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

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DECLERATION

I, Hugh Alderwick, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

ABSTRACT

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. 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 services. ICSs have been given explicit policy objectives to reduce health inequalities.

The research uses a mix of methods to understand how local NHS organizations are collaborating with other sectors to reduce health inequalities under the latest health system reforms in England. The research involved three phases. 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. 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 in England through the new systems. 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 within ICSs to reduce health inequalities, based on in-depth interviews with senior leaders in three more socioeconomically deprived ICSs in England. A framework based on the initial evidence synthesis and broader literature on public policy implementation are used to analyse the data.

Overall, there is little convincing evidence to suggest that collaboration between local health care and non-health care organizations improves health or health equity. 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. Local leaders in England's new ICSs 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. Closer alignment between policy aims, processes, and resources to reduce health inequalities is likely needed to avoid policy failure as ICSs evolve. The findings point to implications for policy and research on cross-sector collaboration to reduce health inequalities in the UK and internationally.

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CHAPTER 1

Introduction

Background

The NHS in England was reorganized under the Health and Care Act 2022[1]—the biggest government overhaul of the NHS in a decade. The changes are based on the idea that collaboration is needed between the NHS, social care, public health, and other sectors to improve health and health equity. Since July 2022, the NHS in England has been formally divided into 42 Integrated Care Systems (ICSs)—area-based partnerships between the NHS, local government, and other agencies, covering populations of around 500,000 to 3 million people—responsible for planning and coordinating services to improve health and care.[2] ICSs are the centrepiece of the new NHS structure and have been given wide-ranging policy objectives by national NHS bodies and government—from improving NHS productivity to influencing broader social and economic conditions shaping health.[3] Organizational collaboration and integration of services are seen as key mechanisms to achieve them.

Reducing health inequalities is one of the four ‘core purposes’ of the new systems.[3] Health inequalities in England are vast and growing. There is currently a gap of almost 20 years in how long a woman can expect to live in good health depending on whether she lives in one of the most or least socioeconomically deprived areas of England.[4] This pattern holds across the population: the more socioecomomic disadvantage people face, the worse their health tends to be.[5,6] There are also inequalities in access to high quality health care.[7,8,9,10,11,12] For example, GP practices in more deprived areas of England are relatively under-funded, under-doctored, and perform less well on a range of quality measures when compared with GP practices in less deprived areas.[12,13] Health inequalities have been widening since 2010 and the covid-19 pandemic exacerbated them further.[6,14] Health inequalities are not unique to England[15] but are larger in England than many comparable countries.[16]

Policymakers in the UK have been concerned—on and off—with how to reduce health inequalities for decades.[17] For example, in 1977, the Labour government commissioned a working group to investigate differences in health outcomes between social groups in the UK and identify implications for policy.[18] Similar reviews were commissioned in the 1990s and 2000s.[17] But health inequalities are complex and deep-rooted,[19] influenced by a combination of social, economic, environmental, and other factors—such as income, education, employment, and housing—and their interactions.[20] While health care services play a role in shaping health inequalities, evidence points to underlying social and economic conditions as dominant factors.[21,22] These multiple and overlapping causes of health inequalities pose challenges for policymakers seeking to address them—for instance, given that a mix of interventions are needed across government and over time.[23] The fragmentation of responsibility and decision-making between different government departments, and complex web of national and local agencies involved in public policy delivery adds to the complexity.[24,25] As a result, cross-sector collaboration is widely promoted as a route to aligning local action to improve health equity.[26,27,28,29,30]

ICSs build on a long history of policies on local cross-sector collaboration in England. Since at least the 1970s, successive governments used a mix of policy measures to try to better integrate NHS and local authority services, such as joint planning initiatives and pooled funding.[31,32,33,34] 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'.[35,36] This included a mix of cross-sector partnerships between the NHS, local government, and other agencies at a local level, such as Health Action Zones (HAZs), to meet wider policy objectives to improve health and reduce health inequalities.[37,38] Looking further afield, local health partnerships have been developed in diverse national contexts for decades—including in Europe, North America, and elsewhere.[39,40,41]

Yet cross-sector collaboration may not deliver what policymakers hope. Despite their long history, little is known about the impact of cross-sector partnerships between local agencies on health or health equity.[42,43,44] Meanwhile, a large body of evidence describes the mix of factors that can hold back effective collaboration—including competing organizational agendas, resource gaps, weak trust, communication issues, power imbalances, and more.[45,46,47,48,49] To make things harder, policy initiatives to tackle health inequalities are frequently ambiguous, underfunded, and undermined by other short-term political objectives, such as targets to improve care in NHS hospitals.[50,51,52,53] Alongside reducing health inequalities, England's new ICSs 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.[3,54] Pressures on the NHS are extreme and contributing to avoidable deaths and harm across England.[55]

Whether ICSs can overcome these challenges and contribute to reduced health inequalities in England is yet to be seen. Studies have focused on the emergence of ICSs prior to their formal establishment in 2022—including analysis of early ICS plans and planning processes,[56,57,58,59] experiences during the pandemic,[60,61] and evolving governance and decision-making.[62,63] But in-depth understanding of how organizations within ICSs are collaborating to reduce health inequalities since the formal introduction of ICSs is lacking. Filling this gap is important given a new UK government was elected in 2024 and is developing its plans on health and the NHS—including how to meet ambitious goals to reduce health inequalities.[64]

This research explores how local NHS organizations are collaborating with other sectors in their area to reduce health inequalities under England's latest NHS reforms. This includes analysing ICSs in their historical context and alongside broader international evidence on local cross-sector partnerships to improve health and health equity. The following sections set out the research aims and thesis structure.

Research aim and objectives

The aim of the research is to understand how local NHS organizations are collaborating with other sectors to reduce health inequalities in England's new ICSs. The research has three objectives:

Objective 1: Synthesize qualitative and quantitative evidence to understand the health impacts of collaboration between local health care and non-health care organizations, as well the factors affecting the functioning of cross-sector partnerships focused on improving health or health equity.

Objective 2: Analyse a mix of data to understand the policy context, development, aims, structure, and characteristics of England's new ICSs—including how they fit with previous national policies on cross-sector collaboration to improve health and reduce health inequalities in England.

Objective 3: Use qualitative methods to understand how local NHS, social care, public health, and other organizations are collaborating to reduce health inequalities in three ICS areas in England.

Thesis structure

To meet these objectives, the research is divided into eight chapters. The first chapter is this one—setting the broad context for the research and providing an outline of what follows in the thesis.

The second chapter describes the approach and methods for the research. It is divided into two parts. The first section provides an overview of the main concepts, theory, and historical context that create a broad framework for the study. This includes three overlapping lenses to understand local cross-sector collaboration on health inequalities in England—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 NHS—and their implications for the research. The second section summarises the approach and methods for each stage of the research, and how the various components of the study fit together. This chapter also defines key terms, such as health inequalities and cross-sector collaboration, that are used throughout the rest of the thesis. It also provides more detail on the policy context and background for cross-sector collaboration in England.

The third chapter presents the findings from an umbrella review—a systematic review of reviews—to synthesize international evidence on the health impacts of collaboration between local health care and non-health care organizations, as well as to understand the factors affecting the functioning of organizational partnerships focused on improving health or health equity. The chapter provides an overview of a large body of qualitative and quantitative evidence to help make sense of the data on organizational collaboration and health. It also develops a framework of key factors shaping how collaborations function in different contexts, which is used to help guide analysis in later chapters.

The fourth chapter analyses the development of ICSs in England and puts them in their longer-term policy context. The idea is to provide an overview of the new systems and factors that may shape their evolution and impact. The policy analysis presented in chapter four involves three broad components.

The first reviews previous national policies encouraging collaboration between local NHS and non-health care organizations in England since 1997, synthesizes evidence on their impacts, and puts these partnerships in their broader policy and political context. The second analyses the evolution and structure of ICSs in England, including how they fit into the broader direction of NHS reform, along with their aims and governance. The third draws on a mix of 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 final part of the chapter identifies implications for ICSs as they evolve.

The fifth chapter provides in-depth analysis of national policy on reducing health inequalities in ICS. The chapter uses a 'policy streams' framework to help structure the analysis—focusing on how national policymakers define and conceptualize ICSs' aims on health inequalities, and the processes and resources expected to deliver them. The chapter analyses a mix of policy documents, early evidence on ICS experiences, and broader evidence on the policy context facing ICSs to understand the extent of alignment between policy aims, processes, and resources to reduce health inequalities, and likely challenges. The analysis identifies major issues that are explored in the following chapters.

The sixth and seventh chapters present findings from a qualitative study into how local NHS and other organizations are collaborating to reduce health inequalities under England's reforms. The research draws on in-depth interviews with 32 senior leaders from NHS, social care, public health, and community-based organizations in three ICSs experiencing high levels of socioeconomic deprivation.

Chapter six focuses on interpretations of national policy objectives on reducing health inequalities among senior leaders in the three ICSs. This includes local interpretations of national health inequalities objectives, how inequalities relate to other priorities, and how these interpretations vary.

Chapter seven then focuses more broadly on local experiences of collaboration to reduce health inequalities in the three ICSs. The focus is on how the NHS is working with other sectors beyond health care to reduce health inequalities. The research identifies 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. These factors are analysed in the context of the key domains in the international literature identified in chapter three. The 'policy streams' framework from chapter five is used to help interpret the results. The findings from chapters six and seven identify implications for policy on cross-sector collaboration in England and other countries.

The final chapter of the thesis—chapter eight—summarizes the research and its implications. It covers the overall study findings, how the research fits into the existing literature and what it adds, the main strengths and limitations of the research, and opportunities for future research. The discussion also stands back to identify overarching implications of the research for policy and practice—including what the study means for future health policy in England. The final part of the discussion reflects on my own position as a researcher and the ways this has shaped the research process, data, and analysis.

A note on style

The thesis is a hybrid of published papers and new material. This creates some stylistic quirks that are worth ironing out—or at least preparing for—in advance. Two are worth highlighting up-front.

First is that all the chapters presenting new research and analysis—chapters three, four, five, six, and seven—are written as individual papers. This means they all have an introduction, methods section, and so on, as well as their own reference lists, and are all intended to be read as standalone papers. Most of these chapters (apart from chapter five) are the final versions of papers that have already been published in peer-reviewed journals (chapters three, six, and seven). Chapter four combines several papers that have already been published with additional text and analysis. All the chapters are written in the same style, but there is some inevitable duplication in the introductory sections between chapters, given they each briefly summarize the policy context and existing relevant research. There are also some minor formatting differences between the chapters, given differences in journal styles. The cover notes provide more detail on the published material—for instance, where the paper has been published and who was involved. They also provide links to the full text of the published papers.

Second is that—as a result—the voice shifts in key parts of the thesis. The introduction, methods, and discussion sections—chapters one, two, and eight—are written in the passive voice, avoiding ‘I’ or ‘we’ where possible when describing the methods, approach, and results. The exception—like now—is when I discuss my role as a researcher and how this affected the research process. The remaining chapters, meanwhile, use ‘we’, given this is the convention when publishing papers with co-authors in most journals. These quirks notwithstanding, the thesis is designed to be read as a coherent whole.

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CHAPTER 2

Theory, approach, and methods

INTRODUCTION

The research uses a mix of methods to explore cross-sector collaboration between local NHS organizations and other sectors to reduce health inequalities in England. This includes an umbrella review to synthesize a large body of relevant international evidence, analysis of national policies on cross-sector collaboration to reduce health inequalities in England over time, and qualitative research to provide in-depth insight into local collaboration experiences under England's latest health system reforms. Local experiences in England are analysed in the context of broader international evidence.

This chapter sets out the approach and methods for the research. The first section provides an overview of the main concepts, theory, and historical context that provides a broad framework for the study. This includes three overlapping lenses to understand local cross-sector collaboration on health inequalities in England, and their implications for the research. This part of the chapter also defines key terms, such as health inequalities and cross-sector collaboration, used throughout the study. The second section summarises the approach and methods for each stage of the research, and how the various components of the study fit together—for instance, how the umbrella review of international evidence in chapter 3 informs the qualitative analysis of collaboration experiences in England's Integrated Care Systems (ICSs) in chapter 7. More detail on the approach and methods is included in relevant chapters of the thesis.

THEORETICAL FRAMEWORK

National policymakers established ICSs across England in 2022 and gave them ambitious policy objectives to reduce health inequalities. A mix of theoretical approaches and concepts can be used to understand the new systems. Three broad lenses are used in the thesis to help analyse England's ICSs:

- As public policy interventions to reduce health inequalities
- As inter-organizational collaborations to achieve major system change
- As an approach to top-down performance management in the NHS.

Lens 1: policy to reduce health inequalities

One way of understanding England's new ICSs is as a public policy intervention to reduce health inequalities. National policymakers in England have given ICSs explicit aims to reduce health inequalities, and framed this as one of the four 'core purposes' of the new systems—as is explored in chapters 5 and 6. Governments in the UK and elsewhere have been concerned with how to reduce health inequalities for many years—for example, with three major UK government commissions reporting since 1980 on health inequalities in the UK and policy action to address them (including the Black Report published in 1980, Acheson Inquiry in 1998, and Marmot Review in 2010).[1] But health inequalities are complex and deep-rooted,[2] and relative health inequalities have been increasing in most European countries for decades, despite explicit national policy efforts to reduce them.[3,4]

Defining health inequalities

Health inequalities can be broadly defined as systematic differences in health between social groups, places, or across the socioeconomic gradient.[5,6] Given some health differences within the population are expected (for instance, between older and younger people) and others are down to random chance,[7] a distinction can be made between health inequalities—a general description of differences in health between individuals or groups—and health inequities—those inequalities in health that are deemed to be systematic, avoidable, and unfair.[8,9,10] Making this distinction depends not just on evidence about differences in health but normative judgements about justice and fairness in society.[8] In England and other European countries, the two terms are generally used synonymously to describe the systematic differences in health between social groups that are widely judged to be unfair and avoidable, such as stark differences in life expectancy by socioeconomic deprivation.[11,12,13] For example, recent government policy documents and guidance from national NHS bodies in England describe health inequalities as 'unfair and avoidable' differences in health across the population.[14,15] Reflecting this, the two terms are used synonymously throughout the thesis. The chapters try to echo the language used in the relevant data being analysed—for instance, the language used in the existing evidence reviewed (for example, in chapter 3), in the national policy documents analysed (for example, in chapter 5), and by people interviewed in the qualitative research (in chapters 6 and 7).

A further distinction can be made between health outcome inequalities and health care inequalities.[16] Health outcome inequalities refer to differences in overall measures of health status, such as morbidity and mortality. For example, people living in more deprived areas in England tend to die earlier than people living in less deprived areas, and spend a greater proportion of their shorter lives in poor health.[17,18] Health care inequalities, meanwhile, refer to differences in quality and outcomes more closely linked to the health care system, such as access to services or the quality of care provided in hospitals and elsewhere. For example, there are persistent inequalities in maternal care and related outcomes for women in the UK depending on their race and ethnicity,[19,20,21] while GP practices in more socioeconomically deprived areas of England are relatively under-doctored, under-funded, and perform less well on a range of quality measures compared with GP practices in less deprived areas.[22]

Inequalities in health care and health outcomes are, of course, intertwined. The availability and quality of health care contributes to overall health outcomes,[23,24] while delivering high quality health care can be more challenging in more deprived areas with greater health and care needs.[25] But making a distinction between these two concepts can help design and assess policy interventions to reduce health inequalities—for example, given the interventions and mechanisms to deliver policy objectives to reduce health inequalities will likely differ depending on the type of inequalities being targeted.[16]

The distinction between health care and health outcome inequalities is also relevant when analysing how national and local leaders conceptualize policy objectives to reduce health inequalities—as is explored in chapters 5 and 6. How policy problems are framed and understood shapes the action taken to address them.[26,27,28,29] A mix of studies have explored how local health leaders interpret health inequalities concepts[30,31,32,33,34,35] and previous policy objectives in England to reduce them.[36,37,38,39] These studies illustrate how leaders from different sectors often have competing interpretations of the problem to be solved—for example, between emphasizing individual risk factors for ill-health and the broader structural factors shaping health inequalities.[30] 'Health inequalities' is used as an umbrella term throughout the thesis, and distinctions are made between different types of inequalities where relevant.

