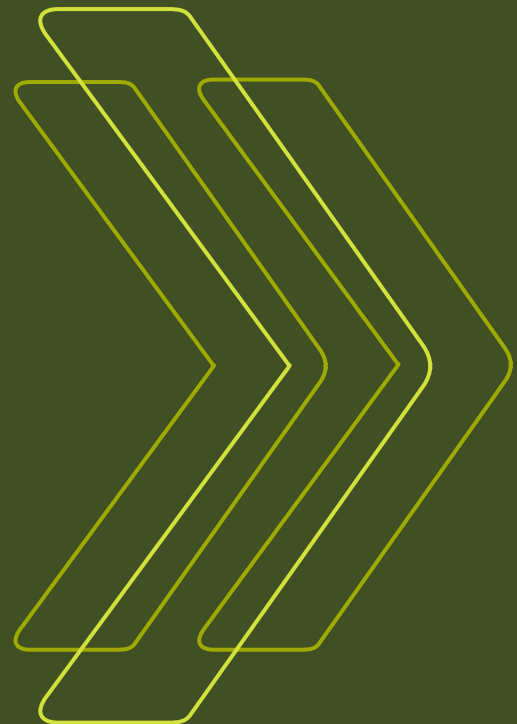


# Driving better health outcomes through integrated care systems

## The role of district councils

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July 2023





# About this project

The work for this project was sponsored by the District Councils' Network. This output was independently developed, researched and written by The King's Fund. All views are the authors' own.



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# Key messages

- District council services – across housing, planning, economic development, welfare, leisure and environmental health – influence some of the most significant determinants of health. Around 80 per cent of the variation observed in population health outcomes is attributable to wider factors such as these, rather than to the quality of health care services. This makes district councils indispensable strategic partners in integrated care systems (ICSs), whose involvement is essential if systems are to deliver population health improvements.
- ICSs have created the opportunity to bring all partners across the NHS, the voluntary sector and local government together to take co-ordinated action on these wider determinants of health. For this opportunity to be realised in full, district councils, with their ability to act as convenors in local places, need to be active partners in ICSs.
- District councils can help bring about a shift to prevention in the health system, pushing resources higher upstream. To deliver on the four core purposes of ICSs, NHS leaders need to work with district councils to develop place-based projects that address the wider determinants of health. In systems without district councils, unitary authorities can play a similar role.
- The case studies in this report demonstrate that district councils are already carrying out significant preventive work. In some ICSs, this is being effectively harnessed. This work now needs to be universally integrated across all ICSs to maximise its benefit.
- ICS leaders interviewed in our case study sites argued that district councils are indispensable partners not only due to their power to influence the wider determinants of health, but also because of their ability to act quickly and flexibly, and their detailed knowledge of local communities.



- To make the most of this contribution, leaders in integrated care boards and district councils should do the following.
  - Embed district council leadership throughout the ICS by identifying leadership roles that make the most of district councils' strengths.
  - Invest in relationships and take time to build better mutual understanding between the NHS and district councils.
  - Progressively deepen these relationships over time by developing processes to enable data-sharing and by exploring opportunities for joint roles, co-location of staff, resource-pooling and joint commissioning.
  - Ensure prevention is at the heart of the system's mission and purpose, including by developing place-based projects to tackle the wider determinants of health.



# 1 Introduction

Improving the health and wellbeing of the population has been a key goal of health policy for many years, including in *The NHS long term plan* (NHS England 2019) and more recently in the Hewitt Review of integrated care systems (ICSs) (Hewitt 2023). ICSs are expected to play a key role in delivering this ambition as part of the core purposes set for them in legislation and national guidance, which include improving population health and reducing health inequalities (NHS England 2020).

Population health is a product of the conditions in which people live their lives and the opportunities available to them – more so than access to health care, which only accounts for around 20 per cent of population health outcomes (Buck *et al* 2018). The work of local government influences many of these ‘wider determinants of health’. ICSs will only be able to meet their key objectives if local authorities are fully involved as system partners.

For around 40 per cent of the population of England, local government is split into a system of both county and district councils (as opposed to having unitary authorities), often referred to as two tiers of local government. Each has control over different service areas (see Table 1). District councils cover smaller geographies, are closer to communities and control many of the services that determine their residents’ everyday environment.

**Table 1 The different tiers of local government**

District councils	County councils
Average population size: 117,443	Average population size: 917,175
Average total area size: 402km <sup>2</sup>	Average total area size: 2,866km <sup>2</sup>
Service areas include: planning, housing, environmental health, leisure and green spaces, benefits and customer services, economic development and community safety	Service areas include: adult and children’s social care, education, strategic and emergency planning, highways and transport, and libraries

Source: Population data taken from the 2021 Census (Office for National Statistics 2022)



County and unitary councils are statutory partners in ICSs – the Health and Care Act 2022 requires that they are represented in the integrated care partnerships (ICPs) and integrated care boards (ICBs) that oversee the work of each ICS. In contrast, there are no such legal requirements to involve district councils. This report contends, however, that district councils need to be fully embedded as core partners within ICSs if the goals of improving population health and tackling inequalities are to be met.

Previous work by The King's Fund has demonstrated that district councils can make a significant contribution to the health and wellbeing of the population through the various functions they are responsible for ([Buck and Dunn 2015](#)). This report updates that earlier work, placing it within the context of the new health and care partnership structures introduced in England in 2022.

While a significant focus for county councils is providing services to support people with social care needs, district councils are focused on preventive action that improves the wellbeing of all people. Much of their work has an impact on the wider determinants of health and there is significant potential – often untapped – to use this to drive health improvement. The role that district councils play in public health has been further exemplified by the vital services they provided during the Covid-19 pandemic and are providing as a result of the current cost-of-living pressures.

### Defining prevention

Prevention can be defined in different ways, including:

- primary prevention – preventing health problems from developing in the first place
- secondary prevention – identifying the early stages of ill health, for example through screening, and intervening before full symptoms develop
- tertiary prevention – managing an established health condition to prevent an exacerbation or a deterioration of the condition.

This report focuses primarily on primary prevention, in particular through action on the wider determinants of health, as this is where district councils have a particularly significant contribution to make. Some of the examples included also relate to secondary prevention, for example identifying and supporting the non-medical needs of people with existing health conditions.





In this report, we examine how to make the most of the potential contribution of district councils to health. In the next section we outline the reasons why district councils have a valuable role to play within ICSs (Section 2). We then offer five principles that describe how ICSs need to function to fully harness the power of district councils (Section 3) and nine enablers that can help local partners move towards that vision (Section 4). Following this, we emphasise the importance of making a strategic shift towards a more preventive system (Section 5). We conclude by providing practical recommendations for ICS leaders and district council leaders (Section 6).

While our focus in this report is on district councils, many of the principles and enablers we identify also have wider applicability to areas where there is unitary (single-tier) local government. Also note that the opportunities we describe relate to the functions that district councils are responsible for, regardless of which organisation carries out these functions in any given part of England.

