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Cite this as: *BMJ* 2022;378:e070910
http://dx.doi.org/10.1136/bmj-2022-070910
Published: 4 July 2022

A cure for everything and nothing? Local partnerships for improving health in England

Collaboration between local agencies is no replacement for national policy and investment, argue **Hugh Alderwick**, **Andrew Hutchings**, and **Nicholas Mays**

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The NHS in England is being reorganised under the Health and Care Act 2022—the biggest overhaul of NHS rules and structures in a decade.[1 2] A key aim of the changes—introduced on 1 July 2022—is to encourage collaboration between NHS, local government, and other agencies to improve health and reduce health inequalities.[3] England will be divided into 42 area based integrated care systems, bringing together NHS organisations, social care, public health, and others to plan and coordinate local services for populations of around 500 000 to three million people.

Partnerships between local agencies to improve health are nothing new.[4] Policy changes in other countries, including the United States and elsewhere in the UK, also emphasise the role of collaboration between organisations and sectors as a route to improving population health.[5-7] Yet little is known about which collaborations work in different contexts.[8-10] And partnership policies may not deliver the benefits that many policy makers imagine. We review previous policies encouraging collaboration between local NHS and non-healthcare organisations in England, synthesise evidence on the effects of these kinds of collaborations, and identify lessons for the latest round of partnership policies in the English NHS.

25 years of partnerships

Numerous national policies have promoted collaboration between NHS, local government, and other agencies to improve health and care over the past 25 years (table 1). These policies have varied in aims and approach, from more narrowly defined initiatives to coordinate local services for older people and people with complex needs, to broader programmes targeting improvements in social and economic factors shaping population health and inequalities.

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

Policy	Date	Summary and activities	Geographical area	Population	Partners	Intended effect
Health improvement programmes	1998	Three year plans for improving health and healthcare and reducing health inequalities. Mechanism to deliver national targets and to identify and respond to local health needs. All health authorities required to develop and implement a plan, combined with a statutory duty on the NHS and local authorities to collaborate to promote health	Health authority areas (100 health authorities established in 1996, later replaced by primary care trusts). Whole of England covered	Whole health authority population	Health authorities, NHS trusts, primary care groups, local authorities, others	Improve population health (including through tackling wider health determinants), improve healthcare services, reduce health inequalities
Health action zones (HAZs)	1998-2003	Local partnerships for improving health and reducing health inequalities, established in areas with high levels of ill health or deprivation. HAZ plans developed by local agencies but needed to reflect seven broad national principles, such as achieving equity, engaging communities, and taking a whole systems approach. Additional funding provided by central government	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. Size varied—from 200 000 to 1.4 million people. Total population of 13 million	Varied depending on local context. HAZ programmes targeted specific populations (eg, young people), health conditions (eg, mental health), health determinants (eg, housing), services (eg, primary care), and whole community	Health authorities and local authorities, working with other partners including NHS trusts, primary care groups, voluntary and community sector, others depending on local context	Identify and address population health needs, reduce health inequalities, increase effectiveness and efficiency of services
New deal for communities (NDC)	1998-2011	Area based regeneration programme in deprived areas. NDC partnerships established to develop 10 year programmes, underpinned by five principles, such as achieving long term change and community engagement. Partnerships given flexibility to plan and fund interventions focused on improving outcomes in health, education, housing, and physical environments, worklessness, and crimeGovernment funding over 10 years	39 NDC areas. Each NDC partnership identified disadvantaged neighbourhoods to focus on—with a maximum of 4000 households per area. Around 384 000 residents of NDC areas in 2003. Average population of around 9900—ranging from 4800 to 21 400	Whole population in targeted neighbourhoods	Local authorities, primary care trust, police, community representatives, and others depending on local context. Average of 7 agencies represented on NDC boards in 2008	Transform areas in relation to key outcomes (on crime, education, health, worklessness, housing, community), reduce inequalities between NDC areas and rest of the country, achieve value for money, engage local communities
Sure Start local programmes	1999-2003	Local partnerships for improving health and wellbeing of children and their families, initially targeting most deprived 20% of areas. Partnerships required to offer some services, such as outreach and support for families and parents. National targets and additional funding provided. From 2003, policy shifted to delivering services through Sure Start centres	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 years 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

Table 1 | Summary of key national policies on local health partnerships in England, 1997-2022 *(Continued)*

