Integrating Health and Social Care: a mixed methods case study of the strategic development and implementation of integrated care services

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Abstract

The integration of health and social care services aims to overcome organisational boundaries, in order to promote person-centred care, and improve patient outcomes, satisfaction and value for money. However, health and social care services are currently faced with the challenge of providing high quality care, to a population who are increasingly living with multiple complex long-term conditions. This often results in care being delivered from multiple providers, subsequently increasing the risk of duplication, inefficiency, poor coordination and experience. Services therefore need to work in partnership and collaboration in order to deliver integrated and person-centred care.

A mixed-methods study was conducted in order to explore the feasibility and practicalities of delivering integrated and person-centred care across organisational boundaries. This included a review of the literature, which informed a case study of integrated Neighbourhood Teams within a rural setting in the United Kingdom. This included a shift from working in organisational silos, to delivering integrated care to the whole population. Participants included staff members working at various levels within the integrated initiative. In-depth interviews with strategic and transformation leaders were conducted in order to enable qualitative explorations of developing and implementing integrated services. Data were transcribed and analysed using a thematic analysis approach. A Partnership Assessment Tool was also distributed in order to assess the operational and practitioner perspective of six key principles of partnership working.

Despite extensive research and policy changes, results revealed that initiatives continue to experience similar barriers in progressing with integration and population health management. Nonetheless, robust case study designs and in-depth qualitative explorations into the experiences of those developing approaches to improve care delivery, add essential value to understanding associated barriers and facilitators. These findings are therefore highly relevant to those developing integrated care initiatives across international contexts. For example, irrespective of national
differences, countries face similar challenges of fragmented services, with partnerships and networks viewed as an international political concepts.

Transferable key enablers for progression included a clear shared vision, organisational commitment, investing time in building relationships, a cultural change, and a period of stability in workforce and leadership. The need to start small and scale up, peer support, developing approaches to measuring outcomes (accounting for impacts at the individual patient and professional level), and a focus on proactively supporting people before expanding models were also highlighted. The systemic, organisational, and professional challenges which were experienced are also likely to be represented across initiatives aiming to integrate care.

While integrating care around the needs of the patient is a desirable objective for increases quality care, this is often met with significant challenges once attempts are made to develop strategies within an environment of uncertainty. In light of the often underestimated lengthy process of large-scale transformation, it was apparent that the initiative remained in its infancy, with full integration yet to be seen. While a combination of relational and technical aspects of integration are necessary for progression, the success of the initiative was largely perceived to be dependent upon the workforce, rather than processes and structures. Relational aspects and increased workforce investment may therefore hold increasing potential to the success of integrated approaches to care delivery and the sustainability of large-scale transformation.
## Contents

Acknowledgements .................................................. i  
Abstract ................................................................... iii  
Contents ................................................................. v  
List of Abbreviations .................................................. ix  
List of Figures ............................................................ x  
List of Tables ............................................................... xi  
Glossary of key terms .................................................. xii  

### Chapter 1: Introduction

1.1 Research introduction and background ......................... 1  
1.2 The case study background ........................................ 7  
1.2.1 Challenges of exploring integrated Neighbourhood Teams 11  
1.3 Rationale and research impact .................................... 13  
1.4 Aims of the research ............................................... 15  
1.5 Research purpose, focus, and questions ....................... 19  

### Chapter 2: Literature Review

2.1 The case for change and integrated care ..................... 30  
2.2 Defining integrated care ......................................... 32  
2.3 Conceptualisation of integrated care ......................... 36  
2.3.1 Types of integration .......................................... 38  
2.3.2 Levels of integration ........................................ 43  
2.3.3 Breadth of integration ...................................... 44  
2.3.4 Degree and intensity of integration ....................... 45  
2.4 The impact of integrated care ................................... 47  
2.5 Complexity of integration ...................................... 55  
2.6 Application of integration and integrated care ............. 61  
2.6.1 Integration at the international level ..................... 61  
2.6.2 Integration at the national level ............................ 63  
2.6.3 Integration at the local level ............................... 66  

v
Chapter 3: Methodology

3.1 Research aims and questions
3.2 Philosophical considerations
3.3 Mixed methods research
   3.3.1 Triangulation and integration
   3.3.2 Application of methods
3.4 Case study design

Chapter 4: Methods

4.1 Ethical considerations
4.2 Semi-structured interviews
   4.2.1 Participant recruitment
   4.2.2 Data collection
   4.2.3 Data analysis
4.3 The Partnership Assessment Tool (study 2)
   4.3.1 Participant recruitment
   4.3.2 Data collection
   4.3.3 Data analysis
4.4 Documentary analysis
4.5 Field notes

Chapter 5: Results - Strategy of integrated care (study 1)

5.1 Research questions and mixing of the data
5.2 Themes derived from data analysis

Chapter 6: Results - Application of integrated care (study 2)

6.1 Research questions and mixing of the data
6.2 Participants and data analysis
6.3 Overall assessment
6.4 Assessment based on partner organisation membership
6.5 Assessment based on Neighbourhood Team membership
6.6 Relative significance and partnership success
6.7 Qualitative Responses
Chapter 7: Results - Progression of integrated care (study 3) 180

7.1 Research questions and mixing of the data 180
7.2 The current Neighbourhood Team model 182
7.3 Themes derived from data analysis 184

Chapter 8: Results – Triangulation 204

8.1 Triangulation protocol 250
8.1.1 Sorting and data preparation 207
8.1.2 Convergence and dissonance coding and assessment 207
8.1.3 Completeness comparison 218
8.1.4 Feedback 219

Chapter 9: Discussion 220

9.1 Process: the strategy of integrated care 221
9.1.1 The development and implementation of the Neighbourhood Teams 221
9.1.2 The process of change 227
9.1.3 Neighbourhood Team working in practice 233
9.2 Impact: application of integrated care 239
9.2.1 Impact and outcomes of the Neighbourhood Teams 239
9.2.2 Measuring outcomes and impact 245
9.4 Conclusion 247

Chapter 10: Conclusions 249

10.1 Contributions to practice 249
10.2 Contributions to knowledge 251
10.3 Strengths and limitations of the research 254
10.4 Personal reflections on journey 259
10.5 Concluding synopsis 261
10.6 Final recommendations 262
10.7 Thesis outputs 264

References 267

List of appendices 296
**List of abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO</td>
<td>Accountable Care Organisations</td>
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<td>ACS</td>
<td>Accountable Care Systems</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<td>CLO</td>
<td>Case Liaison Officer</td>
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<td>CPN</td>
<td>Community Psychiatric Nurse</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>DMIC</td>
<td>Developmental Model of Integrated Care</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>IPC</td>
<td>Integrated Personal Commissioning</td>
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<td>MCP</td>
<td>Multispecialty Community Providers</td>
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<td>MDT</td>
<td>Multidisciplinary Team</td>
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<td>MRC</td>
<td>Medical Research Council</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NT</td>
<td>Neighbourhood Team</td>
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<td>PACS</td>
<td>Primary and Acute Care Systems</td>
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<td>PAT</td>
<td>Partnership Assessment Tool</td>
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<td>PCN</td>
<td>Primary Care Navigator</td>
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<td>PIC</td>
<td>Personal Independence Coordinator</td>
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<td>RQ</td>
<td>Research Question</td>
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<td>STP</td>
<td>Sustainability and Transformation Plan</td>
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<tr>
<td>STS</td>
<td>Socio-Technical Systems</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
</tbody>
</table>
List of Figures

Figure 1.1: Original Neighbourhood Teams Model 8
Figure 1.2: Integrated Neighbourhood Working Model 10
Figure 2.1: Typologies of integrated care (Lewis et al, 2010; Fulop et al, 2005) 39
Figure 2.2: Rainbow Model of Integrated Care (Valentijn, 2016) 57
Figure 2.3 Developmental model of integrated care (Minkman, 2012) 59
Figure 3.1: Relationship between epistemology, theoretical perspectives, methodology, and research methods (Gray, 2014; Crotty, 1998) 74
Figure 3.2: Multiphase mixed methods (Creswell, 2014) 86
Figure 3.3: Conducting case study research (Yin, 2014) 92
Figure 6.1: Partnership Profile scores of all participants 163
Figure 6.2: Participants’ perceptions of the relative significance of the partnership principles 168
Figure 6.3: Participants’ perceptions of partnership achieving its aims and objectives 169
Figure 6.4: Organisational perceptions of partnership achieving its aims and objectives 170
Figure 6.5: Neighbourhood Team perceptions of partnership achieving its aims and objectives 171
## List of Tables

Table 1.1: Theoretical framework (Miller et al, 2016)  
Table 1.2: Terminology of staff within the studies  
Table 2.1: Key definitions of Integration and Integrated Care (Kodner, 2009)  
Table 2.2: Common integrated care perspectives definitions (Goodwin, 2016a)  
Table 2.3: Common attributes of models facilitating health system integration (Armitage et al, 2009)  
Table 2.4: Levels of integrated care (Pike and Mongan, 2014; Curry and Ham, 2010)  
Table 2.5: Components of rainbow model of integrated care (Valentijn et al, 2013)  
Table 3.1: Specific research questions and methods  
Table 3.2: Key ontological and epistemological stances (Snape and Spencer, 2003)  
Table 3.3: Main paradigms or worldviews (Creswell, 2014)  
Table 6.1: Participants Neighbourhood Team and organisational membership  
Table 6.2: Participants organisational membership and professional roles  
Table 6.3: Descriptive statistics for each of the partnership principles  
Table 6.4: Outliers in the data indicated from histograms  
Table 6.5: Mean scores for partner organisations  
Table 6.6: Mean scores of Neighbourhood Teams  
Table 6.7: Partner organisations perceptions of meeting aims and objectives  
Table 6.8: Neighbourhood Team perceptions of meeting aims and objectives  
Table 6.9: Themes of participants’ qualitative responses  
Table 7.1: IPC key shifts and enablers (adapted from IPC framework; NHS England, 2017b)  
Table 8.1: Convergence coding scheme for triangulation protocol (Hopf et al, 2016; Farmer et al, 2006)  
Table 8.2: Convergence coding matrix
Glossary of key terms

**Commissioning:** The process by which public services plan the services that are needed by the people who live in the local area, ensuring that services are available, high quality and appropriate. Commissioning is sometimes described as a cycle involving assessing the needs of the local population, deciding what services are needed, designing a strategy to deliver those services, making sure those services are in place, evaluating how well these services are working, and then making any changes needed.

**Integration:** A coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment, and collaboration within and between the cure and care sectors (Kodner and Spreeuwenberg, 2002).

**Integrated care:** The goal of these [integrated] methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long term problems cutting across multiple services, providers and settings (Kodner and Spreeuwenberg, 2002).

**Integrated care initiative:** A project or service that seeks to provide integrated care for individuals and their families by enabling better joint working across the relevant staff, teams, services and organisations in health, social care and housing support service.

**Manager:** an individual employed to oversee and coordinate the financial, human and physical resources deployed by organisation(s) to achieve set objectives and responsibilities.

**Outcome:** an aim or objective that people would like to achieve or need to happen, for example continuing to live at home, or being able to go out and about.

**Person/patient-centred care:** care which starts with the individual and what their needs and preferences are, and not with the services and what is available.
**Practitioner:** an individual employed to directly provide housing support, social care or healthcare services to service users and carers who is not a member of a professional group but requires particular skills, knowledge and values. Examples include a tenancy support worker, a domiciliary care worker or nursing or therapy assistant.

**Professional:** an individual who is accredited by a professional body to undertake a particular role following successful completion of a course of study and ongoing professional development. Examples include social worker, nurse, physiotherapist, psychologist and doctor.

**Service user:** someone actively in receipt of a health, social care or housing support service regardless of nature of that service or their underlying needs.

**System:** the interconnected organisations and services that have to work together to achieve integrated care for the population concerned.

**Wicked issue:** a problem within society that is long-standing, complex and resistant to change.

*(Miller et al, 2016)*
Chapter 1: Introduction

1.1 Research introduction and background

Integration aims to overcome boundaries between the health and social care sectors, by promoting patient-centred care and improving patient outcomes, satisfaction and value for money (House of Commons Committee of Public Accounts, 2017; National Audit Office, 2017; Kodner, 2009). For example, both separate health and social care systems include a complex range of organisations, professionals and services; with the NHS free at the point of access and local authorities typically only paying for individual packages of care for adults assessed as having high needs and limited means (National Audit Office, 2017; Rummery and Coleman, 2003). Factors such as an ageing population, increasing fragmentation and complexity in service provision, funding, and commissioning, and the funding contrasts in health care and social care all contribute towards the policy goal of integration (Humphries, 2015). The increasing demand for care services results in an increasing pressure of the capacity of local health and social care systems (House of Commons Committee of Public Accounts, 2017; National Audit Office, 2017). National bodies such as the Department of Health (responsible for health and adult social care policy in England), the Department for Communities and Local Government (responsible for local government finance and accountability system), and NHS England (responsible for supporting Clinical Commissioning Groups and the commissioning of NHS services) are aiming to meet this pressure through the integration of health and social care services at the local level (House of Commons Committee of Public Accounts, 2017; National Audit Office, 2017).

There is a concern that the organisation of health and social care services does not achieve continuity of care (i.e. longitudinal use of a regular source of care over time), and that despite various reorganisations, these services have failed to keep pace with changing demands, with gaps in and between systems of care contributing to fragmentation issues for service users, providers and commissioners (Valentijn et al, 2013; Ham et al, 2012; McCormack, et al, 2008). For example, structural and financial barriers between primary and secondary care and health and social care, distinct
organisational and professional cultures, and separate governance and accountability, all contribute to care fragmentation (Glasby et al., 2006). Contributing factors of fragmentation may also include the National Health Service (NHS) design of hospital medical specialities around single organ diseases (Oliver et al., 2014), and primary care consultations and payment systems not designed to treat patients with multiple and complex conditions (Beales and Tulloch, 2013; Roland, 2013). Health and social care services are therefore faced with the challenge of providing high quality, patient-centred care to an ageing population, who are likely to live with complex long-term conditions and receive care from multiple providers; subsequently increasing the risk of duplication, inefficiency, and poor coordination and experience (Nolte, 2017; Ellins et al., 2012; Haggerty 2012; Rosen et al., 2011; Shaw et al., 2011).

There is a long standing concern within health and social care literature and policy that health and social care services need to work together more effectively in order to meet the growing needs of the population (Nolte, 2017; Baggott, 2015). To address these issues, regulatory and policy frameworks have been produced to promote integrated care approaches and improve coordination between health and special care services (Nolte, 2017), with the intent for policy which addresses financial, organisations, and patient concerns (Hughes, 2017). This has occurred alongside the promotion of shifting specialist services from the hospital into the community, to increase accessibility, system responsiveness and potentially reduce costs (Winpenny et al., 2016; Notle et al., 2014). There is therefore an argued need for a shift in resources from a focus on reactive and acute care, towards prevention, self-care, more consistent standards of primary care, and well-coordinated and integrated care (Goodwin et al., 2012). However, as many definitions of integrated care exist, with a lack of universally accepted definition (Goodwin, 2016a) and no definitive blueprint for those seeking to implement integration, each locality or service wishing to organise services in this manner is required to develop an approach which meets the needs for people within their specific context (Miller et al., 2016). Implementing the theory of integrated care into practice has therefore been highlighted as a complex procedure, with the suggestion that a sole focus on structures and processes may not
be sufficient to bring about the necessary transformational change (NHS England, 2018; Plsek, 2003; Plsek and Greenhalgh 2001).

Health care is becoming increasingly complex throughout the world, across all disciplines and levels (Plsek and Greenhalgh, 2001). Viewing health care organisations through a complex adaptive systems lens is an approach which is suggested to contribute to tackling this issue of complexity (Long et al, 2018; Nurjono et al, 2018; Pype et al, 2018; Valentijn et al, 2013; Lipsitz, 2012; Sweeney and Griffiths 2002; Institute of Medicine 2001; Plsek and Greenhalgh 2001). A complex adaptive system has been described as “a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent's actions changes the context for other agents” (Plsek and Greenhalgh, 2001, pg. 625). One of the important properties of these systems is that they include structures, processes and patterns or outcomes (Plsek, 2003; Plsek and Greenhalgh, 2001; Capra, 2002; Capra 1996), which aids understanding of how to achieve transformational change in multiple areas (NHS England, 2018).

It is suggested that in order to be able to achieve large-scale transformation change in complex health and care systems, integrated changes in structures (organisations, policies, regulations, guidance, physical space and equipment, and decision making structures and accountability) processes (pathways, patient journeys, procedures, flows of people, sharing information, and resources) and patterns of behaviour and outcomes (development of trust, honest relationships, power, conflict, and learning) are required (NHS England, 2018; Plsek and Greenhalgh 2001). However, initiatives often focus on changing one of these elements, particularly structures, without the necessary sufficient attention to all three interacting aspects (NHS England, 2018; Plsek, 2003; Plsek and Greenhalgh 2001). For example, while service improvement work has seen some success in focusing on processes to redesign care delivery, the importance of patterns of positive mind-set and behaviour also need to be recognised, in order to achieve fundamental change in complex systems (NHS England, 2018). Complex adaptive systems are discussed further in section 2.5 on page 55.
Integrated health systems have been promoted as a means to improve access, quality and continuity of services in a more efficient way, especially for people with complex needs (e.g. multi-morbidities) (Valentijn et al, 2013; Armitage et al, 2009; Suter et al, 2009; Kodner 2009). However, the literature has highlighted that many definitions of integration and integrated care exist (Goodwin et al, 2017; Baggott, 2015; van der Klauw et al, 2014; Curry et al, 2013; Armitage et al, 2009), conveying a variety of meanings depending on the particular context, organisation and professional group (Robertson, 2011). While the varied use of language and terminology may be interpreted as confusing (Kodner, 2009), it is suggested that this is merely indicative of the multifaceted and complex nature of integrated care (Shaw et al, 2011), which operates on different levels of health systems, both horizontally and vertically (Kodner 2009; Armitage et al, 2009). Kodner and Spreeuwenberg (2002) detail one of the most frequently utilised definitions within the integrated care literature (e.g. Goodwin et al, 2017; Goodwin, 2016a; Sutton and Long, 2014; Shaw et al, 2011; Rosen et al, 2011; Curry and Ham, 2010; Lewis et al, 2010; Johnson, 2009; Lloyd and Wait, 2007). This definition distinguishes between the term ‘integration’ as the structures and processes of service delivery, with ‘integrated care’ concerning the impact and outcomes:

“A coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment, and collaboration within and between the cure and care sectors [integration]. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long term problems cutting across multiple services, providers and settings [integrated care]” (Kodner and Spreeuwenberg, 2002).

Within this definition, ‘integration’ is used to describe the methods and processes to support and facilitate the alignment and coordination of services across separate institutions, teams, operating units and systems (Shaw et al, 2011; Rosen et al, 2011; Kodner and Spreeuwenberg, 2002; Leutz, 1999). In its most simple form, ‘integrated care’ is conceptualised as the organising principle for care delivery, with the aim to
provide services which are designed to deliver the outcome of high quality, cost effective care and high levels of patient satisfaction (Rosen et al, 2011; Shaw et al, 2011; Lloyd and Wait, 2007). The definitions of these terms are more fully explored in section 2.2 on page 32.

Kodner and Spreewenberg’s (2002) definition of integration and integrated care is used throughout the thesis, as it distinguishes between important elements of the nature of integration which concerns the processes involved in bringing organisations and professionals together, and the desired effect of improving outcomes for patients through the delivery of integrated care (Curry and Ham, 2010). These distinctions are also important as they allow for the identification that the structures and processes of integration which support greater organisational and service integration, may not always result in the optimal outcome of integrated care (Lewis et al, 2010; Kodner and Spreeuwenberg, 2002). Kodner and Spreeuwenberg (2002) also make a valuable contribution to defining integrated care through their patient-centred view (Leichsenring, 2004), in the consideration of the “provision of health care, social services, and related supports (e.g. housing) at the right time and place” (Kodner and Spreeuwenberg, 2002, pg. 3). In addition, this definition and distinction provides and understanding of a complex phenomenon (Valentijn et al, 2013; Kodner and Spreewenberg, 2002), and the important properties of complex systems including structures, processes and patterns or outcomes (Plsek, 2003; Plsek and Greenhalgh, 2001; Capra, 2002; Capra 1996). This definition also encompasses various types of integration (i.e. funding, administrative, organisational, service, and clinical). However, it does not specifically identify normative or functional elements of integration, which have been suggested to be important enablers of integration, which provide connectivity across the different levels (Valentijn et al, 2013). Nonetheless, this definition highlights that integrated care has many meanings (Sutton and Long, 2014), and is created by a combination of various integrated activities which operate at different levels rather than created by a single mechanism (Lyngso et al, 2014). This notion is consistent with an early consensus in the integration literature, which suggests that multiple dimensions, components and perspectives therefore need to be considered (Browne et al, 2007).
Despite the increase of integrated care initiatives, there has been variation in their success, and relatively little is known about what factors are associated with successful implementation (Wodchis et al, 2015; Bardsley et al, 2013). While evidence suggests that integration can improve experiences and outcomes of care, and deliver greater efficiency (e.g. Martinez-Gonzalez, et al, 2014; Goodwin et al, 2012; NHS Future Forum 2011; Ham et al, 2011; Curry and Ham 2010; Ouwens et al, 2005), the UK evidence base around integrated care has also been described as lacking focus and generally not of high quality (Nolte, 2017; Nolte, 2012). A systematic review of the effectiveness of integrated care interventions in improving the quality of life of patients with chronic conditions also highlighted mixed evidence, particularly in terms of the effectiveness of case management, chronic care model interventions, discharge management, and multidisciplinary team and self-management interventions (Flanagan et al, 2017). While these outcomes and impacts are inherently difficult to assess due to the complex nature of the aims of integration, the available literature on integrated care programmes and initiatives points to a likely positive impact on the quality of patient care, and improved health or patient satisfaction outcomes (Nolte and Pitchforth, 2014).

Whilst there are historical divisions in the UK between health and social care, the development of new commissioning arrangements (in the form of Clinical Commissioning Groups) presented an opportunity for integration and service improvement (Curry and Ham, 2010). At the local level, leaders are tasked with the responsibility of translating the mechanisms which enable staff to work within a specific integrated care system into practice (Stein and Reider, 2009). It is also recommend that successful integrated care interventions and associated best practices are tailored to the local context (Goodwin et al, 2014; Bardsley et al, 2013). This research therefore examined the challenges faced by an integrated care initiative operating within the NHS in the UK, whilst also providing broader significance to the literature on integration. This was achieved by exploring the strategy and application of integrated care within a case study site, and considering transferable lessons for transforming services and managing change. The
development and implementation of integrated care in order to improve the delivery of services is a key focus of this thesis.

1.2 The case study background

The integrated care initiative of the case study site was developed within a rural county in the East Midlands of the United Kingdom. This county has a population of circa 750,000 which are managed by four Clinical Commissioning Groups (CCGs). CCGs are clinically-led statutory NHS bodies which are responsible for planning and commissioning health care services for their local populations, and have a legal duty to support quality improvement in general practice (Naylor et al, 2003). While one of the CCGs within this county is the case study site for the purpose of this thesis, the integrated care initiative is county-wide (i.e. all four CCGs are implementing the model). In 2017, the CCG had a registered population of circa 250,000 patients.

The approach to integrating care included developing a ‘Neighbourhood Team’ model within registered General Practice (GP) populations, making primary care engagement key to their development and implementation. While the Neighbourhood Teams included 35 GP practices at the beginning of the research study in 2014, 31 GP practices were represented in 2018 following closures. There are five Neighbourhood Teams within the registered CCG population, which included a pilot site, two teams in the South, and two teams in the north. While the pilot site was further on in its development, the South and North teams were at a similar level of development. The aims and objectives of the Neighbourhood Teams were to reduce emergency admissions, facilitate early assisted discharge, deliver care closer to home, and provide quality end of life care. The purpose of the Neighbourhood Teams is to work in a multidisciplinary teams across organisations, in order to proactively support people and deliver person-centred care to adults with multi-morbidities. Due to the existence of multiple long-term conditions within an older population, this population were often referred into the Neighbourhood Teams.
The Neighbourhood Teams initiative was approximately three years along its development and implementation journey at the time of data collection. Throughout this time period, various adaptations and versions of the model were developed. The original ‘Neighbourhood Team’ model which was developed in August 2015 by the CCG is presented in figure 1.1 (referred to in chapter 5). This identifies that the key health and social care services which represented a ‘core member of the multidisciplinary team (MDT)’ included adult social care, mental health services, community services (including Nursing, Physiotherapy and Occupational Therapy), medical support, primary care, and third sector organisations (including Primary Care Navigators). The third sector describes the range of organisations which are neither public nor private, and is often also referred to as the voluntary sector, non-profit sector, social economy, and civil society (Brandsen and Pestoff, 2006). However, the model depicts that primary care was not fully integrated into the model, despite its engagement being key to their development and implementation. The model also depicts a wider network of services, with varying levels of links established (i.e. either established, ongoing or not established).

**Figure 1.1: Original Neighbourhood Teams model**
These MDTs include representatives from the core health and social care services who have been aligned to the Neighbourhood Teams, in order to attend MDT meetings and work together in partnership, by discussing a case load of patients who have been referred into the Neighbourhood Teams. These representatives are expected to work collaboratively across different services, sharing expertise to improve patient care. The design features of the Neighbourhood Teams were initially developed from a local county-wide Sustainable Services Review conducted in 2013. The findings from this review were then adopted by a county-wide Health and Care programme, and transformed into the local Sustainability and Transformation Plan (STP), which detailed the future of the local health and care services. In order to deliver the STP, five areas of work were subsequently developed. This included clinical redesign, capacity optimisation, operational efficiency, workforce productivity and redesign, and right care and commissioning priorities. The clinical redesign area of work was developed to include the Neighbourhood Team initiative, as part of the proactive care programme. However, commencement of the Neighbourhood Teams approach began at the time of the Sustainable Services Review, with the transformation of ‘Integrated Community Teams’ into ‘Neighbourhood Teams’ (see appendix 1 for flowchart of development). The initial development of the Neighbourhood Teams was also heavily influenced by an acute care physician who had in-depth knowledge of his population and used fundamental outreach principles to transfer care into the community.

The Neighbourhood Teams model developed into a county-wide ‘Integrated Neighbourhood Working’ model (figure 1.2) approximately two years after the original model (figure 1.1). Within this model, Neighbourhood Teams remain aligned to GP practices and the core team included; primary care, county council, community health services, mental health services, third sector, clinical pharmacy, and a county care association. This included the professions of: nurses, adult care, community psychiatric nurse, clinical pharmacy, therapists, and generic assessors. The wider Neighbourhood network connected to the core team encompassed the third sector including: wellbeing service, carers’ network, managed care network, specialist health and wellbeing services. The aim of this network was to provide support to the
core MDTs when needed. This model focuses on community empowerment, population identification, awareness/signposting and navigation, person-centred assessment and care and support planning, one to one support, wrap around local support, integrated working core principles and outcomes. However, in comparison to the original Neighbourhood Teams model (figure 1.1), the Integrated Neighbourhood Working model (figure 1.2) does not identify specific organisations within the model, but details the principles of integrated working which should be adopted by all partner organisations and professions. These principles include: having a different conversation, home first, enabling self-care and support, patient-centred care, collective accountability across neighbourhood working, positive risk taking, and assessing immediate needs and barriers to improve quality of life.

Figure 1.2: Integrated Neighbourhood Working model
1.2.1 Challenges of exploring integrated Neighbourhood Teams

As there are difficulties associated with evaluating a live programme which is iterative and continuously evolving, there is the requirement to work within a complex system involving a range of practice settings and procedural arrangements (Abendstern et al, 2011). There was therefore the need to be adaptive within this research process, in light of the changes within the case study setting. A particular challenge of the Neighbourhood Teams was the reorganisation of partner organisations, and the changing of job roles throughout the teams. This created difficulties for recruiting participants and highlighted a lack of leadership and understanding of the implementation process. For example, while the integrated care model promoted integrated working within and across organisations, throughout the research it emerged that there was a lack of knowledge and communication regarding who the operational staff members and practitioners were, who were aligned to the Neighbourhood Teams. The Neighbourhood Teams had also had two different project managers, with the second having left this role during the collection of the study 2 and field notes. It was therefore important to remain engaged with stakeholders and mindful of the aims of the research and the research questions, in order to draw on the available sources of data to gather a full picture of the reality of integration development and implementation.

The evolving nature of integrated care initiatives also resulted in the target population developing from frail older people (aged 65+), to include a whole population approach for adults with multi-morbidities. While frail older people often need input from multidisciplinary teams due to the occurrence of multiple long-term conditions, this shift was made in order to promote a population health approach to the whole population. There were also therefore various referral criteria and scales used to identify the appropriate population throughout the Neighbourhood Teams development. It was therefore acknowledged at the outset that it was likely that the research would be refined and adapted, in response to the evolving and changing nature of service redesign. However, this evolving process allowed for the opportunity to understand the facilitators and barriers and the feasibility and
practicalities of developing and implementing an integrated care initiative in a real-world setting.

As the patient voice is an important aspect of integrated care initiatives, if they are to develop to be centred around patients’ needs, this research originally included considerations of the impact of the Neighbourhood Teams on patient outcome measures (e.g. health-related quality of life). This was in response to the need for research which described outcomes in terms of the impact on people’s health and wellbeing, their care experiences, and whether the services being delivered met their needs (National Voices, 2011). However, due to the complexity of the integrated care initiative, and the significant time needed to plan and implement large-scale service changes (Bardsley et al, 2013), it was therefore not feasible to include patients within the research, with low numbers of patients referred into the Neighbourhood Team model at the time of data collection. It is also acknowledged that assessing the impact of initiatives on those who are likely to experience deteriorating well-being irrespective of the impact of projects, is therefore difficult (Windle et al, 2009). The many definitions of integrated care that exist also contributes to the lack of robust evidence of the impact on health outcomes (Robertson, 2011). However, exploring the impact of integrated care initiatives on patient outcomes remains an important area of research, despite its difficulties.

With the importance of reducing avoidable hospital costs currently attracting a high degree of policy attention and national interest (Bardsley et al, 2013), this research also originally included an economic aspect, in order to consider the effectiveness and produce a cost-analysis of the Neighbourhood Teams (e.g. changes in service use and costs). However, very early on in the research, it was decided that it would not be feasible to adequately analyse the cost-effectiveness of the Neighbourhood Teams alongside other data collection methods, within the time period of the research and the stage of development of the initiative. The research therefore developed to include an exploration of the process of integrated Neighbourhood Teams from the perspective of strategic staff, and the impact on experiences of operational staff and practitioners working within the Neighbourhood Teams.
There are also issues with evaluating services which are implementing NHS reforms. For example through the development of STPs, which have developed into Accountable Care Organisations, which in turn have developed into Integrated Care Systems. Within the case study site, the Neighbourhood Teams were implementing a STP, which had also developed to become one of nine early demonstrator sites of the national change programme of Integrated Personal Commissioning (IPC), led by NHS England and the Local Government Association (see chapter 7).

1.3 Rationale and research impact

While integrated care has become an important component of international health and social care reform, the diversity of integrated care presents challenges for policymakers, managers, professionals, and researchers in developing a shared understanding of its meaning and logic (Goodwin et al, 2017). With no single model accepted to best support developing integrated care and varying conceptualisations, this study is therefore essential as it considers the development and the implementation of integration; in order to identify the process and impact of integrating health and social care services within local population. In addition, due to the variation of its definitions and concepts, depending on the target needs of a population and goal of integrated initiatives, integrated care is therefore also highly context-dependent (Nolte, 2017). Therefore, while evidence of effectiveness of integrated care as a whole may be difficult to obtain, transferable lessons can be learnt across different initiatives, to identify core elements which may support better outcomes (Nolte, 2017).

This research explored the process involved in a local approach to integrating care for their population in the form of Neighbourhood Teams, and considered the impact on the experiences of the health and social care workforce. This allowed for a more detailed understanding of the structures, processes, and patterns of integration actively at play (Ling et al, 2010; Plsek, 2003; Plsek and Greenhalgh, 2001; Capra, 2002; Capra 1996). This provided valuable insights into the operational reality and practical application of a working model of integrated care, and the identification of
possible implementation barriers and key transferable factors for success and large scale transformation. These considerations have national relevance as they highlight issues concurrent with those raised in the ‘NHS five year forward view’ (2014), alongside several Kings Fund publications including: ‘placed based systems of care’ (Ham and Alderwick, 2015), ‘population health systems’ (Alderwick, Ham, and Buck, 2015), and ‘making our health and care systems fit for an ageing population’ (Oliver, Foot and Humphries, 2014).

Historically fragmented health services across the United States and European countries have been identified as resulting in a lack of coordination between health and social care organisations, poor financial incentives, misaligned goals and values, and poor assignment of roles within the care process (Pimperl, 2018). This is associated with unnecessary care quality risks for patients, lack of cost-effectiveness, and a disparity in performance and health outcomes (Rice et al, 2013). There is also an increasing concern of the continued focus on acute and episodic illness, with a dependence on hospital-based care (Notle, 2017). This often results in patients receiving fragmented care, particularly those of multiple complex long-term conditions (NHS England, 2014). Integrating care around the needs of the patient is a therefore desirable objective for organisations or professional bodies attempting to improve the health and well-being of the population and reduce costs. There is also a need for the concept of integrated care to move beyond vague aspirations for care delivery and consider what action can be taken in order to achieve this goal. Being able to consider how integrated care can be achieved is an issue which integrated care initiates have continued to face, often due to those developing and implementing integrated care initiatives experiencing difficulties with conceptualising what integrated care actually means in practice, and particularly how it can be applied (Goodwin, 2016a).

Further research is therefore urgently needed to examine the underpinning assumptions of integrated care, and assesses the development and implementation process and impact from various perspectives (Cameron et al, 2012). It is also necessary to provide a more detailed understanding of the processes and outcomes
of partnership working (Trivedi et al, 2013). This thesis therefore explored what is understood by integration and integrated care, and how these concepts have been applied in practice. This was achieved by exploring the integration and integrated care literature, which informed the development of a case study of Neighbourhood Teams. Within this case study, the development and implementation process and impact was considered from various perspectives of the health and social care workforce (including strategic and operational staff and practitioners). Potential reasons for the variation in success of developing and implementing integrated care initiatives, barrier and facilitators, and feasibility and practicalities were also explored. As it is crucial to facilitate an understanding of how initiatives can develop over time (Miller et al, 2016; Bowling, 2014; Goodwin, 2013a; Kodner and Spreeuwenberg, 2002), this research also contributed knowledge of how the Neighbourhood Teams initiative had developed and implemented over time within a real-world setting.

Due to the complex nature of the case study, there was also critical value in gaining a greater conceptual understanding and clarity of the meaning of integrated care and its various organisational models, in addition to practical examples of how such models may or may not be successful in their aims and objectives (Shaw et al, 2011; Kodner and Kyriacou, 2000). While the unique aspects of working across organisational boundaries and developing and implementing integrated care initiatives represents a level of complexity, transferable lessons can be learnt across different initiatives, to identify core elements which may support better outcomes (Nolte, 2017). As most developed western countries are currently under pressure to provide high quality services to an ageing population who have increasing health and social care needs (Humphries, 2015), these explorations also have key significance to theory and practice cross international contexts.

1.4 Aims of the research

This research began with the initial overarching aim to evaluate the approach to service integration being carried out by a local CCG, in order to build on existing
international and national evidence and address key transferable issues. The implications of the move toward system-integration were aimed to be examined in terms of the feasibility, process and impact on outcomes for both service users and the health and social care workforce. However, in order to be able to examine these aspects and evaluate the case study site’s approach to care integration and understand the level of complexity, it was identified that a broad conceptual understanding of the complex phenomena was needed. Following this conceptual review of the literature, and discussions with leading staff members implementing the integrated model and managing organisational change, more theoretically relevant specific aims emerged with further emphasis on the associated development and implementation processes and impacts of integrating care (see chapter 3).

The potential for integration to reduce fragmentation in patient care and improve service delivery and outcomes motivated the exploration of apparent challenges in achieving integrated care and the gaps between theoretical understanding, policy intent, and practical delivery. This thesis aimed to review the extensive integrated care literature to investigate the key contributing elements of integration and their application in a real world setting, and the implications of these gaps for providers and practitioners, and delivering patient-centred care. While in theory, integrated care represents a simple principle of combining separate parts to work together as a whole to provide high quality care, in practice it is the process of integration to achieve better outcomes that is suggested to be so complex and difficult to describe (Goodwin, 2013b). This seemingly simple principle is suggested to become a significantly complex concept, once attempts to consider what this actually means in practice are made (Miller et al, 2016). A contributing factor includes the significant amount of time required to define and interpret the meaning of the concept in specific concepts, due to the lack of applicability of a standard definition to all circumstances (Goodwin, 2016a). In addition, individual behaviours of the workforce are also considered to add to the complexity of health and social care integration and have the potential to impact on the success of integration, by facilitating change or creating barriers to progression (Glasby and Dickinson, 2014).
It was considered important for the following to be contributed to the literature:

1. An exploration of what is understood by integration and integrated care and to investigate how these concepts have been applied in practice.

2. An exploration of the development and implementation process of an integrated care initiative alongside the impact of the model on staff experience of partnership working.

3. A consideration of the feasibility and practicalities of implementing change in a complex real world setting, and key factors which need to be addressed as part of the transformation and change process of delivering integrated care.

4. A consideration of current important implications for policy and practice including the key barriers and facilitators of success.

The overarching research question was to consider: “How has the concept and strategy of integrated care been developed and implemented in order to provide health and social care within a local population?”

Evaluations which consider process are suggested to be an essential part of designing and testing complex interventions, which are commonly defined as those which include multiple interacting components, with their implementation difficulties, degree of flexibility, and number of individual behaviours, organisational levels and outcomes also acknowledged (Moore et al, 2015; Petticrew, 2011; Craig et al, 2008). The Medical Research Council (MRC) provides guidance and recommendations for evaluating complex interventions, and suggests that process evaluation can contribute towards an understanding of the feasibility of an intervention, following its initial development (Moore et al, 2015; Craig et al, 2008). The use of evaluation to facilitate an understanding of how these interventions work in practice are a crucial part of building an evidence base which informs policy and practice (Craig et al, 2008; Moore et al, 2015). This includes how an intervention may be replicated and
generalisable knowledge on how to implement complex interventions, encompasses issues such as communication and management structures, and how they interact with attitudes and behaviours of implementers, and their impact on shaping the intervention (Moore et al., 2015; Petticrew, 2011). Understanding context is also an important aspect of interpreting findings of a specific evaluation and its generalisability (Moore et al., 2015).

In a reflection on the MRC guidelines (Craig et al., 2008), two of these authors considered that the intention was to encourage a phased and iterative approach (where necessary) to researching complex interventions, with value given to developmental work and the need to be mindful of implementation aspects throughout the entire evaluation process (Craig and Pettigrew, 2013). However, some critics have suggested that the guidance utilises a narrow and simplistic notion of complexity (e.g. Anderson, 2008), and that the evolving nature of interventions results in formal evaluation frameworks to be inappropriate (e.g. Mackenzie et al., 2010; Freeman, 2009). Nonetheless, the aim of the guidance was to make recommendations supported by practical examples and successful methods, and to promote a pragmatic approach to the choice of methods as appropriate to the needs of the evaluation (Craig and Pettigrew, 2013). Due to the complexity of integrated care initiatives, it is also acknowledged that there are certain difficulties associated with evaluating a live programme which is iterative and continuously evolving. In addition to integrated care being a difficult concept to understand, it is also extremely challenging to implement and manage (Kodner, 2009).

The outcomes and impact of the initiative were considered from the perspectives and experiences of operational staff and practitioners working within the model, due to the initiatives stage of development (i.e. not yet a fully functioning model). For example it is essential to consider coordination across organisations and sharing of data and information between professionals (Miller et al., 2016). It is argued that tracking the process of implementation alongside considering outcomes is important in order to understand why desired changes may not be occurring (Bardsley et al., 2013). While attempts to reduce avoidable hospital admissions attracts a high degree
of policy attention, markers of success such as patient and staff experiences may be achieved earlier than the desired indicators of impact such as change in hospital use (Bardsley et al, 2013). However, as planning and implementing large-scale service changes takes time, changes to structure and process may be more reasonably expected than significant outcomes on service use (Bardsley et al, 2013). An evaluation of the processes is also advocated as being equally as important as considerations of outcomes and impacts within feasibility, pilot studies, and scale-up implementation studies (Tsiachristas and Rutten-van Molken, 2017).

1.5 Research purpose, focus, and questions

This thesis aimed to address six research questions. A literature review and three studies were conducted in order to answer these research questions. The literature review informed the development of research questions 2-6. Please see the methodology chapter (page 69) for more detail of the methods used to answer these questions.

Literature review (see chapter 2)

- RQ1: What is meant and understood by integration and integrated care and how have these concepts been implemented in practice?

Process: strategy of integrated care (see chapters 5 and 7)

- RQ2: How has a local approach to integrated care been developed and implemented over time?

- RQ3: What is the feasibility and practicality of developing and implementing integrated care and integrated working?

- RQ4: What are the barriers and facilitators to developing integrated teams, and implementing and sustaining integrated care?
**Impact:** application of integrated care (see chapter 6)

- **RQ5:** How has the local initiative’s approach to integrated care affected staff experience, and what impact has this had on partnership working?

- **RQ6:** What are the practicalities and realities of integrated partnership working for operational staff and practitioners in practice?

Table 1.1 highlights the overall research purpose of the thesis, which in turn informs the focus of the research, and provides the basis for the theoretical framework guiding the thesis (Miller et al, 2016). As the presence of fundamentally different views of what integration is and what it can achieve creates difficulties for professionals and organisations to provide integrated care (Miller et al, 2016), it is therefore essential to investigate the varying underlying interpretations of integrated care in practice. This is seen within the studies of this research, which explore strategic and lead transformation perspectives of developing and implementing integrated care (studies 1 and 3) and operational staff on the ground applying the integrated concept within practice (study 2). In addition, as the changes which are expected within an initiative or intervention alongside how change might be achieved may not be clear at the outset, it is important to develop a theoretical understanding of the likely process of change by drawing on existing evidence alongside new primary research (Craig et al, 2008).

This theoretical framework informed the development of the research questions, and guided thinking throughout the thesis in terms of the focus on process and impact. The framework includes a variety of purposes of an evaluation of an integrated care initiative. This includes improvement, sustainability, social value, learning, and roll-out, which will have varying applicability and importance to stakeholders depending on their varying motivations and interests (Miller et al, 2016). For example, considerations were made as to what could be done to further improve the Neighbourhood Teams (improvement), what worked in practice and what did not (learning), any wider value of the Neighbourhood Teams beyond those immediately
recognised by staff (social value), considerations of the necessary funding and resources to sustain the Neighbourhood Teams (sustainability), and whether the model would be rolled out to other localities (roll-out). Table 1.1 shows that these purposes informed the development of research questions 2-6.

**Table 1.1: Theoretical framework (Miller et al, 2016)**

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement</td>
<td>To provide feedback that can be used to further improve the integrated care initiative.</td>
</tr>
<tr>
<td>Learning</td>
<td>To gather experiences of what worked (and what did not) in this aspect of integrated care for sharing with interested parties (including through academic journals).</td>
</tr>
<tr>
<td>Social Value</td>
<td>To identify the wider value of the integrated care initiative beyond those immediately recognised by the participants and staff.</td>
</tr>
<tr>
<td>Sustainability</td>
<td>To secure or maintain the funding and resources necessary to sustain the integrated care initiative.</td>
</tr>
<tr>
<td>Roll-out</td>
<td>To liaise with stakeholders in order to consider the potential for the integrated care initiative to be rolled out into other services and localities.</td>
</tr>
<tr>
<td>Research Questions</td>
<td>RQ 2-6</td>
</tr>
</tbody>
</table>

**Focus**

<table>
<thead>
<tr>
<th>Process</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To focus on how an integrated care initiative has been developed and implemented and consider the process of change and how the programme design worked in practice. Issues of interest include communication within and outside the initiative, coordination of service user care and support, managing the change and addressing resistance, oversights and incentives, and training and development.</td>
</tr>
</tbody>
</table>

| Research Questions | RQ 2-4 |

<table>
<thead>
<tr>
<th>Impact</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To consider any benefits for professionals and practitioners, and the impact on individuals and teams.</td>
</tr>
</tbody>
</table>

| Research Questions | RQ 5-6 |

The focus of integrated care research is commonly themed under the terms ‘process’, ‘impact’, and ‘economic’ (Miller et al, 2016). While all three focuses can be combined within the correct research design and sufficient resources, Miller explains that it is
not necessary to utilise all three, with the need for the chosen focus to compliment the aims and objectives and research questions (Miller et al, 2016). As shown in table 1.1, the focus of this thesis therefore includes process and impact, in order to addressed the aims of the research and answer the research questions. The economic focus was not adopted as it fell outside of the scope of the research. The focus on process and impact also accommodates the distinction may within Kodner and Spreeuwenberg’s definition of the process integration and the outcome and impact integrated care. In addition, the important principles of complex adaptive systems are suggested to include structures, processes and patterns or outcomes (Plsek, 2003; Plsek and Greenhalgh, 2001; Capra, 2002; Capra 1996), which aids understanding of how to achieve transformational change in multiple areas (NHS England, 2018).

The process of how the Neighbourhood Teams integrated care initiative had been developed and implemented was considered, alongside considerations the process of change and how the initiative worked in practice. This focus also informed the development of research questions 2-4, within studies 1 and 3 through the use of semi-structured interviews. The second focus of this thesis was the impact of the integrated care initiative on the potential benefits for operational staff and practitioners working at the frontline, and the impact on individuals and teams. This focus informed the development of research questions 5-6, which the case study of the Neighbourhood Teams aimed to answer within study 2 through the use of a Partnership Assessment Tool (PAT). Table 1.2 details the terminology used to describe the staff within each of the studies. The thesis had a deliberately broad focus in order to account for the complexity of integrating health and social care, and the variety of factors which can influence its development and implementation. As explained earlier in this chapter, the impact of the initiative was considered from the perspectives and experiences of operational staff and practitioners working within the model, due to the initiatives stage of development (i.e. not yet a fully functioning model). This is in light of the significant time needed to plan and implement large-scale service changes (Bardsley et al, 2013), it was therefore not feasible to include patients within the research, as there were low numbers of patients referred into the
Neighbourhood Team model at the time of data collection (as explained in section 1.2.1).

Table 1.2: Terminology of staff within the studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Term</th>
<th>Includes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Strategic staff</td>
<td>Strategic representatives from core multidisciplinary Neighbourhood Teams including directors, commissioners, and managers.</td>
</tr>
<tr>
<td>2</td>
<td>Operational staff</td>
<td>Operational project staff, practitioners, administrative staff and support staff from a range of organisations including community services, adult social care, mental health services, acute services and the third sector.</td>
</tr>
<tr>
<td>3</td>
<td>Transformation leads</td>
<td>A lead change manager for integrated care and a Neighbourhood Team lead from the pilot site.</td>
</tr>
</tbody>
</table>

The theoretical framework focused on the process and impact of the case study of the Neighbourhood Teams initiative, and addressed research questions 2-6. The literature review chapter addressed research question 1 and described different models and definitions of integration and integrated care which have been utilised, highlighted the issues within the research area, and identified that the evidence base is confusing and lacks clarity. These findings are used in the discussion to compare to the results of this research.
Chapter 2: Literature Review

A comprehensive literature review was conducted in order to explore the vast range of integration and integrated care literature, identify conceptual concepts and processes, the impact of transforming services, and to inform the development of the thesis. This therefore included considerations of process and impact as identified in the theoretical framework (see chapter 1; section 1.5). For most literature review questions, it is important to define the terms which will be explored in the review (Aveyard et al, 2016). However, the purpose of a literature review may be to clarify and develop concepts (Dixon-Woods et al, 2005), where it is often not possible to clearly define the terms used, as they may be initially tentative, fuzzy or contested (Greenhalgh et al, 2005). In these cases it is essential to clarify their meaning and conceptual underpinnings (Aveyard et al, 2016). A concept analysis is an example of such an approach to reviewing published material in order to clarify the working use of a term (Aveyard et al, 2016). An exploration of these concepts involves comparisons of the different ways in which they have been utilised within existing literature (Aveyard et al, 2016). This type of literature review was therefore conducted in order to clarify and develop the concepts of integration and integrated care, and facilitate and inform an understanding of how these concepts had been applied within the literature. This therefore informed an understanding of the approach that the case study site had utilised in order to develop and implement their Neighbourhood Teams. This type of literature review was also conducted due to the broad range of descriptors used and the complexity of the concept. An understanding of the theoretical concepts, models and processes in order to evaluate their application in practice was therefore necessary.

While systematic reviews employ a strict protocol to rigorously review the literature (Aveyard, 2014), a systematic understanding of the evidence of the impacts of integrated care have been suggested to have been hampered by the absence of a sound paradigm through which to examine the process (Nolte, 2017; Goodwin et al, 2004). In addition, true meaning of complex concepts can be lost within the in-depth coding process of systematic literature reviews (Parahoo, 2014), with the
inconsistent coding of variables across studies limiting utilisation for detecting heterogeneity, and the exact sources of which may be difficult to detect (Bartolucci and Hillegass, 2010). The multiple aims of integration also means that the criteria against which success is measured can vary widely, the target populations, size of the intervention groups and the contexts may be different and difficult to compare, and some intended outcomes of integration are not easily measurable (Curry and Ham, 2010). In addition, while narrative reviews emphasise the role of theory, the main aim is to develop an understanding of empirical studies, rather than the development and understanding of theories and concepts (Aveyard et al, 2016). A concept analysis was therefore utilised in order to answer the research question, which explored the meaning and understanding of the concepts of integration and integrated care.

**Research question:** The aim of the literature review was to consider the meaning and understanding of the concepts of integration and integrated care, clarify the working use of the terms, and explore how integrated care approaches which had been utilised to coordinate health and social services. As there was no specific population, comparator or outcome, as the review aimed to explore the application of integrated care and a range of outcomes, research tools for question development such as ‘PICO’ were therefore not utilised (i.e. population, intervention, comparator, outcomes). Following initial exploration of the literature, the focused research question driving the review was developed to consider the development of integration and integrated care, and how these concepts had been utilised and applied within research, policy, and practice:

RQ1: What is meant and understood by integration and integrated care and how have these concepts been implemented in practice?

**Search strategy:** As integration and integrated care are often used as umbrella terms encompassing a wide range of approaches to care delivery (Goodwin, 2016a; Shaw et al, 2011; Stein and Reider, 2009), search terms were utilised in order to encompass their wide and varying application. Search terms and keywords utilised were
integration (e.g. integration, integrated care, coordination, collaboration, multidisciplinary/interdisciplinary working, partnerships, partnership working, and joint working) and care service provision (e.g. health care, health services, integrated health services, health and social care, primary health care, community care, and care coordination). These keywords were informed by relevant literature reviews of integration and integrated care (e.g. Martin et al, 2014; van der Klauw, 2014; Valentijn et al, 2013; Atun et al, 2010; Armitage et al, 2009; Suter et al, 2009; Reed et al, 2005).

Electronic database searches within the main academic health sciences databases were performed following their exploration for relevance (including Medline/PubMed, CINAHL, Web of Science, and Science Direct), alongside grey literature sources (including the Health Foundation, the Kings Fund, Nuffield Trust, Social Care Institute for Excellence, and University of Lincoln search database). Alongside keywords for integration and care provision, MeSH headings were also used (e.g. Delivery of health care, integrated and Primary Health Care) and duplicates were removed. Different searches were run using different terms and results were compared, in order to utilise a reflective approach to the search strategy. Boolean operators were used to combine keywords (i.e. AND, OR, NOT) and truncations were also utilised to identify all possible endings of the word (e.g. integrat*). The keywords were searched for within the title and abstracts of literature, due to the likelihood that the keyword and focus of the paper were likely to be similar (Aveyard et al, 2016). A similar strategy was used for all databases.

Additional search limiters included data range and language. Due to the research question considering the development of integration and integrated care and how the concepts had evolved and been applied, the date restriction from 1999 was utilised. This was a time point at which the most frequently utilised integrated care models had been developed (MacAdam, 2008; Kodner and Spreewenber, 2002). Leutz (1999) clarified thinking about integration and laid the foundations for integration frameworks and models (MacAdam, 2008). For example, he comments on the different varieties of integrated care based on the intensity of the levels, and
distinguishes between linkage (between existing organisations), coordination (through networks but still largely operating through organisational units), and full integration (formally pooling budgets, responsibilities, and resources) (Leutz, 1999). Many people also build on and reference Leutz in their research of integration and integrated care (e.g. Valentijn et al, 2013; Holland and Prince, 2008; Ahgren and Axelsson, 2005; Banks, 2004; Nies, 2004; Kodner and Spreewenberg, 2002; Kodner and Kyriacou, 2000).

Supplementary search strategies were also employed in order to account for the broad range of literature (Aveyard et al, 2016). Systemic reviews of integration and integration care were screened for database inclusion to ensure the scope of sources had been accounted for. The search was then supplemented by hand searching the most frequently cited journals and searching of relevant reference lists (Aveyard et al, 2016; Aveyard, 2014). This included the International Journal of Integrated Care, BMC Health Services Research, and Health and Social Care in the Community. A snowballing sampling method was therefore utilised to allow for the requirements of the review and to be responsive to the literature which had already been obtained (Greenhalgh and Peacock, 2005). A selection of academic books regarding integrated care, partnership working, health and social care, and health policy were also included in order to provide further context for the complex concepts and theories (Aveyard et al, 2016), and the multivariate application of integration. The search strategy was discussed with a subject librarian to ensure all relevant information would be included (Aveyard et al, 2016).

**Inclusion criteria:** The inclusion criteria encompassed literature which:

- Detailed the type of the approach to integrated care (i.e. intervention, model, service, strategy, programme or initiative) designed to develop, promote or facilitate integrated working between health and social care.

- Assessed the structures and processes of integrated care alongside considerations of outcomes for the patient, workforce, and health and social
care system (e.g. reported user-relevant outcomes, patient and staff experience, and cost effectiveness).

- Provided evidence of collaborative working within a multidisciplinary team (represented by at least two health disciplines) or joint arrangements covering operational and strategic issues.

- Were located in Europe, North America and Australasia (i.e. countries which have comparable health systems) and published in the English language.

It is important to understand how these concepts have been developed and implemented over time within various contexts, in order to be able to understand their complexities within real world application and inform practice. Is argued that irrespective of cross-national differences in long-term care, countries face similar challenges, including fragmented services, quality of care, and system and cost inefficiencies (Kodner, 2006). However, due to the UK nature of the case study, the application of integration and integrated care within these contexts was of particular interest. In addition, while the main aim wasn’t to find literature which discussed specific diseases or conditions, literature was included if it discussed the type of approach and strategy of integrated care. Literature searches were carried out in 2015 and updated in 2017 to identify any more recent publications.

**Data analysis:** The search included peer-reviewed articles, academic publications, grey literature such as policy documents and reports from government departments. These were manually examined via title and abstract review (Aveyard et al, 2016). Following the reading of full-texts, literature was then screened for relevance against the inclusion criteria (Aveyard et al, 2016). The quality of the literature was assessed by utilising the Critical Appraisal Skills Programme (CASP) tool, in order to produce meaningful answers to the research questions. Data were identified for relevance within hard copies and then extracted into a data summary sheet. For research
studies this included author and year, country, aim of study or research question, participants, methods, use of theory/definition, and key themes. For non-research evidence this included author and year, country, type of evidence/arguments, main outcomes/messages, use of theory/definition, and key themes. Due to the broad range of the research, data extraction needed to be selective and relevant to the research questions (Aveyard et al, 2016). The process of synthesising the literature was iterative (Aveyard et al, 2016), in order to explore how the concepts of integration and integrated care had been applied within the literature. Due to the nature of the research question, emphasis was given to providing a broad overview of the integrated care literature, rather than quality appraisal. As seen in a literature review conducted by Reed and colleagues, there was therefore the requirement to account for the breadth of literature between different service sectors (i.e. health and social care), professions (i.e. GPs, nurses, social workers), settings (i.e. primary and secondary care), organisations (i.e. private, statutory, and third sector) and types of care (i.e. acute and long-term care) (Reed et al, 2005).

Qualitative and mixed-methods literature were analysed and synthesised thematically by identifying key concepts in individual studies, developing codes and themes from key concepts, checking of consistency of coding/themes between the different studies, translating concepts and generating themes (Thomas and Harden, 2008). This was informed by the method of constant comparative analysis (Lincoln and Guba, 1985; Glaser and Strauss, 1967; Denzin and Lincoln, 1994), which forms the basis of most data analysis and synthesis in literature reviews, particular within qualitative and mixed-methods literature reviews (Aveyard et al, 2016). This includes coding literature, identifying themes in the data, comparing themes across different data, and synthesis of themes and the development of an argument (Aveyard et al, 2016). Within this approach, data are coded with outline codes which are used to create broader categories, with new data either generating new codes or fitting into existing categories (Aveyard et al, 2016). Themes are therefore developed through a process of iterative analysis, until a robust set of themes emerge (Aveyard et al, 2016).
Whilst reviewing the literature, six themes emerged of reoccurring findings, which formed the structure of the conceptual literature review. This method was utilised in order to provide an understanding of the theoretical concepts, models and processes of the complex concepts of integration and integrated care, and to consider their application in practice. Main themes within the integration and integrated care literature included:

1. The case for change
2. Defining integration and integrated care
3. Conceptualisations of integration
4. Complexity of integration and integrated care
5. Impact of integration and integrated care
6. Application of integration and integrated care (international, national, and local)

The output of integrated care models and processes extracted from the literature review are presented at appendix 2.

