (eg existing relationships can support collaboration) <p><i>Cultural and professional</i></p> <ul style="list-style-type: none"> - Conflicting ideologies (eg conflict between medical and social work professions) - Trust and respect (eg lack of trust in other agencies or professions can be a barrier) - Team building (eg joint training between agencies can support collaboration)

	<p><i>Wider context</i></p> <ul style="list-style-type: none"> - Organizational change (eg reorganizations can be a barrier) - Financial uncertainty (eg short-term budgets can be a barrier)
Corbin (2016). What makes intersectoral partnerships for health promotion work? A review of the international literature	<ul style="list-style-type: none"> - Partnership resources (eg time and skills support collaboration) - Mission and purpose (a shared mission can support collaboration) - Financial resources (eg lack of financial resources can be a barrier) - Leadership (eg effective leadership can support collaboration) - Communication (eg quality communication can support collaboration) - Roles and responsibilities (eg role clarity can support collaboration) - Interaction between individual and partnership aims (eg closer alignment can support collaboration) - Partnership tasks (eg implementing tasks to support partnership goals or functioning can support collaboration) - External context (eg lack of political support can be a barrier) - Partnership impact (eg producing results can support collaboration)
Gannon-Leary et al (2006). Collaboration and partnership: A review and reflections on a national project to join up local services in England	<ul style="list-style-type: none"> - Vision and engagement (eg a clear vision can support collaboration) - Governance (eg boundary conflicts between organizations can be a barrier) - Resources and capacity (eg time and resources can support collaboration) - Relationships (eg interpersonal and interorganizational relationships can support collaboration)
Green et al (2014). Cross-sector collaborations in Aboriginal and Torres Strait Islander childhood disability: A systematic integrative review and theory-based synthesis	<p><i>Government level</i></p> <ul style="list-style-type: none"> - Structure of government agencies (eg fragmentation of departments can be a barrier to collaboration) - Policy collaboration (eg policy frameworks supporting collaboration between sectors can support local collaboration) <p><i>Organizational level</i></p> <ul style="list-style-type: none"> - Communication and awareness (eg awareness of other agencies can support collaboration) - Role clarity and responsibility (eg lack of role clarity can be a barrier) - Financial and human resources (eg lack of funding can be a barrier) - Service delivery setting (eg culturally sensitive services can support collaboration)

	<p><i>Service provider level</i></p> <ul style="list-style-type: none"> - Relationships (eg a linking role between agencies can support collaboration) - Shared professional learning (eg interprofessional training can support collaboration)
Guglielmin et al (2018). A scoping review of the implementation of health in all policies at the local level	<ul style="list-style-type: none"> - Funding (eg lack of funding can be a barrier) - Shared vision across sectors (eg establishing a shared vision can support collaboration) - National leadership (eg national policy emphasizing health inequalities can support local collaboration to address them) - Ownership and accountability (eg lack of ownership can be a barrier) - Local leadership and dedicated staff (eg lack of dedicated staff can be a barrier) - Health impact assessment (eg implementing health impact assessments can support collaboration) - Use of indicators (eg lack of data for health impact assessments can be a barrier)
Winters et al (2016). Cross-sector provision in health and social care: an umbrella review	<ul style="list-style-type: none"> - Consumer-centered (eg involving people using services can support collaboration) - Shared vision (eg lack of shared vision can be a barrier) - Leadership (eg effective leadership can support collaboration) - Communication (eg poor communication between partners can be a barrier) - Resources (eg having adequate resources can support collaboration) - History and context (eg history of partnership can support collaboration) - Linkages between sectors (eg shared training and regular meetings can support collaboration) - Role clarity (eg clarifying roles within partnership can support collaboration)
Mackie and Darvill (2016). Factors enabling implementation of integrated health and social care: a systematic review	<ul style="list-style-type: none"> - Co-location of staff and teamwork (eg co-location can support collaboration) - Communication (eg communication between staff can support collaboration) - Organizational processes (eg fragmentation between organizations can be a barrier) - Management support and leadership (eg leadership support can support collaboration) - Resources and capacity (eg a lack of resources can create additional workload and be a barrier) - National policy (eg national payment systems and incentives can be a barrier) - IT systems (eg lack of shared IT systems can be a barrier)

<p>Martin-Misener et al (2012). Strengthening Primary Health Care through Public Health and Primary Care Collaborations Team. A scoping literature review of collaboration between primary care and public health</p>	<p><i>Systemic:</i></p> <ul style="list-style-type: none"> - Policy context (eg policies mandating partnership working can support collaboration) - Funding and resources (eg lack of resources can be a barrier) - Power and control (eg territorial conflicts can be a barrier) - Education and training (eg shared training can support collaboration) <p><i>Organizational:</i></p> <ul style="list-style-type: none"> - Common agenda (eg a lack of common agenda can be a barrier) - Knowledge and resources (eg lack of resources can be a barrier) - Leadership, management, and accountability (eg developing inclusive governance committees can support collaboration) - Geographical proximity (eg co-location can support collaboration) - Shared protocols, tools, and information sharing (eg shared information systems can support collaboration) <p><i>Interactional:</i></p> <ul style="list-style-type: none"> - Shared purpose and philosophy (eg shared values can support collaboration) - Clear roles (eg clarity on roles and can support collaboration) - Positive relationships (eg poor relationships can hinder collaboration) - Effective communication and decision-making (eg open communication and decision-making can support collaboration)
<p>Perkins et al (2010). ‘What counts is what works’? New Labour and partnerships in public health</p>	<ul style="list-style-type: none"> - Engagement of senior management (eg lack of engagement can be a barrier) - Financial and human resources (eg lack of resources can be a barrier) - Sharing information and best practice (eg information sharing can support collaboration) - Wider context (eg shifting policy context can be a barrier) - Geographical boundaries of agencies (eg lack of shared boundaries can be a barrier)
<p>Rantala et al (2014). Intersectoral action: local governments promoting health</p>	<ul style="list-style-type: none"> - National or international influences (eg national policy can support local action) - Political context (eg local political will can support collaboration) - Local mechanisms for ISA (eg health impact assessments can support collaboration)

	<ul style="list-style-type: none"> - Engagement (eg engagement with non-health sectors and other government agencies is needed to support ISA) - Information sharing (eg sharing information can support collaboration) 	
Savic et al (2017). Strategies to facilitate integrated care for people with alcohol and other drug problems: a systematic review	<ul style="list-style-type: none"> - System investment (eg lack of investment in community services can be a barrier) - Government partnerships (eg inter-departmental partnerships can lead to policies, programs, and investments that can support collaboration) - Service contracts (eg government contracts mandating partnership working can support collaboration) - Inter-agency relationships (eg positive relationships can support collaboration) - Shared purpose, values, and priorities (eg shared values between organizations can support collaboration) - Co-location of services (eg co-location can support collaboration, but also can present barriers, such as additional workload) - Staff training (eg staff training in joint working can support collaboration) - Information sharing (eg shared IT systems can support collaboration) - Perceptions of quality in partner agencies (eg lack of confidence in other organizations can be a barrier) - Interprofessional networks (eg territorialism can be a barrier) 	
<i>Studies reporting on supportive and/or constraining factors</i>		
Cooper et al (2016). Interagency collaboration in children and young people's mental health: a systematic review of outcomes, facilitating factors and inhibiting factors	<p>Supportive factors:</p> <ul style="list-style-type: none"> - Good communication - Joint training - Good understanding of other sectors and processes - Mutual valuing, respect, and trust - Senior management support - Protocols on interagency collaboration (eg on data sharing) - A named 'link person' 	<p>Constraining factors:</p> <ul style="list-style-type: none"> - Inadequate resources - Poor communication - Lack of valuing, respect, and trust - Differing perspectives or cultures - Poor understanding across professionals and services - Confidentiality issues (eg unable or unwilling to share information)
Davies et al (2011). A systematic review of integrated working between care homes and health care services	<p>Supportive factors:</p> <ul style="list-style-type: none"> - Health care input and training valued by care homes 	<p>Constraining factors:</p> <ul style="list-style-type: none"> - Lack of trust and confidence between health care and care home staff - Lack of access to health care services

	<ul style="list-style-type: none"> - 'Bottom up' approach to staff training so that all levels of staff are involved - Health care professionals acting as a advocate for care homes - Health care professionals acting as facilitators for sharing good practice and enabling care home staff to network - Health care professionals promoting better access to services for the care home - Care home managers supporting staff access to training 	<ul style="list-style-type: none"> - High staff turnover and lack of access to training - Lack of staff knowledge and confidence - Care homes being professionally isolated - Lack of teamwork in care homes
<p>Herdiana et al (2018). Intersectoral collaboration for the prevention and control of vector borne diseases to support the implementation of a global strategy: a systematic review</p>	<p>Supportive factors:</p> <ul style="list-style-type: none"> - Shared vision (eg agreement on outcomes) - Management (eg implementation capacity) - Relationships (eg consistent communication) - Approach (eg using a participatory approach) - Resources (eg adequate financial and technical support) 	<p>Constraining factors:</p> <ul style="list-style-type: none"> - Political differences - Poor communication and coordination - Financial constraints - Lack of local commitment Insufficient or irregular supplies - Lack of tangible benefits - Weak monitoring or evaluation - Different geographical areas - Professional attitudes and behaviors - Inaccessible area - Poor leadership - Difficulties sharing decision-making and power - Different organizational cultures and histories - Organizational rigidities - Contested planning priorities

<p>Seaton et al (2018). Factors that impact the success of interorganizational health promotion collaborations: a scoping review</p>	<p>Supportive factors:</p> <ul style="list-style-type: none"> - Shared vision and goals - Leadership (including mechanisms for partners to participate in decision-making) - Member skills and characteristics - Organizational commitment - Resources and technical support - Clear roles and responsibilities - Trust, communication, and relationships - Community engagement 	<p>Constraining factors:</p> <ul style="list-style-type: none"> - Absence of supportive factors - Government mandates or policy directives to collaborate - Power imbalances between partners
<p>Sloper, P (2004). Facilitators and barriers for co-ordinated multi-agency services</p>	<p>Supportive factors:</p> <p><i>Service planning:</i></p> <ul style="list-style-type: none"> - Clear and realistic aims - Clearly defined roles and responsibilities - Commitment of leaders and staff - Strong leadership and multi-agency management structures - Agreed timetable for implementation and incremental approach to change - Linking projects to other planning and decision-making processes - Good communication <p><i>Service implementation and management:</i></p> <ul style="list-style-type: none"> - Shared and adequate resources - Staff with the right experience and approach - Joint training and team building 	<p>Constraining factors:</p> <ul style="list-style-type: none"> - Lack of clarity on roles and responsibilities - Differences in organizational aims - Lack of consensus on aims or overambitious aims - Lack of commitment and support from senior managers

	<ul style="list-style-type: none"> - Appropriate support and supervision of staff - Service monitoring and evaluation <p><i>Other:</i></p> <ul style="list-style-type: none"> - Cultural factors (eg understanding partners' aims and functions) - Wider context (eg history of partnership working can support collaboration) 	
Whiteford et al (2014). System-level intersectoral linkages between the mental health and non-clinical support sectors: A qualitative systematic review	<p>Supportive factors:</p> <ul style="list-style-type: none"> - Communication between sectors - Strong leadership (eg mechanisms for resolving conflicts) - Shared perspective or mutual understanding - Co-location and service linkages - Overarching plan and coordination (eg a coordinating body between organizations) - Monitoring (eg service evaluation) - Engagement - Competitive grants (eg can garner interest in participating in collaboration activities or reforms) 	<p>Constraining factors:</p> <ul style="list-style-type: none"> - Lack of funding and resources - Differences in perspective or lack of clarity on roles - Barriers to information sharing - Inappropriate referrals (eg on sector fearing increased activity)
Wildridge et al (2004). How to create successful partnerships: a review of the literature	<p>Supportive factors:</p> <ul style="list-style-type: none"> - Shared vision - Trust - Communication - Effective decision-making and accountability - Effective change management 	<p>Constraining factors:</p> <ul style="list-style-type: none"> - Lack of motivation or perverse incentives - Insufficient resources - Power imbalances - Resource conflicts and 'cost shifting' - Cultural issues (eg between staff in health and social care organizations)

	<ul style="list-style-type: none"> - Legislation (eg that creates flexible rules for organizations to collaborate) - Supportive environment (eg history of collaboration) - Membership characteristics (eg appropriate members involved) - Supportive processes and structures (eg clear roles and guidelines) - Sufficient resources 	<ul style="list-style-type: none"> - Structural differences - Accountability and decision-making differences
Bagnall et al (2019). Whole systems approaches to obesity and other complex public health challenges: a systematic review	<p>Supportive factors:</p> <ul style="list-style-type: none"> - Strong leadership - Community engagement (eg to identify health needs and potential solutions) - Relationships and trust - Community capacity - Good governance and shared values - A effective collaborative team (eg early participation of key stakeholders) - Consistency in language across organizations (eg to overcome differences in values and structures) - Embedding initiatives in broader policy context - Local evaluations (eg to inform interventions) - Sufficient financial support and resources 	NA
Dowling et al (2004). Conceptualising successful partnerships	<p>Supportive factors:</p> <ul style="list-style-type: none"> - Engagement of partners - Agreement on need for and aims of partnership - Trust and respect among partners 	NA

	<ul style="list-style-type: none"> - Satisfactory accountability arrangements - Adequate leadership and management - Wider context (eg financial climate and legal and institutional structures shape partnership success) 	
<p>Errecaborde et al (2019). Factors that enable effective one health collaborations: a scoping review of the literature</p>	<p>Supportive factors:</p> <p><i>Individual level</i></p> <ul style="list-style-type: none"> - Education and training - ‘Just in time’ training - Existing experience and relationships <p><i>Organizational level</i></p> <ul style="list-style-type: none"> - Structures and policies (eg shared response guidelines) - Systems (eg shared information systems) - Culture (eg engaged leadership) - Human resources (eg staff with defined roles and responsibilities) <p><i>Network level</i></p> <ul style="list-style-type: none"> - Network structures (eg coordination mechanisms between organizations) - Network relationships (eg defined roles and responsibilities between partners) - Resources (eg financial and human resources) - Political environment (eg political will) - Network leadership (eg shared decision-making) 	<p>NA</p>

	<ul style="list-style-type: none"> - Network management (eg established lines of communication between organizations) - Monitoring and evaluation - Resource mobilization and allocation (eg financial and human resources) 	
<p>Foster-Fishman et al (2001). Building collaborative capacity in community coalitions: a review and integrative framework</p>	<p>Supportive factors:</p> <p><i>Member capacity</i></p> <ul style="list-style-type: none"> - Works collaboratively with others - Ability to build effective programs - Ability to build an effective coalition infrastructure - Holds positive attitudes about collaboration - Committed to target issues - Holds positive attitudes about other stakeholders - Holds positive attitudes about self (eg as a legitimate partner) - Access to member capacity - Coalition supports member involvement - Coalition builds member capacity (eg provides technical support) <p><i>Relational capacity</i></p> <ul style="list-style-type: none"> - Develops a positive working climate - Develops a shared vision - Promotes power sharing - Values diversity (eg individual and group differences appreciated) 	<p>NA</p>

	<ul style="list-style-type: none"> - Develops positive external relationships <p><i>Organizational capacity</i></p> <ul style="list-style-type: none"> - Effective leadership (eg skilled at conflict resolution) - Task-oriented work environment - Formalized procedures (eg clear member roles and responsibilities) - Effective communication (eg timely information sharing) - Sufficient resources - Continuous improvement orientation <p><i>Programmatic capacity</i></p> <ul style="list-style-type: none"> - Clear objectives - Realistic goals - Driven by and addresses community needs 	
<p>Lopez-Carmen et al (2019) Working together to improve the mental health of indigenous children: A systematic review</p>	<p>Supportive factors:</p> <ul style="list-style-type: none"> - Community involvement - Resources and access (eg increased organizational funding for integrated interventions) - Collaboration between services and systems (eg sharing information between sectors) - Strong relationships - Cultural sensitivity (eg knowledge of historical contexts and trauma of indigenous populations) - Organizational and staff capacity (eg funding and resources for teams to collaborate) 	<p>NA</p>

<p>Zakocs and Edwards (2006). What explains community coalition effectiveness? A review of the literature</p>	<p>Supportive factors:</p> <ul style="list-style-type: none"> - Formalization/rules - Leadership style - Active member participation - Diverse membership - Member agency collaboration - Group cohesion - Open/frequent communication channels - Intensity/scope of actions implemented - Task/goal focused climate - Staff time devoted to tasks - Conflict management - Agency member types - Participatory decision-making - Member experience/expertise - Member benefits - Training/technical assistance - Sectors (agencies) represented - Member ownership/commitment - Effective administration - Efficient use of resources - Target small geographic areas - Coalition readiness - Collaboration before coalition - Comprehensive vision - Supportive organizational climate 	<p>NA</p>
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	<ul style="list-style-type: none"> - Trust - Recognize life cycles - Establish priorities - Innovation - Researcher driven - Written assessment/implement plan - Data-driven planning - Gained political support - Prevention focused - Used media to promote coalition - Used environmental strategies - Dedicated project director - Lead agency known entity - Lead agency noncompetitor - Lead agency director supportive - Length of time members involved - Membership size - Member-perceived fairness - Member satisfaction - Member empowerment - Member sense of community - Member perceived community problems - Member anger/aggression - Member self-discovery - Member independence - Member knowledge of other agencies 	
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	<ul style="list-style-type: none"> - Staff relationships with members - Staff expertise/experience - Paid coordinator - Personnel barriers 	
Roussos and Fawcett (2000). A review of collaborative partnerships as a strategy for improving community health	<p>Supportive factors:</p> <ul style="list-style-type: none"> - Clear vision and mission - Action planning for community and systems change - Developing and supporting leadership - Measuring progress, including on intermediate outcomes - Technical assistance (eg training in community health assessments or evaluation) - Financial resources - Making outcomes matter (eg by promoting partnership outcomes to community members and others) 	NA
	<p>Contextual factors:</p> <ul style="list-style-type: none"> - Social and economic factors - Community social capital - Partnership context (eg history of collaboration, time for partnership) - Community control in agenda setting 	
Auschra C (2018). Barriers to the integration of care in inter-organisational settings: a literature review	NA	<p>Constraining factors:</p> <p><i>Regulation and administration</i></p> <ul style="list-style-type: none"> - Regulatory issues (eg data sharing) - Historical context (eg lack of history of collaboration) - Administrative boundaries <p><i>Funding</i></p>

		<ul style="list-style-type: none"> - Insufficient funding - Fear of cost shifting <i>Inter-organizational</i> - Lack of leadership coordination - Organizational differences (eg in decision-making processes) - Power imbalances - Conflicting aims - Failure to include key partners <i>Organizational</i> - Organizational agenda differs from collective interests - Cultural differences - Previous experiences between organizations <i>Service delivery</i> - Professional differences - Poor communication - Lack of trust - Lack of mutual understanding - Resistance to change - Lack of technical standards (eg for data sharing) <i>Clinical</i> - Lack of information sharing - Confidentiality issues (eg leading to lack of information sharing)
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Mason et al (2015). Integrating funds for health and social care: an evidence review	NA	<p>Constraining factors:</p> <ul style="list-style-type: none"> - Challenges breaking down service barriers (eg professional opposition) - Relational issues (eg poor relationships between sectors) - Difficulty engaging service users - Information technology issues (eg incompatible systems) - Accountability and structural differences (eg challenges transferring funds between organizations)
Williams I (2009). Offender health and social care: a review of the evidence on inter-agency collaboration	NA	<p>Constraining factors:</p> <ul style="list-style-type: none"> - Structural incompatibility (eg health and social care reluctance to work with criminal justice agencies) - Procedural differences (eg different approaches to engaging offenders) - Different professional values (eg between health and criminal justice) - Information sharing (eg difficulties sharing information, both technical and related to professional differences)

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CHAPTER 4

Cross-sector collaboration and health in England: analysing the development of integrated care systems in a long-term policy context

Published papers

This chapter draws on material from several papers already published by HA. This includes two peer-reviewed articles and a series of editorials and briefings. The chapter also included new analysis and additional text to link between the papers. Material from the following papers is included:

(1) Alderwick H. NHS reorganisation after the pandemic. *BMJ*. 2020;371:m4468.

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(2) Alderwick H, Dunn P, Gardner T, Mays N, Dixon J. Will a new NHS structure in England help recovery from the pandemic? *BMJ*. 2021;372:n248.

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(3) Alderwick H, Gardner T, Mays N. England's new health and care bill. *BMJ*. 2021;374:n1767.

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(4) Alderwick H, Hutchings A, Mays N. A cure for everything and nothing? Local partnerships for improving health in England. *BMJ*. 2022;378:e070910.

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<https://www.health.org.uk/sites/default/files/pdf/2022-06/2022%20-%20ICS%20characteristics.pdf>

(6) Alderwick H. Conservative party's legacy on the NHS. *BMJ*. 2024;386:q1491.

<https://www.bmj.com/content/386/bmj.q1491>

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Date	10/11/2024

INTRODUCTION

The NHS in England was reorganized under the Health and Care Act 2022¹—the biggest legislative overhaul of the NHS in a decade. A key aim of the changes is to encourage collaboration between NHS, local government, and other agencies to improve health and reduce health inequalities.² Since July 2022, the NHS in England has been formally divided into 42 geographically-based Integrated Care Systems (ICSs), which bring together the NHS, social care, public health, and other sectors to plan and coordinate services for populations of around 500,000 to 3 million people. ICSs are the centrepiece of the NHS’s new structure and main vehicle for delivering a range of national policy objectives—from improving NHS performance to contributing to broader social and economic development. Policy changes in other countries, including the United States and elsewhere in the UK, also emphasize the role of collaboration between organizations and sectors as a route to improving population health.^{3,4}

Partnerships between local agencies to improve health are nothing new. In England, there is a long history of national policies promoting collaboration between the NHS, local government, and other agencies to improve health and care. Since at least the 1970s, successive governments have used a mix of policy measures to try to better integrate NHS and local authority services, such as joint planning initiatives, pooled funding arrangements, new types of purchasing and provider organizations, and more.^{5,6,7,8} From 1997, an array of area-based policy initiatives were introduced by New Labour governments as part of their approach to tackling complex social problems through ‘joined up government’.^{9,10} This included a mix of cross-sector partnerships between the NHS and other agencies to meet broader policy objectives to improve health and reduce health inequalities.^{11,12} These continued alongside narrower policies to better integrate NHS and social care services, primarily designed to improve care and support for older people and people with multiple long term conditions.

Despite this long policy history, little is known about which collaborations work to improve health or reduce health inequalities in different contexts (*see* chapter 3).^{13,14,15} And local partnerships in England and elsewhere have faced a mix of implementation challenges, such as limited resources and problems overcoming differences in governance and decision-making between organizations and sectors (figure 2, chapter 3).

The immediate pressures facing England’s new ICSs are also substantial. Staff shortages across the NHS and social care are chronic.¹⁶ NHS performance has deteriorated substantially against headline measures since 2010, and worsened further during the covid-19 pandemic.¹⁷ For example, in 2010-11, just 3.9% of patients waited more than four hours in major NHS emergency departments. This grew to 24.6% in 2019-20 and 41.9% in 2023-24.¹⁸ Totemic NHS targets—such as at least 92% of patients starting consultant led treatment within 18 weeks of a general practitioner referral—have been

routinely missed for nearly a decade. Quality has also worsened in key areas outside the spotlight, such as continuity of care in general practice,^{19,20} and public satisfaction with the NHS is at a record low.²¹ Performance in other local public services, such as social care and neighbourhood services, has also declined since 2010,²² and several local authorities in England have declared themselves effectively bankrupt.²³ Improvements in life expectancy have stalled since 2010 and inequalities in health between richer and poorer areas in England have widened.^{24,25} These and other challenges are not evenly distributed between ICSs—and some systems are likely to be better equipped to respond to them than others.²⁶

This chapter analyses the development of ICSs in England and puts them in their longer-term policy context. The aim is to provide an overview of the new systems and understand factors that may shape their evolution and impact. In the first section, we review previous national policies encouraging collaboration between local NHS and non-health care organizations in England since 1997, synthesize evidence on their impacts, and put these partnerships in their broader policy and political context. In the second, we analyse the evolution and structure of ICSs in England, including how they fit into the broader direction of NHS reform, and their aims and governance. In the third section, we use publicly available data to analyse and compare characteristics of England's 42 ICSs in areas that are likely to shape their ability to collaborate effectively. The discussion identifies implications for ICSs as they evolve. Chapter 5 then analyses the specific national policy objectives for ICSs related to reducing health inequalities.

APPROACH AND METHODS

We used a mix of publicly available data and evidence on the broader context for local collaboration policies to inform our analysis. For our analysis of past national policies on local cross-sector collaboration and health,²⁷ we focused on major national policies introduced by central government in England between 1997 and 2022 that included overarching health objectives—for instance, to improve population health, reduce health inequalities, or improve the quality of local health services—and involved both NHS and non-health care agencies, such as local authorities and social care providers. This means that policies focused primarily on collaboration within the NHS (for instance, between GPs and hospitals) or between non-health care agencies (for instance, between social care and housing providers) were not included in our analysis. We selected 1997 as the start date for our review, given the proliferation of area-based partnership policies focused on improving health introduced under New Labour governments. We reviewed official policy documents (for instance, published by central government or national NHS bodies), policy evaluations, and existing summaries of policy on cross-sector collaboration in England to identify relevant initiatives. Key policy documents and evaluations are included in table 1, along with more detail on our inclusion criteria. For each policy, we reviewed relevant documents and summarized data on policy aims, scope, processes, and intended impact to inform comparison and analysis. We drew on data linked to

relevant policies in England identified in our umbrella review (*see* chapter 3) to summarize evidence on the impact of these kinds of collaborations, as well as factors shaping how they work. We supplemented these, where relevant, with more recent reviews of the policies included. We then drew on wider evidence linked to the policy and political context shaping local collaborations in England over the 25-year period to help explain their potential impact.

For our analysis of the development and structure of ICSs, we reviewed official policy documents to understand the evolution, aims, and content of the reforms. This included government legislation to establish ICSs in England, and various strategy and guidance documents from national NHS bodies on their development and implementation. We also drew on wider literature about the direction of NHS reform in England—for instance, the Lansley reforms in 2012 and broader evolution of the NHS’s purchaser-provider split—to put the latest round of NHS reforms in their longer-run context.

For our analysis of the characteristics of England’s 42 ICSs, we collated and analysed publicly available data on ICS geography, population size and deprivation, organizational complexity, and policy context.²⁶ We selected these characteristics because of evidence on their likely role in shaping how NHS and other organizations in ICSs work together to reduce health inequalities.^{26,15} For example, the complexity of the organizational landscape within each ICS is likely to affect how the system functions—for instance, by making it easier or harder for organizations to make decisions and implement service changes across sectors. See tables 2-4 for more detail on the data we used for each characteristic. See chapter 2 for more detail on the rationale for selecting indicators in these areas. We also used these data to identify our sample of ICSs areas for the qualitative research presented in chapters 6 and 7.

ANALYSIS

25 years of partnership policies

There is a long history of national policies in England promoting collaboration between NHS, local government, and other agencies to improve health and care. We identified major policies introduced between 1997-2022 and summarized data on their aims, scope, processes, and intended impact (table 1). These policies vary in aims and approach—from more narrowly defined initiatives to coordinate health and social care services for older people and people with complex needs, to population-wide programmes targeting improvements in social and economic factors shaping health and inequalities.

Some partnerships have been mandated by national policymakers (such as Health and Wellbeing Boards, established across the whole country under the Health and Social Care Act 2012), while others have been voluntary (such as Integrated Care Pilots, in place between 2009-2011 in 16 areas of England). Local agencies have typically been tasked with working together to develop a strategy for improving health and quality of services in their area—and sometimes have been provided with extra

funding or resources to help do so. Some programs involved stronger national direction over the content of local initiatives than others. For instance, recent new care model ‘Vanguards’ received national funding and support to develop three broad ‘models’ of health and social service integration, including collaboration between GPs, hospitals, social care providers, and wider community services.

Policies also evolved over time. For instance, Sure Start began in 1999 as an initiative to improve health and wellbeing of children and young people in areas of high deprivation, through a mix of cross-sector planning and locally developed interventions in a mix of priority areas. But from 2003, the policy shifted to focus on delivering integrated services through Sure Start children’s centres.

Policy promoting cross-sector collaboration persisted through changes in government, but the focus of these initiatives and broader political context in which they were delivered shifted. Area-based partnerships proliferated under New Labour governments from 1997—including Health Action Zones, Sure Start Local Programmes, Local Strategic Partnerships, and more. These policies were combined with a national strategy to reduce health inequalities in England and major public investment in the NHS and social programmes.^{28,29,30} Policies to encourage local partnerships continued under Coalition and Conservative governments—including a series of initiatives to better coordinate NHS and social care services, such as Integrated Care and Support Pioneers, Vanguards, and the Better Care Fund—but explicit aims to reduce health inequalities appeared less prominently. Partnerships since 2010 have been implemented in the context of austerity in public spending,³¹ and national policymakers have often prioritized objectives of improving efficiency and reducing the use of hospitals and other services.³² Throughout the 25-year period, NHS organizations faced mixed—sometimes conflicting—incentives to collaborate and compete within the NHS’s constantly evolving ‘internal market’.^{33,34,35}

England’s new ICSs combine various components of these previous partnership policies—mixing a narrower focus on coordinating health and social care services for patients with broader aims to improve the underlying social and economic determinants of health for whole populations. The result is a broad and ambitious list of policy objectives for the new partnerships, including to improve population health, improve health care services, reduce inequalities in health and health care, improve productivity and value for money, and support social and economic development. Collaboration between agencies and integration of services are seen as key mechanisms to achieve these aims.

ICSs have existed informally since 2016—developed in response to the fragmentation of the English NHS and as part of a broader shift in public policy away from provider competition as the route to improve health services.^{36,37,38} In these early partnerships, NHS engagement with local government and other community partners varied widely, with local government not always treated as an equal partner by local NHS organizations.³⁹ Patient and public involvement was often lacking,³⁹ and few local plans described concrete interventions linked to reducing health inequalities or broader social

and economic factors shaping population health.^{40,41,42} ICSs were formally established across England as mandatory partnerships through the Health and Care Act 2022, explored in more detail below.

Evidence on impact

Despite this long history, evidence that local health partnerships deliver the kind of benefits that policymakers typically expect is lacking (*see* chapter 3).¹⁵ Overall, our umbrella review found little high quality evidence to suggest that collaboration between local health care and non-health care agencies improves health and health equity—in the UK or elsewhere. Evidence of impact on health services is mixed, though some studies suggest closer integration between health and social care services can improve access to care and patient experience. Evidence of impact on resource use and spending is limited and mixed. There is little difference in impacts reported between UK and international studies.^{15,43} For example, Smith et al reviewed evidence on the impact of local organizational partnerships on health and health inequalities in England between 1997 and 2008—including Health Action Zones, Health Improvement Programmes, and other area-based policy initiatives introduced under New Labour governments during the period—and found available studies either reported no or mixed effects on health outcomes (table 3, chapter 3). A synthesis of evidence from evaluations of more recent national policies to promote better integration between health and social care services in England between 2008 and 2020—including Integrated Care Pilots, Integrated Care and Support Pioneers, and New Care Model Vanguard—found local programs achieved mixed results.⁴⁴ For example, Integrated Care Pilots resulted in increased unplanned hospital admissions—the reverse of what was intended—while there is some evidence that sites taking part in both Vanguard and Pioneer programmes may have made reductions in unplanned hospital admissions over time.

Lack of evidence on impact does not necessarily mean collaboration is bad policy. In theory, cross-sector collaboration could help NHS and other local agencies combine skills and resources,^{45,46,47} manage interdependencies and share risks,^{48,49} and—ultimately—tackle complex health problems that cannot be dealt with by a single organisation.^{50,51,52} Most major health challenges facing society fall into this category—and tackling them depends on policy action beyond the reach of health care systems.⁵³ Collaboration may also help improve efficiency by reducing transaction costs—for example, by making it easier to share information and develop processes between organizations and sectors.^{54,55,56}

But making collaboration work in practice is challenging, influenced by power, resources, governance issues, policy context, and more (figure 2, chapter 3).¹⁵ Qualitative studies on the implementation of cross-sector collaboration in England consistently report a mix of barriers to effective partnership working, such as challenges engaging senior leaders, conflicting objectives, shifting policy priorities,

IT and information sharing issues, differences in professional cultures and values, and a long list of other issues depending on the policy initiative.^{12,57,58,59,60,61} Lack of trust between NHS and care home staff, for example, can hold back joint working.⁶⁰ Evaluating the effects of local collaboration is also conceptually and methodologically tricky.^{62,63} As a result, the benefits of collaboration may be overstated, hard to deliver, and hard to measure—or some combination of the three (*see* chapter 3).

