Health inequalities tackled through intersectoral collaboration: process issues and insights

James Woodall

j.woodall@leedsbeckett.ac.uk

Leeds Beckett University

Paige Davies

Leeds Beckett University

Fallon Parker

Leeds Beckett University

Research Article

Keywords:

Posted Date: September 13th, 2024

DOI: https://doi.org/10.21203/rs.3.rs-4920283/v1

Additional Declarations: No competing interests reported.

Abstract

Collaborations, comprising organisations from a diverse range of sectors, are often perceived as being well-placed to tackle persistent health inequalities, but often fail due to a myriad of reasons including political, organizational and cultural barriers. This paper explores issues in relation to the formation of a multi-sector collaboration in one geographic area in the UK, working under the banner of the Health Determinants Research Collaboration (HDRC) – a programme which seeks to further understand health determinants and to improve health outcomes in communities. Through qualitative interviews with eleven of the constituents of the collaboration, the data demonstrated a clear and shared vision for the collaboration and a neat 'dovetailing' of skill-sets related to community brokerage; academic rigour; and statutory legitimacy. While the collaboration under focus here was in its infancy, cultural and practical tensions in ways of working; pace of working; and philosophy were predicted to emerge and required careful monitoring to ensure intended outcomes were not derailed.

Introduction

Complex health and social issues are rarely addressed sufficiently by a single organisation, department or sector [1]. Indeed, individuals or sectors working alone will often achieve inferior outcomes to those working together [2]. Politicians, therefore, often see collaboration and partnership as a 'panacea' for tackling complex health and social problems [3]. Notwithstanding, the size, scale and scope of partnerships designed to improve population health are heterogenous [4]. Some have suggested a typology of partnerships which show varying levels of engagement and interaction between organisations, including: networking; co-operation; co-ordination; coalition; and full collaboration [5].

The determinants of health are multifaceted for individuals and communities, pertaining to a range of issues such as: poverty; education; infrastructure and material resources; and housing [6]. UK government policy has consistently recognised that health differs by social groups and the previous administration proposed 'levelling up' parts of the country [7]. Addressing the root causes of health inequalities is rarely found in 'traditional' health services – such as hospitals and primary care [8], but demand work across various sectors and partners (local government, transport, voluntary and community sector, academia). Given the multifaceted factors influencing health inequalities, collaborative ways of working across sectoral boundaries seems a useful diagnosis to reversing poor health outcomes in certain communities. Indeed, most health issues are cross-sectoral in nature and embrace multiple policy arenas, organizations and professional groups [9]. These ways of working draw heavily on the notion of intersectoral collaboration, defined as:

"a recognised relationship between part or parts of different sectors of society which has been formed to take actions on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone." [10 3]

While not understating recent understanding of the benefits of intersectoral collaboration to improve health outcomes during the Covid-19 pandemic [11], evidence shows a concerning trend that

intersectoral collaboration to improve health has offered, at best, mixed results [12]. Indeed, some communities are not seeing improved health outcomes and, in some cases, inequalities between communities are growing in relation to life expectancy and morbidity [13]. Outcome evaluations have proved useful in increasing understanding of what works to tackle health inequalities [6] but fewer studies have provided an operational blueprint for partnerships or illuminated the processes underpinning success or failure in these collaborations [4, 14, 15]. In addition, where the literature has paid attention to process issues relating to intersectoral collaboration for improved health the focus has often been on health and social care partnerships, with less attention paid to partnerships addressing the social determinants of health [16].

A scoping review of international literature synthesised nine key components necessary for positive partnership processes in promoting health [17]. These included: aligned vision and goals between partner constituents; broad participation from a range of stakeholders; clear leadership; communication within the partnership and external messaging about the partnership; clear role structure and accountability; a balance of partner resources; creating a harmony between maintaining the partnership and 'producing' as a partnership; being mindful of the external context and how this can impact on the partnership; and evaluation of the partnership and its functions. Overlap with these nine components was observed in a recent study which sought to examine ten health promotion partnerships. The study identified the criticality of a shared mission to identify a common purpose and aligned partner-interests which would enable meaningful action [18].