2.1 The case for change

The rationale for integrating care stems from the concern of fragmentation of patient care services across the system, defined as the breakdown in communication and collaboration in providing services to an individual (Curry and Ham, 2010). The concern of fragmentation in health and social care services has been present among health systems across the world for many years, and is suggested to have developed due to organisations, professionals and services operating independently of each other (Curry and Ham, 2010; Kodner, 2009; Stange, 2009). This is suggested to occur at different levels, due to distinct organisational and professional cultures between health and social care, and separate governance and accountability (Shaw et al, 2011; Glasby et al, 2006). In addition, the historical design of health and social care services as separate entities operating independently (Curry and Ham, 2010; Kodner 2009; Stange, 2009), alongside a focus on cure rather than prevention (Nolte, 2017), has resulted in a system which is no longer sufficient or suitable for population needs.
These divisions and fragmentations result in suboptimal care, higher cost, and poor quality of care (Stange, 2009; MacAdam, 2008). There is therefore the need to transform services to promote unity rather than organisational silos. Integration has therefore been suggested to provide the potential to redesign care around patient needs rather than NHS structures, in order to address these issues (Fulop et al, 2005).

Integrated health delivery systems have been promoted as a means to improve access, management, quality, and continuity of care particularly for those with multimorbidities and chronic disease (Armitage et al, 2009; Kodner, 2009; Suter et al, 2009). These particular populations are suggested to benefit from integrated care, due to the likelihood of the need for multidisciplinary care spanning several services and organisations (Ellins et al, 2012; Haggerty 2012; Shaw et al, 2011). National and local policies also advocate more effective partnership working as a potential solution to improving health and care provision (Department of Health, 2013). However, one fundamental issue of implementing integrated care in practice is that those seeking to understand and promote it, often struggle with conceptualising what integrated care actually means, and particularly how it can be applied (Goodwin, 2016a). It is suggested that understanding what exactly is being integrated and for what purpose is necessary, in order for implementers to identify appropriate structures, processes, strategies, and models within the context of population needs (Armitage et al, 2009).

In addition to issues of fragmentation, the health and social care system is considered to have failed to keep pace with the needs of an ageing population, the changing burden of disease, and rising patient expectations (Ham et al, 2012). However, there is the suggestion that the focus on integration and working in partnership across organisational boundaries, may be driven in response to the fragmentation caused by previous market reforms in public services, the changing demography, and public expectations, rather than on the need to improve the care and experience of service users (Glasby and Dickinson 2008). Working in partnership is also often a difficult and complex process, which can require significant investment with often little return (Dickinson and Glasby, 2010). In addition, while it is accepted that a single agency response is insufficient for supporting those with complex needs, there is the concern
that integrated care becomes a buzzword which is supposedly capable of simultaneously tackling a range of different longstanding policy issues (Glasby, 2016). The evidence around mergers and acquisitions as a response to the need for integrated services, also suggests they rarely achieve their objectives or save money, and tend to reduce morale, productivity and service developments (Glasby, 2016).

2.2 Defining integration and integrated care

In order to tackle the issues associated with fragmentation in patient care services, the concept of integrated care has been used in a variety of ways and contexts, utilising a wide range of terminology (e.g. managed care, collaborative care, seamless care and case management) (Baggott, 2015). However, while health policy researchers, practitioners and policy makers are increasingly referring to the need to introduce ‘integrated care’ into health policies, the term has been experienced by implementers to be relatively vague (Kodner, 2009; Lloyd and Wait, 2007), with no shared definition advocated (Goodwin et al, 2017; Baggott, 2015; van der Klauw et al, 2014; Curry et al, 2013; Armitage et al, 2009). This therefore conveys a variety of meanings depending on the particular context, organisation and professional group (Robertson, 2011). However, it is suggested that in order to account for the complex nature of integrated care, rather than the term being narrowly defined, it should be viewed as an overarching term for a broad set of principles featuring several components, which seek to better coordinate care around individual’s needs (Goodwin, 2016a). This can then be applied and adapted to suit localised contexts and population needs. However, the lack of a universal definition of integrated care creates barriers for effective communication, policy formulation, programme development, and evaluation of integrated care (Nurjono et al, 2016).

A number of authors comment on the confusion surrounding terms such as integration, collaboration, joint or multidisciplinary working, and shared processes (Glasby, 2016; Kodner and Spreeuwenberg, 2002; Grone and Garcia-Barbero, 2001). Through a review of the literature, Armitage et al (2009) revealed over 175 definitions and concepts of integrated care, resulting in varied understandings of what
integrated care implies in practice. The literature has also distinguished between terms such as ‘integration’ and ‘integrated care’. However, it is also noted that these terms are often used interchangeably (Banfield et al, 2017). Nonetheless, within the literature, ‘integration’ is used to describe a set of methods and processes to support and facilitate the alignment and coordination of services across separate institutions, teams, operating units and systems (Shaw et al, 2011; Rosen et al, 2011; Kodner and Spreeuwenberg, 2002; Leutz, 1999). In its most simple form, ‘integrated care’ is conceptualised as the organising principle for care delivery, with the aim to provide services which are designed to deliver the outcome of high quality, cost effective care and high levels of patient satisfaction (Rosen et al, 2011; Shaw et al, 2011; Lloyd and Wait, 2007).

Integrated care aims to address fragmentation in patient services and enable more continuous care commonly for an ageing population who are most likely to have increasing incidence of chronic disease and suffer problems with coordination of care and transitions between services (Haggerty 2012; Ellins et al, 2012; Shaw et al, 2011). The concept of integration is suggested to be the defining variable in the meaning of integrated care (Kodner and Spreeuwenberg, 2002). However, it is important to note that the process of integration may not always result in the optimal outcome of integrated care (Lewis et al, 2010; Kodner and Spreeuwenberg, 2002). The distinction between ‘integration’ operating at organisation and managerial levels, and ‘coordination’ operating at clinical and service delivery levels has also been made (Shaw et al, 2011).

While the varied use of language and terminology may be interpreted as confusing (Kodner, 2009), it is suggested that this is merely indicative of the multifaceted and complex nature of integrated care (Shaw et al, 2011), which operates on different levels of health systems, both horizontally and vertically (Kodner 2009; Armitage et al, 2009). However, one particular definition which is frequently used within the literature (e.g. Goodwin et al, 2017; Goodwin, 2016a; Sutton and Long, 2014; Curry and Ham, 2010; Lewis et al, 2010; Johnson, 2009; Lloyd and Wait, 2007) describes integration and integrated care as:
“A coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment, and collaboration within and between the cure and care sectors [integration]. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long term problems cutting across multiple services, providers and settings [integrated care]” (Kodner and Spreeuwenberg, 2002).

This particular definition details the nature of integration which concerns the processes involved in bringing organisations and professionals together, and the desired effect of improving outcomes for patients through the delivery of integrated care (Curry and Ham, 2010). Table 2.1 also presents a Kodner’s (2009) sampling of some of the better known and adopted international definitions of integration and integrated care.

Table 2.1: Key definitions of Integration and Integrated Care (Kodner, 2009)

<table>
<thead>
<tr>
<th>Term and Author</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Integration</strong></td>
<td>Leutz (1999) The search to connect the healthcare system (acute, primary, medical and skilled) with other human service systems (e.g. long term care, education and vocational and housing services) to improve outcomes (clinical, satisfaction and efficiency).</td>
</tr>
<tr>
<td><strong>Integrated Care</strong></td>
<td>Ovretveit (1998) The methods and type of organisation that will provide the most cost effective preventative and caring services to those with the greatest health needs and that will ensure continuity of care and coordination between different services.</td>
</tr>
<tr>
<td><strong>Integrated Care</strong></td>
<td>Grone &amp; Garcia (2001) A concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care rehabilitation, and health promotion... [as] a means to improve the services in relation to access, quality, user satisfaction and efficiency.</td>
</tr>
<tr>
<td><strong>Integration</strong></td>
<td>Kodner &amp; Spreeuwenberg (2002) A coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment, and collaboration within and between the cure and care sectors... [to] enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long term problems cutting across multiple services, providers and settings.</td>
</tr>
</tbody>
</table>
The diversity of integrated care has resulted in the extensive application of concepts and theories drawn from different scientific fields, contributing to the lack of common terminology and standards (Stein and Reider, 2009). This diversity is also fuelled by the various purposes attributed to the term by the different stakeholders (World Health Organisation, 2016). There may therefore be conflicting professional ideals (e.g. clinical vs. managerial) or perspectives based on the various disciplines involved (e.g. public health, social science, or psychology) (Contandriapoulos et al, 2003). The conceptual ambiguity surrounding integrated care also hinders a systematic understanding and successful real world application, and coherency in visions, design, delivery, management and evaluation (Valentijn et al, 2013; Kodner, 2009). Some of the most commonly utilised definitions from these different perspectives and highlighted in table 2.2 (Goodwin, 2016a).

Table 2.2: Common integrated care perspectives definitions (Goodwin, 2016a)

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health system</td>
<td>“Integrated health services: health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course.”</td>
</tr>
<tr>
<td>Management</td>
<td>“The process that involves creating and maintaining, over time, a common structure between independent stakeholders … for the purpose of coordinating their interdependence in order to enable them to work together on a collective project”</td>
</tr>
<tr>
<td>Social Science</td>
<td>“Integration is a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for people by cutting across multiple services, providers and settings. Where the result of such multipronged efforts to promote integration lead to benefits for people the outcome can be called ‘integrated care’”</td>
</tr>
<tr>
<td>Patient</td>
<td>“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”</td>
</tr>
</tbody>
</table>
It is suggested by experts within the field of integrated care, that a single definition should be developed from the most commonly used definitions (Stein and Rieder, 2009). However, as the concept of integrated care is interpreted by those working within health and social care systems and organisations, and patients and carers do not tend to be active participants within the majority of these definitions of integration and integrated care, their voice may therefore not be heard or represented.

2.3 Conceptualisations of integration

As the concept of integration includes many dimensions, no single model of integrated care has been developed which is suited to all contexts, settings and circumstances (Shaw et al, 2011; MacAdam, 2008). This has resulted in an umbrella term which encompasses diverse initiatives that seek to address fragmentation, but differ in underlying scope and values (Shaw et al, 2011; Stein and Reider, 2009). This covers a range of approaches including, co-location of care, the sharing of information of patients, single assessment processes, and integrated management of disease in chronically ill people and others (Baggott, 2015). However, this broad spectrum of approaches often exacerbates the issue of defining what integrated care actually involves, and measuring the comparative impact of such models (Baggott, 2015). It is also suggested that without a congruent definition, which contributes to the apparent lack of conceptual clarity, it is also somewhat difficult to promote integrated care comprehensively in theory and practice (Baggott, 2015; Stein and Reider, 2009; Kodner and Spreeuwenberg, 2002). Nonetheless, while the specific features of successful models may vary, they have typically included the use of case management and access to a wide range of social and health supportive services (MacAdam, 2008). One particular review of the integrated health system literature categorised these models into either system level, programme/service level, or progressive or sequential models (Armitage et al, 2009). The common strategies of these models are detailed in table 2.3.
Table 2.3: Common attributes of models facilitating health system integration (Armitage et al, 2009)

<table>
<thead>
<tr>
<th>Model</th>
<th>Common attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>System level</td>
<td>Models varied but tended to focus on aspects of organisational change.</td>
</tr>
<tr>
<td>Programme or service level</td>
<td>Models focused on case management, co-location, implementation of healthcare teams, the enhanced role of primary care physicians, or the use of a population health approach.</td>
</tr>
<tr>
<td>Progressive or sequential</td>
<td>System integration tended to be seen as a means of achieving improved healthcare performance through a number of stages, from less coordinated care to full integration.</td>
</tr>
</tbody>
</table>

Different taxonomies of integrated care have also been developed in order to compare approaches by examining four key elements including the types, breadth, degree, and processes of integration (Goodwin, 2016a; van der Klauw et al, 2014; Ernst and Young, 2012; Nolte and Mckee, 2008). It is suggested that the level, type and combination of strategies used to integrate care are dependent on the characteristics of the patient population and the specific challenges faced (Leutz, 1999). The flexible concept can therefore be adapted to suit the needs of the target population within its local context. The goals of the integrated care initiative should therefore guide decisions about the processes adopted to best facilitate integrated care within their particular setting (Shaw et al, 2011). When developing a framework for integrating health and social care, those who commission and provide services would therefore be encouraged to consider the type, level, breadth, intensity, contexts and goals of integration for the target population.

A summary of the conceptualisations of integration found within the literature review is presented at appendix 3.
2.3.1 Types of integration

The many dimensions of integrated care have led to the discussion of the different types of integration identified within the literature (e.g. Valentijn et al, 2015a; Goodwin et al, 2014; Valentijn, et al, 2013; Goodwin, 2013a; Ernst and Young, 2012; Rosen et al, 2011; Shaw et al, 2011; Curry and Ham, 2010; Lewis et al, 2010; Armitage et al, 2009; Kodner, 2009; MacAdam, 2008; Nolte and McKee, 2008; Lloyd and Wait, 2007; Fulop et al, 2005; Contandriopoulos et al, 2003; Delnoij et al, 2002). These explorations have led to the identification of the same broad categories of ‘integrative processes’, which aim to merge systems, share clinical standards or values, and bring together structures, services or functions (Pike and Mongan, 2014). These categories can be seen in the form of:

- Systemic integration
- Clinical/service integration
- Organisational integration
- Normative integration
- Functional/administrative integration

The various dimensions of integrated care are suggested to encompass a much broader spectrum than the mere provision of care and the organisational and governance arrangements required to deliver integration, with the suggestion that considerations of process and cultural changes are at least as equally important (Fulop et al, 2005). The aim of integrating care for patients may therefore involve a combination of different types of integration (Lewis et al, 2010). This notion is reflected in one of the most comprehensive and frequently utilised typologies of integrated care within the literature (e.g. Miller et al, 2016; Goodwin et al, 2014; Pike and Morgan, 2014; Valentijn et al 2013; Curry and Ham, 2010; Kodner, 2009), which builds on the dimensions of integration detailed by Fulop et al (2005). This is an example of a model which details the combination of different types of integration which may be sought in response to the goal of integrating care for patients (see figure 2.1; Lewis et al, 2010).
Figure 2.1: Typologies of integrated care (Lewis et al, 2010; Fulop et al, 2005)

Within this model depicted in figure 2.1, Fulop et al (2005) identify organisational, functional, service, and clinical integration as key requirements for effective integration, with normative and systemic integration representing crucial factors in determining the success of integration. As figure 2.1 details, normative integration involves shared values and commitment to integration and enables trust and collaboration in delivering services (Lewis et al, 2010; Fulop et al, 2005). This has also been referenced as relating to relational processes which includes cultural integration (i.e. convergence of values, norms, working methods, approaches and symbols adopted by the various actors and stakeholders) and social integration (i.e. the intensification of social relationships between the various actors and integration of objectives, interests, power and resources of the various actors) within the literature (e.g. Notle and McKee, 2008; Fabbricotti, 2007). However, while shared goals and an integrative culture are considered to be crucial for normative
integration, differing organisational cultures can create barriers to developing integrated care pathways (Lyngso et al, 2016). For example, the focus on acute care in hospitals can contrast with the holistic and long-term approach in primary and community care, making shared goal setting difficult (Lyngso et al, 2016).

It is suggested that integrated organisations may not choose to adopt all of the elements of the model, as they may differ in terms of their underlying purpose and scope (i.e. services for care groups or complete health systems) (Lewis et al, 2010). This model is therefore flexible, with factors which may affect the most relevant and effective types of integrated care may also including the goals of the project, the stakeholders involved, existing local health and social care arrangements, available resources (Shaw et al, 2011), the incentives and governance arrangements, effective leadership, and integrated information systems (Lewis et al, 2010). However, while, it is advocated that all types of integration need sustained and simultaneous attention (Fulop et al, 2005), this is often not always feasible in practice, especially due to limited resources, workforce changes and organisationally dependent priorities.

While those authors who build on Fulop et al’s (2005) typology differentiate between clinical integration and service integration (e.g. Miller et al, 2016; Curry and Ham, 2010; Lewis et al, 2010), these types are often merged into one dimension, and refer to the extent to which services are coordinated and patient care is integrated in a single process across time, place and discipline (e.g. Valentijn et al, 2015a; Goodwin et al, 2014; Valentijn et al, 2013; Pike and Morgan, 2014; Rosen et al, 2011; Shaw et al, 2011; Kodner, 2009; Nolte and McKee, 2008; Delnoij et al, 2002). Functional integration has also been used interchangeably with administrative integration and is often used as an umbrella term for support functions which also include informational integration (i.e. shared access to clinical information) and financial integration (i.e. aligned financial initiatives across organisations) (as seen in Miller et al, 2016; Valentijn et al, 2015a; Goodwin et al, 2014; Valentijn et al, 2013; Shaw et al, 2011; Lewis et al, 2010; Kodner, 2009; Nolte and McKee, 2008; Lloyd and Wait, 2007; Fulop et al, 2005; Contandriopoulos et al, 2003; Delnoij et al, 2002). This has also
been referenced as relating to technical processes which includes structural integration (i.e. the alignment of tasks, functions and activities of organisations and healthcare professionals) within the literature (e.g. Notle and McKee, 2008; Fabbricotti, 2007). However, while these distinctions are useful for conceptualising different types of integrated care, the overlap in the terms adds to the confusion and complexity of its application in practice, rather than the intended clarity sought. An additional type of integration which has also been acknowledged within the literature is that of professional integration, which is considered to regard joint working, group practices and strategic alliances, based on shared competencies, roles, responsibilities and accountability (Valentijn et al, 2015a; Goodwin et al, 2014; Valentijn et al, 2013; Kodner, 2009; Nolte and McKee, 2008; Lloyd and Waite, 2007; Delnoij et al, 2002).

Through a review of integration in action, Rosen and colleagues (2011), identified several integrative processes as mutually reinforcing key components of progress, which also facilitated embedding coordinated care into daily practice. This was based on semi-structured interview data and document analysis, which was analysed based on the conceptual model of integrated care developed by Shaw and colleagues (2011). These integrative processes were observed to create an inseparable web of activities aligning professional behaviour and the delivery of integrated care (Rosen et al, 2011), and are suggested to provide a link between the concept of integrated care and integration (Shaw et al, 2011). These integrative processes were largely similar to those detailed in Lewis and colleagues’ (2010) model (see figure 2.1), with the exception that distinctions were made between administrative, financial and informational integration, rather than the all-encompassing functional integration type often seen throughout the literature (see appendix 3). They also suggested that normative, organisational, administrative and clinical processes were particularly relevant to how organisations operationalised integrated care, and identified skilled leadership, high trust relationships and consistent communication to be particularly important to enable progress (Rosen et al, 2011).
While many attempts of integration have started at the organisational level, it is argued that it may be more beneficial to begin at the frontline team level and patient care journey, to then progress on to considering the most appropriate organisational form required to deliver the required level of integration (Fulop et al, 2005). In a similar vein, it is advised to avoid the tendency to focus on organisationally and structurally based conceptualisations or those which focus on cost effectiveness (Goodwin, 2016a); and concentrate on providing patient-centred definitions which focus on ‘caring’ to allow for a basis for objectives and measuring success (Goodwin and Alonso, 2014). The conceptualisation adopted for a particular programme will therefore affect how success can be judged. As it is unlikely that all types of integration will be relevant to every project (Shaw et al, 2011), it is also important to refrain from making the assumption that organisational integration is the optimal way of achieving integrated care for patients (Lewis et al, 2010; Fulop et al, 2005).

MacAdam (2008) conducted a comprehensive literature review of frameworks of integrated care for older people and revealed that only half of these strategies actually integrated coordinated care for patients, with the remainder focusing on establishing professional or organisational integration. As their inclusion criteria focused on literature which explicitly discussed the detail of comprehensive models of integrated care for older people as the focus of health system reform, these results are applicable to this population. The potential for integration which mainly focuses on bringing together markedly different organisations to impact on improved patient outcomes is also argued to be low, due to the danger of this particular strategy becoming a distraction from other essential tasks (Fulop et al, 2005). The incorrect assumption that organisational integration leads to integrated services at other levels may also result in less attention being given to creating more effective clinical integration (Fulop et al, 2005). The structures and processes which support greater organisational and service integration, may not always result in enhanced outcomes and patient experience associated with effectively integrated care (Kodner and Spreeuwenberg, 2002). It is also suggested that importance should be placed at service and clinical levels, rather than concentrating on the organisational solution (Goodwin and Smith, 2012; Goodwin et al, 2012). The importance of clinical and
service integration is also highlighted due to the requirement for the development of multidisciplinary working and developing trusting relationships (Pike and Mongan, 2014).

2.3.2 Levels of integration

Integrated care has been described as operating on different levels. In order to foster and provide a strategy for integrated care and the promotion of transformational change, integration can be seen as occurring at the individual level (micro), through to the organisational level (meso), and the whole population system level (macro) (Pike and Mongan, 2014; Valentijn et al, 2013; Ham and Curry, 2011; Curry and Ham 2010; Ling et al, 2010; Reed et al, 2005; Epping-Jordan et al, 2004; Kodner and Spreeuwenberg, 2002; Grone and Garcia-Barbero, 2001) (see table 2.4). Alternatively, it is suggested that integration can operate on funding, administrative, organisational, service delivery, and clinical levels (Kodner, 2009; Kodner and Spreeuwenberg, 2002). However, it is argued that the two approaches are not mutually exclusive, with the potential for the funding level to fit within the macro domain (Kodner, 2009). Care coordination, which aims to ensure the experience of seamless care, is an example of a method or tool which can be utilised in order to achieve integration at the micro level (Curry and Ham, 2010). It is argued that as service user experience tends to be influenced more by the nature of team working than organisational arrangements, care coordination is more dependent upon clinical and service integration rather than organisational (Curry and Ham, 2010).
Table 2.4: Levels of integrated care (Pike and Mongan, 2014; Curry and Ham, 2010)

<table>
<thead>
<tr>
<th>Level</th>
<th>Definition</th>
<th>Example Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Micro (individual)</td>
<td>Care of individual</td>
<td>Integrated care for individual service user</td>
</tr>
<tr>
<td>Meso (organisational)</td>
<td>Care of target groups</td>
<td>Integrated care for a particular group of people with specific needs for the same disease or condition (e.g. older people, those with diabetes)</td>
</tr>
<tr>
<td>Macro (system)</td>
<td>Care of whole population</td>
<td>Integrated care delivered across the full spectrum of services of the whole population</td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

While these helpful distinctions between different levels are made, a combination is often used in practice. This is suggested to be due to the limited likelihood of integration improving outcomes unless action is sought at all levels, with particular limited ability of changes made solely at the macro system level to improve outcomes for service users and address care fragmentation (Curry and Ham, 2010). However, it is argued that efforts to integrate care at the system level must be linked to initiatives on the meso level (for particular care groups and populations), and at the micro level (for individual service users and carers) (Curry and Ham, 2010). In a similar vein, the degree to which integrated care can be developed on the micro level appears to be affected by the characteristics of the health care system on the macro level (Delnoij et al, 2002). However, interventions or initiatives which incorporate multiple types and levels, allows for the opportunity of both improved patient outcomes and system level performance (Kodner and Kyriacou, 2000).

2.3.3 Breadth of integration

In terms of the breadth of integration, organisations have been described as providing a range of clinical and functional services in the form of horizontal and vertical integration (World Health Organisation, 2016; Ernst and Young, 2012; Shaw et al, 2011; Ham and Curry, 2011; Curry and Ham 2010; Kodner, 2009; MacAdam, 2008; Reed et al, 2005). For example:
• Horizontal integration is where similar organisations at the same level and stages of the service delivery process are joined together (e.g. mergers of acute hospitals).

• Vertical integration is where different organisations at different levels and stages of the service delivery process are combined across the continuum of care (e.g. integrating primary and secondary care, or general practice and community care).

Virtual integration is often achieved through utilising multidisciplinary teams, by bringing together different professional groups and organisational backgrounds (Harris et al, 2013). However, there are certain obstacles to these forms which have included, the structuring of existing services around functions, specialisation trends, and individualism in physician practice (Hronek and Bleich, 2002). Vertical integration has also been suggested to create the potential for policy challenges and tensions to occur (Lewis et al, 2010). In addition, a systematic review of the literature argued that there were no instances were interventions were purely vertical or horizontal, suggesting that this distinction is a false dichotomy (Atun et al, 2010). Alternatively, it is argued that health interventions are integrated into one or more critical health function, producing a highly heterogeneous picture which includes both non-integrated and integrated interventions (Atun et al, 2010). Nonetheless, a further conceptualisation within the literature is that both horizontal and vertical integration may be either real (i.e. mergers between organisations) or virtual (i.e. alliances, partnerships and networks created by a number of organisations) (Curry and Ham, 2010). Virtual integration is sometimes also referred to as contractual integration, as it is often underpinned by contracts or service agreements between organisations (Curry and Ham, 2010). This further highlights the variation in application of terms, creating issues for implementation and those aiming to understand integrated care in practice.

Due to the lack of evidence of the improvement outcomes associated with the exclusive focus on organisational integration (Fulop et al, 2005), virtual or contractual
integration is often viewed seen as an alternative form. This type of integration is argued to provide benefits which can be attributed to the strategy of bringing together clinical teams and services (i.e. clinical/service integration) and aligned incentives in support of service improvement (Curry and Ham, 2010). An important tool or model of virtual integration is viewed to be that of clinical networks (Fulop et al, 2005). The performance of systems based on virtual integration is also suggested to depend on effective leadership and the development of a collaborative culture (Curry and Ham, 2010). There is however, the suggestion that the virtual nature of practice-based commissioning (placing commissioning power with those at the frontline of primary care service delivery) does not necessarily allow for sufficient power or accountability for integrated care to be delivered at scale (Lewis et al, 2010), creating issues for the development and implementation of integrated care in practice.

2.3.4 Degree and intensity of integration

The different forms of integrated care are often described in terms of a continuum (Aghgren and Axelsson, 2005; Leutz, 1999). Leutz (1999) comments on the different varieties of integrated care based on the intensity of the levels, and distinguishes between linkage (between existing organisations), coordination (through networks but still largely operating through organisational units), and full integration (formally pooling budgets, responsibilities, and resources). This research is based on experiences of reform efforts in the UK and USA, and therefore provides a useful international perspective (MacAdam, 2008). Those strategies which emphasise coordination and full integration have been observed to be at the core of whole system reform in long term care (Kodner, 2006). While coordination operates largely through separate structures of current systems, full integration is seen as more radical and most appropriate for users with high levels of need, with programmes using resources to define new benefits and services (Ernst and Young, 2012; Leutz, 1999). However, full integration may not always be appropriate or indeed necessary, as a service user needs may be satisfied through less organisational integration and
more opportunity for choice and personalisation (Lewis et al, 2010). For example, those with lower-level needs where self-management can be utilised, may not require fully integrated teams which provide multidisciplinary care. Nonetheless, fully integrated models are often viewed as being the strongest form (Kodner, 2009). However, it is suggested that irrespective of the focus of integrated care, in reality initiatives rarely move smoothly along the continuum in a linear fashion from linkage, through to coordination and full integration (Shaw et al, 2011).

2.4 The impact of integrated care

Many benefits have been claimed for integrated care, including better quality care, improved outcomes of care and coordination, efficiency and greater cost effectiveness (Commission on the Future of Health and Social Care in England, 2014; Health Committee, 2014; Martinez-Gonzalez, et al, 2014; Nolte and Pitchforth, 2014; Ham and Walsh, 2013; Goodwin et al, 2012; NHS Future Forum, 2012; Ham et al, 2011; NHS Future Forum 2011; Curry and Ham 2010; Ouwens et al, 2005; Kodner and Kyriacou, 2000). However, the UK evidence base around integrated care has been described as lacking focus and generally not of high quality (Nolte, 2017; Nolte, 2012). In addition, the accumulating evidence base of the effectiveness of integrated care is also varied and is often indirectly derived from studies of different models and separate components (e.g. case management) (Kodner, 2009). For example a systematic review of the effectiveness of integrated care interventions in improving the quality of life of patients with chronic conditions highlighted mixed evidence, particularly in terms of the effectiveness of case management, chronic care model interventions, discharge management, and multidisciplinary team and self-management interventions (Flanagan et al, 2017).

Further systematic reviews have been conducted within the field of integrated care, in order to produce accurate and reliable conclusions. These reviews have been conducted within the areas of health systems integration (Atun, et al, 2010; Armitage et al, 2009), primary care (Martin et al, 2014), and community-based alternatives for older people (Huntley et al 2017; Trivedi et al, 2013); all highlighting the existence of
variation in effectiveness. For example, it is suggested that while interventions which are designed to address the issues of fragmentation may vary greatly within different contexts, this is also likely to be further exacerbated by the intervention complexity and health system characteristics (Atun, et al, 2010). It is also argued that in order to deliver an evidence-based conclusion on the effectiveness of integration, investments should be made in studies with robust designs, comparable control and intervention groups, valid and reliable outcomes, and analysis of costs (Atun, et al, 2010). However, it may not always be possible recruit to comparable control and intervention groups and complete cost analysis (i.e. due to the infancy of many integration initiatives).

Due to this complexity, integrated health systems need to be designed to fit the needs of the population across the care continuum (Armitage et al, 2009). In addition, while some models of interprofessional working were considered to be beneficial in terms of improved quality of care and outcomes, the aims of this type of working needed to be clarified, alongside how different models and working processes may result in different outcomes for different groups (Trivedi et al, 2013). A systematic review on the integration of primary care and mental health services in the United States also highlighted that in order to further assess its effectiveness in practice, more information is needed regarding training, supervision, programme models, and settings (Martin et al, 2014). However, it is suggested that community-based alternative interventions to hospital admission are safe, with the potential to reduce the use of secondary care and length of time receiving care (Huntley et al, 2017). It is therefore suggested that clinicians should have confidence in offering these alternatives and refrain from making the assumption that hospital admission is the optimal course of action for patients (Huntley et al, 2017).

The potential effectiveness of integrated care initiatives has also been further argued to be substantially dependent upon the context in which the interventions are delivered and implemented (Nolte, 2017; Thistlethwaite, 2011; Kaplan et al, 2010; Powell Davis et al, 2006). Attempts to integrate care therefore cannot be seen separately from their clinical, geographic, financial and policy contexts (Ling et al,
Intervention effects will also differ by target population and setting, particularly where initiatives involve a complex interplay of different actors, relationships and processes (Nolte, 2017; Thistlethwaite, 2011). These factors are also identified as a key contributors to the lack of concrete guidelines on how to achieve integration and partnership working (Thistlethwaite, 2011). It is also difficult to come to definite conclusions about what works best, in what form, and in what context, often due to the varied strategies and approaches which are not necessarily comparable across the services and systems in which they are implemented (Nolte, 2017).

In addition, it is argued that the lack of conceptual clarity surrounding integrated care, results in a difficulty to compare experiences and results on both a national and international level, and promote integrated care comprehensively in theory and practice (Stein and Reider, 2009; Kodner and Spreeuwenberg, 2002). This also creates difficulties for those implementing integrated care to be clear about what is intended, and how this can be achieved (Shaw et al, 2011). Nonetheless, it is accepted that integrated care should be patient-centred (i.e. rather than traditionally organisation centred), that there should be clear aims and objectives, and that the evaluation of integrated care projects has been observed to be problematic (Baggott, 2015; Bardsley et al, 2013; NHS Future Forum, 2012). However, in accordance with integrated care, person-centred care is also accepted to be a complex phenomenon, especially when multiple agencies and disciplines are involved in its delivery (Elbourne and May, 2015).

While integrated care is often viewed as a potential solution to the issues faced by health and social care systems (e.g. fragmentation), a number of obstacles which could hamper the successful development of integrated organisations have been identified (Fulop et al, 2005). Consistent delivery of guideline based care has been experienced to be a challenge, often due to the many barriers to implementation which exist. These have been suggested to include inconsistencies in national health policy changes (NHS Future Forum, 2012, 2011; Rosen et al, 2011), operational complexity, regulatory challenges, separate funding and accountability, and cultural
differences (Humphries, 2015; Maruthappu et al, 2015), and changing NHS job roles (Ling et al, 2012). The National Audit Office (2017) also proposes that the main barriers of integration are represented by financial incentives, workforce challenges, information sharing, with the New Local Government Network (2016) noting poorly aligned incentives (based on activity rather than prevention), in addition a reluctance to invest in prevention due to system pressures and rigid national regulation.

The presence of cultural differences between primary and secondary care and between health and social care (Shaw et al, 2011; Glasby et al, 2006), along with the time taken to implement change, presents considerable challenges for integration which is often underestimated (Fulop et al, 2005). Culture has been defined by Schneider and Barbera (2014) as ‘the values and beliefs that characterise organisations, as transmitted by socialisation processes that newcomers have, the decisions made by management, and the stories and myths people tell and retell about their organisations’ (Schneider and Barbera 2014, pg. 10). Culture can therefore have considerable influence on how services operate and work together (Miller, 2016). Organisational and professional cultures are a reoccurring feature in integration research (Miller et al, 2016), and often reference the cultural divide between health and social care which acts as a barrier to joint working (Miller, 2016).

Contributing factors include health services being funded through national taxation where managers are largely accountable upwards to the Health Secretary, as opposed to social care services funded through a mixture of national and local taxation, with managers accountable both upwards and outwards to local elected councillors (Rummery and Coleman, 2003).

A focus on organisational and professional values and cultures is considered to be crucial, in order to contribute towards dealing with issues such as professional identity and professional protectionism, and trust, which can create barriers to successful partnership working (Glasby, 2016). However, there is an argued lack of consensus of the meaning of organisational culture, with competing claims on whether these cultures are able to be shaped by external influences (Scott et al, 2003a). Differing organisational cultures can also create barriers to developing
integrated care pathways (Lyngso et al, 2016). In addition, it is suggested that the link between culture and performance should be treated with caution, as most studies which suggest this link are argued to be methodologically weak (Scott et al, 2003b).

It has also been suggested that in absence of the certain key elements such as the attention to culture differences and the amount of time needed to make integrated care a reality, it is likely that tensions within the system will continue, resulting in services which are organisationally focused rather than person centred (McCormack et al, 2008). These elements include linkages across the inherent boundaries in health and social care systems, linkages between the hierarchies in health and social care organisations, and the facilitation of improved and effective communication between organisations and staff members (McCormack et al, 2008). In addition, there is also the current challenge of normalising joined up working and collaboration within a time of limited resources (Glasby and Dickinson, 2014).

Due to the lengthy process of large scale system transformation and substantial shifts in ways of working, there are inherent difficulties of measuring and showing success, outcomes and impacts. For example, evidence of the impact of integrated care as a whole is difficult to obtain, due to its complex and polymorphous nature across various disciplines and professions (Nolte, 2017; Nolte and McKee, 2008). Several factors which may affect the ability to demonstrate the impact of integrated care initiatives include the barriers to implementation not being fully understood, poor implementation and project management, poorly defined interventions, or changes in the wider context (Bardsley et al, 2013). The difficulties associated with measuring the impact of integration efforts have been summarised by Curry and Ham (2010) to include:

- The manifold nature of the aims of integration mean the criteria against which success is measured can vary widely.

- Despite clear and consistent intentions, the target populations, size of the intervention groups and the contexts may be different and difficult to compare.
Some intended outcomes of integration are not easily measurable (i.e. relational aspects).

Despite indications that integration may be resulting in positive effects, assessing the impact of integration is therefore a significant challenge (Goodwin, 2013a; Curry and Ham, 2010). However, despite these issues, integrated care is suggested to offer the opportunity to address overall healthcare efficiency and effectiveness concerns (Kodner, 2009), with the opportunity for important conclusions regarding effectiveness to be drawn from examples of integrated care models within the literature (Kodner, 2006). It is also suggested that with clear vision, the appropriate combination of strategies and resources, and the circumstances to support it, the many benefits of integration can be brought to the populations at need, alongside the larger health system (Kodner, 2009). However, as planning and implementing large scale service changes takes time, it may be that changes to structure and process may be more reasonably expected, than significant impacts on outcomes (Bardsley et al, 2013). It is also important to consider shorter term effects and changes in process which happen with a service intervention, before the longer term outcomes appear (Bardsley et al, 2013). This is important for those assessing the impact of integrated care initiatives.

In response to the deficiencies in the provision of health care, the Centres for Medicare and Medicaid services in North America implemented the ‘triple aim’ of: improving individual health and patient experience, improving population health, and reducing the costs of health care (Berwick et al, 2008). However, due to their complexity and associated challenges, developing a model which successfully simultaneously achieves all three goals was challenging (Sanna and Reuben, 2013). The increased pressure on health care providers to achieve these aims and provide high quality care with limited resources and in a fragile environment of uncertainty has also been observed to lead to professional burnout and heightened stress levels (Sikka et al, 2015; Bodenheimer and Sinsky, 2014). There have therefore been recent
calls to promote a more realistic ‘quadruple aim’ of health care, which also includes the goal of improving the work life and experience of care providers (Sikka et al, 2015; Bodenheimer and Sinsky, 2014). As health care is fostered on relationships between care providers and care receivers, striving to achieve the triple aim of healthcare (represented by three performance measures) also undermines the very performance needed to achieve these aims.

The success of integrated care models has therefore been typically assessed in terms of the extent to which they improve the quality of care services, deliver better outcomes for service users, and provide services that are more cost effective (Berwick et al, 2008). In reference to key success factors of integrated efforts, the literature has highlighted the importance of clear goals, effective leadership and management, shared values and understanding of roles, good relationships and communication, and professional attitudes (i.e. normative integration), and integrated data systems, common assessment procedures, and joint training and education (i.e. functional integration) (Pike and Mongan, 2014; Ling et al, 2012; MacAdam, 2008). It is suggested that in delivering integrated care, there is a requirement for a balance of activities which acknowledge motivational and cultural factors (i.e. normative), as well as organisational and infrastructural factors (i.e. functional) (Ling et al, 2012). The focus on how to improve service fragmentation for a group of patients has also been suggested to drive successful integration projects (Shaw et al, 2011).

While systematic integrated care reviews have been unable to identify a unified model of integration (e.g. Flanagan et al, 2017; Huntley et al 2017; Martin et al, 2014; Trivedi et al, 2013; Atun, et al, 2010; Armitage et al, 2009; Suter et al, 2009), several key principles and essential components for successful health systems integration have been suggested.

Suter and colleagues (2009) summarise some of these successful principles which were apparent independent of the type of integration model, healthcare context or population group, and suggest that a combination of the following factors are likely to facilitate successful integration:
• Comprehensive services across continuum of care
• Patient focus
• Geographic coverage and rostering
• Financial management
• Standardised care delivery through interprofessional teams
• Organisational culture and leadership
• Performance management
• Information systems
• Governance structure
• Physician integration

These principles link to the different types of integration described by in figure 2.1. For example, comprehensive services across continuum of care, standardised care delivery through interprofessional teams, and physician integration relate to clinical and service integration, through multidisciplinary professionals providing services at within a single process (Lewis et al, 2010; Fulop et al, 2005). In addition, governance structure, performance and financial management, and geographic coverage and rostering relate to systemic integration, where there is a coherence of rules and policies at a organisational level (Lewis et al, 2010; Fulop et al, 2005). Organisational culture and leadership also relate to organisational integration where organisations are brought together (either formally or informally), and information systems relates to functional integration where non-clinical and back-office functions are integrated (Lewis et al, 2010; Fulop et al, 2005). A patient focus should also span all types of integration discussed. However, these principles are lacking in their applicability to normative integration, which is argued to be an important enabler of integration and provides connectivity across the different micro, meso and macro levels (Valentijn et al, 2013).
2.5 Complexity of integration

Integrated care and the majority of global health systems, are often characterised by complexity (Goodwin et al, 2017; Goodwin, 2016a; Goodwin, 2016b; Glasby and Dickinson, 2014; Goodwin, 2013a, Goodwin, 2013b; Valentijn et al, 2013; Kodner, 2009; Kodner and Spreeuwenburg, 2002). The complex nature of care delivery often creates barriers for achieving optimal patient care, with elements such as poor planning and operations, limited resources, inefficiencies, and a lack of effective communication often all playing their part (Glasby and Dickinson, 2014). Despite its benefits, the complexity of integrated care contributes towards the problematic nature of its development and delivery within practice. While in theory, integrated care represents a simple principle of combining separate parts to work together as a whole to provide high quality care, in practice it is the process of integration to achieve better outcomes that is suggested to be so complex and difficult to describe (Goodwin, 2013b). This seemingly simple principle also becomes significantly complex, once attempts to consider what this actually means in practice are made (Miller et al, 2016). This is alongside the inseparable web of activities aligning professional behaviours and the delivery of integrated care (Rosen et al, 2011). A contributing factor is the significant amount of time required to define and interpret its meaning within specific contexts, due to the lack of applicability of a standard definition (Goodwin, 2016a). It is also suggested that in a complex system which involves a range of people, professionals, and politicians, healthcare is likely too complex for a one-size fits all approach to integration, with a simple solution which delivers expected outcomes unlikely to exist (Miller et al, 2016; Armitage et al, 2009).

While the literature has explored the many taxonomies and dimensions of integrated care, Goodwin (2013a) argues that there has been a lack of exploration into understanding the full complexity of integrated care initiatives, for example through complex adaptive systems (Edgren and Barnard, 2012) or the notion that better care coordination results from activities taken at multiple levels (e.g. systemic, organisational, professional) (McDonald et al, 2007). Complex adaptive systems (CAS) are described by Plsek and Greenhalgh (2001) on page 3. However, it is also argued
that there is a need for a clearer definition of how CAS apply to healthcare and comparisons with alternative approaches (The Health Foundation, 2010). Nonetheless, while there is some disagreement within the literature over the terminology of CAS, the key features are considered to generally include embeddedness, nested systems, fuzzy boundaries, distributed control, self-organisation, emergence, unpredictability, non-linearity, phase changes, historicism, sensitivity to initial conditions, non-equilibrium, adaptation, and co-evolution (Holland, 2014; Plsek, 2003; Manson, 2001; Byrne, 1998). Integrated care delivery is considered to represent a CAS as there are multiple participants separated by time and space, with the different rules of engagement for how they should work together emerging and evolving over time (Kuziemsky, 2016). However, approaches based on complexity theory have been seen to have limited success in healthcare, with low rates of modelling implementation often being attributed to the lack of good data from which to build models, the complex social and organisational context of healthcare (i.e. with multiple intersecting and nested stakeholder groups), and the high expertise and time costs of creating sufficiently complex, ecologically valid models (Long et al, 2018). In addition, as there are several layers of nested systems within the health service system alone (i.e. general practices, practice networks, hospitals, hospital networks, and national programs), it is difficult to determine where to focus the core of analyses, and how many levels of analysis are sufficient to provide a complete understanding of the healthcare system (Long et al, 2018).

In order to attempt to understand the complexity of integrated care, Valentijn et al (2013) developed a robust conceptual framework from a primary care perspective termed ‘The Rainbow Model of Integrated Care’, which utilised a theory driven and mixed methods approach. This framework highlights the importance of primary care, its similarities with integrated care (promoting coordination, continuity of care, equity of access, and public health), and its central role in integrating care within a health system (Valentijn et al, 2013). This model was also updated by Valentijn in 2016, to included considerations of the triple aim of integration (see figure 2.2; table 2.5). Within this model it is suggested that different dimensions of integration can be achieved at the micro level (clinical integration), meso level (organisational and
professional integration), and macro level (system integration) (see figure 2.2; table 2.5), which is argued to provide comprehensive insight into the features needed to achieve integrated care within a system (Valentijn et al, 2013). In addition functional integration (e.g. communication and IT) and normative integration (e.g. shared cultural values) also span macro, meso and micro levels and facilitate connectivity between the levels (Valentijn et al, 2015; Goodwin, 2013a; Valentijn et al, 2013).

![Rainbow Model of Integrated Care](image)

**Figure 2.2: Rainbow Model of Integrated Care (Valentijn, 2016; Valentijn et al, 2013)**

**Table 2.5: Components of rainbow model of integrated care (Valentijn et al, 2013)**

<table>
<thead>
<tr>
<th>Level</th>
<th>Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mirco</td>
<td>Clinical</td>
<td>Refers to the extent to which care services are coordinated</td>
</tr>
<tr>
<td>Meso</td>
<td>Professional</td>
<td>Refers to the extent to which professionals coordinate services across various disciplines</td>
</tr>
<tr>
<td>Meso</td>
<td>Organisational</td>
<td>Refers to the extent to which organisations coordinate services across different organisations</td>
</tr>
<tr>
<td>Macro</td>
<td>System</td>
<td>Refers to the alignment of rules and policies within a system</td>
</tr>
<tr>
<td>All</td>
<td>Functional</td>
<td>Refers to the extent to which back-office and support functions are coordinated</td>
</tr>
<tr>
<td>All</td>
<td>Normative</td>
<td>Refers to the extent to which mission, work values etc. are shared within a system</td>
</tr>
</tbody>
</table>
This is therefore a useful unifying conceptual framework, which places person focused, population-based care as the guiding principle for achieving integration across the care continuum, with different integration processes representing interconnected roles among the different dimensions of integrated care on the various levels (Goodwin, 2013a). This is an example of a model which aids the provision of conceptual clarity (Goodwin, 2013a), and identifies many relevant dimensions which can be contextualised to any integrated care setting aiming to improve population health outcomes (World Health Organisation, 2016).

Despite this model’s strengths, it provides a more process driven approach to integrated care, rather than a user-centred understanding (Banfield et al, 2017, Goodwin et al, 2017). In addition, service users were not included in the expert group informing this model, leaving the utility of these features unknown for these stakeholders (Banfield et al, 2017; Valentijn et al, 2015a; Valentijn et al, 2015b). This is however acknowledged by the authors. In addition, this framework did not tackle the wider issues in dealing with the socio-determinants of ill-health or integrating public health approaches into the integrated strategies (Goodwin et al, 2017). This highlights the issue of developing a generic framework in which to judge the key success factors across complex service integration (Goodwin et al, 2017). Nonetheless, collaborations are occurring in order to validate the model within the international context of Singapore (e.g. Nurjono et al, 2016). However, as participants were healthcare providers, including social care providers and patients would therefore provide a more complete picture of its applicability (Nurjono et al, 2016).

Minkman and colleague’s developmental model of integrated care (DMIC) (see figure 2.3) also acknowledges that integrated care is a complex intervention (Goodwin et al, 2017; Goodwin, 2013a; Minkman et al, 2011; Minkman et al, 2009). The model identifies key nine dimensions for integrated care (including client-centeredness, quality care, performance management, result-focused learning, transparent entrepreneurship, commitment, roles and tasks, interprofessional teamwork, and delivery system), and four phases of development from the design to the transformation stage (Miller et al, 2016; Minkman et al, 2012; Minkman et al, 2009).
Unlike other integrated care models, the DMIC is designed to enable leaders and managers to reflect on whether essential elements of integrated care are in place (i.e. the nine dimensions), establishing a four phase programme of change including design, experimentation, expansion and monitoring, and consolidation (Goodwin, et al 2017). These four phases demonstrate that integrated care development is characterised by a changing focus over time in each phase (Minkman, 2016). This is also useful for developing MDTs, from initially determining if the context will be supportive of such an integrated team being introduced, and reviewing any progress in achieving the expected impacts and processes (Miller et al, 2016). In addition, it highlights that management and organisational process to support integrated care occurs simultaneously at many levels and local and national contexts are highly influential in how receptive a care system may be to support integrate care (Goodwin et al, 2017; Goodwin, 2013a).

Figure 2.3 Developmental model of integrated care (Minkman, 2012).
While this model was originally developed in the Netherlands, it is now being utilised in North America, and elsewhere in Europe (Miller et al, 2016). A series of validation studies also indicated its utility in practice, with integrated care coordinators reporting that the model assisted them assessing their integrated care initiative, and supported them in developing ideas for expanding their approach (Minkman, 2016). This was experienced despite the tendency for integrated care to be seen as chaotic, dynamic, and influenced by contextual factors (Minkman, 2016). However, while there has been some success in application of the DMIC approach in some settings, for example in stroke care (Minkman et al, 2011), less is known about how the model may be adapted to the needs of populations with physical and mental co-morbidities and complex health and social care needs (Goodwin et al, 2017).

It is evident that integrated care programmes can operate at various levels, and it is argued that a lack of integration at any one level, has the capability to impede integration across them all (MacAdam, 2008; Kodner and Spreeuwenburg, 2002; Kodner and Kyriacou, 2000), subsequently influencing the effectiveness of the health care system, and highlighting the complexity of integration. These issues are key aspects associated within CAS, which is emerging as a popular area underpinning integrated care. Individual behaviours also add to the complexity of integration and have the potential to impact on the success of integrative attempts, by either embracing change and facilitating partnership working, or creating implementation barriers due to reluctance and disassociation (Glasby and Dickinson, 2014). The changing nature of the health and social care workforces (as key staff members change job roles), the restructuring of services and organisations, and policy directions and priorities changing, also further adds to the complexity of integration and achieving integrated care (Miller et al, 2016). These fluid circumstances therefore require effective leadership which is engaged, informed, adaptive and responsive to the changing demands, expectations and opportunites of the integrated care agenda (Miller et al, 2016), and the varying needs of stakeholders throughout the integrated care journey. However, while this particular area of CAS is acknowledged as a potential contributor and solution to the issues associated with fragmentation, it is not the main focus of this particular research.
2.6 Application of integration and integrated care

2.6.1 Integration at the international level

Integration and integrated care have become key international health policy topics, with a significant amount of international attention and support for the development and delivery of integrated care. The issues created by the integrated care agenda have been observed to be broadly similar across Europe and North America, despite cross-national differences between national health and social care systems (Curry et al., 2013; Lloyd and Wait, 2007; Kodner, 2006). These include fragmented services, disjointed care, suboptimal quality, system inefficiencies, and cost effectiveness (Kodner, 2006), alongside increasing numbers of older people and those living with long-term conditions, and the need to provide complex care within decreasing resources (Curry et al., 2013). Across these countries, integrated care has been typically referred to as shared care (United Kingdom), transmural care (Netherlands), managed care (United States), or other widely recognised formulations such as comprehensive and disease management (Stein and Reider, 2009; Kodner and Spreeuwenberg, 2002; van der Linden et al., 2001; Kodner and Kyriacou, 2000); further exacerbating the issue of understanding integrated care application in practice.

Through an overview of the international literature, Rosen and colleagues (2011) reviewed four case studies from the United States (North Carolina and New York), the Netherlands (Maastricht), and the United Kingdom (Scotland). These were identified by consulting with integrated care experts (i.e. leading academics, policymakers and practitioners with an established interest in integrate care) in order for them to nominate three services or organisations outside England which were considered to be leading on health and social care integration. They therefore incorporated a wide range of perspectives, increasing the transferability and applicability of the review. The review aimed to identify factors which best supported or hindered integration for various populations, and examine the organisational methods used to align incentives and coordinate professional practice (Rosen et al., 2011). Through semi-structured interviews with senior executives, clinicians and
managers, and document analysis, key components for progress with integration were summarised as: the external context (including constraints of national policy); mutually reinforcing integrative processes (including clinical, informational, organisational, financial, administrative, and normative); and leadership (Rosen et al, 2011). While the perspectives of various stakeholders increased the external validity and generalisability of these findings and allowed recommendations to be made at the national and local level, there was a lack of considerations for the applicability of these key components for patients at the centre of the models.

Powell Davies et al (2006) systematically reviewed the international care coordination literature for those with chronic care needs (including Australia, the United Kingdom, North America, New Zealand and the Netherlands), and found that the typology of strategies used at the micro level (patient and provider) accounted for the individual strategies found in other reviews. This provided support for both local and international relevance and application. The strategies identified were divided into either the group of structural arrangements for coordination (including structured relationships and arrangements, and using systems to support coordination), or coordination activities (including providing support for providers and patients and improving communication). The rigorous review highlighted that approaches which facilitated building relationships between providers, co-location, case management, or multidisciplinary teams had to most success in terms of positive health outcomes and service user satisfaction (Powell Davies et al, 2006).

Kodner (2006) set out to explore the well-known North American models of whole-system approaches to health and social care for the frail elderly in the form of the PACE model (Program of All-inclusive Care for Elderly People), the HMO model (Social Health Maintenance Organisations), and the SIPA model (French acronym for System of Integrated Care for Older Persons). This exploration revealed important experiences of the successful implementation and positive patterns of these models in terms of service access, utilisation, costs, care provision, and health outcomes (Kodner, 2006). The key elements which accounted for the successful impact of service initiatives included: umbrella organisational structures, case managed
multidisciplinary teams, organised provider networks, and financial incentives (Kodner, 2006). In their review of the integrated care literature, Cameron and colleagues (2012) discussed UK models of joint working between health and social care services and revealed models which promoted: multiagency teams; placement schemes and co-location; single assessment processes; structural integration; intermediate care for older people; and pooled budgets.

2.6.2 Integration at the national level within the United Kingdom

Integration has consistently featured as a policy goal of governments within the UK. A timeline of the political context of integration developed by the National Audit Office (2017) in the UK is presented at appendix 4. The current focus on integrated care reflects a historic concern within the NHS of the organisation of care across three sectors of the health service (primary, secondary and tertiary) (Shaw et al, 2011). However, these divisions are suggested to reflect those within medicine and clinical practice, rather than how patients utilise services (Fulop et al, 2005). Factors such as an ageing population, increasing fragmentation and complexity in service provision, funding, and commissioning, and the funding contrasts in health care and social care (i.e. free National Health Service and ‘means tested’ social care) all contribute towards the policy goal of integration (Humphries, 2015). Current policy provides opportunities to deliver integrated care, by facilitating working across health and social care boundaries, and between hospitals and practices (NHS England, 2014; Department of Health, 2010; Department of Health, 2000). It is advocated that health and social care services must integrate care around the needs of the patient and focus on improved user outcomes (e.g. Barker et al, 2014; NHS Future Forum, 2012; Department of Health, 2000). Integration therefore has the potential to redesign care around the needs of the patient and promote patient-centred care, rather than around healthcare and organisational structures (Fulop et al, 2005). The majority of attempts to integrate services in this way have historically included modifications of existing processes, rather than radical change needed to the whole continuum of care (Reed et al, 2005).
The implementation of the Health and Social Care Act (2012) presented extensive organisational changes, which created a system of complexity and confused accountabilities (Ham and Murray, 2015). This saw specific duties placed on NHS bodies to integrate care, establishing a more competitive market with greater private and third sector provision (Baggott, 2015). Nonetheless, in order to improve the quality of care and reduce health inequalities, responsibility was then placed with NHS England to encourage Clinical Commissioning Groups (CCGs) to pursue integration, and to ensure that health services were provided in an integrated way (Baggott, 2015). Clinical Commissioning Groups are clinically led statutory NHS bodies responsible for planning and commissioning of health care services for their local area. The development of these new commissioning arrangements presented the opportunity for integration and service improvement (Curry and Ham, 2010). However, this legislation was observed in practice to be interpreted as a threat to the fundamental elements of partnership and collaboration underpinning integrated care, with competition creating trust issues and problems of fragmentation were exacerbated due to the increase of additional providers (Baggott, 2015).

The repeated reorganisation of the NHS has resulted in varying degrees of success. Health policy reforms such as the Health and Social Care Act (2012) which were intended to simplify NHS organisation, are suggested to have resulted in a lack of system leadership at both national and local levels (Ham and Murray, 2015). The term ‘redisorganisation’ has also been used to describe the frequent restructuring which has undermined the ability for the NHS to experience improvements (Smith et al, 2001). Reorganisation has also been observed to lead to loss of skills and knowledge difficult to replace, be distracting and disruptive, reduce staff morale, and incur financial costs (Baggot, 2015).

While integration is not a new concept, more recent policy advocates integration around the needs of the patient, rather than around healthcare, organisational structures, and processes (NHS Future Forum, 2012). In 2014, NHS England published the NHS five year forward view, which promoted the need for integrated care to be at the heart of policy agenda (NHS England, 2014). New care models outlined in this
five year view included Multispecialty Community Providers (MCPs) where GPs and other health and social care professionals collaborate within networks to provide more integrated services outside hospitals, and Primary and Acute Care Systems (PACS) where a single organisation or group of providers are responsible for delivering primary, community, mental health and acute services to the local population (Collins, 2016; NHS England, 2016; Ham and Murray, 2015). These models were developed within 23 vanguard sites to promote integrated services and pooled budgets (Collins, 2016). However, the distinction between MCPs and PACS has become blurred as different care models evolve and increasingly converge (Ham, 2018). In addition, going beyond MCPs and PACs in some areas in order to integrated care for whole populations is also advocated (Ham and Murray, 2015).

