BMJ Open

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

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2023-081954
Article Type:	Original research
Date Submitted by the Author:	10-Nov-2023
Complete List of Authors:	Alderwick, Hugh; Health Foundation, London , Hutchings, Andrew; London School of Hygiene and Tropical Medicine Mays, Nicholas; London School of Hygiene and Tropical Medicine, Public Health and Policy
Keywords:	Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Public health < INFECTIOUS DISEASES, Organisation of health services < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Health Equity, Health Services, QUALITATIVE RESEARCH

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

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

Authors

Hugh Alderwick (corresponding author), Health Foundation,[i] London School of Hygiene and Tropical Medicine[ii] (Hugh.Alderwick@health.org.uk)

Andrew Hutchings, London School of Hygiene and Tropical Medicine[ii] (Andrew.Hutchings@lshtm.ac.uk)

Nicholas Mays, London School of Hygiene and Tropical Medicine[ii] (Nicholas.Mays@lshtm.ac.uk)

Word count: 5,376

Figures and tables: 0

[i] Health Foundation, 8 Salisbury Square, London, EC4Y 8AP, UK

[ii] London School of Hygiene and Tropical Medicine, 15-17 Tavistock Place, London, WC1H 9SH, UK

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

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 ICS 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.[34,35,18] Even then, policy objectives to tackle health inequalities are rarely matched with the resources needed to achieve them,[36,37] and are repeatedly drowned out by higher profile and short-term political priorities, like reducing NHS waiting times or balancing hospital budgets.[38,39]

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,[38,29,44,45] 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[34,35,51] 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. 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.

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. All participants gave informed consent. 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] 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. 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.[30,31,69,70] 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.[30,35]

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.[71,72] 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.[73] 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.[69,74] 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.[75] 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.[76,38] 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.[77,38,78] Our research suggests the same phenomenon was happening to ICSs almost as soon as they were introduced.

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.

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[77,51,73] 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 evolve.

Funding statement

HA's research that contributed to this article was funded by the Health Foundation. HA is Director of Policy at the Health Foundation. This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Author contributions

HA, NM, and AH identified the research question and led 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. All authors are researchers in health policy and public health in the UK and have experience carrying out qualitative and mixed methods research—including research into similar policy initiatives in England.

Competing interests

None declared.

Ethics approval

NHS HRA approval for the 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 before taking part in the study.

REFERENCES

1 UK Government. Health and Care Act 2022. https://bills.parliament.uk/bills/3022/publications
2 Alderwick H, Gardner T, Mays N. England's new health and care bill. BMJ. 2021;374:n1767.
3 Dunn P, Fraser C, Williamson S, Alderwick H. Integrated care systems: what do they look like? Health Foundation. 2022. https://www.health.org.uk/publications/long-reads/integrated-care-systems-what-do-they-look-like
4 Alderwick H, Hutchings A, Mays N. A cure for everything and nothing? Local partnerships for improving health in England. BMJ. 2022;378:e070910.
5 Anderson M, Pitchforth E, Edwards N, Alderwick H, McGuire A, Mossialos E. United Kingdom: health system review. Health Syst Transit. 2022;24:1-194.pmid:35579557.
6 Alley DE, Asomugha CN, Conway PH, Sanghavi DM. Accountable health communities—addressing social needs through Medicare and Medicaid. N Engl J Med. 2016;374:8-11.
7 Raleigh V. What is happening to life expectancy in England? King's Fund. 2022. https://www.kingsfund.org.uk/publications/whats-happening-life-expectancy-england
8 Office for National Statistics. Health state life expectancies by national deprivation deciles, England: 2018 to 2020. 2022. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/2018to2020
9 Cookson R, Propper C, Asaria M, Raine R. Socio-economic inequalities in health care in England. Fiscal Studies. 2016;37(3-4):341:403.
10 Stoye G, Zaranko B, Shipley M, McKee M, Brunner EJ. Educational Inequalities in Hospital Use Among Older Adults in England, 2004-2015. Milbank Quarterly. 2020;98(4):1134-1170.
11 Fisher R, Allen L, Malhotra AM, Alderwick H. Tackling the inverse care law: analysis of policies to improve general practice in deprived areas since 1990. London: Health Foundation. 2022. https://www.health.org.uk/publications/reports/tackling-the-inverse-care-law
12 NHS England. Integrated care systems: design framework. 2021. https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf
13 Hill Dickinson, The Strategy Unit. Briefing note for integrated care boards on legal duties in respect of reducing inequalities. 2022. https://www.midlandsdecisionsupport.nhs.uk/wp-content/uploads/2022/08/Briefing-note-for-Integrated-Care-Boards.pdf
14 NHS England. 2021/22 priorities and operational planning guidance: implementation guidance. 2021. https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf
15 NHS England. Core20PLUS5 (adults): an approach to reducing healthcare inequalities. https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/
16 NHS England. 2023/24 priorities and operational planning guidance. 2023. https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf
17 Barnes M, Bauld M, Benzeval M, Mackenzie M, Sullivan H, Judge K. Health action zones: partnerships for health equity. 2005. Abingdon, New York: Routledge.
18 National Evaluation of Health Action Zones. Health Action Zones: Learning to make a difference. Findings from a preliminary review of Health Action Zones and proposals for a national evaluation. 1999. https://www.pssru.ac.uk/pub/dp1546.pdf
19 Bate A, Foster D. Sure Start (England). House of Commons Library. 2017. https://researchbriefings.files.parliament.uk/documents/CBP-7257/CBP-7257.pdf
20 Belsky J, Melhuish E, Barnes J. Research and policy in developing an early years' initiative: the case of sure start. International Journal of Child Care and Education Policy. 2008:2;1-13. https://link.springer.com/article/10.1007/2288-6729-2-2-1
21 Department of the Environment, Transport and the Regions. Local Strategic Partnerships: government guidance summary. 2001.