Despite evidence showing the key ingredients for collaboration success, it also highlights why some collaborations fail to achieve their intended mission. In reality, partnerships are hard work to establish and maintain [19] and can be costly to sustain and establish [16]. Partnerships can fail because of "deep-rooted political, organizational and cultural barriers" [15, p.126] they also usually have limited ways to measure and evaluate progress [2], so objectively understanding why partnerships fail can be difficult to fully understand. Hubley et al. [20] suggests that partnerships in health promotion face challenges because of differing concepts of health promotion; values; visions and aims; and issues whereby smaller organizations get marginalised or 'pushed out' by larger ones.

Within the United Kingdom, the Health Determinants Research Collaboration (HDRC) is a programme which seeks to increase research capacity and capability within local government to understand health determinants and to improve health outcomes in communities [21]. This is not the first national attempt to address inequalities in the UK, with several policy initiatives and delivery mechanisms established to lessen poor health for communities [15]. The HDRC programme supports a number of local authorities who work with academic partners; voluntary and community sector organisations; decision-makers; and citizens to better understand health influences and to create conditions that will lead to improved health outcomes [22]. This paper focuses on the early implementation of the HDRC programme in one geographical area as well as the collaborative relationship developed prior to receiving funding and during the bid writing phase. There is a range of semantics related to collaboration and partnership

working that will not be rehearsed here [3]; however, it is worth noting the collaboration had clear contractual and financial stipulations bounding the actors and would encompass the following definition:

"a cross-sector, inter-organizational group, working together under some form of recognized governance, towards common goals which would be extremely difficult, if not impossible, to achieve if tackled by any single organization." [3 212]

In order to advance further understanding of the issues related to partnership working for the social determinants of health and in addressing some of the short-comings in the evidence-base, the data collection informing the paper had several key objectives, these were:

1. To explore the initial expectations of constituents working in a multi-sector collaboration.
2. To identify the facilitating and enabling factors which lead to successful collaboration between the statutory sector, voluntary sector and academic partners in addressing health inequalities.
3. To explore cultural differences in working practices between collaborators.

Methodology

Qualitative approaches were deemed to align consistently to the objectives of the study by enabling elucidation of the mechanisms of success and failure within the partnership. To facilitate this, semi-structured interviews with key partnership constituents were used to gather data with the rationale being that they enabled participants the opportunity to talk in detail and depth about their unique experiences in a confidential manner [23]. Data gathering was undertaken by two Research Assistants who were outside of the collaboration.

Sampling was critical to enable a broad-based understanding of the partnership, both in its inception (i.e. bid writing) and early execution of the collaboration post-funding success. Purposive sampling was used to gain in-depth understanding from participants best placed to provide insights into the programme [24]. It was critical to gain the perspectives of those working across a range of sectors in the programme. Eleven people were interviewed using a semi-structured interview schedule – participants represented a range of sectors including those working in local government; the voluntary and community sector; an elected political member; and academics. The interview schedule covered the expectations of working in a multi-sector collaboration; early successes and challenges; the benefits and barriers of working across sectors; and how sustainability of the collaboration can be maintained.

All interviews were undertaken via MS Teams and transcriptions generated through the software were checked for accuracy and to aid familiarisation. Three researchers independently coded an initial selection of transcripts to collaboratively develop a coding framework that could be consistently applied across the entire dataset. Codes were agreed and discrepancies discussed and resolved through discussion. Following recognised methods of thematic analysis [25], once coding had been undertaken across the data a process of thematic organisation and sorting took place. This involved aggregating

codes of similarity to form more coherent themes and conversely disaggregating codes which were too broad and unspecific.

Findings

This section presents five thematic areas deriving from interview analysis. Verbatim quotations have been used for illustrative purposes, but anonymised to protect participants' anonymity.

