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Get Britain Working: qualitative evaluation of a policy for work and health at early implementation sites

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Research Article

Keywords:

Posted Date: October 21st, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11121378/v1

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Additional Declarations: No competing interests reported.

Abstract

Background

Economic inactivity, defined as people of working age who are not employed, seeking work or able to work in the short term, is a growing concern in many countries. A significant contributing factor to this inactivity appears to be ill health. In England, a government policy known as ‘Health and Growth Accelerators’ is being piloted in three regional health systems, called NHS Integrated Care Systems (ICSs), in the North of England. The programme aims to reduce economic inactivity, identifying effective approaches that could later be expanded nationally.

The core strategy of Health and Growth Accelerators is to identify people at risk of becoming economically inactive due to health conditions impacting their health and well-being. The programme then delivers interventions (either targeted at individuals or employing organisations) to better support those with health conditions and to help them remain in or return to work. Initial funding for the three pilot ICS sites was provided for 12 months, after which programme performance and impact were reviewed to inform decisions about continued investment.

Methods

Our study evaluates the initial implementation of Health and Growth Accelerators at the three sites. We conducted interviews with a range of key stakeholders at each site to understand the factors that supported or hindered effective implementation.

Results

Our findings indicate that integration and collaboration with existing local work and health-related programmes are important for successful implementation. However, short timescales and pressures to scale up quickly have posed challenges for integration, in terms of developing working relationships, engagement with the target cohort and staffing of the programme at all sites.

Conclusions

Our analysis suggests that the programme operates in a context that is both ‘high ambiguity’ and ‘high conflict’. This means that the uncertainties associated with the programme and the potential for inter-organisational conflicts may impose limits on the pilot approach. Overall, the combination of uncertainty, short funding cycles and performance timescales associated with policy piloting may constrain attempts to develop sustainable complex large-scale programmes aimed at addressing economic inactivity linked with poor health.

Introduction

Economic inactivity is defined as working age adults who are not working, seeking or available to work (1), which represents a growing global challenge (2). The number of people in the UK economically inactive because of long-term sickness has risen to over 2.5 million since the start of the pandemic (3), with 53% reporting mental health issues (3) and the second most common cause musculoskeletal (MSK) issues (1). This is part of a worldwide trend of declining labour market participation since 2000 across all regions (2). Health issues may be exacerbated by certain industries (e.g. agriculture or construction), limited access to work-based occupational health support (4), inadequate employer support, and waiting lists for elective healthcare (3).

Get Britain Working

The 'Get Britain Working' white paper (5) aims to address economic inactivity. It developed out of the Pathways to Work commission (6) and Additional Work Coach Support pilots (7) among other initiatives.

The policy we address in this paper, Health and Growth Accelerators (hereafter 'Accelerators') aims to reduce health-related economic inactivity in three Integrated Care Systems (ICSs) in England. ICSs cover between 500,000 and 3 million people, with their constituent 'places' serving smaller sub-populations of 250,000 to 500,000 people (8). Accelerators aim to test policy that intends to reduce health-related economic inactivity by working with individuals and with employers to tackle a variety of issues and to experiment with new ways of working that can inform further policy roll out (9). ICSs had significant autonomy over their approach and able to draw on multiple service providers within NHS, local authority, VCSE and private sector organisations to provide interventions. Support could involve individual interventions to address risk factors for economic inactivity, as well as wider organisational interventions directed at employers, such as improved occupational health and cultures of 'good work' (5). The concept of 'good work' was central to engagement with employers, defined broadly as secure, stable, inclusive, fairly-rewarded, providing purpose and progression, valuing diversity and voice and building positive relationships that enable people to thrive (10).

While the National Health Service (NHS) receives policy direction from the government departments NHS England (NHSE) and the Department of Health and Social Care (DHSC), employment-related support is provided primarily through local government under the direction of the Department for Work and Pensions (DWP). Bringing economic inactivity within the NHS remit to create a dual focus on 'health and work' was a new development.

Accelerator pilots took place against a backdrop of a challenging public spending environment, with particularly large and growing deficits in the NHS (11). In this context, Integrated Care Systems were expected to cut their staffing by 50% (12).

Health and Growth Accelerators

Accelerators are underpinned by evidence that the likelihood of a person being unable to return to work increases with the time on sick leave (13). They assume that it is possible to intervene to prevent individuals from leaving employment because of health issues.