https://webarchive.nationalarchives.gov.uk/ukgwa/20010815042253/http://www.local-regions.detr.gov.uk:80/lsp/guidance/index.htm
22 Geddes M, Davis J, Fuller C. Evaluating local strategic partnerships: theory and practice of change. Local Government Studies. 2007;33(1):97-116.
23 Department of Health. Reducing health inequalities: an action report. London: Department of Health; 1999.
24 HM Treasury, Department of Health. Tackling health inequalities: summary of the 2002 cross-cutting review. London: Department of Health; 2002.
25 Department of Health. Tackling health inequalities: a programme for action. London: Department of Health; 2003.
26 NHS England. The NHS long term plan. 2019. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
27 NHS England. NHS long term plan implementation framework. 2019. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/06/long-term-plan-implementation-framework-v1.pdf
28 Graham H, Kelly M. Health inequalities: Concepts, frameworks and policy. Health Development Agency. 2004. https://elevateni.org/app/uploads/2022/01/Health_Inequalities_Concepts_Frameworks_and_Policy.pdf
29 Exworthy M, Powell M. Big windows and little windows: implementation in the congested state. Public Administration. 2004;82(2):263-281.
30 Olivera JN, Ford J, Sowden S, Bambra C. Conceptualisation of health inequalities by local healthcare systems: A document analysis. Health Soc Care Community. 2022;30(6):e3977-e3984.
31 Ford J, Sowden S, Olivera J, Bambra C, Gimson A, Aldridge R, Brayne C. Transforming health systems to reduce health inequalities. Future Healthc J. 2021 Jul;8(2):e204-e209.
32 McMahon NE. What shapes local health system actors' thinking and action on social inequalities in health? A meta-ethnography. Soc Theory Health. 2023;21(2):119-139.
33 Alderwick H, Gottlieb LM. Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems. Milbank Q. 2019;97(2):407-419.
34 Olivera JN, Ford J, Sowden S, Bambra C. Conceptualisation of health inequalities by local healthcare systems: A document analysis. Health Soc Care Community. 2022;30(6):e3977-e3984.
35 Briggs, ADM, Göpfert A, Thorlby R, Allwood D, Alderwick, H. Integrated health and care systems in England: can they help prevent disease? Integrated Healthcare Journal, 2;e000013. doi:10.1136/ihj-2019-000013 ISSN 2399-5351.
36 Exworthy M, Blane D, Marmot M. Tackling health inequalities in the United Kingdom: the progress and pitfalls of policy. Health Serv Res. 2003 Dec;38(6 Pt 2):1905-21.
37 Finch D, Vriend M. Public health grant: what it is and why greater investment is needed. 2023. https://www.health.org.uk/news-and-comment/charts-and-infographics/public-health-grant-what-it-is-and-why-greater-investment-is-needed
38 Exworthy M, Berney L, Powell M. 'How great expectations in Westminster may be dashed locally': the local implementation of national policy on health inequalities. Policy & Politics. 2002;30(1):79-96.
39 Lewis RQ, Checkland K, Durand MA, Ling T, Mays N, Roland M, Smith JA. Integrated Care in England: what can we Learn from a Decade of National Pilot Programmes? Int J Integr Care. 2021;21(4):5.
40 Rochefort DA, Cobb RW (eds). The politics of problem definition: shaping the policy agenda. University Press of Kansas; 1994.
41 Head BW. Wicked problems in public policy: understanding and responding to complex challenged. Palgrave Macmillan;2022. https://doi.org/10.1007/978-3-030-94580-0
42 Koon AD, Hawkins B, Mayhew SH. Framing and the health policy process: a scoping review. Health Policy Plan. 2016 Jul;31(6):801-16.
43 Fischer, Frank. Reframing Public Policy: Discursive Politics and Deliberative Practices. Oxford: Oxford University Press; 2003.