More recently, NHS England (2017) published the Next Steps on the NHS five year forward view, which promoted accelerating integration through local action in the form of partnerships of care providers and commissioning. This includes implementing place-based ‘Sustainability and Transformation Plans’ (STPs) which detail the future of local health and care services. Accountable Care Systems (ACSs) where several healthcare organisations provide all health and social care services to a particular population are currently being established as an extension of the development of STPs, with Accountable Care Organisations (ACOs) managing the agreements of such systems (Moberly, 2017; NHS England, 2017a). ACOs which have been implemented in other countries such as the United States are also recognised within the NHS five year forward view, with potential for increased impact than alternatively proposed models (i.e. MCPs and PACs) (Ham and Murray, 2015). However, the practicalities of achieving this goal of integrated care within the current health and social care landscape creates significant and complex challenges. This is exacerbated by the rebranding of these different models and systems, with the more recent rebranding of ACSs as Integrated Care Systems (ICS) (Ham, 2018). In addition, these systems have no statutory basis and therefore rely on the willingness of NHS organisations to work in partnership to plan how to improve health and care (Ham, 2018).
One approach to integrating care for older people in south-west England in Torbay at the meso level has experienced some success, including reducing emergency bed-day use for people aged 75+ by 24%, and for people over 85 by 32% (Thistlethwaite, 2011). However, several local attempts to introduce integrated care into the NHS have experienced limited success (Greaves et al, 2013; Curry and Ham, 2010). Results from the national Integrated Care Pilot programme indicated that while there were improvements in process and staff perceptions that care was being integrated, limited improvements in clinical effectiveness, cost reduction, and patient satisfaction were achieved (Curry et al, 2013; Greaves et al, 2013; Ernst and Young, 2012). However, evidence has shown that integrated care has the potential to improve patient experience by increasing patient involvement in decision-making, enhancing relationships between patients and providers and strengthening collaborative working and access to care (Mastellos et al, 2014). Enabling partnership working in order to provide integrated care is also viewed as a potential solution to the issues currently faced by the health and social care system (Glasby and Dickinson, 2014; Department of Health, 2013). Working in partnership in order to achieve both individual and jointly agreed outcomes is also becoming a core requirement in delivering effective public services. However, the current challenge is to normalise joined up working and collaboration in a time of limited resources and funding (Glasby and Dickinson, 2014).

2.6.3 Integration at the local level

At the local level, leaders are tasked with the responsibility of operationalising the mechanisms which enable staff to work within a specific integrated care system (Stein and Reider, 2009). In a bid to tackle the challenges associated with the boundaries of integration, national bodies such as the Department of Health and NHS England are aiming to address the funding and demand pressures by supporting local authorities in their integration agendas (commonly through the development of STPs). However, as it is acknowledged that a ‘one size fits all’ approach does not work in these circumstances, these bodies do not suggest a strategy for best practice for
how services should be integrated at the local level, with the option of a broad range of approaches. For example, depending on the focus and goals of initiatives, integrated care can either focus specifically on improving healthcare, or a broader approach incorporating social care and beyond (e.g. housing) (Baggott, 2015). Contributing factors for adopting a local strategy are suggested to include the needs of the population, and existing care services and structures (National Audit Office, 2017), and therefore adaptable to the needs of the target population within its local context. However, patient care experiences are largely determined by their contact with individual organisations, services, and professionals (Curry and Ham, 2010), with large scale transformation through the implementation of new models and STPs remaining a distant concept for most (Ham et al, 2017).

In order to address the needs of an ageing population, a shift in focus from acute care and treatment, to prevention, self-care, primary care and well-coordinated and integrated care is therefore necessary (Goodwin et al, 2012). Currently there is a drive for redirecting care from the acute sector and developing community-based alternatives (Huntley et al, 2017; Nolte, 2017). Community and primary care focusing on incorporating keeping people well for longer, and supporting self-management in the community is also advocated (New Local Government Network, 2016). It is suggested that in order to improve performance, services should be targeted towards the needs, beliefs and values of their populations (Plochg et al, 2006). As most needs cannot be met by a single provider, 'community-based integrated care' aims to provide clear goals based on population needs within limited resources, and seamless continuums of care (Plochg and Klazinga, 2002). Many integrated service innovations are also currently focused within community setting, in attempts to reduce emergency admissions and reduce costs (Huntley et al, 2017; Bardsley et al, 2013; Curry et al, 2013).

Primary care has become a more central focus of the UK health system and a growing international policy trend; in order to improve health outcomes, integrate services, manage costs, and develop community services (Glasby, 2012; Smith and Goodwin, 2006). Primary care also plays an important role in integrating care within a health
system and supporting a population health approach to care delivery which brings care out of the hospitals and into the community (Valentijn et al, 2013). Community orientated primary care has been considered for many years (Alderwick et al, 2015), and can offer a platform for developing integrated care and population health approaches. However, as this increases the level of primary care demand, this opportunity can also result in anxiety and fear of increased workloads (subsequently affecting engagement of primary care physicians). Nonetheless, the need for developing a multilayer commitment from various stakeholders at professional and organisational system levels when leading integrated care approaches in primary care (Valentijn et al, 2015c), alongside managing partners interests and processes from the beginning and building effective relationships (Valentijn et al, 2015d) is also advocated. However, building effective relationships amongst health and social care services who have contrasting cultures can be a challenging task (Lyngso et al, 2016; Scott et al, 2003a).

The responsibility of commissioning local services on behalf of the population being placed within primary care following the Health and Social Care Act (2012), has also transferred the General Practitioner role from one of ‘champion’ of the individual patient, to one of whole population needs and decision making regarding service provision and the use of dwindling public resources (Glasby and Dickinson, 2014). Evidence of the development in primary care suggests that while management and organisational support it crucial it is also variable, GP engagement is essential but extremely difficult to obtain, challenging traditional medical hierarchies can be daunting, and public and local authorities involvement is important but difficult to manage (Glasby, 2012). Since the NHS five year forward view (2014) publication, those who commission and provide health and social care services at several vanguard sites have worked to develop new population-based models for local health services (Collins, 2016). This also involves the challenge of restructuring primary care in order to deliver a broader range of services (Collins, 2016; Ham et al, 2012).

The findings from this literature review informed the development of the specific research questions 2-6, detailed in table 3.1 in the methodology chapter (page 70).
Chapter 3: Methodology

3.1 Research aims and questions

The research sought to explore the strategic process of integration and the impact of an integrated care approach to care delivery for a local population (i.e. the Neighbourhood Teams). This was considered within a context of the feasibilities and practicalities of developing integrated services, complexity of organisational change, and implications for policy and practice. As detailed in section 1.4 the research aims were as follows:

1. An exploration of what is understood by integration and integrated care and to investigate how these concepts have been utilised in practice.

2. An exploration of the development and implementation process of an integrated care initiative alongside the impact of the model on staff experience of partnership working.

3. A consideration of the feasibility and practicalities of implementing change in a complex real world setting, and key factors which need to be addressed as part of the transformation and change process of delivering integrated care.

4. A consideration of current important implications for policy and practice, including issues which need to be addressed in order for integrated approaches to progress within the current health and social care landscape.

As stated in section 1.4 the overarching research question was to consider: “How have the concepts and strategies of integrated care been developed and implemented in order to provide health and social care within a local population?” The specific research questions developed and their associated methods and data obtained are detailed below in table 3.1.
### Table 3.1: Specific research questions and methods

<table>
<thead>
<tr>
<th>Specific RQs</th>
<th>Methods</th>
<th>Data</th>
<th>Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Literature review</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RQ1: What is meant and understood by integration and integrated care and how have these concepts been implemented in practice?</td>
<td>Literature review</td>
<td>Case for change, definitions, conceptualisations, impact, complexity, and international application</td>
<td>Chapter 2</td>
</tr>
<tr>
<td><strong>Process: strategy of integrated care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RQ2: How has a local approach to integrate care been developed and implemented over time?</td>
<td>Study 1: Semi-structured interviews with strategic staff involved in the development and implementation of NTs</td>
<td>Partnership working, processes, experiences, outcomes and impacts, implementation and progress, sustainability, and resource implications.</td>
<td>Chapter 5</td>
</tr>
<tr>
<td>RQ3: What is the feasibility and practicality of developing and implementing integrated care and integrated working?</td>
<td>Study 3: Semi-structured interviews with lead implementers of NTs</td>
<td>Integration agenda progression and evolution of the NTs</td>
<td>Chapter 7</td>
</tr>
<tr>
<td>RQ4: What are the barriers and facilitators to developing integrated teams, and implementing and sustaining integrated care?</td>
<td>Documentary analysis of key CCG and NT documents</td>
<td>Examples include referral rates, core multidisciplinary team membership, principles of operating frameworks, number of GP practices in each NT</td>
<td>Informs entire thesis</td>
</tr>
<tr>
<td><strong>Impact: application of integrated care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RQ5: How has the local initiative’s approach to integrated care affected staff experience, and what impact has this had on partnership working?</td>
<td>Study 2: Partnership Assessment Tool assessing strategic partnerships distributed to operational staff and practitioners</td>
<td>Six principles of partnership working</td>
<td>Chapter 6</td>
</tr>
<tr>
<td>RQ6: What are the practicalities and realities of integrated partnership working for operational staff and practitioners in practice?</td>
<td>Documentary analysis of key CCG and NT documents</td>
<td>Examples include referral rates, core multidisciplinary team membership, principles of operating frameworks, number of GP practices in each NT</td>
<td>Informs entire thesis</td>
</tr>
</tbody>
</table>
While the literature review explored how integration and integrated care have been conceptualised within the literature, the **process** and **impact** focus of the theoretical framework tells the story of the application of these concepts within a case study, and the reality of their development and implementation in practice. The integrated care literature review therefore informed the development of the specific research questions (detailed in table 3.1). Research questions 2-4 address the process focus of the theoretical framework, and research questions 5-6 address the impact focus. The case study of the Neighbourhood Teams aims to answer these research questions.

### 3.2 Philosophical considerations

There is an ongoing debate on the underlying philosophical issues inherent within the practice of research and how to study the social world. The consideration of general philosophical orientations and principles about the world and the nature of research have been explored using philosophical concepts such as ‘epistemologies and ontologies’ (e.g. Crotty, 1998), ‘paradigms’ (e.g. Lincoln et al, 2011), and ‘worldviews’ (e.g. Creswell, 2014). Within these contexts, ontology is the study of being or of what exists (Cardinal et al, 2004), with particular consideration of the nature of existence and what constitutes reality. This has been explained to be ‘the philosophical investigation of the nature, constitution and structure of reality’ (Audi, 1999, pg.563). Epistemology is concerned with knowledge and belief about reality (Dancy, 1985), and how we arrive at our knowledge (Plowright, 2011). According to Guba (1990), paradigms are represented by a patterned set of assumptions regarding reality (ontology), knowledge of that reality (epistemology), and the specific ways of knowing that particular reality (methodology). Creswell (2014) also adopts this conceptualisation in order to utilise the term worldview to represent a set of beliefs guiding action.

One of the key ontological debates within the philosophical nature of research surrounds whether there is a captive social reality, and how this should be constructed (Snape and Spencer, 2003). These are broadly represented in the form of realism, idealism, and materialism (see table 3.2 for definitions).
Table 3.2: Key ontological and epistemological stances (Snape and Spencer, 2003)

<table>
<thead>
<tr>
<th>Ontological stances</th>
<th>Reality exists independent of our beliefs or understanding, with a distinction between beliefs and perceptions developed about the world and the reality of the world.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Realism</td>
<td>Reality exists independent of our beliefs or understanding, with a distinction between beliefs and perceptions developed about the world and the reality of the world.</td>
</tr>
<tr>
<td>Materialism (variant of realism)</td>
<td>While reality exists independent of our beliefs or understanding, only the material or physical world is ‘real’ and beliefs occur through the material world.</td>
</tr>
<tr>
<td>Idealism</td>
<td>No external reality exists independent of our beliefs and understanding, and reality is only comprehensible through the mind and socially constructed meanings.</td>
</tr>
<tr>
<td>Critical realism (variant of realism, influenced by idealism)</td>
<td>Reality exists independent of our beliefs or understanding, and reality is only comprehensible through the mind and socially constructed meanings.</td>
</tr>
<tr>
<td>Subtle idealism (variant acknowledging collective understanding)</td>
<td>Reality is only comprehensible through the mind and socially constructed meanings, which are collectively shared.</td>
</tr>
<tr>
<td>Relativism (variant of idealism)</td>
<td>Reality is only comprehensible through the mind and socially constructed meanings, with no single shared socially reality and a series of varying social constructions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Epistemological stances</th>
<th>The world is independent of the researcher, with social research utilising methods of the natural sciences (i.e. quantitative).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positivism</td>
<td>The world is independent of the researcher, with social research utilising methods of the natural sciences (i.e. quantitative).</td>
</tr>
<tr>
<td>Interpretivism</td>
<td>The social world and the researcher impact on each other, with social research utilising alternative methods to explore and understand the social world from the perspective of the participant and researcher (i.e. qualitative).</td>
</tr>
</tbody>
</table>

Following the comprehensive literature review in chapter 2 and research question development, it was considered that ‘critical realism’ would be an appropriate philosophical approach for this research; which concerned real but complex systems, services, and individuals. Critical realism has particular utility when investigating complex and evolving systems and issues with various layers of reality. For example, this approach acknowledges the existence and role of the subjective knowledge of multiple social actors, alongside the existence of independent structures which create barriers and facilitators for these actors to pursue particular actions, within a...
particular context (Wynn and Williams, 2012). Several philosophical aspects of critical realism therefore relate to the literature findings and enable the specific research questions to be addressed. These aspects include the appreciation that phenomena operate within open systems (a complexity characteristic) and the ability for contextual factors to affect outcomes (Clark et al, 2007). Phenomena such as individual thoughts and actions, team culture, interagency working, financial incentives and policy have the potential to influence the development of systems of care (Byng et al, 2005). Contextual factors include geographical, historical, social, cultural, environmental and physical elements (Sayer, 2000). The important elements of critical realism discussed above are explored throughout the thesis.

A further fundamental element of critical realism is based on the ‘generative theory’ of causation, “in which the objects under consideration undergo a transformation, and where temporal conjunction or interaction of the various causal powers is crucial” (Byng, 2005, pg.72). These are important aspects of this research as developing integrated initiatives in order to deliver improved patient-centred care require large-scale system transformation and continuous change and evolution. The interactions and relationships between different parts of the system, alongside actors or stakeholders who are involved in the development and implementation are also crucial to the success of initiatives. Critical realists also acknowledge the relevance of both individual agency and the influence of the structure and culture of society (Byng et al, 2005), both of which are key to the engagement with local and national initiatives and the process of change and transformation. Interpreting approaches to evaluating health and social care partnerships through a framework of critical realism also allows the facilitation of bridging the tensions between quantitative and qualitative research, alongside those between ontological realism and epistemological relativism. This approach therefore accommodates accounting for the views of multiple stakeholders and actors, in a search for what works for whom and under what circumstances (Dickinson, 2006), in order to provide integrated health and social care.
In terms of the two dominant epistemological traditions within social research, these are conceptualised in the form of positivism and interpretivism. Positivism is often referred to as having an ontologically realist perspective of the world, where reality is objective and facts about the world are universal (Plowright, 2011). The aim of positivism is to look for explanation in behaviour, rather than for the meaning behind it. A contrasting epistemology to positivism is that of interpretivism, which suggests that the subject matter of the social sciences (i.e. people and their institutions), is fundamentally different to that of the natural sciences and therefore necessitates an alternative logic of research procedure (Bryman, 2012). The interpretative approach does not accept an ‘objective reality’ which a positivist approach would take as given (Hesse-Biber, 2010). This position maintains that reality is complex, unpredictable and subjective. For positivists, the world is independent of our knowledge of it, while for interpretivists or relativist there are multiple realities which can be accessed in various ways (Gray, 2014). Snape and Spencer (2003) summarise these key ontological and epistemological stances as presented in table 3.2.

Crotty (1998) and Gray (2014) suggest an interrelationship between the researcher’s view of epistemology, the theoretical stance of the researcher, and the methodology and methods used. These relationships are depicted in figure 3.1.

![Figure 3.1: Relationship between epistemology, theoretical perspectives, methodology, and research methods (Gray, 2014; Crotty, 1998)](image-url)

- **Epistemology**
  - Objectivism
  - Constructivism
  - Subjectivism

- **Theoretical Perspectives**
  - Positivism
  - Interpretivism
    - Symbolic interactionism
    - Phenomenology
  - Critical inquiry
  - Feminism
  - Postmodernism

- **Methodology**
  - Experimental research
  - Survey research
  - Ethnography
  - Phenomenological research
  - Grounded theory
  - Heuristics inquiry
  - Action research
  - Discourse analysis

- **Methods**
  - Sampling
  - Statistical analysis
  - Questionnaire
  - Observation
  - Interview
  - Focus group
  - Case Study
  - Document analysis
  - Content analysis
Crotty (1998) chooses not to include ontology within this framework, as ontological and epistemological issues tend to be implicit, as, to consider ‘the construction of meaning’, is to consider ‘the construction of meaningful reality’ (Crotty, 1998, pg.10). This has led some researchers to use the terms interchangeably and consider them as conceptually similar. However, Crotty considers that if ontology were to be included, it would be placed alongside epistemology and inform the theoretical perspective. This is rationalised by considering that while ontology aims to understand what is, epistemology attempts to understand what it means to know, which in turn informs the theoretical perspective and provides a philosophical background for considering what types of knowledge are legitimate and adequate (Gray, 2014; Crotty, 1998).

Quantitative and qualitative paradigms are traditionally argued to be competing polar opposites, with the quantitative paradigm represented by positivism, and the qualitative paradigm based on interpretivism and constructivism (Gray, 2014). In addition to positivism (or post-positivism) and constructivism, Creswell (2014) also highlights two additional worldviews widely discussed within the literature in the form of transformative and pragmatism. The major elements of these four positions are shown in table 3.3. Pragmatism therefore represents an alternative perspective to positivism and interpretivism which advocates that no division lies between these two ontological and epistemological stances, and promotes the notion that they are merely alternative ways to understand and describe our reality.
Table 3.3: Main paradigms or worldviews (Creswell, 2014)

<table>
<thead>
<tr>
<th>Positivism/Postpositivism</th>
<th>Constructivism</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Determination</td>
<td>• Understanding</td>
</tr>
<tr>
<td>• Reductionism</td>
<td>• Multiple participant meanings</td>
</tr>
<tr>
<td>• Empirical observation and measurement</td>
<td>• Social and historical construction</td>
</tr>
<tr>
<td>• Theory verification</td>
<td>• Theory generation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transformative</th>
<th>Pragmatism</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Political</td>
<td>• Consequences of actions</td>
</tr>
<tr>
<td>• Power and justice orientated</td>
<td>• Problem-centred</td>
</tr>
<tr>
<td>• Collaborative</td>
<td>• Pluralistic</td>
</tr>
<tr>
<td>• Change-orientated</td>
<td>• Real-world practice orientated</td>
</tr>
</tbody>
</table>

Pragmatism was founded by philosophers Peirce (1878), James (1995), and Dewey (1948), who are considered to be the classic pragmatists (Webb, 2007). Pierce is often described as the first spokesman of pragmatism, James its translator to a wider audience, and Dewey the most well-known advocate due to this work with educational systems (Gray, 2014). While they do not always agree on all aspects of pragmatism, their main focus is that the justification of a belief is dependent upon how successful its practical consequence are for society (Gray, 2014; Plowright, 2011). The aim of pragmatism was to help decide which action to take to better understand real-world phenomena (including psychological, social, and educational phenomena) (Johnson and Onwuegbuzie, 2004). Classic pragmatism is considered here to be a theory of truth, and suggests that meaning cannot be given in advance of experience (Morgan, 2014). Rather than discussing reality or truth in relation to traditional metaphysics, this emphasis on human experience which was inherently contextual, emotional, and social, contrasted with the established philosophy of the time (Morgan, 2014).

Since the 1970s, there has been further attention on pragmatism, largely due providing an epistemological justification for mixing approaches and methods (Onwuegbuzie et al, 2009; Johnson and Onwuegbuzie, 2004). Johnson and
Onwuegbuzie (2004) promote pragmatism as a means for researchers to think about the traditional dualisms debated by purists. As classic pragmatism aimed to break down the dualism between realism and idealism, it therefore remains highly relevant for social research (Morgan, 2014). More recent writers of pragmatism include Rorty (1990), Patton (1990), Cherryholmes (1992), and Tashakkori and Teddlie (2010). However, some neo-pragmatists such as Rorty, completely reject correspondence of truth in any form, which many philosophers would disagree with (Johnson and Onwuegbuzie, 2004). In addition, criticisms and pragmatism include the promotion of incremental change rather than more fundamental, structural, or revolutionary change in society, studies failure to provide information on who a pragmatic solution is useful for, and the vague explanation of what is meant by usefulness or workability (Johnson and Onwuegbuzie, 2004).

A pragmatic approach allows for the utilisation of the range of techniques available to examine the research problem (Rossman and Wilson, 1985). The major elements of this position include, consequences of actions, problem centred, pluralistic, and real world practice orientated (Creswell, 2014). Pragmatism takes both a relativist and a fallibilist approach of what knowledge is (rejects the idea that we can ever arrive at a final unequivocal understanding of the world and its characteristics), and considers that beliefs are a ‘work in progress’ and subject to change, amendment and revision (Plowright, 2011). To a pragmatist, “the mandate of science is not to find truth or reality, the existence of which are perpetually in dispute, but to facilitate human problem-solving” (Powell, 2001, pg.884).

In terms of a pragmatist ontology, this would maintain that reality is the practical effect of ideas, whilst the epistemological standpoint would promote beliefs which lead to pragmatic solutions. This is therefore appropriate for this research and allowed value to be added through the exploration of the development and implementation of models of care which are subject to continuous change and evolution, in response to changing population needs, resources, and innovative ideas for improvement. A pragmatic approach was therefore taken for this research, in order utilise the relevant quantitative and qualitative methods to obtain data, and to
explore the various processes and mechanisms within the strategic and operational context. As realism also focuses on the wider environment, a critical realist perspective also considers integration as a pragmatic solution to evolving political, economic and social contexts (Glasby and Dickinson, 2014). The application of such an approach was appropriate in order to investigate a real world evaluation of health services adapting to national policy reform, and allow for the challenges of evaluating such services within an environment of continuous organisational change.

“Real world” research is often related to concerns regarding change and/or policy developments, with the common aim of evaluating an initiative or service, and a focus on issues and problems with direct relevance to peoples’ lives (Robson, 2011). Pragmatism is therefore promoted as being complementary to real world research, where there is a concern to develop solutions to the issues that are in need of being addressed (Robson, 2011). However, Stange and Phillips (2007) acknowledge the difficulties of introducing change in their article titled ‘real change is real hard in the real world’. The design of such research therefore tends to utilise two or more data collection methods in order to address these issues from various angles and perspectives. Real world research also often takes place within open systems where structures, processes, and outcomes are constantly changing, and actors are potentially fallible. However, participants’ experience and explanations of any given phenomenon may provide the most accurate explanation of reality (compared to scientific explanations) (Fletcher, 2016). The type of logic often used by realists known as abductive or retroductive reasoning, is particularly appropriate within this environment, where by the past can be explained, rather than attempting to predict the future (Robson, 2011).

Pragmatism advocates utilising the philosophical and methodological approach which works best for the particular research problem in question (Robson, 2011). It has also been considered as the best philosophical foundation for the justification of combining different methods within one study (Datta, 1994; Howe, 1988). As a philosophical underpinning for mixed methods studies, authors including Patton (1990), Morgan (2007), and Tashakkori and Teddlie (2010) have advocated the
importance of pragmatism for focusing attention on the research problem in social science research, followed by adopting a pluralistic approach to obtain knowledge about the research problem (Creswell, 2014). With this epistemological basis, it is argued that mixed methods should therefore be seen as a paradigm in its own right (Johnson and Onwuegbuzie, 2004). A mixed methods approach was selected for this study, in order to meet the complexities of the subject area highlighted by the literature, and provide a more in depth understanding of the research problem, than either a quantitative or qualitative approach would provide alone (Creswell, 2014). For example, quantitative methods cannot easily access particular elements which health researchers are interested in, such as patient experiences and social interactions (Sale et al, 2002).

Quantitative and qualitative paradigms are traditionally argued to be competing polar opposites, with the quantitative paradigm represented by positivism, and the qualitative paradigm based on interpretivism and constructivism. While purists argue that quantitative and qualitative research are mutually exclusive due to their different ontological and epistemological positions, pragmatists suggest that the debate between the two positions is a false dichotomy (Gray, 2014; Caracelli and Greene, 1997; Brewer and Hunter, 1989). This is supported by those who suggest that differences between qualitative and quantitative paradigms are illusory (Coxon, 2005; Pawson, 1995; Howe, 1988). Although it may be useful to contrast these two research strategies, caution should be taken regarding creating a distinct divide between the two disciplines, as research may represent characteristics from both research strategies. This research therefore utilised both forms of quantitative and qualitative methods, in a combined mixed methods approach in order to provide various perspectives of the process of integrating care, resulting in developing different types of knowledge to address the research questions.

3.3 Mixed Methods Research

Mixed methods research involves collecting and analysing both quantitative and qualitative data within the same study (Creswell and Plano Clark, 2011). Mixed
methods can be conceptualised as bringing together different designs, methods and data, in order to add breadth and depth (Green and Thorogood, 2018). One of the main values of mixed methods research is in the creation of a dialogue between different ways of seeing, interpreting and knowing (Greene, 2007). Additional benefits include increasing the accuracy of research findings, generating new knowledge through triangulation, capturing different voices and constructions of the phenomenon, reflecting the complexity of a phenomenon, and implementing a theoretical framework (Moran-Ellis et al, 2006). However, there is a long-standing debate within social research regarding whether qualitative and quantitative research methods should or indeed can be combined. One rationale for the proposed incompatible nature of these two perspectives is that ontological reality cannot logically be both be mind-dependent (constructivist, transitive, and social) and mind-independent (positivist, intransitive, and realist) (Plowright, 2011).

It is suggested that pragmatism and mixed methods research therefore face some challenging methodological implications in practice, of how to combine different methods which might be rooted in different philosophical traditions (Green and Thorogood, 2018). For example, the orientations of qualitative research (e.g. focus on meaning, flexible research strategies, and reflexivity), can often not sit well with the epistemological underpinnings of more positivist designs (Green and Thorogood, 2018). While there is the realisation that pragmatism provides a highly compatible theoretical underpinning to mixing both quantitative and qualitative methods within the same research project, it is recognised that the design strategies and skills which lie with traditional quantitative and qualitative researchers are markedly different (Robson, 2011). Nonetheless, there are common aspects of these techniques which can be nurtured in order to develop a mixed method approach to this research.

Some authors maintain that qualitative and quantitative research paradigms include incompatible assumptions about how we understand and theorise notions of reality (e.g. Sale et al, 2002). However, Sale et al (2002), also acknowledge that quantitative and qualitative approaches can be combined in order to study complex social phenomena, as complexity itself consists of both interpretivist and positivist
phenomena. The adoption of positivist ideals by qualitative researchers would also suggested that quantitative and qualitative methods shouldn’t necessarily be viewed as conflicting approaches (Snape and Spencer, 2003). The use of multiple methods to obtain appropriate types of data is considered by some to be a key element for the development of robust sociological explanations of the social world (Moran-Ellis et al, 2006). Gorad (2010) suggests an alternative way of presenting the logic of research, and maintains that mixed methods are not a design or represented by paradigms (i.e. not based on different underling logic of reality). Rather than considering quantitative and qualitative paradigms as an unhelpful binary, Gorad (2010) suggest an alternative approach through consideration of design and the full cycle of research work. This includes seven phases including: evidence synthesis, development of idea, feasibilities studies, prototyping and trialing, field studies and design stage, rigours testing, and dissemination impact and monitoring (Gorad, 2010).

During the 1980s, many researchers accepted that both positivist and constructivist paradigms were legitimate and useful for providing different perspectives on the same topic (Greene, 2007). In terms of the purpose of combing these approaches, it has also been suggested to provide different types of knowledge about the area in question, as opposed to simply joining the outputs from separate qualitative and quantitative enquiries (Ritchie, 2003). However, while some authors argue that the extent to which these approaches are different in their philosophical and methodological origins and standpoints results in the lack of effective merging, others recognise these differences, but highlight the value of blending these two data types (Ritchie, 2003).

The use of mixed methods research is also becoming increasingly popular in health systems (Ozawa and Pongpirul, 2014) due to its ability to; allow research to view problems from multiple perspectives, contextualise information, develop a more complete understanding of a problem, triangulate results (i.e. compare and contrast the implications suggested by different data sets), quantify hard-to-measure constructs, provide illustrations of context for trends, and examine processes,
experiences and outcomes (Creswell and Plano Clark, 2011). The complexity and variability of integrated care approaches also calls for the use of mixed methods research (Cretin et al., 2004). In addition, evaluations which consider the processes of complex interventions requires the use of mixed methods, with the importance of quantitative and qualitative methods varying according to the context and stage of the evaluation process (Moore et al., 2015). However, rather than simply combining different methods and types of data, there is a need to consider what the relationship is between them (Greene, 2007).

While evaluations of integrated care initiatives tend to focus on the processes and outcomes, it is argued that these investigations also need to account for the context in which integrated care develops, the diverse perspectives (e.g. service users and providers) and levels of health care provision involved (e.g. linkage, coordination, full integration) (Shaw et al., 2011). In order to do so, traditional research methods (e.g. randomised controlled trials) are often not feasible as they fail to capture the context and evolutionary processes allied to integration (Vrijhoef, 2010), and the complex issues associated with integrated care (Glasby and Dickinson, 2014). Within the field of evaluating programme interventions a multiphase mixed methods design is therefore more common; where concurrent (collection of both types of data during the same stage) or sequential (collection of data in different stages) strategies are used in tandem over time to best understand a long-term programme goal (Creswell, 2014). The use of both quantitative and qualitative methods are promoted in order to develop a suitable approach to measuring and assessing integrated care, in relation to the impact on health outcomes, improved quality of care, service user satisfaction, and effective relationships and systems (Shaw et al., 2011). The qualitative study of the experience of staff members can also help to identify what may or may not be working, and why (Bardsley et al., 2013). This research study therefore utilised these advantageous elements through the interpretation of various perspectives and types of knowledge, in order to address the research questions and consider the application of theory within practice.
3.3.1 Triangulation and integration

Integration in the form of the interaction between the qualitative and quantitative components of a study is an important aspect of mixed methods research (O’Cathain et al, 2010; Creswell et al, 2004; Tashakkori and Teddlie, 1998). For example, a lack of integration and mixing of data can limit the amount of knowledge that these types of studies generate (O’Cathain et al, 2010). While a barrier to effective mixed methods research is considered to be the lack of guidance on effective and well implemented studies of this type (O’Cathain et al, 2010; O’Cathain et al, 2009; Bryman, 2007), literature is emerging which describes how to integrate data in mixed method studies (e.g Creswell, 2014; Creswell and Plano Clark 2011; O’Cathain et al, 2010). Greene, Caracelli, and Graham (1989) suggest five main reasons for considering utilising mixed methods including *triangulation, complementarity, development, initiation, and expansion* (Hesse-Biber, 2010). *Triangulation* refers to the methodological approach where the use of more than one method is utilised in order to examine the same research problem and consider what more can be known about a phenomenon (Moran-Ellis et al, 2006; Farmer et al, 2006; Jick, 1979). The main aim of triangulation is to explore convergence, complementarity, and dissonance (Farmer et al, 2006; Erzerberger and Prein, 1997), which contributes to the overall goal to enhance the validity and credibility of research findings and interpretations (Nowell et al, 2017; Hesse-Biber, 2010; Farmer et al, 2006; Lincoln and Guba, 1985). For example, cross-validation of data across multiple methods is enhanced and rich results are produced, if different methods produce convergent findings about the same research problem (Hesse-Biber, 2010; Erzerberger and Prein, 1997).

*Complementarity* allows for a fuller understanding of the research problem to be gained, clarification of a given research result to be obtained, and for both quantitative and qualitative data to be utilised; allowing for a more complete picture of the research problem (Hesse-Biber, 2010; Farmer et al, 2006). The consideration of the complementarity of various data sources also increases the level of understanding within various dimensions of the same research issue (Fielding and
Fielding, 1986). Dissonance in the unexplained divergences of findings may also lead to the rejection of previous assumptions (Erzerberger and Prein, 1997), which also contributes to increased understanding or the creation of a new hypothesis (Miles and Huberman, 1994). Mixed methods also aids the total understanding of the research problem and development of the research project (Hesse-Biber, 2010), where the results from one methods develops and inform the others (Green et al, 1989). The fourth reason of initiation involves the initiation of a new study, if a study’s findings raises questions or contradictions which require clarification (Hesse-Biber, 2010). Expansion is intended to extend the breadth and range of the injury (Greene et al, 1989), producing detailed findings which enables future research (Hesse-Biber, 2010).

Four types of triangulation have also been identified (Dezin, 1978). This can be in the form of methodological triangulation (the use of more than one research method to collect data); data triangulation (the use of multiple data sources or respondent group); theoretical triangulation (the use of different theoretical perspectives or interpretative frameworks); and investigator triangulation (the involvement of two or more researchers in analysis) (Hopf et al, 2016; Farmer et al, 2006; Burke Johnson et al, 2007; Silverman, 2006; Denzin, 1978). The type of triangulation chosen and the decision to employ single or multiple triangulation techniques depends on the nature of the research question, and should complement the methodological paradigm which informs the question (Farmer et al, 2006; Dootson, 1995). An advantage of data triangulation is through increasing the internal validity of a study (i.e. the extent to which the method is appropriate to answer the research question) (Mason, 2002; Barbour, 2001; Mays and Pope, 2000; Stake, 1995; Lincoln and Guba 1985). An underlying assumption is that data collected in different ways should lead to similar conclusions to be drawn, and approaching the same issue from different angles can help develop a holistic picture of the phenomenon (Pinnock et al, 2008).

While mixed methods research and triangulation of data and methods helps to improve confidence in the research results and overcome research bias (Murray, 1999), incompatibility between units of analysis and theoretical paradigms may exist.
(Green and Thorogood, 2018), and the process of triangulation could increase error and bias (Sim and Sharp, 1998; Begley, 1996). However, exploring triangulation, complementarity, convergence and dissonance provides a better understanding of the research questions, even where there may be discrepancies between methods (O'Cathain et al, 2010; Moffatt et al, 2006). Despite the challenges of triangulation, it allows for the increase of the breadth and depth of our understanding of complex health and social care issues (Green and Thorogood, 2018; Farmer et al, 2006). For example, triangulation takes into account that there is not one reality against which results can be verified or falsified, and that research is therefore dealing with the impact of different versions of the world, subjective knowledge, and social interactions (Flick, 1992).

Triangulation is seen by some as a means to ensuring comprehensiveness rather than a pure test of validity, as it assumes that any weakness in one method will be compensated by strengths in another, and that judgments can be made between different accounts (May and Pope, 2000). Denzin (1989) discussed the possibilities for triangulation from a qualitative perspective, and suggested that validity referred to an improved understanding, rather than a more accurate one (i.e. rejecting the positivist view of validation) (Green and Thorogood, 2018; Denzin, 1989). The aim is therefore not to produce a consistent version of the research problem, but to provide a fuller picture of the research problem, account for the weaknesses of one method, and to challenge any biases that come from one perspective (Green and Thorogood, 2018). While triangulation remains an epistemological claim for the outcome of mixed methods, this has developed to become less concerned with the validity of findings, with more of a focus on engaging with the complex nature of the social world (Fielding and Fielding, 1986). This addresses the difficulties in the interpretation of convergence and divergence in findings generated by different methods (Moran-Ellis et al, 2006). The methods of triangulation and integration were therefore utilised within this research, in order to provide a greater understanding of the development and implementation of the Neighbourhood Teams from the perspective of a variety of staff members, which may either compliment or diverge;
demonstrating the power and utility of mixed methods. How the methods were mixed is discussed below in section 3.3.2.

3.3.2 Application of methods

In order to combine quantitative and qualitative methods, an advanced multiphase mixed methods approach was used to incorporate results from three research studies. A multiphase design combines quantitative and qualitative methods within and between several phases, where phases depend on each other an overall objective (Green and Thorogood, 2018; Lund, 2012; Creswell and Plano Clark, 2011). This type of mixed method design is commonly used within research which evaluates and explores programme implementation and evaluation, where multiple research phases are conducted over a period of time in order to build on and inform each other, and address a common objective (Green and Thorogood, 2018; Creswell, 2014). This mixed methods approach was chosen to allow the data analysis of the first qualitative data set to inform the data collection of the following second data set and build on initial findings (i.e. exploratory sequential approach), which then informed the final third qualitative data set, building directly on the previous two datasets (i.e. explanatory sequential approach) (Creswell, 2014). This is depicted in figure 3.2, where ‘QUAL’ and ‘QUAN’ indicates an emphasis on either qualitative or quantitative data collection, analysis and interpretation (Creswell, 2014). This approach therefore mixed data in order to create a new understanding of integration within the context of Neighbourhood Teams.

Figure 3.2: Multiphase mixed methods (Creswell, 2014; Creswell and Plano Clark, 2011)
The first qualitative element of this research was represented by the perspectives of strategic roles within the Neighbourhood Teams. To capture this strategic perspective of the development and implementation of the integrated approach to care delivery, semi-structured interviews were conducted with representatives from the Clinical Commissioning Group (CCG) and members of the core multidisciplinary Neighbourhood Teams. The detail of these Neighbourhoods Teams is included in section 1.2 on page 7, with an explanation of the interview process and participant recruitment included in section 4.2 on page 94. This enabled initial exploration of the type of approach to integration, feasibility of the initiative, the exploration of the implementation process and any barriers and facilitators, and considerations of the implications for operational staff working within the model. This method was chosen in order to answer the following research questions:

RQ2: How has a local approach to integrated care been developed and implemented over time?

RQ3: What is the feasibility and practicality of developing and implementing integrated care and integrated working?

RQ4: What are the barriers and facilitators to developing integrated teams, and implementing and sustaining integrated care?

The data from the initial phase of strategic interviews then informed the adoption of a Partnership Assessment Tool, which was distributed to a separate sample of operational staff members and practitioners in order to explore their experiences of working within the integrated care model. The process of distribution and participant recruitment is detailed in section 4.3 on page 103. This facilitated a more accurate and appropriate questioning of the operational context and reality of integrated working. This involved capturing the views of a larger population in a broader manner. The data from this questionnaire provided a quantitative element and built upon the results from the initial database. The Partnership Assessment Tool was chosen in order to answer the following research questions:
RQ5: How has the local initiative’s approach to integrated care affected staff experience, and what impact has this had on partnership working?

RQ6: What are the practicalities and realities of integrated partnership working for operational staff and practitioners in practice?

Following analysis of the qualitative and quantitative datasets, alongside documentary analysis which was performed in parallel with these data collection phases throughout the thesis, additional supplementary interviews were conducted with transformation leads. In-depth interviews with the lead implementers of the Neighbourhood Teams were therefore conducted in order to explore further developments. The detail of the interview process and participant recruitment is detailed in section 4.2 on page 94. This method was chosen in order to build on the findings from studies 1 and 2. As highlighted earlier in the thesis, this was in response to the difficulties associated with evaluating a live programme which is iterative and continuously evolving, with the requirement to work within a complex system involving a range of practice settings and procedural arrangements (Abendstern et al, 2011). In addition, as interventions can experience ‘teething problems which are rectified as the evaluation progresses’, the collection of data at multiple time points is therefore valuable (Moore et al, 2015, pg.6).

This four-phase procedure is represented by an initial exploratory phase (i.e. strategic interviews), a following phase of instrument development (i.e. design of the questionnaire based on interview data and an assessment tool previously utilised in the field), a phase of instrument administration to a sample of the population (i.e. questionnaire distribution), and a final explanatory phase of supplementary interviews with transformation leads (Creswell, 2014). The data from the three databases generated by the first, third, and fourth phases were analysed separately, with the findings from the initial exploratory phase used to inform the quantitative measures, which were used to inform the final explanatory phase of the supplementary interviews (Creswell, 2014).
As the type of triangulation should complement the methodological paradigm and research questions, methodological triangulation was utilised to compare results from different methods of data collection (studies 1, 2 and 3), and data triangulation was utilised to account for the range of perspectives which were represented within the results (strategic versus operational staff members and practitioners) (Denzin, 1978). These techniques for mixing data were employed in order to explore the development and implementation of Neighbourhood Teams, from the perspectives of various levels of staff involved in the integrated approach to health and social care delivery. The consideration of the comprehensiveness in the complementarity and dissonance of various data sources and methods, provided a greater understanding of the development and implementation of the Neighbourhood Teams from the perspective of a variety of staff members. In terms of the development of the research, the results from the initial strategic interviews in study 1, contributed towards the adoption of the survey instrument (the Partnership Assessment Tool). The implementation of a sequential design also enabled added value of understanding from the results of both studies. Following the analysis of datasets from studies 1 and 2, additional interviews with strategic transformation leads were initiated in study 3, in order to enable further understanding and clarification, and provide a more complete picture of the development and implementation of the Neighbourhood Teams. Expansion extended the breadth and range of the injury by producing detailed findings which enabled considerations of future research.

3.4 Case Study Design

A case study is a research method which focuses on the circumstances, dynamics, and complexity of a single case, or a small number if cases (Bowling, 2014). A case study approach allows for an in-depth study of a real-world context, and should be considered when an experimental design is inappropriate to answer the research questions, or impossible to undertake (Crowe et al, 2011). In order to focus on a specific context, with a view to understand how a particular issue translates into a real and complex situation, the research strategy therefore employed the use of a
case study design (Yin, 2014; Bowling, 2009; McCormack et al, 2008). As case studies have particular utility in exploring in-depth and complex health service research, they can provide powerful insights into many important aspects of health and healthcare delivery (Crowe et al, 2011). For Hammersley (1992), as case studies do not have any specific or methodological characteristics, it is suggested that they should not be defined as a type of design (Green and Thorogood, 2018). The decision to select a case study would instead be based on what the aims of the sample are (Green and Thorogood, 2018). For example, a survey would be selected if the aim is to generate empirical generalisability, and a case study would be selected if the need is for depth and accuracy (Green and Thorogood, 2018). However, others suggest that case studies do represent a distinct designs and methodological approaches, with implications beyond those of the sample (Green and Thorogood, 2018).

Stake, Merriman, and Yin are three key authors who provide detail of design and methodological procedures to follow when conducting case study research (Creswell et al, 2007). Stake (1995) defined the case study approach from an educational research perceptive, through describing three types which can be used to gain a greater understanding of a phenomenon. These include intrinsic (exploring unique phenomenon with no attempt to generalise beyond the single case), instrumental (using a particular case to gain broader understanding of a phenomenon), and collective (studying multiple cases simultaneously or sequentially) (Silverman, 2017; Crowe et al, 2011; Stake, 1995). However, these types are not mutually exclusive, and case study designs can develop from one type to another during research implementation (Crowe et al, 2011). In addition, the concept of a purely intrinsic case study is rejected by many qualitative researchers, as there is an expectation that studies will be based upon concepts which are developed as a result of the study (Silverman, 2017). Merriam also explored case study research from the perspective of exploring and evaluating educational programmes (Merriam, 2009, 1998). This approach highlighted the purpose and qualitative nature of case study research, and the focus on a specific entity, and understanding and describing the findings (Merriam, 2009). Both Merriman (1998) and Stake (1995) have a similar epistemological viewpoint, from a constructivist perspective, which suggests that
that primary interest is to understand the meaning or knowledge constructed by people (Yazan, 2015).

Yin (2014) suggests that a case study involves studying a phenomenon within its context (e.g. a change in health service management structures within a community), unlike surveys and experiments (Green and Thorogood, 2018). According to Yin (2014), case studies can be exploratory, descriptive or explanatory, and are therefore appropriate when research topics need to be defined broadly, include contextual circumstances, and reply on multiple sources of evidence. These can therefore be utilised to explain causal links and pathways resulting from a new policy initiative or service development (Yin, 2014; Crowe et al, 2011; Robertson et al, 2010; Yin, 2009; Pinnock et al, 2008). Yin also promotes the utility of case studies where there is a need to obtain in-depth explorations of a complex phenomena in real-life contexts, particularly when boundaries between the phenomena and context are not clear (Yin, 2014; Yin, 2009). Another advantage of this approach is the relationship between the participants and the researcher, where participants are enabled to tell their story and describe their views of reality (Bowling, 2014).

While Stake (1995) and Merriman (1998) promote the utility of case studies from a constructivist perspective and the exclusive use of qualitative data, Yin argues against distinctions between qualitative and quantitative orientations due to the incompatible philosophical positions (Yazan, 2015; Yin, 2014). Instead, he draws attention to the similarities between the two research traditions and the common tools, which can be utilised in the design and methods of case studies (Yazan, 2015; Yin, 2014). As the research aimed to utilise mixed methods and a pragmatic approach, the case study approach detailed by Yin (2014) was therefore deemed appropriate. Multiple research methods are also usually employed, in order to investigate complex situations and validate findings (Bowling, 2014).

Yin (2014) provides a flexible approach to case study design, but proposes that effective case study research should progress along six defined stages including: determination of case study design and definition of the research question; designing case studies and method of data collection; preparation for data collection; data
collection; analysis and evaluation of data; and reporting of case findings. These stages offer a comprehensive pathway through the research process, described as a linear but iterative process (Yin, 2014). This is shown in figure 3.3.

![Figure 3.3: Conducting case study research (Yin, 2014)](image)

It is suggested that the motivations and goals of individual health care professionals can also be an important catalyst for the success of integrated care initiatives (Simoens and Scott, 2005). The ability to capture the views and experiences of those working within the integrated model is therefore important in order to consider the feasibility of implementing integrating care into practice, the process of organisational change and the impact on staff experience. The research also explored staff members’ understanding of implementing integrated care and complex system changes, and the strategic and operational reality of overcoming barriers to integration. As the research took a process focus rather than one based on hard clinical outcomes (e.g. reduction in emergency admissions), efficiency and effectiveness elements were not directly measured. However, the research sought to investigate the understanding of such elements and the decision-making process employed to achieve such desired outcomes.

92
While case studies often explore single cases and contribute to the understanding of wider situations, the material they generate has sometime been criticised for not being generalisable (i.e. producing findings which may be transferable to other settings) (Bowling, 2014), and therefore considered to provide limited validity and value as a research design (Stewart, 2014; Merriam, 2009; Yin, 2009). However, this concern can be addressed by showing transparency throughout the research process (Mason, 2002; Barbour, 2001; Mays, 2000; Stake, 1995; Lincoln and Guba 1985), which can be achieved by detailing the steps involved in data collection, and the reasons for the utilising particular methods (Crowe et al, 2011). In addition, although the lessons learnt may not always be transferable, case studies of local examples of integration and partnership working are an important form of evidence, as they provide an insight into the importance of local context, as different approaches appear to provide varying success, depending on local history, geography, and relationships (Glasby and Dickinson, 2014). For example, while evidence of effectiveness of integrated care as a whole may be difficult to obtain, transferable lessons can be learnt across different initiatives, to identify core elements which may support better outcomes (Nolte, 2017). In addition, researchers need to avoid the temptation of collecting as much data as possible, and allow sufficient time for data analysis and interpretation of often highly complex datasets (Crowe et al, 2011).
Chapter 4: Methods

4.1 Ethical considerations

Ethical approval was obtained from the United Kingdom Health Research Authority on 24th May 2016 (see appendix 5) and the local University Research Ethics Committee on 21st September 2015 (see appendix 6). In order to gain these ethical approvals, applications were made to the respective bodies. This included completing research application forms which detailed core study information (e.g. purpose and design on the research, risks and ethical issues, recruitment and consent, confidentiality, dissemination, and management), alongside preparing supplementary research documents which would be used within the studies. For example this included a research protocol, consent forms, participant invitations, and participant information sheets. These documents were formulated by building on the frameworks provided by the Health Research Authority (including recommended style and content), and adapting them in order to inform participants on what to expect from the studies. For example, participants' information sheets included information such as the purpose of the study, what taking part would involve, the possible benefits of taking part, confidentiality and what to do if there were any problems or questions. Participants were guided through this information sheet at the time of data collection. In addition, an interview topic guide for strategic staff members and a questionnaire distributed to operational staff and practitioners (the Partnership Assessment Tool) were developed and informed by the conceptual literature review of integration and integrated care (see chapter 2). A timeline for data collection is shown at appendix 7.

4.2 Semi-structured interviews (studies 1 and 3)

Two key methods for generating qualitative data include individual interviews or focus groups. The value of these methods can be found within the belief that participants can verbally communicate insight into their actively constructed social worlds (Ritchie et al, 2014). It is suggested that the choice of data collection method between individual interviews and focus groups is due to the nature of data sought,
the subject area, and the research participant group (Ritchie et al, 2014). As the study aimed to focus on the experiences of individual participants, rather than the collective interpretation of integrated care, interviews were therefore undertaken rather than focus groups. One advantage of utilising interviews as a method of data collection compared to focus groups is that of anonymity, where participants are more likely to be open and honest about their experiences and perceptions (Braun and Clarke, 2013). For example, this may be particularly evident within the context of work concerns, where participants might not wish to share their true feeling in an open forum, for fear of this impacting negatively on their employment.

The extent to which the researcher directs the interview in terms of what is discussed and how, can be considered along a scale from structured to informal interviews (Green and Thorogood, 2018). While in structured interviews, the researcher must follow a specific set of questions in a particular order to generate comparable answers (typically used in survey designs), informal interviews include natural conversations which happen organically and produce opportunistic data (Green and Thorogood, 2018). Between these extremes are semi-structured interviews, where while an agenda is set by the researcher, participants’ responses determine the kind of information produced, and their relative importance (Green and Thorogood, 2018).

Semi-structured interviews were conducted in order to explore stakeholder understanding, perception, and constructions of strategic and leadership aspects of the Neighbourhood Teams, in order to generate rich and detailed data (Braun and Clark, 2013). These interviews were conducted in order to explore the Neighbourhood Teams as an integrated concept, versus a working model within a real world setting. Semi-structured interviews enable the collection of rich and detailed accounts of participants’ perspectives and experiences, and the generation of normative accounts of the phenomena of interest (Green and Thorogood, 2018; Braun and Clarke, 2013). For example, the aim of these studies was to generate information about participants’ experiences and perceptions of integration within the context of the Neighbourhood Teams.
While there are many benefits of interviews, semi-structured interviews can be a time consuming data collection method, there can be a lack of breadth due to smaller sample sizes (Braun and Clarke, 2013), and there is the potential for researcher bias (Bowling, 2014). A disadvantage from a positivist standpoint would suggest that as interviews only provide accounts of the world and what people say, rather than what they do, this results in a poor substitute for empirical evidence (Green and Thorogood, 2018). Interviews also do not produce information about how people interact or behave outside the context of the interview environment (Green and Thorogood, 2018). However, qualitative interviews are an invaluable and valid resource, if the aim of the research is to generate contextual accounts of participants’ beliefs and experiences, rather than to be interpreted as a representation of another reality or objective accounts (Green and Thorogood, 2018).

While the research determines the topics covered within the semi-structured interviews, this method of data collection allows participants responses to establish the type and importance of the data produced (Green and Thorogood, 2018). This allows for the findings to be driven by participants experiences and perspectives about the research topic in question, rather than any preconceived ideas. However, a topic guide was produced to facilitate the generation of rich and detailed accounts relevant to the research questions (Braun and Clarke, 2013). Brief topic guides provide a list of areas to cover rather than specific questions (Green and Thorogood, 2018). The topic guide was developed from the data obtained from the conceptual literature review, in order to generate the most useful information (Green and Thorogood, 2018). A review of existing literature and evidence also helps to aid understanding and awareness of the key concepts of relevance (Flick, 2009), and the limits and challenges within the research (Boeije, 2010). Qualitative research methods texts were also utilised to develop the topic guide (i.e. developing open questions, using everyday language, including questions which don’t imply judgement, asking about experiences rather than theoretical questions) (e.g. Green and Thorogood, 2018; Braun and Clarke, 2013). Prompts were also designed alongside the main questions in order to encourage participants to expand and provide more detail (Braun and Clarke, 2013). Within the design process of the topic
guide, it was also reflected as to whether the questions would enable the research questions to be answered, whether there were any unintentional assumptions in the questions, and if the questions would be meaningful to participants (Braun and Clarke, 2013). The same questions were used in studies 1 and 3, with the potential for slightly different prompts used based on level of development indicated by previous findings (please see appendix 8).

4.2.1 Participant Recruitment

Study 1: The countywide strategic lead for the Neighbourhood Teams programme was consulted in order to identify key individuals involved in the strategic development. Purposive sampling was then employed to recruit participants, who were approached based on their strategic representative nature to the development of the core multidisciplinary Neighbourhood Teams. This method of sampling involves selecting participants on the basis of the likelihood of their ability to provide rich data, and therefore enables the generation of an insightful and in-depth understanding of the research topic (Braun and Clarke, 2013; Patton, 2002). As this mode of sampling also involves selecting participants on the basis of certain characteristics or experiences of a particular phenomenon, this allows for the focus to be either narrow or broad (Braun and Clarke, 2013). For example, within this study, there was a need for a narrow focus, in order to recruit participants who had experiences of developing the Neighbourhoods Teams from a strategic position. The lack of generalisability of findings from purposive sampling is a criticism of this method (Bowling, 2014). However, purposive sampling enables the seeking of participants due to specific criterion, which considers them to be good sources of information to answer specific research questions, rather than due to the ability to generalise findings (Sandelowski, 1995). In addition, it is suggested that interviewing every implementer is likely to lead to a large volume of data, which is not likely to provide greater insights than recruiting a small well selected sample (Moore et al, 2015). Participants were therefore sampled from all key organisations which were included within the core multidisciplinary teams at the time of data collection, in
order to ensure that the development and implementation of an initiative was explored through the perspectives of the different strategic stakeholders.

Invitation emails and participant information sheets were distributed to eleven potential participants via email, who were invited to contact the lead researcher if they wished to take part. This gave participants time to read through key information before taking part. Participants’ involvement with the research was kept confidential at all times, with complete anonymity throughout. Ten key strategic representatives from the core multidisciplinary Neighbourhood Teams were subsequently recruited as participants. This included directors, commissioners, and managers from:

- Primary Care
- Community Health Services
- Third Sector
- Adult Social Care
- Mental Health Services
- Clinical Commissioning Group

Study 3: A participant from study 1 who had a project management role was approved in order to recruit participants for supplementary follow-up interviews. While this participant had a key project management role within the Neighbourhood Teams, they had changed job roles since these initial interviews were conducted. This participant, alongside one of the strategic leads for the county wide STP were consulted in order to identify key people currently developing and implementing the Neighbourhood Teams. Purposive sampling was then employed to recruit these participants, who were therefore approached based on their lead roles in the current development and implementation of the Neighbourhood Teams and the STP. Invitation emails and participant information sheets were distributed to potential participants via email, who were invited to contact the lead researcher if they wished to take part. Participants’ involvement with the research was kept confidential at all times, and they were given complete anonymity throughout. Two key transformation leads from the pilot site of the Neighbourhood Teams and the local STP were subsequently recruited as participants. This included a lead change manager for integrated care and a Neighbourhood Team lead for the pilot site for implementation.
4.2.2 Data collection
Participants took part in in-depth face-to-face interviews; which are seen as the gold standard of collecting interview data (Novick, 2008). This method was chosen in order to obtain rich and detailed information about participants’ perspectives and experiences (Braun and Clarke, 2013). Primary data were collected within the case study between August-October 2016 (Study 1) and November 2017 (Study 3), in a private room at participants’ workplaces. Only the interviewer and participant were present during data collection. Participants had no previous relationship with the interviewer but understood that the goal of the research was to perform an independent evaluation and exploration into the strategic and leadership approach of the Neighbourhood Teams. All respondents gave written consent to participate in the interviews and for them to be audio-recorded. Interviews lasted between 20-123 minutes.

The semi-structured interview guide of study 1 and 3 included open-ended questions and prompts informed by the review of the conceptual integration and integrated care literature (including Bardsley et al 2013 and Shaw et al, 2011 reports on evaluating integrated care). This schedule included areas such as: functions and processes, partnership working (people, teams and organisations); implementation and progress (barriers and facilitators); and outcomes and impacts (please see appendix 8).

4.2.3 Data Analysis
The aim of qualitative analysis is to tell a story from participants’ perspectives, whilst also considering the broader meaning and implications (Green and Thorogood, 2018). This type of data analysis can also reflect the complexity of any given phenomena, alongside presenting the underlying structures which make sense of such complexity (Green and Thorogood, 2018). The data analysis method chosen should also reflect the aims of the study and generate findings which answer the research questions (Green and Thorogood, 2018). Thematic analysis was therefore chosen as the appropriate method of analysis to address the research questions, including the type
of integrated care model being developed, alongside the feasibility, practicality, barriers and facilitators of implementing integrated care and integrated working. Digital audio recordings were transcribed and anonymised by the researcher and by an external transcribing service. All interviews were included in the analysis. The aim of utilising thematic analysis of this data was therefore to tell the story from participants’ perspectives, whilst also considering its broader meaning within the integrated care initiatives. Thematic analysis is a method which identifies, analyses, organises, describes, and reports themes found within a data set (Braun and Clarke, 2013). The stages of this analysis included transcription, reading and familiarisation (taking note of items of potential interest), coding (complete across entire dataset), searching for themes, reviewing themes (creating thematic maps - see appendix 9 for an example), defining and naming themes, and writing up (finalising analysis) (Braun and Clarke, 2013). While this method is represented by six phases, it is a reflective and iterative process of development over time, which was utilised in order to inductively identify pertinent themes and patterns within the data (Nowell et al, 2017; Braun and Clarke, 2013).