Dovetailing of skills

The strength that collaborative working can bring to tackling complex issues was a highly-salient issue across all of the data set. The notion that collaboration brings strength by offering a more holistic skill-set and network to tackle issues relating to health inequalities was unanimously noted. Each constituent recognised the assets of their own organisation, but also were frank about their weaknesses and deficits in addressing health inequalities. Those participants representing the local authority highlighted the strengths they bring as statutory providers and the responsibilities they have as an organisation to address public health. Conversely, there was broad acknowledgement that the organisation's links with communities could be stronger and moreover the best way to address this was through VCS providers who had established and trusted relationships with a myriad of communities:

"I think for me there's a credibility with the third sector that we [the local authority] wouldn't otherwise have. So, actually, if we want to talk to our residents and communities, the VCS are the people that do that day in, day out." (Participant 1, local authority)

Despite the VCS being lauded for their expertise in working with and alongside communities, these participants too recognised their limitations around generating, analysing, interpreting and optimising research evidence and sometimes having the political levers to make meaningful change. That said, this was compensated through academic and local authority partners being able to address this potential void:

"I guess one of our strap lines at [VCS organisation], unofficially, is that we are good at what we do, but we can't do everything, and we are only a part of the jigsaw." (Participant 4, VCS)

Overall participants were expecting to continue to learn from each other and find ways to 'dovetail' to maximise impact. They further recognised where the strengths and weaknesses of the constituents of the collaboration could be overlayed to ensure competence and expertise in strategic and operational delivery:

"I think the benefit that it brings is everybody can learn from each other. I am a big believer in people have expertise, knowledge, skills, and experience in their own fields, and I think by bringing people together from VCS, academia, and local authorities that everybody learns something from each other." (Participant 3, local authority)

Organisational history

It was suggested that a key element of potential success in the current collaboration was a previous track-record in working together and the organisational histories between constituent organisations. In this particular context, VCS colleagues had worked previously with the local authority and moreover the academic partners had previously had successful research bids and papers with the local authority. These past relationships provided some levels of confidence that future endeavours would be successful:

"You know we have risen to the challenge and because we've worked collaboratively over the last four or five years, we're open to challenge and scrutiny…So, I think we work very well together in that regard". (Participant 7, elected member)

There were, however, also examples where the organisational past could act as barrier for effective collaborative working and that some historical issues may have a deleterious impact in the short-term establishment of the group:

"Our VCS partners, they don't always like the Council. They've got some very understandable gripes about the council, particularly when we come in and tell them what to do." (Participant 1, local authority)

Embracing and reconciling cultural differences

There was a consistent view that each collaborative partner brought different cultural norms and practices which often were contrasting. Some of these differences surrounded timeframes for the delivery of activities relating to the collaboration and others on more practical issues, such as differences in renumeration and annual leave allowance. In terms of the former, each of the different sectors represented commented on how other organisations worked at differing speeds. Academia was often perceived to take too much time to deliver and that this caused difficulties in the local authority where often insight and findings were required quickly for decision-making:

"I think there is a different language between academia and the local authority, and the third sector and I think critically, there's often a difference in time scales, so I think academia, all the wheels turn quite slowly, and as I was saying it, you can perfectly well accept, can't you, that you start a research project and it might take two or three years and then you see some results at the end of it. Local authorities, I think, are used to and want to make decisions potentially quite quickly… 'can you tell us about the research evidence relating to this particular decision, and it is going to cabinet in six weeks' time'." (Participant 1, local authority)

The pace of delivery for the VCS however was suggested to be in stark contrast with a propensity to deliver quickly and achieve results. This, perhaps, is due to funding stipulations in the third sector traditionally being short-term and premised on expedient delivery and outcome success:

“In the third sector, partners at the moment seem to want to rush and get everything done yesterday because that's what they are used to….'Now get things done!' so you know, it is different ways of working, and how people, well what people are used to, which I guess relates to culture and practice.” (Participant 2, local authority)