44 Blackman T, Harrington B, Elliott E, Greene A, Hunter DJ, Marks L, McKee L, Williams G. Framing health inequalities for local intervention: comparative case studies. Sociol Health Illn. 2012;34(1):49-63.
45 Blackman, T, Elliott, E, Greene, A, Harrington, B, Hunter, D, Marks, L, McKee, L, Williams, G & Smith, K. 'Tackling health inequalities in post-devolution Britain: Do targets matter?', Public Administration. 2009;87(4):762-778.
46 Exworthy M, Morcillo V. Primary care doctors' understandings of and strategies to tackle health inequalities: a qualitative study. Prim Health Care Res Dev. 2019 May 21;20:e20.
47 Babbel B, Mackenzie M, Hastings A, Watt G. How do general practitioners understand health inequalities and do their professional roles offer scope for mitigation? Constructions derived from the deep end of primary care. Critical Public Health. 2017;29(2):1–13.
48 Pauly BM, Shahram SZ, Dang PTH, Marcellus L, MacDonald M. Health Equity Talk: Understandings of Health Equity among Health Leaders. AIMS Public Health. 2017 Nov 15;4(5):490-512.
49 Warwick-Giles L, Coleman A, Checkland K. Making Sense of Inequalities: How Do Clinical Commissioning Groups in England Understand their New Role? Social Policy and Administration. 2016. 51(7):1231-1247.
50 Mead R, Thurston M, Bloyce D. From public issues to personal troubles: Individualising social inequalities in health within local public health partnerships. Critical Public Health. 2020 doi: 10.1080/09581596.2020.1763916.
51 Ham H, Alderwick H, Dunn P, McKenna H. Delivering sustainability and transformation plans: from ambitious proposals to credible plans. London: King's Fund; 2017.
52 Moran V, Allen P, Sanderson M, McDermott I, Osipovic D. Challenges of maintaining accountability in networks of health and care organisations: A study of developing Sustainability and Transformation Partnerships in the English National Health Service. Soc Sci Med. 2021;268:113512.
53 Sanderson M, Allen P, Osipovic D, et alDeveloping architecture of system management in the English NHS: evidence from a qualitative study of three Integrated Care SystemsBMJ Open 2023;13:e065993.
54 Sanderson M, Allen P, Osipovic D, et al. The Developing Architecture of System Management: Integrated Care Systems and Sustainability and Transformation Partnerships. 2022. https://prucomm.ac.uk/assets/uploads/The%20Developing%20Architecture%20of%20System%20Management%20Integrated%20Care.pdf
55 Alderwick H, Dunn P, McKenna H, Walsh N, Ham C. Sustainability and transformation plans in the NHS: how are they being developed in practice? London: King's Fund. 2016.
56 Alderwick, H., Hutchings, A., Briggs, A. 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.
57 NHS England. Establishing integrated care systems by April 2021. https://www.england.nhs.uk/wp-content/uploads/2019/03/07_MiCIE_PB_28_03_2019-Establishing-ICSs-by-April-2021.pdf
58 Patton MQ. Qualitative research and evaluation methods. 3rd ed. Thousand Oaks (CA): Sage Publications; 2002.
59 Charles A. Integrated care systems explained. King's Fund. 2022. https://www.kingsfund.org.uk/publications/integrated-care-systems-explained
60 Bradley EH, Curry LA, Devers KJ. Qualitative data analysis for health services research: developing taxonomy, themes, and theory. Health Serv Res. 2007;42(4):1758–72.
61 Nilsen P, Ståhl C, Roback K, Cairney P. Never the twain shall meet? A comparison of implementation science and policy implementation research. Implement Sci. 2013;10;8:63.
62 Schofield J. Time for a revival? Public policy implementation: a review of the literature and an agenda for future research. International Journal of Management Reviews. 2001;3:245-263.
63 Sausman C, Oborn E, Barrett M. Policy translation through localisation: implementing national policy in the UK. Policy & Politics. 2016;44(4):563-589.