A tale of two decades

The potential impact of local collaborations is also shaped by the broader social, political, and economic structures in which they operate (*see* chapters 2 and 3). Policymakers frequently emphasize the role of local organizations and ‘places’ in improving population health.^{64,65,66} Existing studies often focus predominantly on local conditions shaping collaboration functioning, such as the role of local leaders and how organizations share information.¹⁵ But the role of national policy context and political choices is frequently underplayed⁶⁷—particularly in a highly centralized state like the UK, where many powerful levers for improving health and reducing health inequalities lie at a national level. For example, most public spending in England is managed by central government, including social security.⁶⁸ Reforms to social security and reductions in the generosity of working-age benefits in the 2010s may have contributed to increased psychological distress among the unemployed.^{69,70} Local partnerships in England should therefore be understood in their broader political context, as one component in a complex system of factors interacting to shaping health and health inequalities.

Comparing partnership policies in England between two decades—the 2000s and 2010s—helps illustrate the point. A mix of local partnerships were developed in England in the 2000s (table 1). These partnerships were one part of a broader national strategy introduced by central government to reduce health inequalities—focused on supporting families, engaging communities, tackling poverty, improving access to services, and action on underlying social and economic conditions through a mix of social programs, such as the national minimum wage—backed by major increases in investment in the NHS and other public services.^{28,29,30} National policy on NHS resource allocation also increased the share of health care funding going into more deprived areas.⁷¹ Evaluations of the area-based partnerships implemented during this period found little evidence that they achieved their health objectives⁷² and identified various implementation issues.¹² But more recent evidence suggests that the broader collection of policies and investment may have contributed to modest reductions in health inequalities over time.^{73,74,75,76} Local collaborations were one mechanism that may have contributed to these improvements—for instance, by supporting and directing additional spending on local services. Local partnerships continued through the 2010s. But the national policy context shifted. Compared to historic spending increases of around 3% a year, government spending grew at 0.3% a year in real terms between 2009-10 and 2019-20.⁷⁷ Spending on public services fell by 7.8% in real terms. Some services, such as health care, were relatively protected—though NHS spending in England still grew

at less than half the long-run average.⁷⁸ But others, such as housing and local government services, faced major cuts. As a result, the capacity of local government to improve health shrunk significantly—public health budgets, for instance, fell by a quarter per person from 2015 to 2020—with funding falling furthest in more deprived areas.^{79,80,81} And central government lacked an overarching strategy to tackle widening health inequalities.⁸² Local partnerships faced challenges trying to improve health with dwindling resources,⁸³ and struggled to deliver narrower policy objectives to reduce unplanned hospital use.⁴⁴ The national policy context constrained what local areas could deliver—and will continue to shape how local collaborations function in future.

Development and structure of ICSs

ICSs are the latest in this long line of national policies promoting cross-sector collaboration to improve health and reduce health inequalities in England. ICSs were formally established under the Health and Care Act 2022. The Act was introduced during the covid-19 pandemic and included a mix of measures on the NHS, social care, and public health services, as well as contentious changes to strengthen the UK health secretary’s control over the day-to-day running of the NHS in England.

The reforms were shaped by a mix of policy and political considerations, including contested political narratives about the UK’s covid-19 pandemic response and the appropriate role of the secretary of state for health in NHS decision-making.⁸⁴ But a central aim of the legislation was to promote collaboration within the health system to improve services and manage resources, with ICSs at the heart of a new NHS structure created under the reforms.⁸⁵ The legislation reversed key components of the changes made by the Coalition government through the Health and Social Care Act 2012 a decade earlier—the last round of major reforms to the organization and structure of the English NHS.

Context for the legislation

Going into the covid-19 pandemic, the national strategy guiding the development of the NHS in England was the NHS long term plan.³⁷ The plan—published by national NHS bodies in 2019—focused on developing more integrated services within the NHS and between health and social care, boosting disease prevention, and improving cancer, mental health, and other priority services.⁸⁶ A mix of policy mechanisms was proposed to drive progress, including new contracts for general practitioners, revised quality measurement, and greater use of digital technology. The logic was that collaboration between local agencies would improve services, contributing to better population health.

But the rules governing the NHS in England were not designed with this logic in mind. Analysts of institutions often focus on the interaction between the ‘rules in form’—the formal rules that govern how systems work on paper—and the ‘rules in use’—the way things actually work in practice.⁸⁷ At the time of the NHS long term plan, the ‘rules in form’ for the NHS were largely governed by the Health and Social Care Act 2012, which had introduced widespread changes to the organization of the NHS in England and sought to strengthen the role of provider competition within the health system—

for instance, with a new economic regulator for health care and rules on competitive tendering.⁸⁸ The aim of integrating services was supposed to be balanced with competition among providers. In reality, NHS leaders embraced de facto collaboration instead.⁸⁹ The NHS long term plan and five year forward view⁹⁰ before it emphasized closer integration of local planning and services—both within the NHS and between the NHS, local government, and other local services. NHS England established early versions of ICSs—initially called Sustainability and Transformation Plans, then Sustainability and Transformation Partnerships—to coordinate local planning and spending. But these partnerships had no formal powers and still needed to navigate the 2012 Act’s rules on competition. They effectively acted as an additional layer on top of the NHS’s fragmented and complex organizational structure.

As a result, NHS England proposed new legislation to central government in 2019.⁹¹ The idea was to bring the formal rules governing the NHS more closely in line with the direction the system was heading in practice. Proposals included removing requirements to competitively tender some NHS services, and establishing local partnership committees with delegated powers to make decisions on local priorities and spending. The proposals were designed to avoid another major reorganization of the NHS, but risked replacing one set of workarounds with another.⁹² Covid-19 hit and the plans were temporarily shelved. But legislation was quickly back on the agenda⁹³ and NHS England published expanded proposals for changes to NHS rules and structures during the first year of the covid-19 pandemic, including a more substantial overhaul of the organization and governance of the NHS at a local level.⁹⁴ Government published a white paper on the planned changes in early 2021⁹⁵ and a bill to parliament later that year.⁹⁶ The Health and Care Act 2022 was passed in April 2022 and the key changes were implemented soon after, with the NHS’s new ICSs formally established in July 2022.¹

ICSs in a new NHS structure

The 2022 Act established a new NHS structure in England with four layers of NHS agencies and organizational partnerships (box 1). The centrepiece is ICSs: 42 area-based partnerships between the NHS, local government, and other organizations, responsible for planning and coordinating local services for populations of around 500,000 to 3 million people. Everywhere in England is covered by an ICS. The new systems have been given four broad aims by national policymakers:⁹⁷

1. Improve outcomes in population health and health care
2. Tackle inequalities in outcomes, experience, and access
3. Enhance productivity and value for money
4. Help the NHS support broader social and economic development

The structure of ICSs is complex (figure 1). Each statutory ICS is made up of two new bodies: Integrated Care Boards (ICBs)—area-based NHS agencies responsible for controlling most health

care resources to improve health and care for their local population—and Integrated Care Partnerships (ICPs)—looser collaborations of NHS, local government, and other agencies, such as housing or social care providers, responsible for developing an ‘integrated care strategy’ to guide local decisions. ‘Place’ level partnerships of NHS, social care, public health, and other sectors will also be developed to coordinate services at a more local level in each ICS. The geographical boundaries of ‘places’ have not been clearly defined, but typically cover existing local authority areas. To add to the complexity, various existing organizational partnerships, such as Health and Wellbeing Boards—which bring together local authorities, NHS organizations, and other agencies and sectors to develop local health strategies at a local authority level across England—remain in place alongside the new arrangements. Other overlapping policy initiatives, such as primary care networks, also operate at a different scale.⁹⁸

The 2022 Act seeks to embed organizational collaboration as the guiding principle for improving health services in England—both within the NHS (for instance, between NHS commissioners, hospitals, and general practitioners) and between the NHS and other sectors (for instance, between the NHS, social care, and public health). New ICB boards include representatives from NHS providers, diminishing the strength of the NHS’s internal market, as well as representatives from local government. ICSs are intended to be responsible for ‘strategic commissioning’—including assessing population health needs, planning services, and allocating funds to improve local health and health care.^{99,100} New payment models for NHS providers can be developed locally to help do this.¹⁰¹ But the Act removes previous requirements on competitive tendering of clinical services in the NHS—replaced by a new ‘provider selection regime’ that attempts to give more flexibility for commissioners on selecting providers for health service contracts (for example, to avoid unnecessary tendering).^{102,103}

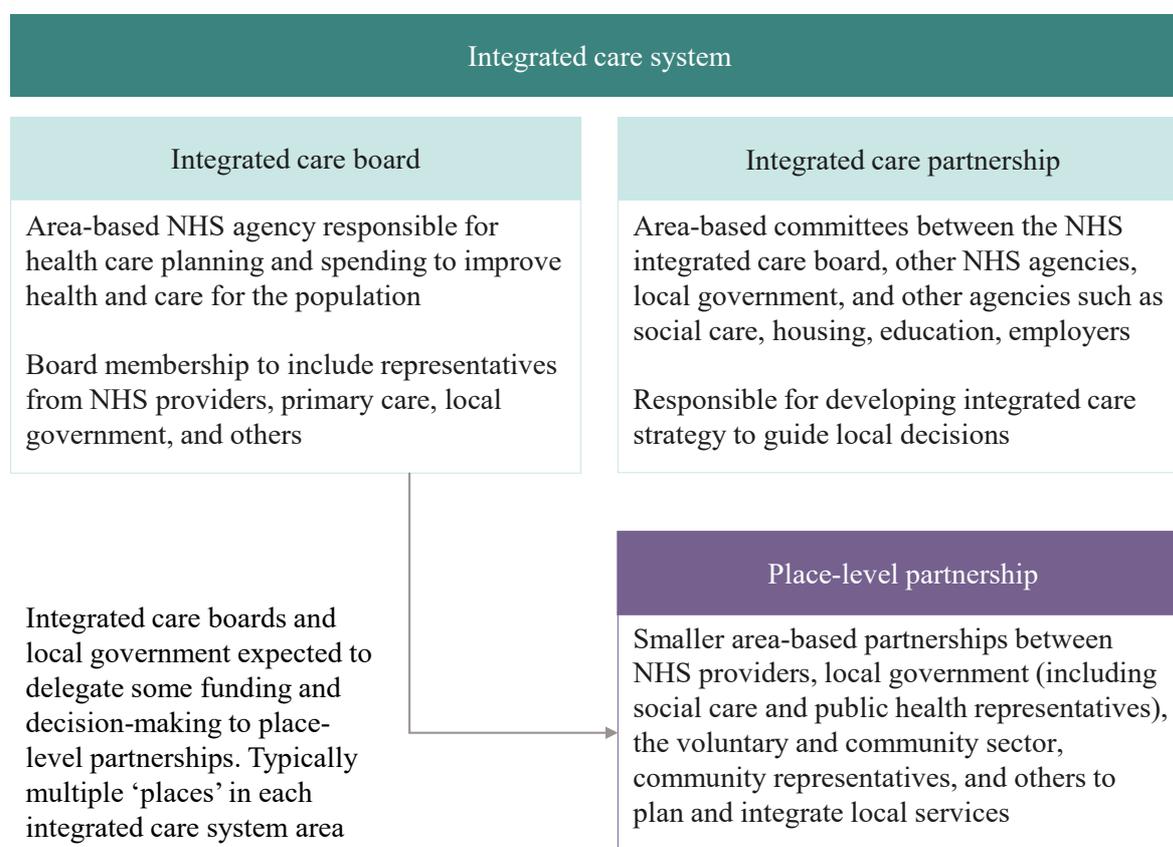
Box 1: summary of key changes to the organization of the in England, after reforms in 2022^{104,1}

- *Places:* NHS organizations will work with local authorities and others to organize and deliver health and social care services in ‘places’—smaller geographical areas within each ICS, defined based on ‘what is meaningful to local people’, but typically based on existing local authority boundaries. Joint decision-making arrangements should be developed between local agencies in each place, which may be given responsibility to manage budgets for NHS, social care, and other services. NHS organizations will be expected to collaborate with local government and other non-health care services to address social, economic, and wider health needs of the local population.
- *Provider collaboratives:* All acute and mental health NHS trusts will need to join a provider collaborative. These may be ‘vertical’—involving primary, community, mental health, and acute hospital services within a ‘place’—or ‘horizontal’—which might include multiple hospitals

providing specialist services across larger areas. NHS providers may be in more than one provider collaborative. Other providers, such as community and ambulance trusts, should join provider collaboratives where this makes sense for patients and other organizations involved in the system.

- *Integrated care systems:* Area-based collaborations between NHS providers, commissioners, local authorities, and others in 42 areas of England, responsible for improving health and health services for the population in their area (which range from around 500,000 to 3 million people). Each ICS is made up of two linked bodies. Integrated Care Boards (ICBs) are new NHS organizations responsible for controlling most NHS resources and planning health care in each ICS. ICBs take on the functions previously held by clinical commissioning groups—local NHS commissioning organizations created under the Health and Social Care Act 2012, now scrapped under the new Act—and can delegate funding and decisions to ‘places’ within their boundaries. ICB boards include representatives from NHS providers, primary care, local authorities, and other organizations. ICBs are joined by Integrated Care Partnerships (ICPs): looser collaborations of NHS, local government, and other non-statutory agencies, responsible for developing an ‘integrated care strategy’ to guide local decisions—including of the ICB. The ICP is a statutory committee of the ICS, convened by the NHS and local authorities in each ICS area. ICSs are expected to deliver their objectives through the work of both bodies and other local agencies.
 - *National and regional NHS bodies:* National NHS bodies will shift their focus to regulating and overseeing these new systems of care. The Act formally merges NHS England and NHS Improvement, to provide a ‘single, clear voice’ to local NHS organizations and others. NHS England will oversee and manage the day-to-day running of the NHS in England, including ICSs. The Care Quality Commission will provide independent assessments of the performance of ICSs. ICSs will take on some planning functions of regional arms of NHS England and Improvement. The Department of Health has overall policy responsibility for health and social care in England.
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Figure 1. Health and social services partnerships under new NHS reforms in England



ICs as another NHS reorganization

As well as considering ICs in the context of previous national policies on cross-sector collaboration, ICs should also be understood in the context of a long line of NHS reorganizations (*see* chapter 2). In its first 30 years, the NHS’s structure was relatively stable. But over the past 30 years, the NHS in England has been on an almost constant treadmill of reform and reorganization.¹⁰⁵ Standing back, the introduction of ICs in England appears to mark the end of the NHS’s 30 year experiment of fostering competition within the health care system—with NHS policy more clearly reverting to its pre-1991 course.

Overall, evidence suggests that previous NHS reorganizations have delivered little measurable benefit.^{88,106,107,108,109,110} Other policies to support NHS improvement, such as boosting investment, expanding the workforce, and modernising services, are likely to have had a greater effect on performance.¹⁰⁸ Reorganizations can also have negative effects, including additional costs, destabilising services and relationships, and delaying or detracting from care improvements. Even when one (more) restructure seems logical or desirable, the cumulative effect of regular

reorganization can drain the energy and confidence of staff.¹¹¹ NHS England's proposals to government in 2020 on the establishment of ICSs stated—perhaps pre-emptively—that it did not want the changes to trigger a ‘distracting top-down reorganisation’ of the NHS.⁹⁴ But it is hard to see how the organizational changes needed to establish ICSs—for instance, scrapping Clinical Commissioning Groups and establishing ICSs as new statutory bodies and formal partnerships—would avoid this.

ICSs re-establish a regional layer in the NHS's structure. NHS leaders have a long history of reinventing the ‘intermediate’ tier of the health service¹¹²—and most national public health care systems have some form of regional management layer. But the 2012 Act opted to remove it, leaving a vacuum in strategic and operational oversight of the NHS in England. In this context, the redevelopment of the regional tier fits with the historical development of the NHS. ICSs bear some resemblance to the Area Health Authorities created through NHS reforms in 1974¹¹³ and Strategic Health Authorities established in the early 2000s.¹¹⁴ But creating organisations is easier on paper than in practice: experience shows that merging and creating new agencies can cause major disruption.¹¹⁵

ICSs also represent another change in approach to NHS commissioning in England. Commissioning organizations have existed in an almost constant state of flux since the birth of the purchaser-provider split in 1991.² Assessing the contribution of commissioning to improvement in the NHS is challenging—and regular reorganisations make it even harder. But, overall, evidence suggests that NHS commissioning in and of itself has consistently failed to have a significant impact on patient care or outcomes.^{116,117,118,119} Indeed, ‘strategic commissioning’ has consistently failed to live up to policy makers’ expectations in several countries—hampered by asymmetries in information, political and market power, and resources.¹²⁰ The latest reforms rest on the hope that ICSs can buck this trend—for instance, through closer collaboration between NHS purchasers and providers to reduce asymmetries of information that have plagued previous versions of commissioning in England and elsewhere.

ICS characteristics

ICSs have been established across the country, but policymakers allowed some flexibility in how the new systems were developed—for instance, in defining ICS boundaries. As a result, ICSs vary widely in composition, complexity, and other factors (tables 2-4), which may affect how they function and their potential impact. There is also substantial variation in health and health care needs and services between ICSs. We collated and analysed publicly available data on the characteristics of England's 42 ICSs,¹²¹ including their geography, population size and deprivation, organizational complexity, and policy context.

The average population covered by an ICS is around 1.5 million people. But the range is large: the smallest covers a population of just over 500,000, while the largest covers more than 3 million people (table 2). Population size is strongly correlated with organizational complexity. Bigger ICSs tend to

involve more NHS organizations and local authorities (table 3). For example, some systems include more than ten upper-tier local authorities—responsible for social care, public health, and other public services—while others cover just one. Bigger ICSs are also likely to involve more ‘places’, which will mean additional governance and infrastructure (such as more local committees to manage). Larger ICSs with more complex governance in local government—for instance, with responsibilities split between local government tiers—will likely face even greater coordination issues (table 3).

The complexity of the organizational landscape within each ICS is likely to affect how the system functions—for instance, by making it easier or harder for organizations to make decisions and implement service changes across sectors. International evidence suggests that differences in organizational governance and decision-making can hold back effective cross-sector collaboration.¹⁵ Evidence from past policy initiatives in England suggests that having fewer participating organisations—ideally with similar geographical boundaries—can help facilitate faster progress.¹⁰

The historical context in each ICS will also have a strong influence on how local agencies work together—for better or worse.¹⁵ For example, the existing relationships between hospitals, social care providers, public health teams, GPs, and other agencies will shape how ICSs develop. A qualitative study on the early development of ICSs found that a stronger history of collaboration between organizations and leaders provided a better foundation for joint planning.¹²² Indeed, some parts of the country may have a head start on ICSs through their involvement in recent similar policy initiatives (table 3). West Yorkshire and Harrogate ICS, for example, has a relatively high concentration of local areas involved in recent policy initiatives on integrated care—including new care model vanguards and integrated care pioneers. The experience of working together in previous versions of ICSs will also make a difference—and national NHS bodies established informal versions of ICSs in waves based on their perceived ‘maturity’,¹²³ before all ICSs were formally established across England in July 2022. Further comparisons of ICS resources, capacity, and use of health services are available elsewhere.²⁶

The scale of the challenge facing ICSs in reducing health inequalities varies widely too (table 4). ICSs have been given a mix of policy objectives to reduce health inequalities (*see* chapter five). To help guide these efforts, national NHS bodies are aiming to target interventions on the most deprived 20% of the population (defined using the Index of Multiple Deprivation (IMD)).¹²⁴ This is not a novel approach: previous area-based initiatives to reduce health inequalities in England, such as Health Action Zones in the 2000s, also focused on areas with high levels of socioeconomic deprivation—at least initially (table 1). Yet the concentration of high deprivation areas is unevenly distributed between ICSs. We calculated the proportion of lower super output areas (LSOAs) within each ICS in the most deprived 20% of areas nationally, using IMD ranks. In some ICSs, such as Surrey

Heartlands, only around 1% of neighbourhoods are in the most deprived 20% of neighbourhoods nationally. At the other end of the spectrum, such as in Birmingham and Solihull ICS, the proportion of ICS neighbourhoods in the most deprived 20% of areas nationally is more like 50%. Inequalities in health, income, and factors also vary within ICSs, as well as smaller neighbourhoods within them.¹²⁵

DISCUSSION

We analysed the structure and development of England's new ICSs, and how they fit within a broader policy context. ICSs stand in a long line of national policies promoting cross-sector collaboration to improve health and care in England. Since 1997, a mix of policies have been introduced to coordinate health and social care services and meet wider policy objectives to improve health and reduce health inequalities. ICSs combine elements of these previous partnership policies and have been given wide-ranging objectives by national policymakers—from improving NHS performance to influencing social and economic conditions shaping health. The 42 new systems are being asked to meet these objectives through a complex web of local organizations and overlapping partnerships between them. Our analysis points to four broad implications for national policy on ICSs as they develop and evolve.

First, the potential benefits of ICSs risk being overstated. The allure of cross-sector collaboration is longstanding and understandable. But evidence suggests that policymakers should not expect too much from England's new ICSs. Despite the clear logic behind greater cross-sector collaboration to improve population health, our umbrella review found limited evidence to suggest that partnerships between local health care and non-health care agencies improve health or reduce health inequalities—in the UK or elsewhere (chapter 3). Narrower efforts to integrate health and social care services may improve patient experience and access to services, but evidence of their effect on resource use and health outcomes is limited—and potential benefits may be modest and take time to be realised. Even then, formal duties to collaborate or mergers of NHS functions do not necessarily produce collaboration in practice. And evidence from past NHS reforms suggests that organizational restructuring to establish ICSs may inadvertently cause harm, such as distracting local leaders and disrupting relationships.

Second, the structure of ICSs risks being complex and vague, and may sideline non-NHS agencies. Establishing a new regional tier of the NHS in England—ICSs—could improve system-wide accountability for improving health and care. Embedding (yet more) formal partnerships between the NHS, local government, and wider agencies may encourage greater cross-sector collaboration to improve health and reduce health inequalities locally. But how ICSs will work in practice and interact with other parts of the health system is unclear. For example, NHS providers are to sit on ICS boards. But how much power will the ICS have over its constituent providers? How will ICSs hold new provider collaboratives to account? And how will NHS providers balance their duty to collaborate with existing responsibilities as individual organisations—particularly Foundation Trusts, which are

technically autonomous agencies with distinct local accountabilities? The role of regulation in overseeing local systems remains vague—for instance, whether performance in individual organizations or broader local systems will be prioritized by national NHS bodies and government.

Integrated Care Partnerships seem to play a bit-part role within the new systems, and risk being sidelined by more powerful NHS agencies, such as NHS providers or new ICBs. The reforms do nothing to address the fundamental structural differences between the NHS and local government, including longstanding imbalances in political power and resources.¹²⁶ Weak involvement of local government and other sectors would undermine policymakers' aims for better integration of services beyond the NHS, and limit the ability of ICSs to tackle social and economic factors that shape health and health inequalities. How the 'place' level of ICSs will be organized and their resources and accountability is also vague. At all levels in the system, there is a major risk that the most visible pressures in NHS hospitals—such as waiting times in emergency departments and the large backlog for elective care¹⁷—dominate local priorities and crowd out broader ICS objectives, such as reducing health inequalities. Political pressure to improve NHS performance in England is substantial.^{127,128,129}

These risks are echoed in the National Audit Office's (NAO) assessment of the starting point for England's new ICSs, based on data collected and analysed just before the formal introduction of the systems in 2022.¹³⁰ The NAO found that the policy framework surrounding ICSs was still under construction, including the approach to assessing ICS performance and monitoring collaboration between the NHS and local government. The NAO also found that, while ICSs have been asked to take a long-term approach to preventing ill-health, the approach to managing the performance of ICSs by national NHS bodies so far has focused on short-term priorities linked to hospital waiting lists.

Third, the task facing ICSs is not equal—and the new systems vary widely in structure, resources, and other factors likely to shape their functioning and impact. For example, our analysis demonstrates wide differences in organizational complexity between ICSs. This will likely affect the ability of systems to agree priorities and implement complex service changes. Our analysis also illustrates how the concentration of areas experiencing the highest socioeconomic deprivation—a target population for national policy on reducing health inequalities—varies substantially between ICSs. Clustering ICSs based on these and other characteristics may help target policy development and analysis on the new systems. For instance, ICSs with similar levels of socioeconomic deprivation may pursue some common approaches to reducing health inequalities—and ICS leaders in areas experiencing the highest concentration of socioeconomic deprivation are likely to be particularly aware of their role in doing so. Understanding the experiences of ICSs in these areas could help inform policy and practice—for instance, by identifying common challenges and potential interventions to address them. Clustering may also help inform the national approach to ICS assessment and improvement.²⁶ We take

a similar approach to identifying case study sites for our qualitative research presented in chapters 6 and 7.

Finally, the impact of local partnerships will ultimately be shaped by national policy choices beyond their control. Our umbrella review identified national policy context as a factor shaping the impact of local health partnerships (chapter 3). Our comparison of the broader political context shaping local cross-sector collaboration initiatives in England in the 2000s and 2010s helps illustrate the point.

The current policy context facing ICSs is daunting. A new UK Labour government was elected in July 2024 on the back of a manifesto that included ambitious goals to rebuild the NHS and reduce health inequalities between English regions. But the legacy of 14 years of Conservative-led governments since 2010 will cast a long shadow on the NHS and other local services. A decade of underinvestment going into covid-19 has constrained what the NHS can do, and worsened the impact of the pandemic on patients and staff.¹³¹ Low capital investment has left staff working in crumbling buildings, with inadequate equipment and IT.¹³² NHS staff shortages are widespread¹³³ and only around a third of staff think there are enough people in their organization to do their job properly.¹³⁴ The NHS elective waiting list stands at 7.5 million and pressures on emergency care are extreme.¹⁷

Health policy failures beyond the NHS are even starker. Public health budgets have been cut.¹³⁵ Investment in wider public services that shape health and inequalities has been weak.^{136,137} England's threadbare social care system has been underfunded and unreformed.¹³⁸ A national strategy to reduce England's vast and growing health inequalities has been absent, despite a similar strategy being in place and making a difference in the 2000s.¹³⁹ Brexit has made things harder for the NHS.¹⁴⁰ Public spending plans inherited by the current Labour government imply NHS spending growing below the long-run average¹³¹ and cuts to 'unprotected' services that shape health, such as local government.¹⁴¹

This does not mean that local partnerships are without agency. Local leaders in ICSs can learn from the various factors that have helped or hindered past collaboration efforts—like the importance of communication, trust, and clear decision-making processes between agencies—to give themselves the best chance of success. They can also learn from the mistakes of earlier versions of ICSs, including limited involvement of local government and other community partners in NHS planning processes, and 'lifestyle drift' in strategies for improving health and reducing health inequalities (whereby changes in individual behaviours are emphasized over more fundamental interventions to address structural social and economic conditions shaping health and health inequalities).^{42,122} But this will only go so far: in the absence of sufficient investment in public services or a cross-government strategy for reducing health inequalities in England, integrated care systems risk being set up to fail. The Hewitt Review—an independent report into the governance and oversight of ICSs, commissioned by government soon after ICSs were formally introduced in 2022—also pointed to the need for stronger and more coordinated central government policy on improving health to enable ICSs to

succeed.^{142,143} For example, the review recommended that central government produce a national health improvement strategy and increase investment in local authority public health budgets over time. The review also argued that ICSs needed to be given greater autonomy by national leaders. We explore these and other implications in more detail in our qualitative research (chapters 6 and 7).

Limitations

Our analysis has several limitations. First, our review of past national policies provides an overview of the aims, mechanisms, and intended impact of relevant policies, rather than providing detailed analysis of each policy individually. This allowed us to compare a large number of partnership policies implemented over many years, and analyse them in the context of broader changes in public policy. Table 1 provides a summary of each policy. But this approach means we miss the richer detail of how individual policies were implemented and evolved. Second, we drew on data from our umbrella review (in chapter 3) and more recent reviews of relevant literature to provide an overall picture of the impact of partnership policies. We did not undertake an additional systematic review of primary studies to understand the impact of the individual policies in our review, which would have identified further data for inclusion. Finally, our analysis of ICS characteristics is limited by the data available. We focused on a small number of indicators relevant to collaboration in ICSs. But ICSs differ in other ways that will affect how they function—for instance, in their leadership capabilities and skills and capacity for improving local services—that are not covered in our analysis here.