“I think some members of the partnership maybe feel a little bit uncomfortable with the fact that we aren't doing a lot of delivery and their instinct is to move into the delivery, whereas I think the right thing to do is take the time, as I said, to really plan what we are going to do and get that shared understanding” (Participant 6, Academia)

A number of participants recognised that these differences in working speed and delivery could be potentially problematic as the collaboration matures:

“I think that a few tensions and conflicts are bubbling because people work differently, but I wouldn't put it as strong as conflict because I think we're still working it through. But we need to be careful that they don't become bigger issues than they need to be if that makes sense.” (Participant 4, local authority)

Operating in a political context

A discourse of shared power and collective decision-making was commonplace across the constituents:

“So I think a really important thing about this project is around kind of parity of esteem. Often, when universities work with local authorities and when volunteer organisations work with the local authorities, it's on a contractual basis. So, the power, the direction, and the control sits with the local authority, whereas because this is funded through a grant and everyone is partners on the grant, even though the grant sits with the local authority, it feels like the meeting of equals and the power has been shared relatively equally, and no one's voice is more important than the others and I think that could be a really important step change, in those types of relationships. It could provide a model for how we work collaboratively in the future.” (Participant 6, Academia)

Notwithstanding, the local authority were the lead organisation for the HDRC. This meant that other organisations needed to operate and understand the political nuances of local government and conform to the restrictions and limitations of working in this environment:

“The difficulty we have got as a local authority are the restrictions that come with that and we are a politically guided organisation, whereas universities and other partner organisations, such as health, volunteering, community sector, they have not got all that, I'm not going to say bureaucracy, but they've not got all those restrictions, so it will be interesting to see how can we remove them, by hearing other people's views and opinions and how they operate and their processes”. (Participant 2, local authority)

All organisations had elements of internal-flux, but with a focus on tackling health inequalities through local government decision-making it was clear that policy-cycles and political timing was going to be an

issue to consider for the collaboration. This both offered clear opportunities for advancing policy decisions, but also some constraints in managing political turnover and electoral successions:

"There will be at least two local elections during the time of this project, which means the elected members changing and people's recollections changing and things. So, I think that could be a challenge as well. I think that could be a really frustrating component of it as well. We'll be getting the elected members on board keeping them on board and getting them to appointment at the end of the project. They are using evidence and research in ways that they weren't doing previously." (Participant 6, Academia)

Expectation of outcomes

The data demonstrated a cohesive vision of the collaboration from all associated members and, in short, that was to improve lives for individuals and communities in the area. Nonetheless, this was viewed through a slightly different lens for each of the stakeholder groups. The VCS partners described the ability to eventually have programmes to deliver in communities that were more finely attuned to people's wants and needs and to continue to establish a firm and long-standing partnership with the local authority:

"Our aspirations are that we will get good quality information to help us deliver services that support people…which will then obviously help them in the long term in terms of health, wellbeing, their own aspirations." (Participant 4, VCS)

Local authority partners emphasised long-term sustainability of research funding and the increased capacity and capability of their workforce to utilise research – this would also extend to elected decision-makers who, in turn, would make better evidence-informed decisions about the population they serve:

"I'd like us to see that we are generating our own research, where there are gaps, and we are using the research that other people are doing. We're feeding that into our decision-making processes and because of that, we're making better decisions and things are changing, or at least we have the potential for change. So on a very, very simple two-sentence level, we are getting the evidence, we're feeding the evidence into decision-making processes and that is then translating into better decisions, policies and action." (Participant 1, local authority)

Academic partners stressed the importance of re-configuring perceptions of research in the local authority and particularly with VCS organisations. With the expectation that research was not to be 'feared' or seen as something that is exclusively done by those in academia. Academics also noted the need to publish and disseminate research to show academic and societal impact.