Policy	Date	Summary and activities	Geographical area	Population	Partners	Intended effect
Local strategic partnerships (LSPs)	2001-	Voluntary partnerships to develop a community strategy to improve economic, environmental, and social wellbeing of an area. Partners expected to implement the strategy to address health, crime, housing, employment, and other issues.Involvement in LSPs required to receive funding for some policy initiatives. LSPs responsible for developing and delivering local area agreements (including central government targets on health)	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, others depending on local context	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
Neighbourhood management	2001-12	Multisector partnerships between public, private, and voluntary sector agencies, working with local communities. Processes to engage residents in influencing local service providers to join up and improve services, such as by improving access. Central government funding provided for seven year programmes	Targeted neighbourhoods in local authority areas. 35 "pathfinders," 30 of these in the most deprived 20% of areas. Average population targeted was 10 200 in 2003—ranging from 2770 to 20 570	Whole population in targeted neighbourhoods	Local authorities (eg, housing and youth and leisure services), police, environmental services, schools, primary care trusts, housing associations, and others depending on local context	Improve and join up local services, make services more responsive to local needs, reduce inequalities between most deprived communities and the rest of the country
Partnerships for older people projects	2005-09	Partnerships to improve health and wellbeing of older people. Agencies worked together to develop and deliver local projects, including to reduce social isolation, promote healthy living, and avoid hospital admission or support early discharge from acute or institutional care. Funding provided for two year projects. Sites could set relevant local targets but also expected to contribute to national targets such as to support more older people to live at home	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 prevention, prevent or delay need for institutional or hospital care
LinkAge Plus pilots	2006-08	Partnerships to improve health and wellbeing of older people. Areas received funding for two years to join up local services, strengthen prevention, and pilot new projects. National principles developed, such as engaging older people, and promoting independence. Pilots built on 2004 LinkAge programme	Local authority areas. Eight pilot areas	People over 50	Local authorities, social care, primary care trusts, jobcentre plus, pension service, voluntary and community sector, others depending on local context	Improve quality of life and wellbeing for older people, bring together local services, improve access and experience of services, achieve efficiencies

Table 1 | Summary of key national policies on local health partnerships in England, 1997-2022 *(Continued)*

Policy	Date	Summary and activities	Geographical area	Population	Partners	Intended effect
Total place pilots	2009-10	Partnerships 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 and integrate services—particularly for people with complex needs—and identify efficiencies	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 focused on target populations (eg, children under 5, older people), others focused on service areas or themes (eg, tackling drug misuse)	Local authorities, primary care trusts, policy authorities, voluntary and community sector, others depending on local context	Improve and integrate services, improve value for money, reduce waste and duplication
Integrated care pilots	2009-11	Pilots to test and evaluate new ways of delivering integrated care within the NHS and between health and social care. Approaches varied, but a common feature was the use of multidisciplinary teams to coordinate services. A mix of local and national performance measures used, and most pilots focused on reducing hospital use. Funding provided for two year pilot programmes	Mixed. 16 pilot areas	Varied depending on local context. Some focused on specific diseases, some on types of services (eg, end of life care), and others were mixed. Sites commonly focused on older people with complex needs	Primary care trusts and other NHS agencies, local authorities, voluntary and community sector, others depending on local context	Improve health and health equity, improve quality of care and satisfaction with services, improve partnerships in care delivery, more effective use of resources, improve relations
Community budgets (including whole place and neighbourhood pilots)	2011-13	Public sector agencies working together to understand patterns of spending across services, identify interventions to deliver best outcomes within resources, and develop a plan to deliver them. Local areas identified which services or outcomes to focus on, and government provided funding for technical and other support	Mixed: local authorities, groups of local authorities, targeted wards, or neighbourhoods within local authorities	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)	Local authorities and other public and voluntary and community sector agencies depending on local context, such as NHS agencies, police, and housing services	Solve complex local problems, improve efficiency, improve and coordinate public services
Health and wellbeing boards	2013-	Statutory partnership board to bring together local agencies responsible for improving local population health and wellbeing. Boards set up as committees of local government and given duties to assess population needs, set out how these will be addressed through a joint health and wellbeing strategy, and promote integration and partnership working	All local authority areas in England. 132 early implementer sites in 2011 and all upper tier local authorities by 2013	Whole local authority population	Local authorities (including public health, social care, children's services, and an elected member), clinical commissioning groups, Healthwatch, others depending on local context	Improve population health and wellbeing, reduce health inequalities, promote integration of services