64 Alderwick H, Gottlieb L. Meanings and misunderstandings: a social determinants of health lexicon for health care systems. Milbank Q. 2019; 97(2): 407–419.
65 Holdroyd I, Vodden A, Srinivasan A, Kuhn I, Bambra C, Ford JA. Systematic review of the effectiveness of the health inequalities strategy in England between 1999 and 2010. BMJ Open2022;12:e063137.
66 Vodden A, Holdroyd I, Bentley C, et al. Evaluation of the national governmental efforts between 1997 and 2010 in reducing health inequalities in England. Public Health2023;218:128-35.
67 Thimm-Kaiser M, Benzekri A, Guilamo-Ramos V. Conceptualizing the Mechanisms of Social Determinants of Health: A Heuristic Framework to Inform Future Directions for Mitigation. The Milbank Quarterly. 2023; 101(2):486-526. doi: https://doi.org/10.1111/1468-0009.12642
68 Solar O, Irwin A. A Conceptual Framework for Action on the Social Determinants of Health: Social Determinants of Health Discussion Paper 2. World Health Organization; 2010. https://iris.who.int/handle/10665/44489
69 Buzelli L, Dunn P, Scott S, Gottlieb L, Alderwick H. A framework for NHS action on social determinants of health. Health Foundation. 2022. https://www.health.org.uk/publications/long-reads/a-framework-for-nhs-action-on-social-determinants-of-health
70 Fisher R, Allen L, Malhotra AM, Alderwick H. Tackling the inverse care law: Analysis of policies to improve general practice in deprived areas since 1990. London: Health Foundation. 2022.
71 Gadsby EW, Peckham S, Coleman A, et al. Commissioning for health improvement following the 2012 health and social care reforms in England: what has changed?. BMC Public Health. 2017;17:211.
72 UK Government. Health and Social Care Act 2012. https://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
73 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.
74 Lantz PM, Goldberg DS, Gollust SE. The Perils of Medicalization for Population Health and Health Equity. Milbank Q. 2023;101(S1):61-82.
75 Nuffield Trust. NHS performance tracker. https://www.nuffieldtrust.org.uk/qualitywatch/nhs-performance-summary
76 Lewis RQ, Checkland K, Durand MA, et al. Integrated Care in England – what can we Learn from a Decade of National Pilot Programmes? International Journal of Integrated Care. 2021;21:5. doi: 10.5334/ijic.5631
77 Alderwick H, Dunn P, McKenna H, et al. Sustainability and transformation plans in the NHS: how are they being developed in practice? London: King's Fund. 2016.
78 Mannion R, Braithwaite J. Unintended consequences of performance measurement in healthcare: 20 salutary lessons from the English National Health Service. Intern Med J. 2012;42(5):569-74.

Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

	Page/line no(s).
Title and abstract	
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	Page 2, lines 1-3
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	Page 2, lines 4-26
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	Pages 2-3, lines 39-87
Purpose or research question - Purpose of the study and specific objectives or questions	Page 3, lines 83-87
Methods	
Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	Pages 3-4, lines 88-142
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	Page 10, lines 446-453
Context - Setting/site and salient contextual factors; rationale**	Pages 3-4, lines 93-129
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	Pages 3-4, lines 93-122
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	Page 10, lines 456-460
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	Page 4, lines 130-142

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Page 4, lines 130-142
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Page 4, lines 120-122
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	Page 4, lines 130-142
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	Page 4, lines 130-142
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	Page 4, lines 135-142

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Pages 4-8, lines 145-338
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Pages 4-8, lines 145-338 (quotes and excerpts throughout)

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	Pages 8-9, lines 339-410
Limitations - Trustworthiness and limitations of findings	Pages 9-10, lines 411-430

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	Page 10, lines 456-457
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	Page 10, lines 444-447

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
DOI: 10.1097/ACM.0000000000000388

BMJ Open

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

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2023-081954.R1
Article Type:	Original research
Date Submitted by the Author:	09-Feb-2024
Complete List of Authors:	Alderwick, Hugh; Health Foundation, London , Hutchings, Andrew; London School of Hygiene and Tropical Medicine Mays, Nicholas; London School of Hygiene and Tropical Medicine, Public Health and Policy
Primary Subject Heading:	Health policy
Secondary Subject Heading:	Public health, Qualitative research
Keywords:	Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Public health < INFECTIOUS DISEASES, Organisation of health services < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Health Equity, Health Services, QUALITATIVE RESEARCH