Table 1. Summary of key national policies on local health partnerships in England, 1997-2022

Policy initiative	Date	Summary and activities	Geographical area	Population	Partners	Intended impact
Health improvement programmes ^{144,145,146,147} (renamed health improvement and modernization plans in 2001)	1998	Local plans for improving health and health care and reducing health inequalities. The plans (to cover a three-year period) were introduced as a mechanism to deliver national targets in health and health care improvement, as well as identifying and responding to local health needs. All Health Authorities were required to develop a plan and implement it. This was combined with a statutory duty on the NHS and local authorities to collaborate to promote health	Health authority areas (population size unknown; 100 health authorities established in 1996, later replaced by PCTs). Whole of England covered	Whole health authority population	Health authorities, NHS trusts, primary care groups, local authorities, others	Improve population health (including through addressing wider health determinants), improve health care services, reduce health inequalities
Health action zones (HAZs) ^{148,149,150,151}	1998-2003	Local partnerships for improving health and reducing health inequalities. HAZs were established in areas with high levels of ill-health or deprivation. HAZ plans were developed by health authorities, local authorities, and other partners at a local level but needed to reflect 7 principles set nationally: achieving equity; engaging communities; working in partnership; engaging front line staff; taking an evidence based approach; developing a person centred approach to service delivery; taking a whole	Mixed: some single health authority and local authority areas, some multiple health authority and local authority areas, and some unitary local authority areas. 26 HAZs by 1999. Total population of 13 million. Individual HAZ population size	Varied depending on local context. HAZ programs targeted specific populations (eg young people, older people), disease groups (eg mental health), health determinants (eg housing), services (eg primary care),	Health authorities and local authorities, working with other partners including NHS trusts, primary care groups, voluntary and community sector, and others depending on local context	Identify and address population health needs, reduce health inequalities, increase effectiveness and efficiency of services

		systems approach. HAZs were provided with additional funding from central government	varied from 200,000 to 1.4 million	and community empowerment		
Crime and disorder reduction partnerships (now Community Safety Partnerships) ^{152, 153, 154, 155}	1998-	Statutory partnerships created under the Crime and Disorder Act 1998. Agencies required to work together to tackle problems related to crime and disorder in their area. Partnerships required to produce a regular audit of local crime and disorder problems, consult their local communities, determine priorities, and implement a strategy for tackling them. Other health and crime reduction partnerships have also been developed, such as Drug (and Alcohol) Action Teams and Multi-Agency Public Protection-Arrangements	Local authority areas. Around 300 community safety partnerships in England	Whole local authority population	Police, local authorities, health agencies (originally health authorities, currently clinical commissioning groups), social care providers, fire and rescue authorities, probation services, voluntary and community sector, others	Tackle local crime and disorder
New deal for communities (NDC) ^{156, 157, 158}	1998-2011	Area-based regeneration programme in some of the most deprived areas in England. NDC partnerships established between local agencies to develop 10-year renewal programmes and help guarantee sustainable investment. Five principles underpinning the programme: achieving long-term change, creating dedicated agencies for neighbourhood renewal, community engagement, engaging partner agencies, and learning and innovation. Partnerships given	39 NDC areas. Each NDC partnership identified specific disadvantaged neighbourhoods to focus on—with a maximum of 4,000 households per area. Approximately 384,000 residents of NDC areas in 2003.	Whole population in targeted neighbourhoods	Local authority, primary care trust, police, community representatives, and others depending on local context. Average of 7 agencies represented on NDC boards in 2008	Transform areas over 10 years in relation to key outcomes (related to crime, education, health, worklessness, housing, and community), reduce inequalities between NCD areas and rest

		flexibility to plan and fund interventions, but these needed to focus on improving outcomes in health, education, housing and physical environments, worklessness, and crime. 'Parent' local authorities acted as the accountable body for NDCs. Government funding provided over 10 years	Average population of around 9,900—ranging from 4,800 to 21,400			of the country, achieve value for money, engage local communities
Sure Start local programmes ^{159,160,161}	1999-2003	Local partnerships for improving health and wellbeing of children and their families in areas of high deprivation. Original aim was to establish 250 local programmes in the most deprived 20% of areas in England, but the programme expanded over time. Local bodies were asked to set up partnership boards to identify local priorities and interventions. All programmes were required to offer: outreach and home visiting; support for families and parents; support for good quality play, learning, and childcare experiences for children; primary and community health care and advice about child health and development; support for people with special needs. Some national targets were also specified (eg reduce number of low birthweight babies). Additional funding was provided for local	Local authority areas. 90 'trailblazer' areas announced in 1999. 521 local programmes running by 2003 and a further 46 'mini' programmes in rural areas	Children under 4 and their families	Early education services, childcare, local authorities (eg social services), NHS agencies, employment support, voluntary and community sector	Improve health and wellbeing of children living in the most deprived areas, improve local services for children and their families, reduce inequalities

		areas. From 2003, emphasis of policy shifted to delivering integrated services through Sure Start children's centres				
Local strategic partnerships (LSPs) ^{162, 163, 164, 165}	2001-	Voluntary partnerships between local public sector and other agencies to develop a community strategy to improve the economic, environmental, and social wellbeing of an area. Partners then expected to implement the local strategy within and between agencies to address cross-cutting issues on health, crime, housing, employment, and other areas. LSPs were also initially tasked with 'rationalisation' of local partnerships in their area. Involvement in LSPs was required to receive funding for some policy initiatives, such as the Neighbourhood Renewal Fund in 2001, which targeted the 88 most deprived areas. LSPs were also involved in developing Local Area Agreements between central and local government from 2004 to 2010	Local authority areas. Originally linked to central government neighbourhood regeneration funding in the most deprived areas. LSPs then developed in most areas of England	Whole local authority population	Local authorities, health authorities, primary care trusts and primary care groups, police, education, employment and benefits agencies, community groups, and other local partners	Improve economic, environmental, and social wellbeing of local communities, reduce inequalities between most deprived communities and the rest of the country, reduce duplication and bureaucracy between agencies
Neighbourhood management ^{166, 167, 168}	2001-2012	Process to bring together local community representatives and service providers to identify problems, improve services, and improve quality of life in some of the most deprived areas in England. Multi-sector	Target neighbourhoods within local authority areas. 35 'pathfinders'	Whole population in targeted neighbourhoods	Local authorities (such as housing and youth and leisure services), police,	Improve and join up local services, make services more responsive to local needs, reduce

		<p>partnerships were established involving public, private, and voluntary and community sector agencies working with members of the public and a dedicated team. Processes were developed to engage residents and influence public service providers to join up and improve services, such as by improving access to services and increasing community safety. Central government funding was provided for seven-year neighbourhood programmes</p>	<p>launched in two waves, with 30 of these areas in the most deprived 20% of areas. Average population targeted estimated at 10,200 in 2003—ranging from 2,770 to 20,570.</p>		<p>environmental services, schools, primary care trusts, housing associations, and other agencies depending on local context</p>	<p>inequalities between most deprived communities and the rest of the country</p>
<p>Local area agreements (LAAs)^{169,170,171}</p>	<p>2004-2010</p>	<p>Three year-agreements between central government and major local public sector agencies setting priorities and targets for public services in each area. Focus of LAAs evolved to cover a range of outcomes—including in relation to children and young people, safer and stronger communities, healthier communities and older people, and economic development. LAAs included a mix of mandatory (eg targets on reducing health inequalities) and locally agreed outcomes. LSPs or equivalent local partnerships were responsible for developing and delivering LAAs. Multi-agency agreements (MAAs) were also developed</p>	<p>Local authority areas. Initially piloted in 9 areas then expanded to cover all local authorities</p>	<p>Whole local authority population</p>	<p>Local government, LAAs, other local partnerships (such as CDRPs), primary care trusts, voluntary and community sector</p>	<p>Improve outcomes for local people (including improved health and reduced health inequalities), improve central and local government relations, improve efficiency, strengthen local partnership working</p>

		across larger geographical areas from 2006, focused on economic development				
Partnerships for older people projects ^{172,173,174}	2005-2009	Partnerships between local health and care agencies to improve health and wellbeing of older people. Agencies worked together to develop and deliver a mix of local projects—two thirds focused on reducing social isolation or promoting healthy living among older people, a third focused on avoiding hospital admission or supporting early discharge from acute or institutional care, and some focused on a range of needs. Additional funding provided to pilot sites for two-year projects. Local sites could set relevant local targets but were also expected to contribute to national targets to support more older people to live at home and reduce emergency bed days	Local authority areas. 29 pilot sites over two waves. Pilots developed a total of 146 ‘core’ local projects	Older people. Average age of service users was 75	NHS agencies, local authorities, housing associations, fire and rescue service, police, others depending on local context	Improve health, wellbeing, and independence for older people, deliver more integrated care for older people, create a shift in resources and culture towards more preventive interventions, prevent or delay need for institutional or hospital care
LinkAge Plus pilots ^{175,176,177}	2006-2008	Partnerships between health, social care, and wider services to improve health and wellbeing of older people. Eight areas received funding for two years to join up local services and pilot new projects. Six principles were developed to guide the approach: engaging older people, reflecting	Local authority areas. Eight pilot areas	People over 50	Local authorities, social care services, primary care trusts, jobcentre plus, pension service, voluntary and community sector	Improve quality of life and wellbeing for older people, bring together local services, improve access and experience of

		people’s needs and aspirations in the design of services, improving access to services (including benefits), identifying and engaging with ‘difficult to reach’ older people, ensuring services promote independence, wellbeing, and active ageing, and maximizing opportunities for efficiency and capacity building. Services should focus on prevention and go beyond integration of health and social care. The pilot built on the 2004 LinkAge programme, which involved joint teams to support older people with personal care, benefits, heating, and housing			organizations, and others	services, achieve efficiencies through joint working
Total place pilots ^{178,179,180}	2009-2010	Partnerships between public sector and other agencies to deliver better value services through a ‘place’ based approach to public spending and service redesign. Partners mapped total public spending in their area to identify opportunities to improve services, develop more integrated services around people’s needs—particularly people with complex and multiple needs—and identify efficiencies through partnership working and redesigning services. Process launched at 2009 budget as part of the government’s ‘operational efficiency programme’	Local authority areas (including groups of local authorities and city-regions). 13 pilot areas. Total population of over 11 million	Varied depending on local context. Some areas focused on target populations (eg children under 5, older people), others focused on service areas or themes (eg healthier neighbourhoods or tackling alcohol and drug abuse)	Local authorities, primary care trusts, policy authorities, voluntary and community sector organizations, others depending on local context	Improve and integrate services, improve value for money, reduce waste and duplication

<p>Integrated care pilots^{181,182,183}</p>	<p>2009-2011</p>	<p>Pilots to test and evaluate new ways of delivering more integrated care. Partner agencies planned and delivered new service models, including within the NHS and between health and social care. Approaches varied depending on local context, but a common feature was the use of multidisciplinary teams to coordinate services. A mix of local and national performance measures were used, and most pilots focused on reducing hospital utilization (among other measures). National funding provided for two-year pilot programmes</p>	<p>Mixed. 16 pilot areas</p>	<p>Primary care trusts and other NHS agencies, local authorities, voluntary and community sector, other partners depending on local context</p>	<p>Mixed. Some focused on disease groups (eg people with COPD), some focused on types of services (eg end of life care), others focused on a mix of target services and populations. Sites commonly focused on older people with complex needs</p>	<p>Improve health and health equity, improve quality of care and satisfaction with services, improve partnerships in care delivery, more effective use of resources, improve relationships</p>
<p>Community budgets (including ‘whole place’ and ‘neighbourhood’ pilots)^{184,185,186,187,188}</p>	<p>2011-2013</p>	<p>Public sector agencies in defined areas working together to improve services and value for money. Local agencies were asked to collaborate to understand patterns of spending across services, identify interventions that could deliver the best outcomes within available resources, and develop a plan and timescales to deliver them. Local areas could identify which services or outcomes to focus on, and government provided funding for technical and other support. Similar community</p>	<p>Mixed: local authorities, groups of local authorities, targeted wards or neighbourhoods within local authorities.</p>	<p>Varied depending on local context. Areas focused on particular service areas (eg integration between health and social care) and population groups (eg families with complex needs)</p>	<p>Local authorities and other public and voluntary and community sector agencies depending on local context, such as NHS agencies, police, and housing services</p>	<p>Solve complex local problems, improve efficiency, improve and coordinate public services</p>

		budget processes were also used for the Troubled Families programme from 2010		depending on local context		
Health and wellbeing boards (HWBs) ^{189,190,191}	2013-	Established under Health and Social Care Act 2012 as a partnership board to bring together local agencies responsible for improving local population health and wellbeing. The board is a formal committee of local authorities. Boards given statutory duties to assess the needs of their local population (through a joint strategic needs assessment), set out how these will be addressed through a joint health and wellbeing strategy (to inform local commissioning decisions), and promote integration and partnership working (eg joint commissioning and pooled budgets)	Local authority areas. Whole of England covered. 132 ‘early implementer’ sites in 2011 and all upper tier local authorities by 2013	Whole local authority population	Local authorities (including a core membership of public health, social care providers, children’s services, and an elected member), clinical commissioning groups, Healthwatch, others depending on local context (eg police)	Improve population health and wellbeing, reduce health inequalities, promote integration of services
Integrated care and support pioneers ^{192,193,194,195,196}	2013-2018	Partnerships to develop and deliver new models of integrated health and social care. To become pioneers, agencies needed to develop plans for ‘whole system integration’, including between the NHS, social care, public health, wider public services, and the voluntary and community sector. Pioneers needed to develop their own approaches to integrating services based on local needs. National bodies expected	Mixed. Some single local authority and CCG area, some single local authority and multiple CCG areas, and some multiple CCG and local authority areas. 25 areas. 14 areas identified in 2013 and	Varied depending on local context. Some focused on the whole population. Others identified target population groups—most commonly fail older people,	Clinical commissioning groups, NHS providers, local authorities, social care providers, voluntary and community sector agencies, others	Improve health and wellbeing, improve quality and coordination of services, deliver more preventive care in the community, deliver more efficient and cost-effective services

		pioneers to deliver improved outcomes and release financial savings within five years. Modest additional funding and a programme of national support and guidance was provided	a further 11 in 2014 and 2015	people with long term conditions, high service users or people at risk of hospital admission	depending on local context	
Better care fund ^{197,198,199,200,201}	2013-	Mandatory joint planning and budget pooling initiative between the NHS and local government. Local agencies asked to work together to develop a local plan for better integration of health and social care for older disabled people in their area, drawing on a pooled budget (with a mandated minimum pooled spend). Initial plans needed to meet a mix of national conditions, including reducing avoidable hospital admissions. Plans need to be signed off locally by Health and Wellbeing Boards. The programme and conditions for how the fund should be spent has evolved over time	Local authority areas	Older people and people with disabilities, other groups depending on local plans	Clinical commissioning groups, local authorities, health and wellbeing boards, NHS providers, social care providers, housing agencies, others depending on local context	Improve health and wellbeing, improve integration of health and social care, strengthen preventive care and reduce avoidable hospital activity, improve efficiency
New care model vanguards ^{202,203,204,205}	2015-2018	Local sites selected to test new ways of delivering integrated health and social care. Relevant models included ‘multispecialty community providers’ (MCPs) (based on developing more integrated health and social care in the community), ‘primary and acute care systems’ (PACS) (seeking to join	Mixed. Some single CCG and local authority areas, some multiple CCG and local authority areas, some areas defined by GP network	Mixed. PACS and MCPs were population-based models; EHCHs focused on care home residents. Around 5 million	Clinical commissioning groups, NHS providers, social care providers, local authorities, voluntary and	Improve health and wellbeing, improve quality and experience of services, improve integration of services, improve

		primary care, hospital, mental health, and other services for the local population), and ‘enhanced health care in care homes’ (EHCHs) (based on care homes working with the NHS and others to improve health and care for their residents). Additional funding available for sites and central support provided	populations. 50 sites in total; 29 sites were PACS, MCPs, and EHCHs—other sites focused largely on hospital care	people covered across all sites	community sector agencies, others depending on local context	efficiency, reduce hospital activity
Sustainability and transformation plans/partnerships (STPs) ^{206,207,208,209,210}	2015-2021	Local plans for improving health and health services. National NHS leaders instructed local NHS leaders to come together and work with local authorities to develop 5-year plans for improving health and health services. Initial guidance asked NHS leaders to consider around 60 questions in their plans, covering three broad areas: improving quality and developing new models of care; improving health and wellbeing; and improving efficiency of services. Areas were asked to develop more integrated models of health and social care and invest in prevention and early intervention. Local leaders were also asked to show how their plans would deliver financial balance for the NHS. Some additional NHS funding was tied to the development of acceptable local	Initially 44 areas (typically spanning multiple CCGs and local authorities). Whole of England covered. Some STP boundaries changed and the number of STPs fell to 42 by 2021	Whole STP population. Average population size of 1.2 million people—ranging from 300,000 to 2.8 million	Clinical commissioning groups, NHS providers, local authorities, others depending on local context	Improve health and wellbeing, reduce inequalities, improve quality of services, improve efficiency

		plans. STPs re-named ‘partnerships’ rather than plans in 2017, and asked to develop new governance structures. A second round of plans were developed in 2019				
Integrated care systems (ICSs) ^{211,212,213,214, 215}	2017-	Local partnerships between NHS, local government, and other agencies to plan and coordinate local services to improve health. Existing STPs evolved into integrated care systems (ICSs). ICSs tasked with coordinating action between local agencies to improve health and reduce inequalities, improve and coordinate local services, and make the best use of existing resources. ICSs must also focus on broader social and economic development in their community. The health and care bill 2021-22 proposes formally establishing integrated care systems in legislation—including new NHS integrated care boards and integrated care partnerships (partnership boards of NHS, local government, and other agencies)	42 areas. Whole of England covered. STPs evolved into ICSs in stages—with all STPs becoming ICSs in July 2021	Whole ICS population. Populations of around 1-3 million	NHS commissioners, providers, local authorities (including social care and public health representatives), others depending on local context	Improve population health, improve health care, reduce inequalities in health and health care, improve productivity and value for money, support broader social and economic development

Table 1 notes and sources

Only key national policies included. Partnerships needed to include overarching health objectives and involve NHS and non-medical agencies, such as local authorities and social care providers. Some legislative changes that enabled local partnerships to occur, such as flexibilities in the Health Act 1999, are

excluded. Policies targeting single areas, such as health and social care devolution in Greater Manchester, are excluded. Start and end dates of programs can be hard to define. For pilots, dates typically cover the period of the funded programme. For broader planning processes, dates typically cover when the policy was initiated through to when the process ended. Data on the policies identified are summarized from publicly available government and NHS policy documents, policy evaluations, and existing summaries of these policies.

Table 2. Integrated care system characteristics: geography and size

Integrated care system	NHS region	Geography		Size	
		% LSOAs urban	Rank	Pop (m)	Rank
Greater Manchester	North West	99%	more urban	3,146,943	large
Cheshire and Merseyside	North West	93%	more urban	2,714,167	large
South Yorkshire and Bassetlaw	North East and Yorkshire	90%	more urban	1,483,968	medium
Staffordshire and Stoke-on-Trent	Midlands	83%	mixed	1,172,053	medium
Shropshire and Telford and Wrekin	Midlands	61%	more rural	521,391	small
Derbyshire	Midlands	80%	mixed	1,111,009	medium
Lincolnshire	Midlands	55%	more rural	806,534	small
Nottingham and Nottinghamshire	Midlands	84%	mixed	1,240,698	medium
Leicester, Leicestershire and Rutland	Midlands	78%	mixed	1,185,265	medium
The Black Country and West Birmingham	Midlands	100%	more urban	1,277,444	medium
Birmingham and Solihull	Midlands	98%	more urban	1,577,949	medium
Coventry and Warwickshire	Midlands	80%	mixed	1,052,979	small
Herefordshire and Worcestershire	Midlands	67%	more rural	818,249	small
Northamptonshire	Midlands	72%	more rural	814,554	small
Cambridgeshire and Peterborough	East of England	60%	more rural	1,008,472	small
Norfolk and Waveney	East of England	53%	more rural	1,086,462	medium
Suffolk and North East Essex	East of England	63%	more rural	1,048,423	small
Bedfordshire, Luton and Milton Keynes	East of England	80%	mixed	1,070,212	medium
Hertfordshire and West Essex	East of England	84%	mixed	1,612,064	medium
Mid and South Essex	East of England	100%	more urban	1,256,523	medium

North West London	London	100%	more urban	2,725,166	large
North Central London	London	100%	more urban	1,734,061	large
North East London	London	100%	more urban	2,342,205	large
South East London	London	100%	more urban	2,051,571	large
South West London	London	100%	more urban	1,726,507	medium
Kent and Medway	South East	75%	mixed	1,966,153	large
Frimley	South East	95%	more urban	808,083	small
Cornwall and the Isles of Scilly	South West	40%	more rural	601,786	small
Devon	South West	68%	more rural	1,273,431	medium
Somerset	South West	53%	more rural	596,836	small
Bristol, North Somerset and South Gloucestershire	South West	92%	more urban	1,057,832	small
Bath and North East Somerset, Swindon and Wiltshire	South West	67%	more rural	980,516	small
Dorset	South West	79%	mixed	819,184	small
Hampshire and the Isle of Wight	South East	82%	mixed	1,916,638	large
Gloucestershire	South West	72%	more rural	676,860	small
Buckinghamshire, Oxfordshire and Berkshire West	South East	72%	more rural	1,935,027	large
Lancashire and South Cumbria	North West	80%	mixed	1,810,011	large
Cumbria and North East	North East and Yorkshire	79%	mixed	3,139,823	large
Humber, Coast, and Vale	North East and Yorkshire	67%	more rural	1,771,076	large
Surrey Heartlands	South East	87%	mixed	1,122,802	medium
Sussex	South East	80%	mixed	1,820,464	large
West Yorkshire and Harrogate	North East and Yorkshire	90%	more urban	2,617,433	large

Table 2 notes and sources

For NHS region, we used NHS England's regional categorization for ICSs.²¹⁶ For % of rural areas and rural/urban rank, we divided ICSs into terciles based on the proportion of lower super output areas (LSOAs) in each ICS classified as urban by the Office of National Statistics (ONS), using the ONS's two-part rural-urban classification for 2011 LSOAs.²¹⁷ We defined ICSs in the middle tercile as 'mixed' (74-87% urban areas), and ICSs in the top tercile 'more urban' (87-100% urban areas). To map LSOAs to ICSs, we used LSOA 2011 data linked to STP 2021 codes, available on the UK government's Open Geography Portal. For population size, we divided ICSs into terciles based on their NHS registered population.²¹⁸ We defined ICSs in the middle tercile as 'medium' (1.1m-1.7m), and ICSs in the top tercile 'large' (1.7m-3.1m).

Table 3. Integrated care system characteristics: organizational complexity and policy context

Integrated care system	Organizational complexity					Policy context		
	UTLAs	Rank	LA tiers	NHS trusts	Rank	ICS wave	Vanguards	Pioneers
Greater Manchester	10	high	Single	11	high	1	2	1
Cheshire and Merseyside	9	high	Single	17	high	6	2	1
South Yorkshire and Bassetlaw	5	high	Mixed	7	high	1		2
Staffordshire and Stoke-on-Trent	2	medium	Mixed	3	medium	6		1
Shropshire and Telford and Wrekin	2	medium	Single	3	medium	6		
Derbyshire	2	medium	Mixed	4	medium	5	1	
Lincolnshire	1	low	Two-tier	3	medium	6		
Nottingham and Nottinghamshire	2	medium	Mixed	4	medium	1	3	2
Leicester, Leicestershire and Rutland	3	medium	Mixed	2	low	6		
The Black Country and West Birmingham	5	high	Single	8	high	6	1	
Birmingham and Solihull	2	medium	Single	4	medium	5	1	
Coventry and Warwickshire	2	medium	Mixed	4	medium	6		
Herefordshire and Worcestershire	2	medium	Mixed	3	medium	6		1
Northamptonshire	2	medium	Single	3	medium	6	1	
Cambridgeshire and Peterborough	2	medium	Mixed	6	high	6		
Norfolk and Waveney	2	medium	Two-tier	5	medium	5		1
Suffolk and North East Essex	2	medium	Two-tier	2	low	2		
Bedfordshire, Luton and Milton Keynes	4	medium	Single	2	low	1		
Hertfordshire and West Essex	2	medium	Two-tier	5	medium	4	1	
Mid and South Essex	3	medium	Mixed	2	low	6		1

North West London	8	high	Single	9	high	5		1
North Central London	5	high	Single	10	high	5		2
North East London	7	high	Single	5	medium	5	1	1
South East London	6	high	Single	5	medium	3		1
South West London	6	high	Single	6	high	4	1	
Kent and Medway	2	medium	Mixed	7	high	6	1	1
Frimley	5	high	Mixed	2	low	1	1	
Cornwall and the Isles of Scilly	2	medium	Single	2	low	5		1
Devon	3	medium	Mixed	6	high	6		1
Somerset	1	low	Two-tier	2	low	5	1	1
Bristol, North Somerset and South Gloucestershire	3	medium	Single	2	low	5		
Bath and North East Somerset, Swindon and Wiltshire	3	medium	Single	4	medium	5		
Dorset	2	medium	Single	3	medium	1		
Hampshire and the Isle of Wight	4	medium	Mixed	6	high	5	2	
Gloucestershire	1	low	Two-tier	2	low	2		
Buckinghamshire, Oxfordshire and Berkshire West	5	high	Mixed	5	medium	1		
Lancashire and South Cumbria	4	medium	Mixed	5	medium	1	2	1
Cumbria and North East	14	high	Mixed	11	high	2	3	1
Humber, Coast, and Vale	6	high	Mixed	5	medium	4	1	1
Surrey Heartlands	1	low	Two-tier	5	medium	1		
Sussex	3	medium	Mixed	5	medium	4		
West Yorkshire and Harrogate	6	high	Mixed	10	high	2	4	3

Table 3 notes and sources

For the number of upper tier local authorities (UTLAs), we reviewed ICS plans and NHS England policy documents on ICSs to identify UTLAs named as partners of each ICS. We cross-checked these against the government’s list of UTLAs (we included the Isles of Scilly and excluded the City of London) to ensure every UTLA had been counted as part of at least one ICS.²¹⁹ The sum of UTLAs in the table is higher than 150 as some UTLAs were named as partners by multiple ICSs. We divided ICSs into terciles based on the count of UTLAs in each ICS. For local authority tier arrangements, we categorized ICSs into three groups: ‘single’ if they have all single tier local authorities in their area, ‘mixed’ if they have a combination of single and two-tier authorities, and ‘two-tier’ if they have all two-tier local authorities in their area. Mixed or two-tier arrangements likely indicate a more complex governance structure.

For NHS Trusts, we used data mapping NHS Trust postcodes from the Care Quality Commission (CQC) directory to ICSs via LSOAs.²⁶ Some Trusts belong to multiple ICSs if they have several sites crossing ICS boundaries. We divided ICSs into terciles based on the count of NHS Trusts in each ICS.

For policy context, we identified the number of sites in each ICS involved in relevant recent policy initiatives within the ICS (new care model ‘vanguards’²²⁰ and integrated care and support ‘pioneers’²²¹) and date the early version of the ICS was created (NHS England established ICSs in ‘waves’ based on their perceived maturity, before all ICSs were formally established under legislation in July 2022). For vanguards, we excluded ‘acute care collaboration’ vanguards, as these models focused primary on collaboration between acute hospitals. Other vanguard models involved collaboration between the NHS and social care—for instance, between GP practices and care homes. For ICS waves, we categorized ICSs into 6 waves based on the year the early version of the ICS was announced (2017-2021). Data on ICS announcements came from a mix of sources.^{222,223,224,225,226,227}

Table 4. Integrated care system characteristics: deprivation

Integrated care system	Deprivation	
	% LSOAs in most deprived quintile	Rank
Greater Manchester	38%	high
Cheshire and Merseyside	35%	high
South Yorkshire and Bassetlaw	36%	high
Staffordshire and Stoke-on-Trent	19%	high
Shropshire and Telford and Wrekin	12%	medium
Derbyshire	18%	high
Lincolnshire	15%	medium
Nottingham and Nottinghamshire	28%	high
Leicester, Leicestershire and Rutland	12%	medium
The Black Country and West Birmingham	48%	high
Birmingham and Solihull	47%	high
Coventry and Warwickshire	13%	medium
Herefordshire and Worcestershire	11%	low
Northamptonshire	15%	medium
Cambridgeshire and Peterborough	12%	medium
Norfolk and Waveney	16%	medium
Suffolk and North East Essex	12%	medium
Bedfordshire, Luton and Milton Keynes	13%	medium
Hertfordshire and West Essex	2%	low
Mid and South Essex	10%	low

North West London	13%	medium
North Central London	21%	high
North East London	25%	high
South East London	17%	medium
South West London	7%	low
Kent and Medway	16%	medium
Frimley	2%	low
Cornwall and the Isles of Scilly	13%	medium
Devon	13%	medium
Somerset	9%	low
Bristol, North Somerset and South Gloucestershire	17%	medium
Bath and North East Somerset, Swindon and Wiltshire	6%	low
Dorset	8%	low
Hampshire and the Isle of Wight	11%	low
Gloucestershire	8%	low
Buckinghamshire, Oxfordshire and Berkshire West	3%	low
Lancashire and South Cumbria	30%	high
Cumbria and North East	33%	high
Humber, Coast, and Vale	19%	high
Surrey Heartlands	1%	low
Sussex	9%	low
West Yorkshire and Harrogate	35%	high

Table 4 notes and sources

We calculated the proportion of LSOAs in the most deprived 20% of areas nationally for each ICS, using 2019 index of multiple deprivation (IMD) ranks²²⁸ for LSOAs. To map LSOAs to ICSs, we used LSOA 2011 data linked to STP 2021 codes, available on the UK government’s Open Geography Portal. We defined ‘high’ deprivation as the top tercile of ICSs with the highest concentration of local areas in the most deprived 20% of areas nationally.

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CHAPTER 5

ICSs and health inequalities: analysis of national policy aims, processes, and resources

INTRODUCTION

Integrated Care Systems (ICSs) are area-based collaborations between the NHS, local government, and other local agencies in England, introduced by central government through the Health and Care Act 2022 (*see* chapter 4). One of the four ‘core purposes’ of ICSs is to reduce health inequalities: to ‘tackle inequalities in outcomes, experience, and access’.¹ This reflects an accumulation of evidence about the impact of health inequalities in England^{2,3,4,5,6}—highlighted in stark terms by the impact of the covid-19 pandemic⁷—and growing awareness of the role of health care systems in reducing them.⁸

But this ‘core purpose’ of ICSs is broad, given health inequalities span both inequalities in health care (such as access to services and quality of care) and broader health outcomes (such as morbidity and mortality),⁸ exist across multiple dimensions, such as geography, socioeconomic status, race and ethnicity, and more,⁹ and are shaped by a combination of social, economic, environmental, and other factors across society.^{10,11} As a result, reducing health inequalities is complex—for instance, requiring a combination of interventions by agencies across sectors and at multiple geographical levels. This complexity is part of the rationale for coordinated action on health inequalities through the new ICSs.¹

Efforts to reduce health inequalities through local partnerships in England are not new. Since the late 1990s, a mix of national policies have encouraged cross-sector collaboration between local NHS organizations, local government, and other agencies to reduce health inequalities (*see* chapter 4). Over the same period, national policy on the NHS has also sought to reduce health inequalities through changes within the health care system—for instance, by increasing the share of health care resources allocated to more socioeconomically deprived areas¹² and investing in new primary care practices in ‘under-doctored’ areas.¹³ Local NHS commissioning bodies were given legal duties to reduce health inequalities in 2012.¹⁴ More recently, national NHS bodies committed to stronger action on health inequalities in the NHS long term plan in 2019,¹⁵ early versions of ICSs in England were asked to develop local plans for reducing health inequalities in response,¹⁶ and NHS England identified several ‘urgent’ priorities for reducing health care inequalities through the NHS’s covid-19 recovery plans.¹⁷

Despite some successes,^{12,13} interpreting and implementing national policy objectives to reduce health inequalities can be challenging at a local level. National policy aims on health inequalities are often ‘muddy’ and change over time.^{18,19,20} Guidance from policymakers on what is expected can be limited or lacking,^{21,22} contributing to confusion on roles and responsibilities and vague local plans.^{14,19,23,24} Competing interpretations of health inequalities and the interventions needed to deliver them are also common.^{25,26,27,28} Lack of dedicated funding and the pull of other competing policy goals with strong political prominence—for instance, to reduce hospital waiting lists and balance NHS budgets—can also cut across stated policy objectives to reduce inequalities.^{29,30} Our analysis on the development and structure of England’s ICSs suggests the new systems may face similar challenges (*see* chapter 4).

One way of conceptualizing the policy process on reducing health inequalities is through the lens of ‘policy streams’. Drawing on broader models of policy streams^{31,32} and policy failure,^{33,34} Exworthy and Powell describe three ‘streams’ that need to align for successful policy implementation on health inequalities.^{35,36,37,38} Policies must have clear goals and objectives (what they call the ‘policy stream’), feasible mechanisms to achieve these objectives (the ‘process stream’), and the financial, human, and other resources to make them happen (the ‘resource stream’). In this chapter, we use Exworthy and Powell’s framework to help analyse how national policymakers conceptualize ICS aims on health inequalities, and the processes and resources expected to deliver them. We analyse publicly available policy documents, early evidence on ICS experiences, and broader evidence on the policy context facing ICSs to understand the extent of alignment between the streams and likely policy challenges as ICSs evolve. We identify questions that we explore further through our qualitative research in chapters 6 and 7.

APPROACH AND METHODS

We used Exworthy and Powell’s policy streams framework to structure our analysis. For our analysis, we wanted to understand how national policymakers in England defined ICS objectives on reducing health inequalities, and how they expect them to be delivered by local leaders. Exworthy and Powell’s framework focuses in detail on the ‘policy stream’ within Kingdon’s Multiple Streams Framework (*see* chapter 2 for a summary), and tries to account for the complexity of policy action on health inequalities in the ‘congested state’—characterized by complex networks of organizations at a mix of geographical levels.^{35,37,38} Exworthy and Powell describe three streams that need to align for successful policy implementation on health inequalities. First is the ‘policy stream’, which focuses on aims and objectives—for instance, how national policymakers define ICS goals to reduce health inequalities. Second is the ‘process stream’, which focuses on mechanisms to achieve these objectives and their technical and political feasibility—for instance, how organizations in ICSs are expected to develop interventions to reduce health inequalities and the processes for holding them to account for doing so. And third is the ‘resource stream’, which focuses on the financial and human resources to make the policy happen—for instance, funding to support ICS initiatives to plan and coordinate local services.

In addition, Exworthy and Powell argue that successful policy implementation is more likely to occur if these three streams are aligned across three further dimensions: vertically between central and local agencies (for instance, with policy objectives on health inequalities clearly stated and translated by central government to ICSs), horizontally between local agencies (for instance, with aims shared by health care, social services, and other agencies responsible for implementing policy changes), and horizontally between national agencies (for instance, with coordination between government health and finance departments to ensure resources are available to meet health inequalities objectives).

To understand policy aims, mechanisms, and resources for ICSs to reduce health inequalities, we analyzed official policy documents published by national NHS bodies and central government in England since 2021—the year government published a white paper with plans on the formal establishment of ICSs across England. We reviewed websites of NHS England, the Care Quality Commission, the Department of Health and Social Care, and other national bodies to identify relevant policy documents. These included documents on the development and structure of ICSs, guidance for the new systems on their role and functions, NHS planning documents and targets, government legislation on the formal duties of ICSs, and early plans for the assessment and oversight regime for the new systems. We analyzed the documents for content linked to ICS objectives to reduce health inequalities and categorized the data by Exworthy and Powell’s three policy streams. Policy aims and mechanisms for ICSs to reduce health inequalities were often implicit rather than explicit, and information from various places needed to be stitched together to understand what was being expected of ICSs.