Table 1 | Summary of key national policies on local health partnerships in England, 1997-2022 *(Continued)*

Policy	Date	Summary and activities	Geographical area	Population	Partners	Intended effect
Integrated care and support pioneers	2013-18	Partnerships to develop new models of integrated health and social care. Agencies developed plans for whole system integration, including between the NHS, social care, public health, wider public services, and the voluntary and community sector. National bodies expected pioneers to deliver improved outcomes and financial savings within five years. Modest additional funding and national support provided	Mixed. Some single local authority and clinical commissioning group (CCG) area, some single local authority and multiple CCG areas, and some multiple CCG and local authority areas. 25 areas in total, identified in stages	Varied depending on local context. Some focused on whole population. Others identified target groups—frail older people, people with long term conditions, high service users, or people at risk of hospital admission	CCGs, NHS providers, local authorities, social care, voluntary and community sector, others depending on local context	Improve health and wellbeing, improve quality and coordination of services, deliver more preventive care in the community, deliver more efficient and cost effective services
Better Care Fund	2013-	Mandatory joint planning and budget pooling between NHS and local government. Agencies develop plans for integrating health and social care for older disabled people and others, drawing on a pooled budget. Plans must meet some national conditions, initially including reducing avoidable hospital admissions. Plans agreed locally by health and wellbeing boards	Local authority areas. Whole of England.	Older people and people with disabilities, other groups depending on local plans	CCGs, local authorities, health and wellbeing boards, NHS providers, social care, 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	2015-18	Local sites tested new ways of delivering integrated health and social care. Relevant models included multispecialty community providers (MCPs), primary and acute care systems (PACS), and enhanced healthcare in care homes (EHCHs). Additional funding and central support provided	Mixed. Some single CCG and local authority areas, some multiple CCG and local authority areas, some GP network populations. 50 sites in total. 29 sites were PACS, MCPs, and EHCHs	Varied depending on local context. PACS and MCPs were population based models; EHCHs focused on care home residents. Around 5 million people covered in total	CCGs, NHS providers, social care, local authorities, voluntary and community sector, others depending on local context	Improve health and wellbeing, improve quality and experience of services, improve integration of services, improve efficiency, reduce hospital activity
Sustainability and transformation plans/partnerships (STPs)	2015-21	Local plans for improving health and health services, initially covering five years. Plans needed to focus on improving quality and integration of services, improving health, and improving NHS efficiency. Some NHS funding tied to the plans. Re-named 'partnerships' in 2017, and developed new governance structures	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—ranging from 300 000 to 2.8 million.	CCGs, NHS providers, local authorities, others depending on local context	Improve health and wellbeing, reduce inequalities, improve quality of services, improve efficiency

Table 1 | Summary of key national policies on local health partnerships in England, 1997-2022 *(Continued)*

Policy	Date	Summary and activities	Geographical area	Population	Partners	Intended effect
Integrated care systems (ICSs)	2017-	Partnerships responsible for planning and coordinating services between NHS, local government, and other agencies to improve health and health services for local populations. ICSs manage NHS resources. ICSs comprise new NHS integrated care boards and statutory integrated care partnerships, with more local partnerships sitting underneath them	42 areas. Whole of England. STPs evolved into ICSs in stages—with all STPs becoming ICSs in July 2021. Legislation in 2022 will formalise the structure of ICSs	Whole ICS population. Whole of England covered. Populations of around 1-3 million	NHS commissioners, NHS providers, local authorities (including social care and public health representatives), others depending on local context	Improve population health, improve healthcare, reduce inequalities in health and healthcare, improve productivity and value for money, support broader social and economic development

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 programmes 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 summarised from publicly available government and NHS policy documents, policy evaluations, and existing summaries of these policies.