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

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

Authors

Hugh Alderwick (corresponding author), Health Foundation,[i] London School of Hygiene and Tropical Medicine[ii] (Hugh.Alderwick@health.org.uk)

Andrew Hutchings, London School of Hygiene and Tropical Medicine[ii] (Andrew.Hutchings@lshtm.ac.uk)

Nicholas Mays, London School of Hygiene and Tropical Medicine[ii] (Nicholas.Mays@lshtm.ac.uk)

Word count: 5,560

Figures and tables: 0

[i] Health Foundation, 8 Salisbury Square, London, EC4Y 8AP, UK

[ii] London School of Hygiene and Tropical Medicine, 15-17 Tavistock Place, London, WC1H 9SH, UK

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

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.[12,16]

How policy problems are framed and understood shapes action to address them.[39,40,41,42] Competing problem definitions interact and evolve.[39,40] 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,[37,29,43,44] as well as individual and organizational perspectives on health inequalities in the UK and elsewhere.[32,45,46,47,48,49] More recently, researchers have analysed how health inequalities are conceptualized in local health planning documents[30,34,50] and tracked the early development of ICSs in England.[51,52,53,54] 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.[55,3]

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'[56] 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.[57] 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.[3,12,58] 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 (supplementary material file 1). 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.[57] 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.[59] 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.[48] 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.[60,61,62] Varied understandings of concepts linked to health inequalities and their causes are widespread.[33,32]

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.[63,64] 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.[31,65,66,67] 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.[68] 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.[30,31,69,70] 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.[55] NHS reforms in 2012 transferred public health functions out of the NHS and into local government.[71,72] 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.[73] 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.[69,74] 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.[75] 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.[76,37] 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.[37,54,77] 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[54,50,73] 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.

Funding statement
HA's research that contributed to this article was funded by the Health Foundation. HA is Director of Policy at the Health Foundation. This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Author contributions
HA, NM, and AH identified the research question and led 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. All authors are researchers in health policy and public health in the UK and have experience carrying out qualitative and mixed methods research—including research into similar policy initiatives in England.

Competing interests
None declared.

Data availability statement
No data are available.

Ethics approval
NHS HRA approval for the 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 before taking part in the study.

REFERENCES

1 UK Government. Health and Care Act 2022. https://bills.parliament.uk/bills/3022/publications
2 Alderwick H, Gardner T, Mays N. England's new health and care bill. BMJ. 2021;374:n1767.
3 Dunn P, Fraser C, Williamson S, Alderwick H. Integrated care systems: what do they look like? Health Foundation. 2022. https://www.health.org.uk/publications/long-reads/integrated-care-systems-what-do-they-look-like
4 Alderwick H, Hutchings A, Mays N. A cure for everything and nothing? Local partnerships for improving health in England. BMJ. 2022;378:e070910.
5 Anderson M, Pitchforth E, Edwards N, Alderwick H, McGuire A, Mossialos E. United Kingdom: health system review. Health Syst Transit. 2022;24:1-194.pmid:35579557.
6 Alley DE, Asomugha CN, Conway PH, Sanghavi DM. Accountable health communities—addressing social needs through Medicare and Medicaid. N Engl J Med. 2016;374:8-11.
7 Raleigh V. What is happening to life expectancy in England? King's Fund. 2022. https://www.kingsfund.org.uk/publications/whats-happening-life-expectancy-england
8 Office for National Statistics. Health state life expectancies by national deprivation deciles, England: 2018 to 2020. 2022. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/2018to2020
9 Cookson R, Propper C, Asaria M, Raine R. Socio-economic inequalities in health care in England. Fiscal Studies. 2016;37(3-4):341:403.
10 Stoye G, Zaranko B, Shipley M, McKee M, Brunner EJ. Educational Inequalities in Hospital Use Among Older Adults in England, 2004-2015. Milbank Quarterly. 2020;98(4):1134-1170.
11 Fisher R, Allen L, Malhotra AM, Alderwick H. Tackling the inverse care law: analysis of policies to improve general practice in deprived areas since 1990. London: Health Foundation. 2022. https://www.health.org.uk/publications/reports/tackling-the-inverse-care-law
12 NHS England. Integrated care systems: design framework. 2021. https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf
13 Hill Dickinson, The Strategy Unit. Briefing note for integrated care boards on legal duties in respect of reducing inequalities. 2022. https://www.midlandsdecisionsupport.nhs.uk/wp-content/uploads/2022/08/Briefing-note-for-Integrated-Care-Boards.pdf
14 NHS England. 2021/22 priorities and operational planning guidance: implementation guidance. 2021. https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf
15 NHS England. Core20PLUS5 (adults): an approach to reducing healthcare inequalities. https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/
16 NHS England. 2023/24 priorities and operational planning guidance. 2023. https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf
17 Barnes M, Bauld M, Benzeval M, Mackenzie M, Sullivan H, Judge K. Health action zones: partnerships for health equity. 2005. Abingdon, New York: Routledge.
18 National Evaluation of Health Action Zones. Health Action Zones: Learning to make a difference. Findings from a preliminary review of Health Action Zones and proposals for a national evaluation. 1999. https://www.pssru.ac.uk/pub/dp1546.pdf
19 Bate A, Foster D. Sure Start (England). House of Commons Library. 2017. https://researchbriefings.files.parliament.uk/documents/CBP-7257/CBP-7257.pdf
20 Belsky J, Melhuish E, Barnes J. Research and policy in developing an early years' initiative: the case of sure start. International Journal of Child Care and Education Policy. 2008:2;1-13. https://link.springer.com/article/10.1007/2288-6729-2-2-1
21 Department of the Environment, Transport and the Regions. Local Strategic Partnerships: government guidance summary. 2001.