Developing themes which represent fundamental concepts within the data (Ryan and Bernard 2003), allows for the characterisation of specific experiences of individual participants into more general insight apparent within the data as a whole (Bradley et al, 2007). In addition, while there are a range of qualitative data approaches such as grounded theory, ethnography, and phenomenology, the core element of generating themes is shared, and includes core skills for conducting many other forms of qualitative research (Nowell et al, 2017). One of the main strengths of thematic analysis is its flexible application to various types of research questions and data, which provides a rich and detailed yet complex account of data (Nowell et al, 2017; Braun and Clarke, 2013; King, 2004). Thematic analysis was therefore utilised rather than alternative approaches, in order to answer the various research questions (i.e. RQ2-4). However, it is possible for this flexibility to lead to a lack of consistency and coherency in the development of themes (Holloway and Todres, 2003). In addition, there is a lack of literature on thematic analysis compared to alternative research methods (e.g. grounded theory, ethnography and phenomenology), which may
present a lack of clarity as how to conduct a rigorous thematic analysis (Nowell et al, 2017). Nonetheless, this can be addressed by applying a clear epistemological position which underpins empirical claims (Holloway and Todres, 2003). Thematic analysis is also useful for examining the perspectives of different participants, highlighting similarities and differences, and generating unanticipated insights (Nowell et al, 2017; Braun and Clarke, 2013; King, 2004).

Thematic analysis also enables the generation of in-depth and detailed results, to enable those who may consider applying the findings to be able to judge the transferability within their own context (Nowell et al, 2017; Lincoln and Guba, 1985). Thematic analysis also stays close to participants own meaning, providing a reliable and valid account of participants’ views, and a narrative which provides useful insights for practice and policy (Green and Thorogood, 2018). However, as thematic analysis focuses on patterns across datasets, it therefore cannot provide a sense of the continuity and contradictions within individual accounts, and the voices of individual participants can get lost within the dataset (Braun and Clarke, 2013). Nonetheless, this method of data analysis was used in order to be able to identify patterns and meanings which link to the broader psychological concepts (e.g. human behaviour, motivations, interpretations), social concepts (e.g. relationships, cultural norms and values), and theoretical concepts (e.g. development and implementation of integrated care). The focus of analysis was on exploring participants’ experiences of involvement with developing integrated services, including the associated challenges and the specific and transferable lessons learnt. This method of analysis was therefore chosen to answer the research questions, rather than grounded theory (i.e. focusing on social processes rather than individual experience), Interpretive Phonological Analysis (focusing on psychological concerns and individual experience), and discourse analysis (focusing on how participants use language) (Bryman, 2012; Braun and Clarke, 2013). However, while this means that thematic analysis cannot make claims about the effects of language (Braun and Clarke, 2013), this was not a focus of the research.
While there is the potential for researcher bias and preconceptions to affect the data analysis (Bowling, 2014), there is the suggestion that analysis of data by one researcher is sufficient and preferred in order to aid consistency (Janesick 2003; Morse and Richards 2002; Morse 1994). As data collection and analysis are interlinked, it is proposed that they should be integrated within a single researcher (Janesick, 2003), which avoids the inclusion of different researcher paradigms influencing analysis (Nowell et al, 2017). However, analysis by a team of researchers is recommended by some (e.g. Pope et al, 2000; Patton 1999; Mays and Pope 1995; Denzin 1978), in order to improve the breadth and depth of analysis and findings (Nowell et al, 2017). An advantage of an initial review of the data to comprehend meaning before coding, helps identify emergent themes without losing the connections between concepts and their context and aids general understanding of the scope and contexts of the key experiences (Bradley et al, 2007). This initial stage of thematic analysis allows the researcher to familiarise themselves with the depth and breadth of the content of data (Braun and Clarke, 2013).

Coding is the process of identifying aspects of the data which relate to the research questions (i.e. RQ2-4) (Braun and Clarke, 2013). Line by line coding was performed in order to refer to substantive elements (e.g. particular behaviours), values (e.g. informing certain statements), emotions (e.g. frustration), and methodological elements (e.g. difficulty in providing explanation) of participants interviews (Salanda, 2015). Data-derived codes which summarise the content of the data were used (e.g. clinical role providing senior support) and research-derived codes which go beyond data content and refer to theoretical frameworks to identify implicit meanings within the data and make assumptions underpinning data content (e.g. the need for leadership skills to facilitate progression). An example coded transcript is included at appendix 10. Coding has been described as a crucial transitional link between data collection and attributable meaning (Charmaz, 2002), in order to facilitate analytic and interpretive processes (including identifying patterns, categorisation and theory building) (Saldana, 2015). An advantage of coding the data in this way also provides a formal system to organise the data and identifies additional links within and between concepts and experiences described (Bradley et al, 2007). Excel was also
used as a tool to support the analysis of the data and organisation of themes. This process was discussed with supervisors, in order to account for any potential bias in data analysis. This included discussing the data obtained from the interviews, the coding process, and the formulation of the themes.

Complete coding was utilised in order to incorporate data of relevance and interest, which could contribute to answering the research questions into the analysis (Braun and Clarke, 2013). This approach was taken to allow for the exploration of participants’ perspectives of the development and implementation of Neighbourhood Teams without making any assumptions about their approach to integration. As highlighted in chapter 2, as integration can mean different things to different people, depending on the context, professional and personal views and behaviour, all data needed to be explored. All data relevant to the research questions were therefore coded, followed by a more specific and selective analytic process (Braun and Clarke, 2013). For example, a code was ‘systematic barriers’, whilst a theme was ‘contextual factors of integration’. Data-derived codes which summarise the content of the data were used (e.g. clinical role providing senior support), alongside research-derived codes which go beyond data content and refer to theoretical frameworks to identify implicit meanings within the data and make assumptions underpinning data content (e.g. the need for leadership skills to facilitate progression) (Braun and Clarke, 2013).

4.3 The Partnership Assessment Tool (study 2)

Following qualitative analysis of the semi-structured interviews with strategic staff (study 1) and a review of the literature (see chapter 2), the tool to address the research questions at the initiative’s stage of development was identified. Through this process, a questionnaire was originally developed which incorporated questions from a tool used within a national evaluation of Partnerships for Older People (Windle et al, 2009), a national evaluation of the Department of Health’s Integrated Care Pilots (Ernst and Young, 2012), and a standardised questionnaire which explored interdisciplinary team performance (Temkin-Greener et al, 2004). However, this mix
of questionnaires would not have been a standardised tool. In addition, following the conceptual literature review (chapter 2) and initial strategic interviews (chapter 5; study 1) a more appropriate tool was selected in the form of a Partnership Assessment Tool (PAT) developed by the Nuffield Institute for Health (Hardy et al, 2003). This was developed as part of a taskforce set up by the government in order to assess strategic partnerships and can be found at http://www.iape.org.il/upload/AssessingStrategicPartnership.pdf.

There is an argued need for an understanding of the health of partnerships, including the identification of shortfalls and guidance for development (Halliday et al, 2004). It is suggested that a key feature of partnership success is the high-level of agreement between partners concerning the value of, and intention towards, partnership working and collaboration (Fischbacher-Smith, 2015; Hardy et al, 2000; Huxham and Vangen, 2005; O'Leary and Vij, 2012). Due to the lack of a consistent definition of partnership working (Powell, Exworth, and Berney, 2001), when exploring staff perceptions of this type of working, it is also suggested that utilising the six principles for partnership working developed by Hardy et al (2000) is more beneficial, than attempting an overarching definition (Rummery and Coleman, 2003). The PAT therefore aims to define common obstacles in partnership working between health and social care, and establishes generic principles which can be applied to different organisational levels (Halliday et al, 2004; Hardy et al, 2000). This PAT which is based on extensive empirical research (Halliday et al, 2004), was therefore selected in order to assess staff members’ perceptions of the Neighbourhood Teams partnership at its stage of development, the impact of the initiative on partnership working, and the practicalities of this way of working in practice.

While the principal aim of this tool is to enable generic assessment of partnership working, it does not offer detailed prescriptions for addressing the problems identified in any particular partnership. How partnership weaknesses or problems are tackled, or how strengths are reinforced and replicated, must therefore depend upon local circumstances, and is therefore likely to require specialist organisational development expertise. This therefore limits the extent to which analysis of findings
can address issues which may be present within the Neighbourhood Teams partnership. In addition, it is suggested that methods used as stand-alone tools to assess partnerships can be open to misinterpretation (Halliday et al 2004). However this method was triangulated with semi-structured interviews, in order to enable further understanding and a more complete picture of the development and implementation of the Neighbourhood Teams.

While a substantial amount of time may be spent developing and implementing plans and objectives, less time is spent assessing how effective the partnership process is, which aims to deliver these objectives (Hardy et al, 2013). Therefore in order to do so, this PAT is based on six partnership principles which have been shown to form the building blocks for successful partnerships (Hardy et al, 2013). The details of these partnership principles and the associated elements are included at appendix 11. These include:

1. Recognise and accept the need for partnership
2. Develop clarity and realism of purpose
3. Ensure commitment and ownership
4. Develop and maintain trust
5. Create clear and robust partnership arrangements
6. Monitor, measure and learn

4.3.1 Participant recruitment

Due to the complexity of integrating care and working across organisational boundaries, obtaining a comprehensive list of those staff members working with these teams was significantly challenging, and exacerbated through organisational change and restructure. For example, throughout the research it emerged that there was a lack of knowledge and communication regarding which operational staff members and practitioners were aligned to the Neighbourhood Teams, and there were various changes in job roles. This highlights the workforce issue of implementing and sustaining integrated care. The numbers of operational staff
working within the integrated care initiative was therefore explored through the interviews with strategic staff representing each organisation within the integrated model (chapter 5). Purposive sampling was then employed to recruit participants. Neighbourhood Team meetings were subsequently attended in May 2017 in order to recruit these participants and explain the purpose of the study. Staff members who were part of the Neighbourhood Team but could not attend the meeting were contacted via email. All operational project staff and practitioners from a range of professions working within the multidisciplinary integrated teams were then invited to complete a questionnaire which included a tool for assessing partnership working (n=44).

4.3.2 Data collection
The assessment tool was distributed in the form of an online questionnaire utilising the ‘Qualtrics’ software, or through a paper version (see appendix 12) based on participant accessibility/preference. This included questions regarding the six partnership principles, alongside questions regarding awareness of and interactions with the Neighbourhood Teams, and perspectives of current partnership success. Staff members either completed the questionnaire via an online link which was sent by email or via paper copies which were distributed to participants at a Neighbourhood Team meeting. Paper copies were made available through a team lead for those who wished to complete the questionnaire through this method, but could not attend the meeting. Paper versions were returned to the researcher via post. Participants had no previous relationship with the interviewer but understood that the goal of the research was to perform an independent evaluation of the Neighbourhood Teams. Informed consent was implied by participants completing the questionnaire. Participants were informed that the questionnaire should take no longer than 10 minutes to complete. The questionnaire data obtained provided a quantitative description of trends, attitudes, and opinions of a specific population (Creswell, 2014), in reference to the principles of partnership working.
4.3.3 Data Analysis

The purpose of the PAT is to provide a comprehensive way and efficient of assessing how effective partnership working is, and to consider how far partners feel that these building blocks are in place. Participants were required to rate their agreement and disagreement with statements regarding the six principles of partnership working (see appendix 11). This therefore highlights areas of agreement and areas of conflict which need to be explored. It also provides a common framework for partners to develop a joint approach to addressing some of the barriers to effective partnership working and can highlight a range of perspectives. While it can identify problem areas, it has been designed as a tool to inform the development of partnerships, rather than as a means for centrally assessing local partnership performance.

4.4 Documentary Analysis

In order to help inform further understanding the process and impact of the integrated Neighbourhood Teams, relevant data were also extracted from commissioning, implementation, and service specification documents. Document analysis is often used as a means of triangulation with other methods, particular in case study research (Bowen, 2009). Key documents were collected throughout the duration of the research, such as corporate information documents, internal policy documents, performance documents, and case reports. However, the identification and retrieval of these documents relied on the availability of documents, cooperation from and liaison with the CCG and Neighbourhood Team leads, and identification of their importance from other research methods, by both the researcher and participants. This therefore relies on the researcher to determine the existence and accessibility, alongside the authenticity and usefulness of particular documents (Bowen, 2009). This therefore results in a level of subjectivity of the documents and the understanding of the data (O’Leary, 2004; Bowen, 2009). An example of the type of data retrieved included the referral rates for each of the five integrated Neighbourhood Teams. The method of documentary analysis took the approach
detailed by Bowen (2009), through the immersion in an iterative process which combines elements of content analysis and thematic analysis.

As documents can provide data on the context within which research participants operate (Bowen, 2009), they were therefore utilised in order to contribute to the understanding of the Neighbourhood Teams, and generate a more complete picture of the phenomenon. However, while advantages of document analysis include their non-reactivity with the researcher, broad coverage, efficiency and availability, convenience, and low cost; an awareness of authenticity, completeness and representativeness of documents is important (Bowling, 2014; Bowen, 2009). For example, the results of document analysis will be determined by the documents used, their completeness, and who they were written by (Bowling, 2014). However, irrespective of theoretical position, documents cannot be regarded as a completely accurate representation of the phenomenon of interest (Bowling, 2014). Nonetheless, they can be valuable sources of data when their social context and process of construction are taken into account.

The analysis of key CCG and Neighbourhood Team documents were utilised throughout the thesis in order to build knowledge of the process of Neighbourhood Team development and implementation and its evolution over time. These documents also aided the development of the Neighbourhood Teams development flowchart (see appendix 1). They included:

- Neighbourhoods Team models (see figures 1.1 and 1.2).

- Corporate information documents (e.g. operational plans and frameworks – see appendix 13).

- Performance documents (frail older people services performance outcomes).

- Neighbourhood Team case reports and referral rates (see appendix 14 for example).
4.5. Field Notes

Field notes are an important source of data as they preserve details of interactions, facilitate an understanding of how people characterise and describe particular activities and groups, convey explanations for when, why and how particular things happen, and identify the practical concerns and conditions which people deal with in their everyday lives (Silverman, 2017; Emerson et al, 1995). Field notes and anecdotal observations of Neighbourhood Team meetings were therefore made whilst attending the meetings to recruit participants for study 2 (see appendix 24). This required the need to integrate and adapt successfully into the research environment, to collect valuable data. In order to keep separate empirical observational notes (detailed in black) and initial interpretations and analytic comments (detailed in red), separate colours were used (as advocated by Green and Thorogood, 2018). Handwritten notes were made and written up straight after each Neighbourhood Team meeting, to ensure that it was possible to remember most of the context of exchanges (Green and Thorogood, 2018). The collection of field notes added another dimension to the findings, as what was considered to be ordinary was established through watching and listening to what people did and said, rather than asking them directly (Silverman, 2017). These field notes were analysed by utilising thematic analysis, in order to identify penitent patterns and themes within the data (Braun and Clarke, 2013).

Please see chapter 8 for the triangulation of the datasets from these methods (i.e. semi-structured interviews, PAT, and field notes).
Chapter 5: Results - Strategy of integrated care (study 1)

5.1 Research questions and mixing of the data

As part of the process focus of the theoretical framework (see page 21), this chapter details the results from the semi-structured in-depth interviews which were conducted in order to gain a strategic and management perspective and understanding of developing and implementing integrated care. These interviews were conducted with ten key strategic representatives and stakeholders of the Neighbourhood Teams. As detailed in the methods chapter (chapter 4; page 94) this included staff members from:

- Primary Care (n=2)
- Community Health Services (n=2)
- Third Sector (n=2)
- Adult Social Care (n=1)
- Mental Health Services (n=1)
- Clinical Commissioning Group (n=2)

As stated in the methodology chapter (see chapter 3; table 3.1), the aim was to address the following research questions:

RQ2: How has a local approach to integrated care been developed and implemented over time?

RQ3: What is the feasibility and practicality of developing and implementing integrated care and integrated working?

RQ4: What are the barriers and facilitators to developing integrated teams, and implementing and sustaining integrated care?

As explained in the methodology chapter (section 3.3.2; page 86), the data collected in these strategic interviews were used to inform the remainder of the study. For example, mixed methods were utilised in order to identify an appropriate tool to assess operational and practitioner staff members understanding and application of integration and partnership working (chapter 6; study 2) and inform understanding of the progression of the integration agenda in the form of the Neighbourhood Teams, based on expert opinion (chapter 7; study 3).
5.2 Themes derived from the analysis

Findings were analysed using thematic analysis (see chapter 4 for methods, appendix 9 for an example thematic map, and appendix 10 for an example of a line by line coded transcript). Themes of data were grouped in order to produce results which concerned the strategic perspective of developing and implementing Neighbourhood Teams. Six overarching themes were subsequently identified across these interviews. These themes included:

1. The purpose and focus of the integrated concept
2. Multidisciplinary team working and engagement
3. Professional roles and responsibilities
4. Contextual factors and challenges of integration
5. Expectations and the reality of integration
6. Future goals for care delivery

Elements which featured across all themes included the importance of leadership and clarity, the need for key shifts and change, and the presence of variation in development and implementation. Results were interpreted within a context of the type and evolution of the integrated model in development, the current feasibility and practicalities of developing and implementing integrated services, and the barriers and facilitators of achieving this complex aim (i.e. RQ2-4).

**Theme 1: The purpose and focus of the integrated concept**

All participants considered the development of the Neighbourhood Teams concept, alongside the strategy which had been employed in order to develop the challenging integration agenda. These considerations included what the strategic representatives felt the purpose was, what should be focused on, and what the priorities should be for this model. The concept was largely viewed by participants as beneficial, with recognition of the value of partnership working. For example:

“I think the concept is really good, and I think organisations are all about working in partnerships, most of the ones that we come into contact with, and we’ve got some
Strategic Clarity

The data revealed that the strategic team were confident that “the idea of bringing together lots of people with lots of skills, and different professional groups together in a single team, managing a defined cohort of people with a degree of risk” (P1), was the correct design for the Neighbourhood Team model. This was considered to include developing both integrated community teams, and a wider neighbourhood network. It was also evident that the Clinical Commissioning Group (CCG) participants were aware of the aims and objectives of the Neighbourhood Teams initiative, including reducing emergency admissions, early assisted discharge, care closer to home, and quality end of life care. However, there was an apparent lack of strategic clarity of the aims, objectives and outcomes of the initiative within partner organisations. It was considered by participants that both the expectation of referrals into the Neighbourhood Teams and the desired outcomes were not clear. The strategy had therefore not been effectively communicated to key strategic leads of core partner organisations of the multidisciplinary teams. For example when considering the outcomes of the Neighbourhood Teams, it was reflected that “we’re not aware of what each Neighbourhood Team’s outcomes are and even if they’ve got them” (P3).

The wider strategic context of the Neighbourhood Teams was also frequently referenced. Participants explained that the model was part of the agenda of a strategic partnership which included all the major health and care organisations across the county. However, it was evident from three participants’ experiences that this county partnership agenda was not necessarily understood by operational staff and practitioners, particularly with regard to how the Neighbourhood Teams sat within this wider context. The importance of the workforce understanding that this wider strategy was part of the process of delivering the Neighbourhood Team model was also recognised. An unsuccessful attempt to engage staff with the agenda from
both a professional and patient perspective was also highlighted. Despite their central and pivotal role to the development of the Neighbourhood Teams, one participant also noted confusion with the actual model itself. This lack of clarity is therefore a potential barrier to staff engagement with the strategy, which may not be being delivered and communicated in a manner which was accessible to key staff working within the model.

The data revealed that staff had initially engaged with the county vision, the concept of partnership working, and the Neighbourhood Team model. However, the continued lack of clarity following the initial implementation process and the associated barriers and challenges hindering progress, had resulted in a certain tiredness and frustration in response to the strategic vision. The complexity of the Neighbourhood Teams history and sensitivity to initial conditions in the difficulties of their development (Pype et al, 2018), had therefore affected progression. In light of these frustrations and lack of progress at scale and pace, a need to relaunch the whole Neighbourhood Team concept was also expressed, with the ‘Sustainability and Transformation Plan’ (STP) identified as a potential tool for rebranding and selling the concept. For example:

“I think if you were to go out and ask my Staff Teams, I think they would still say it is still quite unclear and the vision is not as clear as they would like it to be and that there’s a bit of [name of strategic county partnership] fatigue because it’s been promised and coming for some time, but because of various changes in personnel and a whole raft of historical things that really were before my time, it’s not been delivered in the way they wanted it to be delivered, and as quickly as they wanted it to be delivered.” (P9)

A lack of understanding of the Neighbourhood Team process was also considered to result in the lack of ability to subsequently navigate the system. Several participants commented on the concern that if those who are working in the system were unable to navigate and understand the processes (i.e. staff), then it would be even more challenging for patients to do so. This was considered to result in a time-consuming process, and patients not taking advantage of the services available to them. For example:
“Because if it’s complex for us who are in the system, the lay man at the end of the service potentially, we found they weren’t taking the services up because they didn’t understand what was being offered to them, they didn’t understand how it could benefit them, how it fitted in together with other things they were receiving, that one would prevent the other from happening.” (P3)

Phases of development

With regard to the phases of the development process, participants explained that ‘phase one’ of the Neighbourhood Teams included identifying the core multidisciplinary team (MDT) and developing relationships, coordinating and establishing meetings and the referral process, and shaping teams around geographic boundaries. ‘Phase two’ of the development process was considered to be represented by a whole population health approach and the optimum end goal of successful partnerships working, and a shared responsibility for patients. This was considered to be markedly different from what was currently in place. For example it was explained that:

“I think for me, phase two is about truly integrating, so people rather than coming together occasionally, around maybe a shared purpose of the patient case or a particular problem that needs solving or ensuring that the requirements of a particular practice are there. For me, phase two is about a shared team with a single shared responsibility and purpose for that whole population and I think that’s a very different thing that we are now trying to create.” (P7)

This second phase of the development process was also described as a “proof of concept” (P6&9) where county-wide pilot sites would explore the real feasibility of the model and learn from the experiences of the implementation process. There was also the view to swiftly roll out this standard of the model to the other Neighbourhood Teams. The rationale for why a particular Neighbourhood Team was chosen for the pilot site within this local CCG’s footprint was suggested by two participants to be due to potential for impact of the model, and the specific challenges that this team faced. There was particular reference to primary care challenges, high deprivation, and mental health problems. This chosen pilot site was
also considered to have the added advantage of having the potential to also further develop, due to the team already being bought into the model.

While it was explained that phase two of the development process was not part of the original strategy or a planned phase, as the initial phase had lost developmental momentum, the second phase was therefore designed. It was also suggested that there was a need to divert slightly from the original model in order to integrate those organisations who understandably felt on the outside and not integrated. Those organisations who were part of the wider network rather than the core MDTs, were therefore considered to have less ownership and commitment to the Neighbourhood Teams initiative. The data also revealed that discussions had taken place with countywide CCGs and partner organisations to develop the strategy for phase two, in order to produce agreed common goals. The need for continued discussions and engagement with all of those involved in the model in order to prevent a loss of momentum was also advocated. However it was acknowledged by one participant that this had occurred prior to their involvement with the project (highlighting the changing workforce). For example:

“We’ve had to agree some common ground on what the principles are and what we’re trying to achieve with phase two, there’s been quite a bit of discussion about that. And as well, not just with the CCGs, but all the different partner organisations. So I think in the past there have been – there were discussions before they started setting up the Neighbourhood Teams, because I know people have said, “We were involved at the beginning,” but then maybe weren’t involved later down the line. But I don’t know, that was before my time.” (P6)

The rationale behind the need for a phase two, and why the current model may not be currently representing the original vision and purpose was suggested to be due to a lack of explicit care pathways (including transitional care and frailty). However, as the concept had not changed, the end goals were explained to remain the same.

Focus of the approach
The overall need for a patient priority and focus of the approach to integration was acknowledged by participants, rather than driving a focus on organisational
administrative processes, which often resulted in duplicated work. Two participants explained that there should be a focus on patient needs, rather than complicated and often repeated assessments and processes. This notion was further emphasised by a further participant, who explained that patients are generally concerned about accessing services and receiving care, rather than on the label of different organisations. For example they commented that:

“The reason I think that is because at the end of the day the person at the end of that service has surely got to be the one we should all be focussing on and how we get there is for us to worry about and they shouldn’t care what colour, they don’t care, do they, most older people we come into contact, whether you’ve got a red, blue or green lanyard round your neck. All they care about is, can you fix their problem, can you help them. And that’s all that we should care about really as well.” (P3)

Participants also presented their views on what they believed the appropriate target population for the model should be. While some considered that the purpose of the model was to support frail older people, others noted that although it was a frailty service, it was not intended to be age specific. This highlights the consequences of a lack of clarity of vision, the existence of individual beliefs and organisational culture of what the target population should be, and the complexity of unintended consequences. The data also highlighted the dangers of focusing on frailty, including having a blind spot to other needs, and endorsed a whole population community approach. One participant (P9) compared three different types of patients and commented that those with “multiple-agency” needs, should be the type which the Neighbourhood Teams should target, as opposed to those with “single-agency” and “self-care” needs.

The reasoning behind a loss of focus and clarity was attributed to the difficulties associated with implementing the concept, becoming more focused on or distracted by new initiatives and models, and the loss of particular roles (e.g. specialist clinical input). Implications of this were considered to be a decrease in progress and impact of the initiative (i.e. low referral rates). While it is was acknowledged that it was
advantageous and good practice to learn from others, the data further highlighted the necessity for strategic partners to commit to one particular model. For example:

“Nationally, there’s a lot of models so I think [name of county], as a system, needs to commit to a model and stick with it. “That’s the model going forward, that’s what we’re going to deliver and that’s what it means for individuals,”... I think it’s right that we learn from other places, but not to such an extent that it seems to throw the apple cart up every time something happens.” (P9)

Participants also felt that the focus of the Neighbourhood Team model had unintentionally become directed towards the core MDTs (see figure 1.1), rather than having more of a non-medical community and neighbourhood approach (representing the original vision). While one participant reflected that “in order to have somewhere to start, they started with MDTs” (P9), another noted that if everyone was working as a team, the MDT meeting would then be incidental and not the main focus of the operation of the model. On the other hand data also revealed the recent clarity of the concept, with more of an awareness of how the model could progress, what it can achieve, and the learning that can help facilitate development. However, there were acknowledgments that while more recent progress had been made, there was still a lack of consistency in the key message of the purpose of Neighbourhood Teams and varied interpretations of its intended operational delivery and outcomes, highlighting the key issue of the implications of the lack of clarity. For example:

“So I think, in the last few months it’s become much more crystalised and people are much clearer and the vision around the four ‘phase two’ sites are moving forward. But I think, if you went up to my Staff Teams today and said, “What is the purpose of a Neighbourhood Team, and what is it that you’re supposed to be delivering?” I think you would get various answers, all of which would be correct, but I don’t think you would get a consistent, “this is our message; this is what the Neighbourhood Team is there to do.” (P9)
Application of the model
All participants commented on the variation in the application and progression of the Neighbourhood Teams, and the associated contrast in success. The likelihood of the concept translating into a successful model was attributed to having the appropriate buy-in from the appropriate people (i.e. key organisational partners and those delivering key changes within the STP), a clear understanding of what the initiative was aiming to achieve. The rationale for why variation may have occurred was considered by three participants to include the model adapting to local needs. It was further explained that the original strategy was to not be directive in developing Neighbourhood Teams, with each locality being able to develop the teams based on their different demographic and needs across the system. However, while a level of variation was considered to be appropriate due to locality specific issues, it was explained that the barriers faced were likely to be synonymous across the teams. These included information governance, rules and regulations, large workload of some partner organisations, conflicting priorities, and contrasting cultures.

The lack of clarity of the purpose and strategy flowing down to the staff delivering the model on the ground was perceived to contribute towards the varying application. This was interpreted by three participants to be further exacerbated by a lack of leadership and ownership to drive the changes through to make the new way of working business as usual. However the difficulty of facilitating this capacity to drive the model forward from “essentially multidisciplinary team meetings in GP surgeries” (P9), to a broader delivery was acknowledged with regard to the nature of the substantial changes necessary to achieve the intended optimal broad delivery of service. It was also noted that staff members role within the Neighbourhood Team had been seen and implemented as an add-on to their day job. For example:

“So, each locality, as part of the development, has been given free rein to develop and drive through, but I’m not sure they’ve always fully understood what it is they’re developing and driving through. I think the challenge has been ownership and leadership of that, to really drive it through and deliver it, to make it business as usual,
because it’s a huge change; it’s a completely different way of working. Lots of people have been doing it on top of the day job really.” (P9)

Nonetheless, it was also considered that a certain level of variation in the development and adaptation of Neighbourhood Teams was inevitable due to the variation in availability of certain services within different localities (such as community and third sector services). However, three participants explained that there was still a need for a level of consistency. This was considered to include core MDTs working together and focusing on avoiding admissions to hospital initially, with quick and efficient hospital discharge following in the case of deterioration. This need of a “baseline consistent offer” was acknowledged in order to avoid the implication of variation the Neighbourhood Teams resulting in variation in the quality of patient care, resulting in the potential for a “postcode lottery” (P9). For example, in reference to the need for consistency it was also commented that:

“We have got to thrash that out up front because there’s something about, yes people want to allow the emergence of their own local model, but you have got to do something strategic in enabling and you have got to have a fairly unified overarching model to allow that to happen so that you do not just get extreme variation developing, because then that is where your quality drops off. Because you could end up with - if you end up with 12 to 13 teams whatever it is across the county, you could end up with ten that are absolutely fabulous and two that are actually harming patients.” (P7)

Theme 2: Multidisciplinary team working and engagement

Organisational and professional engagement, alongside multidisciplinary team working were considered by participants to be important factors affecting implementation of the strategy for integration. One of the vehicles for facilitating these factors was the use of regularly scheduled MDT meetings for each of the Neighbourhood Teams (some of which were combined). The data revealed how the MDT meetings operated and what was discussed within this format. For example, it was explained that the format of one MDT meeting was:
“We have a meeting every other week, the whole team tries to get together, so we talk about all the patients on the caseload, what’s changed where they’ve gone and then I update the system with what’s happened to them and just keep a tab on what’s going on, where they’re going, or if they go into hospital I’ll let the clinician know.” (P5)

The mutually beneficial aspects of these meetings for both staff and patients were considered to include: the promotion of a “multidisciplinary approach to elderly people” (P10); the opportune format to discuss patients “face to face and in a team” (P5); enabling communication and relationships between professionals; and the promotion of teamwork, ownership, responsibility, and accessing patients. It was also explained that working with the Neighbourhood Teams had facilitated the understanding of integrated processes and an awareness of the available services across primary care and the community. This in turn was considered to promote continuity of care.

Variation
The MDT meetings were noted as being variable in several aspects, including leadership, quality, effectiveness, regularity, format, and attendance and regular commitment. The data also revealed anecdotal feedback that staff did not meet regularly, with some meetings only occurring every six weeks. Particular variation was noted between the advanced dynamic nature of one of the Neighbourhood Team meetings, with the remaining four being less developed and proactive in their approach. For example:

“[Name of Neighbourhood Team] seems to be much more advanced in the way that they work together. The people who were there were quite proactive and they’re offering, without prompting to do things, and it’s a very vibrant discussion… So it’s a very dynamic meeting for me. The other four meetings, not very dynamic. In fact, one meeting I went to, I think it lasted all of ten minutes and everybody sat there and didn’t say much… The others they’re much shorter, not always a CPN there, not always a social worker there and not that same kind of vibrancy of engagement with it, and not very proactive. Nobody really taking the lead on pushing people and challenging people” (P6)
A contributing factor of variation was considered to include the lack of specialist clinical leadership that this team had received. This was perceived to result in the need for staff members to be more proactive and forthcoming in their discussions, and develop a shared ownership of the process. It was also considered by two participants that this particular Neighbourhood Team had more organisational engagement and contribution with a “broad range of disciplines” (P8), who used each other as a knowledge base for different patient care perspectives. The shared ownership within this team and an open forum for discussion was also highlighted. The current lack of leadership at the majority of the MDT meetings was perceived by some participants to contribute towards variable attendance at the meetings, and a lack of importance placed upon it.

The implications of the variable attendance were considered to be inconsistencies, and the inability to obtain appropriate sufficient referral information. However, the barriers to attendance were perceived by four participants to be workload demands and the capacity to attend, and conflicts of interest (i.e. going out to tender so for a period of time, some organisations couldn’t sit on that team). Another potential reason for the variation in the meetings included the perception that they were an added to staff members’ day jobs, with Neighbourhood Teams working in addition to their normal duties. In order to facilitate MDT working, the need for a change in this perception was advocated, where staff viewed the Neighbourhood Team way of working as important in being part of a new team. However, it was also considered that even if staff were able to attend, they did not necessarily perceive the meeting as beneficial and relevant, in light of their other work demands. For example:

“CPNs and adult social workers, either don’t attend regularly or are not bought in when they go. I think that’s some of the difference between the meetings. I think from what people have told me, people see it as an add-on, so it’s another meeting they’ve just been told they’ve got to go to. Certainly when I’ve talked to some more senior managers about the Neighbourhood Teams they even accept that that’s an issue for them to grapple with, because it’s another piece of work, and they don’t see the benefit of it themselves when they go.” (P6)
Primary Care

The integration of primary care into the model was unanimously considered to be an essential yet significant challenge. The ability to communicate with GPs was perceived to be essential in order to facilitate their engagement. However, despite the critical nature of GP and primary care involvement with the Neighbourhood Team model and process, participants shared their experiences of the variation in team working and GP engagement. For example, it was commented that “some of the GP practices work better with you than others” (P3). The attendance of GPs at the MDT meetings was acknowledged to be variable by the majority of participants, who considered organisational buy-in and lack of progress at scale and pace as potential contributors. Further reasoning behind a lack of GP engagement was considered by three participants as being due to the profession generally not understanding the model or the process and the benefits it could bring, and potentially having their own interpretation of collaboration. For example:

“It absolutely varies and some see the benefit of a wider working and working in a broader sort of neighbourhood kind of collaborative and are very happy and comfortable to work collaboratively. I think others are very honed in on their own practice and what works for their own practice and their own partnership and are not as collaborative as others potentially. Or would see collaboration differently than a prescribed Neighbourhood Team model.” (P7)

Additional contributing factors to the variation in primary care buy-in across the different Neighbourhood Teams included the rurality and accessibility of certain areas, GP shortages, and losing particular engaged members of staff. The time limited nature of GPs job role and perceived relevance of the meeting were also suggested to be barriers to engagement. The contributing factors of workloads and demands currently on GPs was considered to be exacerbated by the model and referral process not necessarily being set up in the manner that they had intended, further affecting their engagement with the process. Two participants commented on the lack of chances to engage with this profession and obtain commitment, particularly if the process had not been implemented in a seamless manner.
This potential reluctance to engage with the process throughout its development stages, was further explained to be due to the anxieties associated with the perception that the Neighbourhood Teams model could increase this level of demand. This in turn was suggested to affect the protective nature of organisations, subsequently contributing to the difficulty of integration and tensions in partnership working, and representing a considerable barrier to implementation. For example:

“I understand it; they’re very busy people, they get however many minutes it is with each patient and they need things to move quite quickly, particularly if we’re going to want them to take on more clinical responsibility. I think they’re very anxious with the level of demand. They’re fighting with the level of demand and just trying to balance everything...I think the challenge is for all organisations, the more tight things become, the more you avidly defend your boundary. I think that makes integration more difficult.” (P9)

Further implications of the variation in GP and primary care engagement, and a loss of clinical input due to workforce changes, were considered to be sub-optimal outcomes. This included lower referral rates, depreciation in staff morale, and a loss in structure, partnership working, and a drive for the Neighbourhood Team concept. The data also further revealed that the loss of clinical leadership had affected staff morale, and suggested that it had subsequently affected engagement and motivation for development and improvement of the Neighbourhood Teams.

Whilst considering what could facilitate and enable GP engagement, all participants suggested that individuals needed to see the benefits of the model for themselves, other staff members, and patients. This was needed in order for staff to truly engage with the process, support the changes, and contribute to driving them forward. In addition to showing GPs the benefits, national drivers, building relationships, ease of access, and developing leadership roles were also considered as key factors facilitating engagement. However, varying approaches were considered to be needed to facilitate GP engagement, due to their different views, priorities, culture, and wider health care involvement. This meant that a one size fits all approach was not appropriate, which is in accordance with the suggestion that complex systems are
inherently too complex for a one-size fits all approach (Miller et al, 2016; Armitage et al, 2009). For example:

“There is not a one size fits all, there is not a kind of a GP view, there are different emerging views and different cultures, some of them sort of historically and geographically based, others just around whether GPs have been involved in commissioning or not, you tend to get different views from GPs that have been exposed to being on the Clinical Commissioning Groups and things like that and understand some of the wider issues around NHS delivery. You have got other GPs that are just going and run their practice and that is what is important to you.” (P7)

The data also highlighted an attempt to increase GP engagement by making the meetings more accessible through organising them to be held at the GP surgeries. However, this had not necessarily resulted in the desired increase in engagement.

**Organisational commitment**

The data suggested that commitment was necessary in order to obtain engagement and buy-in across the organisational partners. It was also considered that partner organisations could get “distracted by other priorities and will commit to other agendas or other outcomes” (P7) in its absence. The presence of conflicting priorities was also identified, particularly in reference to being able to consistently attend MDTs. However, three participants also considered that despite the achievement of organisational buy-in and commitment, successful engagement with the model could be attributable to individuals and the relationships that they form, including facilitators such as shared ownership and professional respect. This highlights the key role of individual thoughts and action within critical realism, and their ability to influence the development of systems of care (Byng et al, 2005). For example:

“It’s the people that make things work sometimes. And once you’ve got that really good link in with somebody, instead of just across a desk and a quick two hour meeting or whatever, fighting about who’s having that and who’s having that, I just would like to see much more stronger links and shared ownership. Because I think once you’ve got that relationship with somebody and you click, and you’ve got that
professional respect for each other which you know, we don’t always get in a GP’s surgery when you’ve got referrals flying across the table.” (P8)

A two-way relationship between the Neighbourhood Teams model promoting partnership working, and organisations embedding it within their teams and organisational cultures was also acknowledged. However, it was unclear to participants as to whose responsibility the promotion of partnership working within the Neighbourhood Team model was, further complicated by the lack of leadership and ownership of the teams. Participants also noted a variation in organisational integration (at the meso level) into the model and feeling like part of the team. For example they commented on the further advanced integration between health and social care compared to physical and mental health, where relationships remained to be formed.

The variety in partnership working was considered to be affected by the barrier of organisational workload demands, which could make individuals territorial rather than integrated. It was also noted that while relationship building was due to individuals, interpersonal relationships were key to the development of the model and working across these organisational barriers, even in light of effective systems and processes. However, the difficulty of developing relationships between the desired organisations was also acknowledged, due to their contrasting cultures and ways of working. This also raised the issue of trust between organisations, which was perceived to be necessary in order to facilitate partnership working, subsequently reducing duplication of workloads and providing continuity of care. Two participants considered the importance for trust to occur across organisational and professional boundaries, with particular reference to assessment processes and discharges. For example:

“For me, that’s more about relationships as in working relationships with people and having trust in each other, rather than pooled budgets…I think it’s reducing, but I think there is duplication. I think, again, it goes back to trust. So, you’ll have nurses in hospital assessing for a discharge, and then you’ll have Continuing Health Care nurses going out and assessing for the fact that they’re now in the community and,
in a short space of time, you could probably have, as a patient, four or five assessments in a very short space of time.” (P9)

One of the facilitators for building relationships and trust was considered to be having the right personalities with the right skills, rather than the appropriate qualifications. One participant noted that they felt that one of the Neighbourhood Teams which they chaired were good at communicating at the operational MDT level. However, while communication may happen between colleagues at the same levels, there may be less communication across different levels of organisations (i.e. between frontline staff and managers).

**Teamwork**

It was reflected in the data that the advantages of the MDT meetings which took place at GP practices, included enabling communication and relationships between professionals. However, another participant commented that while the MDT meetings contributed towards the feeling of teamwork, staff working in the community sometimes felt lonely within their role and they were currently lacking feeling part of a team. In reference to the mutual benefits of the MDT meetings for staff and patient care, two participants also considered these to be the promotion of aspects such as teamwork, ownership, responsibility, and accessing patients. For example:

“We were one team. We were meeting up; we knew who we were responsible for. I think it gives you a sense of ownership as well and you feel responsible... Every team member played an important part because sometimes somebody got referred to a Primary Care Navigator and they have come back and they’ve said, “Well, I’m not sure why they’re feeling a bit dizzy. Doctor, can you have a look at the medication?” and things like that.” (P10)

However, while participants acknowledged the desire for organisations to work in partnership, two participants commented that partner organisations were not currently functioning and operating as a team. For example it was suggested that the organisations were still very separate, and recognised the difficulty of partnership working as it “requires organisations to give up some sovereignty” (P1).
Theme 3: Professional roles and responsibilities

Whilst contemplating their experiences of partnership working, participants identified some of the different roles which had been integrated into the Neighbourhood Team model.

Specialist clinical input

Participants identified different integrated roles within the Neighbourhood Teams. They commented on the valuable specialist clinical role of staff members including a community Geriatrician and two GPs with special interest (wSI) in frailty. Due to their capacity to provide complex community care, compared to other professions such as GPs, these roles were considered to be an essential part of the workforce. For example the data revealed that the ability to perform home assessments was particularly beneficial. In accordance with this view, the success of the Neighbourhood Teams was further considered to regard having the opportunity to administer comprehensive geriatric assessments as part of the GP (wSI) role of delivering patient care within the community, and being able to spend more time with patients. The specialist clinical roles were also interpreted as providing clinical leadership and structure to the MDT meetings. However, due to workforce changes, these roles were no longer operating within the model, subsequently leaving a gap in responsibilities and a loss of momentum. For example:

“But of course we haven’t got that now, we haven’t got anybody that’s qualified enough to change those sorts of medications that they’re on... Because I suppose GPs are just too overwhelmed to sit and do individual medication reviews, where as he used to go to the homes where they would be relaxed...I think his role was very crucial”. (P5)

The implications of the loss of specialist clinical input was also considered to include the deterioration of GP engagement, a decrease in referrals into the MDTs, and a loss of clinical leadership. This gap was highlighted in the data, as since the loss of these roles, the responsibility of triaging patients (i.e. deciding on the order of treatment) had been filled by the Case Liaison Officer (CLO) role. Due the importance of triage
and their lack of clinical training, this was considered by a CLO participant to make them feel “very uncomfortable, because this is people’s lives” (P5).

In addition to providing clinical community care, participants also viewed the specialist clinical roles as providing clinical leadership and structure to the MDT meetings. While there was variable understanding of who currently directed and led the discussions in the meetings, it was explained that either the GPs (wSI) or the community Geriatrian had previously chaired four out of the five meetings (when they were in post). A participant who had chaired the meetings as part of their GP (wSI) role, felt that part of their responsibility was to give direction and focus to the MDT meeting as, “somebody needs to take control and guide people” (P10). There was however variation in what participants felt the community Geriatrian role had provided. While some considered this to be the provision of focus and leadership, others felt that while the intention for the role was to provide leadership and drive clinical change, in practice this role supported GPs to manage frailty within the community.

Participants also cited the ‘Frailty Teams’ role within the Neighbourhood Team model as beneficial, especially due to their heavy reliance on the team to refer patients. The development and integration of the Frailty Team was also perceived to be advantageous for patient care as they worked with partner organisations to support patients (including care planning), particularly with primary care, social care and the third sector. The data revealed that general practice had recognised the patient need for a dedicated clinical input, and that this could be provided by an alternative role within the Frailty Team taking on some of the clinical responsibility:

“We used some funding to have a frailty nursing team...So that’s general practice recognising the patients that would benefit from the input from a dedicated nursing team working very closely with general practice, delivering quite a lot of their care and care planning and integrating with social care, PCN, voluntary sector, just bringing people together, so primary care doesn’t have to do it, but they are very much driving it.” (P2)
Non-clinical roles

The importance of non-clinical roles within the model was also considered. It was explained that the Case Liaison Officer (CLO) was a key role, due to their wealth of knowledge, role in the referral process, and administrative coordination (including organising the meetings and record keeping). However, the challenge of the inconsistency and variation in the requirements of this role was identified, in terms of how it was defined, the time allocation, and employment provider. For example:

“They’re very sporadic and some CCGs have got more than others and they’re employed by various different people. So, again, that’s been allowed to – I wouldn’t even say evolve – that’s been allowed to develop organically, for want of a better phrase and it’s not consistent... Some of them are part-time, some of them might only have one and a half days a week, depending on the size of the surgery.” (P9)

Several participants also explained that there was a reorganisation occurring in one of the partner organisations, resulting in the CLO role currently undergoing a review process. It was speculated that workforce changes would have an impact on the Neighbourhood Teams, due to the need for new staff members to have time to develop knowledge of the process and embed into the team dynamic.

The role of the Primary Care Navigator (PCN) employed by the third sector to support older people to navigate the integrated care system, was also noted by six participants to be overwhelmingly beneficial for delivering patient-centred care. Their ability to be able to provide social support to older people, integrate them into the community, and understand and access complex systems were noted as some of the benefits of this role. For example:

“The title of the role really sums up the key aspect of what it is that the primary care navigators do, and that is – the majority of the work they do is help people to understand this complex pathway or pathways...I think one of the key functions and the roles the PCNs have played in that is helping to unpick that minefield of lack of understanding and explain how there’s benefit and what the outcomes can be for them by accessing services” (P4)
One of the main benefits of the PCN role was explained to be supporting patients to manage their conditions, and appropriately use and access services. A further advantage of the non-clinical PCN role was obtaining a different perspective of patient needs than other partner organisations. For example, three participants identified the ability to be able support patients who may be experiencing anxiety to attend appointments, with their health subsequently declining. An example of where the PCN had played a preventative and proactive role in supporting patients who had the potential of becoming socially isolated was provided:

“I know a PCN was helping one gentleman who had dementia and he was quite anxious and slowly going downhill. The PCN introduced him to a dementia café, and got him back into society and he made friends. And you know when they get isolated they get lonely, they get depressed and they end up back at the doctors because they’re poorly.” (P5)

Participants also explained that this role has also helped to break down some of the barriers that other organisations might experience in accessing patients and having the capacity to spend time with patients and build relationships. For example:

“I think there’s a bit of a fear with some patients that if they admit that they’re getting a bit confused that they’ll put in a home. They don’t see the primary care navigators as somebody from an official organisation, they see them as a bit more of a friend or somebody who’s not official that they can be a bit more honest with. Where people have refused to have assessments or help, they can sometimes open the door for people and then they’ll let people come in.” (P6)

In addition, the extensive knowledge base of PCNs was also perceived as an advantage for patients and partner organisations. The role was perceived as being advantageous for continuity of patient care, especially for reassuring patients who may have forgotten key pieces of information. The data also revealed that since the role had been developed and integrated into the Neighbourhood Team, this had allowed the PCNs to take on responsibilities which had been previously filled by other roles (e.g. CLOs or GPs).
Shared understanding of roles

A lack of organisational and professional understanding about how certain roles could help support patients (promoting a shared responsibility), may however present a barrier to certain professions utilising particular services. On the other hand, the presence of this understanding within the Neighbourhood Teams would act as an enabler of integration. In order to enable partnership working, participants advocated the need for “a better understanding of each other’s roles” (P8), within the Neighbourhood Teams and wider health and social care landscape. This was perceived to include knowledge and awareness of the Neighbourhood Teams and other organisations, the value of what they have to offer patients, and what may or may not be appropriate for them to provide. However, the complexity and time-consuming nature of this task was also noted, including the implication of this including a lack of a partnership working ethos:

“What you need is that sharing of the established roles, the across party working or whatever you want to call it...everybody becomes quite precious about how long it takes to do everything, and I think that’s where that community feeling of togetherness between the professionals starts to break down, because we might be saying, “Well, no. That’s not our remit” so they think we’re being difficult.” (P8)

Participants also explained the lack of understanding of what particular organisations, such as adult social care and mental health, have the capacity to do in terms of patient care, resulting in inappropriate referrals. Training and education may therefore be needed, in order to facilitate an understanding of professional and organisational roles and responsibilities across the Neighbourhood Teams. However, the barrier of accessing other professions in order to share this information was also noted.

Some staff members were also unsure of what their role was within the MDT meeting, potentially due to the lack of leadership and structure within this setting. The data also identified a need for a CLO and a lead for every Neighbourhood Team to separately take on responsibilities of admin coordination, and clinical leadership and direction. Without this clear leadership role directing teams and providing
feedback, the Neighbourhood Teams were not considered to be sustainable as a service as “people will start to drift back to what they know” (P9). This highlights the importance of individual beliefs and action and organisational culture, in determining the sustainability of working across organisational boundaries in the form of Neighbourhoods Teams.

**Leadership and responsibility of managing change**

Participants also considered whose responsibility it was to drive the necessary changes for partnership working and integrated care, and questioned whether the appropriate people had been tasked with this role. Three participants advocated the importance of having the appropriate leaders in place who had belief in the concept, in order to commit to driving change and empowering individuals to also do so. Two of these participants also identified the key attributes needed for this leadership role and noted the importance of commitment to keep the workforce on track and to not revert back to habitual processes, despite experiencing the difficulties and challenges throughout the change process. For example:

“The success factors without a doubt are the people, so workforce bizarrely but definitely the people, the fact that we have an absolute belief that it’s the right thing to do, and the fact that there are some colleagues that are absolutely committed to it and they get it and they are up for driving forward the change, no matter how hard it is. So they absolutely hold the faith about it being the right thing to do.” (P1)

The recent change in leadership roles and subsequent change in a proactive approach to change was also discussed. This was viewed to contribute towards the recent drive and focus of the Neighbourhood Teams. However, the difficulty of having the capacity to identify these leadership roles within the system and current resources was also acknowledged. This was considered to have contributed towards the low rates in referrals into the Neighbourhood Team within its first phase. Due to the scale of the transformation necessary for partnership working, organisational commitment and buy-in to the Neighbourhood Team concept was also deemed to be essential. For example:
“...it is the division and the buy-in and the people committing and truly committing to doing it because this is huge to do and people cannot do it half hearted, and then it is the right leaders and then it’s take away the unhelpful things that do not enable that team to be effective with those groups of patients and then put in the things that they then need to make them more effective so it is just total shift in the way we do things.” (P7)

It was acknowledged that one of the main issues associated with integrated care was enabling systems to deliver integrated teams. A substantial challenge which is associated with this issue was identified to be the difficulty of managing people within the change process, and facilitating the understanding of the need for change, new roles, and ways of working. The issue of the associated anxiety with the process was also noted, alongside the need to reassure staff. For example:

“I think people just need to be a bit brave and understand that the level of demand is going to keep growing, actually. There’s always going to be enough cake to go around. In fact, if anything, we have too much cake... It just means you might be doing something different, and I think people get very anxious about that because ‘this is my comfort space, this is what I know, and this is what my job description says...It’s very difficult, I suppose, when you’re in a role, to be looking down a telescope that looks like it’s getting rid of your role in the future.” (P9)

Several participants promoted the need for shared responsibilities amongst partner organisations, in the form of long-term care planning and developing the Neighbourhood Team concept into a business as usual way of working. The notion of staff members’ roles within the Neighbourhood Team not being part of their daily work was discussed by three participants, who commented that team members had been doing their “normal day to day work” (P6), “own roles” and “regular jobs” (P10) in addition to working with Neighbourhood Teams. This further highlights the issue of organisational commitment to the Neighbourhood Teams initiative. The responsibility of this mind set and operational default way of working was suggested by another participant to be the responsibility of each individual organisation, with the function of the meeting to be a logistical way of initially bringing people together. Due to previous ways of working and separate accountability, organisations and
sectors were suggested to struggle with taking joint action and shared responsibility, despite an intrinsic joint aim of providing optimal patient-centred care. For example:

“I think where we struggle is taking joint action. So, I think the communication is there; I think the difficulty, in pragmatic terms, is we’re facilitating a complex discharge for somebody and the first question is, “Is this health or social care? Who’s funding this? Is it continuing health care? Where does the responsibility sit? Is it the Acute Trust that need to sort out the equipment? Is it the Community?...For me there’s an intrinsic link with the Acute Trust, and it’s quite difficult to get the Acute Trust on board with things that they perceive to be the Community’s responsibility, but there is an absolute inter-dependency between avoiding admissions and keeping people in the community and facilitating discharges.” (P9)

Theme 4: Contextual factors and challenges of integration

A theme which was particularly salient across all interviews was participants’ reflections and interpretation of the contextual factors which affected the development and implementation of integrated care and partnership working. Participants highlighted several challenges and barriers to integrated working based on the context of the Neighbourhood Teams initiative.

Systematic and organisational challenges

One of the biggest barriers to integrated care and partnership working raised by all participants was the system in which the integrated health and social care concept was situated. This relates to the complex nature of systems highlighted within the literature review (see section 2.5; page 55). Participants’ perceptions highlighted an agreement that the system issues had not yet been grasped a way which enabled progression with the integration agenda. These systemic issues and barriers were noted to be transferable, and likely to represent some form of challenge to all initiatives aiming to integrate care. Several participants commented on the role of the system, with one in particular noting that it was “not set up to facilitate integrated working” (P1), and allow different organisations to successfully work in partnership. All participants also explained that as core teams and organisations are on different
systems, this further creates barriers of sharing information and information governance.

Systemic barriers were also apparent throughout participants’ discussions of the lack of communication and collaboration with acute hospital services (e.g. with regard to admissions and discharges). The implications of the longstanding issue of organisations using various systems was also considered to be the reliance on individuals to provide patient information within MDT meetings. This however created issues when these individuals were unable to attend the meetings. The importance of having the appropriate systems and correct environment to support and facilitate integrated working was therefore emphasised. For example:

“The system has to be right. It’s like, if you’re trying to grow something like a very tender tropical type plant in a frost pocket, it won’t happen. If you put it in a conservatory with the right amount of moisture and all of that sort of stuff and it’s got the right temperature and the right growing medium and all that, it will flourish, and this is no different. What we’re trying to do is to grow something actually that’s currently only tender shoots, and we’ve put it in the most hostile, barren environment and then we’re wondering why it doesn’t work.” (P1)

The lack of infrastructure and sufficient workforce was considered to create significant challenges for the necessary system transformation. However, due to the efforts of the Neighbourhood Teams and the STP, these were considered to not be long-term issues. It was also reflected that even if those working within the integrated care model managed to grasp the concept and its associated benefits, the ‘wicked’ system did not allow them to deliver care in the way that the concept of integrated care would promote and encourage. This battle against the system was in turn suggested to potentially discourage originally motivated and engaged staff; particularly those delivering care. For example:

“There’s things built into the system that are stopping people behaving in the way that they’d want to, and it’s trying to unpick what all those things are I think to free people up. Because people normally want to do the right thing. They’re working in the care profession and they’re probably as frustrated as everybody else at not being
able to join up. Because people on the ground notice it even more than people who are not on the ground... If that’s too tough then people give up” (P6)

The impact of tensions of health policy reform and organisational change, including individual organisational accountability and the drive for integration in order to promote continuous and seamless care were also discussed. The data highlighted the current national importance placed on system leadership, but also indicated that irrespective of this, the system did not promote and enable trust between organisations to work together, due to separate ways of working and accountability. For example:

“I don’t think it is there yet. I think that when you talk about system leadership in [name of county], because that system leadership is very much the kind of the thing at the minute with the NHS and I’m sure in the public sector providers and commissioners, but it still feels like people are doing their own bit and that is how it is currently set up, it is currently set up for us all to do our own bit and to have our own boards and to direct the work that we do ourselves and be held to account around the contracts that are currently in place.” (P7)

Resources and workloads
Linked to these contextual issues of systemic and organisational barriers, participants’ also commented on the tensions and frustrations of the lack of resources to support the change necessary for progression. The need to consider the issue of resources in a broad sense was also identified, including the workforce, budgets, time, leadership capacity, and the cost of the state. The additional resources required to support the transition of care form the acute sector into the community was also acknowledged. In addition, the lack of an investment programme for large scale transformation within a context of resource deficiencies was also considered:

“I think another of the issues has been, you know that we have not seen an investment programme to drive delivery of what is you know huge transformation...So do it all within everybody’s existing resource while you are getting busier and patients have a growing set of needs and primary care is getting busier.” (P7)
The ability to provide proactive care under the current health economic climate was further considered by participants. The implications of these challenges and barriers were perceived as impacting on the feasibility of focusing on proactive patient care, increasing the likelihood that patients may get missed or lost in the process, or receive sub-optimal care. While participants felt that resources to support change and provide proactive care were lacking within the context of the Neighbourhood Teams, due to the complexity of integration, sufficient resources can also therefore act as a facilitator and enabler to integration. The data also revealed the commitment of individuals and organisations to improve outcomes for patients, but considered the issue of implementing system transformation in the context of decreasing resources (without impacting upon patient care). For example:

“As individuals, and as organisations, we’re absolutely committed to making sure that happens and getting better outcomes for people, but you’ve still got that tension of – this is against a backdrop of ever-reducing resources...because in any transformation, you have to run two systems for a while. Because there’s no additional funding for that double running. It’s how are you going to switch from business as usual today, to business as usual tomorrow without losing people in the transfer?” (P9)

Another participant also explained that as this new way of integrated working was such a large scale system change in care provision, there needed to be sufficient resources to support the change and provide care to the level that patients required. Participants also further contemplated the implications of a lack of available resources in the form of increased waiting times for patient care and services. Two participants explained their frustrations of insufficient staff members for the level of demand needed. These participants also explained that community services were understaffed (including Physiotherapy, Occupational Therapy, and mental health), resulting in long waiting lists for these services. One of these participants further explained their frustrations of navigating the system to provide proactive and patient centered care under current resource deficiencies. For example:

“I have personally spent 40 minutes on the phone trying to sort somebody out who’s had a fall. We have visited; we are quite happy that medically they’re okay, but
they’re not coping and, if I don’t do something now and they have a fall again, they will end up in hospital…So, Neighbourhood Team, although it’s great, there aren’t enough resources to put services in place very quickly. There is a waiting time for everything. I think that’s where it really struggles.” (P10)

Participants considered the impact of the barrier of increased workloads, with workforce issues and staff changes considered to contribute towards the recent lack of progress of the Neighbourhood Teams. It was explained that internal staff changes had resulted in a lack of consistent project management capacity, subsequently impacting on development and implementation progress. In addition, the perceived lack of time to take a step back and contemplate and reflect on the changes in ways of working was acknowledged to potentially be interpreted to create more work for individuals. For example:

“It’s difficult for people on the ground with huge workloads, with busy schedules, trying to do what they have to do, never mind things that would be nice to do. I recognise that that’s an incredibly difficult thing, but sometimes you create more work for yourself by not stepping back and just thinking a little bit differently. How can this happen differently? What can I do differently which will get a better outcome for this individual that won’t mean I’m back here again next Wednesday doing the same thing?” (P3)

The particularly large workloads of the mental health organisation and the high expectations of the Community Psychiatric Nurse (CPN) job role, were considered to affect the logistics of attending all the required meetings (including attending Neighbourhood Team MDT meetings). In addition, the perception that engagement with the Neighbourhood Teams would result in increased referrals for an already stretched profession, was considered to also be a barrier to MDT attendance. The difficulties associated with the feasibility of organisations working together in partnership in order to integrate care for the patients was summarised, including information governance, separate referral processes and workloads:

“There’s things like information governance and sharing and everybody’s own referral processes and how many cases people are carrying and how busy they are,
and all that stuff makes it quite difficult sometimes for people to just work together easily... I’ve been in meetings where people have discussed a case and then at the end of it they’ll say, “Right, yeah, I’ll take that case, but you’ll have to ring the contact centre to do a referral so I can have it.” And you’re just like, that’s not very joined up. You’ve just had the discussion, why can’t somebody just say, “Yes, I’ll take that case” (P6)

Professional challenges

In addition to the systemic barriers, participants also considered the professional barriers to change, “particularly from a cultural perspective” (P1). They associated the issue of necessary changes in ways of working and professional barriers, with the need for a significant culture change around how organisations perceive themselves and function within their designated teams. For example, the data revealed that there was a need for shared patient responsibility, rather than continuing to operate in silos with a focus on performance indicators and separate accountability (i.e. rather than patient needs). In terms of a need for culture change, it was considered that this was needed at the middle management level the most (i.e. chief executives and senior managers), rather than the ‘ground force’ level. For example, it was explained that in order for the staff at the care delivery level to be able to work together in partnership, “they need people at the middle chunk of the organisation to unblock some of the barriers” (P6). However, it was acknowledged that these middle managers have various roles to juggle, including supporting staff members at lower levels, alongside dealing with issues of resources and staffing.