Health inequalities and the social gradient in England

Health inequalities in England are deep and persistent. Life expectancy and healthy life expectancy—the amount of time people can expect to live in good health, not just how long they might live[40]—at birth are two key measures of population health outcomes. On both, health is far worse for people living in more deprived areas of England.[41] For example, there is currently a gap of almost 20 years in how long a woman can expect to live in good health between people living in richer and poorer areas.[41] These inequalities have persisted and increased over time.[18,42] But health inequalities in England and other countries are not just about differences between the richest and poorest. A large body of evidence documents a 'social gradient' in health: the lower people's socioeconomic position, the worse their health tends to be.[17,43,44,45] This means health inequalities affect the whole population, not just people living in the most deprived areas. The covid-19 pandemic led to a sharp drop in life expectancy across England, but the impact was felt unequally and deepened existing inequalities.[13,46]

Health care inequalities persist too. The NHS is a universal health care system with equity built into key aspects of its design—for instance, with revenue raised predominantly through general taxation,[47] services available free at the point of use, and health care funding allocated geographically based on need.[48,49] The NHS generally compares favourably to other countries' health care systems on equitable access.[50,51,52] Despite this, evidence suggests that—after accounting for differences in health needs—people with higher levels of socioeconomic deprivation tend to receive worse access, quality, and experience of some types of NHS services, such as preventive interventions and specialist treatment.[53,54,55,56,57,58] For example, Cookson et al reviewed a mix of evidence on the socioeconomic distribution of health care in England and found that poorer groups tended to consume a greater quantity of health services (reflecting their greater health care needs), but that richer patients tended to present to health care providers earlier and consume more screening, vaccination, and other preventive services, and also tended to achieve better health care outcomes, such as surgical mortality, even after adjusting for observable differences in risk-factors.[53] Rates of treatable mortality—deaths that could have been avoided through timely and effective health care intervention—are also consistently higher in more deprived areas in England.[59,60] For both health outcome and health care inequalities, studies typically focus on inequalities based on socioeconomic status, such as income and education (or composite measures of socioeconomic deprivation combining data on a mix of factors).[17,18,61] But inequalities also exist by geography,[62] race, ethnicity,[63] and other dimensions.[64]

Factors shaping health inequalities

Health inequalities are shaped by a combination of social, economic, and other factors across society.[65] How health care services are designed and delivered can contribute to health inequalities—for instance, if some groups face additional barriers to accessing high quality care[66,67] or the distribution of resources does not account for differences in needs.[22,68] Health care inequalities can be influenced by decisions at various levels of the system—for instance, in national policy on NHS staffing[69] or local decisions about how primary care interventions are tailored and communicated.[25]

But evidence points to broader social and economic conditions as playing a dominant role in shaping population health outcomes and their distribution.[23,24] Social determinants of health are defined by the World Health Organization (WHO) as 'the conditions in which people are born, grow, live, work and age,' which are 'shaped by the distribution of money, power and resources'.[70] They include income, education, employment, housing, neighbourhood conditions, transportation systems, social connections, and other social and economic factors. Social determinants of health operate at multiple levels.[71] Underlying structural factors, such as a country's macroeconomic policy, public policies on education, employment, housing, social security, and other areas, and broader cultural and institutional contexts shape the distribution of resources across society and people's social position within it. These structural factors, in turn, shape more downstream social factors, such as living and working conditions, and access to money to buy food, clothes, and other basic resources, which form the circumstances of people's daily lives. The interactions of these factors shape health and health inequalities.[72] This includes influencing people's likelihood of adopting harmful health behaviours—including smoking, poor diet, physical inactivity, and harmful alcohol use—that drive a significant burden of preventable disease and mortality in England and other countries.[73,74] These major risk factors for disease are socially patterned, with higher prevalence among more deprived groups.[75]

Social determinants have both direct and complex effects on health. For example, poor air quality, which is more common in poorer neighbourhoods, can quickly exacerbate people's asthma symptoms.[76] Levels of income and education, meanwhile, interact with other factors to shape a range of health outcomes, such as the prevalence of chronic disease and life expectancy, across the life course.[17,45,77,78,79,80] A life course approach is often used as a conceptual framework in public health research and policy to recognize that factors shaping health and health inequalities interact and accumulate throughout people's lives, and that interventions across the lifespan—not just in particular age groups or disease areas—are needed to promote health and reduce health inequalities.[17,81,82]

Policy action to reduce health inequalities

The complex nature of health inequalities poses challenges for policymakers seeking to address them.

For example, given that health inequalities are shaped by the interaction of multiple social, economic, environmental, and other factors, policy to reduce health inequalities depends on interventions across organizations and sectors—for example, between health care, local government, housing agencies, and employers. It also depends on alignment and coordination between multiple levels of government. Yet the 'conventional' delivery of government in the UK has been based on the vertical separation of responsibilities for services and policy areas[83,84]—including the separation of policy departments and the Treasury responsible for their financing—and horizontal coordination problems between health care, social services, and other sectors abound.[85,86,87] Exworthy identifies eight challenges for public policy seeking to tackle social determinants of health.[88] Other literature identifies similar challenges for policy to reduce health inequalities.[89,90] Taken together, a mix of illustrative challenges can be identified for public policy seeking to reduce health inequalities in England or elsewhere (table 1).

Table 1. Example features of health inequalities and challenges for public policy to address them

Features of health inequalities	**Challenges for policymaking**
Multi-faceted and complex phenomena	Policy objectives may be various and contested
Influenced by multiple factors across society	Coordination needed across services and sectors
Influenced by decisions at multiple levels	Alignment needed between levels of government
Social gradient in health	Targeted approaches alone will be insufficient
Life-course perspective	Long-term approach misaligned with political cycles
Cause-effect relationships are complex	Challenges attributing interventions to outcomes
Health care alongside broader social determinants	Risk that health care dominates other determinants
Political and policy context are strong factors	Policy interventions will operate in a broader context

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To help navigate these challenges, a mix of frameworks have been developed to guide public policy approaches to reducing health inequalities. For example, Davey et al reviewed evidence on reducing geographical health inequalities and identified five broad principles for policy—including developing 'healthy-by-default and easy to use' initiatives (such as taxing unhealthy foods to make healthy choices easier, rather than relying on information provision for individuals), 'long-term, multi-sector action' (for example, versus interventions targeting single health determinants), 'locally-designed focus' (for instance, by tailoring interventions to the local context), 'targeting disadvantaged communities' (such as low-income groups), and 'matching of resources to need' (for example, by adjusting local funding for health care and other public services).[90] Similarly, the Marmot Review in 2010 emphasized 'proportionate universalism' as a guiding principle for policy action to address health inequalities—where services are available to all but targeted towards more disadvantaged groups.[17] Other conceptual frameworks define key health determinants (such as education, health care, and broader socio-economic conditions),[11] policy domains (such as tobacco and alcohol),[91] policy mechanisms (such as fiscal and regulatory levers),[92] and target population groups for action on health inequalities (such as people living in more deprived areas or 'inclusion health' groups—an umbrella term used to describe people who are socially excluded, such as sex workers and vulnerable migrants, who often experience a mix of risk factors for ill health, such as poverty and violence).[93,94,95]

A mix of studies have also synthesized evidence on selected policy interventions to reduce health inequalities in the UK and elsewhere. This includes evidence on interventions to reduce health inequalities through general practice,[96] public health policy,[92] addressing social determinants of health,[97,98] and broader economic policy,[99,100] as well as studies that seek to identify consensus among researchers on the policy approaches most likely to reduce health inequalities.[101] Taken together, these studies provide broad pointers for policymakers. For example, Gkioleka et al[96] identified promising strategies through service changes in general practice—for instance, engaging disadvantaged patients in primary prevention and addressing patients' living conditions—while Naik at al[99] found that market regulation of health-related goods, such as alcohol and food, through taxation and subsidies is likely to be effective in improving health and reducing health inequalities. Standing further back, studies examining links between the political economy and health also point to broad characteristics of welfare state regimes and political approaches that may contribute to reduced health inequalities—for instance, the role of social democracy and higher public spending.[102,103,104] Yet these studies generally point to weaknesses and gaps in the evidence base, identify a bias towards describing the problem of inequalities rather than solutions to address them, and call for more research to inform policymaking.

Other studies look historically at periods where policymakers appear to have been successful at reducing health inequalities to identify lessons for policy. Bambra examined trends over the 20th and 21st centuries[105] and global case studies from the post-war period[106] to identify factors shaping reductions in inequalities. Bambra's analysis emphasizes the role of national politics and policy in reducing health inequalities—and points to welfare state expansion, improved access to health care, and enhanced political incorporation (for instance, as previously marginalized groups gain greater representation in policy and politics) as major factors driving changes in inequalities over time.

One period where public policy changes appear to have contributed to reduced health inequalities is during the implementation of the national health inequalities strategy in England in the 2000s, delivered under successive Labour governments. A new UK Labour government was elected in 1997 and introduced a wide-ranging national strategy to reduce health inequalities between 2000 and 2010. The strategy evolved over time and involved a mix of components focused on supporting families, engaging communities, tackling poverty, improving access to public services, and action to improve underlying social and economic conditions through a mix of social programs, such as SureStart and the national minimum wage—backed by major increases in investment in the NHS and other public services.[107,108,109] The strategy included overall targets to reduce inequalities in life expectancy between English regions and socioeconomic groups, alongside commitments to reduce health care inequalities.[110] National policy on NHS resource allocation increased the share of health care funding going to more deprived areas,[111] and various policy initiatives sought to reduce inequalities in access to NHS services—for instance, by establishing new GP practices in more deprived areas.[112,113] Area-based initiatives involving collaboration between the NHS, local government, and other sectors, such as Health Action Zones, were a key component of the strategy (*see* chapters 3 and 4). Overall, evidence suggests that the strategy likely contributed to modest reductions in health inequalities over time.[114,115,116,117] Changes in policy on NHS funding may have contributed to reductions in absolute inequality in mortality amenable to health care.[111] Yet the strategy was not continued after Labour left office in 2010 and health inequalities have since widened.[117]

Policy analysis on health inequalities

The complexity of health inequalities also poses challenges for researchers seeking to analyse public policy interventions to reduce them—for instance, given the need to consider how policy interventions and processes interact at multiple geographical levels. Various conceptual frameworks can be used to support analysis of policy on health inequalities.[129,118] For example, Kingdon's Multiple Streams Framework can help illustrate how policy change happens (or not) through the (mis)alignment of issues requiring policy intervention (the 'problem stream'), feasible solutions to address these issues ('the policy stream'), and the political will to implement them (the 'politics stream')—allowing 'policy windows' to open and close.[119,120] Kingdon's framework emphasizes the role of political ideas and values in shaping the policy 'problems' that receive attention and the solutions considered feasible to address them. As a result, major political events, like elections and new governments, can help create the conditions for new issues to rise up the political agenda and for policy change to happen. The Advocacy Coalition Framework, meanwhile, can help researchers assess how a range of actors with similar beliefs form coalitions to influence policy change over time.[120,121] These and other concepts can support analysis at various stages in the policy process—for instance, to understand why policy objectives to reduce health inequalities appear on the political agenda, or how policy mandates to reduce health inequalities are implemented in practice.

National policymakers in England have already defined broad objectives for ICSs on reducing health inequalities. The analysis presented in the thesis focuses predominantly on the policy process to deliver these objectives—including how policy aims to reduce health inequalities have been defined and interpreted, the policy mechanisms and resources expected to deliver reductions in health inequalities, and the experience of local leaders responsible for implementing the policy in practice.

One way of conceptualizing the policy process on reducing health inequalities is through the lens of 'policy streams'—zooming in on the policy stream within Kingdon's Multiple Steams Framework. While originally focused on the role of ideas and agenda-setting in the US policy process, Kingdon's framework has been used and extended in a mix of contexts to analyse how policies are applied across sectors and levels of government, and how policies are implemented in practice.[120,122,123] Drawing on Kingdon's work and other models of policy streams[119,124] and policy failure,[125,126] Exworthy and Powell describe three 'streams' that need to align for successful policy implementation on health inequalities.[127,128,129] First is the 'policy stream', which focuses on policy 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 within 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). The broader political context influences policy implementation at each of these levels. For example, political decisions about the level and distribution of public spending shape the resources available to reduce health inequalities (in the 'resource' stream) and differences in power between agencies at a local level. The guiding ideas of government at the centre—for instance, on the role of the state in reducing health inequalities, or dimensions of inequality prioritized for policy attention—will also influence the objectives set by policymakers (in the 'policy' stream) and interventions selected to deliver them (in the 'process' stream). These ideas may conflict with priorities at a local level.

Exworthy and Powell's policy streams framework is used to help structure the policy analysis in chapter 5 of the thesis, as well as to inform the interpretation and analysis of qualitative data in chapter 7. Throughout the thesis, the development of ICSs is explored in its broader political context—for example, alongside evidence on government's wider policy approach to reducing health inequalities, and levels of public spending on the NHS, local government, and other local services.

Lens 2: inter-organizational collaboration to achieve major system change

A second lens to understand England's new ICSs is as inter-organizational collaborations to achieve major changes across local health systems. Since July 2022, England's NHS has been formally divided into 42 ICSs—area-based partnerships between the NHS, local government, and other agencies, covering populations of around 500,000 to 3 million people. ICSs are complex systems involving a mix of organizations and overlapping organizational partnerships between them. ICSs have been given ambitious policy goals—from reducing health inequalities to improving productivity and value for money in the NHS. Collaboration between local agencies and integration of services are seen as key mechanisms to achieve these objectives (*see* chapters 4 and 5).

Defining collaboration

Collaboration is a slippery concept that has been explored from a variety of theoretical perspectives across disciplines—including organizational sociology, political science, strategic management, and economics, as well as in applied literature on public health and health policy.[89,130,131,132] As a result, the terms and definitions used to describe inter-organizational collaboration are many and varied, and—worse—frequently conflicting and confusing. At its broadest, inter-organizational collaboration refers to the relationships between two or more distinct organizations to achieve an objective.[130] Collaborations develop for different reasons, take many forms, function in varied ways, and can achieve diverse outcomes—as is explored in more detail below. Understanding how collaborations work in one context—for instance, between private sector organizations choosing to work together under a contract—may be little use in understanding how collaborations function in another—for instance, mandated partnerships between public sector organizations to deliver long-term policy goals.

The focus of the thesis is on local collaboration between health care and non-health care organizations to improve health and reduce health inequalities. 'Non-health care organizations' is an inelegant way of describing organizations from sectors beyond the health care system, such as local government agencies responsible for public health, social care, and other services. Collaboration between health care and other sectors is widely promoted as a route to improving health and health equity—in the UK,[133] Europe,[134] North America,[135] and elsewhere. The term cross-sector collaboration is used throughout the thesis to describe this kind of inter-organizational collaboration that spans sectoral boundaries. And various forms of cross-sector collaboration are studied throughout the research—for instance, by synthesizing evidence on a mix of collaborations to achieve health objectives in diverse country contexts (chapter 3), analysing an array of national policies on local cross-sector collaboration to improve health and reduce health inequalities in England (chapter 4), and focusing in detail on cross-collaboration to reduce health inequalities in England's new ICSs (chapters 4-7 in particular).

Partnership is a related term that—again—is hard to define,[136] but is generally used to describe a broad range of approaches to managing inter-organizational networks.[89,137,138] In a partnership, organizations come together beyond a single transaction, share responsibility for assessing need, and jointly plan and implement action to deliver agreed objectives.[89] The forms of cross-collaboration studied in England in chapters 4 and 5 could all be described as partnerships—some more formal, some less formal. In practice, however, partnerships are often referred to as collaborations, collaborations referred to as partnerships, and both collaborations and partnerships referred to by a long list of other terms instead—such as coalitions, alliances, and more.[130] Both terms are used interchangeably throughout the thesis.

Collaboration in a changing state

Organizational collaboration has a long history[130] and policymakers in the UK have encouraged collaboration between the NHS and local authorities since at least the 1970s.[139,140,141,142] But collaboration has become a central mechanism to deliver public policy in the UK and other countries since the 1990s, when policies to develop local partnerships in the UK proliferated.[89,143,144,145,146]

Skelcher[147] puts this shift towards partnership working in the context of the broader evolution of the UK state. He identifies three caricatured phases. First is the 'overloaded state' of the 1960s and 1970s, characterized by efforts to deliver mainstream welfare programs through large, vertically-organized bureaucracies with strong professional orientation. Second is the 'hollowed out' state of the 1980s and early 1990s, which developed in response to perceived problems of government overreach and changing political ideas about the role of the state. These reforms—often referred to as the New Public Management—were characterized by use of market-mechanisms, contracting out of public services, consumer choice and competition, and a broader desire for state reduction.[148,149,150] One consequence was increasing fragmentation of public bodies and public service delivery, along with muddied accountabilities and reduced visibility of key decision-making bodies. Third is the 'congested state' of the late 1990s, where policymakers seek to navigate this complex web of organizations and responsibilities at multiple levels to deliver cross-cutting policy objectives on health, community development, and other areas. A vast literature has emerged to analyse what 'governance' means in this context and the continued evolution of the UK state from the late 1990s onwards.[151,152,153,154] But the shift towards collaboration and governance through networks in the 'congested state' has remained a persistent feature of UK public policy. In theory, this represents an alternative to traditional governance through hierarchy or markets.[138] In practice, these modes of governance operate alongside each other, interact, and can conflict—as is the case in the NHS.[132,155]

Collaboration drivers

Organizations collaborate for a mix of reasons. Under the right conditions, theory suggests that organizations may achieve better results by combining their skills and capabilities.[156,157,158] From a resource dependence perspective,[159,160] partnerships offer organizations opportunities to access new skills, manage interdependencies, and share risks in the external environment. Partnerships may also allow agencies to tackle complex issues that cannot be addressed by a single organization, including by better understanding policy issues and acting collectively to address them.[161,162,163] The challenge of tackling health inequalities is a case in point (*see* section on policy action to reduce health inequalities). Collaboration could also improve efficiency by reducing transaction costs.[164,165,166,167] Collaboration may also simply be a realistic response to the uneven and fragmented nature of decision-making in the modern state—as Skelcher's analysis of the emergence of the 'congested state' in the UK implies.[147]

But another reason organizations collaborate is because they are forced to. In contrast to many forms of collaboration that emerge in the private sector, collaboration between public sector agencies in England and elsewhere is often mandated from the 'top-down' by central government agencies, rather than through 'bottom up' self-organization.[89,168] England's new ICSs are statutory partnerships between the NHS, local government, and other organizations, with their objectives and structure defined nationally by central government (*see* chapters 4 and 5). Similar mandated partnerships have been developed over the last 30 years in England (*see* chapter 4), as well as in other countries.[169]

Under these kinds of partnerships, local organizations may have some role in setting objectives and developing local strategies, but do so in the context of government priorities and targets—often highly prescriptive ones. For instance, NHS agencies and local government in England were asked to develop local plans for coordinating health and social care services under the Better Care Fund from 2013, yet the plans needed to meet a set of national conditions and pooled budgets with a minimum spend were mandated.[170,171,172,173,174] On the one hand, national policy can help strengthen or enable local partnerships—for instance, by providing extra funding or political support.[175,176,177] But there are also risks, such as developing partnerships without the underlying local relationships needed to deliver them,[178,179] national mandates dampening or conflicting with local priorities,[175,179] and changes in national policy causing confusion or undermining the partnerships they aim to promote.[180]

Collaboration forms

Organizational collaboration can take a variety of forms—from loose networks of informal relationships to formal structures where organizations agree to devolve some of their autonomy.[89] Collaborations that go beyond informal and ad-hoc relationships but stop short of full organizational integration are generally described as partnerships. The organizations involved in collaborations vary too. Health partnerships can involve joint working between health care and social services,[181,182,183] wider public service partnerships,[184,185,186] and community coalitions of diverse stakeholders.[187,188,189] A large literature focuses on public-private partnerships and the factors that influence them.[190] The structure and governance of England's new ICSs is explored in detail in chapter 4 of the research.