Discussion

Tackling health inequalities is complex and requires a wide-range of stakeholders working across multiple sectors to influence change [1]. Working in these ways, however, is challenging and many

collaborations fail to achieve the desired outcomes. This paper sought to understand process issues in a collaboration seeking to reduce health inequalities in a geographical region in the UK – such a contribution can inform future interventions and learning to enhance the likelihood of success. This study gathered the experiences of participants involved in the early set up of an HDRC – a programme which is centred around local government research capacity and development to understand health determinants and to improve health outcomes in communities (Hampshaw et al., 2024). Drawing on a range of constituents from different sectors in the collaboration, the study used qualitative approaches to explore expectations of working collaboratively and, overall, to explore how the initial working period had been perceived by participants.

The central understanding that the collaboration was seeking to address health inequalities was firmly understood by all participants and this shared vision offered a useful anchor for establishing shared comprehension of the work. Partnerships and collaborations have been seen as a panacea for tackling health inequalities and often regarded as providing a feel good factor through doing things differently [26]. They are, however, difficult and can fail [19]. While there was no evidence of failure in the collaboration under study, there were clear cultural differences between organisations which had the potential to manifest and hinder productive working. Differences in approach could be demonstrated in very practical ways – differences in annual leave entitlement amongst key individuals – but also in the pace of decision-making. On the latter point, the VCS was regarded as wanting to work more expediently than other partners and deliver early. This is unsurprising given the general trend for third-sector providers to be commissioned on short-term funding arrangements and achieving objective measures of success [27]. While some of these issues had begun to be apparent, it was clear that in the early phases of the collaboration they had not proved problematic. That said, other HDRC collaborations have suggested the necessity to align expectations and address cultural variances in the first year of the partnership; with this work considered a delicate process [28]. In terms of cultural difference, small and practical issues matter [26]. Differences in annual leave entitlement and working conditions are rarely discussed but can potentially manifest into challenging conversations if left unaddressed. However, the HDRC funding programme has significant longevity and it is apparent from other studies that issues can be reconciled within the timeframe [29].

The notion that the collaboration offered distinct benefits, with each organisation compensating for each other’s limitations was also apparent in the data. Other HDRCs have reported how learning from strengths within the team is critical in forming a strong partnership and understanding [29]. Recognising individual and organisational assets within collaborations seems an important first-stage in any collaborative endeavour. There is little empirical evidence currently about the VCS and their partnerships and relationships with other sectors, but in this study the VCS were regarded as an antidote to the more rigid and often bureaucratic statutory sector and seen as a trusted conduit to facilitate community access. Such characterisations of the VCS are not unusual in supporting the delivery of health interventions to disadvantaged communities [30]. Notwithstanding, the VCS themselves recognised limitations in capability and capacity for research and in identifying and implementing evidence-based interventions [30].

Effective policy-making is one of the key resources in improving public health, reducing health inequalities and fostering supportive environments [1, 31]. However, policy decisions can frequently be underpinned by political timeliness (based on perceived short-term opportunities and political preferences) or mandates from central government, rather than credible research evidence [31]. It was apparent that working in a political context would be essential for all of the collaborative partners given the focus on local government [32]. The notion of political timeliness was key and how this could contest research processes which could be slower to respond to immediate need [33]. University partners were seen to offer rigour in research and evaluation processes, but some concerns were raised about the timeframe for achieving this which might contest the pace of delivery required by local government. This is a tension that is becoming relatively well-recognised with research often regarded as a 'luxury' in local government and not embedded in daily practice. [29, 33].

The study provides some insight into processes of a collaboration working toward reducing health inequalities, but it is clear that such partnerships are dynamic and evolving. The cross-sectional qualitative design offered distinct benefits in providing timely assessment of the collaboration's working practices and to provide feedback to develop the cohesiveness of partners. It is anticipated that this will provide a foundation for future longitudinal exploration of the collaboration's maturity.

Conclusions

This paper sought to explore the initial expectations of constituents working in a multi-sector collaboration seeking to address health inequalities through the HDRC programme. Reflecting and learning on the process of bringing sectors together is an important, but often overlooked, area.