In addition to systemic tensions, anxieties and fears associated with organisational change and restructures were also raised. For example, one participant commented that “as human beings generally we don’t like change, we’re risk adverse” (P1), with another considering that restructuring “can destabilise things, because people feel unnerved by change” (P3). Participants also contemplated the contextual county specific barriers and challenges to integration, including recruiting the appropriate workforce and having professional engagement. For example the lack of availability of staff to be assigned to developing Neighbourhood Teams, alongside also running other services was noted:
There’s so many challenges in [name of county], particularly recruitment, attracting the workforce here...I think it probably is the biggest challenge because [name of community services] have probably got limited Community Nursing that can then be separated out into Neighbourhood Teams whilst running business as usual and the development...We’re not too bad in terms of adult care; we struggle with therapy and we struggle with really experienced social workers.” (P9)

Two participants also considered the particular issue of the difficulty of recruiting GPs to work within the county, and the implications of this on primary care engagement with the Neighbourhood Team concept. Due to their clinical responsibility and oversight within the community, primary care buy-in was considered to be essential for the development and implementation of Neighbourhood Teams. The geographical constraints of the county and the poor reputation of the acute trust, were also considered to impact upon staff recruitment, due to the competition of other counties and the logistics of accessing patients. The impact of the county-specific system challenges on the political buy-in of particular organisations was also considered. For example:

“I am from a very politically-led organisation, and I don’t think that we’ve got the political buy-in that we need at this point. I think it’s achievable, but I think that there is a big system challenge in [name of county] and, understandably, local politicians and councillors and MPs, are reluctant to jump in with the disaster which seems to be [name of hospital trust] and the pitfalls in terms of the big black hole of NHS money and closing hospitals. That’s not what wins votes at the end of the day.” (P9)

Theme 5: Expectations and the reality of integration

Another strong feature of strategic perspectives of the Neighbourhood Teams was the discrepancies between the expectations of integration, and the reality of real world large-scale transformation in practice. Due to the complex nature and challenges of integration, one participant commented that they no longer knew what the expectation of integration actually was. In terms of the practicalities of implementation, all participants were in agreement that while the concept was
appropriate, with the potential for it to be mutually beneficial for both staff and patients, the reality of achieving integrated care was much more complex. Several participants considered the gap between the theory and principles of integrated care, and the reality, practicalities, and challenges of its implementation. For example:

“In principle, if you asked anybody, would it be a good idea for us all to work together and just have one joined up view of the customer and coordinate their care and health needs, nobody would say no...So the principle I think people get. When it gets down to the practicality it can be quite hard...The principle of it I don’t think anybody can say it’s not the right thing to do, I think it’s logistics of trying to operate in that way, day to day.” (P6)

Participants also discussed patients’ expectations of the care that they received, including the assumption that this was coordinated across their care needs, and that information was shared across organisations and sectors. It was explained that this included the assumption that information is communicated and shared between primary and secondary care. Another participant also considered the national need to manage patient expectations and assumptions as to what health and social care services can provide and what they were entitled to. For example they explained the patient assumption that:

“.I have paid my taxes so the NHS is there and whatever I need, I’ll get and we are a very consumer driven society now so it is about, I want this and I want it now. And you see that in people’s behaviours and you see that in people’s expectations, so there’s a massive piece to do around education and that’s national, not just [name of county]. It is national issue around our national culture and how we perceive the NHS and social care.” (P7)

Enabling partnership working to deliver integrated care

Although the focus of the Neighbourhood Team model was intended to be a neighbourhood approach encompassing a variety of partner organisations working together to provide care for patients with multiple needs; in reality this was considered to be a complex aim to achieve. It was noted that while the integrated care and partnership working evidence base suggested that implementing change is
a complex process, achieving this in the real world was harder than originally envisaged. The features of complex adaptive systems discussed in the literature review (section 2.5; page 55) are therefore considered to be apparent within the Neighbourhood Teams concept. In addition, the feasibility and complexity of enabling the Neighbourhood Team model to operate at a larger scale was considered, in order to manage and support a “defined cohort of people” (P1), rather than a few patients in a particular Neighbourhood Team area. In a similar vein, the goal of a population based approach to partnership working was reflected as not having been delivered as expected. This was explained to be due to variable sizes in populations in GP practices and attempts to implement the Neighbourhood Team concept without the appropriate infrastructure in place. The need for both a MDT and a wider Neighbourhood network was also reiterated. For example, it was commented:

“So, I think what they’ve done is, they’ve tried to implement a Neighbourhood Team without the infrastructure in place, and what they’ve ended up with is an MDT that serves the needs of 500 people countywide maybe. Whereas what we need is an MDT that services a much greater number of people. You’ve got your Neighbourhood Team infrastructure starting to be built here and the two eventually align so that you’ve got an MDT operating within a Neighbourhood Team.”(P9)

There was also the expectation that the higher level strategy group would create a strategic plan for implementing integrated care and delivering change, and that this information would flow down to the staff on the ground working within the new model. However, one participant commented that their staff did not necessarily perceive this strategy as something that they needed to understand or engage with, and that their main priority and focus was to carry out their daily duties. The difficulty was considered to lie with enabling these staff to understand the impact and how this will affect their professional roles and the reality of working in health and social care in the UK in years to come. On reflection, this participant considered that staff delivering care needed to see the relevance of Neighbourhood Teams in the overall transformation of services and systems. However, another participant commented that while there was a certain expectation of integration through the development
of Neighbourhood Teams, there had been no guidelines as to how this could be achieved, representing one of the drawbacks of the concept.

The reality of organisations continuing to work separately was further emphasised by partner organisations failing to operate jointly outside of the MDT meeting. For example even in the Neighbourhood Team with the most appropriate function, there was a lack of consistency outside of this meeting. In addition, while the format of this MDT meeting was more organisationally centred without shared ownership for patient care, there was a sense of patient-centred care being delivered outside of the formality of the meeting.

In reference to the perceived difficulty of staff accessing services and delivering integrated care, it was explained that while there was the expectation for the service to provide integrated care once it was identified as a patient need, in reality, the current system provided a ‘no response’ to referrals. In addition, the difficulty in accessing patients was also noted, with particular reference to older patients. While in theory there is a finite number of patients, it was considered that in practice the model was not successfully identifying and accessing them. In addition it was noted that while patients were often known to the system, they were not always being effectively managed. The need to focus on community based neighbourhood care which wraps around the person was therefore emphasised (rather than a focus on the MDT).

In the initial implementation of the Neighbourhood Team model, it was explained that the target population was initially those patients who required a multi-agency approach. However, it was also explained that as the infrastructure was not in place, there was not necessarily a place for these patients under this new approach, resulting in organisations still operating and working quite separately outside of the MDT. For example:

“But again, because the infrastructure around the system isn’t there, there’s almost nowhere for them to go...Well, actually, what happens at the MDT is, you’ll have a situation where everyone will discuss their own social care and say, “Oh, we could probably do x, y and z, so we’ll go out and see her.” Then, the CPN might say, “Oh,
yeah, I know her. I’ll nip out and do my bit,” and that’s okay, but I’m not sure that’s integration. They go away and do their work and then, two weeks, a week later, we all come back and we all have an update on Mrs Miggins and then we all go away.” (P9)

**Primary care and GP engagement**

In terms of the expectation that primary care was integrated into the Neighbourhood Team model, the reality of the current lack of GP engagement meant that this was not necessarily the case. Theoretically primary care should be in the middle of the model, however this was yet to come into fruition. Participants noted that GPs had their own interpretation of what collaboration meant in practice. For example, it was explained that:

“They’ve got their own views of what their local footprint is, what sort of collaboration they want, whether they want to work in an integrated way with other providers or whether they just want to provide services themselves. So I do think there is still a lot of different views out there and there is not a joined up shared view and a single commitment to the modelling outcome.” (P7)

While there was an expectation for GPs to engage with the process, several participants commented on the reality of the barriers associated with a commitment to the model. While there is a national drive to deliver care within the community rather than acute settings, the challenge of delivering the increased demand for care within this setting, and the pressure this subsequently placed on GPs to provide the clinician oversight was acknowledged. Participants also considered that the business mentality of primary care was also perceived to be a potential barrier to GP engagement, further contributing towards the difficulties of integration. This highlights aspects of critical realism and complexity, where the presence of individual beliefs and subjective understanding of the phenomena, are seen to operate within open systems, affecting the outcomes of the initiative.

**Proactive care**

Although participants acknowledged a need and expectation of a preventative and proactive approach toward patient care, the reality of the difficulty of the prevention
agenda in practice was also noted. Proactive care is considered to be a means to proactively identify and support people with complex health and social care needs, in order to live independently at home for as long as possible and avoided unplanned admissions to hospital. Participants considered whether it was feasible to achieve the aims of the Neighbourhood Team model and deliver proactive and preventive care, amongst the ever present barriers and challenges. For example it was suggested that “top-end complex patients” (P9), which will continue to present the highest risk and challenges for the whole system, should not be the focus on the Neighbourhood Teams. Instead, a proactive and preventative approach to patients with less complex needs was advocated (i.e. those needs which require an MDT approach, but do not represent the highest risk of the population who are often in a cycle of reactive urgent care with a focus on clinical needs).

However, a focus on prevention within a stretched system was noted to be a significant challenge. In addition, it was explained that in theory the ability to be able to be proactive so that patients can remain at home with low-level needs would bring various benefits, rather than patients escalating so that they need expensive unplanned and acute care. However, in practice the Neighbourhood Teams were still currently spending a lot of time dealing with acute patient situations, which could have been avoidable if the shift in resources had enabled them to focus on the proactive care. The data further explained that as time had to be allowed for the benefit of proactive care to filter through the system, there would be a time period where resources for both preventative and reactive acute care would need to be provided (i.e. double running costs). In addition, the reality of shifting from reactive to preventative care, and the difficulty of breaking the cycle of focusing on those with more complex needs was contemplated:

“You can’t set up the Neighbourhood Teams and from day one expect them to be proactively managing people...there is a cohort of patients that are already sort of lost to us, even starting practice management with them today, you will not get on top of their health needs and their requirements so they are still going to be in that cycle of reactive urgent and acute care. It’s hard to break that cycle with people.”
Participants also commented on the difficulty of navigating the system, with a reactive and transactional approach being taken, rather than one which was proactive and preventative. In reality it was considered that the acute sector was often not the most appropriate place for patients, and not the best use of resources. This was particularly considered to be older patients whose quality of life could deteriorate rapidly. However, the difficulty of transitioning patient care from the acute sector into the community within the resources available was reiterated. It was also explained that quite often the first time patients became known to the system was when they were admitted to hospital. However, one of the potential benefits of the Neighbourhood Team model was being able to provide the right support for people at the right time, through working in partnership across organisations and sectors. This would mean that people could be provided with care and support within the community sooner, “in a more preventative way, so they wouldn’t have to go into hospital” (P6); therefore reducing the demand on acute services.

The need for change

The potential fear associated with change was also noted, with the expectation that this new way of working would increase the workloads of staff, despite it having the potential to utilise professional skills in an optimum manner. Participants also acknowledged that as integration promoted the need for a substantial shift in ways of working, a change in culture and mind-set was also needed. For example, it was suggested that in reality “people sit back and wait for a referral to come in and then decide if they want to take it” (P7). As the Neighbourhood Team concept is a big change and a completely different way of working, it was considered that this was where need for effective leadership is heightened, through empowering and enabling staff to work in this way. For example:
“We’ve worked in the silos for so many years and everybody’s worked in their own little world for so many years. Myself included, and that is – it is a culture change and you don’t change culture overnight. You don’t change it in a year... it’s ongoing and it takes a long time and you need new blood coming in and you know, and all the rest of it. It’s not a case of these are the neighbourhood meetings, this is how we’re going to work, you’re all going to attend and it’s going to be marvellous. Because you know, it isn’t.” (P8)

It was also suggested that although there was an expectation to evolve and work together, in reality there was a need for everybody to be consistently signed up to a programme of change and committed to the process in order to facilitate successful change in practice. It was also acknowledged that although staff recognised the need for change and that there was an expectation of its necessity, the reality of its implementation was problematic due to the challenges of integrating care. For example:

“They absolutely get that we can’t continue to work as we work, because it’s too stressful for them and there aren’t enough hours in their day, it’s chaotic, and most of all they know that patients aren’t getting the best outcomes that they can get, so everybody recognises that this has got to change but actually making the change is really quite tricky.” (P1)

Timescale
Participants also recognised the need to manage the expectation that as integration is such a significant change, it is therefore a slow and challenging process which needs nurturing. A lack of understanding of the associated challenges was suggested by participants to result in a too high of an expectation placed on what the model could achieve in the timescale set, with the initiative attempting to achieve too much too soon. While individuals were sold a vision with an associated expectation of a fast implementation process, in reality it was considered that within the current system, they were far from a fully operating Neighbourhood Team model. In addition, the importance of clarity and guidance was reiterated within this process. For example:
“So I think possibly was too much too soon maybe? Should there have been more clarity around a formula? Should there have been a single formula? Does one size fit all? There’s all these kinds of questions. Whereas I think perhaps there was a large expectation put on things without really any clear guidance as to what that might look like, how it might be achieved, what the outcomes of that might be.” (P3)

In light of these challenges, participants reflected that one of the lessons learnt had been the identification of the need to start small to then build the model up and progress with development and implementation. It was also considered that the initial implementation of the Neighbourhood Teams model was too overwhelming for the workforce (with unachievable goals), that they did not know where to begin with the change process. For example:

“How do you go from four different organisations to one organisation providing everything in what, essentially, was a blink of an eye? I think it was too big a change, which is why we then came up with Evolution not Revolution. It was actually about, let’s start quite small and grow it... Start with one person. If you just start with one person, then two people, then four people, then eight, it will grow.” (P9)

**Progress**

In terms of the expectation of progress of the initiative and the reality of the issues associated with its implementation, all participants considered that they expected more progression to have been made than was currently apparent. However, it was acknowledged that while there was the expectation that integration would have happened a long time ago, in reality integration takes time. With regards to the referral process, all participants also expressed an expectation of increased numbers than were currently being achieved. Reasons for the smaller than anticipated referral numbers were considered to include the lack of clarity for the focus of Neighbourhood Teams (i.e. the type of patients), a lack of consistency in approach, and lack of action plans once a referral had been made into the service.

The reality of the current model was perceived to be extremely complicated and confusing and remained fragmented rather than integrated. However, while the Neighbourhood Team model had not necessarily evolved in the manner in which it
had been intended, participants identified that the initiative was not yet far enough down the lengthy implementation process to see an impact and change in ways of working. While in theory the Neighbourhood Team should integrate care, in reality through its implementation and evolutionary process, it was apparent that the barriers had caused significant challenges for progression. For example:

“I think it’s a wider issue. I think it’s, in theory and in practice. The Neighbourhood Teams as they evolve should make things far better because you’re getting different disciplines face to face, talking to each other. But I think it’s an evolving process and I think there’s barriers keep getting in the way and people become very stressed and very overworked...and that’s when you start to almost become protective of your own area, and we’ve got to somehow break that down.” (P8)

Theme 6: Future goals for care delivery

Future goals for the Neighbourhood Teams initiative included several shifts and adaptations in delivering care. Several participants discussed that in order for the model to be successful, there was a need for partnership working to be represented in a business as usual manner, rather than solely operating as a team when joined together within the format of the MDT meeting. The importance of consistent organisational commitment and buy-in to the neighbourhood model and approach was reiterated in order to promote shared ownership despite bureaucratic barriers, and facilitate enabling the teams to work together “properly Monday to Friday in that way we’d envisaged and that they see the benefit of” (P1). This participant also noted the need for testing the theory properly, rather than trying to do this as part of the county agenda and STP process. When encouraged to divulge on what was being referred to in terms of theory, it was explained they were acknowledging ‘the theory that we believe that by working in more integrated manner that we will get better experiences” (P1). Another participant advocated the need for working in partnership to be normalised across organisations; however, also noted that there was still considerable work to be done in order to enable individuals to continuously operate as a team, rather than solely within the MDT meetings.
These shifts also included a change in mind-set regarding the referral process, for both staff and patients. It was felt that, rather than there being a referral process, organisations should be able to utilise a model in order to identify patients in need of health and social care, alongside the most appropriate professions to provide such services. For example:

“In fact there should not be a referral process, there should be a model of identifying who the patients around the population that need care, and be that health or social care, and then who is the best person to lead on ensuring that that person gets the right care?... So for me it should be just, we should be getting down some simple questions of, there's a population of X number of people registered with practice, in the next month who needs some sort of proactive intervention and then what is that need? And who is going to make sure that they get it? And it should simply be that.” (P7)

Participants also supported the need for education, guidance and training for staff, patients and politicians, in order to sell the vision and facilitate understanding of the concept and organisational change. It was considered that the Neighbourhood Teams concept would be an “easy sell” (P9) to politicians, once they could see the benefit to the population with first-hand experience. However, the barrier of the concept not currently being tangible and being translated into action and outcomes was also identified. Nonetheless, education and training in terms of “culture and relationships of working between different professional groups” (P7) was perceived to be particularly valuable. Due to the lack of structured feedback, participants also acknowledged the benefit of engagement events and sharing individual stories in order to learn from examples of success and consider where outcomes could be improved. They commented on the particularly powerful nature of individual case studies in order to assess successes and consider what could have been improved.

**Population based community approach**

Through frequent mention of participants’ future goals, the need for an “all encompassing” (P2) and “holistic” (P7) approach to delivering care was noted, which included all age groups and types of services (including the third sector). This was
interpreted to require a promotion and understanding of a population and community based approach. The need to develop structure around the Neighbourhood Teams and to build on integration particularly between primary care and community services was also advocated. Participants also commented on what they felt the ultimate aim for the Neighbourhood Teams was, including partnership working and a community approach. For example:

“I think probably within the phase two is this all-encompassing everybody working together, joining up with the voluntary sector, and even things that are in peoples’ local community they probably wouldn’t even think about… and that whole holistic approach to the customer, and true joined up support, all those organisations, that wraps around and supports that person.” (P6)

The advantage of having a single assessment process for patients was considered, with a suggestion that this would be best placed through the GP practices and the community, rather than through acute care as a default through A&E departments. While the aspiration for a single assessment process was highlighted, the barriers of this being developed, with the concept currently far from being implemented were also acknowledged. However, a further participant advocated the need to develop community capacity through having a single frailty pathway and shifting patient care from the hospital into the community and delivering specialist care. They reflected that:

“I think with some of the work that we need to do around how we get a single frailty pathway for example, that goes from community to hospital and from hospital out, I think there’s an increasing recognition that actually what we need to be doing is looking at moving the specialist capacity that sits in [name of local hospital], and actually moving that out into the community. So that your care of the elderly service is a community based service and not an acute based service.” (P1)

**A proactive approach and continuity of care**

Although the MDT meetings were perceived as having developed to unintentionally represent the whole Neighbourhood Team concept (due to the benefits associated with these team meetings), several participants promoted the mutually beneficial strategy of driving the preventive agenda forward via their increased frequency
(including every morning). Following the concept of prevention, six participants also noted the mutually beneficial outcomes including concepts of self-care and self-management. While prevention was considered to contribute towards reducing demands on other areas such as the acute sector, in order to successfully integrate acute and community services and avoid the continued barrier of silos, there was the need for support from the system. For example:

“That’s the bit where, for me, the Neighbourhood Teams can make a really good impact, but we need the support of the system and we do need to get the Acute Trust on board and figure out how the Urgent Care Pathway is interlinked with the Community Pathways. If we don’t do that, we’re just creating two different silos as opposed to ten, but they’re still silos. They’re still not talking to each other.” (P9)

The concept of having two parallel layers of the system in the form of a prevention and an acute crisis element was also advocated, with the consideration that the MDT level should represent the prevention agenda, and be occurring “regardless of a Neighbourhood Team” (P9). The collaboration and sharing of information between the acute sector and the Neighbourhood Teams, was also considered to be mutually beneficial for both staff and patient experience, through building a rich picture of the patients’ care history. In addition to the benefits of this cohesive network scenario improving staff and patient experience, it was noted that this would also bring further advantages to the system, as “people would be supported to manage their conditions in a more cost efficient way, in a more preventative low level way” (P3).

With further regard to continuity of patient care, participants explained the benefit of attaching additional PCNs to the Neighbourhood Teams, particularly noting the benefit of the potential development of rolling out the position into an acute setting. It was suggested that this had the potential to truly represent the Neighbourhood Team ethos, by enabling a detailed understanding of patient care for all staff involved, contributing to the likelihood of continuity of care. Another participant commented on the integration of Neighbourhood Teams into the acute hospital setting and discussed the inclusion of the rapid response team within this model (i.e. health care providers which respond to hospitalised patients with early signs of
clinical deterioration). These factors of prevention and the reduced need for acute care were also brought together by a further participant who discussed the desired outcomes of the model. For example:

“I think ultimately if we can get those NTs to manage their own population, reducing the need for acute care significantly, so bend the curve is the ask, increase self-care and awareness, so build resilient communities, the resilience piece is really important, alongside reducing health inequalities and reduction in mortality.” (P2)

While participants acknowledged a need for a preventative and a proactive approach towards patient care, they also noted its difficulty. They considered the feasibility and challenges of achieving the aims of the Neighbourhood Team strategy to deliver preventive care, rather than taking a reactive and transactional approach, amongst the ever-present challenges.

**Strategy for progression**

With regard to progression and moving forward with the integrated concept, participants acknowledged an urgency for action to deliver the changes and gain commitment. The data revealed that as the county was in “dire straits” there was an urgent need to “do things differently” (P8). In addition, it was reflected that there was a need for radical changes in the way services were managed, despite the associated national challenges (including system pressures):

“I think we’re at the point of – we’ve just got to do something different because we can’t continue the way we are... I think, if we’re going to do it, we’re going to have to be radical; we can’t have a new service managed in the old way...I think that’s what’s happened nationally. I think that’s been the difficulty. I think that’s been difficult everywhere... I think that the system pressures are increasing year on year, so whereas it’s been running for a couple of years, as I understand it, at least, the system pressures have increased. ” (P9)

The need for a change in accountability and shared responsibility was also acknowledged in order to address further national issues. Due to a lack of progression and an urgent need for action and alternative working processes, two participants acknowledged the need for honest and open conversations regarding how the
integrated care agenda was realistically going to be implemented. This was considered amongst the myriad of challenges and issues within the current health and social care context. For example:

“At the moment the biggest challenge we have is about how do we get people really integrated and actually do we need an honest conversation about actually are we ever going to get there or are we chasing something that nobody believes in and isn’t actually going to support to happen, or do we need to think of a different way of doing it?” (P1)

As part of the phase two of the Neighbourhood Teams initiative, six participants considered the goal and benefit of co-location for some individuals and organisations, in order to improve wider community support. The benefits included opportunistic communication, sharing information, and collaborating. While co-location was acknowledged as advantageous for the Neighbourhood Teams, it was also noted that this should not be the main aspiration, with partnership working to achieve the same goals deemed essential. The future goals associated with phase two also included GP engagement, the transfer of learning, and facilitating the understanding of some of the challenges experienced. Aspirations for the future also included the dual responsibility of the entire Neighbourhood Team workforce to elicit a better understanding of the concept and the model, and enable a shared ownership and commitment despite bureaucratic barriers. For example:

“To get a better understanding and to feel more part of it and for the team to start to feel more a part of it. But then there is some responsibility on their part to try and understand it instead of living in this little bubble – “oh, nothing is going to change and I’ve been a CPN for ten years and this is how it’s always been”. It is a joint venture and it’s all right us saying, “We feel like we’re on the side lines.” But we’ll always feel on the side lines unless we dip our toe in the water again and start being brave and putting ourselves forward. So it’s a joint responsibility really.”(P8)

In terms of a strategy for progression, participants suggested the need for a refocus back on the Neighbourhood Teams concept, infrastructure and system changes, and organisational commitment (including primary care engagement). They also
described their aspirations for the future in reference to having a clear vision and understanding of the barriers and facilitators of integration alongside effective leadership, which were highlighted as being critical for regaining momentum for concept going forward. For example:

“If you get the leadership right, get the governance and you know the sense of purpose and then the kind of contractual stuff to underpin that purpose, you then you know, enable and empower the staff to act differently and then you also put in some investment around any gaps, any transitional needs, any ways of sort of working differently. If you put a bit of investment in that, it makes a difference. You know and then, beyond that I guess it’s then, I suppose it is coming back to the leadership stuff isn’t it? It is about setting a vision and the vision being clear.” (P7)

A period of stability in workforce and leadership was also considered to be an aspiration for the future of the Neighbourhood Teams concept, despite its associated challenges. This would allow a level of consistency and for culture changes to be embedded in practice. The perception that front-line staff were willing to make the change and work together was also provided. The presence of effective leadership was also perceived by several participants to facilitate organisational commitment, culture change, and the empowerment of staff to make changes and have the authority to change and work together within the Neighbourhood Teams. However, it was also acknowledged that there was a need for an agreement on the clinical and organisational governance to enable that to happen. For example:

“I think not only a culture change but the authority to make that change, the empowerment to say, it’s okay to change this, it’s okay to do this a bit differently, it’s okay to take a little bit of a calculated risk. It’s okay that you’re an occupational therapist but you’re going to get a primary care navigator who’s not trained to come out and deal with this because you recognise this is a better outcome for this individual. It’s okay to make that decision, and also okay to sometimes get it wrong.” (P3)

It was further explained what organisational agreements and commitments were lacking, with a suggestion of what system changes needed to be made in the future.
There was also the suggestion that organisational and professional perceptions of partnership may also be a barrier to implementation of successful integrated working. For example it was explained that:

“So if I’m a CPN for example, what we’ve never agreed is as a mental health trust we haven’t got them signed up to go, actually for that Neighbourhood Team, they need a CPN to be allocated to them, that’s their day job....So there’s some big system things that need to change around the way organisations perceive themselves and the way they don’t currently work together on any level, no matter what they tell you.” (P1)

The Multi-specialty Community Providers (MCP) framework and the dissemination and implementation of the county strategy for primary and secondary care development, were also advocated as particular tools for progression within the wider context of implementing organisational change and integrated working. The MCP framework was also considered to facilitate the implementation of capitated budgets (i.e. a budget calculated per person) for the Neighbourhood Teams within the next few years. Despite the difficulties and challenges of integration, two participants commented on their optimism and belief in the concept, but acknowledged that the workforce and the individuals working within the model were the key to its success.
Chapter 6: Results - Application of integrated care (study 2)

6.1 Research questions and mixing of the data

As part of the impact focus of the theoretical framework (page 21), this chapter details the results from the Partnership Assessment Tool (PAT). This was distributed to operational staff and practitioners working within the five Neighbourhood Teams and therefore represents perspectives from various individual actors working within the Neighbourhood Teams. As detailed in the methods chapter (see chapter 4), participants’ roles within these Neighbourhood Teams included clinical team leads, case managers, administrators, care navigators, and professions delivering patient care. This assessment tool was utilised in order to capture a wide range of perspectives from staff delivering the integrated concept. As stated in the methodology chapter (see chapter 3, table 3.1), the aim was to address the following research questions:

RQ5: How has the local initiative’s approach to integrated care affected staff experience, and what impact has this had on partnership working?

RQ6: What are the practicalities and realities of integrated partnership working for operational staff and practitioners in practice?

As explained in the introduction chapter (see chapter 1), the aim of the Neighbourhood Teams is to provide more co-ordinated care and improve the health of individuals and the community by working in a multidisciplinary manner across organisations. This requires organisations and multidisciplinary professionals to work together in partnership to provide streamlined and person/patient-centred care. The findings from the literature review (see chapter 2) also revealed the need for an emphasis on patient-centred care, with findings from initial strategic interviews (see chapter five) highlighting the assumption that care is integrated around their individual needs, and that there is effective communication and collaboration between organisations and professionals. Findings from both of these chapters also indicated that achieving the ultimate goals of patient-centred care, collaboration, partnership working, and integrated care, had proven to be challenging and time-
Progression with the Neighbourhood Teams concept was therefore considered to not have been achieved to the extent to which had been originally envisaged, with development and implementation remaining in its infancy. There is therefore the need to assess staff experiences of working in the Neighbourhood Teams, and the impact of this on the practicalities and realities of the achieving the principles of partnership working in practice. The appropriate tool to be distributed in order to answer these research questions at the initiative’s stage of development, was identified following analysis of the data from the conceptual literature review (see chapter 2) and initial strategic interviews (see chapter 5). The literature also suggests that this particular partnership working assessment tool is the best known and most widely used of such tools (Miller et al, 2016; Fischbacher-Smith, 2015; Glasby and Dickinson, 2014; Halliday et al, 2004; Rummery and Coleman, 2003).

6.2 Participants and data analysis
All Neighbourhood Teams within the Clinical Commissioning Group (CCG) area took part in the partnership assessment. A total number of 31 participants agreed to take part, representing a response rate of 70.45%. In total, 24 female participants (77.42%) and 7 male participants (22.58%) agreed to take part, with a mean age of 43. However, one participant’s data was not included in the analysis as they did not complete the entire partnership assessment. A total number of 30 responses was therefore included in the analysis. Table 6.1 details participants’ professional roles within their organisations. Personal Independence Coordinators were formally known as Primary Care Navigators (referred to in strategic interviews in chapter 5), which involved working closely with GPs and multi-agency teams in order to support older people, carers, and families. Table 6.2 details how many participants worked within each Neighbourhood Team. Five participants’ results were excluded from the Neighbourhood Teams analysis as they worked across the five Neighbourhood Teams (due to low capacity within particular roles for them to be aligned to separate Neighbourhood Teams). A total number of 25 participants’ responses are therefore used within the Neighbourhood Teams comparison in section 6.5.
Table 6.1: Participants organisational membership and professional roles

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Profession</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health services</td>
<td>Occupational Therapist</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Physiotherapist</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Case Liaison Officer</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Clinical Team Lead</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Case Manager</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>13</td>
</tr>
<tr>
<td>County council</td>
<td>Adult Social Care Professional</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>5</td>
</tr>
<tr>
<td>Mental health services</td>
<td>Community Psychiatric Nurse</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Clinical Team Lead</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>5</td>
</tr>
<tr>
<td>Acute services (including care home liaison teams)</td>
<td>Care Home Liaison Practitioner</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Consultant Older People’s Services</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>3</td>
</tr>
<tr>
<td>Third sector (including Age UK &amp; a local independently hospice charity)</td>
<td>Personal Independence Coordinator</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Clinical Team Lead</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>30</td>
</tr>
</tbody>
</table>

Table 6.2: Participants Neighbourhood Team

<table>
<thead>
<tr>
<th>Neighbourhood Teams</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot Site Neighbourhood Team</td>
<td>NT1</td>
</tr>
<tr>
<td>South Neighbourhood Teams</td>
<td>NT2 &amp; NT3</td>
</tr>
<tr>
<td>North Neighbourhood Teams</td>
<td>NT4 &amp; NT5</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

For each partnership principle, participants were required to consider a series of statements about the Neighbourhood Teams partnership. They were asked to consider and indicate the extent to which they agreed or disagreed with each of the statements. Participants could also enter any free text for each of the statements via a comments option. The tool therefore generated both quantitative and qualitative responses.

6.3 Overall assessment

As explained in the methods section 4.3 (page 103), the PAT was developed by the Nuffield Institute for Health (Hardy et al, 2003), as part of a taskforce set up by the
government in order to assess strategic partnerships. This PAT is based on the following six principles, which have been shown to form the building blocks for successful partnerships:

1. Recognise and accept the need for partnership
2. Develop clarity and realism of purpose
3. Ensure commitment and ownership
4. Develop and maintain trust
5. Create clear and robust partnership arrangements
6. Monitor, measure and learn

The PAT is based on staff members identifying and sharing their views of the partnership (i.e. the Neighbourhood Teams), and allowing for areas of consensus and conflict to be identified. For each of the principles, participants indicated their level of agreement or disagreement with the six statements related to the six partnership principles (see appendix 11 for details of these partnership principles and their associated elements). Options included strongly agree, agree, disagree, and strongly disagree. Participants could also enter any free text for each of the statements via a comments option. For example, within principle 1 participants were asked to either agree or disagree with the statement that: “There have been substantial past achievements within the partnership”. Participants’ level of agreement or disagreement were associated with the following scores:

- Strongly agree: 4
- Agree: 3
- Disagree: 2
- Strongly disagree: 1

Participants’ raw data of scores for each of the six principles are detailed in appendix 16, which also shows the total score for each participant. As there are six partnership principles and six statements per principle (i.e. 36 statements), the total scores have the ability to range between 36 (i.e. strongly disagree for each statement) and 144 (i.e. strongly agree with each statement). Table 6.3 also identifies the descriptive statistics for each of the partnership principles (see appendix 17 for SPSS output).
Table 6.3: Descriptive statistics for each of the partnership principles

<table>
<thead>
<tr>
<th>Principles</th>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>P4</th>
<th>P5</th>
<th>P6</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>17.73</td>
<td>16.70</td>
<td>15.83</td>
<td>17.13</td>
<td>16.00</td>
<td>14.26</td>
<td>97.66</td>
</tr>
<tr>
<td>S.D</td>
<td>2.66</td>
<td>3.51</td>
<td>3.42</td>
<td>3.38</td>
<td>2.98</td>
<td>3.30</td>
<td>15.75</td>
</tr>
<tr>
<td>Median</td>
<td>18</td>
<td>18</td>
<td>16</td>
<td>18</td>
<td>16</td>
<td>14</td>
<td>98</td>
</tr>
<tr>
<td>Range</td>
<td>12</td>
<td>17</td>
<td>14</td>
<td>15</td>
<td>14</td>
<td>12</td>
<td>65</td>
</tr>
</tbody>
</table>

Histograms were produced in order to assess the normal distribution of the data (see appendix 18). However, due to the relatively small sample size, it was somewhat difficult to visually assess the normality of the data. A normality test was therefore conducted to further assess the distribution of the data. This indicated that principles 1, 3, 4, and 5 were normally distributed and principles 2 and 6 were non-normal distributions (see appendix 18). Both the standard deviations for normal distribution and medians for non-normally distributed data are therefore reported. The histograms also indicated some potential outliers in the data (see table 6.4). For principles 1-5 outliers were either attributable to participants from acute or community services, from a range of Neighbourhood Teams. However, for principle 6, while all low value outliers were from community service participants, all organisations apart from the acute services were represented in the higher outlier values (from a mix of Neighbourhood Teams). This suggests extreme scores and some potential difficulty in answering the questions regarding this principle for the majority of organisations and teams. High value outliers across all principles were also attributable to the pilot site of the Neighbourhood Teams (NT1). The box plots represented in appendix 18 also show any extreme scores and outliers. These box plots provide similar information to the histograms and the extreme scores shown in table 6.4. However, no extreme scores are shown for principle 3, 5 and 6.
Table 6.4: Outliers in the data indicated from histograms

<table>
<thead>
<tr>
<th>Principles</th>
<th>Outlier value</th>
<th>Organisation</th>
<th>Neighbourhood Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Low</td>
<td>Acute services n=3 Community services n=1</td>
<td>South and North</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>Community services n=1</td>
<td>Pilot Site</td>
</tr>
<tr>
<td>P2</td>
<td>Low</td>
<td>Community services n=1</td>
<td>South</td>
</tr>
<tr>
<td>P3</td>
<td>Low</td>
<td>Acute services n=1 Community services n=1</td>
<td>South and North</td>
</tr>
<tr>
<td>P4</td>
<td>Low</td>
<td>Acute services n=1</td>
<td>South</td>
</tr>
<tr>
<td>P5</td>
<td>High</td>
<td>Community services n=1</td>
<td>Pilot Site</td>
</tr>
<tr>
<td>P6</td>
<td>Low</td>
<td>Community services n=3</td>
<td>South and North</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>Community services n=2 Mental Health services n=1</td>
<td>All NTs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adult social care n=3  Third sector n=1</td>
<td></td>
</tr>
</tbody>
</table>

The means for each principle shows that on average, participants scored principle 1 the highest (indicating the highest level of statement agreement) and principle 6 the lowest (indicating the highest level of statement disagreement). This would indicate that the principle of recognising and accepting the need for the partnership was considered to have been the most developed principle in relation to the Neighbourhood Teams, as opposed to the principle of monitoring, measuring and learning, which was considered to be the least developed. However, the lack of clarity of the outcome measures of the Neighbourhood Teams (highlighted in chapter 5) may help to explain the low scores for this principle.

As part of the assessment tool, these scores were also transferred onto a dartboard graphic which depicted a ‘rapid partnership profile’. These were used as a quick way to graphically identify any differences across perceptions of the principles of partnerships in relation to working on the ground within the Neighbourhood Teams. As an example, figure 6.1 shows the rapid partnership profile developed based on the
mean scores of all participants (encompassing all partner organisations from all five Neighbourhood Teams). These partnership profiles were also developed for the mean scores based on partner organisations and Neighbourhood Teams (see appendix 19). Figure 6.1 highlights that overall participants’ agreement with the statements across the partnership principles was similar, with the scores all lying within the ‘B’ score range (i.e. 13-18). However, principle 1 was scored at the higher end of this score range, whereas principle 6 was at the lower end.

Appendix 20 details how the PAT interprets the results based on participants’ scores. The highlighted sections identifies the explanation associated with participants’ mean scores. For example, for partnership principle 1, the score of 18 meant that “the need for partnership is recognised and accepted”. The table within appendix 20 also shows what the overall assessment of the PAT was, based on the aggregate score of 98 (based on the answers all participants gave to questions regarding the six principles). This indicates that the assessment suggests that the “partnership is performing well enough overall but some aspects may need further exploration and attention.”

![Figure 6.1: Partnership Profile scores of all participants](image)

<table>
<thead>
<tr>
<th>Code</th>
<th>Score Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>19-24</td>
</tr>
<tr>
<td>B</td>
<td>13-18</td>
</tr>
<tr>
<td>C</td>
<td>7-12</td>
</tr>
<tr>
<td>D</td>
<td>6</td>
</tr>
</tbody>
</table>
6.4 Assessment based on partner organisation membership

It is important to consider any differences in partner organisations’ perspectives of partnership working, as difficulties which may only be associated with one organisation, have the potential to destabilise the whole process. For example, complexity theory discussed in the literature review (page 55), suggests that health and social care systems have a large number of elements which interact dynamically, with any element of the system able to be affected by and affect other elements of the system. Table 6.5 shows the mean scores for each partnership profile, based on the participant’s organisational affiliation. This therefore highlights where there may be broad agreement or disagreement between partner organisations. For example, while the third sector (including Age UK and a local independently hospice charity) scored the principles particularly high (i.e. principles 1-4), members of the acute trust scored some principles particularly low (i.e. principles 1, 3, 4). This suggests that participants who work within the third sector have had a more integrated and positive experience of partnership working with the Neighbourhoods Teams, than those working with the acute sector. This could have been due to the contrasting cultures within hospitals who have an acute and episodic focus on care, compared to a more holistic and long-term approach within primary and community care (Lyngso et al, 2016).

How these results can be interpreted in terms of participants’ perceptions of the partnership principles is detailed in appendix 21. For example, with regard to principle 1, while participants from the third sector suggested a ‘very high recognition and acceptance of the need for partnership’ (based on a mean score of 20; see table 6.5), the mean score from acute sector participants suggested that the ‘recognition and acceptance of the need for partnership is limited’ (based on a mean score of 12; see table 6.5). This highlights a variation in experience of recognising and accepting the need for the Neighbourhood Teams partnership. Table 6.5 and appendices 22 and 24 also highlight that the overall third sector scored the partnership principles higher than other organisations (i.e. Code A).
Table 6.5: Mean scores for partner organisations

<table>
<thead>
<tr>
<th>Partner Organisation</th>
<th>Principles</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>18</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>15</td>
<td>15</td>
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<tr>
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<td>B</td>
<td>B</td>
<td>A</td>
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<td></td>
<td></td>
</tr>
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<td>16</td>
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<td></td>
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<td>18</td>
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<tr>
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<td>B</td>
<td>B</td>
<td>B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Services</td>
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<td>16</td>
<td>12</td>
<td>11</td>
<td>14</td>
<td>13</td>
<td>79</td>
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<td>B</td>
<td>C</td>
<td>C</td>
<td>B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third Sector</td>
<td>20</td>
<td>20</td>
<td>19</td>
<td>19</td>
<td>17</td>
<td>15</td>
<td>110</td>
<td></td>
</tr>
<tr>
<td>(n=4)</td>
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<td>A</td>
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<table>
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<td>B</td>
<td>13-18</td>
<td>73-108</td>
</tr>
<tr>
<td>C</td>
<td>7-12</td>
<td>37-72</td>
</tr>
<tr>
<td>D</td>
<td>6</td>
<td>36</td>
</tr>
</tbody>
</table>

6.5 Assessment based on Neighbourhood Team membership

It is also important to consider any differences in Neighbourhood Team perspectives of partnership working, to assess any variation in experiences and understanding of partnership working across Neighbourhood Teams. As the Neighbourhood Teams included a pilot site (NT1), this team was therefore at a further stage of development than the other four Neighbourhood Teams (NTs 2-5). It was therefore interesting to explore whether the principles were more developed within the pilot site, considering its later stage of development and increased time working together across organisational boundaries. However, irrespective of team membership there
is also likely to be differences due to the individuals within the teams, the team dynamic and the relationships that they have made. Table 6.6 highlights where there may be broad agreement or disagreement between Neighbourhood Teams. While there were no overall differences in principles across the Neighbourhood Teams, the pilot site for implementation (NT1) rated some principles slightly higher (i.e. principles 1 and 4). This suggests that participants working within this particular Neighbourhood Team have had a slightly heightened experience and understanding of partnership working than other teams, with particular regard to recognising and accepting the need for the partnership and developing trust within this team. This is not surprising and should be expected given the pilot site nature of this team. This highlights that developing an understanding of the importance of trusting relationships and the need for the Neighbourhood Teams takes time, and that the pilot site had the benefit of an increased amount of time to develop working relationships, than the other four teams.

As explained in chapter 5, as part of the second phase of development of the Neighbourhood Teams, pilot sites were chosen across the county to explore the real feasibility of the model and learn from the experiences of the implementation process. The rationale for why this particular Neighbourhood Team was chosen for the pilot site within this local CCG’s footprint was due to the specific challenges that this team faced (e.g. primary care challenges, high deprivation, and prevalence of mental health issues), and the potential for impact of the model to therefore have. There was also the added advantage of having the potential to also further develop, due to the team already being bought into the model and co-location. This therefore means that the pilot site had the potential advantage of co-location and an increased amount of time engaging with partnership working. While this has the potential to result in all the principles being rated higher within this team than the other four teams not as far on in their development, this was only the case for principles 1 and 4.

However, while participants rated some of the principles higher within the pilot site (representing increased development of the principles in relation to the
Neighbourhood Teams), this did not result in any differences in the overall scores of all principle scores combined. How these results can be interpreted in terms of participants’ perceptions of the partnership principles is detailed in appendix 22. For example, with regard to principle 1, while participants from NT1 would suggest a ‘very high recognition and acceptance of the need for partnership’ (based on a mean score of 19; see table 6.6), the mean score from all other Neighbourhood Teams (i.e. NT 2-5) would suggest that the ‘need for partnership is recognised and accepted’ (based on mean scores of 18 and 17; see table 6.6). In addition, table 6.6 and appendices 23 and 26, indicate that all Neighbourhood Teams rated the partnership principles similarly overall (i.e. Code B).

### Table 6.6: Mean scores of Neighbourhood Teams

<table>
<thead>
<tr>
<th>NT</th>
<th>Principles</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot (NT 1)</td>
<td></td>
<td>19</td>
<td>18</td>
<td>18</td>
<td>19</td>
<td>17</td>
<td>16</td>
<td>108</td>
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<tr>
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<td>B</td>
<td>B</td>
<td>A</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>South (NTs 2&amp;3)</td>
<td></td>
<td>18</td>
<td>16</td>
<td>15</td>
<td>16</td>
<td>15</td>
<td>13</td>
<td>92</td>
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<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>North (NTs 4&amp;5)</td>
<td></td>
<td>17</td>
<td>15</td>
<td>14</td>
<td>17</td>
<td>15</td>
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<td>B</td>
<td>B</td>
<td>B</td>
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<td>B</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Score Range</th>
<th>Total Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>19-24</td>
<td>109-144</td>
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<tr>
<td>B</td>
<td>13-18</td>
<td>73-108</td>
</tr>
<tr>
<td>C</td>
<td>7-12</td>
<td>37-72</td>
</tr>
<tr>
<td>D</td>
<td>6</td>
<td>36</td>
</tr>
</tbody>
</table>

### 6.6 Relative significance and partnership success

Having addressed and scored each of the six statements for each of the six principles, participants’ were also required to consider the relative significance of the principles. Participants were asked to consider how they would weigh the six principles in terms of their current significance for the Neighbourhood Teams partnership, given its
nature, stage of development, and their role within the partnership. For example, with a newly formed partnership, principles one (i.e. recognise and accept the need for partnership) and two (i.e. develop clarity and realism of purpose) may be perceived as being more significant than principle six (i.e. monitor, measure, and learn). Figure 6.2 details participants’ perceptions of the significance of the principles in relation to the Neighbourhood Team partnership. Participants considered principles 1-5 to be relatively significant, with principle 6 considered to be less significant. This suggested that monitoring, measuring and learning within the Neighbourhood Teams was something which was not high on the agenda for operational staff and practitioners, that they didn’t know what they outcome measures were, or that they did not understand then in relation to the Neighbourhood Teams.

![Table showing participants' perceptions of the relative significance of the partnership principles](image)

**Figure 6.2: Participants’ perceptions of the relative significance of the partnership principles**
Participants were also asked to consider how well they thought the partnership was currently achieving its aims and objectives. Overall, the majority of participants either strongly agreed or agreed with the statement that: “the partnership is achieving its aims and objectives” (n=20) (see figure 6.3).

![Overall perception of the partnership achieving its aims and objectives](image)

*Figure 6.3: Participants’ perceptions of partnership achieving its aims and objectives*

When the overall success of the partnership was split into organisational perceptions, there appeared to be more agreement than disagreement with all partner organisations, apart from the acute sector (see table 6.7 and figure 6.4). This highlighted that while a total of 20 participants from community services, adult social care, mental health, and the third sector agreed with the statement that the partnership was achieving its aims and objectives, all participants from acute services disagreed with the statement. This suggests that these acute services had not been integrated into the Neighbourhood Teams as well as other organisations who were situated within the core multidisciplinary teams (MDTs), despite being invited to attend the meetings. This highlights the difficult of integrating with acute services, compared to the other core organisations who had a community and preventative focus, as opposed to the reactive nature of acute services.
Table 6.7: Partner organisations perceptions of meeting aims and objectives

<table>
<thead>
<tr>
<th>Partner Organisation</th>
<th>Agreement</th>
<th>Disagreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Services (n=13)</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Adult Social Care (n=5)</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Mental Health (n=5)</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Third Sector (n=4)</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Acute Sector (n=3)</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

In terms of agreement of whether the partnership have achieved its aims and objectives based on Neighbourhood Team membership, the pilot site (NT1) had the strongest agreement. As this team was further developed, they may have a better understanding of these, contributing to stronger agreement in their achievement. The Neighbourhood Teams in the North of the county (NT4&5) also provided more agreement than disagreement. However, for Neighbourhood Teams in the South of the county (NT2&3), participants displayed more disagreement than agreement. This highlights variation in application of the Neighbourhood Team model in participants’
perceptions of the achievement of its aims and objectives (see table 6.8 and figure 6.5). A contributing factor could be the different needs of the population with the Neighbourhood Teams based on the locality.

**Table 6.8: Neighbourhood Team perceptions of meeting aims and objectives**

<table>
<thead>
<tr>
<th>Neighbourhood Team</th>
<th>Agreement</th>
<th>Disagreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot Site (NT1) (n=9)</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>South (NT2&amp;3) (n=8)</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>North (NT4&amp;5) (n=8)</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>

**Figure 6.5: Neighbourhood Team perceptions of partnership achieving its aims and objectives**

6.7 Qualitative Responses

Participants were also able to provide qualitative comments throughout the PAT. This included options to leave comments for each of the six statement for the principles and a free text section at the end of the questionnaire, which instructed participants
to leave any general comments on the performance of the partnership. These comments were organised into themes shown below in table 6.9. This shows that the two most prominent themes were engagement and multidisciplinary team meeting attendance (n=23), and impact and outcomes (n=15). Table 6.9 also shows whether these statements were positive, neutral or negative. This process involved sentiment analysis, where it is best practice to note if a statement is positive, neutral or negative, to allow for a high level summary of how an item has been perceived, before considering the detail found in common trends (Becker et al, 2016). While there are various methods for identifying sentiment, including sentiment dictionaries (which algorithmically determine sentiment) and syntax and semantics, it is suggested that the most successful approaches are based on data which is manually annotated for sentiment (Becker et al, 2016). While qualitative data is considered to be less suited to tables and graphical illustration than quantitative data, fragments of text can be coded as negative, positive, negative, or neutral, counted and presented in a table, in order to coherently summarise data (Pitchforth et al 2005). As the research questions considered how the development and implementation of the Neighbourhood Teams had effected staff experience, the reality of integrated partnership working in practice, and the impact has this had on partnership working, the numerical assignment to data was also deemed to be appropriate.

This table shows that both engagement and multidisciplinary team meeting attendance included more negative statements (n=17) than positive statements (n=6), and impact and outcomes included more negative statements (n=9) than positive statements (n=6). Overall, there were more negative statements across all themes (n=44; 62%), compared to positive statements (n=19; 27%), and neutral statements (n=8; 11%); suggesting that participants had more negative experiences of partnership working in the Neighbourhood Teams than positive or neutral.

Participants also made comments about the difficulty of answering some of the questions within the PAT, highlighting methodological issues. Participants reported finding the most difficulty with answering the statements in principle six, particularly due to a lack of awareness of the processes involved in the monitoring and
measurement of the partnership. This could contribute towards the low results of principle 6 (indicating the highest level of statement disagreement). They did however make several comments about the impact and outcomes of the partnership throughout the assessment. Participants made the following number of comments of difficulty in answering questions within the six principles:

- Principle 1 (n=1)
- Principle 2 (n=5)
- Principle 3 (n=3)
- Principle 4 (n=4)
- Principle 5 (n=5)
- Principle 6 (n=14)

The details of the qualitative data from the Partnership Assessment Tool and their associated themes is included at appendix 23.

Table 6.9: Themes of participants’ qualitative responses

<table>
<thead>
<tr>
<th>Theme</th>
<th>Total</th>
<th>Positive</th>
<th>Neutral</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement and MDT meeting attendance</td>
<td>23</td>
<td>6</td>
<td>-</td>
<td>17</td>
</tr>
<tr>
<td>Impact and outcomes</td>
<td>15</td>
<td>6</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>Variation and challenges</td>
<td>9</td>
<td>-</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Understanding of the process</td>
<td>8</td>
<td>-</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Aims and objectives</td>
<td>6</td>
<td>2</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Relationships</td>
<td>6</td>
<td>5</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Leadership</td>
<td>4</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>71</strong></td>
<td><strong>19</strong></td>
<td><strong>8</strong></td>
<td><strong>44</strong></td>
</tr>
<tr>
<td><strong>100%</strong></td>
<td><strong>27%</strong></td>
<td><strong>11%</strong></td>
<td><strong>62%</strong></td>
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</table>
In terms of the most prominent theme of engagement and multidisciplinary team meeting attendance one participant revealed that the Neighbourhood Team meetings were initially well attended. The lack of sustainability of the initial interest in the meetings could have been due to conflicting priorities when attending meetings, implementation difficulties, or the impact of individual beliefs which did not see the benefit of the meetings. In addition, three noted that the engagement with these meetings and the multidisciplinary Neighbourhood Teams was mutually beneficial for both staff and patients. These benefits included collaboration and joint action of health and social care professionals (i.e. professional integration), promotion of understanding of different organisations (i.e. organisational integration), networking, and providing support for service users, professionals and organisations. For example:

“The weekly meetings have brought together health and social care professionals who discuss individuals and form an action plan which addresses these needs simultaneously. It saves so much time and is a very efficient medium for problem solving. Quick results are best for patients and staff.”

Having involvement and input from the third sector was also seen to be beneficial. A participant also commented that engagement was understood by the ‘core group’; and suggested that this had not been achieved within the wider Neighbourhood network. This highlights the unintentional focus on the MDT, and the lack of integration outside of the MDT meetings.

In terms of the more negative comments within this theme, it was suggested by two further participants that while there had been initial engagement, this had subsequently diminished throughout the development process. It was also noted that ‘not all partners appear to be actively involved’, with nine participants commenting on the variation in engagement with the Neighbourhood Teams and attendance at the MDT meetings from partner organisations. A particular lack of engagement and commitment was commented on by three participants to be from District Nurses and three participants to be from GPs. This lack of engagement was perceived to impact on the effectiveness of the Neighbourhood Teams. This identifies how the history of
the teams can affect future interactions, with the modifying influence of initial conditions (i.e. complexity theory; Pype et al, 2018). For example:

“Poor attendance at the meetings has meant the effectiveness of the service is not working as it did in the beginning. The loss of GP input [name of GP] in the north, was the start of the gradual splintering of the team and the loss of effectiveness of the service.”

Improved attendance at the MDT meetings and prioritisation was therefore perceived by four participants to improve partnership working performance and referral rates.

The second most prominent theme of impact and outcomes included six positive comments from participants. This included the notion that success was due to individuals (including networking with professionals), which was commented on by two participants. This highlights how complex adaptive systems can affect the success of integrated care initiatives, as they include a collection of individuals who have freedom to act (Pype et al, 2018). This is also supported by a critical realist perspective, which emphasises the importance of individual thoughts and actions (Byng et al, 2005).

Positive outcomes of partnership working also included enabling professionals to provide a timely and integrated response to patients’ needs (i.e. patient-centred care), and to keep patients well at home (one of the Neighbourhood Teams aims). Two participants also commented that while they recognised the need to work together, they considered it was not clear whether this had been achieved yet. This identified the difficulty of showing outcomes of the Neighbourhood Teams initiative within the short-term, potentially affecting staff motivation and engagement.

In terms of a lack of impact it was noted that there was yet to be significant change and an increased number of referrals into the Neighbourhood Teams. For example:

“Since its implementation I haven’t noticed a very real change. Sure enough we talk to the nurses a little more but I haven’t noticed an enhanced number of proactive referrals”.

175
In terms of the difficulty and barriers to impact, one participant commented on the inability to prioritise patients within the Neighbourhood Teams over their own caseload, with another noting the poor database of outcomes which did not reflect true accounts of what was happening within the teams. An inaccurate representation of the partnership working within the teams could create the false perception that the initiative was not working. However, this highlights the difficulty of measuring and showing outcomes which relate to the important features of developing relationships and trust. In reference to feedback of impacts and outcomes of the Neighbourhood Teams partnership, it was noted by four participants that while the development of Neighbourhood Teams had been occurring for some time, they had not received any feedback or objective measurement about what has changed. This has the potential to further affect staff motivation and engagement with the Neighbourhood Teams. However, another participant also commented that they had not personally been involved with the Neighbourhood Teams for enough time to be able to comment on their achievement. This highlights the issue of the infancy of the Neighbourhood Teams initiative, alongside the changing job roles of the health and social care workforce. Two participants also reflected that they felt that while the concept of the Neighbourhood Teams had initially been promising and transformative, the reality of implementation had been complex. One of these participants further explained that they felt that peoples' attitudes had changed, but were unaware of any objective outcome measurements. For example:

“It seems like we had a lot of meetings and conferences about how things were going to change. I would say that people’s attitudes have changed but this is a subjective feeling. With regards to objective outcomes I am unaware of any. I am not sure were I an investor, that I would be putting money into this as a business.”