Some partnerships were mandated by policy makers (such as health and wellbeing boards, established across the whole country in 2012), while others were voluntary initiatives (such as integrated care pilots, in place between 2009 and 2011 in 16 areas). Local agencies have typically been required to work together to develop a strategy for improving health and quality of services in their area—and sometimes have been provided with extra funding to help do so. Some programmes involved stronger national direction over the content of local initiatives than others. For instance, recent "vanguards" of new care models received national funding and support to develop three broad models of health and social service integration, including collaboration between general practices, hospitals, social care, and wider community services.[11]

Area based partnerships proliferated from 1997 under New Labour governments—including health action zones, Sure Start local programmes, and local strategic partnerships. These policies were combined with a national strategy to reduce health inequalities in England and major public investment in the NHS and social programmes.[12-14] 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 the Better Care Fund—but explicit aims to reduce health inequalities appeared less prominently. Partnerships since 2010 were implemented in the context of austerity in public spending,[15] and national policy makers often prioritised objectives of improving efficiency and reducing use of hospitals and other services.[16]

The new integrated care systems (fig 1) mix elements of these previous partnership policies, combining a narrower focus on coordinating health services for patients with broader ambitions to address social and economic determinants of health for populations. The result is a broad and ambitious list of objectives for the partnerships, including to improve population health, improve healthcare services, reduce inequalities in health and healthcare, improve productivity and value for money, and support broader social and economic development.[1] Collaboration between agencies and integration of services are seen as mechanisms to do this.