To assess coherence of the approach in each stream and potential alignment between them, we critically analyzed the policy documents alongside early evidence on ICS approaches to reducing health inequalities. We carried out structured searches in relevant databases—including Medline, Embase, Web of Science Social Sciences Citation Index, The King’s Fund Library Database, and Google Scholar—to identify studies of any type focused on ICS approaches to reducing health inequalities in England. We found relatively few studies, so also identified relevant studies on the broader development of ICSs with relevance to policy implementation on health inequalities—for instance, evidence on emerging governance and planning mechanisms in ICSs.³⁹ We also identified broader evidence that we thought could provide additional insight into the potential impacts of national policy in each area—for instance, on how proposed mechanisms for holding ICSs to account for action to reduce health inequalities fit within broader approaches to performance management in the English NHS. Where relevant, we also refer back to evidence on factors shaping cross-sector collaboration to improve health from our umbrella review presented in chapter 3. For each stream, we considered potential interactions with other streams (for instance, how vague aims in the ‘policy stream’ may contribute to unclear local plans in the ‘process stream’) and alignment between agencies at multiple geographical levels (for instance, how vertical relationships between national NHS bodies and ICSs may affect horizontal relationships between local agencies within them).

ANALYSIS

Our analysis identified a combination of national policy objectives for ICSs on reducing health inequalities, as well as the processes and resources expected to deliver them. Our analysis also points to a mix of implementation challenges in each stream and the interactions between them (table 1).

Table 1. Summary of policy aims, mechanisms, and resources, and likely implementation challenges

Stream	Key components	Likely challenges
<i>Policy stream</i>	<p>ICS aims to reduce health inequalities defined by national NHS bodies and government, including a mix of goals to:</p> <p>Reduce health care inequalities</p> <p>Reduce health outcome inequalities</p> <p>Improve underlying social and economic conditions shaping health inequalities</p>	<p>Vague national policy objectives create potential for confusion and conflict locally</p> <p>Broad policy objectives may translate into lack of concrete action or weak local plans</p> <p>NHS focus on health care inequalities may undermine wider objectives and partners</p> <p>Other ‘hard’ policy objectives on improving NHS performance may crowd out ICS action on health inequalities</p>
<i>Process stream</i>	<p>A mix of processes are expected to help ICSs meet these objectives, including:</p> <p>ICSs aligning action between local agencies and coordinating local services</p> <p>National guidance for ICSs on potential approaches to reducing health inequalities and requirements for local plans</p> <p>Joint planning processes within ICSs, including on how legal duties to reduce health inequalities will be met</p> <p>Data collection and reporting to inform interventions and monitor progress</p> <p>National oversight of ICSs, including targets, assessment, and central support</p> <p>Coordination between national bodies to align wider policy on health inequalities</p>	<p>ICSs may not be able to effectively align action between local NHS and other organizations to reduce health inequalities</p> <p>Complexity and lack of clarity in ICS governance may hold back progress and undermine role of non-NHS partners</p> <p>ICS plans risk being vague or skewed towards narrower policy objectives, and—even then—may not be sufficient to guide local action</p> <p>National NHS approach to targets and performance management may hold back ICS efforts to reduce health inequalities</p> <p>Broader policy and political context may constrain local action—for instance, through weak investment in services that shape health and health inequalities</p>

<i>Resources stream</i>	Resources for ICSs to meet health inequalities objectives broadly cover: General resources and capacity within ICSs, including funding and staffing Targeted health inequalities funding, including a defined allocation to ICSs	General resource constraints across sectors in ICSs likely to act as a barrier to cross-sector collaboration on health inequalities Allocation of resources may work against policy objectives on health inequalities Targeted funding for ICSs to reduce health inequalities is limited and risks being diverted towards other short-term priorities
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Policy stream

ICSs have been given a mix of policy objectives to reduce health inequalities. These objectives are articulated in different ways between policy documents, often described in vague terms, and have evolved over time (for instance, as national bodies produce further guidance). Different terms and concepts, such as ‘inequalities’, ‘health inequalities’, and ‘health care inequalities’, are often used interchangeably. But—broadly speaking—national policymakers in England have tasked ICSs with reducing inequalities in health care services, reducing inequalities in overall health and wellbeing, and improving underlying social and economic conditions that shape health and health care inequalities.

Health care inequalities

NHS England has produced guidance on the role of ICSs in reducing health care inequalities. The main approach is ‘Core20Plus5’—a framework that identifies target groups for action to reduce health care inequalities at both a national and local level.^{40,41,42} This includes the most socioeconomically deprived 20% of the national population (identified using the index of multiple deprivation (IMD)), patients in five clinical areas (including maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension case-finding), and ‘plus’ groups defined locally by ICSs (articulated by NHS England as ‘population groups experiencing poorer than average health access, experience, and/or outcomes’). ICSs are expected to understand the health needs of these groups ‘to make informed decisions about how to ensure equitable access, excellent experience, and optimal outcomes for these populations’. The Core20plus5 approach is linked to broader national programs in the NHS, such as targets for early cancer diagnosis. Versions are available for adults and children.

A mix of other priorities has also been identified by NHS England linked to health care access, such as reducing NHS hospital waiting lists ‘inclusively’ (including by understanding the distribution of waiting lists by socioeconomic deprivation and ethnicity, and ‘prioritising service delivery’ based on these data—for instance, through ‘proactive case finding’), and reducing ‘digital exclusion’ (for example, by ensuring patients are offered face-to-face consultations).^{17,43,44,45} NHS England also aims to ‘hardwire’ objectives to reduce health care inequalities across all aspects of NHS England policy.⁴⁶ These policy objectives are underpinned by broader legal duties for Integrated Care Boards (ICBs) and other NHS bodies to ‘have regard’ to the need to reduce inequalities in access to and outcomes from health services.^{47,48}

Health outcome inequalities

National policymakers also expect ICSs to reduce inequalities in health outcomes and wellbeing. This wider aim is articulated in a mix of policy documents—often identified as an overarching goal for organizational collaboration through ICSs, as well as an expected benefit from it.^{1,49,50} Aims on health inequalities are often stated broadly—for instance, as an ambition for ‘improving population health and tackling inequalities’⁴⁹ or to ‘have the greatest impact on outcomes and inequalities’.¹ Several duties for ICSs to address health inequalities are also defined in legislation through the Health and Care Act 2022.^{47,48} This includes a duty for ICBs to ‘have regard’ to the likely effects of their decisions on the health and wellbeing of the population, including inequalities in health and wellbeing within the population (alongside effects of decisions on quality of services and use of resources—the so called ‘triple aim’ duty). ICBs also have a duty to ensure health services are integrated with other health-related services, such as housing, where this would reduce inequalities in services or outcomes.

Social and economic factors

Finally, ICSs are expected to influence broader social and economic factors that shape health and health inequalities, such as housing, skills, and employment. Like reducing health inequalities, contributing to ‘broader social and economic development’ is defined by NHS England as one of the four ‘core purposes’ of ICSs.¹ National policy documents lack a clear or consistent definition of what this means in practice for ICSs.⁵¹ But influencing the broader social and economic conditions that shape health is frequently articulated as a primary route for ICSs to reduce health inequalities.^{1,52,46,49}

Process stream

A combination of mechanisms is intended to help ICSs meet these policy aims. Overall, national policymakers emphasize the role of collaboration between organizations and sectors through ICSs as the main vehicle for reducing health inequalities (as well as meeting other ICS policy objectives, such as improving quality of services and value for money). For example, national policy documents describe ICSs as the mechanism for ‘aligning action between partners’¹ and ‘overcoming competing

objectives and funding’ to reduce health inequalities.⁵³ As well as closer alignment, organizations in ICSs are expected to integrate health, social care, and wider services to reduce health inequalities.⁵⁴ ‘Place’ level partnerships within ICSs are seen as important vehicles to do this.⁵⁰ Each ICS is required to have a named executive-level leader responsible for system action on health inequalities.⁴³

Joint planning

Various joint planning processes have been mandated by national policymakers to help ICSs coordinate local action. Integrated Care Partnerships (ICPs) are required to develop an ‘integrated care strategy’ setting out local health and care needs and priorities for system-wide improvement.⁵⁵ This includes assessing inequalities in ‘health and care outcomes and experiences’ and how they can be reduced. ICBs are also required to produce five-year plans setting out how they will deliver their functions, informed by the ICP’s integrated care strategy.^{56,57} The plans—which have to be updated annually—must set out how the ICB and NHS bodies within them plan to meet their various legal duties in relation to health and health care inequalities. Health and Wellbeing Boards—‘place’ level partnerships between local government, the NHS, and other local agencies responsible for improving health and wellbeing (table 1, chapter 4)—will also continue to produce assessments of health needs and strategies to address them. Government guidance states that the relationship between ICBs, ICPs, and Health and Wellbeing Boards should ‘be led by a focus on population health and health inequalities’.⁵⁸ At both an ICS and place-level, direct engagement with people and communities is identified as an important mechanism to design effective interventions to reduce health inequalities—for instance, to better understand the needs of underserved groups within ICSs and tailor services more effectively to meet them.⁵⁹

Guidance and data

Guidance has also been produced by national NHS bodies and government for ICSs on interventions to reduce health inequalities. NHS England’s Core20Plus5 framework provides a broad guide for action on health care inequalities.^{40,41,42} This includes national objectives on clinical interventions, such as targets for health checks for people with severe mental illness. Other priorities have also been identified for ICBs and other NHS providers, such as increasing access to vaccinations and other preventive interventions for target groups.⁴³ Government has also produced broader guidance for ICSs, local authorities, and other agencies on place-level interventions to reduce health inequalities.⁶⁰

Data collection and reporting is another mechanism intended to support ICS action. The 2022 Act requires NHS England to produce an annual statement on information related to health inequalities and how this information has been used within the health care system—the intention being that better data collection and reporting will help improve local and national action to reduce health inequalities.⁶¹ NHS England has also produced a health inequalities ‘dashboard’ that aims to inform

local interventions in ICSs,⁶² as well as other indicators to monitor local progress against NHS priorities on health inequalities.⁶³

National oversight

National NHS bodies and government will monitor and oversee the performance of ICSs—including by providing targeted support in systems where performance is deemed poor. NHS England is required to produce annual assessments of ICB progress, including on how ICBs are meeting statutory duties on health inequalities.⁶⁴ Some limited measures on how ICBs are working to reduce health inequalities are included in national NHS operational planning objectives—for instance, targets on uptake of vaccinations and a broad objective to ‘continue to address health inequalities and deliver on the Core20PLUS5 approach’.^{65,66,67} And a new NHS oversight framework is being developed by NHS England that will include indicators on health inequalities, which will be used to identify systems where additional support or central intervention may be needed.⁶⁸ The Care Quality Commission also plans to produce assessments of ICS performance, including an assessment of the effectiveness of local collaboration and how organizations are working together in ICSs to reduce health inequalities.⁶⁹ NHS England reports coordinating with central government agencies to align national policy on inequalities—for instance, to contribute to the government’s 2022 ‘levelling up’ white paper.^{70,71,63}

Resources stream

ICSs have been given a mix of general and targeted resources to meet national policy objectives on health inequalities. The NHS and local government agencies within ICSs receive funding allocations from central government to meet their statutory objectives, including on health inequalities. Within the NHS, weighted capitation formulae have been used since the 1970s to try to allocate health care funding more equitably between regions—for instance, to ensure more resources are directed to areas with higher health care needs or unavoidable service costs.^{72,73} Current NHS area-based allocations for ICBs include a ‘health inequalities adjustment’, using indicators of avoidable mortality to account for unmet health care need (though the level of this adjustment has changed over time).⁷⁴ Central government funding for local government—responsible for social care, public health, and other local services within ICSs—is not allocated in the same way as the NHS. Analysis of local government spending in recent years has found that, on average, local authorities in more deprived areas tended to receive higher funding per capita than local authorities in less deprived areas.^{75,76} But once differences in assessed population needs are accounted for, local authorities in more deprived areas are typically underfunded relative to local authorities in less deprived areas.

Given policymakers want action on health inequalities to be ‘hardwired’ across local systems, a broad interpretation of the resources available would include the totality of funding, staff, and capacity

available in ICS areas—in the NHS, local government, and beyond. But, of course, these resources are contributing to a wide range of policy objectives—not least the other ‘core purposes’ of ICSs.

Targeted resources

Modest targeted funding has also been made available to support ICS interventions on health inequalities. In 2022-23—the first financial year for ICSs after their formal establishment in 2022—national NHS bodies provided an additional £200m nationally for ICBs to fund local approaches to addressing health inequalities.⁷⁰ This was allocated to ICSs using the health inequalities adjustment of the area-based ICB allocation formula. From 2023/24, this targeted funding was absorbed into the broader ICB funding allocations—so made ‘recurrent’ for ICBs, but not targeted in the same way.^{45,77} NHS England has also commissioned a mix of coaching and learning networks for ICSs on approaches to reducing health inequalities—for instance, investing £3m in a programme aiming to develop resources and sharing learning on the role of community-based organizations in ICSs.^{78,79,80}

Analysing the streams

Our analysis points to potential challenges in all three streams and the interactions between them.

Policy stream

In the policy stream, national policy objectives for ICSs to reduce health inequalities appear broad and vague, creating potential for confusion and conflict between local agencies and lack of action to address them. Our umbrella review suggests unclear aims can hold back organizational collaboration, as can lack of clarity on roles and responsibilities (see chapter 3). Past NHS policies on health inequalities have also suffered from ‘muddy’ objectives that are poorly understood locally.^{81,82}

Evidence on the early development of ICSs, prior to their formal establishment in 2022, provide cause for concern. Several studies analysed early ICS plans to assess how local systems understood policy objectives on health inequalities, and their suggested approaches to achieving them. Olivera et al found that health inequalities were conceptualised vaguely and inconsistently in ICS plans, echoing broader vagueness in national policy.⁸³ Goddard found that the plans often mentioned broader social and economic factors shaping health inequalities, but provided limited detail on action to address them—focusing more on action within the health care system and individual-level interventions.⁸⁴ Briggs et al focused on ICS’ plans on disease prevention and, similarly, found that local strategies commonly focused on individual-level programmes targeting behaviour change, rather than more ‘upstream’ or population-level approaches that might be more likely to reduce health inequalities.⁸⁵ While NHS England’s Core20plus5 approach may provide a broad guide to frame potential NHS interventions to reduce health care inequalities in ICSs, Lalani et al suggests that the programme’s clinically oriented approach risks undermining local authorities and others with a broader focus.⁸⁶

Data on ICS interpretations of national policy objectives on health inequalities since their formal implementation in 2022 are more limited. A report commissioned by NHS England suggests that the Core20plus5 framework has been referenced by all 42 ICSs in their first round of formal strategies—though only a small number of areas defined their own ‘plus’ population groups.⁸⁷ Plans also often referred to social and economic determinants of health, such as housing and poverty. But a qualitative study on how ICSs are using health inequalities funding found some differences in views among local leaders about whether they should be focusing on health care or broader health inequalities.⁸⁸

Robertson et al studied more targeted NHS policy objectives to recover elective care services ‘inclusively’, and found that policy guidance on the objective was unclear and a lack of consensus among local leaders on what a fair and equitable approach would look like held back progress.⁸⁹

Studies tracking the broader development of ICSs have also found concern among local leaders that short-term objectives to improve NHS performance—for instance, to reduce NHS waiting times—will take priority over longer-term and broader objectives to reduce health inequalities.^{90,91} Evidence on previous similar policy initiatives in England suggests that ‘hard’ targets on NHS performance and finances often trump longer-term objectives—particularly as NHS pressures increase.^{92,93,94,95} The overriding focus of national NHS planning guidance since 2022 has been on targets to recover NHS performance and productivity after the pandemic—for instance, to improve access to urgent and emergency care and reduce long waiting lists for routine hospital treatment.^{43,44,45} Our qualitative study presented in chapter 6 provides more detailed insight into local interpretations of national policy objectives on health inequalities among senior leaders working in three ICSs in England.

Process stream

In the process stream, it is not clear that the policy mechanisms on offer match the scale of the policy ambition. Collaboration between local NHS and other agencies is identified as the main route to reducing health inequalities in ICSs. Yet our umbrella review found little high quality evidence to suggest that collaboration between local health care and non-health care agencies improves health and health equity, and identified a long list of barriers to successful partnership working, such as cultural differences between organizations and sectors, information sharing issues, and more (*see* chapter 3).

Evidence on the early implementation of ICSs suggests that the new systems are unlikely immune to these challenges. Sanderson et al used qualitative methods to understand emerging governance in England’s ICSs between 2019 and 2021.⁹⁶ They found that organizations struggled to balance organizational and system-wide interests, which allowed a ‘retreat’ from some challenging decisions. The authors noted that ‘making ICSs statutory bodies does not overcome this problem, as partner organisations will retain their organisational sovereignty, and consequently the capacity to disagree

with system-proposed plans'. Other studies on early versions of ICSs identified similar accountability challenges—particularly in generating 'horizontal' accountability between local organizations in ICSs—as well as broader cultural and technical barriers to working across agencies.^{97,98,99} These studies also point to tensions between sectors on the purpose of ICSs and emerging power dynamics within them. Alderwick et al found that NHS engagement with local government and other community partners varied widely in the first round of Sustainability and Transformation Plans in 2016 (which later became ICSs). Sanderson et al also identified concerns among local non-NHS organizations that ICSs would be too NHS-centric—for instance, focused on achieving financial balance in the NHS.⁹⁶

The complexity of ICS governance and lack of clarity from national policymakers about the relationships between their constituent parts is likely to exacerbate these challenges. For instance, the relationship between NHS providers and ICBs is unclear. Meanwhile, ICPs—the wider partnership of local agencies responsible for developing an integrated care strategy to guide local decisions—seem to play a bit part role in the new structure, and risk being sidelined by more powerful NHS bodies, such as the ICB.¹⁰⁰ Joint planning processes are one mechanism intended to bring together local partners and identify collective priorities for action. Analysis of early ICS planning documents suggested that commitment to concrete action on health inequalities was weak.^{19,20,84} Lalani et al's study into how ICSs manage and improve quality—with data collected in 2021 and 2022—also struggled to identify how ICSs planned to reduce health inequalities, particularly at an ICS level.⁸⁶ Analysis commissioned by NHS England of the first round of ICS strategies since their formal establishment in 2022 suggests that the new systems have made a mix of commitments to reduce inequalities in health and health care, and that NHS England guidance has been widely used.⁸⁷ But the plans cover a range of other priorities and how they will translate into action is yet to be seen.

The approach taken by national NHS bodies to managing ICS performance may hold back local action on health inequalities. Over recent decades, the national approach to improving the NHS has typically relied on top-down targets and performance management.¹⁰¹ More broadly, the NHS in England is a centralized health system with a strong degree of political control (*see* chapter 2). In their study on approaches to managing and improving quality in ICSs, Lalani et al identify a risk that this top-down and centralized approach, focused on assuring quality in narrowly defined areas of NHS performance, crowds out broader ICS efforts to reduce health inequalities.⁸⁶ Data since the formal implementation of ICSs in 2022 suggests that this risk is playing out in practice. In their study on ICS health inequalities funding, Bagnall et al reported views from local leaders that NHS England's 'must do' priorities and approach focused on short-term operational targets over reducing health inequalities.⁸⁸ Robertson et al's study on NHS approaches to reducing elective waiting times 'inclusively' also found that national NHS bodies were focusing on targets to reduce long waiting

times instead—the ‘real’ priority for local systems, with strong accountability mechanisms attached.⁸⁹ This fits with broader evidence on weak NHS accountability mechanisms for reducing health inequalities since 2010.¹⁰²

The broader political and policy context in England also risks undermining local action. Since 2010, there has been no coordinated national strategy to reduce health inequalities in England, and funding for public services that shape health and health inequalities has been highly constrained (*see* more detailed analysis in chapter 4). Boris Johnson’s government set ambitious goals for ‘levelling up’ the country in 2022—including a target to reduce gaps in healthy life expectancy between richer and poorer areas of England—but did not match this with the policy changes or investment needed to make it happen.^{103,104} The election of a new UK government in 2024 provides an opportunity to reverse these trends. Our qualitative study presented in chapter 7 provides more detailed insight into how the national policy and political context shapes local collaboration to reduce health inequalities in ICSs.

Resources stream

Finally, in the resource stream, ICSs face major challenges. Our umbrella review identified lack of resources as a common barrier to cross-sector collaboration on health and health equity (*see* chapter 3). General resource constraints in ICSs are widespread. The NHS, local government, and other public services have experienced a long period of low spending growth (*see* chapter 4) and future public spending plans suggest this constraint will continue for several years, leaving a potentially vast gap between the spending needed to improve services and actual government investment.^{105,106} Meanwhile, there are chronic staff gaps across the NHS and other local services.^{107,108,109} And ICBs faced substantial cuts in their running costs less than a year after they were formally introduced.¹¹⁰

National NHS funding allocations for ICBs seek to account for health inequalities.¹¹¹ But funding for other parts of ICSs is not designed with these objectives in mind—and may run against them. For example, central government funding for local government does not follow need,^{112,113} and cuts to local government spending since 2010 have been deepest in more deprived areas.^{114,115,116} Recent analysis also suggests that—after adjusting for differences in patient needs—general practices in more deprived areas are relatively underfunded and under-doctored compared to practices in richer areas.¹¹⁷

Targeted funding for ICSs to reduce health inequalities is limited—around £200m of the £155bn budget for health services in England in 2022-23.¹¹⁸ Bagnall et al studied how ICSs used their health inequalities funding in 2022/23.⁸⁸ Half the systems involved in the study ringfenced their funding allocation for a mix of health inequalities projects, including funding for service interventions (such as new approaches to improve access to general practice for targeted groups) and capacity building

projects (such as building the skills and staffing of central health inequalities teams within ICBs). Others used only some of their funding for health inequalities projects, while some systems put all their health inequalities funding back into their ‘baseline’ budget (for example, to help cover financial deficits elsewhere in the system, such as acute hospital services). The researchers identified a mix of barriers to effective use of the funding, including the approach and behaviour of national NHS bodies, which was ‘overwhelmingly’ focused on short-term priorities to improve NHS performance.

DISCUSSION

We used Exworthy and Powell’s ‘policy streams’ framework to analyze national policy objectives for ICSs on reducing health inequalities, and the processes and resources expected to deliver them.

Overall, we found that national policy objectives for ICSs on health inequalities are broad and vague—spanning narrower objectives to reduce health care inequalities to broader action to improve social and economic conditions shaping health inequalities. Unclear policy objectives may contribute to conflict and confusion between agencies at a local level, and early evidence suggests competing policy objectives to ‘recover’ NHS performance risk dominating the agenda for ICSs. In the process stream, a combination of policy mechanisms is expected to support ICS action to reduce health inequalities, including the design of ICS governance and accountability, joint planning processes, and the oversight and guidance of national NHS bodies for ICSs. But the ability of ICSs to effectively plan and coordinate local action on health inequalities is not clear, and early evidence suggests the approach of national NHS bodies in practice may hold back local collaboration and distort ICS priorities. Major resource constraints across the NHS, local government, and other sectors risk exacerbating these challenges. To make things harder, issues in the policy and process streams may mean the already modest ICS resources to reduce health inequalities are diverted towards other ICS objectives.

Our analysis of the structure and development of ICSs in chapter 4 pointed to a mix of implications for national policy—including unrealistic expectations for ICSs, governance and accountability issues that may hold back effective collaboration, variations among ICSs in key domains likely to shape their functioning and impact, and the central role of wider policy and political choices in shaping what ICSs can deliver on health inequalities and other objectives. Our more detailed analysis of national policy on reducing health inequalities through ICSs suggests three further implications for the development of the new systems and their ability to deliver policy objectives on health inequalities.

First, local interpretations of national policy objectives on reducing health inequalities are likely to vary between ICSs and organizations within them, with implications for their approach and impact. National policy documents point to a mix of objectives for reducing health inequalities through ICSs.

NHS England's Core20plus5 approach provides a broad framework to guide ICS interventions to reduce health care inequalities, focused on a mix of clinical areas and target population groups. But the new systems have also been given broader aims to reduce inequalities in health outcomes and influence the social and economic factors that shape them. These broader aims are described vaguely and inconsistently in the policy documents, and guidance on what policymakers expect is limited.

What will ICSs prioritize? Early evidence on ICS planning suggests that a narrower focus on reducing health care inequalities and individual-level interventions is likely to win out.^{19,84,85} Vague policy objectives on reducing health inequalities are not new^{18,19,20} and leaders from health care, public health, and other sectors often have varied interpretations of health inequalities and the interventions needed to address them.^{25,26,27,28} Given the varied role and focus of organizations within ICSs—for instance, between NHS organizations responsible for purchasing and providing health care, and local authorities responsible for public health, social care, and a wider range of services that shape health inequalities—conflicting interpretations and priorities for action on health inequalities are likely. Our qualitative research presented in chapter 6 explores local interpretations of national policy to reduce health inequalities in more detail, including how interpretations vary between sectors within ICSs.

Second, faith in the ability of ICSs to effectively coordinate local action to reduce health inequalities is high, while the strength of wider policy mechanisms to hold ICSs to account for progress is low. Collaboration between organizations within ICS is identified as the main mechanism to reduce health inequalities in national policy documents. Mandated joint planning processes and new accountabilities are intended to help them do it. Yet evidence from a long line of partnership policies in the UK and elsewhere points to the various barriers to making collaboration work in practice, such as cultural differences between organizations and sectors, information sharing issues, and more (see chapters 3 and 4). Early evidence on the development of ICSs reviewed in this chapter suggests that ICSs will face similar issues, and points to fundamental tensions in ICS governance and decision-making.^{96,97,98} In this context, there is a risk is that the wider policy processes on offer to support ICS action to reduce health inequalities, such as national guidance, data and monitoring, and the emerging approach to performance assessment, prove insufficient levers to ensure progress—particularly given the limited dedicated resources for ICS action on health inequalities and broader pressures facing local systems. Accountability for reducing health inequalities in the NHS has historically been weak,¹⁰² and evidence suggests national NHS bodies are prioritizing other policy objectives instead.^{88,89} As a result, much hinges on the ability of ICSs to coordinate and direct action.

And third, national NHS bodies will play a dominant role in shaping ICS action on health inequalities—for better or worse. In each policy stream, our analysis illustrates how the approach of NHS England looms large locally. For example, national planning guidance for NHS organizations

since the formal establishment of ICSs has focused predominantly on short-term objectives to recover NHS performance, such as targets on elective waiting lists. Early studies on ICSs suggest that NHS England’s approach to performance management has focused primarily on these narrow areas of performance, at the expense of wider—less clearly defined—goals to reduce health inequalities.^{88,89} The top-down and centralized approach to managing NHS performance also risks undermining NHS partnerships with local government and others within ICSs. Understanding how vertical relationships between national NHS bodies and ICSs shapes horizontal relationships within the new systems is therefore crucial. Our qualitative research presented in chapter 7 explores these issues in more detail.

Limitations

Our analysis has several limitations. First, we analyzed publicly available policy documents for ICSs to understand policy aims, mechanisms, and resources linked to policy objectives to reduce health inequalities. We identified a range of relevant policy papers, guidance, and plans for the new systems. But further guidance for ICSs on these objectives may not be publicly available—for instance, detailed in letters or communication to the new systems from national NHS bodies and government. This means we may only have a partial picture of the policy ‘ask’ on reducing health inequalities. And second, our review of evidence on early approaches in ICSs to reducing health inequalities is limited by the data available. ICSs have only formally existed since 2022 and studies on their approaches to reducing health inequalities are limited. We supplemented our search with broader evidence on the development of ICSs and studies on early ICS approaches before the Health and Care Act 2022. Nonetheless, our analysis can only provide an initial view of coherence and alignment between policy streams. Our qualitative research in chapters 6 and 7 offers richer data to supplement the picture.

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CHAPTER 6

Solving poverty or tackling health care inequalities? Qualitative study exploring local interpretations of national policy on health inequalities under new NHS reforms in England

Published papers

This chapter is the final accepted version of the following published paper:

Alderwick H, Hutchings A, Mays N. Solving poverty or tackling healthcare inequalities? Qualitative study exploring local interpretations of national policy on health inequalities under new NHS reforms in England. *BMJ Open*. 2024;14(4):e081954.

<https://bmjopen.bmj.com/content/14/4/e081954>

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Student ID Number	1806276	Title	Mr
First Name(s)	Hugh		
Surname/Family Name	Alderwick		
Thesis Title	A cure for everything and nothing? Local cross-sector collaboration and health inequalities in England		
Primary Supervisor	Nicholas Mays		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

Where was the work published?	BMJ Open https://bmjopen.bmj.com/content/14/4/e081954		
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SECTION D – Multi-authored work

<p>For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)</p>	<p>HA worked with his supervisors, NM and AH, to identify the research question and lead the design and development of the study. HA carried out the interviews with ICS leaders. HA, NM and AH reviewed interview transcripts, identified themes in the data, developed the code structure and interpreted the data. HA coded and analysed all interview transcripts. HA wrote the first draft of the manuscript and incorporated comments from AH and NM. All authors read and approved the final manuscript.</p>
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SECTION E

Student Signature	Hugh Alderwick
Date	07/11/2024

Supervisor Signature	Nicholas Mays
Date	10/11/2024

TITLE

Solving poverty or tackling health care inequalities? Qualitative study exploring local interpretations of national policy on health inequalities under new NHS reforms in England

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ABSTRACT

Objectives. Major reforms to the organization of the NHS in England established 42 integrated care systems (ICSs) to plan and coordinate local services. The changes are based on the idea that cross-sector collaboration is needed to improve health and reduce health inequalities—and similar policy changes are happening elsewhere in the UK and internationally. We explored local interpretations of national policy objectives on reducing health inequalities among senior leaders working in three ICSs.

Design. We carried out qualitative research based on semi-structured interviews with NHS, public health, social care, and other leaders in three ICSs in England.

Setting and participants. We selected three ICSs with varied characteristics all experiencing high levels of socioeconomic deprivation. We conducted 32 in-depth interviews with senior leaders of NHS, local government, and other organizations involved in the ICS's work on health inequalities. Our interviewees comprised 17 leaders from NHS organizations and 15 leaders from other sectors.

Results. Local interpretations of national policy objectives on health inequalities varied, and local leaders had contrasting—sometimes conflicting—perceptions of the boundaries of ICS action on reducing health inequalities. Translating national objectives into local priorities was often a challenge, and clarity from national policymakers was frequently perceived as limited or lacking. Across the three ICSs, local leaders worried that objectives on tackling health inequalities were being crowded out by other short-term policy priorities, such as reducing pressures on NHS hospitals. The behaviour of national policymakers appeared to undermine their stated priorities to reduce health inequalities.

Conclusions. Varied and vague interpretations of NHS policy on health inequalities are not new, but lack of clarity among local health leaders brings major risks—including interventions being poorly targeted or inadvertently widening inequalities. Greater conceptual clarity is likely needed to guide ICS action in future.