Subscribing to a 'shared vision' is a long-standing trope in collaborative working and one which is indeed critical for success [6]. While all partners had a slight difference in their 'road map' for success the shared endpoint was apparent and clear – to reduce health inequalities. Partners had distinct strengths which, when brought together, provided an holistic package that had the potential to effectively navigate the complex and wicked challenges posed by entrenched health inequalities. That said, tensions could potentially emanate between the constituents due to differing ways of working and accepted cultural norms. It is not unusual though for these tensions to be apparent in collaborative working, especially when bringing diverse sectors together [29]. There is a danger of "partnership working as a panacea and imbuing it with overly ambitious aspirations" [26: 821]. This particular HDRC remains in its formative stages and requires maturity in order to harness and maximise potential. Nonetheless the opportunity to dovetail skills and attributes of people and organisations to address health inequalities has great potential to improve population and community health.

Declarations

Ethics approval and consent to participate

All aspects of the study received ethical approval from Leeds Beckett university, School of Health. All participants consented to participate.

Consent for publication

All participants provided consent for publication.

Availability of data and materials

Data available on request from the corresponding author.

Competing interests

No competing interests.

Funding

Funding was provided by National Institute for Health and Care Research, NIHR158707

Authors' contributions

JW was responsible for writing the paper, designing the study, and obtaining ethical approval. He also played a significant role in the data analysis. FP and PD contributed to the data gathering and were actively involved in the analysis process. All authors reviewed the final manuscript.

References

1. Woodall J, Cross R: **Essentials of health promotion**. London: Sage; 2021.
2. Jones J, Barry MM: **Exploring the relationship between synergy and partnership functioning factors in health promotion partnerships**. *Health Promotion International* 2011, **26**(4):408-420.
3. Armistead C, Pettigrew P, Aves S: **Exploring Leadership in Multi-sectoral Partnerships**. *Leadership* 2007, **3**(2):211-230.
4. Willis C, Greene J, Abramowicz A, Riley B: **Strengthening the evidence and action on multi-sectoral partnerships in public health: an action research initiative**. *Health Promotion and Chronic Disease Prevention in Canada: Research, Policy and Practice* 2016, **36**(6):101.
5. Boydell L: **Partnership framework: a model for partnerships in health**. In. Dublin: The Institute of Public Health in Ireland; 2001.
6. Cross R, Woodall J: **Green & Tones' health promotion: planning & strategies**. London: Sage; 2024.
7. Fransham M, Herbertson M, Pop M, Bandeira Morais M, Lee N: **Level best? The levelling up agenda and UK regional inequality**. *Regional Studies* 2023, **57**(11):2339-2352.
8. Woodall J, Morley L: **Health promotion: reconfiguring nurses' practice to reduce social inequalities**. *Nursing Standard* 2024, **39**(4):47-50.