Figure 1 shows the generic model for the Accelerators. All sites targeted patients thought to be at risk of economic inactivity, and two of the three sites also targeted a sub-population of health and care staff. In all sites, individuals in the wider population cohort were invited to take part in the programme via various referral routes, and a 'work coach' matches them with suitable tailored, personalised support. Sites were each assigned a target reduction in economic inactivity (950, 1300 and 2,000 people).

The programme provided funding to ICSs from November 2024, with a projected 'go live' date for delivery of interventions in April 2025 and initial funding until the end of March 2026, when performance was to be reviewed to inform decisions about future funding. Within this time window ICSs were required to plan, establish governance structures for and contract services providers to meet the policy objectives, and begin to deliver services to their target cohorts.

Providers of existing interventions known to be effective for specific health conditions were in some cases commissioned to expand activity. Other existing interventions were adapted to the programme's needs, and new interventions were sought, including digital therapeutics, such as mental health support via an app.

The 'programme theory' for Accelerators embodies uncertainties that piloting is intended to test; namely whether it is possible to accurately identify people at risk of economic inactivity, whether services can engage with them, and whether subsequent interventions do prevent economic inactivity. The scale of the economic inactivity challenge makes this a complex policy space, with other 'work and health' programmes led via local authorities under the direction of the DWP also implemented at the same sites. These included Connect2Work, Economic Inactivity Trailblazers and WorkWell, which have some similarities with Accelerators but differ in terms of scale, target populations and types of interventions. All these programmes were introduced between October 2024 and April 2025.

Policy piloting involves testing new approaches to 'wicked' problems rather than executing a pre-designed solution (14). It allows for innovation and experimentation with different options, allowing an approach to emerge that is grounded in practice and reflects local implementation contexts. Policy pilots are therefore inherently limited in scale in terms of time and reach and epitomise project organisation as a method of control manifested in time-bound activity and milestones, that sits outside of 'business as usual' activity (15).

Like other public policy pilots that have sought large-scale transformation of how services are organised, Accelerators entail changes at multiple levels, across whole health systems and nested relationships across different NHS organisations and geographies. Additionally, Accelerators extend beyond healthcare and encompass diverse organisations, including public and private sector careers and

employment coaching services, voluntary community wellbeing champions (via local authorities), SME employers and digital therapeutics vendors.

Inter-organisational relationships such as these are the domain of governance, that is the structural arrangements through which individuals and organisations coordinate activity(16). For the purposes of this paper this includes the leadership of the programme, assigning responsibilities for different elements, lines of accountability and escalation points, forums for decision-making within the ICS and between the ICS and non-NHS organisations, assurance and contracting arrangements, data collection and evaluation, and new processes established by the programme to identify, engage and support or treat the target cohorts.

In this paper we focus on the factors influencing the set-up of Accelerators, recognising the importance of ‘attending to history’ in large-scale transformation (17) and acknowledging the contexts of implementation, including the relationships, power dynamics and micro-politics of individuals and bodies involved (18).

Our paper aims to investigate how Health and Growth Accelerators were implemented in the three pilot sites and the barriers and enablers to implementation. In so doing we aimed to understand their prospects of success and implications for scaling and wider implementation at other sites.

The sites and the evaluation

Methods

This paper draws on qualitative data from the first phase of a larger multi-site mixed methods evaluation. Within this the quantitative work package aims to investigate whether Accelerators demonstrate comparative improvements in health outcomes and economic inactivity. The research question we address in this paper is: what are the barriers and enablers to implementation of Accelerators?

In our study each site is an Integrated Care System (ICS), pseudonymised as sites A, B, and C. For this first phase of the evaluation, we considered sites’ approaches to meeting programme objectives in terms of identifying people at risk of falling out of work and the approach to introducing new service interventions and support pathways for those identified as ‘at risk’ and/or out of work for health-related reasons.

NHS England, the government department that commissioned the evaluation, facilitated the study team’s contact with key stakeholders in the sites’ programme teams. The study team also asked those key stakeholders to facilitate contact with further programme stakeholders. Participants included programme leads, programme roles involving communications, research, and population health, leads

for elements of the programme, such as mental health and digital interventions, VCSE infrastructure organisations and key stakeholders in parallel local-authority-led work and health programmes.