https://webarchive.nationalarchives.gov.uk/ukgwa/20010815042253/http://www.local-regions.detr.gov.uk:80/lsp/guidance/index.htm
22 Geddes M, Davis J, Fuller C. Evaluating local strategic partnerships: theory and practice of change. Local Government Studies. 2007;33(1):97-116.
23 Department of Health. Reducing health inequalities: an action report. London: Department of Health; 1999.
24 HM Treasury, Department of Health. Tackling health inequalities: summary of the 2002 cross-cutting review. London: Department of Health; 2002.
25 Department of Health. Tackling health inequalities: a programme for action. London: Department of Health; 2003.
26 NHS England. The NHS long term plan. 2019. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
27 NHS England. NHS long term plan implementation framework. 2019. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/06/long-term-plan-implementation-framework-v1.pdf
28 Graham H, Kelly M. Health inequalities: Concepts, frameworks and policy. Health Development Agency. 2004. https://elevateni.org/app/uploads/2022/01/Health_Inequalities_Concepts_Frameworks_and_Policy.pdf
29 Exworthy M, Powell M. Big windows and little windows: implementation in the congested state. Public Administration. 2004;82(2):263-281.
30 Olivera JN, Ford J, Sowden S, Bambra C. Conceptualisation of health inequalities by local healthcare systems: A document analysis. Health Soc Care Community. 2022;30(6):e3977-e3984.
31 Ford J, Sowden S, Olivera J, Bambra C, Gimson A, Aldridge R, Brayne C. Transforming health systems to reduce health inequalities. Future Healthc J. 2021 Jul;8(2):e204-e209.
32 McMahon NE. What shapes local health system actors' thinking and action on social inequalities in health? A meta-ethnography. Soc Theory Health. 2023;21(2):119-139.
33 Alderwick H, Gottlieb LM. Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems. Milbank Q. 2019;97(2):407-419.
34 Briggs, ADM, Göpfert A, Thorlby R, Allwood D, Alderwick, H. Integrated health and care systems in England: can they help prevent disease? Integrated Healthcare Journal, 2;e000013. doi:10.1136/ihj-2019-000013 ISSN 2399-5351.
35 Exworthy M, Blane D, Marmot M. Tackling health inequalities in the United Kingdom: the progress and pitfalls of policy. Health Serv Res. 2003 Dec;38(6 Pt 2):1905-21.
36 Finch D, Vriend M. Public health grant: what it is and why greater investment is needed. 2023. https://www.health.org.uk/news-and-comment/charts-and-infographics/public-health-grant-what-it-is-and-why-greater-investment-is-needed
37 Exworthy M, Berney L, Powell M. 'How great expectations in Westminster may be dashed locally': the local implementation of national policy on health inequalities. Policy & Politics. 2002;30(1):79-96.
38 Lewis RQ, Checkland K, Durand MA, Ling T, Mays N, Roland M, Smith JA. Integrated Care in England: what can we Learn from a Decade of National Pilot Programmes? Int J Integr Care. 2021;21(4):5.
39 Rochefort DA, Cobb RW (eds). The politics of problem definition: shaping the policy agenda. University Press of Kansas; 1994.
40 Head BW. Wicked problems in public policy: understanding and responding to complex challenged. Palgrave Macmillan;2022. https://doi.org/10.1007/978-3-030-94580-0
41 Koon AD, Hawkins B, Mayhew SH. Framing and the health policy process: a scoping review. Health Policy Plan. 2016 Jul;31(6):801-16.
42 Fischer, Frank. Reframing Public Policy: Discursive Politics and Deliberative Practices. Oxford: Oxford University Press; 2003.