Collaborations can also exist at multiple geographical levels. Health in all policies approaches, for example—where health impacts are considered in policy processes across government—have been developed at a national level in governments in Europe, Canada, and elsewhere.[191,192] International collaborations have long been used to help address public health challenges, such as tobacco control and tackling poverty.[193,194] And various local and regional partnerships to improve health have been established in diverse contexts.[195,196,197] In this research, the focus is on cross-sector collaboration at a local level. In the umbrella review of international evidence (chapter 3), this means focusing on cross-sector collaboration to improve health at a sub-national level in various international contexts—for instance, in local authority areas, states or counties, and sometimes smaller populations in cities or neighbourhoods. The research on cross-sector collaboration in England (in chapters 4, 5, 6, and 7) focuses on the local areas or regions covered by the relevant policy, such as the 42 geographical areas covered by the new ICSs.

Collaboration functioning and impact

Collaboration may sound like an obvious route to improving health or delivering other cross-cutting objectives. But collaboration also brings risks, such as coordination problems, conflicting goals, extra costs, and loss of organizational power. For example, insights from new institutional theory suggest that as agencies collaborate, competing institutional rules and norms may come into conflict.[198,199,200] Despite the long history of cross-sector collaboration and its enduring popularity among policymakers, there is limited evidence to suggest that partnerships between local health care and non-health care agencies improve population health or reduce health inequalities—in the UK or elsewhere.[201,202,203]

A large volume of literature documents factors that may shape partnership functioning and impact, such as trust and shared objectives between organizations and leaders.[204,205,206,207,208] Some of these studies synthesize evidence on factors shaping partnerships in particular policy contexts. For instance, Perkins et al synthesized evidence on factors shaping the impact of local public health partnerships introduced in England between 1997 and 2008, such as Health Action Zones and Health Improvement Programmes (involving NHS organizations, local government, housing agencies, and others).[209] The review identified five broad factors that shaped partnership functioning, including engagement of senior managers (for example, lack of engagement can be a barrier), financial and human resources (for example, lack of resources can hold back partnerships), sharing information and best practice (for example, effective information sharing can support collaboration), the wider context (for example, shifting national policy priorities was a barrier), and geographical boundaries (for example, lack of shared boundaries between partner organizations can get in the way of collaboration). Various other reviews also bring together qualitative data on local health partnerships in England.[209,210,211,212,213,214]

Other studies develop broader theories of collaboration functioning based on evidence and theory from different disciplines. Ansell and Gash, for example, reviewed 137 cases of 'collaborative governance' across sectors—all involving public and private partnerships to engage in consensus-oriented decision-making—and identified a mix of variables that influence whether collaborative governance will be successful (such as prior history of conflict or cooperation), along with factors that can support the collaborative process itself (such as trust building and developing commitment and shared understanding).[190] Ostrom and colleagues, meanwhile, analysed how communities in diverse contexts self-governed common pool resources (things that can run out or become unusable if they are not effectively managed, like water systems) through collective action, rather than through states or markets.[215,216,217] Their work identifies a series of design principles that characterized local systems that were sustained over long periods of time, and absent in the ones that failed—including, for instance, the existence of rapid, low cost, arenas for resolving conflicts between local partners.

Taken together, these studies illustrate the range of factors that may shape cross-sector collaboration to improve health or health equity, as well as the need for in-depth analysis to understand how these factors operate in different contexts. Theory on collaboration functioning can also offer insights for understanding England's new ICSs—for instance, in considering how NHS and social care organizations manage the 'common pool' of resources for improving health in their area.[218,219,220] 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. This gap is filled through the umbrella review in chapter 3. The qualitative research in chapter 7 then analyses factors shaping collaboration functioning in England's new ICSs.

Major system change

Cross-sector partnerships are examples of major system change.[221,222] Unlike single interventions, partnerships involve multiple stakeholders, aim to achieve collective impact across organizations and over time, and depend on multiple mechanisms to guide their planning and implementation. At the same time, these objectives may be weakly articulated, conflicting, and subject to change. The settings in which interventions take place are likely to change over time too—for example, in response to leadership changes, external shocks, organizational restructuring, or in response to the interventions being implemented as part of the partnership. These (and other) characteristics of complex systems make the study of partnership working both methodologically and conceptually challenging. A mix of methods is needed to make sense of how they work in different contexts.

Qualitative methods are widely used to understand complex social phenomena,[223] including patterns of collaboration between health and social services agencies.[224] Qualitative methods allow rich, detailed descriptions of how change happens and seek to account for the role of context in shaping the design and delivery of interventions.[225,226] Qualitative methods have also been widely used to help understand and assess organizational reforms to health service planning and delivery in England.[227,228,229,230] In the thesis, a mix of in-depth interviews, documentary analysis, and thematic analysis and comparison of data from three case study sites is used to provide a detailed understanding of how local agencies are collaborating to reduce health inequalities in England's ICSs.

Lens 3: an approach to performance management of public services

A third lens to understand ICSs is as an approach to the top-down performance management of the NHS and other public services in England. A core part of the national policy narrative underpinning the creation of ICSs is that local collaboration is needed to improve health and health services (*see* lens 2).[231,232] This includes more decisions being taken at a local level about how resources are used, and greater flexibility for organizations to identify priorities and design services to meet local needs. ICSs have been linked to broader debates about devolution of health care services within England.[233]

Yet at the same time, ICSs have been established by central government to achieve defined national policy priorities—including to deliver the four 'core purposes' of ICSs.[231,232] The new systems are also the main vehicle for improving the performance of the NHS in England—including meeting high profile political targets to reduce waiting times in NHS accident and emergency departments, and tackling the large backlog of people waiting for routine hospital treatment in England.[234,235,236] This tension raises questions about the balance of central and local control in ICSs, and the role of national policymakers in managing NHS performance—a familiar debate throughout the NHS's history.[237]

Performance management in UK public policy

Performance management—for example, setting targets for public services, using incentives to stimulate performance, and holding local organizations to account for delivering improvements—is a core feature of the approach to managing public services across countries.[238,239,240] But the UK government has been notable for its use of top-down performance management across the public sector in England—often described by political scientists as an 'exceptional case' for its use of performance indicators and accompanying management approaches in the 2000s (famously referred to by Bevan and Hood as 'targets and terror'[241]).[239,242,243] The literature on performance management emphasizes not just the use of targets or other technocratic tools for managing performance, but also the broader institutional 'logics' that underpin them.[239,244,245] For example, the highly centralized and majoritarian structure of the UK state[246,247] provides an explanation for its interventionist and top-down approach to managing public sector performance.[245,248] These institutional logics may also explain why these behaviours persist even when policymakers describe aims to do the opposite.

Matthews illustrates these dynamics in her analysis of the politics of performance management in the UK from 1997 to 2010—using a mix of data to compare the approaches of Labour (1997-2010) and Coalition (2010-2015) governments.[245] Top-down measures to manage performance proliferated under Labour, including national performance frameworks, targets, inspection, performance rankings, and more. The Coalition government promised to dismantle this performance management architecture and decentralize decision-making to local authorities and regions when it came into office. Many of Labour's performance measures were indeed swept away from 2010. Yet—in reality—Matthews identifies continuity in the practices of performance management between the two eras, with top-down intervention in local areas and performance monitoring persisting under the Coalition, and sweeping spending cuts limiting the agency of local leaders. Matthews concludes that, despite promises to 'let go', successive governments have instead sought to 'hold on' to the detail of public service delivery.

Performance management in the English NHS

A similar dynamic can be observed in the politics and performance management of the English NHS. The NHS is—by design—a centralized health system with a strong degree of political control and national oversight.[133] National direction and political management has been a persistent feature in the evolution of the NHS.[249] But since the 1980s in particular—the advent of New Public Management (*see* section on collaboration in a changing state)—the approach of national NHS bodies and government to driving improvement in the health system has relied on top-down targets and performance management.[250,251] Examples include political targets on NHS waiting times and other aspects of performance, ratings of providers, central management and intervention in poor performing health systems, and more.[112,241,252,253] The Coalition government's reforms to the NHS in 2012 partly aimed to devolve responsibility for decision-making and reduce political interference in the day-to-day running of the NHS. But evidence suggests that this did not happen in reality—for instance, with the health secretary directly intervening with chief executives in poor performing NHS trusts—and targets and performance management have remained a key feature of how the NHS works.[254,255,256]

Research into policies on decentralization in the NHS illustrate the limits of 'letting go' in practice. Throughout the history of the NHS, national policymakers have embraced the rhetoric of localism and decentralization of decision-making.[257,258] For example, the 1989 white paper Working for Patients claimed that 'as much power as possible will be delegated to the local level', and similar promises have been made by successive governments since. Yet central grip appears to have strengthened over the same period.[257] Exworthy et al analysed national policy on decentralization in the 2000s—for example, the idea of greater autonomy for 'high performing' NHS trusts—and the degree of local control in the system.[258] They found some parts of the NHS may have experienced greater control over processes (such as service redesign), but identified tighter central control of outcomes through top-down performance management and regulation. These centralizing tendencies also contributed to an unwillingness to exercise autonomy in practice. A decade on, Walshe et al studied the early implementation of health and social care devolution in Greater Manchester[259]—an agreement between the Greater Manchester region and central government in 2015, which gave the combined authority and other bodies a mix of investment and decision-making powers, including some delegation of decision-making for health and social care budgets.[260] They found major limits to local autonomy and control in practice, and close alignment between policy in Greater Manchester and national priorities.

Will national bodies really be able to ‘let go’ this time around? Under the latest reforms, national NHS bodies are responsible for overseeing and managing ICS performance—for instance, by setting targets, monitoring progress, and intervening in local health systems (*see* chapter 4). National bodies have identified a long list of priorities and performance targets for the new systems—mainly focused on improving NHS access.[234,235,236] As this brief history suggests, there is a clear risk that top-down and centralizing tendencies of NHS management hold back local collaboration within ICSs—for instance, by dampening local priorities, undermining ICS leadership agency, and focusing attention on narrowly defined areas of NHS performance. A top-down and centralized approach may also crowd out ICS efforts to reduce health inequalities, which rely on collaboration with sectors beyond the NHS.[261] Thes risks are explored in more detail throughout the thesis—particularly in chapters 6 and 7.

Differences in governance and accountability between the NHS and local government in England complicate the story further. ICSs bring together NHS organizations, local government, and others to plan and coordinate local services (*see* chapter 4 for more detail on the structure and governance of ICSs). This follows the logic that collaboration is needed across sectors to tackle cross-cutting policy problems, such as reducing health inequalities or joining up health and social care services (*see* lens 2 on inter-organizational collaboration). It also builds on a long history of national policy promoting collaboration between the NHS and local government—for instance, through joint planning initiatives, pooled funding arrangements, new types of purchasing and provider organizations, and more.[139,140,141,142] But structural differences between the NHS and local authorities have remained since 1948—including in funding, organization, governance, and accountability. For example, the NHS is a nationally-funded system with spending distributed to local areas according to a needs-based allocation formula. In contrast, local government funding comes from a variety of sources and budgets are set by a mix of considerations—including local political choices and revenue. Unlike the NHS, local authorities have direct democratic accountability to local councillors and residents. These differences will likely shape collaboration within ICSs—for instance, if the requirement for local NHS bodies to report upwards on national targets affects how they work with local government.[261] These structural differences have been a longstanding barrier to joining up local services.[139,140,141,142]

Organizational restructuring in the English NHS

The UK’s approach to managing public services is also characterized by top-down restructuring.[262] Repeated reorganizations—often dubbed ‘redisorganizations’[263]—are a persistent feature of the political approach to reforming the NHS in England. In its first 30 years, the NHS’s structure was relatively stable. The first major NHS reorganization came in 1974, with—in a sign of things to come—better integration between the NHS and local government a key objective.[264]

But over the past 30 years, the NHS in England has been on an almost constant treadmill of reform and reorganization. Local NHS planning bodies in particular have been in a state of organizational flux since the birth of the purchaser-provider split in 1991—with regular changes in their size, functions, and professional involvement.[265] The creation of ICSs through the Health and Care Act 2022 continues this tradition, with a large number of NHS Clinical Commissioning Groups—local purchasing organizations established in 2012—scrapped, and their functions taken on by new NHS Integrated Care Boards (ICBs) within England's ICSs. Overall, evidence suggests that these top-down reorganizations deliver little measurable benefit, [266,267,268,269,270] while organizational restructuring in the NHS can cause harm, such as disrupting local relationships and delaying care improvements.[269,271,272] The thesis analyses the development of ICSs in the context of previous NHS reorganizations in England (*see* chapter 4), and the qualitative research in three of England's new ICSs is used to understand the effects of the latest round of reform (*see* chapter 7).

Overlapping lenses

These three lenses overlap and interrelate to provide a broad framework for analysing England's ICSs. For example, lens 1 illustrates the complexity of policy change to tackle health inequalities, and the need for alignment between organizations and sectors at multiple geographical levels. Lens 2 shows how challenging achieving that alignment can be in practice, and the various factors constraining cross-sector collaboration at a local level—including a mix of local conditions and the broader political context in which collaborations operate. Lens 3, meanwhile, points to the role of national NHS policy and politics in shaping the context for ICSs in England—and the risk that the logics of centralized, top-down performance management may hold back cross-sector collaboration in ICSs. These three lenses are used to inform the approach and analysis throughout the thesis, and the discussion section in chapter 8 reflects on the findings of the research in the context of each lens.

DESIGN AND METHODS

The research is made up of three phases, following the study objectives set out in the introduction:

- *Phase 1.* Review and synthesis of evidence on the impacts of collaboration between local health care and non-health care organizations, and factors shaping how these partnerships function. Phase 1 is designed to meet research objective 1.

- *Phase 2.* Policy analysis of the development, aims, structure, characteristics, and historical context for England's new ICSs. This includes analysis of national policy on reducing health inequalities through ICSs. Phase 2 is designed to meet research objective 2.

- *Phase 3.* 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, carried out between August and December 2022. Phase 3 is designed to meet research objective 3.

Detail on the approach and methods used for each phase of the research is included at the start of each chapter. This includes the design, data, and analytical approach for each component of the research, along with limitations of the methods used and relevant context to help interpret the analysis.

This section provides a brief overview of all three phases and how they fit together. It also provides additional detail on the approach and methods where relevant—for instance, on the analysis of data on the characteristics of England's 42 ICSs (in chapter 4), and how these data were used to inform the approach to sampling case study sites for the qualitative research (in chapters 6 and 7).

Phase 1: umbrella review and synthesis

The first phase of the research involved an umbrella review—a systematic review of reviews—to synthesize qualitative and quantitative evidence on the health impacts of collaboration between local health care and non-health care organizations, as well as to understand the factors affecting the functioning of organizational partnerships focused on improving health or health equity.

Four databases were searched for relevant papers published between 1999 and 2019, and 36 studies (reviews) were included in the review. These reviews included evidence on varying forms of collaborations in diverse country contexts. To find relevant studies, the inclusion criteria focused on identifying reviews of empirical evidence related to collaborations between two or more distinct organizations, collaborations involving health care and non-health organizations at a sub-national level, and collaborations focused on improving health-related outcomes or reducing health inequalities.

A mix of data were extracted from each of the studies—including on study design, collaboration contexts, collaboration type or definition, factors influencing collaboration functioning, and collaboration outcomes. To analyse and synthesize the data extracted on factors influencing collaboration functioning, an inductive approach was used to code the data based on the concepts identified in the studies (such as the role of trust or communication), and overarching themes were identified that best described and linked these concepts together (such as factors related to collaboration motivation and purpose). Links between the different factors identified in the studies (for instance, quality of communication affecting trust between partners) were also identified to help understand their potential interactions. A narrative approach was used to synthesize and report the data. No meta-analysis was carried out as part of the review, given the lack of quality data on health impacts, the broad nature of the phenomena studied, and the heterogeneity of study designs included.

The study provides an overview of a large body of evidence on cross-sector collaboration and health. Results from the study were used to inform the subsequent analysis of cross-sector collaboration in England. In particular, the review identifies a mix of factors shaping collaboration functioning in five domains: collaboration aims and motivation, resources and capabilities, cultures and relationships, governance and leadership, and external context (*see* figure 2, chapter 3). These domains were used as a framework for the analysis of factors shaping cross-sector collaboration in ICSs (in chapter 7). The framework supported analysis and interpretation of the data on collaboration practices in England, while also allowing comparison of the dominant factors shaping collaboration functioning in England (such as the role of national policy) with evidence and experience from other countries. Data from the umbrella review were also used to inform the analysis of national policy on reducing health inequalities in England (in chapters 4 and 5)—for instance, by identifying relevant evidence on past collaboration policies in England, and in helping to assess likely gaps and challenges in the national policy approach on ICSs.

The umbrella review is presented in chapter 3.

Phase 2: policy analysis on England's ICSs

The second phase of the research involved a mix of policy analysis to understand the development, aims, and structure of England's new ICSs, as well to put them in their longer-run historical context.

Past national policies on cross-sector collaboration and health

First, the analysis involved reviewing previous national policies encouraging collaboration between local NHS and non-health care organizations in England since 1997, synthesizing evidence on their impacts, and using a mix of data to put these partnerships in their broader policy and political context. The analysis 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 or reduce health inequalities—and involved both NHS and non-health care agencies, such as local authorities and social care providers.