9. Perkins N, Hunter DJ, Visram S, Finn R, Gosling J, Adams L, Forrest A: **Partnership or insanity: why do health partnerships do the same thing over and over again and expect a different result?** *Journal of Health Services Research & Policy* 2020, **25**(1):41-48.
10. WHO: **Report of a conference on Intersectoral Action for Health: a cornerstone for health-for-all in the twenty-first century, 20-23 April 1997, Halifax, Nova Scotia, Canada**. In.: Geneva: World Health Organization; 1997.
11. South J, Woodall J, Stansfield J, Mapplethorpe T, Passey A, Bagnall A-M: **A qualitative synthesis of practice-based learning from case studies on COVID community champion programmes in England, UK**. *BMC Public Health* 2024, **24**(1):7.
12. Judge K, Bauld L: **Learning from policy failure? Health action zones in England**. *The European Journal of Public Health* 2006, **16**(4):341-343.
13. Marmot M, Allen J, Boyce T, Goldblatt P, Morrison J: **Health equity in England: The Marmot review 10 years on**. In. London: Institute of Health Equity; 2020.
14. McGill E, Marks D, Er V, Penney T, Petticrew M, Egan M: **Qualitative process evaluation from a complex systems perspective: a systematic review and framework for public health evaluators**. *PLoS medicine* 2020, **17**(11):e1003368.
15. Evans D, Killoran A: **Tackling health inequalities through partnership working: Learning from a realistic evaluation**. *Critical Public Health* 2000, **10**(2):125-140.
16. Smith K, Bambra C, Joyce K, Perkins N, Hunter D, Blenkinsopp E: **Partners in health? A systematic review of the impact of organizational partnerships on public health outcomes in England between 1997 and 2008**. *Journal of public health* 2009, **31**(2):210-221.
17. Corbin JH, Jones J, Barry MM: **What makes intersectoral partnerships for health promotion work? A review of the international literature**. *Health promotion international* 2018, **33**(1):4-26.
18. Holt DH, Aveling E-L: **Achieving partnership synergy: resource inputs, shared mission and interdependencies in Danish health promotion partnerships**. *Health promotion international* 2023, **38**(1):daac203.
19. Wildridge V, Childs S, Cawthra L, Madge B: **How to create successful partnerships—a review of the literature**. *Health Information & Libraries Journal* 2004, **21**:3-19.
20. Hubley J, Copeman J, Woodall J: **Practical health promotion**, 3rd edn. Cambridge: Polity Press; 2021.
21. Hampshaw S, Morling J, Black M: **Investing in research infrastructure to address health inequalities: Learning by doing**. *Public Health in Practice* 2024, **7**.
22. **Health Determinants Research Collaborations** [https://www.nihr.ac.uk/explore-nihr/support/health-determinants-research-collaborations.htm]
23. Adeoye-Olatunde OA, Olenik NL: **Research and scholarly methods: Semi-structured interviews**. *Journal of the American College of Clinical Pharmacy* 2021, **4**(10):1358-1367.
24. Patton MQ: **Qualitative research & evaluation methods: Integrating theory and practice**. New York: Sage; 2014.

25. Braun V, Clarke V: **Successful qualitative research**. London: Sage; 2013.
26. Dickinson H, Glasby J: **'Why Partnership Working Doesn't Work'**. *Public Management Review* 2010, **12**(6):811-828.
27. Harradine D, Greenhalgh K: **LinkAge Plus: lessons for third sector organisations and commissioners**. *International Journal of Public Sector Management* 2012, **25**(5):391-403.
28. Newbury-Birch D, Harbin K, Adamson A, Asthana S, Batey C, Buffardi AL, Curley J, Dezateux C, Divers A, Fitzsimmons E: **Establishing Research Ecosystems in Local Government: Ten lessons from the front line of the first year of the NIHR Health Determinants Research Collaborations (HDRCs)**. *NIHR Open Research* 2024.
29. Holding E, Gettings R, Foster A, Dowrick L, Hampshaw S, Haywood A, Homer C, Booth A, Goyder E: **Developing the embedded researcher role: learning from the first year of the National Institute for Health and Care Research (NIHR), Health Determinants Research Collaboration (HDRC), Doncaster, UK**. *Public Health in Practice* 2024:100516.
30. Bach-Mortensen AM, Lange BCL, Montgomery P: **Barriers and facilitators to implementing evidence-based interventions among third sector organisations: a systematic review**. *Implementation Science* 2018, **13**(1):103.
31. van de Goor I, Hämäläinen R-M, Syed A, Juel Lau C, Sandu P, Spitters H, Eklund Karlsson L, Dulf D, Valente A, Castellani T *et al*: **Determinants of evidence use in public health policy making: Results from a study across six EU countries**. *Health Policy* 2017, **121**(3):273-281.
32. Homer C, Woodall J, Freeman C, South J, Cooke J, Holliday J, Hartley A, Mullen S: **Changing the culture: a qualitative study exploring research capacity in local government**. *BMC Public Health* 2022, **22**(1):1341.
33. Woodall J, Homer C, South J, Cooke J, Holliday J, Mullen S, Stafford B, Freeman C, Hartley A: **Evidence-based decision making in a climate of political expediency: insights from local government**. *Perspectives in Public Health* 2024.