There was also variation noted in partnership working by five participants, with considerations that some Neighbourhood Teams and partners organisations were working better together than others. This could be due to the complexity of the interactions between the teams producing unpredictable behaviour, which affected
the team and partnership working within the different Neighbourhood Teams. One of these participants also commented that they did not feel that mental health was at the ‘core’ of the Neighbourhood Team, and considered that they felt that this profession should be working more closely with the partner organisations. This again highlights the evolution of the Neighbourhood Teams to have become focused on the core MDT, with some organisations and professionals feeling that not being part of this meant that they were not part of the Neighbourhood Teams and not involved in integrated working. The variation in practices of differing organisations was considered to be duplication and a silo mentality, which could lead to patients becoming lost within the process. This therefore highlighted a process which was more organisationally-centred than patient-centred. For example, it was explained that there are:

“Frequent examples of differing practices between differing organisations. Differing perceptions of key corporate policies can lead to duplication, disagreement and silo mentality. Often patients gets lost in process because process gets in the way.”

Barriers to the development and implementation of the Neighbourhood Teams and partnership working were considered by three participants to include information governance, resources, skill mix retention, and geography, particularly if the Neighbourhood Teams were on a larger scale. These identified barriers all contribute towards the ability for operational staff and practitioners to work across organisational boundaries in order to deliver patient-centred care.

Within the theme of understanding of the process, seven comments were made by participants, including the lack of understanding of the concept and its impact, the role of certain organisations, communication between organisations, what constitutes a referral, responsibilities, and the process of reporting outcomes. For example it was explained that:

“Across the county, there is still a significant lack of understanding of the concept and how it will positively impact on what we do.”
Differences between the ‘core’ team and the wider network were also made within this theme. For example, while there was mutual understanding within the ‘existing core group’, there was a feeling that involvement from the broader group was ‘not fully appreciated’, highlighting internal tension within the Neighbourhood Teams concept.

Within the theme of relationships, successful partnership working was considered by five participants to be due to individuals and their professional relationships, organisational relationships, the culture of the teams, a high level of trust, and effective communication. This was in accordance with the theme of impacts and outcomes. An implication of these benefits was considered to be increased referrals. For example:

“In this time we have developed our relationships with the other services in the area. This has led to better relationships with these teams, and has also led to a significant increase in referrals to our hospice service in the [name of NT] area”.

However, in accordance with the engagement and MDT meeting attendance theme, it was perceived that there were issues with relationships with District Nurses, ‘who insist assessments are repeated and are grudging in their acceptance of referrals’. This was suggested to result in a lack of partnership working, duplication, and ineffective working relationships. This issue raises concerns within the Neighbourhood Teams that partnership working created issues for accountability, trust, and professional identify.

The theme of aims and objectives highlighted that there was a lack of awareness of the aims and objectives of the Neighbourhood Teams partnership by four participants, including goals, visions, and expectations. One of these participants also commented that they were especially unclear as to how they are being measured. In addition, another participant advocated additional work to be done in order to define a common goal within the Neighbourhood Teams, alongside building trust between organisations and professionals. For example they explained that:
“More work needs to be done to define common purpose and goals and to also build a corporate trust.”

In terms of the theme of **leadership**, in accordance with the theme of engagement and MDT meeting attendance, one participant felt that the Neighbourhood Team meetings used to be more effective when there was medical leadership. They further explained that since this loss of leadership, these meeting were now vague. Another participant also commented on the lack of senior leadership, with senior levels only recently becoming more visible. Two participants advocated the need for top-down guidance and leadership, with consistent management commitment in order to coordinate and clarify roles.
Chapter 7: Results - Progression of integrated care (study 3)

7.1 Research questions and mixing of the data

As part of the process focus of the theoretical framework (see page 21), this chapter details the results from supplementary in-depth interviews, which were conducted in order to gain further insights into the strategic and management perspective of the Neighbourhood Teams. It was also considered whether it had been feasible to address any of the issues and concerns raised in the initial strategic interviews (see chapter five; study 1). The data analysis from studies 1 and 2 identified that integration and partnership working had not been embedded in practice to the extent to which the strategic perspective had anticipated. For example, it was highlighted that there was a lack of GP engagement, clarity of concept, awareness of the aims and objectives, and understanding of other organisations and professional roles. As the data from these studies had not brought the clarity needed, supplementary interviews were therefore conducted with leading Neighbourhood Team implementers (regarding the strategy and application of the model). The purpose of these interviews was to draw on expert opinion of the evolution of the Neighbourhood Teams, and explore their more recent development and implementation. This was also considered alongside participants’ perceptions of progression with the integration agenda.

As detailed in the methods chapter (see chapter 4), these interviews were conducted with two staff members who had leadership roles within the Neighbourhood Teams pilot site and the Sustainability and Transformation Plan (STP). This included a lead change manager for integrated care and a Neighbourhood Team lead for the pilot site for implementation. As stated in the methodology chapter (see chapter 3; table 3.1), the aim was to address and add to the following research questions:

RQ2: How has a local approach to integrated care been developed and implemented over time?

RQ3: What is the feasibility and practicality of developing and implementing integrated care and integrated working?
RQ4: What are the barriers and facilitators to developing integrated teams, and implementing and sustaining integrated care?

The comprehensive literature review (see chapter 2) alongside participants’ considerations of the strategic development and implementation of the Neighbourhood Teams concept (see chapter 5), revealed the development of various national programmes within the UK. These chapters highlighted that this has resulted in multiple options for local initiatives to adopt, in order to work towards the integration agenda and improve care delivery (e.g. Multi-speciality Community Providers, Primary and Acute Care Systems, Sustainability and Transformation Plans, and Accountable Care Systems). However, the findings of initial strategic interviews (see chapter 5) provided the perspective that in order to successfully integrate health and social care services, commitment to a model was needed, alongside local champions who are fully committed to their local integration agenda. Local champions were also required in order to bridge the gap between local knowledge and insights into population needs, and the passion and innovation to be able to drive and support these changes, despite inevitable challenges and set-backs.

The findings of initial strategic interviews (see chapter five) and the application of integrated care in the form of a Partnership Assessment Tool (see chapter 6) also considered that the practical application of various models and approaches to integration were experienced by those on the ground who work to deliver quality patient-centred care. This is also within the context of having to adapt to the ever changing challenging circumstances, in order to improve care and patient experience. Findings from the conceptual literature review (see chapter 2), initial strategic interviews (see chapter 5), and the application of the integrated concept (see chapter 6) also revealed that due to the complexity of this issue and the necessity for local initiatives to mould principles and models to fit the needs of their local population, a one size fits all approach is not appropriate for this type of shift in the delivery of care and services. However, these findings also suggest that there are transferable mind-sets and approaches which can be utilised across a variety of integrated contexts within various systems. The literature review, initial strategic interviews, and the
Partnership Assessment Tool have also highlighted the difficulty of measuring impacts, outcomes and success.

7.2 The current Neighbourhood Team model

The findings from the supplementary strategic interviews which draw on expert opinion within this chapter, alongside documentary analysis (see appendix 13), revealed that the Neighbourhood Team concept was currently being referred to as ‘Integrated Neighbourhood Working’, with Neighbourhood Teams aligned to GP practices and care homes. This highlighted that the core team included; primary care, county council, community health services, mental health services, third sector, clinical pharmacy, and a county care association (i.e. organisational integration). This included the professions of; nurses, adult care, community psychiatric nurse, clinical pharmacy, therapists, and generic assessors (i.e. professional integration). The wider Neighbourhood network connected to the core team encompassed the third sector including; wellbeing service, carers’ network, managed care network, specialist health and wellbeing services.

It was also explained that the county’s STP was currently one of nine early demonstrator sites of the national change programme of Integrated Personal Commissioning (IPC), led by NHS England and the Local Government Association. Table 7.1 details the key shifts and enablers of this framework. This framework was adapted due to its similarities of the approach and vision of the Neighbourhood Teams concept. The IPC was therefore utilised to inform the development of the current Neighbourhood Team model, now being termed ‘Integrated Neighbourhood Working’ (see figure 1.2; page 10) and the operating framework and structure (see appendix 13). The current model included core principles which applied to everyone involved in Neighbourhood working, promoting a shared responsibility. These included:

- Having a different conversation
- Home first
- Enabling self-care and support
• Patient-centred care
• Collective accountability across neighbourhood working
• Positive risk taking
• Assessing immediate needs and barriers to improve quality of life

Table 7.1: IPC key shifts and enablers (adapted from IPC framework; NHS England, 2017b)

<table>
<thead>
<tr>
<th>Key ICP Shifts</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proactive coordination of care</td>
<td>A proactive approach to improving experience of care and preventing crisis</td>
</tr>
<tr>
<td>Community capacity and peer support</td>
<td>A community and peer focus to build knowledge, confidence and connections</td>
</tr>
<tr>
<td>Personalised care and support planning</td>
<td>A different conversation with the people involved in care focused on what is important to the individual</td>
</tr>
<tr>
<td>Choice and control</td>
<td>A shift in control over the resources available to individuals, their carers’ and family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key ICP Enablers</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personalised commissioning and payment</td>
<td>A wider range of care and support options tailored to individual needs and preferences</td>
</tr>
<tr>
<td>Leadership, co-production and change</td>
<td>Strategic endorsement and prioritisation of IPC, with leaders at all levels delivering a coordinated plan</td>
</tr>
<tr>
<td>Workforce</td>
<td>A cross-organisation approach to support and develop people’s roles, skills, knowledge and the wider culture to deliver IPC</td>
</tr>
</tbody>
</table>

The current approach and strategy of Integrated Neighbourhood Working was revealed to be empowering the local population to take an active role in their health and wellbeing with greater choice and control. It is argued that person-centred healthcare provides increased understanding, capacity, and confidence in decision making (Lawn et al, 2009; Boyce et al, 2008; Johnston et al, 2008), and is recommended as a strategy for empowering patients to consider the effectiveness of their care, and provide feedback on the quality and appropriateness of services they have received (Lawn et al, 2009). In order to deliver person-centred care which is personalised, coordinated, and empowering, new models of care are suggested to
need to promote shared decision-making, personalised care and support planning, and self-management support (NHS England, 2015). While person-centred care focusses on the individual, empowerment promotes centrality to the social environment in which the person lives (Pulvirenti et al, 2014). Empowerment is therefore seen to involve a change in the power relations that exist between the individual and the health professional (Pulvirenti et al, 2014), with most definitions including some conceptualisation of personal control and self-efficacy (McAllister et al, 2012). However, empowerment therefore assumes that individuals want to be empowered to self-manage, and that individuals and health professionals have the capacity and skills to change their relationship (Pulvirenti et al, 2014). The degree to which different social groups have the ability to be empowered, and want to be empowered, will also vary (McAllister et al, 2012). Empowerment has therefore been argued to be context and population specific, with the lack of applicability of a universal definition (Zimmerman, 2000). The current Neighbourhood Teams model also indicated a desire for a focus on key outcomes for the population, the workforce, and the system. Interviews also revealed that tools for monitoring these outcomes included the 100 day challenge (sharing case stories), the Plan-Do-Study-Act cycle (which provides a model to test change), and rapid testing.

7.3 Themes derived from data analysis

In order to further consider more recent development and progression of the Neighbourhood Teams initiative, two current strategic leads for the implementation of the Neighbourhood Teams across the county were consulted. This included a lead change manager for integrated care, and a Neighbourhood Team lead for the pilot site for implementation. This led to the following reflections on progression with the integration agenda and the development and implementation of the Neighbourhood Teams, based on the themes developed from the initial strategic interviews.
Theme 1: The purpose and focus of Neighbourhood Teams concept

While a preventative approach of the Neighbourhood Teams was advocated, current implementation leads considered that there still needed to be a shift from being reactive, to delivering proactive and preventative care. However, in order to facilitate this shift, it was acknowledged that there needed to be an active identification of the appropriate population. A balance between being proactive and empowering people to self-manage was also advocated. In addition, while participants also promoted a patient focus, the indication that this was still something which needed to be achieved was given. For example:

“We can draw as many flowcharts and pathways on a piece of paper as you like but we’ve got to practically start to work with real people. I can tell you the principles of what we’re trying to do but we need to get to the nitty gritty…if we only sort 12 patients, then that’s patients that have got a far better plan and are likely to have a different experience”. (P1)

While participants considered that although the vision for the Neighbourhood Teams had been there throughout its development, the focus had been placed on the complex group of individuals who make up the top 2%, through the manner in which it had been previously delivered. The current strategy was explained to include refocusing on promoting more of a whole population approach (also advocated as the appropriate focus in previous strategic considerations). This highlights the continued issue of translating a shared vision of integration into practice (i.e. achieving normative integration). The current strategic perspective also raised issues with the concern of previous models, which while they promoted a nice picture, did not indicate how this was going to be achieved and put into practice.

It was explained that there were currently five key functions which were recognised as part of what strategic leads were now terming ‘Integrated Neighbourhood Working’. These included:

1. A whole population approach
2. Identifying the core team
3. Identifying populations (i.e. population segmentation, risk stratification)
4. Local area coordination (i.e. care navigation based on level of need)
5. Personalised care and support planning (i.e. at non-clinical and clinical levels depending need – ranging from self-care to advanced care planning)

It terms of the design of the model currently in use, it was explained that this was informed by the national programme of the IPC framework of personal health budgets. It was considered that there was the recognition that there needed to be a vehicle in order to deliver the IPC framework, and that the Neighbourhood Team was deemed to be appropriate to do so. The framework was therefore developed in order to shape it for ‘Integrated Neighbourhood Working’, with the ability for each locality to develop it for their area (with some flexibility and variation occurring). However, it was noted that there needed to be clarity on who their population was, with a focus on getting patients to the right place for their care needs, personalised support planning, and wrapping services around them. There was also the perception that the original Clinical Commissioning Group (CCG) model depicted in figure 1.1 (page 8) was flawed, as each locality needed to determine who was important to be in their core MDT. It was explained by participants that the strategy employed when the pilot Neighbourhood Team was first developed, was that the focus needed to be kept to the core group, but in reality that resulted in a lot of key people for patient care being excluded.

Participants explained that the new model currently in use, was referred to in practice as ‘the house’ (see figure 1.2; page 10). It was explained that this model was something which was originally developed in collaboration with Age UK (a Neighbourhood Team partner organisation), which was then shaped into Neighbourhood Working. This model was also represented in the operating framework, with a particular focus on identifying the population, local area coordination, personalised care and support planning, and wrap around local support (see figure 1.1; page 8). It was considered that this model made sense to the frontline staff members more than previous models, as it helped staff to understand a patient
focus, how to adapt it to their needs, and how the workforce could facilitate this approach. For example, it was explained that:

“I think it really helps, you understand that this is not just about statutory services this is about the people, about doing what works and fits for them. I’ll say when we’re talking to different groups, ‘you will recognise people that you are supporting at all of these levels’ It is easy to relate to, it’s easy to see where your service, whether you’re a voluntary service, whether you’re the managed care network for mental health, or whether you’re care home provider. You can see where you fit in with that, you can see the part you play.” (P1).

Participants also considered that this model was more patient-centred, as it did not distinguish between organisations, making the principles the responsibility of all partner organisations and professions. This also allowed for the model to be adapted to each locality, for their population. It was explained that the main differences for teams going live with the new model included:

- A shift to a whole population approach: Along the spectrum of need from the public health self-care prevention agenda, all the way up to those who have complex needs and levels of frailty and need multidisciplinary support

- Developing core teams: While some areas already have an MDT approach, there is not necessarily the right people in place, so there needs to be a readjustment around who their core team is.

- Roles: Each area will have a Neighbourhood Team lead (it has been agreed that these will be substantive posts rather than on a secondment basis), a clinical GP lead, a project manager (more short-term basis). The clinical lead will be expected to work together with the Neighbourhood Team lead and be champions for the programme amongst their peers.
• Recognition of transformational change: There needs to be a programme of work in each locality and not just ‘tinkering around the edges’. This is all about having a different conversation and moving from a medical model to a social health prevention model. This is a massive challenge for workforce and the public and is likely to take between five and ten years to really see a shift.

**Theme 2: Multidisciplinary team working and engagement**

In terms of partnership working, participants considered that there were currently good working relationships within the pilot team and with community third sector services. An advantage for engagement within the pilot team was perceived to be that their immediate core team line managers sat on the project group, enforcing the Neighbourhood Team way of working within their wider teams. However, the engagement of primary care and GPs was considered to remain to be significantly challenging. GP engagement was highlighted as being critical, and that they played an important role in both supporting and delivering the Neighbourhood Teams. However, it was also considered that there had been some difficulty in getting the right message across to GPs, with a lack of understanding of their relevance to the Neighbourhood Teams and how they fit within the model. This was also perceived to contribute towards a lack of engagement and GP distance from the integrated concept. While participants commented on the experiences of some GPs being engaged with the process, issues were considered to include the variation in application and success of the Neighbourhood Teams. This included lack of implementation at scale and pace. The federation of GP practices was also identified as a contributory factor for the lack of engagement with the Neighbourhood Teams process. For example:

“Some of them think we’ve done it before and we’ve just called it something different and we’re trying it again. I think some areas because GPs are federating they’ve got a different approach.” (P1)
The variation in GP engagement was continued to be perceived by participants to be due to professionals needing to experience and see the benefit of this new way of working, before they would engage with the process. It was evident to participants that GPs own professional and individual level of experience needed to be shifted in order to promote partnership working with the wider team. The need to sell it to GPs was also continued to be identified as an important enabler of engagement. A particular challenge of the engagement of some GPs was considered to include a lack of understanding of the Neighbourhood Working vision and focus on working in partnership within the community. For example:

“We have a challenge with particularly one area in the county that is trying to develop an exclusive team, rather than an inclusive team. So we’ve having to do quite a bit of work with them around changing their thought processes and where they are, and that’s been led by GPs, it’s very much a GP federation saying, “we want this, this and this to support us”, and what we’ve been clear about all along is this is not about wrapping care and support around the primary care and GPs this is about wrapping care and support around your community”. (P2)

In terms of the MDT meeting, in order to promote a business as usual approach, participants explained that staff at the pilot site were now being encouraged to see this as team protected time, rather than an MDT meeting. It was rationalised by participants that the process needed to be normalised and that patient care needed to be discussed in an integrated and multidisciplinary manner at all times. However, it was reported by participants that the variation in the MDT meetings across the county remained, with some meeting weekly, fortnightly, monthly, and some not meeting at all. The difficulty of moving to a business as usual approach was also noted due to the substantial shift which was needed to develop Neighbourhood Teams from MDTs to a whole population approach. For example:

“Our challenge around Neighbourhood Working, is the journey we’ve been on. It started as MDTs, some once a week, a fortnight, a month. Now were talking
about a whole population, this is what we will do every day, business as usual, core teams, networks, community (P2).

It was also explained that in one area, MDT working was currently very new to them, which was evident in some of the behaviours currently being observed. In addition, there was particular reference to the inability for some people to see other organisations as partners. Some of this variation was also perceived to be due to the people working in particular areas, the level of seniority, and the lack of organisational commitment and support. Developments for the core team also considered a snowballing effect which eventfully included everybody involved in patient care. However, a lack of integration outside MDT meetings currently remained, with the experience of the complexity of integration explained to be:

“All the providers that sit outside the core MDT are busy doing their own thing sometimes. Unless you make those key contacts really early it’s difficult to keep track of where everybody is.” (P1)

Within the explanation of the difficulty of keeping track of the different providers who are involved in delivering integrated care, with some busy doing their own thing, complexity theory highlights that team members can act autonomously and are guided by internalised basic rules, expressed as either instincts or constructs (Pype et al, 2018). Individual beliefs and behaviours, alongside contrasting organisational cultures may therefore have the potential to affect engagement. Critical realism would also argue that individual behaviours have the potential to impact on the success of integration, by either by embracing change and facilitating partnership working or creating barriers due to reluctance and disassociation (Glasby and Dickinson, 2014).

Theme 3: Professional roles and responsibilities

In terms of the role of care navigation, it was considered by participants that the Personal Independence Coordinators (PIC) (formally Primary Care Navigators) had developed to become core members of the MDTs. Findings suggested that this had
been due to their organisational commitment to attend meetings, their openness and willingness to work with other organisations, and the relationships that they had built up within the teams. Impacting on these elements could have been the individual belief of the value of Neighbourhood Team working, which in turn contributed towards their engagement with the teams and other professionals. It was explained that there had been a high level of trust, purpose and value within that the core team of the pilot site (NT1), with no distinctions between clinical and non-clinical roles in providing patient-centred care existing. Staff were referenced as being confident about what this role provided in terms of early intervention and a ‘quick and easy seamless way of accessing patients and opening up to other providers’ (P1). However, as this role no longer existed within the NTs (due issues with obtaining sustained funding of the roles), it was explained that a gap in early intervention, care navigation, and hand holding (i.e. social support) had now developed. This level of support was something which was perceived to be something which was missing with professionals experiencing a gap where they would have previously referred patients to this PIC service. The need for a sustainable care navigation function was therefore advocated, with the realisation that the function of care navigation was imperative and crucial to Neighbourhood working, with CCGs also being encouraged by participants to consider funding this role. There was also the acknowledgment that implementing change was a time consuming process and that demonstrating success and outcomes was difficult. In addition, it was highlighted that despite these circumstances, staff had needed to adapt to the changing environment in which they were working. For example:

“But I suppose it is the nature of the system that we work in, that services of that kind, that are commissioned in particular ways and funded in particular ways, it’s all then got the potential to change. It can change quite quickly as we’ve found out and then actually we have to very quickly as a team work out what we’re going do it. So it’s really challenged the team to be resourceful and think differently again” (P1)
This consideration shows that the complexity of the system was acknowledged, in its unpredictability, non-linearity, dynamic, and interconnected actions which changes the context for other agents (Plsek and Greenhalgh, 2001), resulting in the workforce having to adapt to these changes in a resilient manner. This also highlights the complexity of an open system which interacts with the internalised rules of its environment, and can lead to changes in these rules impacting on changes in the team, where emergent behaviours can be seen as adaptations to the environmental conditions (i.e. self-organisation) (Pype et al, 2018).

The workforce and effective leadership was considered to be essential for progression with the integration agenda and Neighbourhood Teams. While it was perceived to be important to integrate certain professional roles into the Neighbourhood Teams (e.g. mental health and social workers), it was more important to get the right people with the appropriate commitment and approach. However, the complexity of the importance of individuals who have freedom to act (Pype et al, 2018). and their individual thoughts and action within the integrated concept, created issues for the sustainability of success and being able to transfer this success to other contexts. For example it was explained that:

“Whilst we can talk about our experiences and what’s worked and what hasn’t. The principles of integration working are the same, the operating framework is what it is, that’s what they all should be setting out to achieve, but when you say you need a CPN, a social worker, yes you need those people in terms of their professional roles but it is very much about those as individual people, their commitment, their approach, their flexibility, it’s really quite important you get the right people”. (P2)

This participant also explained that the operating framework should be the ‘golden thread throughout the Integrated Neighbourhood Working programme’, which should be achieved with a ‘local flavour’ in order to adapt to local needs and circumstances (P2).

A change in leadership was also seen by participants to have contributed towards recent progress, with shifts in the types of conversations being had. However,
challenges around some personalities and behaviours within some teams were highlighted in the development and implementation of Neighbourhood Teams. The role of leadership was therefore highlighted as being key for the potential for individuals to hinder progress rather than promote it, with the need to ‘know who your blockers are and your champions’ (P1). The essential role of trust within these teams was also further advocated. For example:

“We need the support in from the beginning, to help them develop as a team, to build that trust, because if you don’t have that trust in there, it will fall over from day one” (P2)

Participants also considered that it was important for the leadership role of the Neighbourhood Team lead to be embedded within the team, so that staff members could approach them to confirm that their plan of action was feasible or appropriate. The need to have clarity that Neighbourhood Working was significantly different to what professionals had previously experienced, and the need for reassurance was also highlighted. In addition, it was contemplated that it was interesting that team members were approaching the Neighbourhood Team lead to ask for permission for action, rather than their organisational line manager. It was explained that while staff went back to their organisations for their professional development, they approached the Neighbourhood Team lead for advice regarding this new way of working.

While the role of CLO (explained in chapter 5; page 129) was considered to be implemented as being critical to the shape, function and performance of the teams, a potential over-reliance on this role was also noted. It was explained that as professionals often waited to be told about a referral within MDT meetings, the gatekeeping nature of this role was perceived to have the potential to be to the detriment of action. Participants also explained that these roles were not considered mandatory, and the resignation of one of the CLOs presented the opportunity to ‘do something different as we know so much more now, that actually there is a different way of making that patient flow, a more seamless way’ (P1). This indicates that the
development of the Neighbourhood Teams in its approach to integration had been influenced by a level of learning throughout the implementation process.

Due to past experiences of contrasting cultures within the organisations integrated into the Neighbourhood Teams (highlighting the impact of the complex history of the teams), surprise at the shift in mind-set of adult social care was noted. However, the issues of contrasting cultures discussed within the literature review (see page 50), presents challenges for embedding and sustaining the new roles and ways of working within integrated care initiatives. While it was perceived that staff members from this organisation would present the most challenge of adapting, it was considered that they had shown the most progress in ways in which they worked. For example it was explained that:

“Adult social care are now getting involved in challenges and conversations from a health, medical, and nursing point of view... You see that shift in behaviour and they just see that as theirs to do now, and they will just pull relevant people in when they need to.” (P1)

It was also advocated that clarity was needed that it was everybody’s responsibly to share the learning with their colleagues and starting to bring more people on board with that way of working.

**Theme 4: Contextual factors and challenges of integration**

In reference to factors which presented challenges to integration, participants considered systems and governance to present significant issues for the Neighbourhood Teams initiative. Participants explained that the outcomes framework had been a particular challenge due to organisations using different systems and having to report particular outcomes and measures. The most frustrating barriers and challenges of Neighbourhood Working were considered to be information governance, information technology, and estates. These strategic challenges therefore focus on the barriers associated with system integration at the macro level, and functional integration; rather than those associated with clinical,
organisational, and professional integration at the micro and meso levels. In addition, while challenges related to normative integration are not highlighted in this regard, the essential role of trust and commitment within these teams were highlighted as important features. It was also explained that certain organisations could still not access key patient care software packages. However, the implementation of a care portal was perceived to be key to the development of staff integrating virtually. This was also considered to present the opportunity to break down some of the mentality that working decisions were only made within MDT meetings. The new model of Neighbourhood Working was also perceived to allow professionals to obtain a different kind of information about individuals, ‘which you can’t access when you’re doing tick box exercises and feeding our beasts of systems’ (P1). It was also explained that professions such as nursing, did not always have the chance to obtain certain patient information, with the system perceived to be a barrier to deliver optimal patient care. For example:

“We don’t understand what makes them tick, and what a good day feels like and what they’re going to cope like when things go wrong, we just don’t seem to get that information… The systems we use I don’t think help, we seem to have lost of the ability to assess-plan-implement, like we were taught to as nurses”. (P1)

Giving people permission to break the habit of box ticking was also advocated. It was explained that due to historical ways of working, certain elements would not show up within individual organisations’ performance meetings if this box ticking process did not occur. Due to the inability to share the right information between organisations and services when people moved between them, system and local level permission to work in a different way was therefore promoted. It was also explained that there was the need to challenge the system, due to different organisations using different assessment tools (all covering similar domains to the Edmonton assessment and personalised care and support planning). The Edmonton Assessment System was developed in order to assess common symptoms in palliative care patients including, pain, tiredness, drowsiness, nausea, lack of appetite, depression, anxiety, shortness
of breath and well-being (Boonyathee et al, 2018). However due to the recent change of assessment tools within a particular partner organisation, they were referenced as being reluctant to make any further changes. In addition, one of the implementation barriers for delivering personalised care and support planning was perceived to include the fact providers and the community had not been set up to accept a different way of working, and were still used to traditional ways of commissioning services.

In reference to professional barriers, it was noted that there was a necessary balance between being prescriptive about action and instructing some professions on what to do, and supporting them to shape and adapt working practice and processes to deliver integrated care and partnership working. However, the difficulty of managing this was also noted. Professional and organisational barriers were experienced by participants as being present, with an example that while recommendations can be made, professions and organisations will have their own perceptions and decision making process about what would be the most beneficial approach and a plan of action. This further highlights the critical realist relevance of individual agency and culture (Byng et al, 2005), which are key for engagement with integrated care initiatives and the process of change. In addition, elements within a complex system are not always aware of the behaviour of the system as a whole, and therefore respond only to what is known locally (The Health Foundation, 2010). The history of the development of the initiative also contributes to shaping present behaviour within the system (The Health Foundation, 2010). It was also noted that while there had been a recommendation for GPs to consider clinical pharmacy as a role to support and enable integrated Neighbourhood Team working, this advice had not consistently been taken. For example:

“We recommended they (GPs) considered clinical pharmacy as a new role to support both Neighbourhood working and GP practices around freeing up capacity, not all areas have decided to go down that route, which is interesting.” (P2)
Theme 5: Expectation and reality of integration

In terms of the progression of partnership working within Neighbourhood Teams a participant noted that those staff members working within the pilot site for the Neighbourhood Teams no longer considered themselves as doing anything different, as this new way of working had been normalised. It was explained that:

“Before it was, this is what we’re trying to do. Now it’s more about the reality and what’s happened, now they have a story to tell.” (P1)

This participant also commented that the reality of an increasing number of colleagues now referring into the Neighbourhood Team suggested progression in success of Integrated Neighbourhood Working, with an additional adult social care staff member aligned to the Neighbourhood Teams. The shift in mind-set of these staff members was also noted, who were explained to now think differently to what they used to, and work in collaboration with colleagues for support. For example, it was explained that a colleague had commented on the shift in a problem-solving approach now being adopted, following engagement and alignment with the integrated initiative. For example:

“Before the Neighbourhood Team existed, I would have thought, well what am I going to do now then? I would have dealt with what I could and then left the other bits a bit unresolved. Whereas now I have a completely different mind-set and problem solving approach when I’m on duty.” (P1)

Participants also highlighted that while staff accept that Integrated Neighbourhood Working was the right approach in principle, it was considered that the feedback had suggested that in reality, the workforce had to experience the benefits before they would truly engage with the process. For example, feedback from a District Nurse included positive experiences with working within the Neighbourhood Teams and developing relationships and trust, despite initial reservations of the process. These benefits of experiencing problem-solving in practice in a collaborative manner, had therefore enabled engagement and the development of mutual trust and respect across organisational and professional boundaries:
“I was a bit dubious, although in principle it’s the right thing to do. But now I know, that that number on my phone for that social worker is a real person who has helped me out, and we’ve problem solved together, who I trust and now she trusts me.” (P1)

In reflection of the development and implementation of the Neighbourhood Teams, one participant suggested that strategic staff had originally considered that the professional barrier of facilitating and enabling organisations and professionals to work differently would be the most difficult aspect of the challenging reality of the expectation to work in partnership. However, it was considered that in reality the systems, permissions, and governance were experienced to be the most significant issues.

It was also explained that there had been recent funding obtained in the form of investment from the Better Care Fund. This fund was designed to reduce pressure on hospitals and support adult social care, by requiring local health bodies and authorities to pool existing funding and produce joint plans for integrating service from 2015–16 (House of Commons Committee of Public Accounts, 2017; National Audit Office, 2017). This provided an incentive for local areas to work together, increasing joint working and the provision of integrated services (Forder et al, 2018; National Audit Office, 2017). The impact of this fund had been the reduction of permanent admissions of older people to residential and nursing care homes, and increased the proportion of older people still at home 91 days after discharge from hospital (National Audit Office, 2017). However, despite local areas aiming to reduce emergency admissions and delayed transfers of care, in 2015-16 the number of emergency admissions increased by 87,000 (costing £311 million more than planned), and the number of delayed days increased by 185,000 (costing £146 million more than planned) (House of Commons Committee of Public Accounts, 2017; National Audit Office, 2017). This could have been partly due to the fund’s performance metrics being affected by factors which are outside of the Fund’s influence (National Audit Office, 2017). In addition, the focus on prioritising reduce emergency admissions and delayed transfers of care contributes to tensions between
local government and NHS England about how the money should be spent (Humphries, 2018).

In light of the increase in demand and constrained resources, it is suggested that the fund has yet to achieve its potential to manage demand for healthcare, support out-of-hospital care, improve outcomes for patients, or save money (House of Commons Committee of Public Accounts, 2017; National Audit Office, 2017). In addition, the Department of Health has not clarified how the Better Care Fund aligns with the STP process (National Audit Office, 2017), creating confusion. It is also suggested that the Better Care Fund merely transferred money from health to local governments, in order to mask the funding pressures on adult social care (House of Commons Committee of Public Accounts, 2017). There is also the disadvantage of juggling other policies which improve joint working (Forder et al, 2018). However, in order to address some of these issues, the Department of Health and Department for Communities and Local Government have published a detailed policy framework in 2017 for the implementation of the Better Care Fund in 2017-18 and 2018-19 (Department of Health and the Department for Communities and Local Government, 2017).

The purpose of the Better Care Fund within the context of the Neighbourhood Teams was perceived to be to engage GPs in particular with the delivery of Neighbourhood Working. However, the perceptions and expectations of the purpose of this funding, alongside associated decision making processes had been experienced to be variable. Potential reasons for variation in interpretation of its purpose was considered to include mixed messages and expectations of the mode of distribution of the funding. Attempting to coordinate a county-wide response with some level of consistency was reflected as being particularly challenging, with specific regard to developing appropriate operating and outcomes frameworks. This further highlights the reality of the complex nature of managing change and integrating organisations with historically different structures, processes, and outcomes measures.
Theme 6: Aspirations and future goals for care delivery

Participants’ considerations of future goals for the Neighbourhood Teams initiative included investing time in building relationships, starting small and scaling up, having a different approach to referrals, colleagues supporting the learning of others, and focusing on proactively supporting people. Quick wins were also included to be improving relationships between core team networks and partnership building. However, in reality it was acknowledged in chapter 5 that it takes a significant amount of time to build these relationships and work in an effective collaborative manner.

The personalised care and support plans were considered to be key to the future progression of integrated and person-centre care. However, it was noted by participants that this plan ideally needed to be kept with the person, rather than being reliant on systems to share this information (which are largely organisationally separate). An advantage of this was considered to be the easy access of information for paramedics, and the acute sector being able to respond to patients’ needs. However, it was also acknowledged that this also would be a substantial shift in ways of working for staff and systems and processes. For example:

“But again that’s a very different way of working, because your assessment and plan sits in your file in your folder in a certain place and they don’t see the relevance of it to everyone else but we’re encouraging the personalised care and support planning on one page profiles, throughout [name of Neighbourhood Team] and also on the ward, so that we would expect to see people coming in and out of hospital with them” (P1)

While it was considered by participants that strategic leads had been ‘tinkering’ with the Neighbourhood Teams programme for the last three years, the next eighteen months to two years was perceived to be where real transformational change would be seen, with significant difference being shown. The rationale for why progress was expected over the coming months was considered to be having buy-in from the system, and the STP process (see page 65 for an explanation and critique of these systems). The implication of this was considered to be that the county was now in a
very different place to where it was a year ago, with further improvements and impacts expected. For example it explained that:

“The STP is now the plan for [name of county], we are moving into a very different world here, and that’s only really just kicked off... I think we’re starting to see that the impact of having that plan and that team in place and starting to really hone in and focus on some of those key priorities for [name of county]...All the seven chief executives from across the health providers, CCGs and the county council, they come together on a weekly basis now. So in a sense they are holding the system to account around the STP. I think Neighbourhood Working is the one thing we’re all hanging our hat on.” (P2)

This participant also explained that there had been investment into Neighbourhood Working which there had not been before (i.e. the Better Care Fund). This had resulted in the roll-out of phase two of other Neighbourhood Teams in other localities across the county (in addition to the pilot site).

The aspiration of being able to measure success, outcomes and impacts was also noted as extremely important. The use of case studies were promoted as a useful tool for showing outcomes, particularly for elements which were not tangible, with a large amount of learning perceived to have come out of the pilot team. For example it was explained that:

“That’s why we want to do case studies, that’s where the real power is. It’s not in a graph showing a trajectory, it’s not in a spreadsheet that tells you how many Edmonton assessments you’ve done, or how many end of life plans you’ve put in place. Because just because you’ve put the plan in place doesn’t mean it’s going to work. It doesn’t mean you will get the outcome that you want, that will be realised at a point of time down the line. They’ve all got really good stories to tell.” (P1)

However, as there were still currently only small numbers of patients, the challenges of showing outcomes and performance indicators from a system point of view was also acknowledged. It was explained that the development and implementation work
currently being done within the Neighbourhood Teams was not necessarily going to show outcomes at this point in time (such as reducing unnecessary admissions and A&E attendance). The difficulty of showing the success and the impact of partnership working was explained:

“All of its going to be retrospective, we’ve got to be really mindful that wherever information is shared that that’s actually reflective of the reality and the narrative that goes with that. It’s not just seeing a trend on a graph, there’s so many interdependencies as to why that would be like that.” (P1)

It was considered that the time that it takes in order to show an impact that work such as the personalised care and support plans have on unnecessary admissions and people dying in their chosen place of death, may take up to 18 months to realise. Due to a historical process of number crunching, the unease of reporting outcomes in this manner was also highlighted. This raised concerns about the outcomes framework that had been developed and the level and type of evidence needed to show impact. Particular concern was expressed that if system outcomes were not shown, that the interpretation would be that the integrated working had not been successful. Participants’ aspirations for future evaluation of the Neighbourhood Working initiative therefore included considering outcomes for the system, workforce, and the people. Being able to build an evidence base which differentiated between different levels of change was considered to be extremely important, as this would highlight that although there may not have been an impact on the system, the impact at the individual level (on the local people or the workforce) may have been significant. While building effective relationships and trust were also seen by participants as important outcomes of success which needed identifying, this was an element which also takes a considerable amount of time to achieve. For example, it was explained that it had taken six months in order to get the pilot site into ‘a position where they were able to have different conversations, they were working collectively, and really understood each other’s roles’ (P2). In addition, building effective relationships amongst health and social care services who have contrasting cultures is a somewhat challenging yet important task (Lyngso et al, 2016; Scott et al, 2003a).
It was explained that as the Neighbourhood Teams approach was a significant change in ways of working, its time consuming nature would add to the complex nature of working in partnership and showing impact and outcomes:

“The team do work really well and they do trust each other’s judgement but that takes time to build just because you have people aligned to a team, and they are turning up to talk about patients every fortnight, it doesn’t mean you’re going to get the outcomes that you expect straight away, because this is really different...giving permissions and freedom to work in a different way, and that takes time to build.” (P1)

The issue of Neighbourhood Team case reports (see appendix 14 for an example) which just showed numbers of referrals, the source of the referral and case manager was highlighted by one participant as not demonstrating any impact or outcome. They explained that while you may have a certain number of referrals, that did not necessarily mean that the right outcome was achieved. The disadvantage of focusing on number crunching also meant that important indicators of success such as effective partnership working were being missed. For example:

“I think we’re a little, there’s a bit of were the victims of our own success, because just when we’re talking about reporting and number crunching numbers of referrals there’s a lot of conversations that happen in those offices with hot-desking, just pure opportunity that stop a referral being necessary in the first place because actually you just sort something out, or actually you talk about it and realise there is actually another way...and it doesn’t come to the Neighbourhood Team because people are prepared to get on with it. Capturing that is really difficult.” (P1)

However, there was the acknowledgment that pressure on the Neighbourhood Teams to hit the targets for this year had reduced significantly, with the recognition from STP leads that this process takes time to show outcomes.
Chapter 8: Results - Triangulation

As discussed in the methodology chapter (page 83), triangulation refers to the methodological approach where more than one method is utilised to examine the same research problem; contributing to the validity and credibility of research findings, and providing a more complete picture (Hesse-Biber, 2010; Farmer et al, 2006; Lincoln and Guba, 1985; Jick, 1979). The main aim of triangulation is to explore complementarity (offering complementary information on the same issue from various data sources), convergence (where findings from each method agree and come together to form a new whole), and dissonance (unexplained divergences/contradictions of findings) (O’Cathain et al, 2010; Farmer et al, 2006; Erzerberger and Prein, 1997; Foster, 1997). Exploring these aspects provides a better understanding of the research questions, even where there may be discrepancies between methods (O’Cathain et al, 2010; Moffatt et al, 2006). These methods therefore provided a greater understanding of the development and implementation of the Neighbourhood Teams from the perspective of a variety of staff members, which may either compliment or diverge, demonstrating the power and utility of mixed methods. Triangulation therefore allowed for multiple perspectives to be brought together (i.e. mixing of data sources) in order to answer the overarching research question: “How has the concept and strategy of integrated care been developed and implemented in order to provide health and social care within a local population?”

As detailed in the methods chapter, methodological triangulation was utilised to compare results from four methods of data collection (i.e. two sets of interviews, PAT survey results, and field notes) and data triangulation was utilised to account for the range of perspectives which were represented within the results (strategic versus operational staff members and practitioners) (Denzin, 1978). These types of triangulation were utilised after separate analysis of the different qualitative and quantitative datasets, in order to generate further understanding from the research (O’Cathain et al, 2010; Farmer et al, 2006). As detailed in the methods section, semi-structured interviews were conducted with strategic staff members from the
Neighbourhood Teams (n=10), to explore their perspectives of the strategic development and implementation of the integrated approach to care delivery (study 1). The findings from these were used to inform the decision to utilise the Partnership Assessment Tool and distribute it to a separate sample of operational staff members and practitioners (n=30), in order to explore their experiences of working within the integrated care model (study 2). As the findings from studies 1 and 2 had not brought clarity of the integrated approach, additional semi-structured interviews were therefore performed with key transformation leads (n=2); in order to enable further understanding and provide a more complete picture of the development and implementation of the Neighbourhood Teams (study 3). Field notes which were collected during attendance at the Neighbourhood Team meetings were also used in order to further improve understanding and a fuller picture of the research problem (see appendix 24).

8.1 Triangulation protocol

The approach to triangulation and integration was based on the triangulation protocol and methods proposed by Farmer et al (2006), which is also relevant to mixed methods studies despite being developed for multiple qualitative methods (Hopf et al, 2016; O’Cathain et al, 2010). This protocol was developed in response to the argued lack of detail within the literature of the nature of this analytical process (O’Cathain et al, 2010; Farmer et al, 2006), and in order to document and clearly articulate the process which had aided the development of the integrated findings (Farmer et al, 2006). The triangulation protocol was well informed by their experiences as qualitative researchers, the existing literature, and the research experiences of the national Project Advisory Group (Farmer et al, 2006). As it is suggested that this technique includes the most detailed description of how to carry out the triangulation process (O’Cathain et al, 2010), this technique was therefore utilised. The use of a triangulation protocol was also deemed appropriate within the context of a pragmatic stance within mixed methods research (O’Cathain et al, 2010; Mays and Pope, 2000). Triangulating different data sources (i.e. types of
respondents), case study contexts (i.e. multiple Neighbourhood Teams, and methods (i.e. interviews, field notes, survey) also allowed for the credibility and the transferability of the findings to be enhanced (Farmer et al, 2006).

This technique was also adopted as it triangulated findings at the interpretation stage rather than analysis stage, as comparisons are made of the findings from different data sources, which captured the views of different participants within each study. Alternative examples of techniques which triangulate findings at the analysis stage includes ‘following a thread’ (Moran-Ellis et al, 2006) and ‘mixed methods matrix’ (Miles and Huberman, 1994). However, these are often used where the same participants or ‘single cases’ are used across different datasets to make comparisons, or concurrently collect data from qualitative and quantitative components (O’Cathain et al, 2010; Adamson et al, 2009; O’Cathain et al, 2008). In addition, developing a common analysis of a diverse set of data without losing the characteristics of each type of data, presents a challenge for integrated analysis (Moran-Ellis et al, 2006).

A triangulation protocol was applied to interpret and integrate key findings from the three studies and field notes (identified in the sorting stage), in order to identify areas of agreement, dissonance, and silence across the methods and data (Farmer et al, 2006). The protocol includes steps of:

- Sorting (dataset preparation)
- Convergence coding scheme
- Convergence assessment
- Completeness comparison
- Researcher comparison
- Feedback
8.1.1 Sorting and data preparation

The first step of sorting and dataset preparation involved sorting key findings from each dataset into similarly categorised segments which addressed the overarching research question, to determine areas of content overlap and divergence (Farmer et al, 2006).

8.1.2 Convergence and dissonance coding and assessment

The second step of developing a convergence coding scheme and third step of convergence assessment, involved constructing a matrix to allow comparisons of main findings represented in the individual studies, and identify the key themes discussed in each data set (Hopf et al, 2016; Farmer et al, 2006). This coding scheme allowed the findings to be displayed and considerations to be made of where there is agreement, partial agreement, dissonance or silence between findings from different components (Hopf et al, 2016; O’Cathain et al, 2010; Farmer et al, 2006). The detail of when to apply these codes is included in table 8.1. It is suggested that silence could either be expected due to the strengths of different methods in examining different aspects of a phenomenon, or be unexpected in which case the level of understanding would then be increased (O’Cathain et al, 2010).

Table 8.1: Convergence coding scheme for triangulation protocol (Hopf et al, 2016; Farmer et al, 2006)

<table>
<thead>
<tr>
<th>Coding label</th>
<th>Convergence coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreement (A)</td>
<td>The finding was identified in a particular study.</td>
</tr>
<tr>
<td>Partial agreement (PA)</td>
<td>The finding was partially covered.</td>
</tr>
<tr>
<td>Dissonance (D)</td>
<td>There was disagreement or contradiction in the findings.</td>
</tr>
<tr>
<td>Silence (S)</td>
<td>The finding was not covered.</td>
</tr>
</tbody>
</table>
Bringing together themes from the two sets of strategic interviews, the PAT and Neighbourhood Team meeting field notes, facilitated the identification of overriding ‘meta-themes’ and findings which cut across the findings from different respondents and methods (O’Cathain et al, 2010; Farmer et al, 2006). These themes are therefore represented across both process and impact elements of the theoretical framework.

The key themes developed from convergence or dissonance coding and assessment, form the rows of the convergence coding scheme used to summarise similarities and differences between the four datasets (table 8.2). These four datasets includes:

- I.S.I (S1) = Study 1-Initial Strategic Interviews (see chapter 5)
- PAT (S2) = Study 2-Partnership Assessment Tool (see chapter 6)
- S.S.I (S3) = Study 3-Supplementary Strategic Interviews (see chapter 7)
- F.N = Field Notes taken during NT meetings (see appendix 24)

Bold font indicates either agreement or partial agreement across all four datasets. While the interviews did not produce information about how participants interacted or behaved outside the context of the interview environment (Green and Thorogood, 2018), these findings are validated by contextual field notes and observations collected during attendance at the Neighbourhood Team meetings.
### Table 8.2 Convergence coding matrix

<table>
<thead>
<tr>
<th>Focus and purpose</th>
<th>Key Themes and Findings</th>
<th>I.S.I (S1)</th>
<th>PAT (S2)</th>
<th>S.S.I (S3)</th>
<th>FN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lack of clarity of concept and consistency in the understanding of aims and objectives of the NTs.</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>S</td>
</tr>
<tr>
<td></td>
<td>Unintentional focus of the NTs on the core MDT.</td>
<td>A</td>
<td>PA</td>
<td>A</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>A shift is needed from reactive to proactive care.</td>
<td>A</td>
<td>S</td>
<td>A</td>
<td>PA</td>
</tr>
<tr>
<td></td>
<td>Patient focus is needed rather than organisational focus.</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>There is a need to actively identify the appropriate population and adapt to local needs.</td>
<td>A</td>
<td>S</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>Working in partnership across organisational boundaries is the right thing to do in principle.</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>MDT working and engagement</td>
<td>Individuals and the relationships that they develop within MDTs are often the key to the success of integration.</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>There is variation in attendance and engagement of MDTs, with a lack of integration outside of the MDT.</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>The integration of the voluntary/third sector is beneficial.</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary care and GP engagement is key yet difficult to obtain and sustain.</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A lack of organisational commitment and trust will affect the success of integration.</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>Mental health had not been as successfully integrated as the other core organisations.</td>
<td>A</td>
<td>A</td>
<td>S</td>
<td>D</td>
</tr>
<tr>
<td>Professional roles and responsibilities</td>
<td>Care navigation is a key role within the NTs.</td>
<td>A</td>
<td>PA</td>
<td>A</td>
<td>PA</td>
</tr>
<tr>
<td></td>
<td>Medical/clinical leadership is an important feature of the NTs.</td>
<td>A</td>
<td>A</td>
<td>PA</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>Having the right workforce and leaders, alongside a level of consistency, is crucial for progress.</td>
<td>A</td>
<td>PA</td>
<td>A</td>
<td>PA</td>
</tr>
<tr>
<td></td>
<td>An understanding of other professions and organisational roles is a key component for integration.</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>There is a lack of clarity of responsibilities within the NTs.</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Contextual factors and challenges</td>
<td>Barriers and facilitators include workforce and skill mix, primary care engagement, resources, information governance and the integrated care system.</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>Patients can get missed or lost in the process due to fragmentation and varying practices.</td>
<td>A</td>
<td>A</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td></td>
<td>Organisations continue to perform multiple and different assessments (duplication).</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Expectations and reality</td>
<td>There has been a loss of momentum, as while the initial NT concept was promising, the reality of integration is complex.</td>
<td>A</td>
<td>A</td>
<td>S</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>Investment in the NTs is needed in order to successfully integrate.</td>
<td>A</td>
<td>S</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>Starting small and scaling up is a more successful approach than trying to change too much too soon.</td>
<td>A</td>
<td>S</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Future goals and changes</td>
<td>A different approach to referrals is needed.</td>
<td>A</td>
<td>PA</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>MDT working needs to be business as usual, rather than an add on to normal working duties.</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>PA</td>
</tr>
<tr>
<td></td>
<td>A different approach to measuring outcomes and impacts is needed.</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>PA</td>
</tr>
</tbody>
</table>
**The focus and purpose of the integrated concept:** There was agreement across all four datasets and strategic and operational and practitioner staff groups, that working in partnership across organisational boundaries was the right thing to do in principle, and that this required a patient focus rather than an organisational focus. However, a lack of clarity of concept and consistency in the awareness and understanding of the aims and objectives of the Neighbourhood Teams was identified in all three studies (which included staff members at different levels). For example in study 1, while participants who worked within the CCG were aware of the aims and objectives, there was an apparent lack of strategic clarity of these within partner organisations. In addition, while the quantitative data in study 2 suggested that the majority of participants considered the Neighbourhood Teams to be achieving their aims and objectives, the qualitative data highlighted a lack of awareness of these, with the need for a common goal of these teams to be defined. The silence of these considerations within the field notes is perhaps not surprising, considering the aim of these meetings to discuss patients and work together, rather than discuss more strategic elements.

Studies 1 and 3 also identified the need to actively identify the appropriate population, with a whole population approach advocated (as opposed to the unintentional focus on frail older people). These studies alongside the field notes also acknowledged that integration models and approaches needed to be able to adapt to the local needs of the intended population. There was a concern highlighted within the field notes that as the Neighbourhood Teams needed to be adapted to meet the needs of their own populations, the approach within the pilot site would not be able to be rolled out to the other Neighbourhood Teams successfully. The need for a shift from reactive to proactive care was also identified by strategic staff in studies 1 and 3. While this was not explicitly stated within the field notes, one staff member did comment that patients often declined help and support until they got to crisis level, highlighting the difficulty of implementing the prevention agenda. There was also silence from the PAT dataset; suggesting that this was more of a concern for strategic staff.
The Neighbourhood Teams were considered within the strategic interviews (studies 1 and 3) to have unintentionally developed with a focus on multidisciplinary teams (MDTs) and meetings, with those organisations not in the ‘core’ team feeling left out of the process (i.e. more organisationally centred than patient). The reality of developing teams to work in partnership was highlighted to have resulted in the Neighbourhood Teams evolving in a way which was not originally intended by strategic leads. While the PAT findings did not identify this outcome as unintentional, key differences between the ‘core’ team and the wider network were noted, with some organisations and professionals feeling that not being part of the ‘core’ team, meant that they were not part of the Neighbourhood Teams or involved in integrated working (e.g., mental health). However, the field notes highlighted that while it was the strategic vision that there was too much focus on the core MDT’s meeting and therefore wanted to phase it out, the operational and practitioner level staff commented that they found the meeting beneficial and necessary to formalise referrals. There was also apprehension and anxiety associated with the strategic decision to phase out these meetings, with considerations that this would result in more demoralisation and that staff wanted to be reassured that the core team remained the same. This highlights a disparity between the strategic and practitioner level vision and resistance to change. It was also highlighted in the field notes that staff saw the CCG input as interference, as they were only recently perceived to have shown an interest in the pilot site and its ways of working together. Practitioner level concerns was also perceived not to be fed back up to the strategic level.

**MDT working and engagement:** Successful integration was perceived across all four datasets to be due to individuals and the relationships they developed and nurtured across MDTs (including professional relationships, organisational relationships, the culture of teams, a high level of trust, and effective communication; study 2). All three studies also highlighted that the people working in the Neighbourhood Team model had the ability to either help or hinder progress. This highlights the importance of importance of individual beliefs and subjective knowledge which could affect
engagement with the Neighbourhood Teams. Developing effective relationships was therefore considered to be crucial for effective development and implementation, and considered to influence ineffective referrals and duplication. All four datasets also identified a variance in attendance and engagement within the MDTs and acknowledged a lack of integration outside of the MDT meeting (with staff considering real MDT working to only be achieved when discussing patients within the MDT meeting). Field notes highlighted the variation in attendance at team meetings, with high representation of core MDTs at the pilot site, and low engagement within the South. However, staff did acknowledge the logistical barrier of conflicting priorities to attend meetings (study 1 and field notes). Study 3 and the field notes also highlighted that providers outside of the MDT are often busy doing their own thing. For example, field notes identified that staff commented on the pockets of people doing different things such as the frailty team.

The third sector involvement within the Neighbourhood Teams was also considered across all four datasets to be advantageous, and with particular mutual benefits noted for both patients and staff in both studies 1 and 2. However, all four datasets highlighted the challenging nature of primary care and GP engagement, with a lack of understanding from GPs of how they fit within the model. This was supported in the field notes where it was identified that while GPs often did not attend MDT meetings, their engagement was important for making the Neighbourhood Teams concept work in practice. Strategic staff in studies 1 and 3 also noted that some GPs did not see the benefit of the NT model, so there was the need to sell the concept to them. This again highlights how individual beliefs and subjective knowledge can affect GPs engagement with the Neighbourhood Teams. Study 1 also reflected that GP engagement was difficult to sustain due to implementation difficulties which had meant the initiative had not been implemented as originally envisaged. Consistent organisational commitment and trust was also acknowledged as essential across all datasets. For example within the field notes, one staff member emphasised the importance of commitment to attend meetings, as staff would only have to attend one or two meetings where there was low attendance, to then form the perception that they were not beneficial, affecting their own engagement and attendance. The
principle of developing and maintaining trust within the PAT also produced high agreement from participants, suggesting a high value and importance placed on this principle. Study 2, Study 3, and the field notes also suggested better developed relationships, trust, and ownership within the pilot site (NT1).

In terms of the integration of mental health into the Neighbourhood Teams, study 1 highlighted that this core organisation often felt on the side lines. This was supported in study 2, where one participant commented that they did not feel that mental health was at the ‘core’ of the Neighbourhood Team, and considered that they felt that they should be working more closely with partner organisations. However, observations within the field notes highlighted that within the pilot site, a mental health member of staff displayed evidence of successful integration and engagement in being the most vocal member of staff within the meeting. This further highlights the differences between teams and how success can be due to individuals. This highlights how the subjective knowledge of social actors, alongside the existence of independent structures which create barriers and facilities for these actors to pursue action within the context of the Neighbourhood Teams (Wynn and Williams, 2012).

**Professional roles and responsibilities:** Having an understanding of the roles and responsibilities of other professions and organisations was considered to be a key component for integration, within all four datasets. Both strategic and operational staff (studies 1 and 2) identified that this lack of understanding, could lead to inappropriate referrals. Participants in study 1 also advocated shared responsibility for patients across organisational boundaries, but were unclear as to the responsibility the promotion of partnership working, managing change, and clinical leadership within the Neighbourhood Team. This was further complicated by the lack of leadership and ownership of the teams. Field notes also highlighted that operational staff and practitioners were unsure who was responsible for updating staff on the plan going forward and sharing information regarding referral processes. The strategic staff within studies 1 and 3 suggested that having the right workforce and leaders is crucial for progression with the Neighbourhood Teams. Interestingly
these studies also highlighted that strategic staff considered that having the right personalities and approach was more important than the right qualifications. This was partially supported within the field notes, where staff commented that the Neighbourhood Teams concept only worked with the correct attitudes and personalities within the teams.