1997 was selected as the start date for the review, given the proliferation of area-based partnership policies focused on improving health introduced under New Labour governments (*see* section on collaboration in a changing state). Official policy documents, policy evaluations, and policy studies were reviewed to identify relevant policies. For each policy, data on policy aims, scope, processes, and intended impact were summarized to inform comparison and analysis. Data linked to relevant policies in England identified in the umbrella review were used to help understand the impact and functioning of these kinds of partnerships, and were supplemented with more recent reviews where relevant. The analysis 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 instance, evidence on broader changes in public policy and government spending on local services.

This part of the analysis is presented in chapter 4.

Development and structure of ICSs in England

Second, the analysis focused on the development and structure of England's new ICSs, and the broader reforms that led to their formal introduction. Official policy documents were reviewed to understand the evolution, aims, and content of the reforms. The analysis also drew on wider literature about the direction of NHS reform in England—including evidence on previous NHS reorganizations in England and changes in policy on NHS commissioning since the 1990s. Based on analysis of the policy documents, a summary of the new structure of the NHS in England was developed, along with the various cross-sector partnerships between the NHS and other bodies that make up ICSs. This part of the analysis provides an overview of the new systems to provide context for the rest of the research.

This part of the analysis is presented in chapter 4.

Characteristics of England's ICSs in domains linked to collaboration

Third, a mix of publicly available data on the characteristics of England's 42 ICSs were collated and analysed,[273] including data on their geography, population size and deprivation, organizational complexity, and policy context. These characteristics were selected because of evidence on their likely role in shaping how NHS and other organizations in ICSs work together to reduce health inequalities—including evidence from the umbrella review presented in chapter 3. Table 2 summarizes the characteristics that were selected, the rationale for their selection, and the indicators used to compare ICSs on each characteristic. More detail on the indicators that were selected, how they are constructed (for indicators that were developed as part of the analysis), and sources for the data is included in chapter 4 (*see* tables 2-4 in particular).

Table 2. ICS characteristics used to guide comparison and case study sampling

Characteristic	Rationale	Indicators
Geographical context	The geographical context of collaborating agencies affects partnership functioning.[274] For example, the proximity of agencies may affect how agencies work together and communicate. Geographical context also shapes health and health services. For example, there are distinct challenges delivering services in rural areas[275,276] and health issues experienced in coastal communities[277]	NHS England region Proportion of ICS areas covered by rural/urban areas

Size	The size of the population covered by the partnership may affect how partnerships function. For example, it may be easier to assess health needs and target interventions with a smaller population	Registered NHS population
Organizational complexity	The complexity of the organizational landscape—for instance, the number of agencies involved and how responsibilities are shared between them—is likely to affect partnership functioning in a mix of ways. For example, differences in organizational governance and decision-making can hold back collaboration.[274] These challenges may be exacerbated when the number of agencies involved in the partnership is greater[278]	Number of upper tier local authorities (UTLAs) Number of NHS trusts Type of local government arrangements
Policy context	How partnerships function is strongly shaped by the historic relationships between local agencies.[274] There is a long history of policy initiatives in England that encourage collaboration between health and social services agencies—including new care model 'vanguards'[279] and integrated care and support 'pioneers'.[280] Early versions of ICSs were also established by NHS England in 'waves' based on perceived 'maturity',[281] before all ICSs were formally established under legislation in July 2022	Number of vanguard sites Number of pioneer sites ICS 'wave'
Socioeconomic deprivation	Reducing health inequalities is a policy priority for ICSs. The focus of the study is on how NHS and non-NHS agencies are collaborating to reduce health inequalities. National NHS bodies are seeking to reduce inequalities by targeting efforts on the most deprived areas of the population (identified by IMD).[282] Previous area-based initiatives to reduce health inequalities, such as Health Action Zones in the early 2000s, also focused on areas with high levels of deprivation. Areas with similar levels of deprivation are likely	Proportion of lower super output areas (LSOAs) in the most deprived 20% of areas nationally, using index of multiple deprivation (IMD) ranks

	to pursue some common approaches, and leaders in these areas are likely to be particularly aware of their role in tackling health inequalities	

Chapter 4 analyses these data to provide an overall summary of the characteristics of England's ICSs, and how they vary. The comparisons are used to identify implications for national policy. The data are used the data to guide the sampling of case study sites for the qualitative research in phase 3.

Current national policy on reducing health inequalities in ICSs

Fourth, the analysis focused on national policy on reducing health inequalities in England through ICSs, including how national policymakers define and conceptualize ICSs' aims on health inequalities, and the processes and resources expected to deliver them. Exworthy and Powell's policy streams framework was used to structure the analysis (*see* section on policy analysis on health inequalities for an overview and background). Exworthy and Powell describe three 'streams' that need to align for successful policy implementation on health inequalities.[127,128,129] 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 them happen (the 'resource stream').

To understand policy aims, processes, and resources for ICSs to reduce health inequalities, the analysis focused on 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 creation of ICSs across England. The policy documents were analyzed for content linked to ICS objectives to reduce health inequalities, and the data were categorized by Exworthy and Powell's three policy streams.

To assess coherence of the approach in each stream and potential alignment between them, the policy documents were analysed alongside early evidence on ICS approaches to reducing health inequalities. Structured literature searches were carried out in several databases to identify studies on ICS approaches to reducing health inequalities in England. Major studies on the broader development of ICSs with relevance to policy implementation on health inequalities were also identified, alongside wider evidence that could provide additional insight into 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. For each stream, the analysis considered potential interactions with other streams and alignment between agencies at multiple levels, such as horizontal (local-local) and vertical (national-local) relationships.

This part of the analysis is presented in chapter 5.

Across these different components, the policy analysis in phase two of the research is used to identify key implications for the development of the new systems and their ability to deliver policy objectives on health inequalities. These implications are then explored in more detail in phase 3 of the study.

Phase 3: in-depth analysis of collaboration in three ICSs

The final phase of the research involved a qualitative study to understand how local health care and social services organizations are collaborating to reduce health inequalities under England's reforms. In-depth interviews were conducted with 32 senior leaders from NHS, social care, public health, and community-based organizations in three ICSs experiencing high levels of socioeconomic deprivation.

A purposive sample of ICSs with varied characteristics all experiencing high levels of socioeconomic deprivation was identified, using the data collated on England's ICSs in phase two of the research. A sub-group of ICSs experiencing the highest concentration of socioeconomic deprivation relative to other ICSs in England was initially identified (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.[282] 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, three ICSs were then identified 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 the same region of England, or with a similar policy context and history of cross-sector collaboration. This gave a relatively heterogenous mix of three ICSs all serving more socioeconomically deprived populations in England (table 3). ICS leaders from the three areas that were selected all agreed to participate in the study. To ensure participants and ICS areas are not identifiable, the three areas are referred to as ICS A, ICS B, and ICS C throughout the research. All participants are described as 'leaders' when reporting the results, along with their role and sector.

Table 3. 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, ‘high’ deprivation was defined as the top tercile of ICSs with the highest concentration of local areas in the most deprived 20% of areas nationally. For geographical context, ICSs were divided into terciles based on the proportion of local areas in each ICS classified as urban by the Office of National Statistics. ICSs in the middle tercile were defined as ‘mixed’ (74-87% urban areas), and ICSs in the top tercile were defined as ‘urban’ (87-100% urban areas). For population size, ICSs were divided into terciles based on their NHS registered population. ICSs in the middle tercile were defined as ‘medium’ (1.1m-1.7m), and ICSs in the top tercile were defined as ‘large’ (1.7m-3.1m).

ICSs are complex systems involving various organizations and organizational partnerships. The 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.[283,284] 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). In phase 3 of the study, the research focuses on overall experiences of collaboration on health inequalities across the ICS, including the relationship between action at different geographical levels.

In each ICS, in-depth interviews were carried out 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. The 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. See table 2, chapter 7 for more detail on the interviewees.

A semi-structured interview guide was used 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 (*see* 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 the analysis of national policy on ICSs (*see* phase 2) and existing literature on cross-sector collaboration and health inequalities (*see* phase 1). Interviews were carried out online, lasted an average of 44 minutes, and took place between August and December 2022.

The data were analyzed using the constant comparative method of qualitative analysis.[285] Interview transcripts were reviewed line by line to identify themes in the data, and the themes were refined iteratively as new concepts emerged. An integrated approach[286] was used 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 identified in the umbrella review (*see* phase 1). These domains were used as a conceptual framework to organize the analysis and help interpret the data. Given the importance of understanding policy aims on health inequalities and likely differences in interpretation between groups (*see* sections on defining health inequalities and policy analysis on health inequalities), additional in-depth analysis was also carried out into local interpretations of national health inequalities objectives among the interviewees, how inequalities related to other priorities for the ICS, and how these interpretations varied between ICSs and professional groups.

The analysis of local conceptualizations of national policy on health inequalities is presented in chapter 6. The analysis summarising the overall findings from phase 3 is presented in chapter 7.

NHS HRA approval for the qualitative study was granted on February 1 2022 (IRAS ID: 311479; REC ref: 22/HRA/0415). Ethical approval for the study was granted by the London School of Hygiene and Tropical Medicine research ethics committee on February 22 2022 (LSHTM ethics ref: 26737). All participants gave informed consent to participate in the study before taking part.

Reflexivity

Reflexivity in qualitative research means sensitivity to the ways in which the researcher and the research process have shaped the collected data and data analysis.[287] 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, characteristics, and more.[288] Several parts of my background have shaped the research—not least my role as Director of Policy at the Health Foundation, my previous work researching and analysing ICSs and similar policy initiatives, and my public position as an expert commentator on government policy on health and health care in the UK. This includes active engagement in the national policy process to develop ICSs. These issues and how they likely influence the research are explored in the discussion (chapter 8).

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CHAPTER 3

The impacts of collaboration between local health care and non-health care organizations and factors shaping how they work: a systematic review of reviews

Published papers

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

Alderwick H, Hutchings A, Briggs A, Mays N et al. The impacts of collaboration between local health care and non-health care organizations and factors shaping how they work: a systematic review of reviews. BMC Public Health. 2021;21:753.
https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-021-10630-1

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RESEARCH PAPER COVER SHEET

Please note that a cover sheet must be completed for each research paper included within a thesis.

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/s12889-021-10630-1		
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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)	HA worked with his supervisors, NM and AH, to identify the research question and lead the design and development of the review. HA and AB screened the search results and assessed them against inclusion criteria. NM and AH reviewed sample papers for inclusion. HA extracted, coded, and analysed data from the included papers. AH contributed to analysis of studies reporting quantitative impacts of collaboration. HA wrote the first draft of the manuscript and incorporated comments from all authors. All authors read and approved the final manuscript.

SECTION E

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Date	07/11/2024

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Date	10/11/2024

TITLE

The impacts of collaboration between local health care and non-health care organizations and factors shaping how they work: a systematic review of reviews

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ABSTRACT

Background. Policymakers in many countries promote collaboration between health care organizations and other sectors as a route to improving population health. Local collaborations have been developed for decades. Yet little is known about the impact of cross-sector collaboration on health and health equity.

Methods. We carried out a systematic review of reviews to synthesize evidence on the health impacts of collaboration between local health care and non-health care organizations, and to understand the factors affecting how these partnerships functioned. We searched four databases and included 36 studies (reviews) in our review. We extracted data from these studies and used Nvivo 12 to help categorize the data. We assessed risk of bias in the studies using standardized tools. We used a narrative approach to synthesizing and reporting the data.

Results. The 36 studies we reviewed included evidence on varying forms of collaboration in diverse contexts. Some studies included data on collaborations with broad population health goals, such as preventing disease and reducing health inequalities. Others focused on collaborations with a narrower focus, such as better integration between health care and social services. Overall, there is little convincing evidence to suggest that collaboration between local health care and non-health care organizations improves health outcomes. Evidence of impact on health services is mixed. And evidence of impact on resource use and spending are limited and mixed. Despite this, many studies report on factors associated with better or worse collaboration. We grouped these into five domains: motivation and purpose, relationships and cultures, resources and capabilities, governance and leadership, and external factors. But data linking factors in these domains to collaboration outcomes is sparse.

Conclusions. In theory, collaboration between local health care and non-health care organizations might contribute to better population health. But we know little about which kinds of collaborations work, for whom, and in what contexts. The benefits of collaboration may be hard to deliver, hard to measure, and overestimated by policymakers. Ultimately, local collaborations should be understood within their macro-level political and economic context, and as one component within a wider system of factors and interventions interacting to shape population health.

BACKGROUND

Collaboration between health care, social services, and other sectors is increasingly seen as a route to improving health and health equity.[1,2,3,4,5] The reasons for this are not hard to find. Population health is influenced by a broad range of factors—including structural social and economic conditions, public policies on education, social security, health care, and other areas, living and working environments, and more.[6,7] While access to health care is an important part of this picture, wider non-medical factors, such as education and income, play a major role in shaping health and its distribution.[8,9,10,11,12,13,14,15] These factors, in turn, are influenced by the activities of multiple organizations and groups, such as national and local governments, social services agencies, schools, and employers. Cross-sector partnerships have been proposed as a way to coordinate these activities to improve people's health.

Collaboration between sectors to improve health is nothing new. Health in all policies approaches, for example—where health impacts are considered in policy processes across government—have been developed by governments in Europe, Canada, and elsewhere.[16,17] International collaborations have long been used to help address public health challenges, such as tobacco control and tackling poverty.[18,19] And various local and regional partnerships to improve health have been established in diverse contexts.[20,21,22] This includes joint working between health care and social services,[23,24,25] wider public service partnerships,[26,27,28] and community coalitions of diverse stakeholders[29,30,31]—sometimes covering states or counties, and sometimes targeting smaller populations in cities or neighbourhoods. These collaborations can be voluntary, mandated, or developed in response to national policy.

Despite their long history, little is known about the impact of cross-sector partnerships between local agencies on health outcomes.[32,33,34] Multiple studies and reports have identified potential characteristics of effective partnership working, such as trust and shared objectives between organizations and their leaders.[35,36,37,38,39] But evidence that these partnerships actually achieve their stated objectives—improvements in health or reductions in health inequalities—is hard to find. Many partnerships end up being costly, hard to manage, and struggle to navigate the various cultural, organizational, and accountability issues they face.[40] When subject to closer inspection, even the most mature partnerships can appear less robust and ready to transform their community's health than their reputations might suggest.[41]

Lack of evidence on effectiveness of local partnership working has not deterred policymakers from promoting it. Cross-sector collaboration is currently in vogue among policymakers in the US, UK, and elsewhere—often linked to a growing interest in the health care system's role in addressing the social determinants of health.[42] In England, for example, sustainability and transformation partnerships have been established between health care organizations, social services organizations, and public health in 42 areas of England (covering populations of around one to three million), with the aim of improving health and making better use of local resources.[43] These partnerships build on a long history of efforts to better coordinate health and social services to improve health in England, including Health Action Zones, Local Strategic Partnerships, Integrated Care and Support Pioneers, and more.[44,45] In the US, collaborations between health care and non-health agencies are being encouraged through federal programs,[46] state initiatives,[47] and alternative payment models.[48] Partnership between local agencies has also been a core part of the COVID-19 response—and collaboration is likely to remain a policy mechanism of choice as health systems recover from the pandemic.

The logic behind these policy initiatives varies. Under the right conditions, theory suggests that organizations may achieve better results by combining their skills and capabilities.[49,50,51] From a resource dependence perspective,[52,53] partnerships offer organizations opportunities to access new skills, manage interdependencies, and share risks. Partnerships may also help improve efficiency by reducing transaction costs.[54,55,56,57] At the same time, partnerships bring their own risks, such as coordination problems, conflicting goals, and loss of power. As organizations collaborate, competing institutional rules and norms may come into conflict.[58,59] And despite the best efforts of local organizations and the individuals within them, local partnerships are shaped by the broader political economy in which they operate.[60]

So how do we make sense of existing evidence to inform today's policies on collaboration? The literature on organizational collaboration and health is vast and varied, including several reviews of different kinds of partnership working. Yet there is no up-to-date synthesis of the evidence on the impacts of partnerships between local health care and non-health care organizations, and the factors shaping their success. There is also no overarching review of reviews on the mix of evidence related to organizational collaboration and health. We systematically review evidence on the impact of collaboration between local health care and non-health care organizations, as well as the factors shaping partnership functioning.

METHODS

Design

We carried out a systematic review of reviews to synthesize qualitative and quantitative evidence on the health impacts of collaboration between local health care and non-health care organizations, as well as to understand the factors affecting the functioning of organizational partnerships focused on improving health. Unlike most umbrella reviews,[61] which review systematic reviews only, we reviewed systematic and other reviews (such as scoping reviews) of relevant literature. This is because we wanted to identify evidence on how and why partnerships may succeed or fail, not just data on effectiveness. The search strategy was developed with a health services research information specialist and reviewed using Peer-Review for Electronic Search Strategies guidance,[62] with feedback incorporated into the strategy. The protocol for the systematic review was not registered.

Literature search

We conducted searches in Medline, Embase, Web of Science Social Sciences Citation Index, and Health Management Information Consortium for relevant studies (reviews) in English published between January 1999 and December 2019. We screened reference lists of relevant papers and contacted experts to identify potential further studies for inclusion. The search strategy was tested in Medline to ensure that key 'tracer papers' were found in our searches.[63] Additional File 1 outlines our search strategy in Medline. For the purposes of the search, we defined collaboration as activities between distinct organizations working together to achieve health goals, including through formal and informal partnership arrangements. This relatively inclusive definition of collaboration was adopted, in part, to reflect the body of literature that we sought to review, where organizational collaboration is often broadly defined and multiple forms of collaboration are typically studied together (see Table 1).

Study selection

Inclusion criteria were developed to identify relevant studies (see Box 1). These focused on identifying reviews of empirical evidence related to collaborations between two or more distinct organizations, collaborations involving health care and non-health organizations at a sub-national level, and collaborations focused on improving health or reducing inequalities. A key aim of the review was to understand factors affecting the success of organizational partnerships, not just their health impacts. We therefore included studies reporting data on partnership mechanisms and processes affecting the success of relevant organizational collaborations, even if they did not report the impact of these collaborations on outcomes.