Strengths and limitations of this study

- This is a qualitative study providing in-depth insights from senior leaders in England's new ICSs—including leaders from NHS, local government, and other community-based organizations.
 - Our structured sampling approach meant we were able to carry out interviews in three ICSs with varied characteristics all experiencing high levels of socioeconomic deprivation.
 - Our findings represent specific experiences of leaders in three areas of England where reducing inequalities may be high on the agenda, rather than general experiences of ICSs nationally.
 - We carried out our fieldwork soon after the reforms, so our research represents leaders' initial interpretations of ICS policy objectives on health inequalities, which are likely to evolve.
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INTRODUCTION

The Health and Care Act 2022 introduced major changes to the rules and structures of the NHS in England, undoing components of the market-based reforms introduced by the Coalition government a decade earlier.^{1,2} The changes are based on the idea that cross-sector collaboration is needed to improve health and reduce health inequalities. Since July 2022, 42 integrated care systems (ICSs)—area-based partnerships between the NHS, social care, public health, and other services in England—have been responsible for planning and coordinating health and care services for populations of around 500,000 to 3 million people.³ Each ICSs is made up of a new NHS body and wider committee of NHS, local government, and other agencies. The reforms build on a long history of policies on cross-sector collaboration on health,⁴ and echo policy changes across the UK and in other countries.^{5,6}

ICSs have been given explicit objectives by national policymakers to reduce health inequalities. Gaps in life expectancy between the most and least socially disadvantaged groups in England are wide and growing,^{7,8} and there are inequalities in access to high quality health care.^{9,10,11} One of the four 'core purposes' of ICSs—defined by NHS England, the national body responsible for the day-to-day running of the English NHS—is to 'tackle inequalities in outcomes, experience, and access'.¹² NHS bodies and new ICSs have various legal duties on health inequalities: some broad (such as to consider the effects of their decisions on inequalities in population health and wellbeing), some more specific (such as to reduce inequalities in access to health services).^{1,13} NHS England has also produced broad guidance for ICSs on reducing inequalities, setting out priorities for 'recovering' services affected by covid-19¹⁴ and target groups for action on health care inequalities (including the 20% most deprived of the population and people with selected clinical conditions—an approach known as core20plus5).¹⁵ Modest additional funding (£200m nationally in 2022-23) has been provided to support these efforts.¹⁶

ICs are the latest in a long line of local partnerships tasked with delivering national policy objectives on health inequalities.⁴ For example, a mix of area-based partnerships between the NHS, local government, and other agencies was established to improve health and reduce health inequalities under Labour governments from 1997 to 2010—including Health Action Zones,^{17,18} Sure Start Local Programmes,^{19,20} Local Strategic Partnerships,^{21,22} and more—as part of a broader national strategy to reduce gaps in life expectancy and infant mortality between richer and poorer areas in England.^{23,24,25} More recently, the NHS Long Term Plan in 2019 committed to stronger NHS action on health inequalities,²⁶ and partnerships between the NHS, local government, and community-based organizations—early versions of ICs—were asked to develop local plans for how to do it.²⁷

But translating national policy into local action is not easy. Health inequalities are complex²⁸ and policy objectives to reduce them are often ambiguous, partial, and shifting.^{29,30,31} Health leaders have competing interpretations of the problem to be solved—for instance, between ‘individualized’ and broader structural interpretations of inequalities.^{32,33} And local plans for action on health inequalities are often vague.^{30,34,18} Even then, policy objectives to tackle health inequalities are rarely matched with the resources needed to achieve them,^{35,36} and are repeatedly drowned out by higher profile and short-term political priorities, like reducing NHS waiting times or balancing hospital budgets.^{37,38} Alongside reducing health inequalities, England’s new ICs are expected to deliver a mix of other national policy objectives, such as increasing NHS productivity, as well as meeting targets to improve access to urgent and emergency care and reduce long waiting times for routine hospital treatment.^{12,39}

How policy problems are framed and understood shapes action to address them.^{40,41,42,43} Competing problem definitions interact and evolve.^{40,41} And lack of clarity on aims and objectives can hold back collaboration between local agencies expected to work together to deliver them.⁴ Previous studies have examined how past national policies on health inequalities in England have been interpreted by local leaders,^{37,29,44,45} as well as individual and organizational perspectives on health inequalities in the UK and elsewhere.^{32,46,47,48,49,50} More recently, researchers have analysed how health inequalities are conceptualized in local health planning documents^{30,34,51} and tracked the early development of ICs in England.^{52,53,54,55} But in-depth understanding of how England’s new ICs are interpreting national policy on health inequalities is limited. We conducted qualitative research with NHS, public health, social care, and other leaders in three more socioeconomically deprived ICs to gain insight into local interpretations of national health inequalities objectives, how inequalities relate to other priorities, and how these interpretations vary.

METHODS

Design and sample

We used qualitative methods to explore local interpretations of national policy objectives on health

inequalities among senior leaders involved in England's new ICSs. Our sample comprised 32 leaders from NHS, social care, public health, and community-based organizations in three ICS areas.

We identified a purposive sample of ICSs with varied characteristics experiencing high levels of socioeconomic deprivation. We collated a mix of publicly available data on the characteristics of each of England's 42 ICSs³—including geographical context (NHS region and proportion of rural/urban areas), population size, organizational complexity (number of NHS trusts and upper tier local authorities), policy context (number of sites involved in relevant policy initiatives in the ICS, and the date the early version of the ICS was established), and socioeconomic deprivation (proportion of the ICSs' lower super output areas (LSOAs) in the most deprived 20% of areas nationally, using index of multiple deprivation (IMD) ranks). We selected these characteristics because of evidence on their likely relevance to how organizations in ICSs work together to reduce health inequalities.^{56,3}

We used these data to identify a sub-group of 14 ICSs experiencing the highest concentration of socioeconomic deprivation relative to other ICSs in England (the top tercile of ICSs with the highest concentration of LSOAs in most deprived 20% of areas nationally). National NHS bodies are seeking to reduce health inequalities by targeting efforts on the most deprived groups¹⁵—and areas with similar levels of socioeconomic deprivation may pursue common approaches. The experiences of ICSs in these areas are therefore likely to be particularly relevant to understand and inform policy in England. We then identified three ICSs within this sub-group that varied in population size (which is strongly correlated with organizational complexity), geographical region, rurality, and policy context—for example, by avoiding selecting all three sites from an early 'wave' of NHS England's ICS programme (NHS England established early ICSs in waves based on perceived 'maturity'⁵⁷ of local partnerships). This gave us a relatively heterogenous mix of three ICSs all serving more socioeconomically deprived populations. ICS leaders from the three areas we selected all agreed to participate in the research. ICS A is a large system covering a mixed rural/urban area; ICS B is a medium size system covering a more urban area; ICS C is a large system covering a more urban area.

In each ICS, we conducted in-depth interviews with senior leaders of NHS, local government, and other organizations involved in the ICS's work on health inequalities. This included leaders from NHS integrated care boards (ICBs) (such as ICB chief executives and directors of strategy), NHS providers (such as NHS Trust chief executives and GPs), local authorities (such as directors of public health and adult social care), and other community-based organizations (such as leaders of charities working with the ICS to represent the public or provide services)—as well as those involved in the day-to-day management of ICS work on health inequalities. Participants were identified through web-based research and snowball sampling.⁵⁸ Our sample comprised 17 leaders from NHS organizations (including those working within the ICB) and 15 from local government or other organizations outside the NHS. We describe all research participants as 'leaders' when reporting the results.

ICSs are complex systems involving a mix of organizations and partnerships between them. ICSs themselves are made up of two bodies: ICBs (area-based NHS agencies responsible for controlling most NHS resources to improve health and care for their local population) and integrated care partnerships (looser collaborations between NHS, local government, and other agencies, responsible for developing an integrated care plan to guide local decisions—including those of the ICB). ICSs are expected to deliver their objectives through the work of both bodies and other local agencies.^{3,12,59} In our research, we focused on interpretations of policy objectives and priorities for the ICS as a whole.

Data collection and analysis

We used a semi-structured interview guide with questions on leaders' interpretation of national policy objectives on health inequalities, local priorities, and how these linked to other objectives for the ICS (appendix 2). All participants gave informed consent verbally. Interviews were carried out online, lasted an average of 44 minutes, and took place between August and December 2022. All interviews were recorded, professionally transcribed, and anonymized at the point of transcription. We analyzed the data using the constant comparative method of qualitative analysis.⁵⁸ We reviewed the transcripts line by line to identify themes in the data, and refined them iteratively as new concepts emerged. All authors (HA, NM, AH) reviewed a sample of the transcripts and worked collaboratively to develop the code structure. We used an integrated approach to do this based on the themes identified in the data and key domains in our interview guide.⁶⁰ One author (HA) then analyzed all transcripts and the authors met regularly to discuss interpretation of the data and any changes to the coding framework. We used NVivo (release 1.3) to facilitate our analysis of the data.

Patient and public involvement

No patients or members of the public were involved in this study.

RESULTS

We found varied interpretations of policy objectives on health inequalities—both within and between ICS areas. Leaders had different perceptions of the boundaries of ICS action on health inequalities—particularly the balance between action on health care and wider health inequalities. Leaders everywhere worried that action on health inequalities would be crowded out by other priorities.

Varied and vague interpretations

Interpretations of national policy objectives on health inequalities varied. Some leaders interpreted national policy objectives for ICSs broadly—for example, as being about tackling poverty, improving social and economic conditions, and reducing inequalities in life expectancy. One NHS leader in ICS C said they were focusing on poverty as the 'core driver of the vast majority of health inequalities we're facing'. Another said, while clinical priorities and access to preventive services were important, 'we've really tried to go at social, you know, broader determinants of health type perspectives'.

Others conceptualized ICSs' role on health inequalities as a mix of linked objectives within the NHS and beyond. A local authority leader in ICS B, for example, described how the ICS had a role in 'tackling clinical inequality' (such as improving diabetes outcomes for marginalized groups), reducing inequalities in risk factors for ill-health (such as physical activity), and acting on the 'wider determinants of health'. An NHS leader in ICS A described similar objectives to prevent disease, reduce health care inequalities, and support action to improve social and economic conditions.

But several leaders were struggling to interpret national policy objectives. A local authority leader in ICS C said they were unsure which inequalities they were supposed to prioritize—for instance, inequalities within the 'places' that made up their ICS, inequalities between these places, or inequalities between their ICS and the rest of the country. Another said leaders were 'struggling to whittle down the big amorphous blob of health inequalities into some actual things that we can do'—and 'going round in circles' trying to do it. An NHS leader in ICS A said they were 'still working it out', while others pointed to governance structures or planning processes instead of their interpretation of national policy objectives on health inequalities or planned action to address them.

Translating national policy objectives into local priorities was often a challenge. ICS leaders were in the process of developing their strategies when we carried out our interviews. Some could point to high level objectives on reducing health inequalities, such as reducing gaps in healthy life expectancy, or priority areas, such as improving mental health services. But others said it was too early to articulate priorities or felt in the dark about the process to develop them. Some felt their ICS's priorities on health inequalities were vague. An NHS leader in ICS A, for instance, said:

'I've been to a few meetings and [leader's name], they all trot out the whole "la la, core20PLUS5, we're going to do this, we're going to make everything better", but I haven't heard anything specific, I haven't heard anybody mention anything rather than just sound bites, in all honesty.'

—NHS leader, ICS A.

National guidance for ICSs did not always help provide clarity. Several leaders mentioned NHS England's core20plus5 framework, which identifies priority groups for action on reducing health inequalities, including the 20% most deprived of the population and people with selected clinical conditions. Some found the framework a helpful starting point for local plans. But others thought it focused too narrowly on clinical priorities, might not fit their local context, or risked widening inequalities (if the focus was on targeting the 20% most deprived in each ICS rather than nationally). More broadly, leaders often thought national guidance for ICSs on health inequalities was vague:

'Other than the usual broad brush, "oh, integrated working" and, you know, [...] "system leadership" and they bandy terms around, like this – personalised care, that's another one. They all talk about these kind of things and then we actually say, "alright then, well what do you mean?" There's not very much under that.'

—NHS leader, ICS A.

'I think the thing that I see most of, and I don't know what its status is, is the kind of core twenty plus five work. That seems to have some level of visibility. Even if I don't really understand what it means in, kind of, how it translates. But beyond that, no I don't have clarity on what the ask is.'

—Local authority leader, ICS C.

Lack of clarity was not always seen as a drawback by local leaders, given they often wanted flexibility to address local needs. But several worried about unintended consequences—including lack of clarity on ICS objectives on health inequalities skewing priorities towards other high-profile areas (such as objectives to increase elective care activity), or misinterpretation and inconsistent implementation of policy objectives between ICSs (such as national policy to reduce NHS waiting lists 'inclusively').

Health care versus health inequalities

Lack of clarity about policy objectives contributed to conflicting views about the primary role of ICSs and where they should focus their attention. A major tension running throughout our interviews was differing perceptions of the boundaries of ICS action on health inequalities—particularly how far the ICS should extend its focus beyond reducing health care inequalities (such as differences in access to care) to address the broader social and economic conditions shaping health inequalities (such as housing conditions). Varying interpretations could be found within ICS areas and professional groups.

For some, ICSs would only succeed if they looked beyond health care services:

'Over many years [...] they've been really probably the national ill health service, focussing in on treating illness and disease as opposed to thinking about primary prevention and working more effectively with public health on how do we get population health outcomes improved and therefore reduce health inequalities. And that lens of the wider determinants of health is to my mind the right lens to be looking through in order to improve population health outcomes.'

—Local authority leader, ICS C.

Others described how their ICS needed to do both—combining action on reducing health care inequalities with broader efforts to tackle underlying social and economic conditions in their area:

'You just look at the healthy life expectancy across the patch and you can see the inequity. You look at things like vaccine uptake, screening uptake, and they're some of the, kind of, proxy measures that you can see that maybe start to explain some of the differences in life expectancy. You look at smoking

rates, obesity rates, alcohol, all of that kind of stuff, unemployment, housing situation, and you start to get to grips as to why, and, as I say, it's clear that it's issues greater than just what the health service can manage, so it needs that integrated approach.'

—NHS leader, ICS A.

But several leaders—particularly from local government—wanted their ICS to focus primarily on health care inequalities, and worried about the consequences of NHS leaders misinterpreting their role and purpose:

'I think there's something for me about ensuring that the ICS is absolutely focused on healthcare inequalities as its first and foremost responsibility. Get the inequalities within the NHS, what's in their grasp. [...] They're not going to solve poverty at an ICS level.'

—Local authority leader, ICS A.

'It's an easy get out to say, you know, "Marmot says that it's the social determinants that matter most". Well then, and "we need to focus on housing and jobs and things". Well, the ICS doesn't do much, doesn't have big levers on housing and jobs and stuff, so yes, we can do a bit on anchor work, but it's fairly marginal to what we can do to actually try and ensure that our services strive to have the most equitable access and outcomes for our residents.'

—Local authority leader, ICS C.

'I think there is a misconception about what is the role of the NHS in tackling health inequalities. [...] I always kind of giggle in the background, some people might discover health inequalities, and then they go, "you know, we need to solve poverty" and you go "Christ, that'd be great. In the meantime, can you just make sure your services are open on an evening and actually the transport routes are fine, and actually the literacy levels of your leaflets are not of a reading age of a 20-year-old?"'

—Local authority leader, ICS A.

These differences in interpretation created potential conflict between leaders and organizations. Some described the risk of the NHS 'stepping on toes' or failing to acknowledge others' skills and expertise. Others worried about NHS leaders framing health inequalities as 'new' and the risk of alienating local authorities and others with a long history of working to address them. One NHS leader described how:

'I just had a conversation with the DPH [...] We were talking about some of the wider determinant stuff and she said, "Well, you know, of course, that's not really the NHS's business", you know, "We've got all this in our strategies" you know? So, it was just a little bit of a [...] Just a gentle, sort

of, shove back.'

—NHS leader, ICS C.

Tension was not always seen as a bad thing. An NHS leader in ICS C gave the example of learning to dance with a partner, saying 'you have to acknowledge that you will stand on each other's bloody toes, you know', otherwise 'you don't move anywhere and you don't learn anything'. Several leaders described ongoing conversations in their ICS to define roles and responsibilities of different organizations, including work in one area to define the contribution of public health professionals in the ICS. And public health leaders frequently described their efforts to help other partners in their ICS understand different kinds of health inequalities and potential approaches to reducing them.

Threaded throughout or crowded out?

Whatever their interpretation of the boundaries of ICS action on health inequalities, leaders often conceptualized reducing health inequalities as a cross-cutting objective linked to other ICS priorities:

'So I think whenever we discuss anything, we've got this absolute agreement we need to look at it through... so we always look at things through a financial lens, a quality lens, but I think we also need to start – whatever we do – we look through a health inequalities lens. Is this a line to our strategic aim of reducing health inequalities, no matter what it is?'

—NHS leader, ICS A.

'I mean it runs through everything, it literally runs through everything doesn't it, this inequalities work. Every single strategy, every single plan is what we are looking to make a shift on in terms of this agenda.'

—Local authority leader, ICS B.

'I think we need to get to a strategy which clearly puts population health management and understanding and tackling health inequalities as the core of our overarching strategy, and inequalities needs to be threaded through all of our other pieces of work.'

—NHS leader, ICS C.

But—in reality—leaders frequently described how other priorities risked crowding out action on health inequalities. Interviewees in every ICS described how responding to acute pressures in the NHS and social care, such as long waiting lists for elective care, tended to dominate the agenda. This 'crowding out' effect happened at a mix of levels—from senior leaders to front-line staff. An NHS leader in ICS B, for example, described how the limited 'bandwidth' of the ICS team was being taken up with a series of meetings on ambulance response times, elective waiting lists, and other operational pressures—and said they were 'increasingly spending more time on those short-term issues' over

longer-term objectives. Another NHS leader in ICS C described how their clinicians ‘would love to be spending more time’ on initiatives to reduce health inequalities, such as a local programme where respiratory consultants visited a community hub to provide clinical advice alongside other services focused on housing, food, benefits, and other social needs—‘but they are saying we can’t because we’ve got these clinics to do and we’ve got these patients to see and we’ve got a full ED department’.

Leaders gave a mix of explanations for this crowding out effect. One was that pressures on the NHS, like long ambulance response times, were the most visible priorities. Another was that pressures on the NHS were so extreme—so ‘unacceptably bad’, as one local authority leader in ICS A put it—that short-term action to address them was understandable, and might even be needed to create space for work on health inequalities. One NHS leader in ICS C said: ‘if we don’t get through winter, then, you know, nobody’s going to give us the time of day to do the other stuff’. Others pointed to the lack of resources—people and money—to deliver objectives on health inequalities. An NHS leader in ICS A described the risk ‘that the secondary care hospital sector sucks every possible penny of growth’.

But the approach of national policymakers was also identified as a major factor shaping local priorities and behaviour. Despite the presence of health inequalities in national policy documents, local leaders frequently described how the overriding focus from national NHS bodies and politicians was on holding ICSs to account for NHS performance—a focus that appeared to be increasing:

‘I don’t think I’ve had a conversation on health inequalities or population health with NHS England since we’ve been in existence, but I’d need more than my fingers and toes to count the number of conversations I’ve had on ambulance handover. We’re really being driven to be focused on optimising the existing system’s delivery.’

—NHS leader, ICS A.

‘I mean, the chair of the ICS, [name], I think is fine. I think [they] gets it but, of course, you know, the way the NHS, because they’re part of the NHS, the NHS is the NHS, so, they call the chiefs and chief executives in and berate them for their performance on ambulances. You know what I mean? That’s the top of the priority. I don’t know if they even talk at these meetings about inequalities, you know? It’s all about performance.’

—Local authority leader, ICS B.

‘I cannot explain in seven weeks, eight weeks, how much their focus has changed, it’s unbelievable. It’s almost as if, if you came into one job as an ICB chief exec, and you’ve got another job now, which is basically being the chief operating officer for the system, and that is the absolute focus from them, you know. So I’m on, you know, regular phone calls with them about those short-term issues, whether

it's private care access, ambulance turnaround times, 104 week wait, 78 week waits, cancer waiting times. That is the absolute focus.'

—NHS leader, ICS B.

DISCUSSION

We analysed local interpretations of national health inequalities objectives in three more socioeconomically deprived ICSs in England. Overall, we found local interpretations of policy objectives on health inequalities varied, and local leaders had contrasting—sometimes conflicting—perceptions of the boundaries of ICS action. Translating national objectives into local priorities was often a challenge, and clarity from national policymakers was frequently perceived as limited or lacking. Across the three ICSs, local leaders worried that objectives on reducing health inequalities were being crowded out by other policy priorities, such as pressures on NHS hospitals. The behaviour of national policymakers appeared to undermine their stated priorities on reducing health inequalities.

Vagueness in NHS policy on health inequalities is nothing new. National NHS bodies in England committed to stronger action to reduce health inequalities in 2019,^{26,27} but lacked a systematic approach to achieving it³¹ and expected local leaders—early versions of ICSs—to develop their own approaches. Olivera et al analysed the local plans that followed and found health inequalities were conceptualized vaguely and inconsistently, echoing the broader vagueness in national NHS policy.³⁰ In 2012, Warwick-Giles et al found that the NHS's new clinical commissioning groups—organizations established to purchase local health services under the Lansley reforms in 2012, before being scrapped under the latest round of NHS reforms in 2022—were unclear on their duties to tackle health inequalities, and suffered from limited guidance from national policymakers.⁴⁹ Looking further back, Exworthy and Powell found similarly 'muddy' NHS objectives on health inequalities in the 1990s and 2000s.²⁹ This is, perhaps, unsurprising. How local agencies 'translate' national policy in their own context is a central part of the policy process—and often an intentional policy feature.^{61,62,63} Varied understandings of concepts linked to health inequalities and their causes are widespread.^{64,32}

But lack of clarity among ICS leaders on health inequalities brings major risks. Health inequalities are complex and deeply rooted. Reducing them is challenging, but possible.^{65,66} Yet progress on reducing health inequalities will not happen unless national and local agencies take a coherent and systematic approach—including clarity on the 'problem' to be addressed, priorities and principles for action, and potential interventions at different levels.^{31,67,68,69} Without this, there is a risk of interventions being poorly targeted, conflict and confusion between local agencies, and broad strategies that fail to translate into action. Local leaders also risk being judged against measures they have limited power or resources to improve.⁷⁰ ICSs may even inadvertently widen inequalities—for instance, if some groups receive disproportionate attention, individual-level interventions are pursued without wider system-level changes, or efforts to tackle inequalities within ICSs are not matched with wider policy to reduce

inequalities between them.^{30,31,71,72} National NHS bodies have produced guidance for ICSs on reducing health inequalities, including priorities for ‘recovering’ services after covid-19 and the core20plus5 framework.^{15,16} But our research suggests that more clarity is needed to guide ICS action—including the respective roles of NHS-led ICBs and other partnership groups and bodies at a local level.

Some of these risks appeared to be playing out already in our research. A major unresolved tension among local leaders was differing perceptions of the boundary for ICS action on health inequalities—particularly how far the ICS should extend its focus beyond reducing health care inequalities (such as differences in access to health care) to address the broader social and economic conditions shaping health inequalities (such as housing conditions). Studies often report that health system leaders predominantly focus on individual-level interpretations of health inequalities—for instance, emphasizing individual risk factors for ill-health and the importance of improving access to services.³² Recent analysis of local health system plans in England, produced by early versions of ICSs, also found that areas tended to frame action on preventing ill-health and reducing health inequalities narrowly—for instance, focusing on individual behaviour change or better disease management.^{30,34}

Our research painted a more complex picture. Leaders from across professional groups—including the NHS, public health, and social care—held varied views about ICSs’ remit on health inequalities. NHS leaders often emphasized social and economic factors, like poverty or housing, as key drivers of health inequalities to be tackled by the ICS. Yet several local authority leaders were concerned about the NHS misunderstanding its role and focus—for instance, NHS leaders ‘discovering’ health inequalities and social determinants of health but failing to sufficiently recognize their primary role in tackling the health care inequalities more firmly within the NHS’s control. Unclear or unrealistic aims, competing agendas, and failure to understand other organizations’ expertise can all hold back partnership working.⁵⁶ NHS reforms in 2012 transferred public health functions out of the NHS and into local government.^{73,74} Yet the complex structure of England’s new ICSs—each made up of several overlapping partnership bodies, including an NHS-led agency coupled with a broader partnership of local organizations—risks causing confusion.⁷⁵ There are also broader risks from greater NHS action on social determinants of health, such as medicalizing poverty and other social issues (for instance, by framing structural social issues as problems that can be diagnosed and treated by clinicians) and inefficient allocation of resources to address them.^{71,76} Future research should explore this tension further and how the framing of NHS plans on health inequalities may be shifting.

Finally, our research highlights how ICS objectives on reducing health inequalities are being crowded out by higher profile policy objectives, such as reducing pressure on acute hospitals and improving ambulance performance. Pressures on the NHS are extreme: by September 2023, the waiting list for routine hospital treatment in England had reached almost 8 million—the highest since records began—and 28% of people attending emergency departments waited more than four hours to be

seen.⁷⁷ Evidence from a long line of policy initiatives in England tells us that broader goals on improving health and reducing inequalities often fade as pressures on NHS services and finances increase.^{78,37} Despite rhetoric about long-term policy, national NHS bodies and government frequently focus on ‘hard’ targets (like the size of waiting lists) and short-term political priorities instead.^{37,55,79} Our research suggests the same phenomenon was happening to ICSs almost as soon as they were introduced. This represents a repeated failure among national policymakers to learn from past policy.

Limitations

Our study has several limitations. First, we focused on gaining in-depth insights from three ICSs (out of 42 in total), so our findings represent the specific experiences of leaders in these case study sites rather than general experiences of ICSs across England. However, our structured sampling approach meant we were able to target ICSs with varied characteristics all experiencing high levels of socioeconomic deprivation. Leaders in these ICSs are likely to be particularly aware of their role in reducing health inequalities—and our findings are likely to have strong relevance to ICSs serving similar populations. The findings are also relevant to national policymakers targeting efforts to reduce health inequalities at more socioeconomically deprived groups.¹⁵

Second, our interviews focused on senior leaders in ICSs. This meant we were able to understand the high-level perspectives of the most senior leaders responsible for overseeing and directing the ICSs work on health inequalities. Our sample included a diverse mix of leaders from NHS providers, ICBs, local authorities, and other community-based groups. But our research does not focus on the perspectives of people directly providing services or patients and service users experiencing inequalities.

Third, we carried out our fieldwork between August and December 2022—early in the evolution of ICSs (formally established in July 2022). This allowed us to understand leaders’ perspectives as they developed their system’s plans, and—in some cases—new teams to deliver them. But it also means our research represents leaders’ initial interpretations of policy objectives on health inequalities—interpretations that are likely to evolve. That said, ICSs have existed informally for several years^{55,51,75} and national policy initiatives over decades have encouraged local partnerships on health inequalities.⁴

CONCLUSION

Reforms to the NHS in England established 42 integrated care systems responsible for planning and coordinating local health and care services. The changes are based on the idea that cross-sector collaboration is needed to improve health and reduce health inequalities—and similar policy changes are happening elsewhere in the UK and internationally. We used qualitative methods to explore local interpretations of national policy objectives on health inequalities in England among senior leaders working in three ICSs—including from the NHS, social care, public health, and community-based organizations. Local leaders had varying interpretations of national policy objectives and different

views on the boundaries for ICS action. Clarity from national policymakers was frequently perceived as limited or lacking. Across all three ICS areas, local leaders were concerned that objectives on reducing health inequalities were being crowded out by other policy priorities. Our findings have implications for policy and practice—including the need for greater conceptual clarity as ICSs and other national policies encouraging cross-sector collaboration to reduce health inequalities evolve.

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CHAPTER 7

Cross-sector collaboration to reduce health inequalities: a qualitative study of local collaboration between health care, social services, and other sectors under health system reforms in England

Published papers

This chapter is the final accepted version of the following published paper:

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SECTION A – Student Details

Student ID Number	1806276	Title	Mr
First Name(s)	Hugh		
Surname/Family Name	Alderwick		
Thesis Title	A cure for everything and nothing? Local cross-sector collaboration and health inequalities in England		
Primary Supervisor	Nicholas Mays		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

Where was the work published?	BMC Public Health https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-024-20089-5		
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SECTION D – Multi-authored work

<p>For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)</p>	<p>HA worked with his supervisors, NM and AH, to identify the research question and lead the design and development of the study. HA carried out the interviews with ICS leaders. HA, NM and AH reviewed interview transcripts, identified themes in the data, developed the code structure and interpreted the data. HA coded and analysed all interview transcripts. HA wrote the first draft of the manuscript and incorporated comments from AH and NM. All authors read and approved the final manuscript.</p>
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SECTION E

Student Signature	Hugh Alderwick
Date	07/11/2024

Supervisor Signature	Nicholas Mays
Date	10/11/2024

TITLE

Cross-sector collaboration to reduce health inequalities: a qualitative study of local collaboration between health care, social services, and other sectors under health system reforms in England

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ABSTRACT

Background: Policymakers across countries promote cross-sector collaboration as a route to improving health and health equity. In England, major health system reforms in 2022 established 42 integrated care systems (ICSs)—area-based partnerships between health care, social care, public health, and other sectors—to plan and coordinate local services. ICSs cover the whole of England and have been given explicit policy objectives to reduce health inequalities, alongside other national priorities.

Methods: We used qualitative methods to understand how local health care and social services organizations are collaborating to reduce health inequalities under England's reforms. We conducted in-depth interviews between August and December 2022—soon after the reforms were implemented—with 32 senior leaders from NHS, social care, public health, and community-based organizations in three ICSs experiencing high levels of socioeconomic deprivation. We used a framework based on international evidence on cross-sector collaboration to help analyse the data.

Results: Leaders described strong commitment to working together to reduce health inequalities, but faced a combination of conceptual, cultural, capacity, and other challenges in doing so. A mix of factors shaped local collaboration—from how national policy aims are defined and understood, to the resources and relationships among local organizations to deliver them. These factors interact and have varying influence. The national policy context played a dominant role in shaping local collaboration experiences—frequently making it harder not easier. Organizational restructuring to establish ICSs also caused major disruption, with unintended effects on the partnership working it aimed to promote.

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Conclusions: The major influences on cross-sector collaboration in England mirror key areas identified in international research, offering opportunities for learning between countries. But our data highlight the pervasive—frequently perverse—influence of national policy on local collaboration in England. National policymakers risked undermining their own reforms. Closer alignment between policy, process, and resources to reduce health inequalities is likely needed to avoid policy failure as ICSs evolve.

Keywords: Health Policy, Intersectoral Collaboration, Health Care Reform, Health Inequalities, Qualitative Research

BACKGROUND

Cross-sector collaboration between health care, social services, and other sectors is widely promoted as a route to improving population health.^{1,2,3} The idea is that coordinated action is needed to tackle complex health challenges that extend beyond organizational boundaries, such as preventing obesity or improving services for people with multiple health and social care needs. In England, policymakers recently overhauled the structure of the NHS to embed cross-sector collaboration at a local level.^{4,5} Since July 2022, England’s NHS has been formally divided into 42 integrated care systems (ICSs)—area-based partnerships between the NHS, social care, public health, and other agencies, covering populations of around 500,000 to 3 million—responsible for planning and coordinating local services to improve health and care.⁶ Similar policies are being pursued in other UK countries and internationally.^{7,8} For example, in the US, federal policymakers are testing Accountable Health Communities to join up health care and social services,⁹ while state Medicaid reforms in Oregon, Washington, and elsewhere focus on developing regional cross-sector partnerships to improve health and health equity.^{10,11}

A major aim of England’s new ICSs is to reduce health inequalities. ICSs have been given four ‘core purposes’ by national policymakers, including to ‘tackle inequalities in outcomes, experience, and access’.¹² NHS leaders have identified broad priorities to guide ICS action, such as target groups for interventions to reduce health care inequalities,^{13,14} and provided modest additional funding to support local efforts.¹⁵ But the task facing ICSs is substantial: inequalities in health outcomes between richer and poorer areas in England are wide,^{16,17} and there are persistent gaps in access to high quality health care.^{18,19,20} Local government agencies in England—responsible for social care, public health, and other services that influence health—have faced deep cuts since 2010, with funding falling furthest in poorer areas.^{21,22,23} ICSs are also expected to deliver other high-profile policy objectives, including improving quality and efficiency in the NHS and reducing long waiting lists for hospital treatment.^{12,24}

Making cross-sector collaboration work has proved a persistent challenge. ICSs build on a long history of policies encouraging local collaboration to improve health and reduce health inequalities in England.²⁵ Local health partnerships have been developed in diverse national contexts for decades—

including in Europe, North America, and elsewhere.^{26,27,28} Yet there is little high quality evidence to suggest that collaboration between local health care and non-health care agencies improves health or health equity.²⁹ Meanwhile, a large body of evidence describes the mix of factors that can hold back effective collaboration—including competing organizational agendas, resource gaps, communication issues, power imbalances, and more.²⁹ To make things harder, policy initiatives to tackle health inequalities are frequently ambiguous, underfunded, and undermined by other short-term political objectives.^{30,31,32,33}

Whether England's new ICSs can overcome these challenges and meet policymakers' expectations is yet to be seen. ICSs have existed informally for several years, but only recently gained formal powers from central government. Each ICS is made up of a new NHS body and wider committee of NHS, local government, and other agencies. Studies have focused on the emergence of ICSs prior to their formal establishment in 2022, including analysis of early ICS plans and planning processes,^{34,35,36} experiences during the pandemic,^{37,38} and evolving governance and decision-making processes.^{39,40} Olivera et al analysed early ICS plans and found vague and inconsistent conceptualization of health inequalities, and lack of commitment to concrete action.³⁴ Our previous research focused on ICS interpretations of policy aims on health inequalities.⁴¹ But in-depth understanding of how ICSs are collaborating to reduce health inequalities is lacking—as is data on the implementation of ICSs since the 2022 reforms. We conducted qualitative research with senior NHS, public health, social care, and other leaders in three more socioeconomically deprived ICSs to understand local experiences of collaboration to reduce health inequalities in England. We focus on how the NHS is working with other sectors beyond health care to reduce health inequalities, and analyse factors shaping cross-sector collaboration across key domains identified in the international literature.²⁹ We use theory on public policy implementation to help interpret the results, drawing on Exworthy and Powell's concept of 'policy streams' and their alignment at multiple levels.^{42,43,44} Our findings can inform future policy on cross-sector collaboration to improve health and reduce health inequalities in England and beyond.