Consistent commitment was also considered to be needed from management and leadership roles across all datasets. Study 1 also advocated a level of consistency in workforce, with reorganisations and workforce changes considered to create delays in Neighbourhood Team progression, with new members needing time to develop knowledge of the processes and embed into the team dynamic. The difficulty of managing people and facilitating an understanding of the need for change, new roles, and ways of working were also identified. Field notes highlighted that constant changes and new people coming into the team had also meant that the relationships which had been built were then lost. In terms of the important of clinical leadership, study 1 suggested that specialist clinical roles had the capacity to provide complex community care, and leadership and structure to the MDTs. The implication of the loss of specialist clinical input was also considered in studies 1 and 2 to be lack of leadership and direction of the MDT meetings. However, field notes suggested that the most developed team was the pilot site, which had worked in partnership to direct and take ownership of these meetings without, this specialist clinical input.

All datasets considered the role of care navigation within the third sector (i.e. Primary Care Navigators / Primary Independent Coordinators) to be a key role within the Neighbourhood Teams and experienced as being mutually beneficial for patients and staff. However, due to funding issues, study 3 explained that these roles were no longer currently operating within the Neighbourhood Teams, creating a gap in patient care (including early intervention, care navigation, social support). While this care navigation role was not reflected as being key within study 2 and field notes, having involvement and input from the third sector was seen to be beneficial. However, as this role was present at the NT meeting, this may have not been explicitly discussed as being essential.
**Contextual factors and challenges:** All datasets highlighted that organisations continue to perform duplicated assessments of patients. In light of this duplication, a member of staff in the field notes suggested that it would be helpful for organisations to know what other organisations offered. In addition, study 2 suggested that the reality of variation in practices of partner organisations was considered to be duplication and a silo mentality, which could lead to patients becoming lost within the process. This was supported in study 1 where the implications of challenges and barriers to integration were perceived as impacting on the feasibility of focusing on proactive patient care, increasing the likelihood that patients may get missed or lost in the process, or receive sub-optimal care. This however was not covered within the supplementary strategic interview findings (study 3) and field notes.

Key barriers and facilitators to development and implementation of the Neighbourhood Teams and partnership working were considered across datasets to include workforce and skill mix, primary care engagement, resources, information governance, and the integrated care system. For example, findings highlighted the challenge of organisations using different systems (study 1, study 3 and field notes), with strategic staff members in studies 1 and 3 suggesting that systems and information governance created significant barriers for integration. The solution to access information via GPs was noted as inappropriate by staff in the field notes, due to their busy workloads. The practicality of being able to prioritise patients within the Neighbourhood Teams, over own organisational caseloads was also noted within study 1 and field notes.

**Expectations and the reality of integration:** While the concept of the Neighbourhood Teams was considered to have been initially promising and transformative, the reality of implementation was considered to have been complex by operational and practitioners who completed the PAT. For example, while initial progression had been seen with District Nurse engagement and increased referrals into the Neighbourhood Teams, this had subsequently diminished as the development process lost momentum. This was supported by findings that explained that as the initial phase
of the Neighbourhood Teams had lost developmental momentum, the second phase was therefore designed (study 1), and that the pilot site felt that it was losing its spirit (field notes). Studies 1 and 3 highlighted that there needed to be investment from the system in order to achieve transformational change. It was also considered within the field notes that while there was commitment from people on the ground working within the Neighbourhood Teams, there was a need for consistent long-term commitment of funders which was considered to be lacking. However, study 3 also highlighted that there had been an investment from the better care fund.

The strategic staff in studies 1 and 3 suggested that trying to change too much too soon had not worked, and that there was a need to start small and scale up. For example, a lack of understanding of the associated challenges was suggested by participants in study 1 to result in a too high of an expectation placed on what the model could achieve in the timescale set. This was supported in the field notes where there was a perception that they were still trying to do too much too soon with the Neighbourhood Teams, with unrealistic time scales set. This suggests a lack of learning from experience.

**Future goals:** All four datasets considered that there had been issues with the process of referring patients into the Neighbourhood Teams, with a lack of clarity around the referral process. The wider implications of a lack of understanding of organisational and professional roles was considered within study 2 to include the occurrence of inappropriate referrals into the Neighbourhood Teams. The experience of receiving inappropriate referrals was shared by operational staff and practitioners within study 2 and field notes. In addition in the field notes, staff were concerned that referrals were not being accurately reported, with subjective rather than objective processes. A different approach to referrals was therefore advocated (study 1, study 3, field notes). For example in study 1, a shift in mind-set regarding the referral process was suggested for both staff and patients, where rather than there being a referral process, organisations should be able to utilise a model in order to identify patients in need of health and social care.
All studies identified that there was difficulty in measuring outcomes and showing impact of integrated working due to its time-consuming nature and challenge of showing impact of features which were not tangible and difficult to measure (i.e. developing relationships and working in partnership). Study 3 also highlighted the poor database of outcomes, which included case reports which just showed numbers and source of referrals. The disadvantage of focusing on number crunching was suggested to be that it did not reflect true accounts of what was happening in the team, and that important indicators of success were being missed (such as effective partnership working). The field notes also highlighted that these reports had not been sent to the CCG for a significant amount of time, and that the meetings were often cancelled. One member of staff noted their surprise that there was a perception within the CCG that the Neighbourhood Teams were working well, in spite of the lack of reporting and meetings taking place.

A lack of awareness of the impacts of outcomes of the Neighbourhood Teams was also highlighted in the PAT findings, where there was low scoring and difficulty in answering the questions within the principle of measure, monitor and learn (principle 6), and there were comments of a lack of awareness and reporting of objective outcomes within qualitative data. In reference to feedback of impacts and outcomes of the Neighbourhood Teams partnership, while the development of Neighbourhood Teams had been occurring for some time, staff in study 2 and the field notes considered that they had not been given any feedback of objective measures of impact and success. This suggests that the reality of integration means that it takes time to achieve outcomes, and that the information regarding impact that is available is not fed back to operational staff, potentially affecting morale and engagement. A different approach to measuring outcomes and impacts was therefore advocated.

It was considered across all datasets that MDT working needed to be business as usual. For example, working in partnership within the Neighbourhood Teams was seen within all three studies as an ‘add on’ to normal day to day working within their own organisations, with the inability to prioritise Neighbourhood Team working with staff members own caseloads. It was also noted in initial strategic interviews (study
1) that if everyone was working as a team, the MDT meeting would be incidental and not the main focus of the operation of the model. Neighbourhood Team and partnership working was therefore considered to have not yet achieved a business as usual mentality. Partial agreement in field notes suggested that some staff only dedicated time of one and a half hours for the MDT meeting and to work with the Neighbourhood Team, as they had no more time to give as this would take away from their daily work.

8.1.3 Completeness comparison

The fourth step of completeness comparison included comparing the nature and scope of the topic areas for each dataset, to enhance the completeness of the united set of findings and identify key differences in scope and/or coverage (Farmer et al, 2006). The majority of the findings from the three studies (see chapters 5-7) were validated within the field notes (see appendix 24). Findings that were consistent across data sources (i.e. data triangulation) and confirmed by multiple data sets (i.e. methodological triangulation), provided greater confidence in the credibility of interpretations and the potential to transfer key learnings to other similar contexts (Farmer et al, 2006). However, discrepancies were often accounted for due to the different data sources, in the strategic versus operational and practitioner perspectives. These included the identification that the staff on the ground within the pilot site felt that the focus on the MDT was appropriate (with the need for the MDT meetings to remain as a key feature), and that there was successful integration, engagement, and ownership from all members within the core organisations (with a lack of need for specialist clinical leadership). However, examples of dissonance between data sets provides the opportunity to identify further analysis to explore the source of differences (Farmer et al, 2006).
8.1.4 Feedback

Step five of the triangulation protocol includes comparing the assessments of convergence or dissonance and completeness of the key findings and themes with multiple researchers to clarify interpretations and determine degree of agreement (Farmer et al, 2006). However, researcher triangulation was not utilised, as integration techniques in mixed methods studies are often easier for single researchers, as larger teams include the management of team dynamics and responsibilities, and can be a time consuming process (O’Cathain et al, 2010). The final step of feedback of triangulated results from received from supervisors for review and clarification purposes.
Chapter 9: Discussion

The overarching research question of this research was “How has the concept and strategy of integrated care been developed and implemented in order to provide health and social care within a local population?” Participants’ considerations of the strategy of the development and implementation of integrated Neighbourhood Teams is detailed in the process focus of the theoretical framework (studies 1 and 3), and the application of partnership working in the impact focus of the theoretical framework (study 2). Chapter 8 also details the triangulation of these three studies, alongside field notes of attendance at the Neighbourhood Team meetings, which further improved understanding and provided a fuller picture of the research problem. These findings presented various transferable implications for clinical practice, management, and policy. These results are applicable to staff from a wide range of contexts and disciplines faced with navigating their way through the challenges of complexity, uncertainty, and managing change at various levels. This includes the importance of shared values, contrasting cultures, effective leadership which promotes influence rather than power, professional identify, and trust and building relationships. These factors are discussed below in relation to wider literature.

9.1 Process: the strategy of integrated care

The process focus of the theoretical framework explored the strategy of integrated care, which had been applied within a case study site within the United Kingdom. The aim was to explore the development and implementation of Neighbourhood Teams over time, the feasibility and practicalities of integration, and factors which enable or impede the development and implementation of integrated care within practice. This included semi-structured interviews with strategic representatives of the Neighbourhood Teams (study 1), and transformation leads (study 3). The qualitative aspects of these studies included working practices, barriers and facilitators, and staff experience, have also allowed for insights into the ‘softer’ cultural aspects of the development and implementation of integrated care initiatives to be examined (as
opposed to ‘hard’ system outcomes), which have been experienced as difficult to obtain (Greaves et al, 2013). These two research studies were conducted in order to address three research questions (RQ 2-4):

RQ2: How has a local approach to integrated care been developed and implemented over time?

RQ3: What is the feasibility and process of developing and implementing integrated care and integrated working?

RQ4: What are the barriers and facilitators to developing integrated teams, and implementing and sustaining integrated care?

These are discussed below in relation to study findings and the wider literature.

9.1.1. The development and implementation of the Neighbourhood Teams

This section considers how the integrated care initiative had been developed and implemented. Strategic interviews which were conducted in order to explore the development and implementation of the Neighbourhood Teams, identified the confidence of the strategic group in the appropriateness of the integrated concept. This was considered to include an integrated multidisciplinary approach to managing care for a defined cohort within the community; including a Neighbourhood network and a focus on prevention. These elements are in accordance with recent literature which considers that a population and ‘place-based’ approach with a community, network, and neighbourhood mentality, should be a central part of integrated care strategies (e.g. Goodwin 2016a; New Local Government Network 2016; Alderwick, et al, 2015). However, in light of the lack of progress of the Neighbourhood Teams at scale and pace, a need to relaunch the whole concept was expressed, with the ‘Sustainability and Transformation Plan’ (STP) identified as a potential tool for rebranding and selling the concept. As part of the implementation of STPs, ‘place-based’ approaches require local NHS organisations to come together to develop plans, with a local population focus for how services will be delivered in their area,
rather than on individual organisations (Ham and Alderwick, 2015). One of the tools to promote this way of working is in the development of the Better Care Fund (discussed in chapter 7; page 198).

While it is suggested that the Better Care Fund will not resolve the fundamental differences between the NHS and social care in terms of entitlement and eligibility, it is suggested that there is general agreement that place-based planning is an appropriate way to ensure that resources are utilised to obtain the best outcomes for individuals and populations (Humphries, 2018). However, due to failure of this fund to fulfil its potential to reduce pressure on hospitals, there is the suggestion that integration should now be delivered within the context of these STPs (House of Commons Committee of Public Accounts, 2017). The challenge for local areas is therefore to now contemplate how to build on small-scale initiatives, to create a systemic approach to improving population health across services and sectors, with system-wide plans needing the appropriate foundations in place to make these plans a reality (Alderwick et al, 2015). While it is argued that place-based planning will be critical to the future of health and social care, in order to do so it is suggested that the NHS needs to engage more effectively with local government and local populations (House of Commons Committee of Public Accounts, 2017). Networks are also prevalent within health and social care (Kodner, 2009; Provan and Milward, 2006), and are considered to promote flexibility and commitment, and address the conflicting demands of regulation and market competition present in many Western health care systems (Valentijn et al, 2013). For those with complex needs, a flexible and networked approach may be more appropriate, where a designated core team empowers and supports patients, calling on a responsive provider network when necessary (Fulop et al, 2005). The Neighbourhood Team concept therefore aligns with new understanding of the key features of integrated care initiatives, in terms of a focus on an integrated care network, with community and placed based approach. However, in practice, findings suggested that there was a lack of integration occurring outside of the core MDT, highlighting the complexity of building relationships across organisational boundaries.
Findings from the strategic interviews explained that the Neighbourhood Teams were based on the principles of various integration types highlighted in the literature review, including systemic, organisational, clinical/service, functional/administrative and normative (Valentijn et al, 2013; Lewis et al, 2010; Fulop et al, 2005). For example, participants promoted the need for a shared vision (i.e. normative integration), and an understanding of the integration strategy across organisational boundaries (i.e. organisational integration), alongside the merging of organisational and professional perspectives and cultures (i.e. organisational and professional integration). These types of integration have been suggested to all be necessary dimensions for effective integration (Valentijn et al, 2013; Lewis et al, 2010; Fulop et al, 2005). The importance of clinical and service integration is also highlighted due to the requirement for the development of multidisciplinary working and developing trusting relationships (Pike and Mongan, 2014). However, it is also considered that as these existing models of integration are heavily influenced by the provider and organisational perspectives (e.g. Valentijn et al, 2013; Fulop et al, 2005), which is useful for conceptualising integration from a professional perspective, they may be less relevant for patients who may be more concerned with relational aspects of care (Banfield et al, 2017). It is therefore yet to be seen whether this type of integration is relevant for patients, who may have different conceptualisations of relevance.

The importance of frontline staff understanding the Neighbourhood Team concept and strategy for integrated care and partnership working was recognised. The lack of perceived clarity of the purpose and focus of the model could therefore represent a potential substantial barrier to strategy engagement, which may not be being delivered in a manner which is accessible to key staff on the ground. Participants highlighted fatigue and frustration in response to the strategic vision, and the importance of providing the appropriate environment to facilitate integrated working. The necessity of strategic and organisational commitment to a model rather than getting distracted by emerging national initiatives and frameworks likely disorganise established plans was also raised. The lack of universally applied definitions of integration and integrated care also further amplifies the essential
nature of partners agreement on the details of their approach and vision, rather than ‘pick one off the shelf’ (Goodwin, 2016a, pg.1). However, as measurable outcomes in the majority of community health programmes may not emerge for three to ten years post implementation (Roussos and Fawcett, 2000), the sustainability of and commitment to community care initiatives is therefore essential.

Throughout strategic interviews, participants championed the critical need for a clear shared vision (i.e. normative integration), in order to promote engagement and commitment to the Neighbourhoods Teams. While phase one of the development process had not obtained sufficient organisational commitment, in reference to engagement with the Neighbourhood Teams and attendance at MDT meetings, it was explained that the common goals between CCGs and partner organisations had been developed for phase two of the model. This promoted shared visions and values; working towards normative integration. The need for this type of integration is reflected within the literature, which advocates the need for a significant culture change at both clinical and management levels; an absence of which may result in a lack of long-term integration sustainability (Maruthappu et al, 2015). In addition, shared values are seen as an important feature of organisational change, a lack of which has the potential for resistance and disengagement with the process (Branson, 2008). As described in the literature review, culture has been defined to include values and beliefs which characterise organisations (Schneider and Barbera, 2014). In a similar way to culture, values can also shape the behaviour of individuals and practitioners, with personal societal and professional influences (Miller et al, 2016). While structural barriers play their part in the complex myriad of integrated care challenges, organisational barriers in the form of variation in culture and values can therefore often represent the most diverse and conflicting factors (Miller et al, 2016).

The potential clashing of cultures, such as those between providers of medical services and long-term care services, or between physicians and other service providers, is argued to be one of the reasons for why many integration efforts fail (Valentijn et al, 2013; Suter et al, 2009; Boerma and Rico, 2006; Coburn, 2001; Friedman and Goes, 2001; Hardy et al, 1999; Hawkins 1998). Integration is therefore
argued to be largely shaped by professional behaviour, beliefs, and attitudes, aligning with a critical realist perspective (Shortell and Kaluzny, 2006; Ahgren and Axelsson, 2005; Huxham and Vangen, 2005). Key factors which are argued to present a barrier to culture change include ineffective leadership, perceived lack of ownership, and subculture diversity within health care organisations and systems (Scott et al, 2003a). A lack of normative integration which promotes a shared vision and work values within a system (Lewis et al, 2010; Fulop et al, 2005), and cultural processes converging values, norms, working processes and approaches (Notle and McKee, 2008; Fabbricotti, 2007) noted by participants, also suggested that a cultural change was needed around how partner organisations perceived themselves and functioned within their designated Neighbourhood Teams. Due to past experiences of contrasting cultures within the organisations integrated into the Neighbourhood Teams, highlighting the impact of the complex history of the teams, surprise at the shift in mind-set of adult social care was therefore noted. The importance of leadership within organisational and culture change in the form of integrated services is discussed further in section 9.1.2 (page 227).

Findings from strategic interviews, alongside the literature review, suggested that when designing integrated services, it is important to develop an approach which is suitable for the target population (e.g. Goodwin, 2016a; Shaw et al, 2011; Armitage et al, 2009). While there was agreement regarding the need for the integrated concept which was patient focused, there was variation in understanding of the target population of the model, the aims and objectives, and the desired outcomes. In reference to the target population for referrals, although some participants understood this to be frail older people, others noted that it was not intended to be age specific, with a whole population approach advocated. This highlights the consequences of a lack of shared vision (Valentijn et al, 2013; Branson, 2008), the relevance of individual agency and culture (Byng et al, 2005) in the existence of individual beliefs and organisational culture of what the target population should be, and the complexity of unpredictable, non-linear, and dynamic systems leading to random and chaotic behaviours and unintended consequences (Rouse, 2008; Plsek and Greenhalgh, 2001; Rouse, 2000). The implications of this was considered to be
confusion for staff referring patients into the model, who noted inappropriate referrals and an unclear referral process for mental health, adult social care, and therapy services. In addition, while participants who worked within the CCG were aware of the aims and objectives, there was an apparent lack of strategic clarity of these within partner organisations. These CCG participants explained that these included care closer to home, admissions avoidance, early assisted discharge and end of life care. However, it is suggested that the focus on outcomes such as admissions avoidance does not promote continuity of care or a culture of patient-centred care, due to a focus on the event, disease or problem (Goodman et al, 2011). It may therefore be more appropriate to concentrate on service user defined outcomes. However, the difficulty in measuring the outcomes of these types of initiatives was also acknowledged.

In addition, the delivery of healthcare operating within complex systems, where tensions are likely to be present due to separate targets, priorities, accountability and contradictory elements of competition and coordination (i.e. within the Health and Social Care Act, 2012), is exacerbated through the dominance of care decisions being made within unique contexts (Plsek and Greenhalgh, 2001). The challenge of aligning goals and working patterns across organisations with separate accountability and targets was therefore apparent, with governance and accountability making services more organisationally centred, creating significant issues for the goal of patient-centred care. As identified in the literature review (section 2.5, page 55), there is also the identification of the integrated care as a complex adaptive system (CAS) (Kuziemsky, 2016; Edgren and Barnard, 2012), with the lack of integration at any one level, having the capability to impede integration across all levels. The broad range of health and social care organisations which are required to contribute towards population health (Kodner, 2009; Axelsson and Axelsson 2006), therefore results in varying cultures, professional roles and responsibilities, and clinical approaches (Kodner and Spreeuwewenb, 2002). The key features of CAS are considered to generally include embeddedness, nested systems, fuzzy boundaries, distributed control, self-organisation, emergence, unpredictability, non-linearity, phase changes, historicism, sensitivity to initial conditions, non-equilibrium, adaptation, and co-
evolution (Holland, 2014; Plsek, 2003; Manson, 2001; Byrne, 1998). However, the boundaries of social systems are considered to be harder to define and control than in a classic CAS (Walton, 2014). For example, as there are several layers of nested systems within the health service system alone, a patient may therefore pass through multiple different practices and hospitals over an episode of care, interacting with various individual agents operating within different contexts (Long et al, 2018).

While a focus on prevention and care was advocated by strategic participants, the challenges of shifting from a reactive to a proactive approach and mentality in practice was also noted. The main barriers were considered to be the lack of resources to support this shift and the difficulty of breaking the cycle of focusing on those patients with more complex needs. This is in accordance with the challenges for the prevention agenda which are considered by the New Local Government Network (2016) to include, insufficient funding and resources to cover up front costs and lack of financial incentives. Further contextual challenges for the prevention agenda were also considered to include a lack of strong system leadership, and vision across sectors, and lack of organisational commitment (New Local Government Network, 2016). These factors were also considered by participants in study 1, who explained that while there is currently national importance placed on system leadership, the system does not promote and enable trust between organisations, due to separate working practices and accountability. This may further contribute to the lack of organisational commitment which was noted by strategic participants. In addition, health policy reforms such as the Health and Social Care Act (2012), are suggested to have resulted in a lack of system leadership at both national and local levels, and further contributed to a system of complexity and confused accountabilities (Ham and Murray, 2015).

9.1.2 The process of change

Several challenges associated with managing organisational change and developing integrated services were highlighted throughout both the process and impact focus
of the theoretical framework (including issues of accountability, trust, and professional identity. While there is a need to work together more effectively and collaboratively, integration goes beyond this notion, with the promotion of radical change in the way professionals perceive their roles and work together. As the majority of attempts to integrate services have historically included modifications of existing processes, rather than radical change needed to the whole continuum of care (Reed et al, 2005), there is therefore the need to do things differently and promote new ways of working within health and social care. However, preparing professionals for this new way of working to provide effective and efficient care and also improve patient experience, in fragile environments of uncertainty is a complex, dynamic, and challenging process. Nonetheless, organisational change is argued to be a necessary and continuing process, essential for organisations to adapt to the needs of their users, improve services, and exercise sustainability (Parkin, 2009). However, it is argued that in order to achieve the necessary transformation in patient services, radical changes need to be supported by staff at all levels (including the system/environment, organisation, team, and individual/patient) (Miller et al, 2016; Reed et al, 2005; Ferlie and Shortell, 2001).

Radical change is suggested to involve changes in values, beliefs, and practices, that underpin and give shape and meaning to structural aspects of organisations (Chreim et al, 2012; Balogun and Hailey, 2008). However, obtaining an agreement radical change from multiple actors in a health and social care setting requires a variety of enabling factors (Chreim et al, 2012). For example, different organisational factors such as embedded power and interest, alongside a lack of resources, can restrict the ability of organisations to move from one model to another (Chreim et al, 2012).

While study 1 suggested that there needed to be a larger investment and long-term commitment in integrated care initiatives, in order to achieve transformation change and see significant improvements in the delivery of patient-centred care, study 3 acknowledged that the initiative had received investment from the Better Care Fund. However, it is argued that a bolder and more ambitious framework is needed from approaches such as the Better Care Fund, where a larger pooling of NHS and social care budgets become a powerful catalyst for change, rather than as a distracting top-
down initiative affecting less than 5 per cent of total NHS and social care spending (Humphries, 2018).

Humphries (2018) advocates a significant transformation fund which shifts care away from hospitals and long-term care, towards care and prevention in people’s own homes and communities. While this is the aim of the Neighbourhood Teams, the strategic perspective highlighted that there had not been sufficient funding, to make the changes and work in an integrated manner. It is suggested that this could be achieved with a local ring-fenced health and social care budget with a single commissioner (i.e. as recommended by the Barker Commission) (Humphries, 2018). It is also argued that in order for radical changes to the delivery system to be achieved, the implementation of new models of care needs to be prioritised (Ham et al, 2012). However, this will involve a shift in attitudes towards risk-taking in order to support transformation, with local leaders playing a key part in translating the ideas of integration into practice (Ham et al, 2012). In addition, complex non-linear and dynamic interactions can result in small changes having large effects (The Health Foundation, 2010; Rouse, 2008; Rouse, 2000), which may not always be intentional or desired.

The importance of leadership within the Neighbourhood Teams was highlighted throughout the results. For example, without a clear leadership role, the Neighbourhood Teams were considered to not be sustainable as a service, with staff reverting back to habitual processes and more comfortable ways of working. This highlights the critical realist position of the importance of individual beliefs and action, team culture, and interagency working, in the development of systems of care (Byng et al, 2005). This is also therefore important for determining the sustainability of working across organisational boundaries in the form of Neighbourhoods Teams. While it was considered by participants that the appropriate people hadn’t always necessarily been given the role of leadership, the difficulty of identifying these roles within the current system and resources was identified. In addition, while the presence of effective leadership was perceived by several strategic participants to facilitate organisational commitment, culture change, and the empowerment of staff
to have the authority to change and work together. However, it was also acknowledged that there was a need for an agreement on the clinical and organisational governance to enable this to happen. In accordance with participants’ considerations of the importance of leadership throughout integration and change, leadership has been commonly suggested to be an enabler of integration within the literature (e.g. Ling et al, 2012; Curry and Ham, 2010; Suter et al, 2009), throughout all phases of developing partnerships (Jones and Barry, 2011; Weiss et al, 2002; Roussos and Fawcett, 2000). For example, the presence of perceived effective boundary-spanning leadership was found to be particularly important for the sustainability of innovative programmes in community care, via bridging cultural differences, and promoting pooled resources and power (Cramm et al, 2012; Sullivan et al, 2012; Williams, 2002). Strategic participants therefore suggested that local champions were needed in order to drive change and guide the workforce to adapt to substantially different ways of working.

Continuity of leadership is also considered to be an enabling factor for change (Singh et al, 2010). For example, workforce changes, particularly in terms of leadership and project management roles, were perceived by participants to impact negatively on the progression of the integration agenda. The difficulty of managing change is considered to be amplified without consistent project management and leadership; and often restricts integrated care initiatives to short-term projects (Maruthappu et al, 2015). It is also argued that the fluid circumstances of the changing nature of the health and social care workforce, the restructuring of services and organisations, and policy directions and priorities changing, further adds to the complexity of integration and achieving integrated care (Miller et al, 2016). The failure to achieve change within these circumstances is argued to be due to underlying patterns of relationships, decision-making, power, conflict and learning in the system remain unchanged and unchallenged (NHS England, 2018; Plsek, 2003). In a complex system where individual agents have freedom to act, these elements are suggested to be as important parts of the system as the structures and processes (Plsek, 2003). In addition to Kodner and Spreeuwenberg’s (2002) process definition of integration, in practice integration therefore requires effective leadership which is engaged, informed, adaptive and
responsive to the changing demands, expectations and opportunities of the integrated care agenda (Miller et al, 2016). The potential for structural and organisational integration and change leading to unintended short-term negative outcomes (discussed in section 9.1.3) also heightens the importance for clarity of the longer-term aims and objectives of initiatives (Glasby and Dickinson, 2014). This is further exacerbated by reorganisations compounding the ability to consider the impacts of changes over time. For example in study 1, reorganisations and workforce changes were considered to create delays in the progression of the Neighbourhood Teams development and progression, as new members of the workforce needed the time to develop knowledge of the processes and embed into the team dynamic.

Previous perspectives that change within the NHS should be driven from the top down are suggested to be misplaced within practice, due to some organisational leaders consequently waiting to be told what action to take, rather than taking ownership of the process themselves (Ham and Murray, 2015). Top-down strategies of change in health and care are also considered to be somewhat limiting (McNulty and Ferlie, 2004). Initial strategic interviews in study 1 identified that the original strategy was to not be directive in developing Neighbourhood Teams, with each locality being able to develop the teams based on their different demographic and needs across the system. However, due to variation in application of the Neighbourhood Teams model and a lack of focus, study 3 suggested that strategic leads were now more prescriptive about which roles need to be integrated within the Neighbourhood Teams (i.e. mandatory roles of a Neighbourhood Team lead, a clinical lead, and a project manager). In addition, the findings from study 2 and the field notes highlighted that participants felt that the strategic plan to divert from MDT meetings was considered incorrect and was therefore resisted. These findings also suggested a lack of operational and practitioner engagement with the strategic plan, which was considered as interference and not well informed, considering the strategic lack of awareness of what was happening within the Neighbourhood Teams.

It is therefore argued that leadership needs to be distributed to different agents within different groups and levels, in order to drive change forward (Charles et al,
It is recognised that effective partnership working requires leadership which is distributed across the organisation, decision making which is promoted from the bottom up, and leaders who are empowered to work within and across organisations where they may have a lack of hierarchical authority over others (Fischbacher-Smith, 2015; Goodwin, 2000; VanVactor, 2012). While this approach which shifts the balance of power and authority does not complement the centralised traditions of many partner organisations, it is argued that it is necessary in order for local partnerships to realise their potential (Fischbacher-Smith, 2015). In addition, as it is argued that as there is no sole leader who is in charge of a complex adaptive system, the approach should emphasise leadership rather than traditional management techniques; promoting influence rather than power (Rouse, 2008). As system behaviours are often unpredictable and uncontrollable (Plsek and Greenhalgh, 2001), behaviours of CAS can therefore usually be more easily influenced than controlled, with their management sufficiently challenging (Rouse, 2008). There is therefore the need for leaders who guide learning, rather than impose controls, and work within the system to facilitate the development of whole communities and improve whole systems of care (Kelley-Patterson, 2012).

Power is considered to be a central mechanism, which can act as barrier or facilitator to radical change (Greenwood and Hinings, 1996). While the literature on major change highlights the role of senior management (Jick and Peiperl, 2011), changes which involve managerial challenges to professional autonomy may result in a lack of engagement with and commitment to the managerial change plan (Waring and Currie, 2009). The difficulty of partnership working was also acknowledged by participants to be due to the requirement for organisations to relinquish some power and authority. While the value of partnership working was recognised, participants also noted the dominance of certain members of staff, professions and perspectives within a multidisciplinary environment. There is therefore the need to manage individual behaviours within the change process of operating within multidisciplinary environments. In addition, as highlighted in the literature review, as integrated care systems have no statutory basis, they therefore rely on the willingness of NHS
organisations to work in partnership to plan how to improve health and care (Ham, 2018). This therefore creates issues for engagement, commitment, power, authority and leadership. In addition, networks require voluntary collaboration between organisations and therefore rely on relationships and mutual interests, rather than a formal structure of authority (Valentijn et al, 2013). For example, power and authority cannot be exercised as organisations remain autonomous (Goodwin et al, 2004). In addition, a consequence of professionals being encouraged to take a shared responsibility for patients is considered to be the threat to professional autonomy, where traditional hierarchy and clear defined roles are therefore blurred (Boon et al, 2004).

9.1.3 Neighbourhood Team working in practice

As it takes a significant amount of time to develop, define, interpret, and nurture what integrated care programmes mean within their specific contexts (Goodwin, 2016a; Fulop et al, 2005), it was considered that the initiative initially attempted to achieve too much too soon. The implications of this was that the task seemed too daunting for the workforce, with the initiative losing momentum along the development and implementation journey, also impacting on the engagement from initially motivated staff. The data obtained throughout studies 1 and 3 also highlighted the reality that the majority of partner organisations within the Neighbourhood Teams, remained largely separate (i.e. not currently functioning or operating as one team). A contributing factor was considered to be organisations not working in partnership outside the formality of the MDT meetings. However, it is suggested that for integration to occur, partners need to move beyond meeting and discussing patients, and is likely to be dependent on membership, structure, leadership and capacity to develop shared values (i.e. normative integration) (as discussed in section 9.1.1 and 9.1.2) (Harris et al, 2013).

Although the focus of the Neighbourhood Team model was intended by strategic leads to be a neighbourhood approach encompassing a variety of partner
organisations working together to provide care for patients with multiple needs; in reality this was considered to be a complex aim to achieve. It was noted by participants that while the integrated care and partnership working evidence base suggests that implementing change is a challenging process, achieving this in the real world was harder than originally envisaged. Strategic findings revealed that the model had not necessarily developed in a manner which had been expected or originally intended by strategic leads. While strategic staff reported their confidence in the appropriateness of the concept (discussed in section 9.1.1), one of the main unintended consequences was the focus on the core MDTs and meetings, with those organisations not in the ‘core’ team feeling left out of the process. Key differences between the ‘core’ team and the wider network were also noted within the PAT and field notes (discussed in section 9.2). This highlights how the unpredictable nonlinear and dynamic nature of complex systems, alongside behaviour patterns emerging rather than being designed into the system (Rouse, 2008), had therefore led to unintended developments of the Neighbourhood Teams. The features of complex adaptive systems discussed in the literature review (section 2.5, page 55) are therefore considered to be apparent within the Neighbourhood Teams concept.

Throughout the strategic interviews, participants commonly cited the essential role of primary care, the challenges associated with its integration with partner organisations, and its variable engagement with the Neighbourhood Teams. Primary care is considered to be a key feature of a more integrated and patient-centered health and social care system (Miller, 2018; European Commission, 2017; WHO, 2015; Valentijn et al, 2013). However, obtaining commitment and engagement from GPs within integration initiatives and reform in primary care has been experienced to be challenging, both nationally and internationally (Barai, 2015; Crabtree et al, 2011). As primary care is viewed as a useful platform to implement integrated care, community and primary engagement is therefore considered to be essential (Maruthappu et al, 2015). Valentijn et al’s (2013) ‘Rainbow Model of Integrated Care’ advocates the importance of primary care, its similarities with integrated care (promoting coordination, continuity of care, equity of access, and public health), and its central role in integrating care within a health system. The responsibility of the
commissioning local services on behalf of the population being placed within primary care following the Health and Social Care Act (2012), has also transferred the GP role from one of ‘champion’ of the individual patient, to one of whole population needs and decision-making regarding service provision and the use of ever-dwindling public resources (Glasby and Dickinson, 2014). Evidence of the development in primary care suggests that while management and organisational support is crucial it is also variable, GP engagement is essential but extremely difficult to obtain, challenging traditional medical hierarchies can be daunting, and public and local authorities involvement is important but difficult to manage (Glasby, 2012). Individual behaviours of the workforce are considered to add to the complexity of health and social care integration and have the potential to impact on the success of integration, by facilitating change or creating barriers to progression (Glasby and Dickinson, 2014). The potential influence that individual actors have on the success of integration therefore results in significant variation in engagement with different approaches to transform services to deliver patient-centred care.

Findings highlighted the challenging nature of primary care and GP engagement across all four datasets, with a lack of understanding from GPs of how they fit within the model. Strategic staff in studies 1 and 3 also noted that as some GPs did not see the benefit of the NT model, there was the need to sell the concept to them. In addition, national drivers, building relationships, ease of access, and developing leadership roles were also considered as key factors facilitating engagement. This further highlights a critical realist perspective where individual beliefs and subjective knowledge can affect GPs engagement with the Neighbourhood Teams. Varying approaches were also considered to be needed to facilitate GP engagement, due to their different views, priorities, culture, and wider health care involvement. This suggests that a one size fits all approach was therefore not appropriate, which is in accordance with the suggestion that complex systems are inherently too complex such an approach (Miller et al, 2016; Armitage et al, 2009). This further highlights the complexity of integration, in an unpredictable, non-linear, and dynamic system, which can lead to random and chaotic behaviours and unintended consequences (Rouse, 2008; Rouse, 2000).
The impact of professional identity, power, and autonomy were identified in section 9.1.2 as contributing towards embracing or resisting change. The importance of GP engagement in change programmes has also been highlighted within the literature (e.g. Ovretveit, 2005). For example, a case study of developing community care highlighted that as physicians’ role was relatively autonomous prior to integration, the shift to community care required them to see their role differently, and relinquish some control of patient care (Chreim et al, 2012). This was experienced to be difficult, due to apprehension involved in relying on the capabilities of other health professionals, and subsequently delayed the development and implementation of the integrated services (Chreim et al, 2012). However, over a period of time, colocation had enabled understanding of each other’s roles and the development of trust between professions (Chreim et al, 2012). This was therefore argued to highlight how radical change occurs through various subsystem micro changes which are non-linear, subject to both intentional and emergent activities and events, with barriers and facilitators occurring within a variety of mechanisms (Chreim et al, 2012). The CAS principle of team members acting autonomously and being guided by internalised basic rules also relates to the challenge of professional identity (Pype et al, 2018). For example, it is suggested that the characteristics, values and norms of the profession are internalised during professional identity formation (Cruess et al, 2014; Sibbald et al, 2013). While primary care engagement was perceived by participants to be crucial, potential reasons for a lack of GP engagement and recognition of the benefits of partnership working, were considered to be the business mentality of primary care and their autonomous provider status.

GPs working within Britain have historically operated as independent contractors, resulting in the majority operating outside of NHS organisations and management structures (Glendinning et al, 2002). There is therefore years of culture embedded in how GPs and primary care practice and work with others. As GPs have traditionally owned the practices in which they work, with their businesses combining profit with public sector benefits, they are not directly managed by the government (Miller, 2017). This highlights aspects of critical realism and complexity, where the presence of individual beliefs and subjective understanding of the phenomena, are seen to
operate within open system, affecting the outcomes of the initiative. For example, the subjective knowledge of multiple social actors in this regard, alongside the existence of independent structures, can create barriers and facilitators for these actors to pursue actions, within particular contexts (Wynn and Williams, 2012). This therefore has the potential to influence the development of systems of care through individual thought and action, team culture, interagency working, and financial incentives and policy (Byng et al, 2005). However, the use of local incentive payments are one of the tools used to encourage GPs to adopt health promotion practices (Miller 2018). Nonetheless, the independent business mentality of GPs could therefore have affected their perception of the suitability of the vision for delivering care in the community (in light its threat to their professional identity), and their engagement with the Neighbourhood Teams in their lack of active participation in referring patients into the teams.

Implementation difficulties of other international models (e.g. Kaiser Permanente) have also been partly attributed to lack of physician engagement with new plans (Gitterman, 2003). In addition, it is considered to be difficult to challenge those with expertise, who have not initially been sold on a concept. The potential reluctance to engage with the Neighbourhood Team way of working was considered to be due to the anxieties associated with the perception that this would increase this level of demand for an already stretched profession. In addition, throughout the process of the research project, 6 out of 38 GP practices also closed. These anxieties have the potential to create a barrier to engagement with the Neighbourhood Team concept and a missed opportunity for a source of referrals into the teams. Contributing factors to lack of engagement included systemic complexities, business mentality, and individual behaviours. There is therefore the need to develop a multilayer commitment from various stakeholders at professional and organisational system levels when leading integrated care approaches in primary care (Valentijn et al, 2015c), alongside managing partners interests and processes from the beginning and building effective relationships (Valentijn et al, 2015d).
Interpersonal relationships and trust were considered by strategic participants to be key to the development of the model and partnership working across organisational barriers, including having the right personalities with the right skills, rather than the appropriate qualifications. However, it was suggested that due to separate working practices and accountabilities, the health and social care system did not promote and enable trust between organisations. The literature suggest that respect, trust, and building relationships are important for successful collaboration, and that time is required to build and sustain these elements (Lyngso et al, 2016; Vakola, 2013). It was also considered that successful engagement with the model and the change process could be attributable to individual staff members and the relationships that they form, irrespective of organisational commitment. Developing effective relationships was considered to be crucial for effective development and implementation, and considered to influence ineffective referrals and duplication. This highlights the importance of individual beliefs and subjective knowledge which could affect engagement with the Neighbourhood Teams.

The critical nature of individual staff members in the success of implementing integrated care has implications for the recruitment, training and education of those driving the complex and turbulent process of simultaneously developing and implementing integrated care. A review of the literature on integration of primary care and mental health services also highlighted that more information was needed regarding training, supervision, programme models, and settings, in order to further assess its effectiveness in practice (Martin et al, 2014). In order to facilitate partnership working, participants also advocated a more in-depth understanding of partner organisations roles, responsibilities, and skills. The type of information which could enable this level of understanding is suggested to include perspectives, values, assets, political environment, and history (Cramm et al, 2012). However, while several respondents promoted the utility of gaining a greater understanding of partner organisations and their roles within the wider health and social care landscape, it is acknowledged that it can be somewhat difficult for staff to find the time and space to identify the roles of other organisations and professions and how
they operate, their priorities, and the constraints they experience (Glasby and Dickinson, 2014).

9.2 Impact: application of integrated care

The impact focus of the theoretical framework explored the application of the strategic approach to integrating care in the form of Neighbourhood Teams, which had been applied within a case study site within the United Kingdom. The aim was to explore the impact of frontline staff experiences of working in the Neighbourhood Teams, and the practicalities and realities of the achieving the principles of partnership working in practice. This included the completion of a Partnership Assessment Tool (PAT), which was distributed to operational staff and practitioners in order to address two research questions:

RQ4: How has the local initiative’s approach to integrated care affected staff experience, and what impact has this had on partnership working?

RQ5: What are the practicalities and realities of integrated partnership working for operational staff and practitioners in practice?

In addition, field notes were collected of attendance at the Neighbourhood Team meetings, which further improved understanding and provided a fuller picture of the research problem. Findings are discussed below in relation to study findings and the wider literature.

9.2.1 Impact and outcomes of the Neighbourhood Teams

Partnerships as a political concept is central to both the UK’s health and social care agenda, and more broadly to an international preoccupation with the networked governance of welfare delivery (Rummery and Coleman, 2003). Operational staff and practitioners who took part in the Partnership Assessment Tool (PAT) associated with the principle of recognising and accepting the need for a partnership, with adult social
care and the third sector scoring this principle highly. There was however less agreement that this principle had been achieved within the acute sector. This could have been due to cultural barriers discussed in section 9.1.1. One particular barrier which is highlighted in the acute care mind-set, is the perception that the hospital should be at the centre of the integration process, with an acute and episodic focus on care (Lyngso et al, 2016; Shortell et al 1993). This therefore contrasts with the concept of integrated and population-based health-care delivery (Coddington et al, 2001), and the more holistic and long-term approach within primary and community care (Lyngso et al, 2016). This is reflected in the findings which also highlighted the less integrated and positive experiences of partnership working for those working with the acute sector, compared to those within the community. The complexity of the history of the development of the initiative and sensitivity to initial conditions therefore contributed to shaping present behaviour within the system and the difficulties of the team development (Pype et al, 2018; The Health Foundation, 2010). However, the issues of clashing cultures, presents challenges for embedding and sustaining the new roles and ways of working within integrated care initiatives.

In addition to the accepted need for the partnership, findings also highlighted the overall need for a patient priority and focus of the approach to integration, rather than driving a focus on organisational administrative processes (often resulting in duplicated work). A focus on the patient and quality of care is often the driving force for team collaboration, where team members acknowledge others’ expertise and seek advice from other team members (Pype et al, 2018). This was evident within the Neighbourhood Teams, particularly in relation to team working with PICs and PCN from the third sector. However, issues with collaborating with district nurses was highlighted within the PAT and field notes, in their acceptance of assessments performed by other professions or organisations, and their negative attitudes towards accepting referrals. Frontline staff members also commented on the distinct lack of engagement from GPs. This was suggested to result in a lack of partnership working, duplication, and ineffective working relationships. This highlights how team members can act autonomously and are guided by internalised basic rules which can produce unpredictable behaviour (Pype et al, 2018), affecting collaboration across
organisational and professional boundaries. In addition, this identifies how the history of the teams can affect future interactions, with the modifying influence of initial conditions (i.e. complexity theory; Pype et al, 2018). It is also suggested that there is a risk of damaging integrated health and social care partnerships in a bid to improve them, with organisational changes having the potential to damage existing relationships and present challenges for joint working in the short term (Glasby and Dickinson, 2014).

While participants scored the principle of developing and maintaining trust highly (principle 4), it was also noted that more work needed to be done to define a common purpose, goals, and to build a corporate trust within the Neighbourhood Teams. This suggests a lack of normative integration where a shared mission and work values within a system are promoted (Lewis et al, 2010; Fulop et al), and cultural processes where values, norms, working processes and approaches are converged (Notle and McKee, 2008; Fabbricotti, 2007). A focus on organisational and professional values and cultures is considered to be crucial, in order to contribute towards dealing with issues such as professional identity and professional protectionism, ineffective relationships, and trust, which can create barriers to successful partnership working (Glasby, 2016). However, there is an argued lack of consensus of the meaning of organisational culture, with competing claims on whether these cultures are able to be shaped by external influences (Scott et al, 2003a). The development and implementation of an integrated health system also requires leadership which promotes a vision that is consistent with the organisational culture (Suter et al, 2009), in order for staff to be enabled to take ownership of the process (Miller 2000; Shortell et al, 2000; Friedman et al, 2001).

Complex organisational and professional cultures therefore require consistent strategic input and distributed leadership in order to manage and implement change at various levels (Charles et al, 2018; Fischbacher-Smith, 2015; Chreim et al, 2012; Chreim et al, 2010). However, distributed leadership requires new forms of communication, interaction and power-sharing, alongside staff development (Fischbacher-Smith, 2015; VanVactor, 2012). This is particularly important when
change is associated with anxiety and fears, which can affect motivations to engage with change strategies. Due to the individual perceptions and behaviours, the workforce can therefore either facilitate partnership working and organisational change by engaging with the process or create barriers to implementation due to reluctance and disassociation (Glasby and Dickinson, 2014). However, being able to tap into and track the success attributed to individuals is significantly problematic.

In accordance with strategic findings, key differences between the ‘core’ team and the wider network were noted within the PAT findings, with some mental health professionals feeling that not being integrated into the ‘core’ team, meant that they were not involved in integrated partnership working. However, observations within the field notes highlighted that within the pilot site, a mental health member of staff displayed evidence of successful integration and engagement in being the most vocal member of staff within the meeting. This further highlights the differences between teams and how success can be due to individuals, and how the subjective knowledge of social actors, alongside the existence of independent structures which create barriers and facilities for these actors to pursue action within the context of the Neighbourhood Teams (Wynn and Williams, 2012). The field notes also highlighted that while it was the strategic vision to phase out the MDT meetings, apprehension and anxiety was associated with the decision. This was suggested to have the potential to result in further demoralisation, with staff wanting to be reassured that the core team remained the same. This highlights a disparity between the strategic and practitioner level vision and resistance to change.

Anxieties and fears were also noted by participants to be associated with organisational change and restructures. As humans can be risk adverse and feel unnerved by change, this can effect motivations to embrace and engage with such shifts and new ways of working. This also influences the perception that new ways of working and task shifting will threaten professional identity and job roles, further affecting resistance to change. In addition, while organisational and behaviour change needs to be supported by staff at all levels, there are many perspectives shaping integrated care due to individual beliefs, thoughts and action (Byng et al,
This potential reluctance to engage with the process throughout its development stages, was further explained to be due to the anxieties associated with the perception that the Neighbourhood Teams model could increase this level of demand. This in turn was suggested to affect the protective nature of organisations, subsequently contributing to the difficulty of integration and tensions in partnership working, and representing a considerable barrier to implementation.

The literature suggests that there is a difference between expressed values (i.e. what would be publically articulated in partnership settings) and implicit values (i.e. what people actually think and feel in practice), within the context of organisational patterns of behaviour (Miller, 2016; Schein, 2010). Implicit values could include the feeling of wanting to maintain the status and distinctiveness of professions, which can lead to resistance to collaborative working, despite an acceptance of the appropriateness of the approach (Miller, 2016). The potential threat to professional identity may therefore lead to a reluctance to collaborate, as it could be perceived as threatening existing professional boundaries (Masterson, 2002). Enablers of change therefore need to be recognised, developed and supported at every level, in order to then progress to create new systems from the inside out (New Local Government Network, 2016). This is also acknowledged in study 1, where participants noted that the frustrations of the barriers to working in partnership were likely to be experienced the most by the staff on the ground. In addition, the challenge of change exists for staff who need to adapt to new cultures in order to make the necessary adaptation within the work environment.

The PAT highlighted that participants recognised the value of integration and partnership working in order to deliver integrated and patient-centred care. However, despite integrated efforts to provide more holistic care, the reality was considered by respondents to currently still be substantially fragmented rather than achieving the elusive goal of integration. There therefore appeared to be significant tensions between Neighbourhood Team working as a concept versus a working model within practice. In accordance with findings from studies 1 and 3, study 2 identified the importance of individuals within the model and the relationships which
they form, and were considered to be key to the success of the implementation of the Neighbourhood Teams. Frontline staff members also considered that with senior roles only just starting to become visible, there needed to be commitment from management to coordinate roles and top down guidance on the Neighbourhood Team concept. This therefore reiterates the importance of leadership throughout all phases of developing partnerships (e.g. Jones and Barry, 2011; Weiss et al, 2002; Roussos and Fawcett, 2000). However, it is suggested that top-down strategies are misplaced (Ham and Murray, 2015) and limiting within practice (e.g. McNulty and Ferlie, 2004).

Staff working at the frontline were suggested to have not sufficiently been supported or prepared for the large-scale changes necessary to work in partnership to deliver integrated care. There also appeared to be disconnect and lack of communication between the experiences of those delivering care and decision makers. In terms of organisational understanding and commitment, one frontline member of staff also commented that due to frustrations and a lack of progress, they would be reluctant to engage with anything which was associated with the label of the strategic vision and the Neighbourhood Team initiative. This highlights the implication of disillusion amongst stakeholders on the progression of the initiative. However, the key variable of the local context of an initiative, particularly the interplay of people, relationships and processes, is identified as a key contributing factor to the lack of concrete guidelines on how to achieve integration and partnership working (Glasby and Dickinson, 2014; Thistlethwaite, 2011). In an attempt to develop a framework for evaluating the collaboration process of a partnership, Bell et al (2013) considered the following aspects to be key contributors: shared ambition and commitment, mutual gains, relationship dynamics, organisation dynamics, and process management. However, it is also suggested that while there has been a focus on organisational structures and processes, less attention has been paid to the outcome and impact on people and relationships, with managers’ awareness of these factors of professional engagement crucial for progression with the integrated care agenda (Ignatowicz et al, 2014).
9.2.2 Measuring outcomes and impact

While the concept was perceived to be promising, with potential for patient care improvements, it was considered by some participants to have fallen short in its delivery and implementation. Staff also noted a perceived lack of progress with the model, particularly in reference to the number of proactive referrals, and the inability to prioritise patients seen by Neighbourhood Team over own caseload. The difficulty in measuring outcomes and showing impact of integrated working was highlighted throughout the findings, due to its time-consuming nature and challenge of showing impact of features which were not tangible and difficult to measure (i.e. developing relationships and working in partnership). The disadvantage of focusing on number crunching and the poor database for showing outcomes, was also suggested to be that this did not reflect true accounts of what was happening in the team, and that important indicators of success were being missed (such as effective partnership working). This suggests that the reality of integration means that it takes time to achieve outcomes, and that the information regarding impact that is available is not fed back to operational staff, potentially affecting morale and engagement. A different approach to measuring outcomes and impacts was therefore promoted. The field notes also highlighted that case reports had not been sent to the CCG for a significant amount of time, and that the meetings were often cancelled. This provoked surprise that there was a perception within the CCG that the Neighbourhood Teams were working well, in spite of the lack of reporting and meetings taking place. A lack of awareness of the impacts of outcomes of the Neighbourhood Teams was also highlighted in the PAT findings, where there was low scoring and difficulty in answering the questions within the principle of measure, monitor and learn (principle 6), and there were comments of a lack of awareness and reporting of objective outcomes within qualitative data.

It is acknowledged within the literature that partnership success is difficult to measure, and involves consideration of process and outcomes (Dowling et al, 2004), where success in one may not result in success overall (Fischbacher-Smith (2015). With a historic and habitual focus on structures and processes, policy makers,
managers, and practitioners are not often used to focusing on outcomes, particularly in a problematic real world setting. However, it is suggested that both policy makers and frontline services should focus on what the outcomes are that they are aiming to achieve, before focusing on the structures and processes (Glasby and Dickinson, 2014). It is also important to distinguish between the overall outcome (i.e. reducing hospital admissions) and the processes which may facilitate achieving these goals (i.e. a single assessment process) (Glasby and Dickinson, 2014). However, as planning and implementing large-scale service changes takes time, changes to structure and process may be more reasonably expected, than significant impacts on service use and outcomes (Bardsley et al, 2013). While attempts to reduce avoidable hospital admissions attracts a high degree of policy attention, markers of success such as patient and staff experiences may be achieved earlier than the desired indicators of impact such as change in hospital use (Bardsley et al, 2013). The manner in which integrated care evidence is being generated may therefore need to be adapted in order to understand the success of approaches, with much of the available evidence on outcomes produced using quantitative methods (Nolte, 2017). It is also suggested that a focus on organisationally and structurally based conceptualisations or those which focus on cost effectiveness should be avoided (Goodwin, 2016a), with a focus on providing patient-centred definitions which concentrate on ‘caring’ to allow for a basis for objectives and measuring success advocated instead (Goodwin and Alonso, 2014).

The difficulties associated with measuring the impact of integrated efforts are summarised by Curry and Ham (2010) to include: the multiple aims of integration resulting in the criteria against which success is measured varying widely; the target populations, size of the intervention groups and the contexts may be different and difficult to compare (despite clear and consistent intentions); and some intended outcomes of integration are not easily measurable (i.e. relational aspects). As there are issues with measuring success and outcomes, it is therefore difficult to show comparable, measurable success after a short period of time. As measurable outcomes in the majority of community health programmes may not emerge for three to ten years post-implementation (Roussos and Fawcett 2000), the
sustainability of and commitment to community care initiatives is paramount. The increasing likelihood of discontinued community initiatives also provokes disillusion amongst stakeholders, in an already fragile environment (Cramm et al, 2013). Partnership literature consistently emphasises the importance of establishing a clear shared vision and strategy for implementation and change (Eilbert and Lafronza, 2005; Hardy et al, 2003; Hardy et al, 2000), in order to develop initiatives and support successful change in practice.

Despite the inconsistencies and difficulties associated with the application of integrated care, it is perceived to be a viable option for solving the problems of the fragmentation of services. The available literature on integrated care programmes and initiatives has pointed to a likely positive impact on the quality of patient care, improved health, and patient satisfaction (Nolte and Pitchforth, 2014). However, there is acknowledged difficulty in measuring the success of integrated approaches, due to the subjective and personal nature of patient care experiences, and the significant amount of time needed to show improvement in outcomes. Whilst it is possible to put a value on patient-centred care, it is more difficult to attribute a cost to this type of care (including relational and behavioural enablers such as well-developed relationships and communication). In addition, although there is a reported lack of information regarding integrated working outcomes for older people, their continued and changing needs may utilise more than one model or initiatives, following referral into an integrated care system (Goodman et al, 2011). It is apparent that integrated care still remains a relatively new concept, with its development, implementation, challenges, and roll out of new models of care remaining a challenge and in their infancy (Goodwin, 2016b).

9.3 Conclusion

Through the research studies, participants recognised the value of integration and partnership working in order to deliver integrated and patient-centred care. However, they also acknowledged the substantial difficulties of attempting to implement the complex process, with achieving this goal within a real world setting
perceived to be harder than originally envisaged. Key contributing factors of progress and success were considered to stem from the workforce, including absolute belief in the concept despite difficulties, commitment to driving the change, leadership skills, and developing relationships. It is considered that progression at scale and pace will need consistent organisational commitment, and a significant shift in behaviour and organisational culture. As the success of the integrated care initiative was largely perceived to be dependent upon the people and the relationships that they form, rather than processes, relational aspects may therefore hold increasing potential to effect the success of integrated approaches to care delivery. There is therefore the need to consistently manage change and uncertainty at all levels from policy leaders to patients (including system, organisation, team and individual levels). This has the potential to effect the impact of organisational change, and the success of integrated approaches to patient-centred care delivery.
Chapter 10: Conclusions

10.1 Contributions to practice

This thesis provides transferable evidence for initiatives aiming to integrate care across various contexts. This includes the real feasibilities and practicalities of developing and implementing integrated care initiatives across organisations, at various levels. For example, systems and processes and cultures and values were revealed as either potential enablers or barriers, with systemic, organisational, professional, and policy issues all contributing towards the complex mix of challenges which need to be navigated throughout the process of integration.

One key element which was highlighted by this case study was the sheer amount of time and commitment that it takes for change to occur, and for new cultures and ways of working to be embedded. As the amount of time needed is often underestimated, this can result in initiatives aiming to achieve too much too soon, without sufficient recognition of these elements alongside organisational and professional barriers. This can also result in disengagement, demotivation and disillusion of staff. There is therefore the need to start small and scale up once the process has been sufficiently embedded. While the importance of the workforce was emphasised throughout this research, there was a lack of workforce investment within this case study, with key positions of project management and Neighbourhood Team leads only being offered on a short-term or secondment basis. Importance therefore needs to be placed on the workforce tasked with the important yet daunting goal of integration at the outset, with support from the system facilitating consistency where possible.

The existence of practice variations within the five Neighbourhood Teams (despite the same vision, operational framework, and model) highlights the importance of the individuals and their commitment and ownership, alongside the effective development of relationships, teamwork and collaborations. A variation in the level of buy-in of the aims and objectives by individual staff members was also highlighted. In addition, despite the leadership that the other four Neighbourhood Teams had
received from the community Geriatrician, the pilot site developed to experience more progression than the other teams. This was potentially due to the opportunity to develop the teams and take shared ownership and leadership, (resulting in more advanced collaboration and teamwork). However, the pilot site also had the added advantage of co-location within a community hospital. Nonetheless, this highlights the critical nature of relational aspects of integration, shared values, collaboration, and partnership working.

Integration was perceived by strategic leads to be much harder to achieve than originally envisaged, highlighting the gap between theory and practice, and expectations and reality. A further prominent element of this case study was the importance of provider engagement, with particular regard to primary care and the challenge of engaging GPs with the process. Primary care plays an important role in going beyond integrated care and developing population health models. This heightens the need for effective feedback loops and processes of learning from both successes and challenges (e.g. utilising the Plan-Do-Study-Act cycle). However, this case study also revealed the difficulty of measuring outcomes within the context of the goal of integrated care. There is also often the need to recognise the potential for long-term impact for patients, in absence of definitive short-term system outcomes.