The inclusion criteria also focused on excluding studies examining closely related but distinct phenomena—for example, evidence related to service delivery level partnerships (such as multidisciplinary teams), or interprofessional collaboration (for example, between clinicians and social workers), without a clear focus on collaboration at an organizational level.

BOX 1: Inclusion and exclusion criteria for the systematic review

Include if the study:

- Focuses on collaboration between two or more distinct organizations that aims to improve health-related outcomes. Health-related outcomes includes improvements in services, such as care quality, as well as impacts on health outcomes and inequalities.
- Focuses on collaborations at a local level—meaning that the collaborations operate primarily at a sub-national level, such as a state, region, county, or neighbourhood.
- Focuses on collaborations with at least one health care organization (eg a hospital or primary care practice), and at least one non-health care organization (eg local government, housing, social services, or transportation agencies).[*]
- Is a systematic or other type of scholarly review of empirical data on collaboration outcomes or processes and mechanisms that may affect collaboration outcomes.

Exclude if the study:

- Focuses on collaboration between professional groups within single organizations, or within merged organizations (even if these organizations were recently distinct).
- Focuses on service delivery partnerships (eg multidisciplinary teams working in primary care) or interprofessional collaboration (eg between clinicians and social workers) without any focus on related collaboration at an organizational level.
- Focuses on collaborations between organizations within the health care system (eg between primary care practices) or between agencies focused on academic research.
- Is not a review article or does not include empirical data on collaboration outcomes or processes and mechanisms thought to affect collaboration outcomes. Reviews of partnership models or theoretical frameworks related to partnerships were excluded.

Titles and abstracts of all papers were screened by a member of the review team to identify relevant studies, with the full text reviewed if it appeared relevant. A 10% sample was screened by a second author, in line with umbrella reviews of a similar scale.[64,65] Studies were assessed against the inclusion and exclusion criteria. Disagreements about inclusion were resolved by consensus and discussion with

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[*] Depending on local or national context, local government, public health, and social services agencies may deliver some health care or closely related services. Terms for these organizations were therefore included in our literature searches. However, for the purposes of study selection and analysis, these types of organizations and services were not viewed as health care organizations. This means that reviews focused on collaborations between health care and public health, or between health care and social services, were included in the review.

a third reviewer if necessary. For the studies included, we assessed risk of bias using the AMSTAR 2 critical appraisal tool[66] (for all studies reviewing quantitative evidence on collaboration impacts) and the Critical Appraisal Skills Programme (CASP) systematic review checklist[67] (for studies that only reported qualitative evidence on factors influencing collaboration functioning).

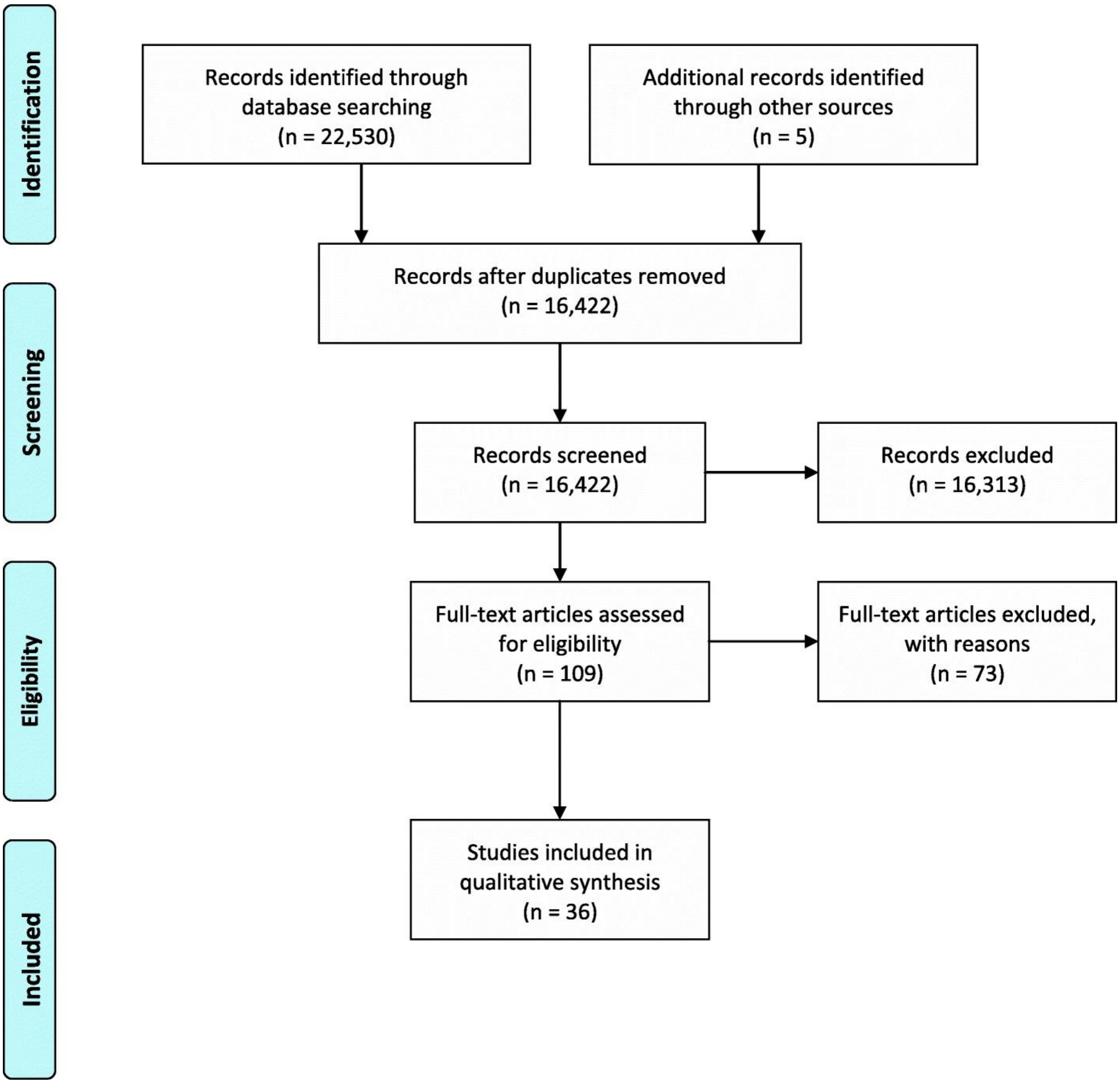
Data extraction and synthesis

For included studies, we extracted and summarized data in templates covering the following domains: study design, collaboration contexts, collaboration type or definition, factors influencing collaboration functioning, and collaboration outcomes. We extracted assessments of statistical heterogeneity and pooled effects of impact where meta-analyses were reported. We used Nvivo 12 to help categorize the data and identify themes between the studies. We grouped data on collaboration impacts by type of effects reported (such as evidence of impact on health outcomes or spending). For data on factors influencing collaboration functioning, we used an inductive approach to code the data based on the concepts identified in the studies (such as the role of trust or communication). We developed the code structure iteratively as data were coded and compared,[68] and identified overarching themes that linked the concepts identified in the studies (such as factors related to collaboration motivation and purpose). No meta-analysis was carried out as part of the review, given the lack of quality data on health impacts, the broad nature of the phenomena studied, and the heterogeneity of study designs included. We use a narrative approach to reporting the data synthesis.[69]

RESULTS

Our search identified 16,417 papers, after duplicates were removed. Thirty-six reviews were included in our review (Figure 1).[70,71,72,73,74,75,76,77,78,79,80,81,82,83,84,85,86,87,88,89,90,91,92,93,94,95,96,97,98,99,100,101,102,103,104,105] Studies that were reviewed in full but did not meet our inclusion criteria were focused on describing collaboration models or theories,[106,107,108,109,110,111,112,113,114,115,116,117,118,119,120] evidence related to service-level interventions[121,122,123,124,125,126,127,128,129,130,131,132,133,134,135,136,137,138,139,140,141,142] or inter-professional collaboration[143,144,145,146,147] without a clear focus on organizational collaboration, collaboration within the health care system,[148,149,150,151,152] or collaboration primarily at national or international levels.[153,154] Other studies were excluded because they were not a review of empirical evidence or the phenomenon reviewed was unclear,[155,156,157,158,159,160,161,162,163,164,165,166,167,168,169,170,171] or they repeated or were superseded by another study from the same authors.[172,173,174,175,176,177] One study could not be obtained.[178]

Figure 1. PRISMA flow diagram



Collaboration type and context

Table 1 describes the context and type of collaborations in the included studies. The studies reviewed collaborations from a range of contexts. Some studies focused on collaborations in a single country, such as the UK[70,71,72,74,75,76,100] or US.[80,90,98] The majority of studies included evidence on collaborations from multiple countries and contexts (or did not define the country contexts of the studies reviewed). The definitions of collaboration used in the studies varied widely, as did the types of organizations involved and the aims of the collaborations.

Some studies reviewed collaborations with broad population health goals, such as preventing disease and reducing health inequalities.[70,71,77,78,79,80,81,85,87,92,95,98] These collaborations often involved health care and social services organizations, public health agencies, and other sectors including housing and education, and more. Other studies reviewed evidence on collaborations with a narrower scope or focus, such as integration between health care and social services,[72,73,74,82,84,99,100,104] or care for people with mental health needs.[83,91,97]

Even within single studies, multiple kinds of collaboration were typically studied together, and interventions were often weakly described. Many reviews combined evidence on collaboration at an organizational-level (such as joint planning or funding of services) with more targeted strategies or interventions that resulted from organizational collaboration (such as care coordination programs for target populations). Evidence related to the impact and functioning of organizational partnerships was therefore hard to disentangle from evidence on related policies and interventions—for example, evidence on specific service-level changes.

Quality of evidence

Overall, the quality of evidence reviewed was weak (see Table 2). The methods of the studies varied, including umbrella reviews, systematic reviews and meta-analyses, scoping reviews, and narrative reviews. Of the reviews that reported data on collaboration impacts, most were deemed to be critically low quality and only three reviews were deemed to be high quality. Of the reviews that only reported data on factors influencing collaboration functioning, most had multiple sources of potential bias—including weak search strategies and limited approaches to assessing and reporting risk of bias in the studies they reviewed. We have not excluded studies from our narrative synthesis based on the quality of the reviews, but we do note limitations or uncertainty in the evidence presented.

Impacts of collaboration

Twenty-one studies reported on collaboration impacts at a mix of individual and population levels.[70,72,73,74,77,79,80,82,83,86,89,90,91,92,93,96,97,99,101,102,104] They included evidence on health outcomes and health-related behaviours, service access and quality, resource use and spending, and organization or system-level processes related to collaboration. Evidence from the studies on collaboration impacts is summarized in Table 3.

Health outcomes

Most studies assessing the impact of collaboration on health outcomes, such as quality of life, mortality or health equity, found no, mixed, or limited evidence of impact. A review and meta-analysis of collaboration between local health and non-health agencies for health improvement found little or no evidence of health benefits.[77] Meta-analysis of effects on mortality, for example, found no effect (relative risk = 1.04 in favour of control, 95% CI 0.92 to 1.17) (see Table 3 for effects on morbidity).[77] A review of public sector collaborations to improve health in targeted communities in England found no evidence of population health improvements.[70] A review of community-level interventions to improve health in the US found insufficient evidence related to population health impacts—though it did find that these interventions could contribute to positive changes in health-related behaviours, such as smoking.[80] Ndumbe-Eyoh and Moffat found mixed impacts on health outcomes and limited evidence on equity impacts of collaboration to improve health for disadvantaged groups.[79]

Mason et al reviewed integrated funding initiatives between health care and social services agencies and found that, in the studies assessing health effects (such as quality of life and mortality), most reported no significant difference compared with usual care.[99] Cameron's et al's review of collaboration between health care and social services agencies found no or marginal improvements in health outcomes in studies with comparative designs (some studies with weaker designs reported improvements).[72] Winters et al found that most studies did not report positive outcomes (though did not define these outcomes clearly).[82] And Liljas et al's review of collaboration to provide more integrated care for older people with multimorbidity found that no studies examining mortality effects reported significant changes in mortality rates.[102] Five reviews found that evidence on health outcomes was limited.[74,86,93,104,83]

Evidence of impact from some kinds of collaborations was more promising. Anderson et al reviewed evidence on community coalitions to reduce health inequalities among minority groups and concluded that community coalition-driven interventions could benefit minority populations.[92] Community-level system changes—for example, focused on improving housing or green spaces—had little or no impact on measures of health status or health behaviour. But interventions targeting changes in the health and social care system—for example, to improve quality of care—led to small improvements on measures of health status or behaviour in large samples of community residents (though the evidence was rated as very low certainty). More positive impacts were also reported from lay community health worker and group-based health education interventions in large samples of community residents (though, again, the evidence was rated low or very low certainty). Bagnall et al's review of systems approaches to reducing obesity found that most studies reported some positive effects, including on health-related behaviours and body mass index.[101] One review of collaboration between health and a range of non-health sectors (such education and housing) to prevent and control vector-borne disease also found positive effects in the majority of studies that measured outcomes, including incidence and prevalence of disease.[96]

Lopez-Carmen et al's review of collaboration to improve mental health among indigenous children found few quality evaluations to draw on, but identified some studies reporting positive outcomes among children and their families receiving particular interventions.[91] Similarly, a review of primary care and public health collaboration described weaknesses in the evidence but reported some positive outcomes at an individual and population level, related to chronic disease management, disease control, and maternal child health.[89]

Service use and quality

Several reviews reported evidence that collaboration in a mix of contexts could improve access to services,[73,91,96,79,89] including for disadvantaged groups.[79,91] Cooper et al's review of collaboration in children and young people's mental health services, however, found more mixed evidence—with some studies suggesting more equitable access and others reporting reductions in access.[83] Some models of financial integration between health care and social service agencies may also have the unintended effect of reducing access for some groups (for example, by creating financial incentives to deny access to more costly patients).[99]

A review of integrated care interventions (including a mix of organizational and service level changes to improve coordination of services) found inconsistent evidence on overall health care utilization and activity, as well as on a range of specific utilization measures (such as clinician contacts and length of stay).[73] Cameron et al's review of health and social care collaboration found some evidence that intermediate care could reduce inappropriate admissions to institutional care.[72] Liljas et al's review of health and social care collaboration found mixed evidence on hospital admissions, readmissions, and length of stay.[102]

Evidence of impact on quality of services was mixed. Five reviews reported mixed impacts on quality of care[99,83,104,83] and patient satisfaction.[102] Dowling et al's review of health and social care partnerships in England found no clear or consistent evidence of improvements in services.[74] Baxter et al found evidence of improvements in patient satisfaction and perceived quality of care related to integrated care interventions.[73] A review of primary care and public health collaboration also reported some improvements in quality of care.[89]

Reviews of some targeted collaboration interventions reported positive impacts. For example, a review and meta-analysis of collaboration to improve child welfare outcomes in the US found that family drug treatment courts were positively associated with entry (odds ratio = 2.94, 95% CI 1.50 to 5.75) and completion (odds ratio = 2.07, 95% CI 1.26 to 3.41) of substance use services, and that family drug treatment courts (odds ratio = 2.40, 95% CI 1.75 to 3.29) and recovery coaches (odds ratio = 1.52, 95% CI 1.17 to 1.99) were associated with increased likelihood of children being reunited with families.[90] Whiteford et al found that collaboration between mental health care agencies and non-medical supports could increase housing stability, reduce recidivism rates, and improve employment-related outcomes, though also noted that positive outcomes had not been reported in all programs reviewed.[97] The reviews of these interventions, however, were of critically low quality (see Table 2).