The paper analyses qualitative data collected through interviews. This was supplemented by notes from meetings and workshops with NHS England and participant sites, including their own research and evaluation teams. In this way our approach recognises that policy evaluation is a highly political and interactive part of the larger policy process (19), in which ongoing engagement with the different 'communities of interpretation' complemented the study team's emergent understanding of the various meanings given to Accelerators.

The three participant sites were centred on city regions in the North of England, with Site A also encompassing a large rural geography. Semi-structured interviews were conducted with 27 key stakeholders involved in implementing Accelerators at each site (site A n=12, site B n=8, site C n=8). The sites' characteristics in relation to health services and economic inactivity are shown in Table 1.

Table 1. Site characteristics

	Site A	**Site B**	**Site C**
Estimate of population inactive due to health in 2025[1]	165,805	108,635	78,970
% of adult population	9.1%	7.3%	8.9%
Total population	3005,519	2429,755	1392,105
NHS healthcare providers	494 GP practices 48 hospitals	402 GP practices 22 hospitals	260 GP practices 9 hospitals

Source: NHS South Central and West, 2025 (20)

Analysis

Cross case thematic analysis (21) was conducted by MG through manual coding. It focussed on how sites planned to fulfil their brief for implementing Health and Growth Accelerators, which organisations were involved, the extent of tailoring to local contexts, the key health issues focussed on in each ICS and any variation in approaches across their localities. The evaluation of the implementation of the Accelerators will be followed by a further programme delivery evaluation.

In the first instance high level codes derived from the literature on health policy implementation, the Health and Growth Accelerators policy documentation and the research question were applied to the data, covering: governance, relationships, population health management, introduction of digital therapeutics and patient engagement. These codes were agreed with the wider study team. Within these themes, MG and PB then examined and iteratively refined the coding in relation to respondents' reports of barriers and enablers of implementation at their sites. The study team then considered the implications of these findings for implementation of complex system transformation in the context of policy piloting.

We present our findings below, related to how the sites approached the policy implementation, what facilitated and hindered these processes, and any differences between sites.

Findings

Our findings themes related to stakeholders' knowledge, the alignment of related programmes, governance and data-led approaches represented both barriers to and enablers of Accelerator implementation across the three sites and are outlined below. We go on to discuss how these intersect with the characteristics of policy piloting as an approach to policy-led change.

Knowledge and experience of work and health

Sites' experiences of making previous funding bids related to health and work and of programmes that could be considered forerunners of Accelerators were a significant facilitator of implementation. For example, Site C had recently been commissioned to investigate the causes of high economic inactivity in one of its geographical areas. Sites A and B had prior experience of bidding for funding for work and health initiatives. These experiences had facilitated what was characterised by sites as a necessary shift in 'mindset', especially within health and care organisations, to recognising the inter-relationships between health, under-employment and quality of work. *It's a massive mindset shift for health, this is, because we don't normally do that...N27od Site C*

However, in terms of the knowledge necessary for planning Accelerator implementation, the landscape of existing activity related to health and/or work was complex. All sites had a range of services and organisations already supporting people with aspects of work and health, including NHS, private and VCSE sector providers and wide variation in types and scales of provision of interventions across different localities. This was most pertinent in Site A, which had a large geographical footprint. Site B had embraced the variation, electing to devolve budgets to its five constituent 'places', allowing them to make decisions on provision of interventions based on local needs and providers. The interventions offered are highly heterogeneous and address a spectrum of health issues including physical and mental health, women's health, support for carers, and also employer-focussed interventions, reflecting the diversity in the health and work issues that Accelerators seek to address. Sites differed to some extent in which specific work and health issues were included in their suite of interventions, for example, with site

C promoting support for neurodiverse young people and Site C aiming to support working carers. While the types of interventions to be included were part of each site's core design, variation in provider availability meant that sites offered the same or similar interventions via different providers across their localities. VCSE sector organisations, often comparatively small and hyper-local, were often selected as providers, in part due to their ability to mobilise quickly. Understanding this landscape within short timescales was challenging, comprising a substantial element of the implementation work required.