APPROACH AND METHODS

Study design and sample

We conducted a qualitative study of how local health care and social services organizations are collaborating to reduce health inequalities under NHS reforms in England. Our sample included 32 leaders from NHS, social care, public health, and community-based organizations in three ICSs.

We identified a purposive sample of ICSs with varied characteristics all experiencing high levels of socioeconomic deprivation (defined using the index of multiple deprivation—an official measure of relative deprivation for small areas in England that combines a mix of data on income, employment, education and skills, health, crime, barriers to housing and services, and living environments). To do this, we collated publicly available data on the characteristics of England's 42 ICSs,⁶ including their

geography, population size and deprivation, organizational complexity, and policy context (box 1). We selected these characteristics because of evidence on their likely role in shaping how health care and other organizations in ICSs work together to reduce health inequalities.^{6,29} For example, differences in organizational governance and decision-making can hold back effective collaboration,²⁹ and these challenges may be exacerbated when a greater number of organizations are involved in local partnerships.³² We used these data to identify a sub-group of ICSs experiencing the highest concentration of socioeconomic deprivation relative to other ICSs in England (the top tercile of ICSs with the highest concentration of local areas in the most deprived 20% of areas nationally). National NHS bodies are aiming to reduce health inequalities by targeting efforts on the most deprived population groups (the 20% most deprived of the population).¹³ ICS leaders in these areas are likely to be particularly aware of their role in reducing health inequalities, and ICSs with similar levels of socioeconomic deprivation may pursue some common approaches. Understanding the experiences of ICSs in these areas is therefore important to inform policy and practice in England.

Within this sub-group of high deprivation areas, we identified three ICSs that varied in population size (which is strongly correlated with organizational complexity), geographical region, rurality, and recent policy context—for example, by avoiding selecting all three sites from the same region of England, or with a similar policy context and history of cross-sector collaboration. This gave us a relatively heterogenous mix of three ICSs all serving more socioeconomically deprived populations in England (table 1). ICS leaders from the three areas we selected all agreed to participate in the study.

Box 1. ICS characteristics used to guide case study sampling

For each of England's 42 ICSs, we collated data on⁶:

- Socioeconomic deprivation—the proportion of lower super output areas (LSOAs) in the most deprived 20% of areas nationally, using index of multiple deprivation (IMD) ranks
 - Geographical context—including NHS region and proportion of rural/urban areas
 - Population size—the NHS registered population
 - Organizational complexity—including the number of NHS trusts and upper tier local authorities
 - Policy context—including the number of sites involved in relevant recent policy initiatives within the ICS (new care model ‘vanguards’⁴⁵ and integrated care and support ‘pioneers’⁴⁶) and date the early version of the ICS was created (NHS England established ICSs in ‘waves’ based on their perceived maturity,⁴⁷ before all ICSs were formally established under legislation in July 2022).
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Table 1. Selected case study characteristics compared to all ICSs

	Socioeconomic deprivation	Geographical context	Population size	Policy context
ICS A	High	Mixed	Large	Earlier ICS wave, high involvement in relevant policy initiatives
ICS B	High	Urban	Medium	Later ICS wave, moderate involvement in relevant policy initiatives
ICS C	High	Urban	Large	Later ICS wave, high involvement in relevant policy initiatives

Notes. For socioeconomic deprivation, we defined ‘high’ deprivation as the top tercile of ICSs with the highest concentration of local areas in the most deprived 20% of areas nationally. For geographical context, we divided ICSs into terciles based on the proportion of local areas in each ICS classified as urban by the Office of National Statistics. We defined ICSs in the middle tercile as ‘mixed’ (74-87% urban areas), and ICSs in the top tercile ‘urban’ (87-100% urban areas). For population size, we divided ICSs into terciles based on their NHS registered population. We defined ICSs in the middle tercile as ‘medium’ (1.1m-1.7m), and ICSs in the top tercile ‘large’ (1.7m-3.1m).

ICSs are complex systems involving various organizations and organizational partnerships. The NHS’s new ICSs are themselves made up of two linked bodies: integrated care boards (ICBs—area-based NHS agencies responsible for controlling most NHS resources to improve health and care for the ICS population), and integrated care partnerships (ICPs—looser collaborations between NHS, local government, and other agencies, responsible for developing an integrated care plan to guide local decisions, including those of the ICB). ICSs are expected to deliver their objectives through the work of both bodies and other local agencies.^{12,48} This includes additional local partnerships between the NHS, local authorities, and other relevant organizations at a ‘place’ level within each ICS—smaller geographical units, often based around local authority boundaries (most ICSs include multiple local authority areas). NHS England and other national bodies are responsible for overseeing and managing the performance of ICSs—for instance, by setting targets, monitoring progress, and assessing performance. Over recent decades, the approach of national NHS bodies to driving improvement in the health system has typically relied on top-down targets and performance management.^{49,50} More broadly, the English NHS is a centralized health system with strong political

involvement.⁸ In our research, we focused on overall experiences of collaboration on health inequalities across the ICS, including the relationship between action at different geographical levels.

In each ICS, we carried out in-depth interviews with senior leaders of NHS, local government, and other organizations involved in the ICS’s work on health inequalities. This included leaders from NHS ICBs (such as ICB chief executives and directors of strategy), NHS providers (such as NHS Trust chief executives and general practitioners), local authorities (such as directors of public health and adult social care), and other community-based organizations (such as leaders of charities working with the ICS to represent community interests or provide services)—as well as those involved in the day-to-day management of the ICS’s work on health inequalities. Participants were identified through web-based research and snowball sampling,⁵¹ and contacted via email. Our sample included 17 leaders from the NHS (including those working in the NHS’s new ICBs) and 15 from public health, social care, and other sectors outside the NHS (table 2). We describe all participants as ‘leaders’ when reporting the results.

Table 2. Interviewee sectors

	NHS		Other sectors			<i>Total</i>
	ICB	Provider	Public health	Social care	Community	
ICS A	3	2	2	1	0	8
ICS B	3	1	2	2	1	9
ICS C	4	4	3	2	2	15
<i>Total</i>	10	7	7	5	3	32

Data collection and analysis

We used a semi-structured interview guide with questions on ICS aims and priorities, how ICS work on health inequalities is being led and managed, and factors shaping the experience of collaboration between the NHS and other sectors to reduce health inequalities (appendix 2). The interview guide was designed to gain a broad understanding of the early development of ICS work on health inequalities, and was informed by our analysis of national policy on ICSs and existing literature on cross-sector collaboration.²⁹ Interviews were carried out online, lasted an average of 44 minutes, and took place between August and December 2022—soon after ICSs were formally introduced across England. One researcher (HA) carried out one interview with each research participant individually. All interviews were audio recorded, professionally transcribed, and anonymized at the point of transcription. Field notes were also made during the interviews. We asked interviewees to share relevant documents (such as draft ICS plans or papers describing relevant local initiatives) when they

referred to them in their responses. Participants did not review interview transcripts or feed back on research findings.

We analyzed the data using the constant comparative method of qualitative analysis.⁵¹ We reviewed the transcripts line by line to identify themes in the data and refined these themes iteratively as new concepts emerged. All authors (HA, NM, AH) reviewed a sample of the transcripts and worked collaboratively to develop the code structure. One author (HA) then analyzed all transcripts and the authors met regularly to discuss interpretation of the data and any changes to the coding framework. We used an integrated approach⁵² to develop the code structure based on the themes identified in the data and broader evidence on factors shaping local collaboration between health care and non-health care organizations. Our recent umbrella review identified a mix of factors shaping cross-sector collaboration in five domains (box 2).²⁹ We used these domains as a conceptual framework to organize our analysis and help interpret the data. For example, our analysis identified cultural differences between the NHS and other sectors as a barrier to local collaboration, which we grouped alongside other factors linked to the broader theme of culture and relationships—one of the five domains identified in the literature. We used NVivo (release 1.3) to facilitate our analysis of the data. Where relevant, we accessed publicly available documents on ICS initiatives to cross-check examples mentioned by our interviewees. More detailed analysis of study data on local conceptualizations of national policy on health inequalities is reported elsewhere,⁴¹ while this paper focuses on the overall research findings.

Box 2. Factors shaping cross-sector collaboration identified in the international literature

A recent umbrella review synthesized evidence on collaborations between local health care and non-health care organizations and factors shaping how they function. The review included 36 studies (reviews) with evidence on varying forms of collaboration in diverse contexts: some included data on large organizational collaborations with broad population health goals, such as preventing disease and reducing health inequalities; others focused on collaborations with a narrower scope and focus, such as better integration between health and social care services. The study included data from the UK, US, and other countries and points to a mix of dominant factors in five interrelated domains:

- *Motivation and purpose*—such as vision, aims, perceived impacts, and commitment to collaboration. For example, unclear aims or lack of commitment can hold back collaboration
- *Relationships and cultures*—such as trust, values, professional cultures, and communication. For example, shared values and history of joint working can help organizations collaborate
- *Resources and capabilities*—such as funding, staff, and skills, and how these resources are distributed. For example, lack of resources is commonly identified as a barrier to collaboration

- *Governance and leadership*—such as decision-making, accountability, engagement, and involvement. For example, clarity on accountability is thought to help collaborations function
- *External factors*—such as national policy, politics, and broader institutional contexts. For example, national policy changes can conflict with local priorities or disrupt existing relationships

RESULTS

We identified a combination of factors shaping local collaboration between the NHS and other sectors to reduce health inequalities, spanning the five domains identified in the international literature (figure 1). These factors interact and have varying influence—and the national policy context in England played a dominant role in shaping local collaboration experiences across all five domains (table 3).

Figure 1. Factors shaping cross-sector collaboration on health inequalities, and example interactions

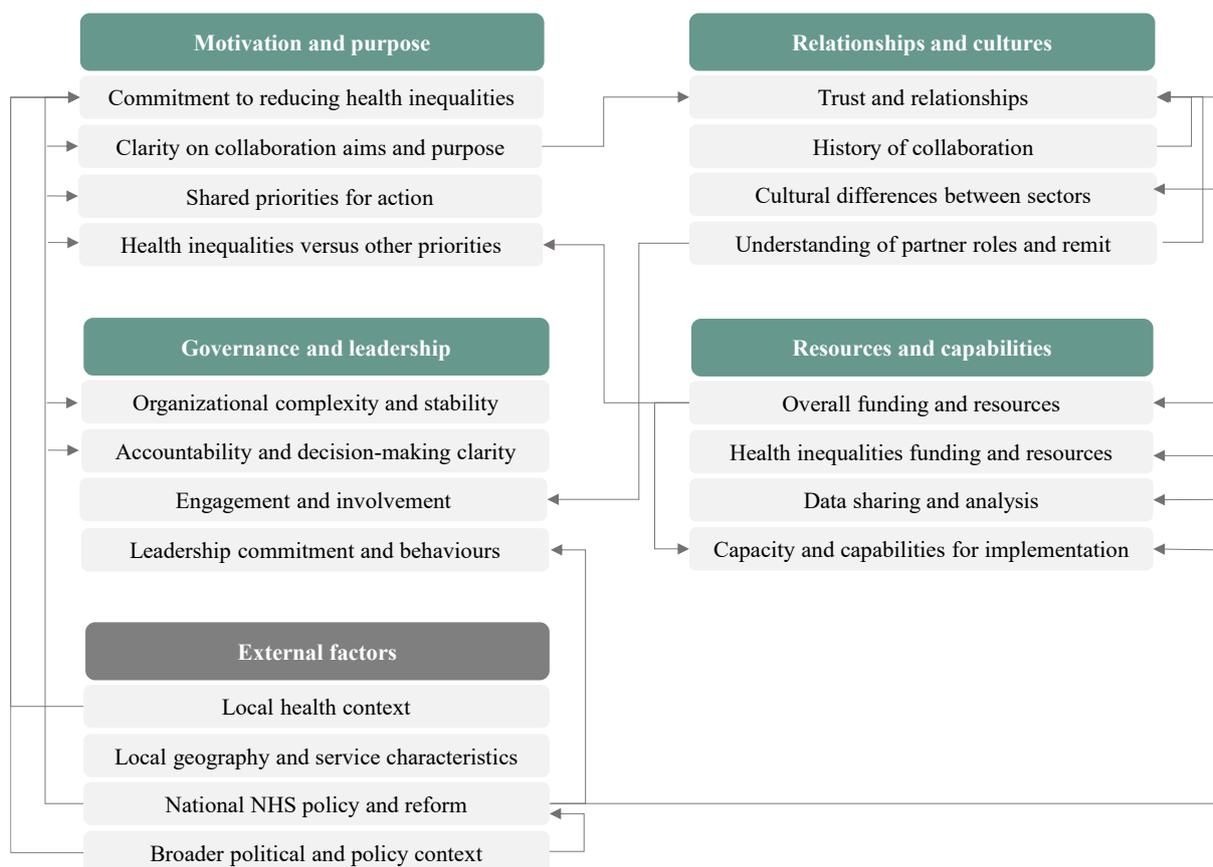


Table 3. Examples of the dominant role of national policy in shaping local collaboration experiences

Domain	Influence of national policy
<i>Motivation and purpose</i>	<ul style="list-style-type: none"> - ICSs given explicit policy objectives to reduce health inequalities - Vague national policy guidance contributes to lack of clarity on ICS aims and purpose - Overriding focus of national NHS bodies on other short-term policy priorities
<i>Governance and leadership</i>	<ul style="list-style-type: none"> - Formal governance framework for ICSs defined by national policymakers - National accountability differences between NHS and local government creates tension - NHS restructuring causes organizational upheaval and leadership turnover
<i>Relationships and cultures</i>	<ul style="list-style-type: none"> - NHS restructuring destabilizes local relationships and existing partnerships - Top-down, hierarchical approach of national NHS bodies can cause local conflict - Frequency of reform contributes to fatalism and scepticism about local partnerships
<i>Resources and capabilities</i>	<ul style="list-style-type: none"> - Insufficient funding and resources can hold back what local partnerships can deliver - Short-term and limited health inequalities funding can constrain effective investment - NHS restructuring can create capacity or capability gaps and divert local resources

Motivation and purpose

Interviewees generally described strong commitment among local leaders to work together to reduce health inequalities. The scale of the health challenges facing their community—exacerbated by the covid-19 pandemic and cost of living crisis—was often identified as a unifying force. For example:

‘Honestly, in [ICS A], we’re absolutely at the bloody table. I guess that’s the thing. I don’t care what agency you’re from. For us up here, it is unjust that our population is suffering so much.’

—Regional public health leader, ICS A.

‘So there’s a collective will because of what we’re facing—particularly, I think, exacerbated by the cost of living crisis’

—ICS leader, ICS B.

But this high-level commitment did not necessarily translate into shared priorities for action. Leaders’ interpretations of national policy objectives on health inequalities varied—both within and between ICS areas. Perceptions of the ICSs’ role in tackling health inequalities varied too, with leaders articulating different views on how far the ICS—and NHS agencies within them—should extend their focus beyond reducing health care inequalities (such as differences in access to care) to address the broader social and economic conditions shaping health inequalities (such as poor housing conditions).

The result was often lack of clarity. Some leaders could point to broad objectives for their ICS on reducing health inequalities, such as reducing gaps in healthy life expectancy or improving care for

specific population groups. Leaders often described how reducing health inequalities should be a cross-cutting objective throughout their ICS plans ('it literally runs through everything, doesn't it, this health inequalities work'). But others felt their ICS's priorities on health inequalities were vague ('I haven't heard anything specific') or under construction ('a work in progress')—and several said they were struggling to know where to start. For example, an ICS leader in ICS C described how: 'well, it's massively complex, it's kind of in everything [...], so how do you, kind of—and it's so entrenched as well, and so multifactorial—how do you start to make headway?'. National policy guidance often contributed to this lack of clarity (*see external context*). Vague and varied perceptions of ICSs' role also created potential for conflict between sectors (*see relationships and cultures*).

'Crowding out' health inequalities

A widespread challenge was prioritizing work on health inequalities. Despite local leaders' strong motivation to reduce health inequalities, interviewees in every ICS described how short-term pressures in the NHS and social care, such as long waiting times for ambulances and hospital care, risked dominating the agenda. These short-term pressures tended to have a 'crowding out' effect:

'If you think about the kind of health inequalities piece, it's up there but it gets drowned out in the day to day'

—ICS leader, ICS A.

'So trying to get airtime at the same time as there being queues of ambulances outside the door, to take one example, it's quite tricky [...]. So there's a great deal of lip service played to inequalities but forcing that into concrete action is often more difficult when the environment is so noisy.'

—NHS provider leader, ICS C.

'This is just one more priority amongst all of the other priorities in an environment where there is not enough money or people or stability. [...] If you look at the pressure the NHS particularly is under in terms of the urgent emergency care, hospital discharges, ambulance waits... you know, it's harsh.'

—Local authority social care leader, ICS B.

Beyond short-term pressures, leaders pointed to a mix of other factors contributing to this crowding out effect, including insufficient resources (*see resources and capabilities*), the behaviour and focus of national policymakers, and organizational restructuring and uncertainty (*see external context*).

Governance and leadership

In all three ICSs, structures for governing and managing local work on health inequalities were still being developed. Establishing ICSs involved forming new NHS organizations, partnership committees, and decision-making processes—and often meant substantial upheaval. ICS leaders were seeking to do this in a complex organizational environment, involving multiple agencies (such as NHS providers and local authorities) and existing partnership bodies (such as Health and Wellbeing

Boards, which bring together local authorities, NHS organizations, and other services to develop local health strategies). This required careful navigation. For instance, a leader in ICS A described how:

'I have resisted the temptation to dive straight in, to say this is ICS or ICB led, because, actually, our local authorities have been at health inequalities for bloody decades. And we need to be really careful not to disrupt that ecosystem in an unhelpful way and alienate. So [...] we're working together at the moment to figure out how best we do this.'

—ICS leader, ICS A.

Meantime, interviewees frequently described being unclear about how and where decisions related to health inequalities would be made. Some pointed to practical challenges making decisions in new ICS structures. For example, a leader in ICS A described how there were more than 50 people on their new integrated care partnership committee; 'I mean, we can't even be round a table, we have to meet cabaret-style. It's really, really tricky.' Some worried that their new partnership committee would lack 'teeth', with real power held by the NHS-led ICB ('the health lot are going to steamroller them'). But a bigger challenge was defining the right balance of power and decision-making between different geographical levels in each ICS—particularly between 'systems' (across the whole ICS) and 'places' (smaller area-based partnerships within them, typically organized around local authority boundaries).

Place versus system

This tension was playing out in all three ICSs. Leaders across sectors emphasized the importance of place-level action on health inequalities—for instance, given the public health expertise in local government, longstanding local partnerships (such as Health and Wellbeing Boards), and close links with community-based groups at this more local level. Local authority leaders frequently highlighted that their primary focus and accountability lay locally too. For instance, a local authority public health leader in ICS C said: 'to be honest, our accountability is to our local residents, and, whether ICB or ICP likes it or not, [...] the decisions are made by the local politicians, not the ICS. We're not accountable to the NHS.' Interviewees also stressed that differences in context within ICSs, which span varied geographical areas and diverse populations, meant place-level approaches were essential to effectively address health inequalities. A local authority public health leader in ICS B described how 'the [ICS B] big broad-brush picture actually doesn't represent what [place X] looks like.'

Views on where this left system-wide action across the ICS varied. Leaders in ICS A, for example, talked about ensuring the ICS was 'enabling, not dictating' to local areas, at the same time as identifying issues where the ICS can 'can do once and do better' than places acting alone. In ICS C, ICS leaders described plans to develop the ICS's capabilities to support local action on health inequalities—including data analytics, training and development, and communities of practice to identify and spread promising interventions—and suggested this might involve using a greater proportion of their NHS funding allocation for the ICS on system-wide initiatives in future. For some,

ICSs also represented an opportunity to reallocate resources between areas—for instance, between more and less socioeconomically deprived ‘places’ in the ICS—to help address health inequalities.

Yet leaders frequently identified the tension between systems and places as a barrier to progress:

‘Because we haven’t got this clear demarcation yet between “this is [ICS C] wide, this is [...] place”, there’s a lot of, like, to’ing and fro’ing and duplication in the system [...]. I feel like the fact that they still haven’t worked out this [ICS C]-local split is a massive barrier.’

—Local authority social care leader, ICS C.

‘One of the barriers at times can be what I call the push-pull between place and system’

—ICS leader, ICS A.

For some organizations, such as large NHS hospital providers—often spanning multiple places, and sometimes spanning multiple ICSs—this tension was having an impact on service planning:

‘We want to be raising equality in maternity services that we provide. The different boroughs may want to have different maternity services and different ways of delivering maternity services, and actually the tension therefore is how do we, as a large bureaucratic organisation with enormous overheads, deliver a flexible enough service that meets the needs across those [X] different boroughs, when the needs are actually quite diverse. [...] That’s something that we are literally scratching our heads over.’

—NHS provider leader, ICS C.

Engagement and involvement

At all levels of the system, leaders described the importance of engaging the right individuals and organizations to make progress on health inequalities. For example, a leader in ICS A described ‘this constant round of work that we need to do, [...] going back and checking with local places, constant engagement with our local authority chief executives, informing them of what we’re doing, keeping them happy so they can keep their politicians happy.’ This included engagement with groups outside the public sector. A leader in ICS C, for instance, talked about how they were designing their ICS governance to ensure involvement of people using services, so ‘we have as many service users with decision making voices around the table as the statutory sector’. In some areas, this appeared to be making a difference. For example, a local authority social care leader in ICS A said: ‘I’ve never known social care to be as actively pulled into this as we are currently. [...] We’re delighted’.

But not all interviewees felt meaningfully involved in their ICS’s work. A local authority public health leader in ICS C, for example, talked about being invited to a series of ICS workshops by NHS leaders, but said ‘it’s like a tick-box; [...] it’s engagement for the sake of it, rather than true engagement’. Leaders from community-based organizations in two ICSs described challenges engaging GPs and other NHS staff in their work—even when it was commissioned by NHS agencies.

One said: ‘there are people who really should be speaking to us and should be having to speak to us who have just, you know, been really hard to pin down’. For some, a lack of understanding among NHS leaders of work in other sectors was one factor holding back effective involvement (*see* cultures and relationships). Lack of time and resources was another barrier (*see* resources and capabilities). For example, a local authority public health leader involved in developing ICS plans described how ‘you cannot co-design in a meaningful way a strategy between July and December with no funding’.

Leadership

Across sectors, interviewees in all ICSs emphasized the importance of senior leadership in enabling collaboration—for instance, by articulating the importance of tackling health inequalities and bringing local organizations together to do it. Different kinds of leaders appeared to matter in different sectors, such as clinical leaders in the NHS and political leaders in local authorities. The skills and experience of local authority Directors of Public Health and other public health leaders were often recognized as important within ICSs, including in bridging gaps between organizations and sectors (*see* resources and capabilities). On the flipside, leadership turnover—sometimes a direct result of organizational restructuring to establish ICSs (*see* external context)—was identified as a barrier to effective joint working. Beyond individual roles, interviewees emphasized the importance of ‘system leadership’—for instance, leaders across sectors making joint decisions—for collaboration to work. For one ICS leader, this meant ‘being humble in the NHS and knowing... it's almost, where do you play the leadership, the intellectual capacity, in the health and care leadership? [...] For me, the intellectual capacity that deals with this most effectively is often in local government, not in health’. But leadership behaviours did not always match this approach in practice (*see* relationships and cultures).

Relationships and cultures

Whatever formal governance structures were emerging in ICSs, interviewees consistently described how trust and strong relationships between leaders and organizations were needed to make progress:

‘You can sit four people in a room from organisations, but if they have no knowledge of each other, don't trust and respect each other, you can have any memorandum of agreement, whatever you like, it's not going to work. You need humans with history, with respect, with trust.’

—Primary care leader, ICS A.

Leaders pointed to a mix of factors that could foster these kinds of relationships, including shared aims, open communication, understanding of each others’ organizations, a positive history of joint working, and more. Leaders also often stressed that strong relationships take time and effort to develop. In some areas, interviewees thought relationships between leaders and organizations were already strong—particularly at a ‘place’ level and where organizations and leaders had a long track record of collaboration. The covid-19 response—often involving partnership working between the NHS, local authorities, and various community groups—was frequently thought to have strengthened

local relationships, providing a platform for future collaboration. For example, an NHS provider leader in ICS C described how ‘relationships were built because of the need driven by covid, and we’re kind of just re-warming up those relationships to face this year’s pandemic, which is the cost of living crisis’.

But relationships were not strong everywhere. For some interviewees, motivation to collaborate among organizational leaders was not always backed up with the behaviours needed to make it a reality. For example, an NHS provider leader in ICS B said that local leaders had ‘a shared understanding about why we’re here and what our priorities ought to be’, but ‘our relationships aren’t always great in the how we go about it’. For several interviewees, NHS leaders in particular needed to adapt their behaviour to make ICSs work—shifting from more competitive to collaborative leadership styles. For example, a local authority public health leader in ICS B described the lack of collaboration between local NHS providers, saying: ‘you go to the chief exec’s meeting and, you know, some of the time they’re barely civil to each other, sometimes they’re absolutely not civil to each other’.

Relationships could also be more challenging between ‘middle managers’ working on the detail of how services are funded or delivered between sectors—for instance, between NHS and local authority staff making decisions about funding services for people with complex health and social care needs.

In all ICSs, organizational restructuring to establish integrated care systems had harmed some local relationships (*see external context*). Leaders in local government and community-based organizations often talked about disruption of key relationships with the NHS—including loss of NHS staff from clinical commissioning groups (local NHS purchasing organizations that were abolished under the reforms to establish ICSs) with knowledge of their local context, not knowing who to go to for key NHS programs or issues, and having to establish relationships from scratch with new NHS staff.

Cultural differences

Differences in culture between the NHS and other sectors could also hold back collaboration. Leaders outside the NHS often talked about the NHS’s top-down, hierarchical culture, with a heavy focus on reporting upwards to national NHS bodies. This could skew ICSs’ focus towards high-profile national targets linked to hospitals. But it could also conflict with ways of working in other sectors—and often contributed to a perception that NHS organizations expected others to adapt to fit their needs:

‘I think the top-down approach to doing things that the NHS has is a barrier. They fixate on counting beans not things that are making a difference to people’s lives. [...] I’ve had several conversations with people in the NHS that NHS E[ngland] need to know this by four o’clock today. I’m like, “well, that’s really nice but I don’t work for NHS E[ngland], so I don’t care”. And they don’t get that way of working because local authorities don’t work that way. [...] There isn’t a national top-down thing on councils. [...] And to be able to do something quick and different on the ground when half of the

partnership have that—“we need to get permission, we need to make sure, and then we need to report it ten times”—is sometimes quite difficult.’

—Local authority social care leader, ICS C.

‘One function that we have to do within that [ICS health inequalities advisory group] is report on our progress on Core20PLUS5, because the NHS—and I’ve just been upfront with the DPHs [Directors of Public Health] and I just said, “look, the NHS is a top-down organisation, we’re different to you as local authorities, we will have to report our progress on the Core20PLUS5, so we just need to build that in, we just all need to accept that, that we’re going to have to do it.”’

—ICS leader, ICS A.

For some, lack of understanding among NHS leaders about how other sectors work exacerbated these challenges. Some local government leaders, for example, talked about the NHS not understanding the social care sector and the diverse range of services provided beyond care homes. A community-based organization leader in ICS C talked about being ‘horrified by the lack of understanding’ among NHS leaders about the voluntary and community-sector—including the assumption that the sector was just about people volunteering in the community rather than organizations contracted to deliver a wide mix of local services. But some interviewees talked more positively about a growing understanding in the NHS about the skills and capabilities of other sectors. A local authority leader in ICS B, for instance, talked about how the ‘ICS dynamic’ was helping shift understanding among NHS staff:

‘For a lot of NHS people, they’re actually seeing what local government can do in a really practical way. [...] So you can just see light bulbs going on when they go, “actually, gosh, there is someone here that can do this”. [...] They can just see, actually, we get there is another way of doing this that might be better than seeing it all through the prism of primary care, community services and, you know, big hospitals. So I do think there’s a cultural shift going on which could be really valuable’

—Local authority public health leader, ICS B.

‘Stepping on toes’

Varied perceptions of the role of ICSs in tackling health inequalities created tension. Perceptions varied within areas and professional groups (*see* motivation and purpose). But several leaders—particularly from local government—wanted their ICS to focus primarily on reducing health care inequalities, and were concerned about NHS leaders in integrated care boards and other organizations misinterpreting their role and focus. One public health leader in ICS C, for example, talked about a ‘misconception’ that the NHS is now responsible for solving poverty through ICSs. Another described how the ICS should be ‘absolutely focused on healthcare inequalities as its first and foremost responsibility. Get the inequalities within the NHS, what’s in their grasp. They’re not going to solve poverty at an ICS level.’ Several leaders described a caricatured dynamic where NHS leaders appear to have ‘discovered’ health inequalities, and—as an NHS provider leader in ICS C put it—‘public

health teams in particular just sort of go: “well, hello!?””. Leaders described a mix of potential negative effects of this dynamic, including the NHS ‘stepping on toes’, failing to acknowledge others’ skills and expertise, and alienating local authorities with a long history of action to reduce inequalities.

Resources and capabilities

Lack of funding and resources was consistently identified as a major barrier to local efforts to reduce health inequalities. Part of this was about general resource constraints across the NHS, local government, and other sectors holding back what the system could deliver. Leaders pointed to gaps in funding (‘don’t have the money’) and staff (‘don’t have the workforce’), as well as the capacity of existing staff to prioritize work on health inequalities. As a result, organizations often lacked capacity to plan or deliver new services and prioritized meeting short-term pressures on core services instead (*see motivation and purpose*):

‘There is no question that we’re under-resourced compared to the amount of stuff that we need to do.’
—ICS leader, ICS C.

‘I think the big elephant in the room is a lot of this does need local government delivery. And those budgets, you know, the cuts to local government funding have been eye watering.’
—Local authority public health leader, ICS B.

‘People just don’t have the mental or emotional bandwidth sometimes to engage with this stuff, because all of this work in inequalities and wider determinants is on top of everything else we were already doing’
—ICS leader, ICS A.

Interviewees also pointed to a lack of dedicated resources to support work on health inequalities. ICSs had been allocated modest additional funding by NHS England for health inequalities interventions—and some organizations had access to other funding for targeted local projects. Leaders welcomed the central funding and gave a mix of examples of how it was being used, including interventions on alcohol and drugs-related issues, grants to voluntary and community sector organizations for place-level projects, and community engagement. But the small sums provided and lack of certainty about whether they would be available to ICSs over the long-term were often identified as barriers to effective investment. More broadly, leaders pointed to how short-term funding pots—often with strings attached to each—could hold back the sustained and systemic changes needed to tackle inequalities:

‘The resources we have—£[X] billion for [ICS population size]—sounds like it’s a lot, but within that £[X] billion, when it arrives in our region, a lot of that is already spoken for. So a lot of that resource goes straight into secondary care contracts, and then the rest goes into our prescribing budgets,

commissioning ambulance services, mental health trust. So the actual discretionary spend for you to be innovative and to do things differently is very, very small.'

—NHS provider leader, ICS A.

'I think the key thing for us is the money runs out in March and we only really started to deliver in September, so it's, kind of like, "Oh my God, we've got this deadline in March". [...] And then, by the way, there's no money after March.'

—Community-based organization leader, ICS B.

'For us, it was very much billed as a one-off fund. And it was peanuts. You know, it translated into, kind of, broadly speaking about three quarters of a million to a million pounds between each area. A huge amount of energy, of, kind of, bureaucratic energy, went into that process because it's the, kind of, easy thing to do, to spend a bit of money on some new projects. But as we know, nothing is easier than spending a little bit of money on some new projects. System change is so, so, so much harder.'