The District Councils' Network commissioned this independent report, which is based on qualitative research in four case study sites (Lincolnshire; Leicestershire, Leicester and Rutland; Norfolk and Waveney; and Suffolk and north-east Essex), selected on the basis of their reported success to date in involving district councils within the ICS. In each site we conducted in-depth interviews with relevant ICB staff and people working in local government. Our findings from these sites were then tested in a workshop with a much larger and more representative range of district councils and systems. The report also includes other illustrative examples that the District Councils' Network shared with us. For more information on our research methods, see the Appendix.



## 2 The value of district councils as partners within ICSs

District councils influence some of the most significant determinants of health, including housing conditions, job opportunities and the built and natural environment (Buck and Dunn 2015; Buck and Gregory 2013). This makes them indispensable partners within ICSs.

Beyond what they bring as service providers, in our case study sites, ICS leaders and district council officers also highlighted strategic strengths that district councils can bring to partnership working, including their agility and their leadership role within local communities. In this section we summarise three main strengths of district councils, identified through our research – their:

- ability to influence the wider determinants of health
- ability to be fast and agile
- closeness to communities.

ICS leaders in our case study sites argued that the scale at which NHS organisations and county councils operate makes it difficult for them to match district councils' agility and closeness to communities, and that the services that district councils provide give them leverage over some of the wider determinants of health that other ICS partners do not have.

### Ability to influence the wider determinants of health

District councils are major players in relation to the wider determinants of health. The box on pages 10–12 describes how district councils contribute to many of the key strategic goals of the health system through their ability to influence these wider determinants. By focusing on the things that district councils (and, in other areas, unitary authorities) have responsibility for, ICSs can move towards a more

holistic way of thinking about what produces good health outcomes for local people, and deliver the shift towards prevention called for in *The NHS long term plan* (NHS England 2019).

**Figure 1** How district council services can support the health and care system **K**





## Functions of district councils and their impact on population health

### Managing long-term conditions, reducing obesity and supporting healthy ageing

Physical inactivity is a major cause of premature deaths and access to green spaces has a significant positive impact on mental and physical health (Buck and Dunn 2015). District councils provide leisure and wellbeing services and access to green spaces. They also provide services such as community centres that can act as hubs for physical activity and wellbeing outreach programmes.

Many leisure and wellbeing services that district councils offer are now targeted at high-risk groups, including people with long-term conditions, people who are currently less active and older people. Recent analysis that the District Councils' Network commissioned (Health Economics Consulting *et al* 2022) found that improving access to these services through a national social prescription programme could see:

- almost 45,000 diseases avoided over 10 years
- a 3.7-year reduction in the healthy life expectancy gap
- savings to the NHS of £314 million.

### Improving mental health and wellbeing

Communities and homelessness prevention teams in district councils have direct insight into the mental health needs of their communities and have launched accessible, hyper-local preventive mental health projects – for example, providing access to green and community spaces, or convening professional and community support. District councils are involved in the provision of a wide range of services that support better mental health outcomes, such as recovery groups, wellbeing walking programmes and projects tackling social isolation.

### Reducing food and fuel poverty

The rising cost of living has highlighted the crucial role that district councils play in ensuring the welfare and financial sustainability of their residents. District councils run various types of welfare and financial support services, from revenues and benefit services to debt advice and support for finance management.

*continued on next page*



## Functions of district councils and their impact on population health *continued*

As food and fuel poverty rise, district councils are now offering 'warm and well' services to residents, improving the energy efficiency of their homes and offering advice to do so even further. District councils also sometimes run food education and low-cost cookery campaigns.

### Assisting hospital discharge

District councils are responsible for administering the Disabled Facilities Grant, adapting homes to ensure residents can return home from hospital and reducing the likelihood of readmission. Some councils, such as those in Leicestershire, are now playing a bigger, strategic role in relation to hospital discharge by developing multidisciplinary support for people leaving hospital (as detailed in the box entitled 'Facilitating hospital discharge in Leicester, Leicestershire and Rutland' later in this section).

### Creating healthy homes and thriving places

The health impact of poor housing has an estimated cost to the NHS of £1.4 billion a year (Garrett *et al* 2021). District councils have responsibility for housebuilding, homelessness prevention, housing adaptation and enforcement powers to improve the condition of private rented housing. Planned legislation will further strengthen their role in driving up standards in the private rented sector.

District council planning teams shape the environments we live in and play a key role in creating places that encourage physical activity and healthy lives. The link between health and planning has been historically overlooked but it is crucial that health stakeholders engage with district planners on:

- neighbourhood design
- active travel and walkability infrastructure
- improved standards for new housing so it is more energy efficient
- improved exposure to green spaces
- a reduction in air pollution.

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## Functions of district councils and their impact on population health *continued*

District councils also promote sustainable and equitable economic development through their economic growth teams and other functions. A strong local economy is associated with a range of better physical and mental health outcomes, primarily through good-quality stable employment (Buck and Dunn 2015).

### Safeguarding environmental health

District councils provide a range of environmental health services, including tackling pollution, food safety inspections, pest control and emergency planning. Food-borne diseases alone cause around 16,000 hospitalisations a year (Daniel *et al* 2020). The annual mortality from human-made air pollution in the UK is roughly equivalent to between 28,000 and 36,000 deaths (Office for Health Improvement and Disparities 2022), and district councils can reduce these health impacts through planning, communication campaigns and enforcement.

## Ability to be fast and agile

*They're smaller and agile – that's the biggest difference I find in working with them [district councils] in comparison to big organisations where you need so many layers of approval... if they say it's okay, it's okay. You go ahead and progress with your project.*

(ICB integration lead)

District councils are smaller than many of the other bodies that make up ICSs, and this can bring significant advantages. NHS leaders interviewed in our research often brought up district councils' ability to move quickly and offer strategic leadership in challenging situations as one of the main advantages that comes from working with them.

These abilities were particularly valuable during the Covid-19 pandemic in crucial moments such as the vaccine rollout, where district councils took the lead in finding sites and volunteers for the programme, which prevented more than 100,000 deaths (Timmins 2022; Local Government Association 2021a). People we interviewed



in district councils felt that this work was crucial for their ‘credibility’ with partner organisations, and that it has helped to embed closer working with the health and care system since then.

### Closeness to communities

*They’ve got the real gems, the nuggets of pure gold information around what actually is the real problem... they’ve got the real intel.*

(Senior ICB manager)

Perhaps the most important contribution that district councils can make to ICSs relates to their links into local communities. This has a number of aspects to it, including:

- councillors’ democratic legitimacy as local leaders and their closeness to the communities they represent
- the data and insights about communities that district councils hold for the range of service areas they are responsible for
- the small size of the geographies they cover.