Getting your heads around the actual scale of the programme, the responsibilities within it…was a little trickier. N26nn Site C

ICS' understanding of the landscape of work and health activity involved grasping existing interventions in their areas and the nature of health initiatives being led by their local authorities through engaging with them. This was important to avoid duplication of effort and targeting of the same individuals or groups by different programmes. ICS programme teams also needed to draw on expertise and networks in local authorities related to employers and employment.

[The Integrated Care Board] is the accountable body for the Accelerator. However, very early on, we recognised that we couldn't approach one of these three [separate work and health] programmes in isolation and instead, we needed to really think about all three programmes in a really integrated way. N18yj Site B

Alignment of programmes

The overlap of Accelerators with other work and health programmes generated an underestimated proportion of the implementation work. The requirement for ICSs to align with existing programmes and activity related to work, employment and health made it necessary for them to work in partnership to implement Accelerators and to partner with the VCSE sector for services delivery.

The complexity of the programme is probably one of them that was tricky initially for not just me but for other people trying to understand the interplay between Growth Accelerator, Trailblazer, Pathways to Work, and other work-related programmes that are taking place. As you mentioned, some pieces are being run through the mayoral combined authorities. N26nn Site C

These partnerships lent significance to respective relationships and invoked existing inter-organisational micro-politics, including power asymmetries, organisational jurisdictions and traditional areas of knowledge and control. This arose not least from the government award of funding and ownership of the Accelerators to NHS Integrated Care Systems despite local government's ostensibly greater knowledge and experience in employment support, occupational and public health and in addressing the 'wider determinants' of health, which are central to the policy. In this respect, some respondents questioned the rationale for ICSs leading Accelerators, which brought tensions in terms of remit.

I couldn't understand why it was being done through the NHS rather than the local authority. Given that the whole mantra of the reason why health went into the authority was around the wider determinants. And nobody really, kind of, explained or, you know, there wasn't any reasoning behind why the funding was going through that way. You know, people have made it work, and actually there's some really good practice and, you know. But that was one of my first thoughts, was, was the ICB set up to do this type of work? N16vm Site A

Good existing relationships between ICS, local government, VCSE sector and other organisations were reported to have supported Accelerator implementation. Mutual goodwill and a willingness of partners to work together facilitated the set-up of shared governance across parallel programmes at our sites and meant that stakeholders did not have to convince others of the value of involvement with the Accelerators.

At strategic level we've got good relationships for the most part that enables us to have quite honest conversations. And it feels like ambition is quite well aligned, which I think is probably helped by the, again, by the pathways to work commission, it's set out quite a clear roadmap for us. So, it feels like we're already all travelling in the same direction. We've got really supportive political leaders. So, that, yeah, that helps; it means you're not constantly having to, you know, fight the good fight to get people onboard. N28pf Site C

Collaborative inter-organisational relationships rested to some extent on the continuity of key staff, and therefore working relationships within public services in their regions, which was seen as an advantage. However, it was also acknowledged that ongoing ICS and local authority restructuring at the time of implementation might threaten such relationships.

Within the ICB, I think it's just the goodwill of people. People are really bought in, they're really passionate, everyone's doing this on top of their day jobs. Everyone's doing this, you know, we're about to have a hammer down on us to say half of us are made unemployed in a week's time…So, that's really good, that's the main enabler, people wanting to do this, wanting to do good, knowing that it's a good thing to do. N08nd Site C

At all sites, while establishing collaboration between ICSs and local authorities was considered a success, it brought the distinct cultures and ways of working of partners into play. Differences between ICS and local authority expectations, timelines and prioritisation of Accelerators generated tensions that reflected governance challenges in making respective responsibilities and lines of accountability for collaborative work explicit.

We had expectations that [local government body name] would undertake some elements of the work, for example, testing the [programme] identity with interested groups, public groups, and that didn't happen. If we'd known that that wasn't going to happen to the extent we thought it was going to happen, we would have picked up that task ourselves. But by the time it became clear it wasn't going to happen, it was too late for us to do that…I feel that we're still in a situation where it's not entirely clear who is actually leading this and who holds authority and accountability. N05fs Site B

There was recognition that developing trust and shared understanding of different ways of working between partners would take time.

They operate very differently to us…they don't understand what we're doing and I don't understand what they're doing… so we end up with quite a lot of trickiness, because we probably didn't invest enough time in the beginning understanding how we should operate and get that clear between us. N27od Site C

It was determined during implementation that it would make sense to integrate Accelerators with local authority-led work and health programmes, such as Trailblazers, in the long term to avoid confusion for patients.