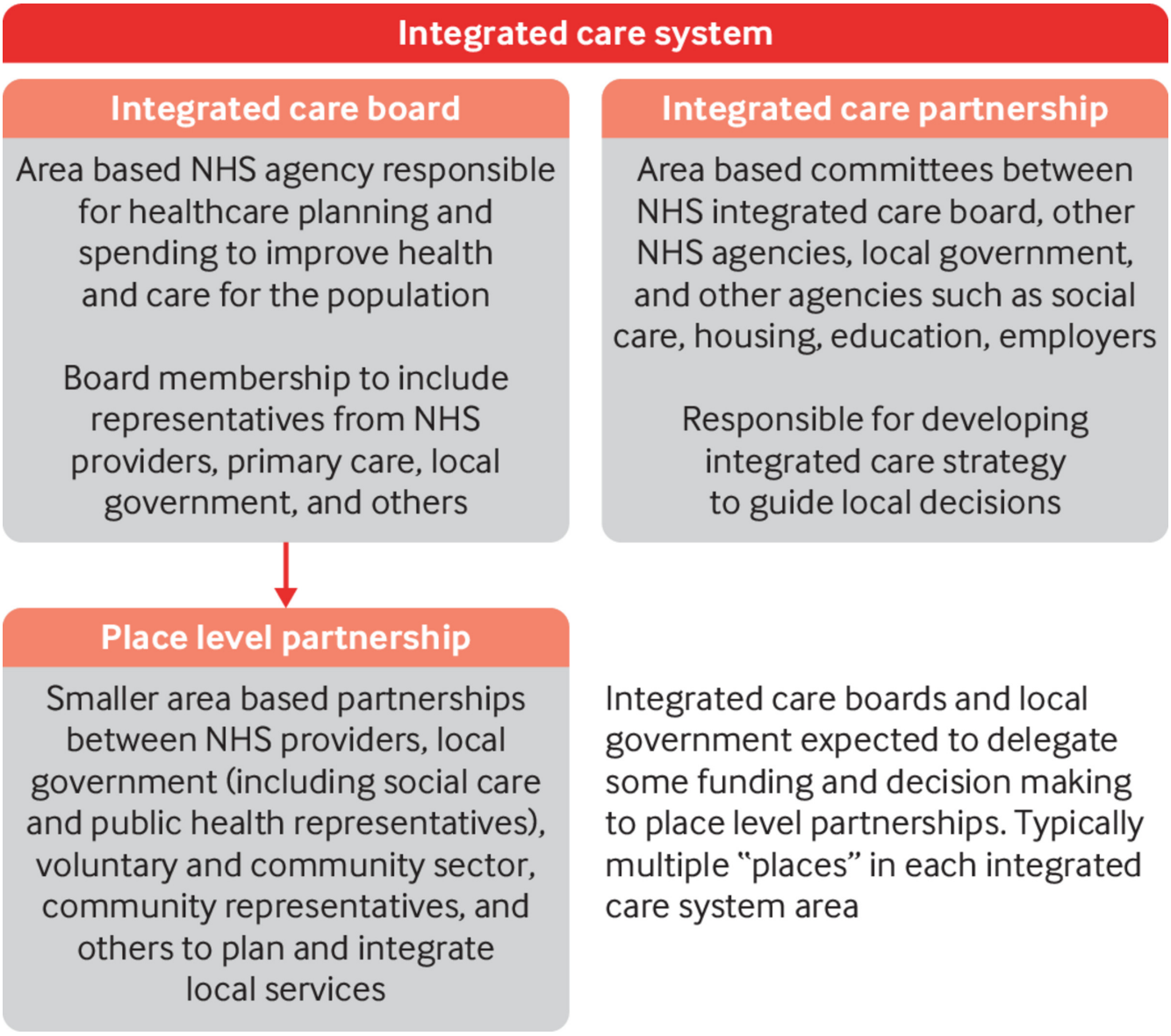

Fig 1 | Organisation of health and care partnerships in England's integrated care systems. Each integrated care system will be made up of two bodies: integrated care boards, responsible for controlling most healthcare resources in their area, and broader integrated care partnerships, responsible for developing an integrated care strategy to guide local decisions

Integrated care systems have existed informally since 2016—developed in response to the fragmentation of the English NHS and as part of a broader shift in policy away from provider competition as the route to improve services.[3 17 18] 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.[19] Patient and public involvement was often lacking,[19] and few local plans described interventions linked to social and economic determinants of health.[20 21] Integrated care systems will be expected to produce new five year plans in 2023, setting out how they will deliver the ambitious objectives given to them by national policy makers.[22]

Evidence on local partnerships is limited

Despite this long history, evidence that local health partnerships deliver the kind of benefits that policy makers typically expect is lacking. Overall, there is little high quality evidence to suggest that collaboration between healthcare and other agencies improves population health.[8-10] For example, a recent umbrella review found most studies assessing the effect of collaboration between healthcare and non-healthcare agencies on health outcomes such as quality of life or health equity found no, mixed, or limited evidence of benefit.[10]

Evidence of impact on health services is also mixed—though some studies suggest closer integration between health and social care can improve access to care and patient experience.[10 23] There is little difference in effects reported between UK and international studies.[10 23]

This does not mean collaboration is a bad policy. In theory, collaboration could help local agencies combine skills and resources,[24-26] manage interdependencies and share risks,[27 28] and—ultimately—tackle complex health problems that cannot be dealt with by a single organisation.[29-31] Most major health

challenges facing society fall into this category—and tackling them depends on policy action beyond the reach of healthcare systems.[32] Collaboration may also help improve efficiency by reducing transaction costs—for example, by making it easier to share information and develop processes between agencies.[33-35]

But making collaboration work in practice is challenging, influenced by power, resources, governance issues, policy context, and more.[10] Lack of trust between NHS and care home staff, for example, can hold back joint working.[36] Evaluating the effects of collaboration is also conceptually and methodologically tricky.[37 38] As a result, the benefits of collaboration may be overstated, hard to deliver, and hard to measure—or some combination of the three.

Although evidence on the effects of collaboration is thin, a mix of studies identify factors influencing how local partnerships function—for better or worse.[10] These factors can be grouped into five overlapping domains related to motivation and purpose, relationships and cultures, resources and capabilities, governance and leadership, and external factors (box 1).[10] Data linking factors in these domains to collaboration outcomes are limited, but some factors are likely to have a more powerful influence than others. For example, good communication between local agencies may help coordinate complex interventions. But broader political decisions about the level and distribution of funding for the NHS, local government, and other social services will fundamentally shape local resources available for improving health and reducing inequalities. For example, closer integration between health and social care services is little good without adequate funding or staff to deliver them.

Box 1: Factors shaping how local health partnerships function[10]

Studies on collaboration between healthcare and social services agencies identify various factors shaping how local partnerships function. These factors interrelate and cover five domains:

- *Motivation and purpose*—such as vision, aims, perceived benefits, and commitment to collaboration. For example, unclear or unrealistic aims may hold back collaboration
- *Relationships and cultures*—such as trust, values, and communication between partners. For example, historical relationships between agencies can shape collaboration efforts
- *Resources and capabilities*—such as access to funding, staff, and skills. For example, lack of resources for joint working is commonly identified as a barrier to collaboration
- *Governance and leadership*—such as decision making, engagement, and involvement. For example, direct community involvement may help collaborations be more effective
- *External factors*—such as national policy, institutional contexts, and geography. For example, national policy changes may confuse or conflict with local priorities

National policy choices shape local partnerships

Current policy in England emphasises the role of local agencies and "places" in improving population health.[1 39 40] But the role of national policy and political choices is often underplayed,[41] particularly in a highly centralised state like the UK, where many powerful levers for improving health lie at a national level. For example, most public spending, including social security, is managed by central government,[42] and recent reforms to social security may have contributed to increased psychological distress among unemployed people in England.[43 44] Local partnerships are strongly shaped by national policy choices and must be understood within the broader political and economic context in which they are developed.