There was a widely held view in our interviews that these links into local communities are more extensive than those that other ICS partners hold, and in particular are likely to involve closer contact and better relationships with the individuals and communities who have the most complex health and social care needs. Moreover, interviewees noted that district councils also have access to ‘huge amounts of data and information’ about the local population that the rest of the system simply does not have, as well as insights that come from close working relationships with local voluntary sector organisations and community groups. This includes:

- knowledge of the most vulnerable people and groups in the local population
- influential individuals who can act as ‘gatekeepers’ within the community
- local assets
- data about key wider determinants of health such as housing.



These links, our interviewees reported, enable district councils to have a better sense of where there are particularly high levels of needs in the population (and to develop that sense more quickly during crises), and an understanding of what local people see as being their most important priorities. Bringing this information into ICSs and their associated structures allows for better planning and targeting of services, so that they can have greater impact, be more inclusive and responsive to local concerns.

*We [in the NHS] don't touch and feel and engage with our local communities in the way that our district councils obviously do, so we see that as a really important asset.*

(ICB chief executive)

## Examples

The unique strengths of district councils described in this section allow them to deliver improved population health through action on the wider determinants of health. The next three boxes describe examples from our case study sites that illustrate what this can look like in practice. What these examples demonstrate is that district councils can make an important contribution to meeting immediate priorities as well as longer-term goals. Their influence over the wider determinants of health can help ICSs meet some of the pressing challenges currently facing the NHS, including long waiting lists for elective treatment and delays in being able to discharge people from hospital back to the community.

Table 2 provides further brief examples that illustrate how the various functions of district councils can be deployed to address the wider determinants of health, drawn from the District Councils' Network's repository of examples from its members.





## Supporting people on waiting lists and facilitating discharge in Norfolk and Waveney

Reducing waiting lists for NHS care has been a major focus for the Norfolk and Waveney ICS since the Covid-19 pandemic. One priority has been seeing if anything can be done to improve the social situations of people on waiting lists to avoid these exacerbating their health problems while they wait for NHS care.

District councils have led a Waiting Well project, involving them hosting multi-agency teams that have contacted people on orthopaedic waiting lists to see if there are things within the gift of any ICS partner organisations that could help people manage while they wait. Overall, 17 per cent of those contacted have had unmet needs identified. Support provided has included making minor alterations to people's homes and using social prescribers to connect them with specialist support in relation to welfare rights, relationship difficulties, social isolation, housing or other issues. They have also referred people to a dedicated physiotherapy team when appropriate.

District councils have also been delivering a District Direct service at the Norfolk and Norwich University Hospital and at Hellesdon Hospital. This service operates on wards, in the Emergency Department and with the pre-operative assessment team. Its role is to expedite discharge where this is delayed for non-medical reasons, such as cluttered or unhygienic homes, or requirements for alarms, key safes or other adaptations. The service has a dedicated budget to address all of these barriers and all officers have the means to make payments on the same day as referral. In the last financial year (2022/23), the service was estimated to have saved 12,790 bed days, at a value of more than £8.5 million.

For further details, contact Jamie Sutterby, Director of People and Communities at South Norfolk and Broadland District Councils: [Jamie.Sutterby@southnorfolkandbroadland.gov.uk](mailto:Jamie.Sutterby@southnorfolkandbroadland.gov.uk)



## Responding to the cost-of-living crisis in Lincolnshire

The cost-of-living crisis is a good example of a complex challenge for which service integration is necessary. Rather than being a discrete phenomenon requiring input from a single service or agency, inflationary pressures affect people's lives in a variety of ways that have consequences for their health and much else besides.

In Lincolnshire, district councils have jointly led the system's response to the crisis. This was felt to be a good fit as districts already had the best connections to the most vulnerable people. Much of the focus of the work in this area has been on guiding people through the various types of support that are available to them and what the eligibility criteria for them are, to help improve their financial resilience. This has helped people get the support they need. And through mapping the various things going on in the system, it has also helped to integrate services and reduce duplication.

## Facilitating hospital discharge in Leicester, Leicestershire and Rutland

In Leicester, Leicestershire and Rutland, there is a focus on how multi-agency working can help people stay out of hospital and aid with discharge processes.

The Lightbulb Project hosted at Blaby District Council brings together a range of partners that can help to meet people's health needs inside their homes – working on things like installing equipment such as shower chairs or grab rails, and offering energy advice to help people to keep their homes warm during winter. The service also provides a range of grants to support hospital discharge and to cover the costs of improving an individual's home, such as repairing a broken roof or any other things that could have an impact on their health.

This multi-agency work sits alongside the work of hospital enablement teams, involving housing specialists based in all hospitals across Leicester, Leicestershire and Rutland picking up any housing issues that may delay discharge – including dealing with people who are homeless or individuals whose property is no longer suitable because of their health conditions. This work has delivered demonstrable improvements in outcomes and reduced costs for the system.

For further details, contact Teresa Neal, Business, Partnerships and Health Improvement Group Manager at Blaby District Council: [Teresa.Neal@blaby.gov.uk](mailto:Teresa.Neal@blaby.gov.uk)



**Table 2** Examples of district council initiatives on the wider determinants of health

**Healthy housing support**

Lancaster City Council	The council's holistic Home Improvement Agency (HIA) has developed an integrated adaptation service providing residents with a one-stop shop for all forms of home adaptations to get them back into their homes from hospital and keep them out of care ( <a href="#">District Councils' Network 2023</a> ).
Nuneaton and Bedworth Borough Council	The council runs a social housing regeneration project that supports and enhances access to improved and affordable housing – improving health and providing training and employment opportunities ( <a href="#">Local Government Association 2022c</a> ).
North Devon District Council	The council has new temporary accommodation pods to house rough sleepers in north Devon, offering them safe accommodation and helping the council's rough sleeper outreach team to address their often-complex needs ( <a href="#">District Councils' Network 2023</a> ).

**Improving mental health**

Sevenoaks District Council	The council is running a pilot mentoring scheme for young people to improve their mental health and tackle isolation ( <a href="#">Local Government Association 2023b</a> ).
New Forest District Council	A mental health homelessness practitioner (a qualified nurse) has been embedded into the council's homelessness and support team to provide swift support to service users and free up general practitioner (GP) appointment time ( <a href="#">District Councils' Network 2023</a> ).
Cambridge City Council	The council is supporting The Edge Café in Cambridge to provide support to people recovering from substance misuse and those with mental health problems by running recovery groups ( <a href="#">Local Government Association 2022b</a> ).

**Tackling health inequalities**

North West Leicestershire District Council	In the face of current pressures, the council has created a new food poverty officer role to provide vital support to those needing to obtain food and debt advice, while rolling out low-cost cooking courses ( <a href="#">District Councils' Network 2023</a> ).
North Warwickshire Borough Council	The council's Positive Energy Solutions project is designed to support those who are struggling with their energy bills. This initiative provides them with money-saving solutions to alleviate fuel poverty ( <a href="#">District Councils' Network 2023</a> ).
Reigate and Banstead Borough Council	The council has established health creation networks, creating groups and listening events for underrepresented communities that experience health inequalities ( <a href="#">District Councils' Network 2023</a> ).