43 Blackman T, Harrington B, Elliott E, Greene A, Hunter DJ, Marks L, McKee L, Williams G. Framing health inequalities for local intervention: comparative case studies. Sociol Health Illn. 2012;34(1):49-63.
44 Blackman, T, Elliott, E, Greene, A, Harrington, B, Hunter, D, Marks, L, McKee, L, Williams, G & Smith, K. 'Tackling health inequalities in post-devolution Britain: Do targets matter?', Public Administration. 2009;87(4):762-778.
45 Exworthy M, Morcillo V. Primary care doctors' understandings of and strategies to tackle health inequalities: a qualitative study. Prim Health Care Res Dev. 2019 May 21;20:e20.
46 Babbel B, Mackenzie M, Hastings A, Watt G. How do general practitioners understand health inequalities and do their professional roles offer scope for mitigation? Constructions derived from the deep end of primary care. Critical Public Health. 2017;29(2):1–13.
47 Pauly BM, Shahram SZ, Dang PTH, Marcellus L, MacDonald M. Health Equity Talk: Understandings of Health Equity among Health Leaders. AIMS Public Health. 2017 Nov 15;4(5):490-512.
48 Warwick-Giles L, Coleman A, Checkland K. Making Sense of Inequalities: How Do Clinical Commissioning Groups in England Understand their New Role? Social Policy and Administration. 2016. 51(7):1231-1247.
49 Mead R, Thurston M, Bloyce D. From public issues to personal troubles: Individualising social inequalities in health within local public health partnerships. Critical Public Health. 2020 doi: 10.1080/09581596.2020.1763916.
50 Ham H, Alderwick H, Dunn P, McKenna H. Delivering sustainability and transformation plans: from ambitious proposals to credible plans. London: King's Fund; 2017.
51 Moran V, Allen P, Sanderson M, McDermott I, Osipovic D. Challenges of maintaining accountability in networks of health and care organisations: A study of developing Sustainability and Transformation Partnerships in the English National Health Service. Soc Sci Med. 2021;268:113512.
52 Sanderson M, Allen P, Osipovic D, et alDeveloping architecture of system management in the English NHS: evidence from a qualitative study of three Integrated Care SystemsBMJ Open 2023;13:e065993.
53 Sanderson M, Allen P, Osipovic D, et al. The Developing Architecture of System Management: Integrated Care Systems and Sustainability and Transformation Partnerships. 2022. https://prucomm.ac.uk/assets/uploads/The%20Developing%20Architecture%20of%20System%20Management%20Integrated%20Care.pdf
54 Alderwick H, Dunn P, McKenna H, Walsh N, Ham C. Sustainability and transformation plans in the NHS: how are they being developed in practice? London: King's Fund. 2016.
55 Alderwick, H., Hutchings, A., Briggs, A. 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.
56 NHS England. Establishing integrated care systems by April 2021. https://www.england.nhs.uk/wp-content/uploads/2019/03/07_MiCIE_PB_28_03_2019-Establishing-ICSs-by-April-2021.pdf
57 Patton MQ. Qualitative research and evaluation methods. 3rd ed. Thousand Oaks (CA): Sage Publications; 2002.
58 Charles A. Integrated care systems explained. King's Fund. 2022. https://www.kingsfund.org.uk/publications/integrated-care-systems-explained
59 Bradley EH, Curry LA, Devers KJ. Qualitative data analysis for health services research: developing taxonomy, themes, and theory. Health Serv Res. 2007;42(4):1758–72.
60 Nilsen P, Ståhl C, Roback K, Cairney P. Never the twain shall meet? A comparison of implementation science and policy implementation research. Implement Sci. 2013;10;8:63.
61 Schofield J. Time for a revival? Public policy implementation: a review of the literature and an agenda for future research. International Journal of Management Reviews. 2001;3:245-263.
62 Sausman C, Oborn E, Barrett M. Policy translation through localisation: implementing national policy in the UK. Policy & Politics. 2016;44(4):563-589.