My worry was that they'd all be trying to contact the same people, and the person would be getting contacted by many different work programmes. N16vm Site A

Sites had aspirations of taking a 'no wrong door' approach that would allow people in the target cohort to take multiple routes into the most suitable programme for their needs and circumstances. However, programme integration was not part of the brief for Accelerators, therefore some misalignment was incorporated from the start, creating additional work for all programmes in their attempts to align programmes. This included Accelerators and other programmes having to report different datasets. More fundamentally, the ICS could access health data as a means of identifying a cohort, local authorities could not and had to take different approaches to recruitment.

Frustration arose from partners working 'for two different masters' meaning that Accelerators and related programmes experienced mismatched requests and expectations from government departments; NHS England, who they are usually accountable to, and DWP.

We were having to work, you know, like, answer to two different masters and work within two different systems and two different... So, a big frustration for us as we were working through that was there was no alignment between, like, DWP expectations and NHS England expectations, and there was no alignment of deadlines and things like that. N28pf Site C

Governance

To implement Accelerators, sites had to rapidly establish governance structures for decision-making about planning and delivery. This involved mobilising support within the ICS in the first instance, for which senior support within both the ICS and the local authority was considered significant in making Accelerator implementation a priority. This was particularly important in terms of professionals being able to reprioritise existing workloads to free up capacity for Accelerators.

Some of the asks aren't given enough notice, considering the…how busy everybody is and how much pressure everybody's under even without this work, so obviously adding this work on top of that. N12px Site B

Respondents were unequivocal about the enabling role of robust governance for the programme, including joint meetings and forums for decision-making, boundary-spanning roles and establishing structures for communication between partner organisations. These helped to operationalise working relationships and supported knowledge-sharing between the ICS and local authorities.

One of the most important things over the last few months has been setting up shared governance. That's been quite fundamental, I think, for setting foundations of how we work together on these three programmes. N18yj Site B

In implementing the programme, the speed of mobilisation demanded by the initial 12-month timelines impinged on the recruitment of expertise and on provider contracting. VCSE sector providers were critical to sites being able to respond rapidly to the needs of the programme by providing many interventions because they were considered more flexible than statutory providers and could deploy interventions more rapidly 'off the shelf' or through adapting existing work. On the other hand, digital therapeutics interventions had to go through more conventional procurement processes, including being assessed for potential value to the programme, though strong links between ICS and their health innovation networks were reported to have facilitated timely technology assessment and assurance. Short timescales were problematic for engaging specific governance-related expertise to enact procedures such as data sharing agreements in a timely way, and this introduced delays.

The one-year funding thing didn't take into account that each organisation, the NHS or Integrated Care Board and the combined authority had themselves an awful lot of governance to get through. N18yj Site B

The programme's timelines impinged on the scope for sites to engage in more comprehensive design of their approaches, including because they were unable to fully explore provider and intervention options, so that they tended to approach organisations already known to them. Timescales also limited patient and public involvement in the design, which respondents noted may compromise effectiveness in terms of understanding of how to engage the target cohort. This was particularly a concern for populations at highest risk of economic inactivity and poor health, and especially in relation to digital therapeutics.

There is a risk that again, the pressure of getting people through and showing it's worked, we might end up with…the low-hanging fruit of the people in the least deprived areas. And that actually the people we really want to get in this programme are the people in the most deprived areas, but they don't engage or sign up via this route, would be my difficulty with this. And again, that's come from the pressure from about that we have to make it work…and therefore I think we'll be forced to go with people who actually need a lot longer to engage and get invited, and we've just not been given that time to make sure we can target those communities. We're trying to go with deprivation first, which is part of our cohort. If they're going to take a couple of months to warm up, then the group of people that may be from the least deprived who just sign up and go through. N08nd Site C

The short programme timescales in combination with funding decisions being reliant on Accelerators' performance generated pressure on ICSs to evidence their impact on economic inactivity. In this respect

there was ambivalence expressed about whether effective interventions that had previously lost funding could be resumed as part of Accelerators if they could produce more reliable impact, while possibly not meeting the innovation imperative.