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**Table 2** Examples of district council initiatives on the wider determinants of health *continued*

**Getting people moving**

Cherwell District Council      Move Together is an evidence-based pathway providing behavioural support, specifically targeting people who have long-term conditions and need help and support to be more active ([District Councils' Network 2023](#)).

**Health advice on the doorstep**

Test Valley Borough Council      The council has created a town-centre health hub, initially to provide health checks for local residents, but the services on offer will expand over time as part of town-centre regeneration plans. The hub is a joint venture between the Borough Council, NHS Hampshire and Isle of Wight Integrated Care Board and the Andover Primary Care Network ([Local Government Association 2023a](#)).

Babergh and Mid Suffolk District Councils      The councils are taking health promotion out to parks and green spaces through outdoor activities and cooking sessions ([Local Government Association 2022a](#)).



## 3 Principles for success

The four sites that we focused on for this research were selected based on feedback from the District Councils' Network, which identified areas where the integration of district councils into ICSs appeared to be going well. In this section, we explore what we learnt about 'what good looks like' across different aspects of the relationship between district councils and ICSs, and offer five principles that we believe form a foundation underpinning positive outcomes.

### Principle one: Create effective local partnership structures

While ICSs bring partners together to plan in a collaborative way across large geographies, the delivery of integrated services often needs to happen more locally (Charles 2022). The scale of ICSs (typically covering populations of between 1 and 3 million people) means they have a broad range of circumstances in terms of deprivation, rurality, demographics and other characteristics. Designing services that respond to these local circumstances is best done through more local partnership structures, and district councils (covering an average population of around 117,000) are the key public body operating at this level.

It is through delivering practical programmes of work together at this local level that district councils can have the most direct impact on outcomes, often by redesigning services, working in multi-agency teams or combining data in different ways to better meet the needs of local people. This is by no means the sole level at which district councils can make a vital contribution, but it is the foundation on which their wider system roles are built. Getting these local partnership structures right is therefore key.

Our case study areas had varying vehicles for partnership work on delivery at those more local scales – whether that was health and wellbeing partnerships in Norfolk or local delivery partnerships in Leicestershire. These kinds of structures are able to draw on the unique strengths of district councils and focus on preventive interventions around the wider determinants of health.



### Examples of local partnership structures in our case study sites

In Norfolk, eight health and wellbeing partnerships have been created based around district council geographies. These partnerships bring together colleagues from county and district councils, the NHS, primary care, voluntary sector organisations and a wide range of other agencies including the police. They focus primarily on tackling the wider determinants of health through co-ordinated action, and also support social prescribing.

In Leicestershire, seven local delivery partnerships perform a similar role, and are also based on district council geographies. Seven community health and wellbeing plans set the priorities of each partnership, and the health and wellbeing strategy at county level in turn shapes these plans (see principle 2).

## Principle two: Align agendas across levels in the ICS

The local partnerships described in principle 1 need to be embedded within wider ICS structures to ensure that work at the system level and at more local levels is aligned and mutually supportive. As one of our interviewees put it, there has to be some kind of 'golden thread' that brings together work at all levels and across all partners within a system to give it direction and ensure best outcomes.

Strategy documents are important in creating this golden thread, and giving district councils a role in shaping these is vital. Strategies at system level need to be 'useful [and] open-ended', as one interviewee noted, meaning that they offer broad direction but are also malleable to specific priorities and plans at local levels. This flexibility is important as otherwise there is a risk that strategies and plans function as top-down documents that erase the local nuance that exists within systems.

For example, in Leicestershire, the seven community health and wellbeing plans at neighbourhood level each give emphasis to specific local concerns but at the same time follow a consistent framework derived from the place-level plan that Leicestershire Health and Wellbeing Board oversees, and this plan is itself shaped by (and shapes) the integrated care plan at system level.

Once strategies are set, ensuring that agendas stay aligned requires constant communication. This can include bringing leaders from different boards and



partnerships together on a regular basis and having people attend meetings beyond the boundary of their 'patch', so that people understand the wider context their work forms a part of. One district council officer described the ambition of such work as follows:

*So the idea is that what's happening at grassroots level links all the way back through the system all the way to the ICB... and similarly, you know, back down so you kind of get that better flow [of information].*

(District council officer)

This continual two-way exchange not only helps build shared purpose, but also helps counter the impact of hierarchies in systems. There can be a tendency for the higher tiers within a system to take on a dominant role and to become seen as more important than the others. However, if all scales of work and all partners within a system are involved in the process of agenda-setting, then local priorities will be able to work their way up the system, preventing a dynamic where priorities simply cascade down.

### **Principle three: Embed district council leadership throughout the system**

To help achieve the strategic alignment described in principle 2, district council voices need to be heard at all levels – not just within more local structures. Statutorily, ICBs are required to have representation from a local government body in their area that has social care responsibilities ([Local Government Association 2021b](#)). Beyond this minimum requirement, however, there is little that compels ICSs to involve district councils specifically, or to create spaces for them to take on leadership roles.

In our research sites, we found that going further than the minimum requirements had helped to create a system that gets the most out of all partners involved. A range of different leadership roles had been taken on across our sites. This included being involved in integrated care partnerships (ICPs) – with the feedback being that this was a major help in terms of making sure that district councils' perspectives were taken into account at a system level. As one district council chief executive put it:

*When you look at the purpose of those groups [ICPs and ICBs] around the wider determinants of health, I think that's something we feel quite strongly about as*



*districts that we should be there. And also that's where a lot of decisions are being made around funding.*

(District council chief executive)

Representation of district councils on the ICP and/or ICB has also been a focus in several other ICSs outside of our research sites.

### **Involvement of district councils in the Hampshire and Isle of Wight ICB and ICP**

Hampshire and Isle of Wight ICB has a district leader elected to the board to sit alongside statutory partners to ensure district council integration. The ICP also has two district chief executives nominated to the partnership to ensure practical implementation of policy throughout the public sector. In recognising the complex geography across the county, the director of public health and the ICB lead director facilitate a quarterly health assembly at which all partners are invited to work through themes in the ICB strategy and develop actions for delivery relevant to local places through the district-based partnerships.

Beyond involvement in ICPs, in some sites we also heard about the positive impact that having district council employees take on wider leadership roles within the ICS could make. In Lincolnshire, for example, two district council chief executives are members of the Better Lives Lincolnshire leadership team, meaning that, as one interviewee mentioned, 'district councils are completely bolted in' to the fabric of the system, rather than being seen as a more external partner or add-on. Similarly, in Leicestershire, district councils play a leading role in a number of the key partnership boards at county level, which in turn form an important part of the wider ICS structures.