63 Holdroyd I, Vodden A, Srinivasan A, Kuhn I, Bambra C, Ford JA. Systematic review of the effectiveness of the health inequalities strategy in England between 1999 and 2010. BMJ Open2022;12:e063137.
64 Vodden A, Holdroyd I, Bentley C, et al. Evaluation of the national governmental efforts between 1997 and 2010 in reducing health inequalities in England. Public Health2023;218:128-35.
65 Thimm-Kaiser M, Benzekri A, Guilamo-Ramos V. Conceptualizing the Mechanisms of Social Determinants of Health: A Heuristic Framework to Inform Future Directions for Mitigation. The Milbank Quarterly. 2023; 101(2):486-526. doi: https://doi.org/10.1111/1468-0009.12642
66 Solar O, Irwin A. A Conceptual Framework for Action on the Social Determinants of Health: Social Determinants of Health Discussion Paper 2. World Health Organization; 2010. https://iris.who.int/handle/10665/44489
67 Porroche-Escudero A, Popay J, Ward F, et al. From fringe to centre-stage: experiences of mainstreaming health equity in a health research collaboration. Health Res Policy Sys. 2021;19:28.
68 Capper B, Ford J, Kelly M. Has the pandemic resulted in a renewed and improved focus on heath inequalities in England? A discourse analysis of the framing of health inequalities in national policy. Public Health Pract (Oxf). 2023;6;5:100382.
69 Buzelli L, Dunn P, Scott S, Gottlieb L, Alderwick H. A framework for NHS action on social determinants of health. Health Foundation. 2022. https://www.health.org.uk/publications/long-reads/a-framework-for-nhs-action-on-social-determinants-of-health
70 Fisher R, Allen L, Malhotra AM, Alderwick H. Tackling the inverse care law: Analysis of policies to improve general practice in deprived areas since 1990. London: Health Foundation. 2022.
71 Gadsby EW, Peckham S, Coleman A, et al. Commissioning for health improvement following the 2012 health and social care reforms in England: what has changed?. BMC Public Health. 2017;17:211.
72 UK Government. Health and Social Care Act 2012. https://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
73 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.
74 Lantz PM, Goldberg DS, Gollust SE. The Perils of Medicalization for Population Health and Health Equity. Milbank Q. 2023;101(S1):61-82.
75 Nuffield Trust. NHS performance tracker. https://www.nuffieldtrust.org.uk/qualitywatch/nhs-performance-summary
76 Lewis RQ, Checkland K, Durand MA, et al. Integrated Care in England – what can we Learn from a Decade of National Pilot Programmes? International Journal of Integrated Care. 2021;21:5. doi: 10.5334/ijic.5631
77 Mannion R, Braithwaite J. Unintended consequences of performance measurement in healthcare: 20 salutary lessons from the English National Health Service. Intern Med J. 2012;42(5):569-74.

INTERVIEW GUIDE

[Note: this analysis on interpretations of policy objectives on health inequalities is part of a larger study on cross-sector collaboration to reduce health inequalities in England. We include the full interview guide for the study below, but the analysis only reports data from a sub-set of questions.]

(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?

Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

	Page/line no(s).
Title and abstract	
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	Page 2, lines 1-3
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	Page 2, lines 4-26
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	Pages 2-3, lines 39-87
Purpose or research question - Purpose of the study and specific objectives or questions	Page 3, lines 83-87
Methods	
Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	Pages 3-4, lines 88-142
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	Page 10, lines 446-453
Context - Setting/site and salient contextual factors; rationale**	Pages 3-4, lines 93-129
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	Pages 3-4, lines 93-122
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	Page 10, lines 456-460
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	Page 4, lines 130-142

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Page 4, lines 130-142
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Page 4, lines 120-122
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	Page 4, lines 130-142
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	Page 4, lines 130-142
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	Page 4, lines 135-142

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Pages 4-8, lines 145-338
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Pages 4-8, lines 145-338 (quotes and excerpts throughout)

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	Pages 8-9, lines 339-410
Limitations - Trustworthiness and limitations of findings	Pages 9-10, lines 411-430

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	Page 10, lines 456-457
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	Page 10, lines 444-447

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
DOI: 10.1097/ACM.0000000000000388