On the one hand we were running these really high impact pre-employment programmes across [Site B] and then that funding has gone. So, some of this and I think this has been a bit of a challenge, has been to see, are we actually genuinely delivering new things with this Accelerator or are we plugging gaps that we didn't have before but all of a sudden have…N04wz Site B

Data-led approach

A population health data-led approach to the Accelerators was encouraged by NHS England. Systems' access to GP records made it possible for the sites to identify a target cohort and to track some health-related outcomes of the programme as well as supplying the minimum dataset stipulated by NHS England for sites to collect. This access allowed them, with some input from general practices providing the data, to search patient records for patients in receipt of multiple GP 'fit notes' within a 12-month period, which served as a proxy for the risk of falling out of work. GPs and other healthcare providers could also refer patients into the Accelerator programme at Site C, introducing wider discussions of patients' work circumstances into primary care. However, using such a proxy provided an uncertain basis for identifying an 'at risk' cohort and did not guarantee that sites would be able to recruit them. There was no equivalent access to health data for local authority-led work and health programmes.

I know that the ICB are wanting to specifically target individuals via data, so its very data driven. We [the local authority organisation] have sort of levels of deprivation, but it's not personalised, so we don't have access to personalised data…we have to rely on our providers or us as an organisation raising awareness of the benefits of these services that we do commission. N22tl Site A

Reliance on population health data for recruitment and evaluation, and associated challenges around rapid mobilisation of information governance expertise was exacerbated by reduction of ICS staffing at the time of Accelerator implementation entailed losses of expertise.

The programme funder's need to evaluate and compare sites' performance required that sites collect a dataset. It included metrics focussed on programme outcomes, including referrals, referral source, programme starts and completions, and numbers 'kept well and in work' and 'supported to return to work'.

Discussion

Our study had four principal intersecting findings. First, knowledge of the work and health context was a key enabler of the programme. Second, integration with parallel work and health programmes under separate leadership took on outsized importance. Third, establishing governance was a key enabler for

sites, providing a structure to support the partnership working required. In this context establishing system-wide governance for programme delivery and collaboration was successful, however, a data-led approach, understanding of a complex landscape and working relationships with multiple stakeholders made integration challenging. Finally, these challenges were compounded by the time frame allowed for piloting, which also undermined attempts to develop new ways of working.

Accelerators as would-be infrastructures

The commissioning of services to provide people with support for issues related to work and health operationalise the innovation sought by Health and Growth Accelerator policy. However, given the transformational imperative, arguably the more significant innovation is development of infrastructure for multiple sectors and bodies at different levels to work together to implement policy that demands collective expertise and shared responsibility.

Infrastructures are, by definition, intended to be long-term and future-oriented because they provide platforms for other activity, embodying durable social and organisational arrangements (22). In this context, our study found that establishing robust governance and building on existing knowledge and partner relationships were important foundations for implementation. Interventions have little value in isolation and can only be effective within the context of a set of processes that identify, recruit and match people who have employment and health-related needs with tailored support and with interventions. Unlike many policy-led changes, these processes cut across multiple sectors and demand significant ongoing coordination between providers, programme teams, local authority partners, primary care, work coaches, employers, and target cohorts.

Policy paradox - innovation versus impact

The function of policy pilots in enabling experimentation(9) is seen, in our findings to be manifested in Accelerator sites testing new interventions and infrastructures for collaboration. Sites' need to determine the effectiveness of interventions in reducing economic inactivity entailed compromises between the scope for innovation and the need to demonstrate impact in short timescales. This encapsulates the policy paradox at work, in which the very mode of piloting as an approach to implementing policy can clash with policy objectives (15). In this respect, tensions between the demand for innovation and the longer time horizons of infrastructure-building (23) may favour more discrete, standalone forms of innovation in Accelerators, such as digital therapeutics, rather than the less visible building blocks of deep-seated change.

Large-scale system change, of the kind that Accelerators aim for, brings associated inter-organisational relationships into play, particularly in terms of demands for collaboration between different organisations and/or sectors with different interests (24). Micro-politics surfaced especially where ICSs had no formal authority to direct the action of partners (18) and had to rely on mutual goodwill. In this context, the alignment of programmes and the requirement for mutual understanding of partners'

operational priorities and how they are managed demand development of trust and relational working that take time (24, 25).