## Principle four: Invest in relationships

*The relationships are probably the key thing that makes it work. We've worked quite hard to build those relationships – going above and beyond to make sure we're available to connect with system partners one to one.*

(District council chief executive)

Underpinning all the formal arrangements described above are human relationships, and these have to be built through conscious effort. One ICB leader we interviewed described the strength of relationships with districts that they enjoy in their patch as being the result of a 'deliberate act on my behalf'.

In our interviews, we heard numerous examples of what this active and conscious building of relationships can involve in practice. Some of our sites had deliberately created spaces where colleagues from the NHS, district councils and other parts of the system could come together to work out the 'messy stuff' (such as the complex logistical discussions that need to take place to make joint projects happen). These meetings existed for problem-solving, but also so that the relationships between leaders could be strengthened, allowing them to work together more smoothly.

Relationship-building is particularly important when structural arrangements are complex. In systems where the geographical footprints that different organisations and partnership bodies cover do not map onto each other easily, frequent communication and informal relationships become all the more crucial in ensuring that the work being done at each level of the system stays aligned.

Ultimately, there is no substitute for simply having open minds and being prepared to listen to one another. Perhaps the most important element in this is treating all partners within the ICS with respect and making sure their contributions are listened to and valued. As one ICB employee put it when asked about the key to building good relationships with district councils:

*I think get to learn about them. Shut up and sit down and listen to all the stuff that they do and what they think – that's what we've found really interesting... It's just that mutual respect of appreciating their knowledge and what they're doing.*

(ICB employee)



### Principle five: Build shared purpose and collective accountability

It would be entirely possible to have everything described in the previous four principles in place without achieving the full potential of partnership working. This is because something else is also needed: a shared sense of purpose that binds together the organisations involved in the ICS. Shared purpose is a driving force throughout all of the above. Without it, even the best-designed structures and processes or the strongest relationships will not deliver results.

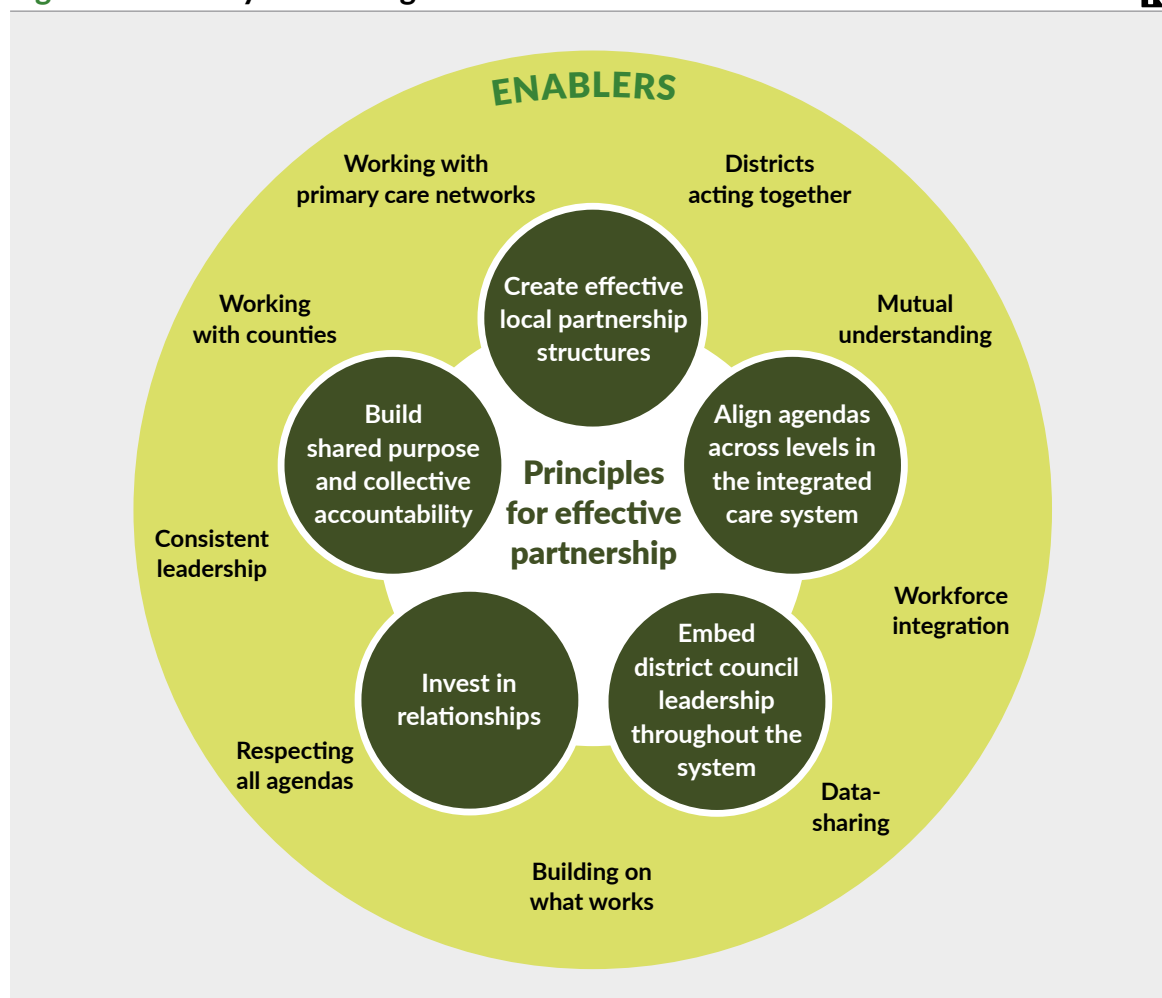
Specifically, there needs to be shared purpose about improving population health and reducing health inequalities through co-ordinated action on the wider determinants of health. As described in Section 2, district councils' powers regarding housing, planning, economic development, leisure services, green spaces and environmental health mean they are ideally placed to help deliver these ambitions.

In addition to shared purpose, there also needs to be collective accountability for delivering on the commitments that partners agree on. ICS leaders need to ensure that a significant proportion of the partnership's time, energy and resources is focused on tackling the wider determinants of health. This should include agreeing shared outcomes around the wider determinants of health and then creating mechanisms for monitoring and supporting delivery. It could also include aiming to progressively shift more of the partnership's combined budget into preventive activities over time, in line with the recommendations of the Hewitt Review of ICSs ([Hewitt 2023](#)).

# 4 How to get there: actions that enable integration

The previous section described what ‘good’ looks like in terms of the involvement of district councils in ICSs, based around five principles for success. In this section we describe enabling actions that can help to put these principles into practice (see Figure 2 for a summary), again drawing on the experience of our case study sites.

**Figure 2** Summary of enabling actions





## Districts acting together

The scale of ICSs is such that it is unlikely that the district councils that sit within them will be completely homogenous. In many of the sites that we looked at for this project, there was a range of political leadership, rurality and self-understood cultures between the different districts within systems.