—Local authority public health leader, ICS C.

Weak capacity in ICSs to lead work on health inequalities was often identified as a constraint too. Examples included teams and posts to focus on health inequalities not yet being recruited in ICBs, limited capacity for data analytics, and lack of resources for planning and engagement across sectors. The transition to ICSs and ongoing organizational restructuring in the NHS contributed to these staffing gaps (*see external context*). A senior manager for health inequalities in ICS B described how:

'When I went for interview, you know, one of the questions I asked was, "Is there a team?" And I was told, "yes, you know, there will be a team very quickly", but immediately it became apparent there wasn't one and it took a lot of hard work just to get one other person recruited and I had to go and identify an external pot of funds. [...] I mean, you know, this agenda is massive, so, it feels, since last May, just running, running, running, running [...] Given that health inequalities was supposed to be one out of the four main aims—reasons for existing—it didn't sit right.'

—ICS leader, ICS B.

In this context, key individuals were often thought to be crucial for driving cross-sector action on health inequalities. As well as senior organizational leaders (*see governance and leadership*), interviewees pointed to people able to bridge gaps between sectors—sometimes in jointly funded-posts between the NHS and local government—along with passionate clinicians and others making change happen in local services. In ICS A, public health specialists worked in several NHS trusts and led work on health inequalities, collaborating with local authorities and others. One described how 'it's helpful to have interlopers like myself, who basically just work for everyone, [...] who have got the permission to roam around the system and join things together and overcome some of those silos.'

Data sharing and analysis

Leaders consistently described how access to high-quality data, including data shared across sectors, was needed to tackle health inequalities—including to understand gaps in services and outcomes, design interventions to address them, track progress over time, and make the case for action with different groups. Leaders in all areas described efforts to use existing data to prioritize action on health inequalities. Organizations were developing various platforms and ‘dashboards’ to help do this, often stitching together a mix of data held locally to create a picture of health inequalities across the ICS. But gaps in data and lack of access to relevant information was frequently identified as a barrier.

One common challenge was sharing data between sectors. As one ICS leader put it: ‘data sharing, you know, all of that information governance stuff, can get in the way quite quickly’. Some leaders gave examples where data had been shared across sectors to target interventions during the covid-19 pandemic (such as shielding vulnerable groups and vaccination programs), or establish particular demonstration programs (such as to deliver more proactive care for high risk groups), but said these data were no longer able to be shared after the programs ended (‘we’ve got to do another whole round of getting these data agreements in place, and that’s just nuts’). This consumed time and resources.

But access to data was not the only issue. Capacity to analyse the data and make it useful to local agencies was another challenge—and NHS restructuring had created further gaps in some ICSs:

‘It’s not just about linking the data and it’s not just about having data, it’s also about having the people who can analyse it, interpret it, and make sure it’s usable, because until we have that then we can’t do the widespread analysis, the front-line analysis [...] we can only rely on a central team doing what they have capacity to do. I think that’s a real barrier for us’

—ICS leader, ICS C.

‘I think where we’ve struggled is data. That’s been a really big gap. So everyone talks about PHM [population health management] like it’s the great panacea. The CCG has jettisoned or lost almost all of their informatic capacity outside of performance management during the transition. So at the moment we still don’t have as an ICS informatics officer [...] and there’s no clarity about what the ICS informatics capacity is. [...] So the ability for the NHS to actually look at inequalities is quite limited.’

—Local authority public health leader, ICS B.

Moving from rhetoric to reality

Resource and capacity gaps contributed to a broader challenge of moving from rhetoric to reality on action to reduce health inequalities. Leaders often talked about a struggle getting beyond describing inequalities to identifying tangible priorities for improvement and making changes in services to achieve them. Short-term pressures tended to dominate instead (*see* motivation and purpose).

Interviewees described a mix of work underway to help organizations across the ICS understand and

prioritize action on health inequalities. For instance, in ICS A, local authority leaders had developed ‘toolkits’ for local authorities and NHS providers to help guide interventions to reduce health inequalities, and were now working on similar frameworks for mental health trusts and primary care settings. In ICS C, leaders were considering how to apply quality improvement principles to guide action on health inequalities. In all ICSs, leaders could point to a mix of cross-sector initiatives on health inequalities (table 4). Nonetheless, leaders frequently worried about an implementation gap:

‘They’re just, you know, putting out their statements and telling us what great things they’re going to tackle but nothing about how this is going to work or anything’

—Primary care leader, ICS A.

‘There’s a lot of talking about inequalities and not as much action.’

—Local authority social care leader, ICS B.

‘I think the risk is we keep telling the problem and not doing the interventions. Population health management is just the data bit. It’s just the tool. And I keep saying that to people: [...] “What’s the intervention?” So I think the risk is we’ll do the data bit and not do the intervention’.

—Regional public health leader, ICS A.

‘This whole agenda is how you get beyond rhetoric and saying the right thing and warm words into actions that meaningfully change [...] behaviours in health and care organisations [...] that ultimately lead to something being different on the ground. And you know, everyone buys in to that warm words and rhetoric. What actual change is driven from this is a whole other question. [...] There’s a systemic challenge about moving from rhetoric to reality’

—Local authority public health leader, ICS C.

Table 4. Examples of cross-sector initiatives on health inequalities

Focus	Approach
Social and economic determinants	<ul style="list-style-type: none"> - Identifying households at risk of damp, cold, and other housing-related issues and providing targeted health and social support - Increasing access to skills and employment for people living in more deprived areas, including jobs in health and social care
Selected risk factors	<ul style="list-style-type: none"> - Coordinated tobacco control programs across the NHS and local government, including population measures and targeted support - Identifying people at risk of developing diabetes in general practice and referral to culturally appropriate prevention support

Conditions or population groups	<ul style="list-style-type: none"> - Improving maternity care and support for women from Black, Asian, and minority ethnic groups, and more deprived areas - Social prescribing and peer support programs for people with mental health conditions, with a mix of community support
Service design and access	<ul style="list-style-type: none"> - Identifying people waiting for hospital treatment from more deprived areas and providing proactive health and social support - Service redesign to improve access for more deprived groups, such as changes in opening times, setting, or communication
Mechanisms to plan or fund services	<ul style="list-style-type: none"> - Flexible funding for local areas within ICSs to design and deliver their own projects to meet health inequalities objectives - Community engagement in areas experiencing worse outcomes to understand barriers to services and priorities for improvement

External factors

The broader context in which local organizations operated had a major impact on how they worked together on health inequalities. This included a combination of local factors, such as health needs and geography, and the broader policy context, such as national NHS policy and wider policy and politics on health. The national policy context in the NHS in particular played a dominant role in shaping collaboration experiences across other domains, such as aims, resources, and relationships (table 3).

At a local level, leaders described a mix of contextual factors influencing the ICS’s work on health inequalities. Examples included the geography and boundaries of the ICS (for example, large and diverse ICSs creating challenges for the coherence of health inequalities plans), the scale of local health needs (for example, stark inequalities in services and outcomes providing motivation for collaboration—*see* motivation and purpose), and the composition of local health services (for example, with dominant NHS providers having outsized power and influence over how resources are used). The political context in local government also shaped how collaborations worked—for better and worse. In some areas, support of local politicians for action on health inequalities added weight to local efforts (‘we’ve got politicians who are really up for this’). But mixed political leadership of different local authorities within an ICS area—for example, with both Labour and Conservative-led administrations—could make planning and framing issues on health inequalities more difficult.

NHS policy context

At a national level, the biggest factor influencing ICSs was the national policy context in the NHS. Many leaders welcomed the explicit national policy objective for ICSs to reduce health inequalities. This helped give profile to work on health inequalities in ICSs and effectively mandated partnership

working to achieve it. For example, a local authority social care leader in ICS C described how the national mandate for ICSs on health inequalities had been a ‘driver’ for the NHS to work differently with local authorities in their area, rather than just thinking ‘well that’s public health and that should be sorted by the council’. But translating this broad objective into tangible priorities was a challenge, and leaders often thought national policy guidance for ICSs on health inequalities was vague (*see* motivation and purpose). Several interviewees could point to policy documents on ICSs’ role in tackling health and health care inequalities (such as the Core20Plus5 framework¹³), but did not always understand what they meant in practice or find them helpful for their local system. For instance, a leader of ICS A said: ‘well, there’s no clarity at all, is there’. Broader aspects of national NHS policy, such as short-term funding cycles, were identified as barriers to work on health inequalities too.

More fundamentally, leaders described how the behaviour of national NHS bodies undermined the ICS’s work on health inequalities in practice. The overriding priority of national NHS bodies appeared to be on holding ICSs to account for short-term improvements in NHS performance. For example, an ICS leader in ICS A said: ‘I don’t think I’ve had a conversation on health inequalities or population health with NHS England since we’ve been in existence, but I’d need more than my fingers and toes to count the number of conversations I’ve had on ambulance handover [of patients at acute hospitals].’ Similarly, an ICS leader in ICS C described how ‘even with a big, sort of, program around health inequalities, it’s not the thing that chief execs are asked about when they’re, you know, having those focus calls with NHS England’. This focus on short-term improvements in NHS performance appeared to be increasing, exacerbated by ‘hard’ targets on hospital performance and political pressure to meet them:

‘I cannot explain in seven weeks, eight weeks, how much their focus has changed, it’s unbelievable. It’s almost as if, if you came into one job as an ICB chief exec, and you’ve got another job now, which is basically being the chief operating officer for the system, and that is the absolute focus from them, you know. So I’m on, you know, regular phone calls with them about those short-term issues, whether it’s private care access, ambulance turnaround times, 104 week wait, 78 week waits, cancer waiting times. That is the absolute focus.’

—ICS leader, ICS B.

The ‘top-down’ and bureaucratic approach of NHS England was identified as a barrier to collaboration too, contributing to cultural differences between the NHS and other sectors (*see* relationships and cultures) and limiting the agency of local leaders to make decisions. For example, an ICS leader in ICS C described how national NHS bodies tell you ‘on the one hand that the ICS is the one that’s always in control, and then the next time sending you an edict telling you you have to do X. What the fuck? You know, make up your mind’. Reporting upwards to national bodies also consumed time and energy. An NHS provider leader in ICS A, for instance, described NHS England as a

‘hungry beast upstairs that needs to be fed constantly’, and said that ‘the time it takes us to feed the beast and to give updates and all of that is time we haven’t got to spend on driving things forward’.

Organizational restructuring

Organizational restructuring in the NHS to establish ICSs caused major disruption. At the time of our fieldwork, new organizations and organizational partnerships were being established, existing NHS organizations were being restructured, and teams and individuals were being recruited or consulted on their jobs. The scale of upheaval varied, but leaders in all ICSs described the ongoing process of the NHS reorganization and its unintended effects on local partnerships. Examples included lack of clarity about new NHS structures and responsibilities, loss of analytical and other staff, gaps in NHS leadership and management, disrupted local relationships, and time and energy being diverted towards managing the process of structural change. A local authority public health leader in ICS A, for example, described their ‘concern’ about the lack of clarity on NHS roles and responsibilities in their area, looking for answers to questions like: ‘who’s the place-based director? Who’s going to be the director of nursing? What’s the accountability in terms of infection prevention control? Where does quality sit? What happens when there’s a suicide?’ Local authority leaders also described spending substantial extra time supporting the development of new NHS structures and strategies.

Interviewees often commented on the scale of the changes underway and challenging context in which they were being introduced, such as pressures on health and care services and the ongoing effects of covid-19. For some, there was a sense time was being lost while the NHS reorganized itself:

‘I think they’re just rearranging the chairs on the Titanic at the moment, because they haven’t actually got round to thinking about anything. [...] They haven’t even organized their people, so how they can start to organize strategy, budgets, resources? I don’t know. [...] It’s time being wasted.’

Primary care leader—ICS A.

‘There is instability [...] in terms of the extent of the reform. This is massive. The health reform is massive, isn’t it—the establishment of ICSs, the concept of ICBs, the bringing of councils into those for the first time as a, sort of, formal part of the structure, so that’s huge and hasn’t finished yet. [...] We cannot keep all of the plates spinning in the way that is expected, so some things are giving.’

Local authority adult social care leader—ICS B.

‘If this had been the council, we would have restructured ready for June. The CCG people, structures, are still being restructured ready for something that happened in June, so it’s like... it’s the NHS is a much slower beast than the local authorities.’

Local authority adult social care leader—ICS C.

Despite widespread support for collaboration to reduce health inequalities (*see* motivation and purpose), there was also a sense of fatalism about the future of ICSs and perceived inevitability of

further NHS restructuring. For some, this contributed to short-termism, instability, and scepticism about ICSs' potential impact.

'This stuff takes time, and have we got the political will to see this through? If you kind of think about ICBs, yes they've given us all these new statutory responsibilities, but we know that it's like with NHS structures: the clock's already ticking. I sort of think we've got three years really—if that—to really prove ourselves. And what can you do in three years when it comes to health inequalities?'

ICS leader—ICS A.

'You can see the opportunities. Whether there's time to take some before the next reorganization comes, like, only time will tell. I'm not sure'.

NHS provider leader—ICS C.

'The NHS is constantly changing and never achieving any of these big things it sets out to achieve anyway. [...] Part of that could be well, yes, you're just going through the motions and then you'll do another big massive restructure in four years' time, so you can't measure what's said anyway.'

Local authority social care leader—ICS C.

Broader political and policy context

The broader political and policy context exacerbated these challenges—and sometimes created them. Several interviewees described a lack of policy coherence in central government on health inequalities as a barrier to collaboration. Some pointed to gaps in national NHS reforms on the role of wider services and sectors in shaping health inequalities—for instance, with existing local government structures focused on reducing health inequalities (such as health and wellbeing boards) not sufficiently 'respected' in national NHS reforms to establish ICSs, or national policy documents lacking sufficient detail on the role of local government, housing, or other sectors in reducing health inequalities. Others pointed to cuts in funding for public health and wider public services holding back government policy objectives on health inequalities. The broader context of increasing inequalities and growing economic challenges in England were also identified as constraining factors.

Political leadership was often identified as a barrier to local efforts to reduce health inequalities too—for example, with regular ministerial changes creating policy instability, and a perceived overriding focus among politicians on short-term improvements in NHS performance ahead of the next UK general election undermining longer-term objectives to improve health and reduce health inequalities:

'In the last year it's been disgraceful. That's the only polite word I can think of. You know, so, health inequalities and prevention were seen as priorities, then we're told "actually, you can't talk about health inequalities and prevention is off the agenda". [...] So, actually, there's been this oscillation.'

NHS provider leader—ICS B.

'I'm paraphrasing here and nobody actually says this openly, but you can see in the national meetings: "well, you're here to deliver: it's the next six weeks, getting through winter, then the eighteen months up to the election". And, effectively, when you've already got a government that's rowing back on potential public health commitments [...] and public health funding is going to actually be reduced, you can see that it's going to be difficult to hold the line at a local level.'
ICS leader—ICS B.

DISCUSSION

We analysed experiences of collaboration between the NHS, social care, public health, and other sectors to reduce health inequalities under NHS reforms in England. We identified a mix of factors shaping local collaboration—from how national policy aims are defined and understood, to the resources and relationships among local organizations to deliver them. We mapped these factors to key domains in the international literature and identified interactions between them. Overall, local leaders described strong commitment to working together to reduce health inequalities in England's new ICSs, but faced a combination of conceptual, cultural, capacity, and other challenges in doing so. The national policy context played a dominant role in shaping local collaboration experiences—frequently making it harder not easier—and the spectre of further NHS restructuring loomed large.

In many ways, our findings are consistent with international evidence on cross-sector collaboration between health care and non-health care organizations.²⁹ We identified factors shaping collaboration functioning in England across five domains identified in the international literature, including motivation and purpose, relationships and cultures, resources and capabilities, governance and leadership, and external factors. These domains provided a useful framework to analyse and interpret local experiences in England. And several common factors that appear across multiple studies of local collaboration in diverse country contexts, such as the role of trust between partners, meaningful involvement across sectors, and sufficient resources, were identified in our research too. Our findings also link to broader literature on major system change in England and elsewhere—for instance, in emphasizing the role of differences in meaning, values, power, and resources between organizations and leaders in shaping the formulation and implementation of major system change.^{53,54,55} But evidence on the interaction between factors shaping collaboration functioning and their relative importance in different contexts is limited.²⁹ Existing studies on cross-sector collaboration also often focus predominantly on local conditions shaping how collaborations work.

Our research highlights the pervasive—frequently perverse—influence of national policy on local collaboration in England. Despite national policymakers mandating partnership working to reduce health inequalities, our data suggest the national policy context often harmed rather than helped local leaders seeking to achieve these objectives. Theory on policy implementation can help illustrate some of these challenges and how they might be addressed. Drawing on models of policy failure^{56,57} and

policy streams,^{58,59} Exworthy and Powell describe three ‘streams’ that need to align for successful policy implementation on health inequalities.^{42,43,44} Policies must have clear goals and objectives (the policy stream), feasible mechanisms to achieve these objectives (the process stream), and the financial, human, and other resources to make it happen (the resource stream). These streams also need to align at multiple levels: vertically between central and local agencies (for instance, with policy objectives on health inequalities clearly stated and translated by central government), horizontally between local agencies (for instance, with aims shared by health care, social services, and other agencies responsible for implementing policy changes), and horizontally between national agencies (for instance, with coordination between government health and finance departments to ensure resources are available to meet health inequalities objectives). Complex policy issues like health inequalities, which are affected by decisions across multiple agencies and sectors, make coordination at each level more challenging.

Our study identified misalignment across all three policy streams, both vertically and horizontally. In the policy stream, national policy objectives on health inequalities were vague, contributing to lack of clarity on local priorities and potential conflict between sectors within ICSs. Horizontal coordination at a national level appeared weak, with the behaviour of national policymakers undermining their stated aims on health inequalities—focusing predominantly on short-term political priorities to improve NHS performance instead. In the process stream, ICSs had been established by national NHS bodies as a mechanism to reduce health inequalities, but their governance and accountability was muddy and local leaders were struggling to turn rhetoric on health inequalities into tangible action. The top-down culture of national NHS bodies affected local relationships and constrained leadership agency in ICSs, while the frequency of top-down NHS reform contributed to capability gaps in ICSs, and scepticism and fatalism about their potential impact. In the resource stream, ICSs felt constrained by lack of resources from central government—influenced, in turn, by misalignment between policy and resources centrally. In each stream, national policy context strongly shaped local experiences.

The dominant role of national policy in England is not a surprise—and not, in itself, a problem. The NHS is a national health care system with a strong emphasis on geographic equity of access,⁸ and there is a high degree of centralization in UK public policy.^{60,61} Studies of previous health partnerships in England also emphasize the influence of national policy context on how local collaborations work—for better and worse.^{32,62,63,64} Indeed, a growing body of evidence suggests that England’s last cross-government strategy to reduce health inequalities, introduced and delivered under Labour governments in the 2000s—involving a mix of investment in public services, new social programs, such as SureStart and the national minimum wage, and various area-based initiatives spanning the NHS and social services—had a positive impact, contributing to reductions in health inequalities over time.^{65,66} In other words, central government matters, and central government can help.

Fast forward to 2024, however, and the problem for ICSs is that national policymakers in England do not appear to have been using their dominant role to enable effective policy implementation on health inequalities. This fits with broader evidence on the Conservative government's record on health policy in the 2010s and early 2020s. In contrast to the 2000s, there has been no national strategy to reduce health inequalities in England, and investment in public services that shape health and its distribution has been weak.^{67,68,25} Cuts in spending on local government and public health services since 2010 have hit poorer areas hardest, contributing to growing inequalities.^{21,22,23} And funding for key cross-sector policy interventions that evidence shows can improve health and reduce health inequalities, such as SureStart programs for young children, have fallen substantially.^{69,70} In the NHS, constrained resources and top-down pressure to reduce hospital admissions have held back a series of policy initiatives to better integrate health and social care services locally.³² Closer alignment between policy, process, and resources on health inequalities will likely be required to enable ICSs to make progress in future. The election of a new UK government in July 2024 provides an opportunity to make this happen—for instance, by developing a new cross-government strategy to reduce health inequalities in England and boosting funding for public health and other local services. The approach of national NHS bodies will also need to change to ensure that short-term targets to improve NHS performance do not crowd out the broader action needed to reduce health inequalities through ICSs. This may require stronger measures and accountability for meeting health inequalities objectives.⁷¹

While our research focuses on policy in England, similar issues occur internationally. For instance, stronger coordination between fragmented national agencies and greater policy alignment at federal, state, and local levels is needed to support effective action to reduce health inequalities in the US.^{72,73}

Our research also illustrates the disruption caused by NHS restructuring. The NHS in England is frequently reorganized—and local NHS planning bodies have been in almost constant organizational flux since the 1990s.⁷⁴ Evidence suggests these top-down reorganizations deliver little measurable benefit,^{75,76,77,78,79} while organizational restructuring can cause harm.^{78,80,81} Examples of disruption identified in our research included lack of clarity about roles and responsibilities, loss of analytical and other staff, gaps in NHS leadership and management, disrupted local relationships, and time and energy being diverted from other priorities. In the short-term, at least, the introduction of ICSs had, in some cases, paradoxically posed challenges to the kind of partnership working the reforms were aiming to promote. The threat of further reorganization appeared ingrained in local leaders' psyche. These practical and psychological risks of restructuring are not unique to the NHS, given major health system reforms in high-income countries frequently involve organizational and governance changes.⁸²

Limitations

Our study has several limitations. First, we focused on collaboration experiences in three ICSs in England (out of 42), so our findings reflect in-depth experiences in selected ICSs rather than overall

experiences nationally. However, our structured sampling approach meant we were able to target ICSs in areas with strong relevance to national policy on reducing health inequalities. We identified three ICSs with varied characteristics all experiencing high levels of socioeconomic deprivation. National policymakers in England are targeting efforts to reduce health inequalities at populations in more socioeconomically deprived areas.¹³ Leaders in these ICSs are likely to be particularly aware of their role in reducing health inequalities, and their experiences relevant to other ICSs in similar areas.

Second, our interviews focused on senior organizational leaders in ICSs. This meant we were able to understand high-level perspectives from the most senior leaders responsible for overseeing and directing work on health inequalities in ICSs—as well as the key individuals routinely engaging with national policymakers. It also meant we could gain perspectives from individuals able to describe the overall experiences of their organization and how it works with others. Our sample included a diverse mix of leaders from NHS, social care, public health, and community-based organizations. But our research does not focus on perspectives of people providing services or patients and populations experiencing inequalities. Our sample also excludes national leaders responsible for developing policy on health inequalities and their experiences working with local leaders in ICSs. We use wider evidence on national policy on health inequalities to help interpret and triangulate our findings.

Third, our study data were collected between August and December 2022—early in the development of ICSs, which were formally established in July 2022. This allowed us to understand local perspectives as leaders were collaborating to develop and implement plans on health inequalities—as well as to understand the impact of organizational restructuring to establish ICSs. ICSs had existed informally for several years prior to 2022,^{36,39} and a series of relatively recent policy initiatives had focused on area-based partnerships to reduce health inequalities,²⁵ so organizations in ICSs were not starting from scratch. But the timing of our fieldwork means our data represent early experiences of collaboration in ICSs after the 2022 reforms, when ICSs were given formal powers. These experiences will evolve as ICSs develop—for instance, as the articulation and understanding of national policy objectives evolves. Further research is needed to track experiences over time.

CONCLUSION

Policymakers in different countries promote collaboration between health care, social services, and other sectors to improve health and reduce health inequalities. Under major reforms in England, national policymakers established area-based partnerships between health care and social services and gave them objectives to reduce health inequalities. We used qualitative methods to analyse experiences of cross-sector collaboration between the NHS and other sectors to reduce health inequalities in England's new ICSs. Local leaders described strong commitment to working together to reduce health inequalities in their area, but faced a combination of conceptual, cultural, capacity, and other challenges in doing so. We identified factors shaping how local collaborations are

functioning in England across key domains identified in the international literature, including motivation and purpose, relationships and cultures, resources and capabilities, governance and leadership, and external factors. These findings offer pointers for policy and practice about where to focus efforts to improve local collaboration. The national policy context in particular played a dominant role in shaping collaboration experiences in England—frequently making it harder not easier—and NHS restructuring caused major disruption. Closer alignment between policy aims, processes, and resources on health inequalities is likely needed to avoid policy failure as ICSs evolve.

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CHAPTER 8

Discussion and conclusion

DISCUSSION

Major reforms to the English NHS in 2022 led to the creation of 42 Integrated Care Systems (ICSs) across the country—area-based partnerships between the NHS, local government, and other agencies, covering populations of around 500,000 to 3 million people. National policymakers have given the new systems a mix of objectives, including to reduce health inequalities. Similar policies are being developed in other countries. This research has explored how local NHS organizations are collaborating with other sectors to reduce health inequalities under England’s latest NHS reforms. This has included analysing ICSs in their historical context and alongside broader international evidence on local cross-sector partnerships to improve health and reduce health inequalities.

The research has involved three broad phases, following the objectives set out in chapter 1. First was an umbrella review to synthesize a large body of international evidence on the health impacts of collaboration between local health care and non-health care organizations, and the factors shaping how these partnerships function (chapter 3). Second was analysis of the policy context, development, aims, structure, and characteristics of England’s new ICSs—including in-depth analysis of national policy on reducing health inequalities through the new systems (chapters 4 and 5). Phase two also included analysis of how ICSs fit with previous national policies on cross-sector collaboration to improve health and reduce health inequalities in England since 1997. Third was qualitative analysis of how local NHS, social care, public health, and other organizations are collaborating to reduce health inequalities in three ICS areas in England (chapters 6 and 7). A combination of ‘lenses’ was used to help guide the research, each focusing on different ways to conceptualize ICSs—including as public policy interventions to reduce health inequalities, as inter-organizational collaborations to achieve major system change, and as an approach to top-down performance management in the English NHS.

This discussion summarizes the research and its implications, and is divided into six sections. The first summarizes the study results. The second discusses how the research fits into the existing literature and the insights it adds. The third discusses the main strengths and limitations of the research. The fourth provides an overview of the main implications of the research for policy and practice. The fifth identifies opportunities for future research in this area. The final section reflects on my position as a researcher and the ways this has shaped the research process, data, and analysis.

Summary of findings

Umbrella review

Overall, the umbrella review found little convincing evidence to suggest that collaboration between local health care and non-health care organizations improves health or reduces health inequalities—in the UK or elsewhere. Evidence of impact on health services is mixed, though some studies suggest that collaboration may improve access to services, and one high quality review found that integrated care interventions may improve patient satisfaction.¹ Evidence on resource use and spending was

limited and mixed. Where meta-analyses indicated positive impacts, there was generally substantial heterogeneity. The quality of evidence reviewed was generally weak and the types of collaborations studied varied widely. There may be several explanations for the lack of evidence on impact. The benefits of cross-sector collaboration may be overstated, hard to deliver, and hard to measure—or some combination of the three.

Despite this, many studies report on factors and mechanisms associated with better or worse collaboration. These were grouped into five domains—covering motivation and purpose, relationships and cultures, resources and capabilities, governance and leadership, and external factors. Several factors, such as the quality of communication between partners or availability of sufficient resources, appear consistently across multiple studies. But without better evidence on the impact of different collaborative efforts, it is difficult to know how and whether these and other factors shape collaboration outcomes in different contexts. There are also limited data on the interaction between factors, their relative importance in different contexts, and the conflicts and trade-offs between them. As a result, we know little about which kinds of collaborations work, for whom, and in what contexts.

Policy analysis

The analysis of national policy on ICSs put the new systems in context, considered their likely impacts based on past experience in England, and identified various policy challenges for ICSs as the systems evolve. ICSs stand in a long line of policies promoting cross-sector collaboration to improve health and care in England. They also stand in a long line of NHS reorganizations—and represent a broader shift in public policy away from provider competition as the route to improve health services.

Since 1997, a mix of policies have been introduced in England to coordinate health and social care services and meet wider policy objectives to improve health and reduce health inequalities. Studies on the implementation of these policies consistently report a mix of barriers to effective partnership working, such as conflicting objectives, shifting policy priorities, IT and information sharing issues, and differences in professional cultures and values. Evidence on impact is limited. But conceptualizing local collaborations as one component in a complex system—including the broader social, political, and economic structures in which local collaborations operate—may help us better understand their potential contribution to improving health and reducing health inequalities.

Comparing partnership policies in England between two decades—the 2000s and 2010s—helps illustrate the point. Unlike in the 2010s, local partnerships in the 2000s were implemented as part of a broader national strategy to reduce health inequalities in England, involving a mix of policy change and investment across government. Taken together, evidence suggests these changes contributed to reductions in health inequalities. Local partnerships were one mechanism that may have helped do it.

The analysis found that ICSs combine various elements of England's previous partnership policies and have been given wide-ranging policy objectives—from improving NHS performance to reducing

health inequalities and influencing the social and economic conditions that shape them. The 42 new systems are being asked to meet these objectives through a complex web of local organizations and overlapping partnerships between them. But the task facing the new systems is not equal. Analysis of publicly available data on the characteristics of the 42 ICSs demonstrates substantial variation in structure, resources, and other factors likely to shape the functioning and impact of the new systems. The analysis also illustrates how the concentration of local areas experiencing the highest socioeconomic deprivation—a target population for national policy on reducing health inequalities—varies widely between ICSs.

The in-depth analysis of national policy on reducing health inequalities in ICSs used Exworthy and Powell’s ‘policy streams’ framework to help structure the analysis—focusing on policy aims, processes, and resources. The analysis points to a mix of implementation challenges in each stream and the interactions between them. Overall, national policy objectives for ICSs are broad and vague. Unclear objectives may contribute to conflict and confusion between agencies at a local level, and early evidence suggests competing policy objectives to ‘recover’ NHS performance risk dominating the agenda for ICSs. In the process stream, a combination of policy mechanisms is expected to support ICS action to reduce health inequalities, such as joint planning processes, national oversight, and the design of ICS governance and accountability. But the ability of ICSs to effectively plan and coordinate local action on health inequalities is not clear, and early evidence suggests the approach of national NHS bodies in practice may hold back local collaboration and distort ICS priorities. Major resource constraints across the NHS, local government, and other sectors risk exacerbating these challenges. To make things harder, issues in the policy and process streams may mean the already modest ICS resources to reduce health inequalities are diverted towards other ICS objectives instead.

Taken together, the policy analysis identified a mix of challenges for the new systems—including unrealistic expectations, governance and accountability issues, weak mechanisms and resources to deliver policy objectives to reduce health inequalities, and the risk that the centralized and top-down approach to performance management in the English NHS holds back collaboration between organizations within ICSs.

Qualitative research in three ICSs

The qualitative research focused on senior leaders’ experiences of collaboration between the NHS, social care, public health, and other sectors to reduce health inequalities in three of the more socioeconomically deprived ICSs in England. The analysis identified a mix of factors shaping local collaboration—from how national policy aims are defined and understood, to the resources and relationships among local organizations to deliver them. The analysis mapped these factors to key domains identified in the umbrella review and identified interactions between them, such as links between national policy and local relationships.

Overall, local leaders described having a strong commitment to working together to reduce health inequalities in England's new ICSs, but faced a combination of conceptual, cultural, capacity, and other challenges in doing so. The national policy context played a dominant role in shaping local collaboration experiences—frequently making it harder not easier. For example, the top-down and hierarchical approach of national NHS bodies caused conflict between local agencies, and short-term and limited funding held back what partnerships could deliver. Organizational restructuring to establish ICSs had also caused major disruption, with unintended effects on the partnership working it aimed to promote. The threat of further NHS restructuring loomed large in local leaders' psyche.

The qualitative research also explored local interpretations of national policy objectives on reducing health inequalities among senior leaders working in the three ICSs. It found that local interpretations of national policy objectives on health inequalities varied, and local leaders had contrasting—sometimes conflicting—perceptions of the boundaries of ICS action on reducing health inequalities. Translating national objectives into local priorities was often a challenge, and clarity from national policymakers was frequently perceived as limited or lacking. Across the three ICSs studied, local leaders worried that objectives on tackling health inequalities were being crowded out by other short-term policy priorities in the NHS, such as reducing pressures on NHS hospitals. The behaviour of national policymakers appeared to undermine their stated priorities to reduce health inequalities.