While Accelerators are based on the notion of personalised, relationship-based support, restricted timelines also limit the capacity to engage with and support individuals with whom such processes may take longer. This includes subsets of the target cohort such as those for whom English is not their first language and the digitally excluded. In this respect, the pilot programme tends to seek easier to support patients - 'low hanging fruit' - for the purposes of demonstrating what works. This means that while ostensibly aiming to test new ways of working, and an implied goal of 'transformational' system change (5), the programme, certainly as a pilot, nonetheless perpetuates the search for 'quick wins'. What works with easier to engage populations may not work with those who most need support, and the programme may need to adapt to take account of diminishing returns.

Our study sites' implementation challenges, arising from the intersection of short programme timescales, a complex policy problem and the necessity of multi-stakeholder collaboration, point to Accelerators being characteristic of what Matland (1995) (26) refers to as a 'high ambiguity' and 'high conflict' policy. It is high in ambiguity because of their multiple uncertainties, including whether they can identify people at risk of falling out of work, whether people will take up the interventions offered and whether various targeted health-related interventions can prevent people from falling out of work. Accelerators are susceptible to conflict due to the need for alliances that support effective joint working between different organisations in circumstances that invoke power asymmetries and culture differences (25), for example in terms of the relative lack of power of VCSE sector organisations compared with public sector bodies (27).

Given this work has taken place against the backdrop of a reduction in ICS headcount (12), capacity was challenged, with an expectation that staff work 'over and above' and a demand for rapid reprioritisation of staff resources. In these ways projectified work can affect staff wellbeing and the sustainability of programmes (28) and as such, notions of 'good work' (29) that are promoted by the Accelerator policy may not necessarily be modelled by the programme itself. This issue recognises that policy is not developed in a vacuum but within existing cultures, ways of working and systems of decision-making that are rarely scrutinized as part of the policy process (30).

Conclusions

Our evaluation suggests that piloting as an approach a poor fit for the relational demands of policy when there are short timescales (15). The implementation of a 'high ambiguity' and 'high conflict' policy via piloting entails work to reduce ambiguity and/or conflict, for example through collective processes of social learning between stakeholder organisations (15). However, consistent underestimation of the relational demands of policy piloting means they are not accounted for in time or resources and may produce static policy that quickly becomes obsolete (31). In the context of health-related economic inactivity as a long-term policy dilemma, the sustainability and scaling of Health and Growth

Accelerators may benefit from consideration of mechanisms, such as periodic multi-stakeholder reviews, that can support their adaptation to highly uncertain and changing environments (31).

Strengths and limitations

Our study provides insight into how Health and Growth Accelerators may perform in delivering on the policy aims and what is important to consider in implementing the programme at other sites should the policy be extended. We contribute to theory on policy piloting by considering the implications of policy implementation that entails system-wide infrastructure building. Conceptualising Accelerators as would-be infrastructures means not only a need to take a longer-term perspective on policy implementation but also using approaches that recognise and embrace their inherently multi-stakeholder character. Taking this perspective highlights a need to factor in exploratory forms of engagement and knowledge exchange that can support future demands for system-wide collaboration. In this respect, the capacity of the programme to have an impact on health-related economic activity depends on effectively addressing those wider determinants and will take greater time the more health inequalities are implicated.

The study is limited in so far as the findings are based on a snapshot at the time of our evaluation of how Accelerator sites were managing programme implementation, which was continually evolving. The small number of interviews resulting from the finite numbers of key stakeholders involved in the implementation was also a limitation. This will be mitigated by the study team's planned evaluation of the *delivery* of Accelerators.

By considering the practices and characteristics of policy piloting we contribute insights related to addressing a complex cross-cutting policy issue in the context of a policy paradox. Nonetheless, the pilots enabled initial development of the system-wide infrastructures necessary for Health and Growth Accelerators. They will require a long-term perspective that allows Integrated Care Systems to build adaptive ways of working with public health partners and engagement with the populations who most need support.

Declarations

Author Contribution

MG collected and analysed the data, prepared the article draft and edited the draft in response to team feedback. KS reviewed the original draft and proposed edits. RM reviewed the original draft and proposed edits. KM reviewed the original draft and proposed edits. PB conceptualised the study, supervised the study, acquired funding, reviewed the original draft and proposed edits and approved the final manuscript.