Resource use and spending

Evidence on the resource use and spending impacts of collaboration was limited and mixed. Hayes et al's review of collaborations between health and non-health organizations found some evidence of increased costs, and—even though economic data were not provided for all studies—'it was clear that in most studies the interventions required additional resources'.[77]

Two reviews focused on collaborations to deliver more integrated health and care services found inconsistent evidence on costs,[73] or weak evidence that did not generally report cost reductions.[72] A review of collaboration between mental health care and non-medical supports found that while some studies reported 'improved cost efficiency across sectors', there were also examples of initiatives where costs fell for some partners but increased for others.[97]

A review of integrated funding initiatives between health and social care organizations[99] reported impacts on hospital costs and utilization together. It found that most schemes reported mixed (14 schemes) or unclear evidence (5 schemes), around a third of studies found no significant effect on hospital costs or utilization (11 schemes), three schemes reported a reduction in hospital costs or utilization, and one scheme reported increased utilization. Other studies sought evidence on the cost impacts of collaboration but found little data.[104,101,96,92]

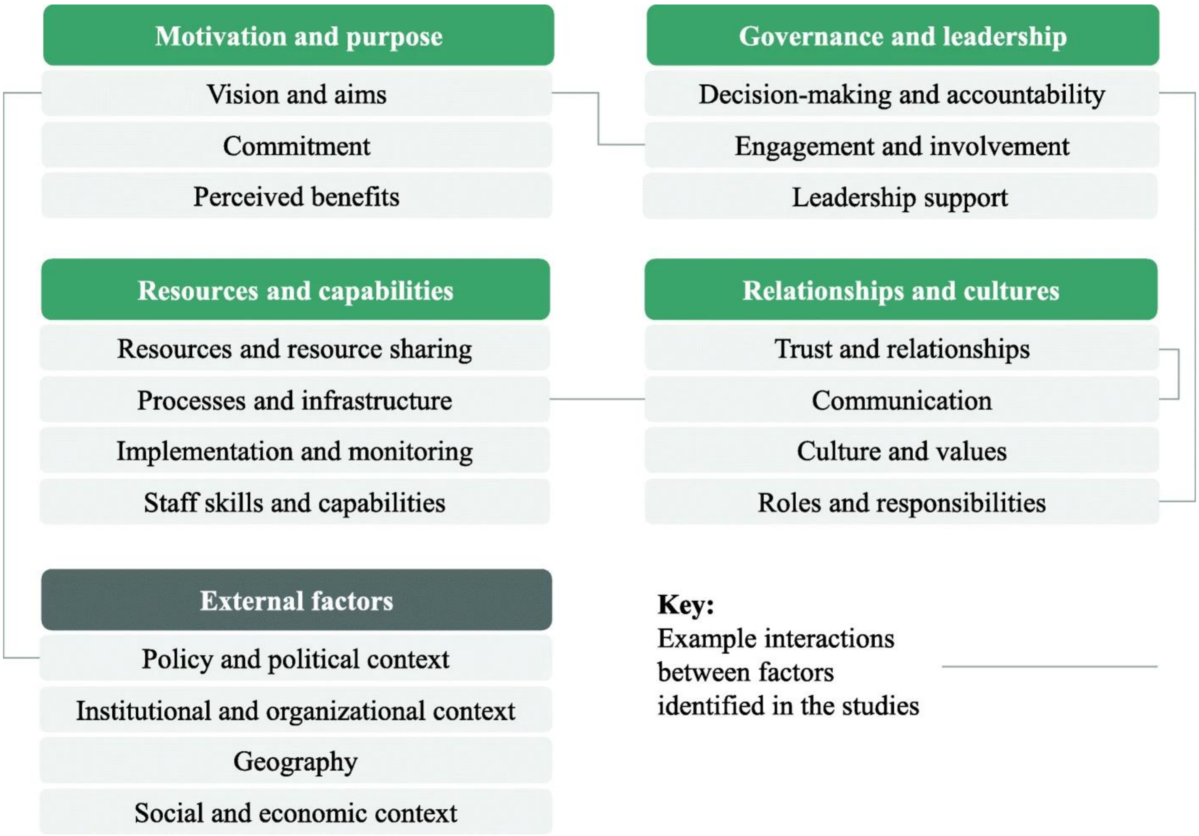
Process impacts

Some reviews reported qualitative evidence on changes in organizational or system-level processes as impacts of collaboration. These included improved collaboration processes and organizational capacity,[91,97] stakeholder buy-in,[93] implementation of policies and programs related to health promotion,[80] and an increased focus on health inequalities in local plans.[70] Potential negative impacts included increased time commitment and challenges to professional identities.[83] There were also some unintended consequences of financial incentives related collaboration, such as 'upcoding' (of 'nursing home certifiable' patients in a US demonstration program),[99] cost shifting,[97] and skewing local priorities.[89] More broadly, qualitative evidence on factors shaping collaboration functioning—outlined in the following section—describe various processes that can support or constrain joint working.

Factors influencing collaboration functioning

Twenty-nine studies reported on factors shaping the success and functioning of organizational collaboration (see Table 4). This included factors related to collaboration aims and motivation, resources and capabilities, cultures and relationships, governance and leadership, and external context (Figure 2). The factors overlap and interrelate, and sometimes come into conflict.

Figure 2. Factors influencing collaboration functioning and example interactions between them



Notes. The interactions between factors are examples identified in the studies reviewed. They are not an exhaustive list of all interactions between the factors identified. The relationships may move in both directions (eg involving staff may help create a shared vision, while having a shared vision may help with the task of engaging other partners), and may support or constrain collaboration in different contexts (eg national policies can help or hinder)

Motivation and purpose

Organizations collaborated for different reasons, which shaped how they worked together. A shared vision between local organizations and clear aims for collaboration were commonly identified as factors contributing to partnership success.[105,72,74,75,100,86,87,93,95,78,96,97,101,103,80,81,85] Involving organizational staff was identified as one route to creating a shared vision;[72,80,81,95] and a shared vision, in turn, may help with the task of engaging other partners.[80] On the flipside, unclear or unrealistic aims, competing agendas, and uncertain benefits were all identified as factors that can hold back organizational collaboration.[89,71,86,72,75,95,83,84,96]

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 agencies[86] (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 was thought to be open and frequent (though partners may disagree about how and when communication should happen[85]),[105,93,98,89,81,82] and involve sharing of information and best practice.[71,91,78,103] Various mechanisms were identified to help agencies do this (see section on resources and capabilities), such as regularly scheduled meetings and protocols for information sharing.[82,93] But communication issues within the partnerships studied were widespread, exacerbated by lacking or incompatible information systems, conflicting procedures, lack of trust between organizations and professions, and more.[72,71,76,86,97,83,84] The quality of communication was thought to affect various other factors shaping collaboration success, such as trust and understanding between partners.[88,89,81,94,82]

Resources and capabilities

Organizational collaborations depended on having sufficient resources to fund and deliver interventions, such as new service models or programs.[105,100,86,87,88,89,91,93,95,101,103,80,81,83,85] Lack of resources for joint working—funding, staff, equipment—was identified as a common barrier to collaboration,[105,71,72,86,89,91,95,96,97,83,84,85] and could result in increased staff workload.[100,94] Short-term or uncertain funding also held back some collaborations.[71,75,86,89]

Sharing resources between agencies—for example, through pooled budgets—was identified as one mechanism that may facilitate joint working,[72,71,86,103,89] and, in some cases, as a route to accessing additional resources.[103] But studies also found that sharing resources could lead to challenges in ensuring equitable funding between agencies,[86,89,82,99,105] and could create fears of cost-shifting among some partners.[84,105] Ultimately, having resources is not enough: resources also needed to be used effectively by local agencies to generate positive impact.[98,93]

The ability of organizations to collaborate was shaped, in part, by the infrastructure in place between them. Shared processes and systems—such as agreements for sharing information, joint meetings, and planning processes (see section on governance and leadership)—were thought to support organizations to communicate and work together.[75,100,87,88,89,91,93,103,82,83,85] Several studies suggested that co-location or close proximity of teams may support joint working[85,100,89,97,103,83]—though this appears to relate largely to teams delivering services. Health impact assessments—a mix of methods and tools to help identify the health and equity impacts of a particular policy or program—were also identified as a key mechanism for local governments and other partners seeking to promote intersectoral action.[78,95] On the flipside, fragmented or conflicting processes between agencies could hold back local partnerships.[105,76,88,89,96,99,82,83,84] Collaborations also needed skills to plan and implement their chosen interventions,[86,87,93,98,80,105] and monitor and evaluate the results.[101,74,86,93,95,78,96,97,80,85]

The skills and capabilities of staff also shaped collaboration functioning. Staff able to work across organizational and professional boundaries—sometimes referred to as ‘boundary spanners’—were thought to contribute to partnership success.[75,89,94,82,83,85,105] Staff training on collaboration processes and joint training between agencies were thought to help improve collaboration and understanding between sectors,[72,75,86,88,89,93,94,95,98,104,103,80,82,83] while high staff turnover or lack of continuity of key staff could hold back collaboration.[86,88,91,104,82,85]

Governance and leadership

Differences in decision-making processes, competition for power and resources, and lack of accountability between agencies were identified as barriers to collaboration.[105,89,96,99,81,84,88,95] As a result, clear decision-making and accountability arrangements were thought to contribute to collaboration success.[74,75,81,85,97,105] The literature is not particularly clear what this means in practice. Example mechanisms included conflict-resolution processes,[98,97,103] such as a neutral convener,[103] and formalized rules or contracts between agencies.[98,89]

The literature is more clear, however, that good governance means involving all relevant agencies and stakeholders.[105,88,89,93,78,96,97,98,101,80,82,84,85] This includes front-line staff.[75,82,86,89] But broad membership could also bring challenges for decision-making, such as limiting the chance of consensus.[81] Multiple studies identified the importance of community involvement—including direct involvement of community members and community-based organizations—for collaborations to be successful.[74,89,101,80,81,82] This may help ensure that organizations understand community needs and design appropriate interventions.[89,91,101,81]

Senior leaders played a key role in shaping how local collaborations and their governance functioned—for better or worse.[105,74,100,86,87,88,93,95,96,97,98,80,101,81,82,83,84,85] Leadership commitment was thought to be needed for collaborations to work (see section on motivation and purpose). Leaders used their power to free up resources for joint working,[88,95,85] help resolve conflicts,[87,97] promote openness and information sharing between agencies,[93,85] and more. But leaders could also block partnership working by defending territorial or organizational interests.[88,84] The collective involvement of organizational leaders—beyond their individual impact—was thought to contribute to partnership effectiveness.[85,82,81,80]

External factors

Collaborations do not exist in a vacuum. While the internal characteristics of partnerships—their leadership, governance, composition, and so on—mattered, the broader context in which local agencies operated shaped how they worked together and the impact they could achieve.

National policy context influenced the local partnerships reviewed. On the one hand, national policies promoted or incentivized joint working in several contexts studied.[103,105,76,100,94,95,89,78] Government policies on tackling health inequalities, for example, facilitated local partnerships to develop in Europe and elsewhere.[78,95] In some contexts, such as the UK, national policymakers also mandated partnership working between agencies—though some studies suggested that doing so risks lowering the chances of partnership success, including by undermining the time needed to develop local relationships.[81,105] On the other hand, some studies suggested that national policy priorities could dampen or conflict with local priorities.[95,105] And constantly shifting national policies may confuse or undermine local partnerships—as was experienced by those involved in area-based partnerships between health care, social services, and other sectors in England in the late 1990s and early 2000s.[71] Policies not directly focused on collaboration—for example, payment systems in the health care sector—could also create barriers to collaboration between health and social care.[100]

The institutional and organizational context of health care, social services, and other sectors also shaped local collaborations.[74,84,94,99] For example, Mason et al identified differences in national performance systems, pension schemes, and employment arrangements as barriers to collaboration between health and social services in the UK.[99] Several studies also noted that organizational restructuring could hold back local collaboration[72,86,89,71]—for example, by creating uncertainty among agencies[89] and requiring leaders to renegotiate relationships.[71]

Other external factors identified in the literature included political context[78,96,85]—for instance, 'political will'—and the geographical location and boundaries of collaborating agenices.[71,86,96,105] Finally, the social and economic context within which partnerships operate was recognized as a factor shaping collaboration functioning potential and impact.[80,85,95]

DISCUSSION

Collaboration between health care, social services, and other sectors is often seen as a common-sense route to improving population health. We sought to review evidence on the health impacts of collaboration between local health care and non-health care organizations, as well as the factors shaping their functioning and success. We identified 36 studies that reviewed evidence on local collaborations in various contexts and synthesized the results.

Overall, there is little convincing evidence to suggest that collaboration between local health care and non-health care organizations improves health outcomes. Evidence of impact on health services is mixed—though some studies suggest collaboration may improve access to services, and one high quality review found that integrated care interventions may improve patient satisfaction.[73] Evidence on resource use and spending was limited and mixed. Across the studies reviewed, positive impacts appear more likely to be reported for more targeted interventions (for example, health system and community outreach interventions reviewed by Anderson et al[92]) or narrow measures of impact (such as access). 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. On the one hand, the emperor may simply have no clothes: collaboration between health care and non-health care organizations may not deliver the kinds of impacts that many policymakers expect. On the other, collaborations may be fiendishly difficult to do—as illustrated by the many barriers to joint working identified in the literature—so while effective partnerships may contribute to better health, implementation issues render them rare. A further explanation is that the effects of collaboration are difficult to measure. Evaluating these kinds of collaborations brings significant methodological challenges[179,180]—given that they are hard to define, involve multiple organizations and interventions spread over space and time, have diverse and often long-term aims, and operate alongside many other factors that affect health. This is particularly the case for collaborations focused on broad population health improvements. The impact of local collaborations may be positive, but modest—and easily drowned out by the combination of other factors influencing the population's health. A mix of these explanations may be true—with benefits overestimated, hard to deliver, and hard to measure.

Many studies report on factors and mechanisms associated with better or worse collaboration. We grouped these into five domains—covering motivation and purpose, relationships and cultures, resources and capabilities, governance and leadership, and external factors. These factors offer pointers for practitioners and policymakers seeking to foster collaboration, as well as examples of issues faced in various contexts. Several factors, such as quality of communication between partners and availability of 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 actually shape collaboration outcomes. 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.

Despite this, collaboration between local agencies to improve health looks here to stay. Faith in collaboration has been a driver of health policies in various countries over decades—and currently forms part of health system reforms in the US, UK, and elsewhere.[42,43,46,47] COVID-19 may stoke policymakers' belief in collaboration even further. The Secretary of State for Health and Social Care in England, for example, has described the positive impact of collaboration between local services as a core lesson from the COVID-19 response, and identified increased collaboration between the NHS, local government, and wider public services as a policy priority as the country recovers from the pandemic.[181] Legislation has been proposed to formalize existing health and social care partnerships in England.[182] The evidence reviewed here suggests that policymakers and local leaders should be realistic about the kind of impacts that collaboration may deliver on its own. The potential benefits of closer working between health care and social services agencies—for example, on preventing health service use and reducing costs—have often been overstated.[43,183] And the various cultural, institutional, practical, and other issues that hold back collaboration risk being underplayed.

Ultimately, local collaborations are shaped by the broader social, political, and economic structures in which they operate. Better communication, say, may help agencies coordinate local health interventions. But broader state and national policy decisions—for example, government policies on the level and distribution of spending on income support, education, and social services—will fundamentally shape health and health inequalities in those communities.[184,185,7] Local collaborations must therefore be understood within their broader political context, and alongside other interventions that interact to shape population health.

Conceptualizing collaborations as one component in a complex system may help us better understand their potential contribution to improving health. Take health partnerships in England under the New Labour governments (1997 to 2010) as one example. Various 'area based' collaborations between health care, social services, and other agencies were developed in England in the late 1990s and 2000s as part of a broader national strategy to reduce health inequalities between richer and poorer areas. The strategy evolved over time and involved a range of interventions—including better support for families, engaging communities, efforts to tackle poverty, improving NHS prevention and treatment, and a mix of other policy measures, combined with increased investment in the NHS, social care and other services.[186,187,188] Evaluations of the local collaborations developed during this period found no clear evidence of their effect on health outcomes.[70,71] But more recent evidence suggests that the broader government strategy may have been partially effective in reducing health inequalities over time—associated with reductions in regional inequalities in life expectancy and infant mortality.[189,190] Local collaborations may have contributed to a complex system of interventions affecting health, operating at multiple levels. For example, local collaborations were one mechanism supporting the delivery of potentially powerful policy interventions introduced by government, such as additional spending on the NHS and social programs.

Disentangling the distinctive impact of local collaborations from the broader context in which they operate will remain a challenge for researchers. But some methods may help identify features of collaboration that have the potential to contribute to better health in different contexts. Positive deviance sampling,[191,192] 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. 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.[193] This kind of approach might be utilized in other contexts to help understand whether organizations in communities with better population health have distinct patterns of cross-sector collaboration.

Limitations

This study has several limitations. First, the kinds of collaboration described in the literature are often broadly defined and weakly described. Information on the form of collaboration—for example, which agencies work together and how—is often limited. And multiple types of collaboration are often studied together, making the evidence hard to disentangle. Our review excluded studies that focused on collaboration between professionals or services—for example, through multi-disciplinary teams at a service level—without a clear focus on collaboration at an organizational level. But some studies that we included reviewed evidence on a mix of collaboration interventions—not all directly related to our phenomena of interest.

Second, our search strategy focused on identifying evidence on collaboration between health care and non-health care organizations broadly speaking—with terms like collaboration, coalition, and partnership, alongside terms related to health and social services organizations and inter-organizational working (see Additional File 1). This broad approach is a strength of the review, given that it identified a large body of relevant literature on collaboration between agencies to improve health. But it also means that reviews of interventions involving organizational collaboration but not using these terms—for example, evidence on pooled financing models to fund local health interventions—may not have been identified fully through our searches.

Third, we only synthesized evidence from reviews of the literature. This allowed us to make sense of a large body of diverse evidence. But it is likely that some relevant primary studies have not been included in our review. It means that some studies may be duplicated between reviews—though this is unlikely to skew our findings, given the lack of convincing evidence overall, and the fact that we did not undertake a pooled quantitative analysis of collaboration impacts. It means that a heterogenous mix of interventions and contexts were studied together. Our study design—two steps removed from the primary evidence—also means that the context and richness of the original primary data are largely lost in our review. The exclusion of non-English language papers will have also affected the studies we identified.

Finally, our study is limited by the quality of evidence reviewed. The reviews included in our study were typically poor quality, and themselves often cited the limitations of the primary studies they reviewed. Weak descriptions of the factors shaping collaboration functioning make it difficult to identify the mechanisms that might help collaboration efforts in different contexts. Nonetheless, the evidence reviewed provides useful pointers for policy and practice.

CONCLUSION

Collaboration between health care, social services, and other sectors is widely promoted as a route to improving population health. Theory suggests that collaboration might help local organizations combine their skills and resources to better meet community needs. But competing institutional norms and priorities may also create conditions for conflict. We found little convincing evidence to suggest that collaboration between local health care and non-health care organizations improves health outcomes. The literature offers pointers for policymakers and practitioners on factors thought to be associated with better or worse collaboration. But, overall, we know little about which collaborations work, for whom, and in what contexts. Local collaborations should be understood within their broader political context, and alongside other interventions and factors that interact to shape population health.