How the research fits in

The research adds to our understanding of the impact and functioning of cross-sector collaborations to reduce health inequalities—both in England and other contexts. The three lenses introduced in chapter 2 offer a broad framework to understand where the research fits in and the contribution it makes.

Policy to reduce health inequalities

The first lens conceptualizes ICSs as public policy interventions to reduce health inequalities.

Policymakers in the UK and elsewhere have sought to reduce health inequalities for decades,^{2,3,4} but health inequalities are complex, deep-rooted, and influenced by a combination of social, economic, and other factors across society.^{5,6,7,8}

One challenge is how health inequalities are defined and understood by different actors. Literature on policy problems and framing illustrates how the way in which policy issues, like health inequalities, are defined and understood shapes action to address them.^{9,10,11,12} Previous studies have examined how past national policies on health inequalities in England have been interpreted by local leaders,^{13,14,15,16} as well as individual and organizational perspectives on health inequalities in the UK and elsewhere.^{17,18,19,20,21,22} Researchers have also analysed how health inequalities are conceptualized in local health planning documents.^{23,24} Studies often report that health care leaders predominantly focus on individual-level interpretations of health inequalities—for instance, emphasizing individual risk factors for ill-health, access to services, and better disease management.^{17,23,132} This may conflict

with broader interpretations from leaders in public health or other sectors beyond the NHS—for instance, emphasizing the role of social and economic conditions and the environments in which people live.

The research in chapter 7 adds to this picture by illustrating how leaders from different professional groups in ICSs—including within the NHS, public health, and social care—held varied views about ICSs’ role on health inequalities. Perhaps surprisingly, NHS leaders often emphasized social and economic factors, like poverty or housing, as key drivers of health inequalities to be tackled by the ICS. Local authority leaders were concerned about the NHS misunderstanding its role and focus. The NHS’s ‘discovery’ of social determinants of health brings several risks, such as medicalizing social issues, confusion between local agencies, and poorly targeted interventions. A growing literature on health system approaches to addressing social needs in the US and UK identifies similar issues.^{25,26,27}

The analysis of policy aims, mechanisms, and resources to reduce health inequalities in ICSs (*see* chapter 5) provides new insight into the likely policy challenges facing ICSs as they evolve. Previous research has focused on particular components of policy on reducing health inequalities in ICSs—including the content of local plans,^{23,24,28,29} the articulation and development of particular policy interventions (such as to reduce the NHS backlog ‘inclusively’),³⁰ and how ICS funding for health inequalities has been used by local systems.³¹ The analysis in this thesis used a broader a ‘policy streams’ framework to analyse a mix of data and evidence on the policy process to reduce health inequalities in ICSs, and alignment between policy at different levels. This approach provides a more comprehensive analysis of national policy on reducing health inequalities in ICSs and the likely challenges the new systems as they seek to do it—more closely aligned with a political science approach to thinking about policy implementation. It also adds to the literature on the complexity of policy action to reduce health inequalities in the ‘congested state’^{32,33,34,35}—for instance, with ICSs struggling to coordinate between multiple agencies and overlapping partnerships between them.

The research also fits with broader evidence on the role of national policy and political choices in shaping action to reduce health inequalities. A mix of frameworks identify domains and interventions for action to reduce health inequalities (*see* chapter 2). Various studies point to the strong influence of national policy and politics—for instance, in expanding access to health care and other public services and determining levels of public spending.^{36,37,38,39,40} The analysis of national policy on ICSs (chapter 5) and qualitative research with local areas (chapters 6 and 7) also emphasizes the dominant role of national policy and political choices in shaping local action on health inequalities in England—for instance, in shaping the resources available to local agencies and directing their efforts through targets and top-down performance management. The analysis of policies on local health partnerships in England since 1997 also illustrates the strong role of national policy and political choices in shaping what local partnerships can do. The research adds to a growing body of literature exploring the

development of government policy on reducing health inequalities in England since the 2000s.^{41,42,43,44}

Inter-organizational collaboration

The second lens conceptualizes ICSs as local inter-organizational collaborations to achieve major system change. Chapter 2 provides an overview of theory, concepts, and evidence on cross-sector collaboration—including the role of collaboration in UK public policy, the different reasons organizations might collaborate, and how local collaborations can vary in their form, functioning, and impact in different contexts. Several reviews have synthesized evidence on impacts of collaboration between local health care and non-health care agencies—though the most relevant studies are more than a decade old.^{45,46,47} A broader literature documents various factors that may shape the functioning and impact of cross-sector collaboration in different contexts, such as trust and shared objectives between organizations and leaders.^{48,49,50,51,52} This includes local health partnerships in England.^{53,54,55,56,57,58} Theories of organizational collaboration also point to factors affecting partnership functioning.^{59,60,61,62}

Yet there is no up-to-date synthesis of evidence on the impacts of partnerships between local health care and non-health care organizations on health and health equity, and the factors shaping their success. There is also no overarching review of existing reviews on the mix of evidence related to cross-sector collaboration and health. The umbrella review in chapter 3 fills this gap in the literature, and has already been widely cited by researchers studying collaboration in the UK and elsewhere.⁶³ The review also develops a new framework to understand and analyse factors shaping local cross-sector collaboration between health care and non-health care agencies—as is illustrated in chapter 7.

The research also adds to our understanding of the current state of local health partnerships in England. The qualitative research in chapters 6 and 7 provides new insight into how local health care and social services organizations are collaborating to reduce health inequalities under England's latest health system reforms. Studies have focused on the emergence of ICSs before their formal establishment in 2022, including analysis of early ICS plans and planning processes,^{23,24,28,29} experiences during the pandemic,^{64,65} and evolving governance and decision-making.^{66,67} But in-depth understanding of how ICSs are collaborating to reduce health inequalities since the formal introduction of ICSs is lacking. The thesis provides an initial picture to inform policy and practice.

In many ways, the findings from the qualitative research in England (*see* chapters 6 and 7) are consistent with international evidence on cross-sector collaboration between health care and non-health care organizations. The study identifies a mix of factors shaping collaboration functioning spanning the five domains identified in the umbrella review (in chapter 3). Several common factors that appear across multiple studies of local collaboration in diverse country contexts, such as the role of trust between partners, meaningful involvement across sectors, and sufficient resources, were

present in England too. The findings also link to broader literature on major system change in England and elsewhere—for instance, in emphasizing the role of differences in meaning, values, power, and resources between organizations and leaders in shaping the formulation and implementation of major system change.^{68,69,70} But the qualitative study on ICSs in the thesis provides new insight into how these factors interrelate and their impact in the current policy context in England—particularly the pervasive influence of national policy on collaboration functioning in other domains. Despite national policymakers mandating partnership working to reduce health inequalities, the data suggest that the national policy context often harmed rather than helped local leaders seeking to achieve these goals.

Performance management of public services

The third lens conceptualizes ICSs as an approach to the top-down performance management of the NHS and other public services in England. Chapter 2 describes how the UK government has been notable internationally for its use of top-down performance management across the public sector in England—for example, the use of performance targets and a mix of mechanisms to hold local leaders to account for delivery.^{71,72,73} Despite promises to ‘let go’, successive governments have instead sought to ‘hold on’ to the detail of public service delivery.⁷⁴ Literature on the development of the NHS in England points to a similar dynamic. Since the 1980s in particular, the approach of national NHS bodies and government to driving improvement in the health service has relied on top-down targets and performance management.^{75,76} Throughout the history of the NHS, national policymakers have embraced the rhetoric of localism and decentralization of decision-making, but evidence suggests that local autonomy has been limited in practice and central grip has increased.^{77,78,79}

The research presented in the thesis provides further evidence of these centralizing tendencies and their effects on local collaboration to reduce health inequalities in ICSs. A core part of the national policy narrative underpinning the creation of ICSs in England was that local collaboration and greater local control is needed to improve health and health services.^{80,81} Yet the analysis of national policy on ICSs in chapter 5 illustrates how the role of national NHS bodies—unsurprisingly—looms large across policy aims, processes, and resources for ICSs. The qualitative research in three ICSs in chapters 6 and 7 illustrates how this dynamic is playing out in practice, with strong top-down performance management of ICSs by national NHS bodies—focused predominantly on holding ICSs to account for short-term targets to improve NHS performance—contributing to conflict between sectors at a local level and crowding out broader action needed to reduce health inequalities.

The research also provides further evidence on the disruption caused by NHS restructuring—a regular feature of the UK government’s approach to managing public services.⁸² The English NHS is regularly reorganized. Evidence suggests these top-down reorganizations deliver little measurable benefit,^{83,84,85,86,87} while organizational restructuring can cause harm.^{86,88,89} The qualitative research in chapter 7 provides new evidence on the disruption caused by the latest round of reforms—including

lack of clarity about roles and responsibilities, loss of analytical and other staff, gaps in NHS leadership and management, disrupted local relationships, and time and energy being diverted from other priorities. These findings are relevant to research on health system reform in other countries.⁹⁰

Strengths and limitations

The study has a mix of strengths and limitations. Each chapter of the thesis that presents research and analysis (chapters 3-7) includes a section outlining the main limitations of the research, along with some of the ways these limitations were mitigated and the strengths of the relevant study. This section briefly summarizes key strengths and limitations for each of the three phases of the research.

The first phase of the research was an umbrella review to synthesize evidence on the health impacts of collaboration between local health care and non-health care organizations, and the factors shaping how these partnerships function (*see* chapter 3). The study has several limitations—including challenges disentangling evidence on varied forms of collaboration in one overarching review, the risk that some interventions involving organizational collaboration to improve health or health equity may have been excluded, the loss of contextual richness from an umbrella review design, and the quality of evidence reviewed. The approach and methods for the review involved various steps to mitigate these limitations, such as including both quantitative and qualitative evidence. The study design also has various strengths—including the ability to make sense of a large body of international literature on organizational collaboration and health, as well as the policy relevance of the search given its explicit focus on collaboration between local health care and non-health care agencies.

The second phase of the research was analysis of the policy context, development, aims, structure, and characteristics of England's ICSs. Again, the research has several strengths and limitations. The approach to analysing past national policies on cross-sector collaboration to improve health or reduce health inequalities in England since 1997 allowed a large number of partnership policies implemented over several decades to be compared together, and analysed in the context of broader changes in public policy (*see* chapter 4). But the approach taken to reviewing these policies—comparing summary data on policy aims, mechanisms, and intended impact of relevant policies, rather than detailed analysis of each policy individually—meant that the richer detail of how policies were implemented and evolved was missed. The analysis of ICS characteristics focused on a small number of indicators relevant to collaboration in ICSs and provides a transparent approach to cluster and compare the new systems (*see* chapter 4). Yet the approach is limited by the data available. Comparable data on other key variables shaping collaboration functioning in ICSs—for instance, their leadership skills or capabilities for service improvement—are not available. The more targeted analysis of policy aims, processes, and mechanisms for reducing health inequalities in ICSs was informed by theory on public policy implementation and combined a wide range of evidence and

analysis from policy documents, evaluations, and other sources (*see* chapter 5). But data on ICSs' approaches to reducing health inequalities are limited, so the analysis only provides an early view.

The third phase of the research was qualitative analysis of how local NHS, social care, public health, and other organizations are collaborating to reduce health inequalities in three ICS areas in England (*see* chapters 6 and 7). Three features of the research are particularly important to highlight. First is that the research focused on collaboration experiences in three ICSs in England (out of 42), so the findings reflect in-depth experiences in selected ICSs rather than overall experiences of ICSs nationally. However, the structured sampling approach used to identify the sites—which involved selecting three ICSs with varied characteristics all experiencing high levels of socioeconomic deprivation—meant the study targeted ICSs in areas with strong relevance to national policy on reducing health inequalities. The findings also offer lessons for ICSs serving similar populations.

Second, the interviews focused on senior organizational leaders in ICSs. On the one hand, this is a limitation of the study, as it means the data do not include perspectives of people using or providing services, or national policymakers responsible for overseeing ICSs. On the other, the sampling of interviewees was a key strength of the study and the insight it was able to offer—for example, because the study was able to gain high-level perspectives from the most senior leaders in ICSs with knowledge of how their organization works with other organizations, and given the sample involved senior leaders from a mix of sectors within each ICS. Finally, the study data were collected between August and December 2022—early in the development of ICSs. This means the data only represent early experiences of ICSs soon after the reforms were implemented. But it also enabled the research to understand leaders' perspectives as they were collaborating to develop and implement plans on health inequalities. It also provided insight into the impact of organizational restructuring to establish ICSs.

Implications for policy and practice

Standing back, there are four overarching implications of the study for policy and practice in England.

First is that the potential impact of ICSs or other local health partnerships should not be overstated. Policymakers in England have set ambitious objectives for ICSs to reduce health inequalities. Policies promoting local health partnerships to improve health and health equity have been developed in England for decades. The logic that cross-sector collaboration can help reduce health inequalities is hard to argue with. Health inequalities are shaped by a combination of social, economic, and other factors across society—not just access to health care. These factors are influenced by the activities of multiple organizations and groups. As a result, cross-sector collaboration is an opportunity to better align these activities to reduce health inequalities. So far, so sensible. Yet the research has found little high-quality evidence to suggest that local cross-sector collaboration between health care and non-health care agencies improves health or reduces health inequalities. Policymakers expecting ICSs to fix entrenched health inequalities in the UK will therefore be disappointed. Instead, the research

suggests that local collaborations should be understood in their macro-level political and economic context, and as one component in a complex system of factors and interventions interacting to shape health inequalities. This provides a more realistic framing for their potential contribution and impact.

Greater clarity is also needed on the distinctive role of NHS organizations in reducing health inequalities. The NHS has a central role to play in reducing health inequalities by providing equitable access to health care.^{91,92,93} Yet national policymakers are increasingly emphasizing the NHS's contribution to improving broader social and economic conditions, and local NHS leaders in our qualitative research (in chapters 6 and 7) often emphasized social and economic factors, like poverty or housing, as key drivers of health inequalities to be tackled by the ICS. NHS action to address people's social needs—for instance, through 'social prescribing' schemes where health care staff identify patients' unmet social needs, such as food insecurity, and make referrals to relevant social services—is not new.²⁶ Similar approaches are being developed in other countries.^{94,95} But there are also risks, such as such as medicalizing poverty and other social issues and inefficient allocation of resources to address them. For example, greater emphasis on the NHS's role in addressing social and economic factors may shift the focus towards individual-level interventions targeting patients and behaviours, and away from more 'upstream' public policy interventions needed to improve conditions across the population (such as strengthening social security, employment, and housing conditions).²⁶ Community-based organizations, such as agencies providing housing support or food assistance, may orient their language and services towards health care system priorities—particularly if this becomes a route to access resources.⁹⁶ Extra investment in schemes to identify and address social needs within the health care system may also deliver greater benefit if invested directly in social supports outside the NHS instead. In either case, lack of clarity on roles and responsibilities in ICSs can cause conflict.

Second is that we know a lot about the factors that can help or hinder local cross-sector collaboration in England and elsewhere—even if data linking these factors to better health or health equity are limited. Lack of evidence on the impact of local health partnerships has not stopped policymakers promoting them. The history of NHS reorganizations suggests that ICSs may not last long, but local health partnerships of some variety are likely to endure—as they have done in England since at least the 1970s. This raises the question of how national and local leaders best make these policies work.

The research has synthesized a mix of evidence on factors shaping local cross-sector collaboration between health care and non-health care organizations, and how these interact. The five domains identified in the umbrella review—covering factors related to motivation and purpose, relationships and cultures, resources and capabilities, governance and leadership, and external factors—provide a broad framework to guide local leaders, as well as examples of issues faced in different contexts. For example, local leaders can learn from evidence on the importance of communication, trust, and clear decision-making processes between agencies to give themselves the best chance of success. The

qualitative research in chapters 6 and 7 illustrates how these and other factors are being experienced by senior leaders in England's ICSs today. It also points to potential priorities for local leaders, such as developing a better shared understanding of the role of ICSs in reducing health inequalities and the distinctive contribution of different agencies. But this will only take them so far. A major challenge for local leaders in ICSs is that the underlying tensions in the design of the new systems—including their complex governance structure, power imbalances between constituent parts of the system, and accountability differences between the NHS and local government—cannot be fixed locally.

Third is that national policy and politics play a dominant role in shaping the experience and impact of local health partnerships in England. This role is often understated in policy rhetoric on local collaboration in England, where policymakers emphasize the role of 'places' and local leaders in shaping health inequalities. Part of this dominance is down to the institutional logics of top-down and centralized performance management in UK public policy and the English NHS. The qualitative research in chapters 6 and 7, for instance, illustrates the major influence of national policymakers and NHS performance management in shaping collaboration experiences in ICSs—frequently making it harder not easier to prioritize reducing health inequalities. The overriding focus on meeting NHS policy objectives to improve hospital performance are a clear example. But a bigger factor is the wider political choices that shape the context for local partnerships and their ability to meet policy objectives to reduce health inequalities—for instance, political choices on the level and distribution of spending on health care, public health, and other public services. The political context for ICSs to date has been challenging. In contrast to the 2000s, there has been no national strategy to reduce health inequalities in England since 2010,^{97,98} investment in public services that shape health has been weak,⁹⁹ and deep cuts in spending on local government and public health since 2010 have hit poorer areas hardest.^{100,101,102} Political failure since 2010 left the health system in crisis—then covid-19 hit and made it worse.¹⁰³ The result is that ICSs have been asked to swim against a strong tide of national policies making it harder to achieve their objectives to improve health and reduce health inequalities.

Fourth is that alignment between policy aims, processes, and resources is needed at multiple levels to make progress on reducing health inequalities. Exworthy and Powell's 'policy streams' framework has been used in the thesis to help frame analysis of policy on health inequalities.^{32,34,35} Exworthy and Powell describe how three policy 'streams'—policy aims, processes, and resources—need to align both vertically (for instance, between national and local bodies) and horizontally (between central government agencies nationally, as well as between NHS, local government, and other organizations locally) for successful policy implementation on health inequalities to happen. The analysis in the thesis identifies lack of alignment between these three streams at multiple levels—for example, with misalignment between policy aims and resources to reduce health inequalities in central government. The result is that no amount of coordination locally within ICSs will be enough to account for unclear

policy aims, weak policy mechanisms, and insufficient resources to meet policy objectives on health inequalities from national policymakers. England's new ICSs risk being set up to fail.

These implications raise questions for the new UK Labour government—elected in July 2024. Labour's manifesto included ambitious goals to rebuild the English NHS and reduce health inequalities between English regions. Yet Labour's 'health mission' plans provided limited detail on how this would be done,¹⁰⁴ while public spending plans inherited by Labour imply NHS spending growing below the long-run average¹⁰⁵ and cuts to 'unprotected' services that shape health inequalities, such as local government.¹⁰⁶ Meantime, the NHS elective waiting list stands at 7.5 million and pressures on emergency care are extreme.¹⁰⁷ These pressures are likely to dominate the political agenda. Closer alignment between policy aims, processes, and resources on health inequalities is likely needed to avoid policy failure as ICSs evolve—for example, through a new cross-government strategy to reduce health inequalities in England and increased funding for public health and other local services.

Future research

The study points to a mix of priorities for future research. The umbrella review in chapter 3 highlights the challenge of disentangling the distinctive impact of local collaborations from the broader context in which they operate. But some methods may help identify features of collaboration that have the potential to contribute to better health in different contexts. Positive deviance sampling,^{108,109} for example, is based on the assumption that elements of 'what works' can already be found in organizations or communities that consistently experience better performance on selected indicators than would otherwise be expected given their local context and characteristics. Feasible solutions to complex problems may be identified by studying these cases. Positive deviance sampling is increasingly used in health services research to identify approaches for improvement—including Brewster et al's study of collaboration among health care and social service agencies in areas that achieve relatively low health care utilization and costs for older adults in the US.¹¹⁰ This kind of approach might be utilized in other contexts to help understand whether organizations in communities with better health or narrower health inequalities have distinct patterns of cross-sector collaboration.

The analysis of the characteristics of England's 42 ICSs in chapter 4 points to the potential of cluster analysis to compare and assess the new systems. The new systems vary widely in structure, resources, and other factors likely to shape their functioning and impact. Grouping ICSs based on these features may help inform the national approach to ICS assessment and improvement—for instance, by comparing progress of like-for-like systems. Cluster analysis has been used to identify common groupings of health systems in a mix of contexts—including within¹¹¹ and between health systems.¹¹² For example, Shortell et al drew on resource dependence and new institutional theory to define eight characteristics of accountable care organizations (ACOs) in the United States—including size, scope,

use of performance management mechanisms, and other factors—and used these to group ACOs into three distinct clusters.¹¹¹ These clusters have been updated and used to compare ACO performance over time.^{113,114} Similar approaches could be used to develop a taxonomy of ICSs based on factors relevant to their development and functioning—for instance, drawing on the analysis presented in chapter 4—and used to compare performance between systems to identify lessons for improvement.

Finally, further research is needed to track the development and impact of ICSs over time. The thesis points to a mix of questions for future research. For example, the qualitative study in chapter 7 points to varied and vague interpretations of national policy aims on health inequalities at a local level. Policy clarity may have improved over time—and qualitative research with leaders from NHS, local government, and other sectors could be used to test this. Mixed methods study designs¹¹⁵ are also needed to better understand the potential links between collaboration functioning (for instance, the ability of local agencies to plan new services) and impact (such as changes in measures of health care utilization or outcomes) in ICSs. A challenge will be defining impact measures that could feasibly be influenced by local collaboration, given the findings of our umbrella review (*see* chapter 3) and the broad objectives for ICSs (*see* chapters 4 and 5). This is particularly true for impacts on health inequalities, given the various types and dimensions of health inequalities that could be considered, the broad range of factors that influence them (*see* chapter 2), and the risk that new interventions may initially widen health inequalities.¹¹⁶ Future studies of collaboration in ICSs or similar policy initiatives in England should explicitly consider the role of national policy and political context in shaping collaboration functioning.

Reflexivity

Reflexivity means sensitivity to the ways in which the researcher and the research process have shaped the collected data and data analysis.¹¹⁷ There are a mix of ways to understand and report on reflexivity and how this has shaped the research—including reflecting on researcher experience, assumptions, position in relation to research participants, personal characteristics, and more.¹¹⁸ ‘Insider’ and ‘outsider’ perspectives and how researchers move between them is one framing often used to consider the position of the researcher in relation to research participants.^{119,120} These ideas are rooted in interpretivist assumptions that there is an inevitable interaction between the researcher and their research participants, and that researchers interpret data based on their own experiences and context.¹²¹

I am Director of Policy at the Health Foundation—an independent charity working to improve health and health care in the UK through research, analysis, and funding. My role involves leading the Foundation’s research and analysis on the NHS and social care in the UK, directing external funding for research in these areas, and actively using evidence and analysis to inform the national policy process in England—for instance, engaging with national policymakers to inform government

legislation, policy initiatives, and spending decisions. I used to work at another independent think tank, the King's Fund, which had similar objectives. I have also spent time carrying out research in the United States as a Harkness Fellow in health care policy and practice, based at the University of California, San Francisco, and Berkeley. Through each of these roles, I have published research using a mix of methods and policy analysis on health systems in the UK and US, as well as health care system approaches to influencing social and economic determinants of health and reducing health inequalities. My role also involves publicly commenting on the direction of health policy in the UK—for instance, through regular journal editorials and appearing in national print and broadcast media.

As a result, I have produced a mix of research and analysis on ICSs in England (and had already done so before starting the PhD), and given my view publicly on the new systems—including through public events,¹²² editorials in the *BMJ* analysing government plans as they developed,^{123,124,125,126,127} formal evidence to parliament and MPs,^{128,129} and more. I have researched early versions of ICSs^{130,131,132} and provided assessments on their development.¹³³ I have also produced analysis intended to inform and frame issues for ICS leaders.²⁶

On the one hand, my position and background gave me 'insider' status in my research for the thesis—particularly when carrying out qualitative research in the three ICS areas. Research participants may have known about my role and previous work on ICSs, and are likely to have known about the Health Foundation and its work. This includes being supportive of the general shift towards 'place-based' systems and collaboration in the NHS.^{129,134} My position will have almost certainly made it easier to access senior interviewees from the sites selected—including chief executives and other senior NHS and local government leaders. ICS leaders from the three areas I selected all agreed to participate in the research. It may have also made it easier to develop trust and understanding in the interviews.

On the other hand, my position also gave me 'outsider' status, which likely shaped the data collection. I work in health policy research rather than the health care system—and interviewees may have been aware of my role in assessing national policy at arms-length from ICSs and the organizations within them. Interviewees may have also known about the content of my work on ICSs, which includes warnings for government about the risks of structural reorganization to establish ICSs and suggestion that the potential benefits of ICSs (and organizational collaboration) have been overstated by policymakers. This may have created distance between me and interviewees. It could have contributed to a perception that I was going to provide a judgement on the new systems and their progress. And it may have shaped my own perceptions of the new systems and their likely challenges and progress. I felt both these insider and outsider perspectives throughout the research—frequently simultaneously.

The methods used throughout the research sought to mitigate bias in data collection and analysis. For example, in the umbrella review (chapter 3), my research strategy was developed with a research information specialist and reviewed using Peer Review for Electronic Search Strategies guidance,¹³⁵ a

proportion of titles and abstracts of relevant papers were screened by co-authors, and a mix of other standard approaches used in systematic reviews were followed. In my policy analysis on ICSs (chapters 4 and 5), I used theory to help frame my analysis and triangulated data from a mix of sources. And in my qualitative research (chapters 6 and 7) I used a mix of approaches to mitigate bias—including a structured sampling approach, collaboration with co-authors to develop the code structure, and use of international evidence on cross-sector collaboration and health to help frame the analysis. More broadly, my two supervisors provided oversight and challenge throughout the research.

CONCLUSION

Policymakers across countries promote cross-sector collaboration as a route to improving population health. Yet little is known about the impact of cross-sector collaboration on health and health equity. The research used a mix of methods to explore cross-sector collaboration between local NHS organizations and other sectors to reduce health inequalities in England. This included analysing ICSs in their historical context and alongside broader international evidence from a mix of contexts.

Overall, there is little convincing evidence to suggest that collaboration between local health care and non-health care organizations improves health or reduces health inequalities. Local collaborations should be understood in their broader political and economic context, and as one component within a wider system of factors interacting to shape health and health inequalities. The role of national policy context and political choices is frequently underplayed in policy rhetoric on health inequalities. Local cross-sector collaboration on its own is unlikely to have a major impact without wider policy change.

Local leaders in England's new ICSs described strong commitment to working together to reduce health inequalities under the latest health system reforms, but faced a combination of conceptual, cultural, capacity, and other challenges in doing so. A mix of factors shaped local collaboration—from how national policy aims are defined and understood, to the resources and relationships among local organizations to deliver them. These factors interact and have varying influence. The national policy context played a dominant role in shaping local collaboration experiences—frequently making it harder not easier. Closer alignment between policy aims, process, and resources to reduce health inequalities is likely needed to avoid policy failure as ICSs evolve. The findings point to several lessons for policy and research on cross-sector collaboration in England and internationally.

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APPENDICES

APPENDIX 1: Medline search strategy

Database: Ovid MEDLINE(R) <1946 to December Week 1 2019>

1 ((collaborat* or partners* or alliance* or coalition* or network* or joined-up or coordinat* or integrat* or joint-working or cooperat*) adj4 (organisation* or organization* or inter-organisation* or inter-organization* or agenc* or multi-agency or institution* or cross-sector* or multi-sector* or multisector* or inter-agency or interagency or intersector* or interinstitution* or health care or healthcare or health system* or NHS or health service* or hospital* or primary care or general practi* or community service* or community health service* or mental health or public health or local government or social care or social service*)).ti,ab. (55828)

2 Health Care Coalitions/ (2337)

3 Intersectoral Collaboration/ (1699)

4 Cooperative Behavior/ (42493)

5 Interinstitutional Relations/ (10581)

6 (health or outcome* or quality or equity or inequit* or inequalit* or mortality or morbidity or prevent*).ti,ab. (4385986)

7 Health Equity/ (940)

8 review.ti,ab. (1249016)

9 "Systematic Review"/ (116819)

10 1 or 2 or 3 or 4 or 5 (103911)

11 6 or 7 (4386064)

12 8 or 9 (1253693)

13 10 and 11 and 12 (6240)

14 limit 13 to (english language and yr="1999 -Current") (5454)

APPENDIX 2: Interview guide

(1) Let's start by having you describe what you do. Could you tell me about your role?

- (a) Title and responsibilities
- (b) Role in the ICS (and/or how their organization fits in the ICS)

Interpretation of national policy objectives and local priorities

(2) One of the overall national policy objectives for integrated care systems is to reduce health inequalities. Could you tell me about how you've interpreted this objective?

- (a) What types of inequalities are you being asked to reduce? (Eg health care, health outcomes)
- (b) Is there clarity from policymakers on the groups to target? (Eg deprivation, ethnicity)
- (c) Are there any key goals or measures that you're aiming for, or being measured against?

(3) Could you tell me about your ICSs' priorities for reducing health inequalities?

- (a) How have local priorities on reducing health inequalities been developed? Role of the ICB/P?
- (b) How far are these priorities shared between local agencies, including those beyond the NHS?

Content of local approaches to reduce inequalities

For this study, we're interested in approaches being developed to reduce health inequalities that involve collaboration between NHS and non-NHS organizations, like local government or housing providers. This might be new ways of planning or delivering services.

(4) Could you tell me about the main approaches or interventions being developed in your ICS/organization that involve this kind of collaboration to tackle health inequalities?

[Note each approach or intervention mentioned, and for each one probe:]

- (a) What is the focus of the approach? (eg population group, services, or process)
- (b) What does the approach involve? (eg types of interventions or activities)
- (c) What organizations are involved? (ie which NHS and non-NHS agencies)
- (d) How do NHS and non-NHS organizations work together to deliver the approach?
- (e) Where did the approach come from?

How local agencies are collaborating to reduce inequalities

Standing back, we want to know about how agencies are coordinating work on reducing health inequalities within the ICS, and the kind of things that make collaboration easier or harder.

(5) Could you tell me about how work on health inequalities is led and managed in your ICS?

- (a) How does decision-making on health inequalities work?
 - (b) Are there clear roles and responsibilities for different local agencies linked to inequalities?
 - (c) How does the leadership of the ICS demonstrate its support for work on health inequalities?
 - (d) How are resources and other kinds of support—like people, funding, or management capacity—made available to support the ICSs work on reducing health inequalities?
- (6) Now I want to talk about things that shape how well agencies work together on reducing health inequalities—and I’m particularly thinking about collaboration between NHS organizations, like hospitals or the ICB, and non-NHS organizations, like local government. So first, things that help: what do you think supports, or has supported, efforts to reduce health inequalities in your area?
- (7) And now things that can get in the way: could you tell me about the main barriers or challenges to collaboration between NHS and non-NHS organizations on reducing health inequalities?
- (8) Thinking about the range of other priorities for your ICS, like reducing waiting times for hospital treatment, how does work on reducing health inequalities fit in?
- (9) Before we finish, is there anything we haven’t talked about yet that you feel is important to understand how local agencies in your area are working together to reduce health inequalities?

APPENDIX 3: Script for gaining informed consent

Thank you for agreeing to speak to me today. For our research, we are trying to understand how NHS, local government, and other agencies are working together to reduce health inequalities. We're interested in how this is being done within integrated care systems in England—and we're interested in talking to you because of your role in developing and leading these efforts in your area.

I want to ask you a few questions to confirm your consent for being involved in the study:

- (1) Do you confirm that you have read the information sheet [dated, version] for the study, and that you have had the opportunity to consider the information, ask questions and have had these answered satisfactorily?
- (2) Do you understand that your participation is voluntary and that you are free to withdraw at any time without giving any reason?
- (3) Do you agree to take part in the study?

To make sure that we have an accurate transcript of our conversation for us to analyze, we would like your permission to record this interview. As we say in the information sheet, if you would like me to turn off the voice recorder at any point, please let me know and I will do so. I would also like to reiterate that your participation is voluntary and your name will not be identified when we write up our research findings.

So, before we start, do I have your permission to turn on my voice recorder?

[Turn on Dictaphone]

Just to make sure we've got your consent recorded, I'm going to just repeat those three questions:

- (1) Do you confirm that you have read the information sheet [dated, version] for the study, and that you have had the opportunity to consider the information, ask questions and have had these answered satisfactorily?
- (2) Do you understand that your participation is voluntary and that you are free to withdraw at any time without giving any reason?
- (3) Do you agree to take part in the study?