Nonetheless, the districts in these systems recognised that it was important for them to be able to work together where there are areas of shared interest, and, on those issues, act as one within the infrastructure of the ICS. This is because, as one district council employee put it, 'we recognise that it's really hard for some of our health partners to navigate what we do at a district level... so we need to try and make it as easy as possible for them to interact with us'.

Understandably, achieving this level of co-ordination can be challenging – and it is unrealistic to expect to achieve this on every issue. However, as one interviewee explained, the key is to see the big picture: 'It can be quite... distracting having a debate about who gets a seat at what table. The more important thing is to make sure a collective voice is acknowledged and embraced.' This realisation was a prerequisite to making progress in the site in question.

## Promoting mutual understanding

During our interviews, it was frequently explained that helping NHS colleagues to understand what district councils are and what they do (and vice versa) can sometimes be half the battle in terms of improving relationships. One interviewee put it like this:

*I spend a lot of my time in this space in a lot of meetings – navigating health and social care colleagues back through to what district councils actually deliver on the ground and not to repeat what already exists.*

(District council officer)



Integration has brought together organisations in the public sector that were previously much more siloed from each other. This means that there is now much to learn. As one interviewee stated: 'There needs to be education of all the staff, in all the system partners... about the fact that we will be working with other organisations offering services that we're not used to.' This applies both to senior leaders and to staff at all levels.

An important enabler in several of the sites we examined was having people employed by the ICB whose job descriptions were specifically about 'joining dots with the wider partnership', as one interviewee highlighted – linking people together and building understanding across the NHS and local government. This involved being a link both in a formal sense, in terms of attending various committees and having a role within different structures within the ICS, and in an informal sense, through the deliberate cultivation of relationships.

### **Building an integrated workforce**

Beyond promoting mutual understanding across the various organisations involved in the ICS, some sites described a more ambitious vision, which would involve moving towards an integrated workforce in areas where it makes sense to do so.

Creating joint roles between ICS partners in key areas like community engagement can help strengthen relationships across boundaries and deliver a more co-ordinated service for local people. Similarly, establishing multidisciplinary teams and enabling co-location (having multiple teams operate out of the same building) have also been found to help improve co-operation across agencies.



### Joint roles in Suffolk and north-east Essex

In Suffolk and North East Essex ICS, creating joint roles has been instrumental in bringing together partners within the ICS. Key people within its Health and Wellbeing Alliance (the partnership body at place level) have jobs that split between district councils, the county and the ICB. Similarly, within districts themselves, numerous officers have roles split between different districts, or between a district and the county. This helps break down barriers between ICS partners and builds a culture where 'we are all public servants' first, and where organisational agendas and identities come second.

To complement these joint roles, the system in Suffolk and north-east Essex also makes use of joint training to help integrate organisations. Staff in districts recognise that the NHS, as a result of its national-level offer to employees, is able to make a significant contribution in terms of staff training. Consequently, they have secured access to NHS training for district staff, and then reciprocated the offer to NHS staff. This enables both organisations to make savings, and allows for relationships to be forged between staff, and for ideas and ways of working to be shared beyond organisational boundaries.

Districts also run apprenticeship schemes that local NHS organisations are now part of as a potential host for placements.

### A facilitative approach to data-sharing

Sharing data and creating 'a shared data story', where there is a common understanding of community need and service performance, are powerful ways of enabling system partners to get the most out of working together. District councils have a huge amount of helpful information from the services they run, in areas such as housing and the environment, about specific local needs, which they can share with NHS colleagues as appropriate. By bringing information from multiple sources together, it is possible to make faster progress on health inequalities and other priorities.

However, in practice, sharing data can prove very difficult. Organisations involved in ICSs can often be highly risk averse when it comes to information governance, and at times in our research there seemed to be a level of distrust about councils' ability to act as responsible handlers of data and information. In one case, we heard



a story about how information was not shared with a local authority because NHS colleagues were not sure whether council emails would be secure to send it to.

Maximising the impact of partnership working in ICSs means maintaining appropriate information governance without letting excessive caution prevent improvements that would benefit local people. In practice, this often means simply building trust between NHS and local government colleagues and seeking expert advice before deciding that sharing data is not permissible.

### Building from what already exists locally

Most areas have been building partnership structures for some years and the advent of statutory ICSs should not mean starting from square one, particularly where there are local bodies or arrangements that already function well. Our sites recommended building 'out' from 'existing infrastructure', meaning going through a process of identifying what already works well in current systems – whether that be a particular team, committee or group of colleagues who have been able to build co-operative relationships – and seeking to preserve that as new structures are created.

This might mean a variety of things in practice, from using existing professional networks as the building blocks for new areas of collaboration, to, as in one of our sites, building new place-based partnerships around relationships and infrastructure that had already been created before the ICS took its current statutory form. Building on the work of health and wellbeing boards is particularly important – strong connections between these and district councils were seen to be a key enabler in all of the sites we studied.

### Acting on all partners' priorities

As described in Section 1, working closely with district councils through ICSs can help the NHS to achieve its strategic objectives around population health and inequalities. However, to function successfully, ICSs also need to help local government partners achieve their own objectives. This was a central part of the rationale for creating ICSs, whose four core purposes include working to 'help the NHS support broader social and economic development' (NHS England 2020).



Our sites reported that things worked best when NHS support is offered to agendas that districts 'own', for example finding ways to assist with the goal of stimulating the local economy and improving employment opportunities, as well as the other way round. This creates a two-way, equitable relationship, which goes beyond seeing districts simply in terms of 'what we [districts] can bring' to existing NHS goals.

### Consistent leadership and purpose

Consistency of leadership and purpose over time is vital because frequently changing approaches, priorities and projects can be a source of significant frustration for colleagues in partner organisations. For example, we heard from people working in councils who reported having had 'their fingers burnt' previously due to a lack of consistency from NHS leaders they have worked with, who from their perspective seem to 'pop up, disappear, pop up, disappear'.

Some of our case study sites had benefited from having the same people in key leadership posts over several years. While this cannot be replicated everywhere, it is nonetheless possible to establish consistency of purpose over time, even when some of the individuals involved move on. This requires ensuring that the strategic vision for the ICS is embedded within the organisations involved rather than being dependent on key individuals.

### Positive relationships with counties

District councils are, of course, only one part of the local government picture. County councils have an important role to play, and we heard from many of our sites about how relationships between districts and counties can be hugely important for determining the success of district council engagement with the system. In particular, positive relationships with directors of public health are crucial, as these people are uniquely placed to act as a go-between for local government and the NHS, and are champions for focusing on the preventive agendas where district councils can play a major role.