TABLE 1: study context and collaboration type

Study	**Context**	**Collaboration type**
Anderson et al (2015). Community coalition-driven interventions to reduce health disparities among racial and ethnic minority populations	- Community coalitions with at least one racial or ethnic minority group representing the target population, and at least two community public or private organizations - Studies included focused on academic and community partnerships, partnerships between public health and other agencies, community-based agency partnerships - Health or health care agency was lead sector in 13 studies	- Community coalitions, defined as 'conglomerates of citizen groups, public and private organizations, and professions that are characterized by representation from multiple community sectors in bottom-up planning and decision making. They operate through partnerships and emphasize using local assets and resources to build community capacity. The focus of a community coalition may vary depending on the sectors of the community involved (eg education, public safety, public health)' - Four types of interventions used by coalitions: broad-scale community system-level change (eg improving housing or green spaces), broad-scale health or social care system-level change (eg to improve quality of care), lay community health outreach workers (eg to promote behaviour change), group-based health education and support for targeted groups (eg diabetes)
Andersson et al (2011) Organizational approaches to collaboration in vocational rehabilitation-an international literature review	- Vocational rehabilitation, defined as 'a multidisciplinary intervention to help individuals to return to work after an occupational injury, or a period of unemployment or sickness' - Typical partners include health care and social services, occupational health services, employment services, and social or private insurance - Studies from Sweden, Canada, US, Netherlands, UK, Australia, Belgium, Norway	- Seven models of collaboration in studies reviewed, often in combination: information exchange, case coordination, interagency meetings, multidisciplinary teams, 'partnership' ('formal agreements between two or more organizations to integrate their services across organizational boundaries), co-location, budget pooling
Auschra C (2018). Barriers to the integration of care in inter-organisational settings:	- 'Inter-organizational collaborations' to support integrated care - Focus on 'health service delivery' (not defined). Studies largely focus on health care and social services	- Inter-organizational collaborations, defined as 'dyadic relationships between two partner organisations or as inter-organisational networks, implying relationships between at least three partners'

a literature review		- Integrated care defined as 'a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical domains designed to create connectivity, alignment and collaboration within and between the cure and care sector'
Bagnall et al (2019). Whole systems approaches to obesity and other complex public health challenges: a systematic review	- Systems approaches to obesity - Studies from US, Canada, UK, Europe, and others involved in the WHO Healthy Cities Network - Interventions targeted a mix of population groups, including adults, children, deprived areas, minority groups, socially excluded groups, people with disabilities - Partnerships poorly described. Partners include local government, health care, schools, community groups, childcare, and others	- Whole systems approaches to obesity, defined as 'those that consider the multifactorial drivers of overweight and obesity, involve transformative co-ordinated action across a broad range of disciplines and stakeholders, operate across all levels of governance and throughout the life course' - Heterogenous and wide-ranging interventions
Baxter et al (2018). The effects of integrated care: a systematic review of UK and international evidence	- Studies of integrated care focused on a range of population groups, most commonly older people - Studies from the UK, US, Canada, Australia, Netherlands, Sweden, Spain, Germany, Switzerland, France, Norway, Finland, New Zealand, Austria	- Integrated care, defined as 'changes to health or both health and health-related service delivery which aim to increase integration and/or coordination' - Interventions with four broad elements, often in combination: patient care interventions, changes to organizations and systems, changing staff or employment arrangements, changes to finance or governance arrangements
Cameron et al (2014). Factors that promote and hinder joint and integrated working between health and social care services: a review of research literature	- 'Jointly organised' services for older people and people with mental health conditions in the UK	- Studies included focused on service delivery partnerships, 'structurally integrated services', and pooled budgets
Cooper et al (2016). Interagency collaboration in	- 'Interagency collaboration' across child and young people's mental health services	- Interagency collaboration, defined as 'the process in which different professional services work together to try and positively impact care'

children and young people's mental health: a systematic review of outcomes, facilitating factors and inhibiting factors	- Sectors include child and adolescent mental health services, school-based providers, child welfare, counseling - Studies from the UK, North America, Scandinavia, Australia	- Partnerships involved two or more agencies or professional groups
Corbin (2016). What makes intersectoral partnerships for health promotion work? A review of the international literature	- 'Intersectoral partnerships' focused on health promotion - Partnerships focused on cancer, violence prevention, HIV/AIDS, nutrition labeling, physical activity - Studies from the US, Ireland, Tanzania, Canada, Netherlands, Australia, UK	- Partnership defined as 'any arrangement in which people and/or organizations join together to promote health'
Davies et al (2011). A systematic review of integrated working between care homes and health care services	- Integrated working between primary health care and care homes for older people - Studies from UK, Australia, USA, Sweden	- Integration between health and care services, defined as micro level collaboration (eg staff working together), meso level collaboration (eg organizational structures to support teams to work together), and macro level collaboration (eg joint funding for health care and care homes) - Studies included examples of micro, meso, and macro integration
Dowling et al (2004). Conceptualising successful partnerships	- Health and social care partnerships in England - Wider policy context of New Labour's focus on partnership working in the delivery of health care, social services and other public services	- Partnerships defined as 'a joint working arrangement where partners are otherwise independent bodies cooperating to achieve a common goal; this may involve the creation of new organizational structures or processes to plan and implement a joint program, as well as sharing relevant information, risks and rewards'
Errecaborde et al (2019). Factors that enable effective one health collaborations: a scoping review of the literature	- Focuses on 'One Health' collaborations, defined as 'the integrative effort of multiple disciplines working to attain optimal health for people, animals, and the environment' - Collaborations in response to infectious disease-related events	- Collaboration defined as two or more sectors working together - Focused on both preparedness (eg planned or ongoing work) and responsive (eg emergency health events) collaborations

	- Studies from Europe, the Americas, Asia, Africa, Oceana, Middle East	
Foster-Fishman et al (2001). Building collaborative capacity in community coalitions: a review and integrative framework	- Community coalitions focused on improving health and wellbeing - Context not described, but article is US-focused	- Community coalitions not defined - Review focused on ‘all forms of collaborative venues including task forces, community coalitions, multiple stakeholder groups, interagency coordinating councils, and coordinating communities’
Gannon-Leary et al (2006). Collaboration and partnership: A review and reflections on a national project to join up local services in England	- Partnership working between public services in England - Review part of a wider evaluation of the Framework for Multi-Agency Environments project (a UK government initiative focused on multi-agency information sharing at a local authority level to improve services)	Collaboration defined in two ways: - ‘a mechanism for developing a multi-agency partnership strategy in which partners work together towards a common set of goals’ - ‘the function of exchanging information, altering activities, sharing resources and developing the capacity of another organization or individual for mutual benefit in order to achieve a common aim’
Green et al (2014). Cross-sector collaborations in Aboriginal and Torres Strait Islander childhood disability: A systematic integrative review and theory-based synthesis	- Collaborations among services for Aboriginal and Torres Strait Islander children with a disability and their families - National policy context of Australian government initiatives to coordinate public services for this group	- Focus on ‘collaboration or interaction within or across two or more providers/sectors’ - Collaboration models included collaboration within the health sector, between health and education sectors, and in schools or early childhood development centers - Most studies focused on hearing impairment and learning disabilities
Guglielmin et al (2018). A scoping review of the implementation of health in all policies at the local level	- Local health in all policies approaches, defined as ‘an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity’	- Studies focused on ‘multiple government sectors (and may or may not include the private sector) collaborating (working together in some capacity)' - Local partnerships at a ‘city or municipal’ level

	- Studies from 14 countries, most commonly Sweden, Australia, Canada, Finland, Netherlands, Norway	
Hayes et al (2011). Collaboration between local health and local government agencies for health improvement	- 'Interagency collaboration' and partnership between statutory health and local government agencies with interventions aimed at improving health	- Collaboration defined as 'two or more parties that pursue an agreed set of goals and work cooperatively toward a set of shared health outcomes' - Collaborations focused on care for individual patients through multi-disciplinary teams, population level health promotion or disease prevention, mental health, chronic disease management, healthy lifestyles, frail elderly
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	- Collaboration to support vector-borne disease management - Studies from Americas, Western Pacific, South East Asia, Africa - Collaborations involving 26 sectors, including health, education, housing, immigration, child and women welfare, rural development, and others	- Intersectoral collaboration, defined as 'a recognised relationship between health sector and another sector to take action on an issue to achieve health outcome to be more effective, efficient or sustainable', and 'cooperation between different sectors of society such as the public sector, civil society and the private sector' - Interventions primarily sub-national (10 studies focused on national or broader collaborations), and most commonly focused on community or health education
Liljas et al (2019). Impact of integrated care on patient-related outcomes among older people: a systematic review	- Integrated health and social care for older adults with multimorbidity - Studies from North America and Western Europe	- Integrated care, defined as 'a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors' - Studies focused on 'organisational level' integration (eg collaboration between health and social care agencies) and 'system level' integration (eg planning, purchasing, and other activities across the system)
Lopez-Carmen et al (2019) Working together to improve the mental health of	- Collaboration focused on improving children's mental health among indigenous children in Canada, Australia, New Zealand, Norway, US	- Intersectoral service integration, defined as 'individual, organizational, or inter-organizational levels of collaboration or coordination between [primary health care] and a categorically different education, mental health, juvenile

indigenous children: A systematic review	- Sectors considered were primary health care, specialist mental health, education, child protection, criminal justice	justice and/or child protection service to provide more comprehensive support to address mental health or an (explicitly identified) determinant of Indigenous children's mental health' - Main strategies for service integration: community health workers, multidisciplinary teams, staff and organizational capacity building, community engagement, empowering families, counselling, adaption of care to address cultural factors, strengthening culture and identity
Mackie and Darvill (2016). Factors enabling implementation of integrated health and social care: a systematic review	- Integration of health and social care services in the UK - Studies focus on integrated care in community settings, targeting people with long term conditions	- Integrated care, defined as 'an organising principle for care delivery to improve patient care and experience through improved coordination'
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	- Collaboration between primary care and public health - Studies from the US, UK, other Western European countries, Canada Australia, New Zealand	- Collaborations aimed at improving health care by coordinating services, improving access to care, applying a population perspective to medical practice, using clinical practice to identify and address community health problems, strengthening health promotion and health protection by mobilizing community campaigns, and collaborating around policy, training and research
Mason et al (2015). Integrating funds for health and social care: an evidence review	- Integration of finances between health and social care organizations - Studies from England, Scotland, Northern Ireland, Canada, Australia, US, Sweden	- Eight types of integration: transfer payments (eg one authority contributes to the budget of another), cross-charging (eg compensating one sector for failures in another), aligned budgets (eg partners use own resources for joint objectives), lead commissioning (eg one agency leads purchasing based on joint aims), pooled funds (both agencies pay into joint fund for agreed aims), integrated management/provision with pooled funds (eg partners pool

		resources and staff), structural integration (eg finances integrated under single agency), lead commissioning with aligned incentives (eg pay for performance schemes)
Ndumbe-Eyoh and Moffat (2013). Intersectoral action for health equity: a systematic review	- ‘Intersectoral action’ initiatives in the US, UK, Canada, Australia, New Zealand - Most studies focused on local or community initiatives. All interventions focused on disadvantaged groups	- Intersectoral action, defined as ‘intersectoral interventions, policies and programs, undertaken by the public health sector in collaboration with governmental and non-governmental sectors outside of health’ - Interventions categorized into three groups: upstream (eg improving housing conditions), midstream (eg food security), downstream (eg care coordination)
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	- Collaboration between agencies to improve child welfare outcomes - All studies focused on substance use and included participants in the US - Legislation in the US mandates that agencies collaborate to deliver outcomes related to child safety, permanency, and wellbeing	- Studies included categorized as ‘coordination’ (‘more formalized joint working, but no sanctions for non-compliance’) and ‘integration’ (‘organizations merge to create new joint identity') - Interventions involved a team of individuals (eg families, treatment providers, mentors, and the courts) to address caregivers' substance use and improve child welfare outcomes
Perkins et al (2010). ‘What counts is what works’? New Labour and partnerships in public health	See Smith et al (2009)	See Smith et al (2009)
Rantala et al (2014). Intersectoral action: local governments promoting health	- ‘Intersectoral action’, including issue-specific approaches (eg to reduce obesity) and broader health goals	- Intersectoral action (ISA), defined as ‘how the health sector works with other governmental and non-state sectors to improve health and well-being, address the complex risk factors for health and ensure full access to health and health equity’

	- 25 local government cases in 19 countries from the WHO regions of the Americas, Eastern Mediterranean, Europe, South-East Asia and Western Pacific - Population size ranges from less than 50,000 to around 10,000,000	
Roussos and Fawcett (2000). A review of collaborative partnerships as a strategy for improving community health	- Community level interventions involving 'collaborative partnerships' to improve health in the US - Collaborations focused on a wide range of health issues, including substance use, adolescent pregnancy, cardiovascular disease, crime and violence, health services, HIV/AIDS, immunization, infant mortality, lead poisoning, nutrition, food security	- Collaborative partnerships, defined as 'an alliance among people and organizations from multiple sectors, such as schools and businesses, working together to achieve a common purpose. In public health, collaborative partnerships attempt to improve conditions and outcomes related to the health and wellbeing of entire communities'
Savic et al (2017). Strategies to facilitate integrated care for people with alcohol and other drug problems: a systematic review	- Integrated care for people with alcohol and drug problems - Studies from North America, Europe, Australia	- Integrated care, conceptualized as coordination between alcohol and drug services, and coordination between alcohol and drug services and non-alcohol and drug services, such as mental health, community health, and housing - Most studies focus on strategies to integrate services between alcohol and drug services and non- alcohol and drug services
Seaton et al (2018). Factors that impact the success of interorganizational health promotion collaborations: a scoping review	- Collaboration for health promotion involving two or more partners - Studies from the US, Canada, Australia, Denmark, Northern Ireland, South Africa, Sweden, UK - Collaborations focused on a range of health improvement issues, such as HIV and disease prevention	- Interorganizational collaboration, defined as 'partners engaging as a group to work synergistically across organizational boundaries toward a common intended goal'
Sloper, P (2004). Facilitators and barriers for co-ordinated multi-agency services	- 'Multi-agency' working in public services - Wider context of national policies in UK to encouraging joint working between public sector agencies	- Multi-agency working not defined - Studies range in focused from 'strategic level working' (eg joint planning) to multi-disciplinary teams

Smith et al (2009). A systematic review of the impact of organizational partnerships on public health outcomes in England between 1997 and 2008	- ‘Public health partnerships’ in England related to Health Action Zones, Health Improvement Programmes, and other national policy initiatives - Key partners include health care organizations, local government, housing, schools, and others	- Public health partnerships, defined as ‘organizational partnerships (of two or more organizational bodies), which aim to improve public health outcomes (through population health improvement and/or a reduction in health inequalities)’
Whiteford et al (2014). System-level intersectoral linkages between the mental health and non-clinical support sectors: A qualitative systematic review	- Collaboration between mental health and non-clinical services - Non-medical services included justice system, social services, education, vocational support, child welfare, substance abuse, employment, housing, government welfare, and other community-based services - Studies focused on people with mental health needs and homeless population	- ‘System-level intersectoral linkage’, defined as ‘any attempt to improve the service system for a defined population by implementing linkages between agencies and programs or reconfiguring or consolidating agencies at the policy, program or organisational level’ - Models of collaboration studied include: joint service planning and information exchange, multi-agency care plans, formal collaboration agreements (eg memoranda of understanding), staff training (including shared training), information sharing and joint information systems, joint service provision, co-location of services, single lead agency models
Wildridge et al (2004). How to create successful partnerships: a review of the literature	- Context of government policy in UK promoting partnership working between health and social care agencies, as well as wider public services	- Not defined - Focus is largely on health and social care partnerships
Williams I (2009). Offender health and social care: a review of the evidence on inter-agency collaboration	- Crime prevention and reduction partnerships in England - Partnerships associated with national policy initiatives to encourage collaboration between criminal justice agencies and health and social care - Agencies involved include criminal justice, health, local government, housing, and others	- Focuses on ‘formally instituted partnership bodies in England with a clear criminal justice remit’, including Drug (and Alcohol) Action Teams (D(A)ATs), Crime and Disorder Reduction Partnerships (CDRPs), Multi-Agency Public Protection-Arrangements (MAPPAs) and Youth Offending Teams (YOTs)’

Winters et al (2016). Cross-sector provision in health and social care: an umbrella review	- 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	- 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'
Zakocs and Edwards (2006). What explains community coalition effectiveness? A review of the literature	- 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	- 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

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[†] 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	- Systematic review - 35 studies included	Low	NA	- 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	- Systematic review - 167 studies included	High	NA	- 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	- Review - 46 papers, reporting on 30 studies	Critically low	NA	- 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	- Systematic review - 33 studies included	Critically low	NA	- 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				- 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	- 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	- 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	- 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	- Review - 26 articles included	NA	1,2,5	- No formal quality assessment

TABLE 3: summary of evidence on collaboration impacts

		Collaboration impacts			
Paper	**Outcomes studied**	*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 *	- Measures of improved health, health status, survival, or health-related lifestyle factors - Studies included with any measure of mortality, morbidity, or behaviour change	- 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	- Some studies reported additional costs associated with partnership interventions	NA

		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%) - 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%) - 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			

		-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

		of moderate magnitude in large samples of community residents - 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			

Smith et al (2009). A systematic review of the impact of organizational partnerships on public health outcomes in England between 1997 and 2008 ‡	- 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)	- 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	NA	NA	- Qualitative studies found that partnership initiatives had helped embed or increase focus on health inequalities
Liljas et al (2019). Impact of integrated care on patient-related outcomes among older people: a systematic review ‡	- Patient satisfaction, hospital admission, length of hospital stay, hospital readmission, mortality	- No studies examining mortality reported significant changes in mortality rates	- Mixed impacts on hospital admissions, readmissions, and length of stay - Mixed impacts on patient satisfaction	NA	NA
Ndumbe-Eyoh and Moffat (2013). Intersectoral action for health equity: a systematic review ‡	- Impact on health equity or social determinants of health, such as housing or employment, for deprived groups	- Mixed impacts on health outcomes - Limited evidence on equity impacts	- More downstream interventions 'moderately effective' in increasing access to services for marginalized groups	NA	NA

Bagnall et al (2019). Whole systems approaches to obesity and other complex public health challenges: a systematic review ‡	- Focused broadly on evidence of effectiveness and cost-effectiveness of whole systems approaches	- 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	NA	- Limited evidence on cost-effectiveness	NA
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 ‡	- Outcomes related to the prevention and control of vector borne diseases, such as disease incidence or prevalence	- Most studies measuring disease indicators reported positive effects, such as reduction of cases	- Most studies measuring vector variables (adult density, pupae or larval indices) reported declining vector indices - Improvements in access to intervention and treatment	NA	NA
Davies et al (2011). A systematic review of integrated working between care homes and health care services §	- 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)	- Some improvements in outcomes reported, but the majority of studies found that the intervention had mixed effects or no effect	- Some improvements in outcomes reported, but the majority of studies found that the intervention had mixed effects or no effect	- Insufficient evidence on costs	NA