Acknowledgement

The study was funded by the National Institute for Health and Care Research (NIHR), Reference: NIHR163715 Rose-NET: Manchester-Leeds Collaborative National Evaluation Team.

Data Availability

The data used and/or analysed during the current study are available from the corresponding author on reasonable request.

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Footnotes

1. Extrapolated from ONS data from 2023 and 2024

Figures

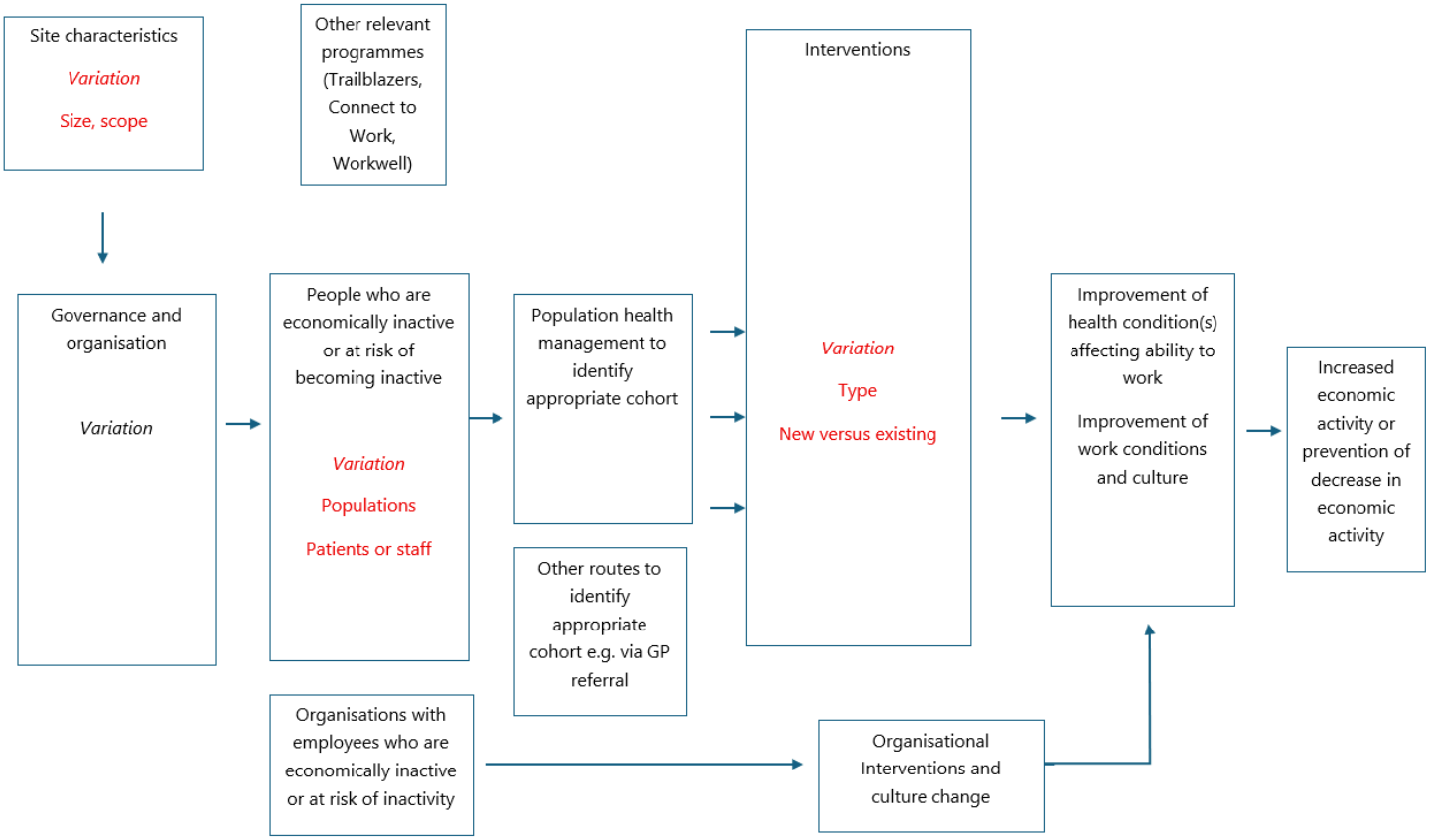

Figure 1

Generic model for Health and Growth Accelerators