Making these relationships work, though, is not without challenges. At times, political differences between districts and counties can prove difficult and past experiences can lead to mistrust. However, our case study sites show that these





barriers are not impossible to overcome. Interviewees argued that local government involvement in ICSs need not be a zero-sum game where greater influence for district councils equates to less influence for county councils. Collectively, district, unitary and county councils wield vital preventive levers and, by acting together, the opportunities to improve health outcomes are greater. As with creating bonds between districts, the key is to invest in building relationships and working together on identified areas of shared interest.

### **Positive relationships with primary care networks**

Primary care networks are vital delivery partners at the local level for district councils and some degree of alignment of priorities – and potentially pooling of resources – is necessary for achieving best outcomes. Some of our interviewees argued that if district councils could improve their links with primary care networks, this would also help them have influence upwards into ICSs, as their general tie into the health system would be greater.

However, relationships with primary care networks have sometimes been quite difficult to forge. This is often because primary care network geographies and district council geographies are not aligned, and also because there is rarely capacity in primary care to build relationships with local government. Nonetheless, where these issues can be overcome through the kind of relationship-building approaches described elsewhere in this report, this was seen to be helpful.



## 5 Making a strategic shift to a more preventive system

ICSs were created to transform the approach taken to health and care in England. At the heart of this transformation is the need for a fundamental shift towards preventing illness and improving population health – something that is needed both to improve health outcomes and for economic reasons ([Haldane and Rebolledo 2022](#)).

It has long been recognised that the proportion of NHS and wider resources invested in prevention and early intervention is inadequate, a point made forcefully in the Hewitt Review of ICSs ([Hewitt 2023](#)). Correcting this imbalance can only happen if local government and voluntary sector organisations are active partners in ICSs. District councils, specifically, are key strategic partners because of their power to influence many of the wider determinants of health – action on which needs to form a key component of a more preventive approach to health.

The examples included in this report offer glimpses of what could be achieved if ICS leaders make the most of their partnerships with district councils. In many parts of England, district councils are already helping to deliver improvements in health outcomes. However, the full potential remains largely untapped because systems have not yet succeeded in fundamentally shifting their focus and resources towards prevention and population health.

There are, of course, reasons why making this shift is difficult, particularly in the current environment. Extreme service pressures make it harder for organisations to look beyond immediate challenges and to prioritise the system-wide transformation needed to deliver sustainable improvement. Planned cuts to staffing levels also risk driving ICBs to look inwards over the coming months – at the potential expense of their wider work with local partners. But the immediate difficulties in meeting demand for services will never be solved if the bigger issues around population health remain unaddressed. It is therefore vital that leaders create space for bringing about this strategic shift at the same time as tackling the here and now.



In most ICSs, the focus of work with district councils to date has been on getting the basics right – ensuring district councils have a voice within the ICS and building the necessary relationships (and in some systems there is still work to be done on these fronts). There is now a need to go beyond this and to take practical action that makes full use of the assets that district councils have at their disposal. This can be done by developing place-based projects that respond to the needs of local communities and tackle the key determinants of health they face. Given their small scale, closeness to communities and agility, district councils can provide an ideal testing ground for innovative preventive health work.

Taking forward this locally focused action requires the existence of effective partnership arrangements at place level within ICSs. At present, place-based boards are not well developed in many ICSs and do not yet typically control delegated budgets from ICBs (Naylor and Charles 2022). This situation will need to change as ICSs mature if they are to reach a key ambition set out in guidance (NHS England and Local Government Association 2021) and more recently in the Hewitt Review (Hewitt 2023), which is to embody the principle of subsidiarity where decisions are made at the most local level possible.

The strategic shift to prevention will also require stronger collective accountability within ICSs. Building a sense of shared purpose around tackling the wider determinants of health is a vital first step, but partner organisations then need to be able to hold each other to account for delivery.

Despite the challenges, we believe that there is still significant potential to improve health population outcomes and to reduce health inequalities by placing district councils at the heart of ICSs. The following section summarises our recommendations for doing so.



## 6 Recommendations

Realising the opportunities described in this report will require action from all parties. What follows is a series of recommendations, first for NHS leaders working in ICBs, and second for officers and elected members in district councils.

While the focus of this report is on district councils, our recommendations also apply to areas with unitary councils as it is the services and functions that district councils provide that make them indispensable partners in ICSs, rather than the organisational form itself.

### Recommendations for ICB leaders

- **Ensure prevention is at the heart of the system's mission and purpose.** Crucially, this needs to include a renewed focus on the wider determinants of health, with district councils playing a major role in this.
- **Create opportunities for district councils to lead.** It is important that the voice of district councils is heard throughout key ICS governance processes. It is also vital that space is made for district councils to take on leadership roles within systems, and that their expertise is brought into decision-making and delivery.
- **Use district councils to trial new place-based projects.** District council services are already influencing population health outcomes. ICSs should identify immediate opportunities to build on this by harnessing these services as part of place-based action. Using district councils as testing grounds for local interventions will be key to making the shift to a more preventive system.
- **Hold district councils to account for delivery.** Shared ambitions on prevention need backing up with clear accountability. ICSs should create mechanisms for monitoring and supporting delivery that place clear goals and accountability on district councils, enabling them to demonstrate what progress has been made.



- **Bring together data.** Combining data across partner agencies and analysing this together can be a powerful way of developing a shared and more nuanced understanding of what is needed to improve outcomes. To enable data-sharing, building trust between ICBs and district councils in relation to information governance is essential.
- **Aim to deepen integration over time.** While there are already encouraging examples of what can occur when district councils take an active leadership role in ICSs, partners should aim to move beyond simply ‘working together’ and towards deeper integration and co-commissioning of services. This means breaking down the barriers between organisations through things like joint roles, co-location, pooled resources and joint commissioning.
- **Invest in building relationships.** Strong relationships with district councils underpin everything. Actively building relationships and learning about partners in district councils – in terms of their responsibilities, strengths and priorities – are essential for achieving the best possible outcomes.

### Recommendations for district councils

- **Advocate on behalf of district councils.** District councils need to actively promote themselves and the contribution they can make to system working. Leaders in district councils need to be prepared to push themselves forward, explain how their work already influences population health and offer their services as testing grounds for place-based projects.
- **Identify areas of shared priority.** District councils should work out where areas of alignment exist between their priorities and those of others involved in the ICS. This applies as much to interacting with other districts within the footprint of the system as it does to NHS partners.
- **Accept accountability.** To maximise their impact in ICSs, district councils need to be willing to take responsibility for specific goals on behalf of their system partners, and then to be monitored against these goals and held to account for delivery.



- **Invest in building relationships.** As for NHS leaders, it is important that district councils put effort into cultivating connections with partners across their ICS. Beyond colleagues in the NHS, they also need to ensure effective working relationships with leaders in other districts and in upper-tier authorities, including directors of public health.

Running through all of these recommendations is the need to be ambitious about what district councils can achieve on behalf of the wider health and care system. ICSs have the potential to transform the approach taken to health and care in England. Through their creation, opportunities arise to address the wider determinants of health and to make the relationship between organisations more collaborative. District councils are key to making a reality of this vision.