Mason et al (2015). Integrating funds for health and social care: an evidence review §	- Focused broadly on effectiveness or cost-effectiveness, including a range of health and service level outcomes	- 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	- Impact on secondary care utilization was mixed - Impact on quality of care and user experience was mixed	- Impact on secondary care costs was mixed	- Some studies found unintended consequences, such as ‘upcoding’
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 §	- Outcomes related to ‘safety, permanency, and well-being for child welfare involved families’	NA	- 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 $I^2 = 71\%$)	NA	NA

			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 - 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 $I^2 = 48\%$).		
Lopez-Carmen et al (2019) Working together to improve the mental health of indigenous children: A systematic review §	- Effects of integrated mental health services for indigenous children, including children's mental health outcomes	- Improvements in children's psychosocial functioning, stress management, and individual 'empowerment' - 'Empowerment' of families and communities	- Improved access to services, utilization	NA	- Greater collaboration between health and non-health services and 'strengthened organizational capacity'

Whiteford et al (2014). System-level intersectoral linkages between the mental health and non-clinical support sectors: A qualitative systematic review §	- Focused broadly on outcomes for services or clients from intersectoral linkages between clinical and non-clinical mental health services	NA	- 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	- Improved efficiency, though also examples of cost shifting	- Improvements in interagency communication, mutual understanding of services
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 §	- Focused broadly on outcomes of primary care and public health collaborations, including outcomes related to individuals and populations, health professionals, and health service delivery	- Improvements in chronic disease management, disease control, maternal and child health	- Improvements in access to care, immunization rates, and care processes, such as needs assessments	NA	- 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

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’				
AMSTAR 2 overall confidence assessment: * High † Medium ‡ Low § Critically low					

TABLE 4: summary of evidence on factors influencing collaboration functioning

Paper	**Factors influencing collaboration functioning**
Studies reporting on generic factors	
Andersson et al (2011) Organizational approaches to collaboration in vocational rehabilitation-an international literature review	- 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	*Organizational* - 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) *Cultural and professional* - 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)

	Wider context - 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	- 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	- 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	*Government level* - 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) *Organizational level* - 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)

	Service provider level - 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	- 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	- 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	- 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)

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	*Systemic:* - 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) *Organizational:* - 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) *Interactional:* - 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)
Perkins et al (2010). 'What counts is what works'? New Labour and partnerships in public health	- 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)
Rantala et al (2014). Intersectoral action: local governments promoting health	- 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)

	- 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	- 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)	
Studies reporting on supportive and/or constraining factors		
Cooper et al (2016). Interagency collaboration in children and young people's mental health: a systematic review of outcomes, facilitating factors and inhibiting factors	Supportive factors: - 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'	Constraining factors: - 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	Supportive factors: - Health care input and training valued by care homes	Constraining factors: - Lack of trust and confidence between health care and care home staff - Lack of access to health care services

	- ‘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	- 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
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	Supportive factors: - 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)	Constraining factors: - 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

Seaton et al (2018). Factors that impact the success of interorganizational health promotion collaborations: a scoping review	Supportive factors: - 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	Constraining factors: - Absence of supportive factors - Government mandates or policy directives to collaborate - Power imbalances between partners
Sloper, P (2004). Facilitators and barriers for co-ordinated multi-agency services	Supportive factors: *Service planning:* - 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 *Service implementation and management:* - Shared and adequate resources - Staff with the right experience and approach - Joint training and team building	Constraining factors: - 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

	- Appropriate support and supervision of staff - Service monitoring and evaluation *Other:* - 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	Supportive factors: - 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)	Constraining factors: - 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	Supportive factors: - Shared vision - Trust - Communication - Effective decision-making and accountability - Effective change management	Constraining factors: - 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)

	- 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	- 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	Supportive factors: - 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 stuctures) - 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	Supportive factors: - Engagement of partners - Agreement on need for and aims of partnership - Trust and respect among partners	NA

	- Satisfactory accountability arrangements - Adequate leadership and management - Wider context (eg financial climate and legal and institutional structures shape partnership success)	
Errecaborde et al (2019). Factors that enable effective one health collaborations: a scoping review of the literature	Supportive factors: *Individual level* - Education and training - 'Just in time' training - Existing experience and relationships *Organizational level* - 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) *Network level* - 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)	NA

	- Network management (eg established lines of communication between organizations) - Monitoring and evaluation - Resource mobilization and allocation (eg financial and human resources)	
Foster-Fishman et al (2001). Building collaborative capacity in community coalitions: a review and integrative framework	Supportive factors: *Member capacity* - 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) *Relational capacity* - Develops a positive working climate - Develops a shared vision - Promotes power sharing - Values diversity (eg individual and group differences appreciated)	NA

	- Develops positive external relationships *Organizational capacity* - 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 *Programmatic capacity* - Clear objectives - Realistic goals - Driven by and addresses community needs	
Lopez-Carmen et al (2019) Working together to improve the mental health of indigenous children: A systematic review	Supportive factors: - 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)	NA

Zakocs and Edwards (2006). What explains community coalition effectiveness? A review of the literature	Supportive factors: - 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	NA

	- 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	

	- 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	Supportive factors: - 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
	Contextual factors: - 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	Constraining factors: *Regulation and administration* - Regulatory issues (eg data sharing) - Historical context (eg lack of history of collaboration) - Administrative boundaries *Funding*

		- Insufficient funding - Fear of cost shifting *Inter-organizational* - Lack of leadership coordination - Organizational differences (eg in decision-making processes) - Power imbalances - Conflicting aims - Failure to include key partners *Organizational* - Organizational agenda differs from collective interests - Cultural differences - Previous experiences between organizations *Service delivery* - Professional differences - Poor communication - Lack of trust - Lack of mutual understanding - Resistance to change - Lack of technical standards (eg for data sharing) *Clinical* - Lack of information sharing - Confidentiality issues (eg leading to lack of information sharing)

Mason et al (2015). Integrating funds for health and social care: an evidence review	NA	Constraining factors: - 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	Constraining factors: - 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. https://www.bmj.com/content/371/bmj.m4468

(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. https://www.bmj.com/content/372/bmj.n248.full

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INTRODUCTION

The NHS in England was reorganized under the Health and Care Act 2022[1]—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 Vanguards—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 underplayed[67]—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 objectives[72] 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 view[90] 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 agenda[93] 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 2021[95] 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]

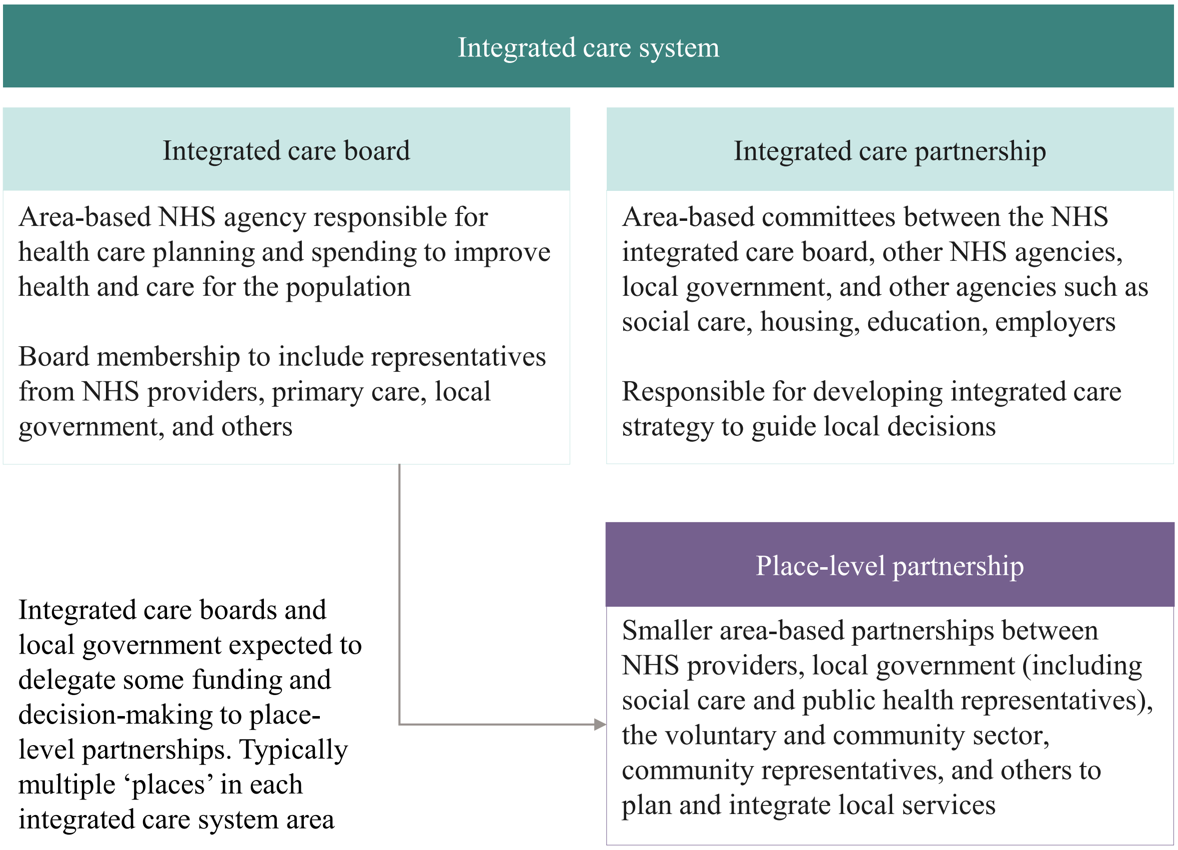
- *Places*: NHS organizations will work with local authorities and others to organize and deliver health and social care services in 'places'—smaller geographical areas within each ICS, defined based on 'what is meaningful to local people', but typically based on existing local authority boundaries. 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.

Figure 1. Health and social services partnerships under new NHS reforms in England



Integrated care system

Integrated care board

Area-based NHS agency responsible for health care planning and spending to improve health and care for the population

Board membership to include representatives from NHS providers, primary care, local government, and others

Integrated care partnership

Area-based committees between the NHS integrated care board, other NHS agencies, local government, and other agencies such as social care, housing, education, employers

Responsible for developing integrated care strategy to guide local decisions

Integrated care boards and local government expected to delegate some funding and decision-making to place-level partnerships. Typically multiple ‘places’ in each integrated care system area

Place-level partnership

Smaller area-based partnerships between NHS providers, local government (including social care and public health representatives), the voluntary and community sector, community representatives, and others to plan and integrate local services

ICSs as another NHS reorganization

As well as considering ICSs in the context of previous national policies on cross-sector collaboration, ICSs 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 ICSs 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 service[112]—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 1974[113] 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 care[17]—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 widespread[133] 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 average[131] 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 NCD 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

		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	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.		environmental services, schools, primary care trusts, housing associations, and other agencies depending on local context	inequalities between most deprived communities and the rest of the country
Local area agreements (LAAs)[169,170,171]	2004-2010	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	Local authority areas. Initially piloted in 9 areas then expanded to cover all local authorities	Whole local authority population	Local government, LAAs, other local partnerships (such as CDRPs), primary care trusts, voluntary and community sector	Improve outcomes for local people (including improved health and reduced health inequalities), improve central and local government relations, improve efficiency, strengthen local partnership working

		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

Integrated care pilots[181,182,183]	2009-2011	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	Mixed. 16 pilot areas	Primary care trusts and other NHS agencies, local authorities, voluntary and community sector, other partners depending on local context	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	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
Community budgets (including 'whole place' and 'neighbourhood' pilots)[184,185,186,187,188]	2011-2013	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	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

		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

	Geography			Size	
Integrated care system	**NHS region**	**% 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

	Organizational complexity					Policy context		
Integrated care system	**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) ranks[228] 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 pandemic[7]—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 areas[12] 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 steam' 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**
Policy stream	ICS aims to reduce health inequalities defined by national NHS bodies and government, including a mix of goals to: Reduce health care inequalities Reduce health outcome inequalities Improve underlying social and economic conditions shaping health inequalities	Vague national policy objectives create potential for confusion and conflict locally Broad policy objectives may translate into lack of concrete action or weak local plans NHS focus on health care inequalities may undermine wider objectives and partners Other ‘hard’ policy objectives on improving NHS performance may crowd out ICS action on health inequalities
Process stream	A mix of processes are expected to help ICSs meet these objectives, including: ICSs aligning action between local agencies and coordinating local services National guidance for ICSs on potential approaches to reducing health inequalities and requirements for local plans Joint planning processes within ICSs, including on how legal duties to reduce health inequalities will be met Data collection and reporting to inform interventions and monitor progress National oversight of ICSs, including targets, assessment, and central support Coordination between national bodies to align wider policy on health inequalities	ICSs may not be able to effectively align action between local NHS and other organizations to reduce health inequalities Complexity and lack of clarity in ICS governance may hold back progress and undermine role of non-NHS partners ICS plans risk being vague or skewed towards narrower policy objectives, and—even then—may not be sufficient to guide local action National NHS approach to targets and performance management may hold back ICS efforts to reduce health inequalities Broader policy and political context may constrain local action—for instance, through weak investment in services that shape health and health inequalities

Resources stream	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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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

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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)	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.

SECTION E

Student Signature	[redacted] 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.

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-19[14] 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]

ICSs 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 ICSs—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 complex[28] 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 ICSs 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 ICSs in England.[52,53,54,55] But in-depth understanding of how England's new ICSs 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 ICSs 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 ICSs[3]—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 groups[15]—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 it[31] 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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Student ID Number	1806276	**Title**	Mr
First Name(s)	Hugh		
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Thesis Title	A cure for everything and nothing? Local cross-sector collaboration and health inequalities in England		
Primary Supervisor	Nicholas Mays		

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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)	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.

SECTION E

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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 on[6]:

- 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).

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**			***Total***
	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
Total	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 approach[52] 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

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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

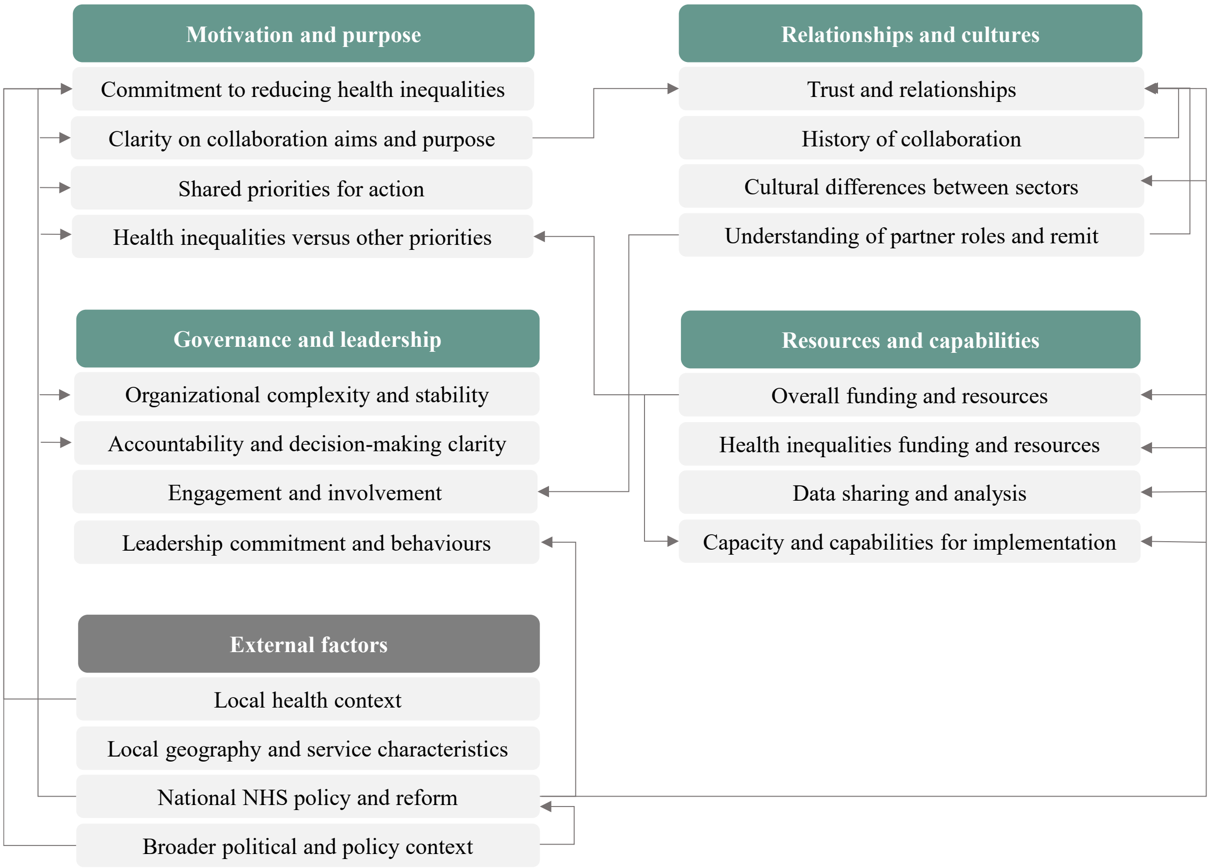

Table 3. Examples of the dominant role of national policy in shaping local collaboration experiences

Domain	Influence of national policy
Motivation and purpose	- 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
Governance and leadership	- 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
Relationships and cultures	- 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
Resources and capabilities	- 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

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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 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	- 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	- 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	- 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	- 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	- 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

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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 framework[13]), 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 managament.[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 average[105] 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 a 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 within[111] 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 designs[115] 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>

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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)

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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?