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 part of a broader national strategy introduced by central government to reduce health inequalities by supporting families, engaging communities, tackling poverty, improving access to services, and action on underlying social and economic factors—backed by major increases in investment in the NHS and other public services.[12-14] National policy on NHS resource allocation also increased the share of healthcare funding in more deprived areas. Evaluations of the area based partnerships implemented during this period found little evidence that they achieved their objectives[45] and identified various implementation issues.[46] But more recent evidence suggests the broader collection of policies may have contributed to modest reductions in health inequalities over time.[47-50]

Local partnerships continued through the 2010s, but the national policy context shifted. Compared with historical spending increases of around 3% a year, government spending grew at 0.3% a year in real terms between 2009-10 and 2019-20.[51] Spending on public services fell by 7.8% in real terms. Healthcare was relatively protected (though NHS spending in England still grew at less than half the long run average).[52] But other services, such as housing and local government services, faced major cuts. As a result, the capacity of local government to improve health shrank substantially. Public health budgets, for instance, fell by a quarter per person from 2015 to 2020, with funding falling furthest in more deprived areas.[53-55] And central government lacked an overarching national strategy to tackle widening health inequalities.[56] Local partnerships faced challenges trying to improve health with dwindling resources[57] and struggled to deliver narrower objectives to reduce unplanned hospital use.[58]

Lessons for England's new partnerships

The allure of cross-sector collaboration is long standing and understandable. But evidence suggests that policy makers should not expect too much from the new integrated care systems in England. Local agencies can learn from the various factors that have helped or hindered past collaboration efforts—such as the role of trust, communication, and clear decision making processes between agencies—to provide the best chance for success.

They can also learn from the mistakes of earlier versions of integrated care systems in England, including limited involvement of local government and other community partners in NHS planning processes, and "lifestyle drift" in strategies for improving population health.[20 21] The covid-19 pandemic appears to have enhanced joint working in some parts of the country, but the strength of collaboration varies widely, and weak involvement of social care and others beyond the NHS persists.[59]

But while there are lessons for local leaders, the effect of local partnerships will ultimately be shaped by national policy choices beyond their control. And these currently fall short. Government has set ambitious targets for reducing health inequalities in England but has so far failed to deliver the policy changes or investment needed to achieve them.[60-62] NHS spending is planned to grow by around 3.5% a year to 2024-25, close to the historical average. But spending on social care is barely enough to keep up with demand, public health funding is flat, and local government spending is on track to be smaller in 2024-25 than in 2010.[63 64] There is also a risk that the most visible national pressures—such as the six and a half

million people waiting for elective care[65]—dominate policy priorities. Without sufficient funding or a clear national strategy for reducing health inequalities, integrated care systems risk being set up to fail by national policy makers. The government's forthcoming "health disparities" white paper—expected later in 2022—has a lot of ground to make up.

Key messages

- Area based partnerships between the NHS, local government, and others are being established to plan and coordinate services
- Policy makers have ambitious aims for the new partnerships—including to improve health, reduce health inequalities, and contribute to broader social and economic development
- Despite a long history of national policies encouraging local health partnerships in England, evidence that they deliver the expected benefits is lacking
- New local partnerships risk being undermined by national policy choices beyond their control, including insufficient funding for local government and public health services

Contributors and sources: All authors are researchers in health policy and public health in the UK and have experience analysing healthcare system reforms in England and elsewhere. All authors contributed to the intellectual content. HA wrote the first draft. NM and AH commented and made revisions. All authors agreed the final manuscript. HA is the guarantor.

Competing interests: We have read and understood BMJ policy on declaration of interests and have no relevant interests to declare.

Provenance and peer review: Not commissioned; externally peer reviewed.

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