As we have demonstrated in this report, district councils bring unique resources and assets to ICSs, and through their various functions can help systems shift the focus upstream towards the wider determinants of health. They can also play a major role in linking together health organisations with local communities.

It is vital that the potential and role of district councils are understood and championed within ICSs. The five principles described in this report and the recommendations we have set out here offer a route to make that happen.



# Appendix: Methods

Our approach to this research was based around four case study ICS areas (Lincolnshire; Leicester, Leicestershire and Rutland; Norfolk and Waveney; and Suffolk and north-east Essex). These sites were selected through conversations with the District Councils' Network, which identified through its knowledge of its members, sites where the process of integration was felt to be going well (see Table 3 on page 38 for further details on the sites).

In each area, we conducted multiple interviews (including group interviews), ensuring that we spoke to a number of people on both the ICS side and the district council side. To help people feel comfortable to speak freely, we tried to ensure that our group interviews kept these two sides separate. The exception to this approach was Suffolk and north-east Essex. Here we conducted one group interview, which included people from both district councils and the ICB.

In total we interviewed 26 people. The district representatives we interviewed were all officers; we did not speak to any councillors during this research.

All interviews were recorded. The interviewers took extensive notes both during the interview and then afterwards while listening back to the recordings. Listening back to the recordings allowed us to transcribe accurate quotes.

The research team then analysed our notes, with cross-cutting themes being identified and drawn out.

Following the interview stage of our research, we held an engagement workshop to test and refine our emerging findings, and to help generate the recommendations presented in Section 6 of this report. People from ICBs and district councils outside of our case study sites attended this workshop. As the case study sites were selected because they were areas where things were felt to be going well, the workshop helped us get a more rounded perspective of how things were going in other places.

In addition to the research process described above, we also worked with the District Councils' Network to identify further examples that could be relevant for inclusion in the report.



**Table 3** Size and local government composition of the case study sites

ICS	Population	Councils included
Leicester, Leicestershire and Rutland	More than 1.1 million, 700,000 of whom live in district council areas	<p><b>Seven district councils:</b></p> <ul style="list-style-type: none"> <li>• Blaby District Council</li> <li>• Charnwood Borough Council</li> <li>• Harborough District Council</li> <li>• Hinckley and Bosworth Borough Council</li> <li>• Melton Borough Council</li> <li>• North West Leicestershire District Council</li> <li>• Oadby and Wigston Borough Council</li> </ul> <p><b>Three unitary/county councils:</b></p> <ul style="list-style-type: none"> <li>• Leicester City Council</li> <li>• Leicestershire County Council</li> <li>• Rutland County Council</li> </ul>
Lincolnshire	More than 1.08 million, more than 750,000 of whom live in district council areas	<p><b>Seven district councils:</b></p> <ul style="list-style-type: none"> <li>• Boston Borough Council</li> <li>• City of Lincoln Council</li> <li>• East Lindsey District Council</li> <li>• North Kesteven District Council</li> <li>• South Holland District Council</li> <li>• South Kesteven District Council</li> <li>• West Lindsey District Council</li> </ul> <p><b>Two unitary councils:</b></p> <ul style="list-style-type: none"> <li>• North East Lincolnshire Council</li> <li>• North Lincolnshire Council</li> </ul> <p><b>One county council:</b></p> <ul style="list-style-type: none"> <li>• Lincolnshire County Council</li> </ul>

*continued on next page*





**Table 3** Size and local government composition of the case study sites *continued*

ICS	Population	Councils included
Norfolk and Waveney	1.1 million, all of whom live in district council areas	<p><b>Eight district councils:</b></p> <ul style="list-style-type: none"> <li>• Borough Council of King's Lynn and West Norfolk</li> <li>• Breckland Council</li> <li>• Broadland District Council</li> <li>• East Suffolk Council</li> <li>• Great Yarmouth Borough Council</li> <li>• North Norfolk District Council</li> <li>• Norwich City Council</li> <li>• South Norfolk Council</li> </ul> <p><b>Two county councils:</b></p> <ul style="list-style-type: none"> <li>• Norfolk County Council</li> <li>• Suffolk County Council</li> </ul>
Suffolk and North East Essex	1 million, all of whom live in district council areas	<p><b>Seven district councils</b></p> <ul style="list-style-type: none"> <li>• Babergh District Council</li> <li>• Colchester City Council</li> <li>• East Suffolk Council</li> <li>• Ipswich Borough Council</li> <li>• Mid Suffolk District Council</li> <li>• Tendring District Council</li> <li>• West Suffolk Council</li> </ul> <p><b>Two county councils:</b></p> <ul style="list-style-type: none"> <li>• Essex County Council</li> <li>• Suffolk County Council</li> </ul>



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# Acknowledgements

We would like to thank the District Councils' Network for funding this project, and their assistance throughout – particularly in identifying and contacting people for interviews and to attend our workshop. Special thanks to David Sharman for sharing his feedback, insight and experience, and to James Hood.

We would also like to thank everyone who participated in interviews for this project, or who attended our workshop. People in district councils and in ICSs were facing many pressures during the period of our research, so we really appreciate them taking the time to speak with us.

Numerous colleagues at The King's Fund also contributed in important ways to this project. We are grateful to David Buck and to Sally Warren for their feedback on early drafts of this project, and to Gemma Umali, Megan Price, Lisa Oxlade and Helen Joubert for their assistance in editing and communications. Likewise, we would like to thank Nick Golding for his help on communications from the District Councils' Network's side.



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**Published by**

The King's Fund  
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London W1G 0AN  
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[publications@kingsfund.org.uk](mailto:publications@kingsfund.org.uk)

[www.kingsfund.org.uk](http://www.kingsfund.org.uk)

© The King's Fund 2023

First published 2023  
by The King's Fund

Charity registration number:  
1126980

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ISBN: 978 1 915303 11-0

A catalogue record for this  
publication is available from  
the British Library

Edited by Rowena Mayhew

Typeset by  
Grasshopper Design Company,  
[www.grasshopperdesign.net](http://www.grasshopperdesign.net)

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District councils have statutory powers over service areas including planning, housing, benefits, and leisure and green spaces, which affect many of the most significant determinants of health. This makes them indispensable partners in integrated care systems (ICSs), which have a responsibility to improve the health and wellbeing of the populations they serve.

Drawing on interviews with district council leaders and officers and integrated care board employees in four case study sites, *Driving better health outcomes through integrated care systems: the role of district councils* examines how to make the most of the potential contribution of district councils to health. In the report the authors:

- identify five principles that underpin successful involvement of district councils in ICSs
- outline the actions that enable integration between ICSs and district councils
- offer recommendations to ICB leaders and district council leaders to put the principles and enablers into practice.

The report concludes by underlining the unique resources of district councils and the role they can play in addressing the wider determinants of health through partnership working in ICSs.