This research also focuses on the tensions of power and trust between different organisations and providers, including conflicting agendas, accountability targets, and funding. This in turn creates anxiety amongst teams and can promote the tendency to be territorial and protective, rather than collaborative. Effective distributed leadership which focused on influence rather than power is therefore key to overcoming these barriers to integration. However, the extent to which health and social care can successfully work in partnership within the current economic climate of uncertainty and already stretched resources and funding is becoming increasingly problematic.

Practical implications for managers include identifying and unblocking some of the barriers which impede the effective partnership working of various stakeholders. However, middle managers often do not have the power to make the changes, even
though they have been given the authority to do so. This creates challenges for achieving the elusive goal of integrated patient-centred care. Interestingly the case study revealed that staff approached the Neighbourhood Team lead to ask for permission and advice to work in an adapted way, rather than their organisational line managers. This is important for managers to identify this opportunity to empower staff to make changes, and to challenge the system and those with clinical expertise, whilst also offering reassurance and advice. Reassurance is also needed as staff can feel unnerved by change and can display professional resistance to task shifting, due to being protective of their professional identity and role within the health system.

10.2 Contributions to knowledge

Considerations of the implications for policy and practice have been explored throughout this research. This research provides robust information about contributory factors for the progression of an integrated project, and in-depth information into the process of integrating services. The implications of the practicalities involved in the development and implementation of an integrated care initiative included several transferable lessons. The findings of this research are highly relevant to those developing integrated care initiatives across international contexts. Robust case study designs and in-depth qualitative explorations into the experiences of those developing approaches to improve care delivery, add essential value to understanding the progression of integrated care initiatives and the associated barriers and facilitators. This research highlights that in order to achieve and sustain integrated care amidst current health and social care challenges (which are likely to continue to increase), we are now at a time point where necessary progression at scale and pace is dependent upon real commitment to a model and strategy, and radical changes in ways of working across all levels of the system.

Patient/person centred care creates mutual benefits at the system, organisational, and patient level. This type of care is therefore one of the main drivers and intended outcomes of the majority of integrated care initiatives. However, while delivering
care around the needs of the patient is the aim of many initiatives and policies, with the *NHS five year forward view* promoting the need for integrated care to be at the heart of policy agenda, this research suggests that organisations and certain professionals remain at the centre, rather than patients. This research provides a practical investigation of how procedurally driven integration can be affected by individual human and organisational factors and interactions. As these factors are implicit within health and social care systems, this has the potential to threaten integrated care missions within various contexts. The obstacles which professional and organisational issues create reinforces the potentially mythic nature of person centred care, particularly within the current health and social care landscape.

While technical, systemic and structural obstacles have consequences for integration agenda progression, organisational and professional barriers in the form of the variation in cultures and values often represent the most diverse challenges. As individual behaviours have the potential to either act as a barrier or a facilitator to integrated working collaboration and the development and implementation of integrated care, relational aspects of integration are therefore key. For example, aspects of critical realism and complexity were highlighted, where the presence of individual beliefs and subjective understanding of the phenomena, were seen to operate within open systems, affecting the outcomes of the initiative. Individual perceptions and behaviours also influence the level of commitment, engagement and ownership; and therefore have the power to destabilise plans and slow progress. The other side of this double-edged sword is the success of the initiatives attributed to certain individuals, with a lack of progress once these individuals’ roles changed. These individual human factors does not represent true integration and threatens the sustainability of integrated initiatives and services, irrespective of the presence of well-designed operational plans, models, procedures and frameworks.

This research suggests that while developing a workforce to include various key roles with the appropriate qualifications is deemed necessary, the individual personalities and behaviours (including their commitment and approach) are crucial for building integration and enabling relationships. Improvements in patient care require a
different kind of communication which is founded on well-developed relationships and collaborations. The role of leadership is therefore key for managing and identifying integration champions and those who present implementation and progression barriers. Consistent strong local distributed leadership focusing on influence rather than power, and a sound organisational approach are also needed in order to provide focus and direction. As relationships also need to be considered within the context and environment that they are being developed (e.g. geography, access, rurality, transport, social network), this case study acts as a lens to examine their impact.

While those projects aiming to implement change vary in their approaches, there are several universal aspects, including complex policy environments, cultural and territorial issues, resources, unclear aims and objectives, and difficulty in defining outcomes and measures of success. Managing change is also an extremely important element of working towards the integration agenda. While change is essential to implement integrated care, significant challenges exist for staff who need to adapt to new cultures in order to make the necessary adaptation within the work environment. This research also suggests that staff working at the operational level were not sufficiently supported or prepared for the large-scale changes necessary to work in partnership to deliver integrated care. There also appeared to be disconnect and lack of communication between the experiences of those delivering care and decision makers.

Integration was considered within the case study site to be much more complex than originally envisaged by those developing and implementing the model. Further appreciation is therefore needed of the level of complexity associated with the shift from working in organisational silos to delivering integrated care to the whole population, the operational constraints which create difficulties for leveraging action, that different territories create challenges which need to be negotiated, and the impact of local issues. Nonetheless, while the literature provides some examples of successful initiates and lessons learnt, in the presence of separate organisational governance and accountability, and the absence of a single model of best practice,
an adaptable approach which employs key enablers and tailoring to the needs of the population is paramount. However, it is important to be mindful that each initiative will have different starting points, financial pressures and organisational relationships. This research shows that within the UK, the development of STPs can provide a pragmatic approach, which harnesses the endeavours of local integrated approaches.

This research also contributes towards the growing body of evidence which promotes the need to see integrated care as operating within an ‘ecosystem’. An ecosystem is understood to be an organic collection of multiple interconnected actors and stakeholders involved in care provision, who hold shared values of optimum care delivery. Collaboration is considered to be a key aspect of developing and implementing integrated ecosystems. The integrated concept of Neighbourhood Working mirrors these principles, through developing networked core multidisciplinary teams, who connect with a wider neighbourhood network (i.e. the ecosystem). Ecosystems also allow for the appreciation of the adaptive and active role of people within the health and social care system, and the relationship between human factors, organisational issues, and quality care. A key implication is that no single part of the system can achieve the goals by working in silo. The vision therefore needs to be adopted and reinforced by each part of the system. This research also identifies with Socio-Technical Systems design principles, which can be applied to a range of integrated ecosystems within various contexts, in order to enhance quality and improve outcomes for both patients and providers. In addition, as health care is fostered on relationships between care providers and receivers, the impact that human interactions and the ability to build new relationships have on the redesign of services is also evident throughout this case study.

10.3 Strengths and limitations of the research

A mixed methods approach was selected for this study, in order to meet the complexities of the subject area highlighted by the literature, and provide a more in depth understanding of the research problem, than either a quantitative or
qualitative approach would provide alone (Creswell, 2014). While, pragmatism and mixed methods face some challenging methodological questions of how to combine different methods which might be rooted in different philosophical traditions (Green and Thorogood, 2018). Nonetheless, it is argued that quantitative and qualitative approaches can be combined in order to study complex social phenomena, as complexity itself consists of both interpretivist and positivist phenomena (Sale et al, 2002). While the volume, complexity, and varied formats of qualitative data (e.g., audio recordings, transcriptions, documents, and field notes) often lack consistent structure, they are considered to be useful for conducting a comprehensive analysis (Dey, 1993). The triangulation of data and methods also enabled further understanding and a more complete picture of the development and implementation of the Neighbourhood Teams. However, researcher triangulation was not utilised, as integration techniques in mixed methods studies are often easier for single researchers, as larger teams include the management of team dynamics and responsibilities, and can be a time consuming process (O’Cathain et al, 2010).

Semi-structured interviews were conducted in order to enable the collection of rich and detailed accounts of participants’ perspectives and experiences, and the generation of normative accounts of the Neighbourhood Teams (Green and Thorogood, 2018; Braun and Clarke, 2013). However, interviews do not produce information about how people interact or behave outside the context of the interview environment (Green and Thorogood, 2018). While purposive sampling was employed to increase the likelihood of participants ability to provide rich data and enabled the generation of an insightful and in-depth understanding of the research topic (Braun and Clarke, 2013; Patton, 2002), the lack of generalisability of findings from this sampling is also acknowledged (Bowling, 2014). However, participants also had complete anonymity throughout, to enable the sharing of honest and open responses. One advantage of utilising interviews as a method of data collection compared to focus groups is that of anonymity, where participants are more likely to be open and honest about their experiences and perceptions (Braun and Clarke, 2013). Thematic analysis was utilised in order to tell the story from participants’ perspectives, whilst also considering its broader meaning within the integrated care
initiative. As detailed in the methods section 4.2.3, while there is the potential for researcher bias and preconceptions to affect the data analysis (Bowling, 2014), it is suggested that analysis of data by one researcher is sufficient and preferred in order to aid consistency (Janesick 2003; Morse and Richards 2002; Morse 1994).

Due to the varied contexts in which integrates care initiatives are implemented, the need for case studies in which they are examined are essential, in order to facilitate an understanding of the extent and nature of integration and how particular designs emerge (Atun et al, 2010). The ability to explore the change of these initiatives over time, also enables a more detailed insight into their evolution, compared to cross-section studies (Chreim et al, 2012). Whilst the appreciation of the contribution of the barrier and facilitators of integration are transferable across settings (e.g. systemic factors and resources, complexity, leadership, organisational cultures, and developing trusting relationships), the case study nature of this study may limit the applicably of some contextual aspects (i.e. the geographical constraints of the county). However, it is argued that irrespective of cross-national differences in long-term care, countries face broadly similar challenges, including fragmented services, disjointed care, less-than-optimal quality, system inefficiencies and issues with costs (Kodner, 2006). In addition, partnerships as a political concept is central to both the UK’s health and social care agenda, and more broadly to an international preoccupation with the networked governance of welfare delivery (Rummery and Coleman, 2003).

Learning from case studies of working models of integrated care therefore provides valuable insights into the operational reality and practical examples of why initiatives may or may not be successful in their aims and objectives. As there is critical value in gaining a greater conceptual understanding and clarity of the meaning of integrated care, this also provides a real world application of theory in practice, including implementation barriers and key factors for success. The utility of case studies are also promoted where there is a need to obtain in-depth explorations of a complex phenomena in real-life contexts, particularly when boundaries between the phenomena and context are not clear (Yin, 2014; Yin, 2009). Nonetheless, it is
acknowledged that as examples of integrated care may not be directly comparable, this creates difficulty for generalisations to be made across initiatives (Robertson, 2011). This is considered within the methods chapter (section 3.4), where while case studies contribute to the understanding of wider situations, as they often explore single cases, the material they generate is often not generalisable (Bowling, 2014).

As identified in section 1.2.1, there were certain challenges involved in exploring integrated Neighbourhood Teams. This included the high turnover of staff and workforce changes within the Neighbourhood Teams initiative (including restructures, changes in job role, retirements), which created issues for the recruitment of strategic participants (chapters 5 and 7). This was exacerbated due to the short-term and secondment basis nature of key roles within the initiatives (including project management and team leads). In addition, the variation in the extent to which multidisciplinary teams had been integrated, created issues for the recruitment of operational staff and practitioners (chapter 6). In a similar vein, the variation in integration across the Neighbourhood Teams and engagement with the process, was also likely to impact engagement with this research. However, identifying these challenges and tensions generated further evidence of the issues related with the ‘people’ aspect of policy implementation within this case study.

The Partnership Assessment Tool (PAT) which was distributed to operational staff and practitioners in chapter 6 was based on extensive empirical research (Halliday et al, 2004; Hardy et al, 2000), and was therefore selected in order to assess staff members’ perceptions of the Neighbourhood Teams partnership at its stage of development. However, a potential limitation of the PAT data is the relatively small sample size of 30 participants, which would therefore decrease the power of any comparative statistical tests, and any inferences that could be made. However, as there were only 44 members of staff working at the operational and practitioner level at the time of data collection, this is the highest number of participants that the study could obtain, if there was a 100% response rate (the study achieved 70.45%). This is therefore the number of people within the integrated Neighbourhood Teams workforce who agreed to take part at the time of data collection, resulting in a relatively small sample
size being obtained. However, as minimal numbers of representatives from organisations were assigned to Neighbourhood Teams (i.e. one mental health professional), their views and perceptions of the development and implementation of the integrated initiatives may not be representative of the whole profession. Nonetheless, as representatives of the profession are aligned to teams, these individuals were the only people who had experiences of working directly within the Neighbourhood Teams.

The purpose of the quantitative data was to assess this workforce’s experiences of working in the Neighbourhood Teams, and the impact that this has had on the practicalities and realities of achieving the principles of partnership working in practice. This meant that there was a predefined sample size of potential participants. As the integrated workforce were also developing at the time of data collection, with some participants not being in their current roles for a long period of time, this may therefore have affected their ability to answer questions regarding the partnership principles in relation to the Neighbourhood Teams. The amount of time and experience of working within the Neighbourhood Teams may therefore have contributed to some variation in the data. For example, one participant commented that they had not been involved with the Neighbourhood Teams for enough time to be able to comment on their achievement in terms of measuring their impact and success.

In a similar vein, due to the advanced developmental nature of the pilot site (NT1), it could be expected that there would be more integration and understanding of partnership principles within this team. However, while chapter 6 considered any differences between Neighbourhood Teams, although there were higher ratings of principles 1 and 4 within the pilot site, no overall differences were present (see page 166). However, the pilot site did have the highest rating of strong agreement that the Neighbourhood Teams were achieving their aims and objectives. As the Neighbourhood Teams were changing throughout their developmental process, one participant also considered that as the teams were currently going through a period of transition, they could not comment on whether the new aims and objective were
being achieved. In addition, while the tool asked about the aims and objectives of the Neighbourhood Teams, findings from chapter 5 indicated that not all partner organisations were aware of these. The potential limitations of the PAT itself are also discussed in the methods 4.3 (page 103).

10.4 Personal reflections on journey
The initial aim of this research was to examine the implications of the move towards integration, in terms of the processes and impact on outcomes. However, based on the conceptual literature review and collaborations with the case study site, it was considered that this aim was too broad due to the associated complexities of integration. In addition, the impact of the practicalities and challenges of evaluating integrated care in practice on the progression of the study, were not known at the time of the development of the research protocol. The research aims were therefore transformed into more specific and theoretically based aims, which explored the real feasibilities and practicalities of developing and implementing large-scale transformation, in order to provide health and social care for defined populations. As the underlying shape of the integrated initiative was subject to change and refinement, the thesis also therefore had to adapt to these changes, in order to fit the on-going context of development and implementation.

The complex and uncertain nature of this research presented several challenges. The multiple simultaneous changes within health and social care (including workforce, organisational, operational and policy changes) presented considerable challenges for research within these areas. For example, changes in project management, strategic leads, models and operational frameworks exacerbated the already complex aim of integrating care and undermined the level of consistency needed for progression and sustainability. However, it is accepted that some of these changes are unavoidable and are inherent within health and social care landscapes. As policies within the UK can be short-term and subject to change it is also somewhat difficult for initiatives to remain up to date with changes, and for researchers to consider the extent of their impact.
While these issues are accepted to be addressed within research which focuses on large-scale transformation, it was considered by strategic staff and transformation leads (chapters 5 and 7) that they were somewhat underestimated in practice. In addition, sustaining change within the NHS is also extremely difficult. These changes were experienced throughout the process of data collection to occur at a considerably faster and more frequent rate, than the research process designed to evaluate progression with the integration agenda. Nonetheless, this allowed me to develop an understanding and appreciation for social science and real world research, which accounts for iterative and pragmatic approaches within the research process. This also informed a recognition of the impact of complexities of real world evaluation and the inherent challenges of evaluating integrated care approaches; which were used to inform the research. A conflict within health policy (e.g. the Health and Social Care Act, 2012) also remains with competition, separate targets, accountability, and organisationally-centred care, and the promotion of integrated and patient-centred care (e.g. with personal health budgets).

One particular challenge which those developing and implementing integrated care initiatives face is the many definitions of the concepts of ‘integration’ and ‘integrated care’ which exist. As discussed in chapter 2, these terms can mean different things to different people, creating wide-spread variation and application. While this has its advantages for allowing for flexibility and adaptations to different contexts depending on patient needs and local issues, confusion is often created in the space of the clarity needed. Integration can also take place and various levels (i.e. team, service, and organisation), further contributing to diversity, and often ambiguity. Nonetheless, this research process has developed my skills as a researcher including wider considerations of philosophy and methodology, the use of mixed-methods to evaluate services from various stakeholder viewpoints, managing changes in the research process out of the researcher’s control, and enhancing problem solving and project management skills.
10.5 Concluding synopsis

While integrating care around the needs of the patient is a desirable objective for the enhancement of quality care, this is often met with significant challenges once attempts are made to develop strategies within an environment of uncertainty. In light of the often underestimated lengthy process of large-scale transformation, it was apparent that the initiative remained in its infancy, with full integration yet to be seen. While a combination of relational and technical aspects of integration are necessary for progression, the success of the initiative was largely perceived to be dependent upon the workforce, rather than processes and structures. Relational aspects and increased workforce investment may therefore hold increasing potential to the success of integrated approaches to care delivery and the sustainability of large-scale transformation. However, this then raises questions for sustainability and transferability.

Despite extensive research and policy changes, this case study highlights that the difficulty of turning the concept of integrated care into an operational reality remains. It is evident that initiatives are continuing to experience similar barriers in progressing with the integration agenda and population health management (e.g. systemic, normative, organisational, and professional). Contributing factors include the necessary shift in professional skills, roles and cultures, within a system which was not designed for collaboration and integration in mind, or promoting a focus on prevention and community care. Nonetheless, robust case study designs and in-depth qualitative explorations into the experiences of those developing approaches to improve care delivery, add essential value to understanding associated barriers and facilitators. These findings are therefore highly relevant to those developing integrated care initiatives across international contexts.

Transferable key enablers for progression include a clear shared vision, organisational commitment, investing time in building relationships, cultural change, and period of stability in workforce and leadership. The need to start small and scale up, peer support, developing approaches to measuring outcomes (accounting for impacts at the individual patient and professional level), and focus on proactively supporting
people before expanding models were also highlighted. The systemic, organisational, and professional challenges which were experienced are also likely to be represented across initiatives aiming to integrate care. Due to the complexity associated with integrated care, there is therefore no quick route to its success. Instead, the solution lies with investment over time in order to build trust, well-developed relationships, and sustained commitment; achieved through empowering staff to make the changes and work in a different collaborative way. Relationships between integrated care stakeholders is a key aspect of building a more accountable and collaborative system.

With the continued focus on integrated care systems, future research therefore needs to address how Sustainability and Transformation Plans, Accountable Care Organisations, and Integrated Care Systems have been implemented and developed in practice, the development of outcomes frameworks which account for impacts at the individual patient and professional level, strategies for strengthening relationships and trust across organisational cultures, the role of primary care in integration, and exploration into workforce planning and organisational champions and leaders. In addition, exploring the impact of integrated care initiatives on patient outcomes remains an important area of research, despite its difficulties.

10.6 Final recommendations

Managing change:

- Significant radical changes at various levels (i.e. system, organisation, team, and individual) are needed to move away from organisationally centred processes and improve care delivery. Organisational and behaviour change need to be supported by staff at all levels including politicians, professionals, and patients, with more shared ownership which allows for adaptations to local needs in delivering person-centered. Co-production also needs to promote equal partners, with cultural shift being embedded within practice.
• Where change induces fear and anxiety, more explicit provision of a clear rationale and understanding for why and how change will occur, alongside promoting a shared vision with simple goals, will contribute towards staff amenability to new ways of working. Staff need to be reassured and given permission and freedom to engage with this different way of working.

• In order to achieve the full potential of partnerships there is a need for effective and consistent distributed leadership to manage and sustain change. The process of collaboration and partnership working needs to be continuously and consistently managed and monitored throughout their development and implementation. Leaders therefore need dedicated time to fulfil their roles, and the value of effective project management and effective communication should not be underestimated.

Investing in the workforce:

• As health services run on people and not processes, it is important to provide sufficient resources and investment into developing the appropriate workforce to tackle the significant issues and challenges associated with delivering patient-centred and integrated care. There is therefore the need for support and investment from the system if transformational change is to be achieved.

• Staff need to feel valued and empowered to make the necessary changes to work in partnership. These factors are key for the improvement and development of integrated care, irrespective of differences in populations, partner organisations, and the focus of individual initiatives.

• There is a need to recognise importance of certain professional roles and for them to be offered on a permanent basis (i.e. project management, team
leads, and clinical champions). The opportunities and solutions which lie with the third sector also need further exploration and investment.

Measuring outcomes:

- There is a need to develop an effective outcomes framework which accounts for important indicators, and sets realistic and measurable objectives. This includes relational aspects which demonstrate collaboration and partnership working, despite their measurement difficulty. Case studies also have their advantages for showing this type of impact.

- The majority of measures of the success of integration concentrate on systemic criteria such as reduced emergency admissions. There is therefore a need to develop an evidence base which differentiates between different types of outcomes and levels of change at the system, organisational, and patient level. Although there might not be an impact on the system, the impact at the individual person level, or the workforce may be significant.

10.7 Thesis Outputs

Conferences:


- University of Lincoln - British Sociological Association Early Career Forum (2017): Ethics, vulnerability and emotion in the research process. Oral Presentation


• University of Lincoln College of Social Science Conference (2015) - Poster Presentation

• Harrogate – Medicine 2015: Royal College of physicians Annual Conference: Delivering the future hospital. Poster presentation.

Book Chapters:

• *Designing Integrated Care Ecosystems - The development and implementation of an Integrated Care Ecosystem within the United Kingdom*

• *Knowledge, Skills and Values for Health and Social Care: Making Integration Work*

Publications:


• *BMC Health Services Research* – The practicalities of the integrated working journey: a qualitative study of the strategic perspective of developing integrated care within the United Kingdom - Peer review stage
• *BMC Health Services Research* – The practicalities of the integrated working journey: a qualitative study of the strategic perspective of implementing integrated care within the United Kingdom – Writing stage

• *Prospero: International prospective register of systematic reviews.* A systematic review of models and processes of integrated care services for older people. University of York: Centre for Reviews and Dissemination.

Presentations:


• University of Lincoln - Three minute thesis (2016) – Evaluating integrated care models

• Neighbourhood Teams engagement event (2016) – Evaluating the development and implementing of the Neighbourhood Teams

• Sheffield University - Evidence Synthesis of Qualitative Research in Europe (2015) – Synthesising qualitative research on the models and processes of integrated health and social care.

Engagement events:

• Neighbourhood Teams and Sustainability and Transformation Plan meetings

• Neighbourhood Teams engagement events

• Fit for frailty engagement event
References


List of appendices

1. Chapter 1: Neighbourhood teams development flowchart
2. Chapter 2: Integrated models and processes
3. Chapter 2: Summary of conceptualisations of integrated care
4. Chapter 2: Timeline of integration political context
5. Chapter 4: Health Research Authority ethical approval
6. Chapter 4: University ethical approval
7. Chapter 4: Timeline of data collection
8. Chapter 4: Interview topic guide
9. Chapter 4: Example thematic map
10. Chapter 4: Exampled coded transcript
11. Chapter 4: Partnership assessment principles and associated elements
12. Chapter 4: Paper version of the Partnership Assessment Tool
13. Chapter 4: Operational plan
14. Chapter 4: Document analysis - example NT case report
15. Chapter 5: Summary of research questions and thematic data
16. Chapter 6: Participant partnership principle scores
17. Chapter 6: Descriptive statistics
18. Chapter 6: Normal distribution considerations
19. Chapter 6: Rapid partnership profiles
20. Chapter 6: Partnership principles, scores and explanations
21. Chapter 6: Interpretation of partner organisation scores
22. Chapter 6: Interpretation of Neighbourhood Team scores
23. Chapter 6: Qualitative data and themes
24. Chapter 8: Neighbourhood Teams meeting attendance field notes
Appendix 1 – Chapter 1: Flowchart of Neighbourhood Teams development

Both work streams align closely with LSSR and the Better Care Fund, sharing some of the same objectives:
- Fewer people admitted to hospital
- Increase people living at home following discharge

**LWCCG Operational Plan: 2014 – 2016**

- **Main Work Streams:**
  1. Development of Integrated Frailty Pathway
  2. Development of Integrated A&E Services
  3. Development of wider services to support improved access to care

- **List of interventions:**
  1) Integrate Out of Hours Service and A&E Stream
  2) Walk-in Centre – Decommisions
  3) Review liaison psychiatric service in general hospitals

- **Benefits:**
  - By 2016 it is expected that...
    - More people will be supported at home
    - Fewer people will be admitted to hospital
    - People will be supported to return to home safely following a stay in hospital

- **Integrated element of overall Urgent Care Programme**
- **Direct action from initial LSSR blue print**

- **List of interventions:**
  1) Develop Neighbourhood Teams
  2) Care Homes
  3) Community Geriatrician
  4) Implement Diabetes Commissioning Specification
  5) Implement Dementia Model of Care
  6) Improve identification and treatment of AF
  7) Increase self-care options
  8) Improve access to specialist end of life care
  9) Commission appropriate level of intermediate care

- **Interventions:**
  - Frailty Pathway
  - Neighbourhood Teams

- **Benefits:**
  - Will be the key that explicit links are made to this ongoing programme of work
  - Central to the programme
  - Transform original 5 Integrated Community Teams – operational in supporting older people in the community.
  - Work commenced in 2012 in order to implement ICT

- **Additional Programmes:**
  - Reducing inequalities and improving life expectancy
  - Improving outcomes in cancer
  - Mental health and learning disabilities

- **List of interventions:**
  1) Improved QoL
  2) Health promotion education
  3) Self-management
  4) Care closer to home
  5) High quality, safe services
  6) Only necessary admissions to hospital
  7) Short stays in hospital
  8) Professional education for self-management
  9) Professionals’ core knowledge and roles
  10) Utilise available resources
  11) Achievement of associated national targets
  12) People with mental health conditions better supported
Appendix 2 - Chapter 2: Integrated models and processes


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<thead>
<tr>
<th>Type</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Structures</td>
<td>Organisations being merged together, the creation of new organisation, contractual agreements between two or more organisations, joint planning bodies</td>
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<tr>
<td>Support functions</td>
<td>One organisation taking on functions such as human resources (HR), finance, information technology (IT), procurement support on behalf of others, jointly outsourcing to another organisation</td>
</tr>
<tr>
<td>Services</td>
<td>Staff, funding and/or other resources are brought together from separate organisations into a single service that is jointly managed</td>
</tr>
<tr>
<td>Practice</td>
<td>Care pathways, shared guidelines and case management processes that connect the work of different professionals and services in the service user journey</td>
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<tr>
<td>Learning</td>
<td>Training and development opportunities that can be accessed by staff from different organisations and that can be jointly funded and delivered</td>
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<tr>
<td>Values and visions</td>
<td>Development of a common vision of what the separate organisations and services will achieve and the principles that will guide their work</td>
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<tr>
<td>Systems governance</td>
<td>A coming together of the outcome frameworks, performance monitoring and incentives (bought financial and reputational) through which separate organisations are held accountable</td>
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2. Valentijn (2016) – Triple aim and rainbow of integrated care

![Diagram ofTriple Aim outcomes and integrated care mechanisms]


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<thead>
<tr>
<th>Level</th>
<th>Type</th>
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<tbody>
<tr>
<td>Mirco</td>
<td>Clinical</td>
<td>The coordination of person-focused care in a single process across time, place and discipline</td>
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<tr>
<td>Meso</td>
<td>Professional</td>
<td>Inter-professional partnerships based on shared competences, roles, responsibilities and accountability to deliver a comprehensive continuum of care to a defined population</td>
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<tr>
<td>Meso</td>
<td>Organisational</td>
<td>Inter-organisational relationships, including common governance mechanisms, to deliver comprehensive services to a defined population</td>
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<tr>
<td>Macro</td>
<td>System</td>
<td>A horizontal and vertical integrated system, based on a coherent set of rules and policies between care providers and external stakeholders for the benefit of people and populations</td>
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<tr>
<td>All</td>
<td>Functional (e.g. communication and IT)</td>
<td>Key support functions and activities (i.e., financial, management and information systems) structured around the primary process of service delivery to coordinate and support accountability and decision-making between organisations and professionals in order to add overall value to the system</td>
</tr>
<tr>
<td>All</td>
<td>Normative (e.g. shared cultural values)</td>
<td>The development and maintenance of a common frame of reference (i.e. shared mission, vision, values and culture) between organisations, professional groups and individuals</td>
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<tr>
<td>Level</td>
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<td>Key Features</td>
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<td>Mirco</td>
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<td>- Centrality of client needs</td>
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<td>- Agreements on interdisciplinary collaboration</td>
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<td>- Multidisciplinary guidelines and protocols</td>
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<td>- Inter-professional governance</td>
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<tr>
<td></td>
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<td>- Clinical leadership</td>
</tr>
<tr>
<td>Meso</td>
<td>Organisational</td>
<td>- Value creation for organisation</td>
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<td>- Informal managerial network</td>
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<td>- Interest management</td>
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<td>- Performance management</td>
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<td>- Population needs as binding agent</td>
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<td></td>
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<td>- Organisational features</td>
</tr>
<tr>
<td>Macro</td>
<td>System</td>
<td>- Social value creation</td>
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<td>- Available resources</td>
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<td>- Population features</td>
</tr>
<tr>
<td>All</td>
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<td>- Human resource management</td>
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<td>- Information management</td>
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<td>- Resource management</td>
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<td>- Support systems and services</td>
</tr>
<tr>
<td>All</td>
<td>Normative</td>
<td>- Collective attitude and trust</td>
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<td>- Sense of urgency</td>
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<td>- Reliable behaviour</td>
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<td>- Conflict management</td>
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<td>- Visionary leadership</td>
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<td></td>
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<td>- Shared vision</td>
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</table>
4. Valentijn (2013) - The rainbow model of Integrated Care

<table>
<thead>
<tr>
<th>Level</th>
<th>Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Micro</td>
<td>Clinical</td>
<td>Refers to the extent to which care services are co-ordinated</td>
</tr>
<tr>
<td>Meso</td>
<td>Professional</td>
<td>Refers to the extent to which professionals coordinate services across various disciplines</td>
</tr>
<tr>
<td>Meso</td>
<td>Organisational</td>
<td>Refers to the extent to which organisations coordinate services across different organisations</td>
</tr>
<tr>
<td>Macro</td>
<td>System</td>
<td>Refers to the alignment of rules and policies within a system</td>
</tr>
<tr>
<td>All</td>
<td>Functional</td>
<td>Refers to the extent to which back-office and support functions are coordinated</td>
</tr>
<tr>
<td>All</td>
<td>Normative</td>
<td>Refers to the extent to which mission, work values etc. are shared within a system</td>
</tr>
</tbody>
</table>
5. Pike and Mongan (2014)

Based on Kings Fund (Curry and Ham, 2010), Nuffield Trust (Shaw et al., 2011), European Observatory (Notle and McKee, 2008), Canadian Policy Research Networks. All identified the same broach categories of integrative processes

<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systemic</td>
<td>The co-ordinating and aligning policies, rules and regulatory frameworks</td>
</tr>
<tr>
<td>Organisational</td>
<td>The co-ordinating structures, governance systems and relationships across different organisations</td>
</tr>
<tr>
<td>Clinical / Service</td>
<td>How care services are coordinated</td>
</tr>
<tr>
<td>Normative</td>
<td>The extent to which mission, work values etc. are shared within a system</td>
</tr>
<tr>
<td>Financial</td>
<td>The budgetary and payment systems in place across the participating organisations</td>
</tr>
<tr>
<td>Informational</td>
<td>The clinical and managerial information systems to support practice across different care settings</td>
</tr>
</tbody>
</table>
### 6. Ernst and Young (2012)

<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional</td>
<td>The extent to which key support functions and activities such as financial management, human resources, strategic planning, information management and quality improvement are coordinated across operating units.</td>
</tr>
<tr>
<td>Organisational</td>
<td>The creation of networks, mergers, contracting or strategic alliances between healthcare institutions. This type of integration can be achieved through mergers or structural changes or through contracts between separate organisations (NHS Confederation, 2006).</td>
</tr>
<tr>
<td>Clinical</td>
<td>Extent to which patient care services are coordinated across the various personnel, functions, activities and operating units of a system. This type of integration will include the following consideration: ‘at the clinical team level, is care for patients integrated in a single process both intra- and inter-professionally through, for example, the use of shared guidelines along the whole pathway of care?’ (NHS Confederation, 2006)</td>
</tr>
<tr>
<td>Professional</td>
<td>Joint working, group practices, contracting or strategic alliances of healthcare professionals within and between institutions and organisations.</td>
</tr>
</tbody>
</table>

Two elements or processes of integration that are described by F as crucial to determining success:

<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Normative</td>
<td>Shared values play a key part in coordinating and securing collaboration in the delivery of care.</td>
</tr>
<tr>
<td>Systemic</td>
<td>Rules and policies are coherently implemented at the various levels of the organisation.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systemic</td>
<td>Coordinating and aligning policies, rules and regulatory frameworks at all organisational levels. This is sometimes termed as ‘integrated delivery system’ (Fulop et al., 2005).</td>
</tr>
<tr>
<td>Normative</td>
<td>Developing shared values, culture and vision across organisations, professional groups and individuals.</td>
</tr>
<tr>
<td>Organisational</td>
<td>Coordinating structures, governance systems and relationships across organisations.</td>
</tr>
<tr>
<td>Administrative</td>
<td>Aligning back office functions, budgets and financial systems.</td>
</tr>
<tr>
<td>Clinical</td>
<td>Coordinating information and services and integrating patient care within a single process.</td>
</tr>
</tbody>
</table>
### Type Definition

<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical</strong></td>
<td>Aim to achieve consistent clinical standards across different settings (e.g. across community clinics, hospitals and day centres), underpinned by guidelines in clinical settings, or shared working practices (e.g. shared single assessment).</td>
</tr>
<tr>
<td><strong>Organisational</strong></td>
<td>Relates to the governance arrangements between participating organisations. They encompass: the relationships between organisations (e.g. partnership); structural integration (e.g. through merger or contractual relationships); arrangements to define and implement goals and objectives; and assurance frameworks to ensure agreed objectives are achieved.</td>
</tr>
<tr>
<td><strong>Administrative</strong></td>
<td>Administrative and functional links across participating organisations (e.g. human resource management, shared administrative Functions; central employment of shared staff; and joint education and training across professional groups).</td>
</tr>
<tr>
<td><strong>Normative</strong></td>
<td>Relate to developing shared values and aligned professional standards across participating individuals, groups and organisations.</td>
</tr>
<tr>
<td><strong>Additional</strong></td>
<td><strong>Informational</strong> Shared access to clinical information</td>
</tr>
</tbody>
</table>
Budgetary arrangements and payment systems in place across the participating organisations


<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational</td>
<td>Where organisations are brought together by mergers or by structural change.</td>
</tr>
<tr>
<td>Service (Functional)</td>
<td>Where different clinical services or support/back-office functions are integrated.</td>
</tr>
<tr>
<td>Clinical</td>
<td>Where the focus is on care for a particular condition.</td>
</tr>
</tbody>
</table>


![Figure 1: Typologies of Integrated Care](source: adapted from Fulop and others (2005))

- Organisational integration, where organisations are brought together formally by mergers or through ‘collectives’ and/or virtually through coordinated provider networks or via contracts between separate organisations brokered by a purchaser.
- Functional integration, where non-clinical support and back-office functions are integrated, such as electronic patient records.
- Service integration, where different clinical services provided are integrated at an organisational level, such as through teams of multi-disciplinary professionals.
- Clinical integration, where care by professionals and providers to patients is integrated into a single or coherent process within and/or across professions, such as through use of shared guidelines and protocols.
- Normative integration, where an ethos of shared values and commitment to coordinating work enables trust and collaboration in delivering healthcare.
- Systemic integration, where there is coherence of rules and policies at all organisational levels. This is sometimes termed an ‘integrated delivery system’.
<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional</td>
<td>Where non-clinical support and back office functions are integrated, such as electronic patient records</td>
</tr>
<tr>
<td>Organisational</td>
<td>Where organisations are brought together formally by mergers or through ‘collectives’ and/or virtually through co-ordinated provider networks or via contracts between separate organisations brokered by a purchaser</td>
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<tr>
<td>Normative</td>
<td>Where an ethos of shared values and commitment to coordinating work enables trust and collaboration in delivering healthcare.</td>
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<tr>
<td>Systemic</td>
<td>Where there is a coherence of rules and policies at all organisational levels. This sometimes termed on ‘integrated delivery system’.</td>
</tr>
</tbody>
</table>

11. **Kodner (2009)**

<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional</td>
<td>The degree to which back-office and support functions are co-ordinated across all units</td>
</tr>
<tr>
<td>Organisational</td>
<td>Relationships between healthcare organisations</td>
</tr>
<tr>
<td>Professional</td>
<td>Provider relationships within and between organisations</td>
</tr>
<tr>
<td>Clinical / service</td>
<td>Coordination of services and the integration of care in a single process across time, place, and discipline</td>
</tr>
<tr>
<td>Normative</td>
<td>Shared missions, work values, and organisational/professional culture</td>
</tr>
<tr>
<td>Systemic</td>
<td>Alignment of policies and incentives at the organisational level</td>
</tr>
</tbody>
</table>
12. **Nolte and McKee (2008)**

<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional</td>
<td>Extent to which key support functions and activities such as financial management, human resources, strategic planning, information management and quality improvement are coordinated across operating units</td>
</tr>
<tr>
<td>Organisational</td>
<td>Creation of networks, mergers, contracting or strategic alliances between healthcare institutions</td>
</tr>
<tr>
<td>Professional</td>
<td>Joint working, group practices, contracting or strategic alliances of healthcare professionals within and between institutions and organizations</td>
</tr>
<tr>
<td>Clinical</td>
<td>Extent to which patient care services are coordinated across the various personnel, functions, activities and operating units of a system</td>
</tr>
</tbody>
</table>

(FabbriCOTTI 2007).

13. **MacAdam (2008)**

<table>
<thead>
<tr>
<th>Process</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>System integration</td>
<td>Includes activities such as strategic planning, financing, and purchasing systems, program eligibility and service coverage, within a geographical area or across a country or province.</td>
</tr>
<tr>
<td>Organisational integration</td>
<td>Refers to the coordination and management of activities among acute, rehabilitation, community care and primary care provider agencies or individuals.</td>
</tr>
<tr>
<td>Clinical integration</td>
<td>Concerns the direct care and support provided to older people by their direct caregivers (Edwards and Miller, 2003).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organisational</strong></td>
<td>How the organisation is formally structured. For example by mergers and/ or structural change or virtually through contracts between separate organisations.</td>
</tr>
<tr>
<td><strong>Functional</strong></td>
<td>How non-clinical support and back-office functions are integrated.</td>
</tr>
<tr>
<td><strong>Service</strong></td>
<td>At the organisational level, how clinical services offered by the organisation are integrated with each other.</td>
</tr>
<tr>
<td><strong>Clinical</strong></td>
<td>At the clinical team level, integrating care for patients in a single process, both intra and inter-professionally (e.g. through the use of shared guidelines).</td>
</tr>
<tr>
<td><strong>Systemic</strong></td>
<td>The coherence of rules and policies at the various levels of organisation.</td>
</tr>
<tr>
<td><strong>Normative</strong></td>
<td>The role of shared values in co-ordinating work and securing collaboration in the delivery of healthcare</td>
</tr>
</tbody>
</table>

Source: Mowlam and Fulop (2005), adapted from Contandriopoulos and Denis (2001)

Based on the work of Shortell et al (2000)

<table>
<thead>
<tr>
<th>Level</th>
<th>Type</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Meso</td>
<td>Organisational</td>
<td>On the meso level of health systems, e.g. in the form of mergers, contracting or strategic alliances between health care institutions.</td>
</tr>
<tr>
<td>Micro</td>
<td>Clinical</td>
<td>On the micro level of health care systems, i.e. continuity, co-operation and coherence in the primary process of care delivery to <em>individual</em> patients.</td>
</tr>
<tr>
<td>Meso</td>
<td>Professional</td>
<td>On the meso level of health care systems, e.g. in the form of mergers (e.g. group practices), contracting or strategic alliances between health care professionals.</td>
</tr>
<tr>
<td>Macro</td>
<td>Functional</td>
<td>On the macro level of a health care system, i.e. mainstreaming of the financing and regulation of cure, care, prevention, and social services.</td>
</tr>
</tbody>
</table>

**Systems:**
- Clinical
- Organisational structure (governance)
- Representation and value

**Dimensions:**
- Integration of care
- Clinical team integration (medical integration)
- Functional integration
- Normative integration
- Systemic integration
All identify the same broad approaches which seek to:

- Merge systems (systems)
- Share clinical standards (clinical) or values (normative)
- Bring together structures (organisational/governance), services (service) or functions (functional, financial, informational)

<table>
<thead>
<tr>
<th>Main types</th>
<th>Sub-sets</th>
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</thead>
<tbody>
<tr>
<td>Systemic</td>
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<td>Normative</td>
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<tr>
<td>Organisational</td>
<td>Structures Governance</td>
</tr>
<tr>
<td>Clinical</td>
<td>Service Professional</td>
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<tr>
<td>Functional</td>
<td>Administrative Informational Financial</td>
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<th>Info</th>
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<tr>
<td>Systemic</td>
<td>Refers to the alignment of rules and policies within a system</td>
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<tr>
<td>Organisational</td>
<td>Refers to the extent to which organisations co-ordinate services across different organisations</td>
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<tr>
<td>Service/clinical</td>
<td>Refers to the extent to which care services are co-ordinated</td>
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</tr>
<tr>
<td>Professional</td>
<td>Refers to the extent to which professionals co-ordinate services across various disciplines</td>
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</tr>
<tr>
<td>Functional</td>
<td>Refers to the extent to which back-office and support functions are coordinated</td>
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<tr>
<td>Normative</td>
<td>Refers to the extent to which mission, work values etc. are shared within a system</td>
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<table>
<thead>
<tr>
<th><strong>Level</strong></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Micro</td>
<td>Care at the individual service user level</td>
</tr>
<tr>
<td>Meso</td>
<td>Care at the organisational level (i.e. for a particular group of people with specific needs for the same disease or condition)</td>
</tr>
<tr>
<td>Macro</td>
<td>Care at the system level (i.e. delivering care across the full spectrum of services to the whole population).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Breadth</strong></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Horizontal</td>
<td>Similar organisations at the same level and stage of service delivery process are joined together (e.g. mergers of acute hospitals)</td>
</tr>
<tr>
<td>Vertical</td>
<td>Different organisations at different levels and stages of service delivery process are combined across the continuum of care (e.g. integrating primary and secondary care)</td>
</tr>
<tr>
<td>Real</td>
<td>Mergers between organisations</td>
</tr>
<tr>
<td>Virtual/contractual</td>
<td>Alliances, partnerships and networks created by a number of organisations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Degree &amp; Intensity</strong></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linkage</td>
<td>Links are made between existing organisations</td>
</tr>
<tr>
<td>Co-ordination</td>
<td>Through networks but still largely operating through organisational units and separate structures of current systems</td>
</tr>
<tr>
<td>Full integration</td>
<td>Formally pooling budgets, responsibilities, and resources in a more radical form, often for users with high levels of need.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Processes</strong></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relational / Behavioural</td>
<td>Cultural - Convergence of values, norms, working methods, approaches and symbols adopted by the (various) actors</td>
</tr>
<tr>
<td></td>
<td>Social - The intensification of social relationships between the (various) actors and integration of objectives, interests, power and resources of the (various) actors</td>
</tr>
<tr>
<td>Technical</td>
<td>Structural integration - The alignment of tasks, functions and activities of organizations and healthcare professionals</td>
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</tbody>
</table>
Appendix 4 – Chapter 2: Timeline of integration political context (National Audit Office, 2017)

Integration timeline

The Departments have sought to accelerate integration through new powers and legislative duties; funding transfers; and pilot programmes.

1999
- Health Act 1999: Established local authorities and NHS bodies to pool budgets and enable local commissioning arrangements which allow the delegation of service provision.

2001
- Health and Social Care Act 2001: Open local authorities and NHS bodies the opportunity to integrate social care, mental health, or primary care services into single organisations called ‘care trusts’.

2006
- Integration Care Pilots: Between 2003 and 2012, the Department of health supported local health and social care organisations to explore ways to integrate care at a local level around England. The pilots integrated services within and across organisations, making it easier for older patients with multiple, long-term conditions.

2013
- Integrated Care: Our Shared Commitment: the Department of Health and local partners make a commitment to ‘integrate health and social care across England by 2015 and local teams to submit plans by April 2017 demonstrating how they will achieve this.

2015
- Spending Review 2015: Announced the need for £3.5 billion of NHS funding from clinical commissioning groups allocated via the ‘Better Care Fund’.

2016
- CCGs and Local Government: Overview: The NHS and local government are combining their efforts to improve care and reduce costs. The NHS has signed agreements with local authorities to share resources and improve outcomes.

New powers and legislative duties

- New powers and legislative duties for local authorities and NHS bodies to pool budgets and enable local commissioning arrangements to delegate service provision.

- The Health and Social Care Act 2012: Established local health and wellbeing boards in each local authority area, with a duty to promote integrated commissioning and delivery of health and social care services. The Health and Social Care Act 2012 requires local authorities to promote integration where this would promote wellbeing, improve quality, or prevent care needs from developing.

- Five Year Forward View: Called for a ‘radical upgrade’ in the provision and public health models of care which shift care from hospitals to settings closer to people’s homes.

- New models of care programmes: Introduced seven new models of care focused around the Five Year Forward View, to be piloted at 15 “vanguard” sites.
Appendix 5 - Chapter 4: Health Research Authority ethical approval

Miss Anna Thomson
University of Lincoln
Erbyford Pool
Lincoln
LN6 7TS
28 June 2016

Dear Miss Thomson

Study title: Evaluating new models of care for frail older people
IRAS project ID: 186782
Sponsor: University of Lincoln

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

The current document set has been provided to the HRA to bring a study processed though pre-HRA Approval systems under HRA Approval. I am pleased to confirm that the above referenced study has been given HRA Approval. This has been issued on the basis described in the submitted document set and any clarifications noted in this letter. Any new participating NHS organisations in England added either through this submission or through subsequent amendments should be set up in accordance with HRA Approval processes and confirmation by the participating NHS organisation that they are ready to deliver the study should be on the basis of capacity and capability alone.

Participation of NHS Organisations in England
The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. Please read Appendix B carefully, in particular the following sections:

- Participating NHS organisations in England – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- Confirmation of capacity and capability - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
• Allocation of responsibilities and rights are agreed and documented (4.1 of rFRA assessment criteria) - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:
• A – List of documents reviewed during HRA assessment
• B – Summary of HRA assessment

After HRA Approval

The attached document “After HRA Approval – guidance for sponsors and investigators” gives detailed guidance on reporting expectations for studies with HRA Approval, including:
• Working with organisations hosting the research
• Registration of Research
• Notifying amendments
• Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rc-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application
procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net. Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training
We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is 186782. Please quote this on all correspondence.

Yours sincerely

Alison Thorpe
Senior Assessor

Email: hra.approval@nhs.net

Copy to: Dr Patrick Bourke, University of Lincoln, Sponsor Contact
Mrs Janice Wiseman, Lincolnshire Community Health Services NHS Trust, Lead NHD R&D Contact
Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
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<td>Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)</td>
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Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the participating NHS organisations, capacity and capability and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Dr Patrick Bourke; pbourke@lincoln.ac.uk_01522 660 100

<table>
<thead>
<tr>
<th>HRA assessment criteria</th>
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<tr>
<td><strong>1.1 IRAS application completed correctly</strong></td>
<td>Yes</td>
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<td><strong>2.1 Participant information/consent documents and consent process</strong></td>
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<tr>
<td><strong>3.1 Protocol assessment</strong></td>
<td>Yes</td>
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<td><strong>4.1 Allocation of responsibilities and rights are agreed and documented</strong></td>
<td>Yes</td>
<td>The sponsor intends that the statement of activities acts as the only agreement for this study.</td>
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<td><strong>4.2 Insurance/indemnity arrangements assessed</strong></td>
<td>Yes</td>
<td>Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study.</td>
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<td>Compliance with the Data Protection Act and data security issues assessed</td>
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<td>CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed</td>
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<td>5.3</td>
<td>Compliance with any applicable laws or regulations</td>
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<tr>
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<td>CTIMPS – Clinical Trials Authorisation (CTA) letter received</td>
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<td>6.3</td>
<td>Devices – MHRA notice of no objection received</td>
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<tr>
<td>6.4</td>
<td>Other regulatory approvals and authorisations received</td>
<td>Not Applicable</td>
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</table>

**Participating NHS Organisations in England**

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

There is one type of participating NHS organisation. Staff members within [REDACTED] Clinical Commissioning Group will be invited to complete an online questionnaire, with semi-structured interviews being conducted with commissioners and managers.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local CRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for...
participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

### Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

The HRA has determined that participating NHS organisations in England are not expected to formally confirm their capacity and capability to host this research, because the study involves an online questionnaire with some staff also being asked to participate in a single interview conducted at a time convenient to them.

- The HRA has informed the relevant research management offices that you intend to undertake the research at their organisation. However, you should still support and liaise with these organisations as necessary.
- Following issue of the HRA Approval letter, and subject to the two conditions below, it is expected that these organisations will become participating NHS organisations 35 days after issue of this Letter of HRA Approval (no later than 29 July 2016):
  - You may not include the NHS organisation if they provide justification to the sponsor and the HRA as to why the organisation cannot participate.
  - You may not include the NHS organisation if they request additional time to confirm, until they notify you that the considerations have been satisfactorily completed.
- You may include NHS organisations in this study in advance of the deadline above where the organisation confirms by email to the CI and sponsor that the research may proceed.
- The document “Collaborative working between sponsors and NHS organisations in England for HRA Approval studies, where no formal confirmation of capacity and capability is expected” provides further information for the sponsor and NHS organisations on working with NHS organisations in England where no formal confirmation of capacity and capability is required, and the processes involved in adding new organisations. Further study specific details are provided in the Participating NHS Organisations and Allocation of responsibilities and rights are agreed and documented (4 1 of HRA assessment criteria) sections of this Appendix.

### Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

The Chief Investigator will be taking responsibility for the research activities conducted, no principal investigator or local collaborator is expected.

GCP training is not a generic training expectation, in line with the HRA statement on training expectations.
**HR Good Practice Resource Pack Expectations**

<table>
<thead>
<tr>
<th>This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken</th>
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<tbody>
<tr>
<td>The study involved interviews with staff only in non NHS locations or non-care areas in NHS locations therefore there are no HR Good Practice expectations for access arrangements.</td>
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</table>

**Other Information to Aid Study Set-up**

<table>
<thead>
<tr>
<th>This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.</th>
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<tbody>
<tr>
<td>- The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.</td>
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</table>
RE: Evaluating new models of care for frail older people.

Dear Anna

Thank you for your amendments to the EA2 submitted 10.09.2015 (full document name listed below). Permission is hereby given for the above study, on the basis described in the EA2 v2 application form.

On behalf of the committee, I would like to wish you all success in your research.

Yours sincerely

Dr Karen Windle
Co-Chair Ethics Committee on behalf of the School of Health and Social Care Ethics Committee.

kwindle@lincoln.ac.uk

01522 886173

cc. Dr Zowie Davy
Chair Ethics Committee

Resubmitted document:

## Appendix 7 – Chapter 4: Timeline of data collection

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Appendix 8 – Chapter 4: Interview topic guide

Evaluating new models of integrated care

Strategic Staff Interview Topic Guide

Introduction:

- Welcome participants and thank them for taking part. Go through participant information sheet and give participants time to ask any questions.
- Introduce the study and explain that the purpose is to discuss the strategic perspective of developing Neighbourhood Teams.
- Explain confidentiality and anonymity and that data will be recorded with their permission.
- Reiterate that participants can refuse to answer any questions and are free terminate the interview at any time, and ask participant to sign the consent form.

Individual introduction and background information

1. Can you give me a brief description of your job role and your work with the Neighbourhood Teams?

Integrated Neighbourhood Teams - Function & Processes

1. Could you give a description of the Neighbourhood Teams?
   How would you define them? Would you consider them to be clearly defined?

2. What would you say are the overarching aims and objectives of the Neighbourhood Teams?
   Why these in particular? Are these clear? Have these been achieved?

3. How would you define integrated working/integrated care?
   What does it mean to you?

4. Has the approach to integrating care changed in any way over time?
   To your knowledge, how was the initiative first developed? Has it changed since its first conception?
Partnership working (people, teams and organisations)

1. Which sectors/organisations are involved in the development and implementation of the Neighbourhood Teams? 
   What are their roles in relation to integration?

2. Would you say that there is active participation of these key staff groups? 
   Do they appear willing to work in the same way as strategy encourages? What might affect their ability to engage with the Neighbourhood Teams initiative?

Implementation and progress (barriers and facilitators)

1. What progress has been made since the Neighbourhood Teams were first implemented? 
   What stage in the implementation process are they now? Is this where you expected to be? Is this consistent with the strategy? Any deviations?

2. Have there been any difficulties in the development and implementation process? 
   Are there and barriers to integrated working that you have experienced? What might be causing them?

3. What would you say were the critical success factors for implementing organisational change and integrating care? 
   What has enabled staff to work together? How have the Neighbourhood Teams been successful in their development and implementation?

Outcomes and impacts

1. What are the desired outcomes of the Neighbourhood Teams? 
   Is there a plan for how they are supposed to arise? Have these been achieved? What outcomes are intended for patients?

2. How are you defining and measuring success? 
   Any Key Performance Indicators or frameworks? How successful have they been in achieving their aims and objectives?

Closure:

- Thank the participants for their time.
- Ask if there are any questions or if there are any further comments that they wish to make.
Appendix 9 – Chapter 4: Thematic map example

Purpose and focus of integrated concept

What is the model?
Target Group?
County-wide agenda

Core MDT

On MDT / Meeting
On frail older people
Why have these occurred?

Key members and services

Unintended focus

Community and patient focus

MDT meetings

Aims and Objectives

Changes / how this have evolved

Phases of development

Aims and Objectives

Vision / intentions

Lack of strategic clarity of purpose and focus

Context

Attendance
Mutually beneficial for staff and patients

MDT meetings

Mutually beneficial for staff and patients

Aims and Objectives

Vision / intentions

Lack of strategic clarity of purpose and focus

Context

MDT meetings

Key members and services

Unintended focus

On MDT / Meeting
On frail older people
Why have these occurred?

Appendix 9 – Chapter 4: Thematic map example
Appendix 10 - Chapter 4: Example coded transcript

**Themes**

The purpose and focus of the integrated concept

Multidisciplinary team working and engagement

Professional roles and responsibilities

Contextual factors and challenges of integration

Expectations and the reality of integration

Aspirations and future goals for care delivery

**P1 Interview**

AT: If you wouldn’t mind introducing yourself and giving a brief description of your job role and your work with the NTs?

P1: I’m [name of participant], I work for [name of organisation] and I have been over the last four or five years been doing work towards developing integration and particularly around frailty services and integrated community teams more generally known as Neighbourhood Teams, and I am currently leading that work county wide on behalf of the LHAC program, trying to get some momentum back behind the Neighbourhood concept and how we get that integration agenda really working.

AT: When you say back behind, do you feel like there was previously a bit more of momentum behind it?

P1: Yes, I think over the last 18 months we’ve lost some of the focus on Neighbourhood working just because it’s been really difficult to get it up and running and I think people have drifted off to the next shiny thing that comes along whatever that may be, and I think that we’ve certainly, if I look at [name of commissioning area], I think we’ve definitely lost some focus and I think losing DS our Geriatrician, and our two GPs with extended roles in frailty has definitely caused us to slow down with some of the work that we’ve been doing and the impact we were having.
AT: So with your job role and the NTs it’s not necessarily that your job role might have changed, it’s that maybe the resources and the focus has?

P1: I think it’s more around, because my role is and has always been service development and service improvement and so I’m applying those sort of techniques that we’ve used for lots of other pathways and things over the years, to try and get integrated community teams working and then that wider Neighbourhood network and that community capacity building, so I think that the skills and techniques that I’ve used for a number of years still apply, but it is just about how we get people focused back on integrated teams, NT, whatever you want to call them, and about how we ensure we manage to get some of the system changes in place that we need to facilitate then to really fly.

AT: So would you say that DS’s input was one of main drivers for this model?

P1: I think for [name of clinical commissioning group] it definitely was, for the other three CCGs county wide, then they didn’t have a community Geriatrician, that was only [name of clinical commissioning group]. I think interestingly what we thought DS’s role would do and what it actually did, I think were two different things. It would be really interesting, what you pick up when you go round doing this work, because I think we expected initially the intention being that he would come out to provide the clinical leadership and really drive the clinical change through across all four NTs and actually what I think he provided support to GPs to manage frail older people in the community for longer because they knew that they had him as a back stop and they used him for that purpose, and where we’ve got the clinical leadership and where we’ve got the increased utilisation involvement in NTs was where we had the two GPs working.

AT: Has that been lost when DS left?

P1: Yes because DS provided them with the senior support, clinical support and feedback.

AT: So would you say that the GP engagement has lessened since then?

P1: Yes, it’s definitely deteriorating

AT: Are you looking to replace DS?
P1: I think we’re looking to replace the concept of having that specialist support to the Neighbourhood, to the community. I’m not sure at the moment whether we’re looking to replace like for like. So, because I think with some of the work that we need to do around how we get a single frailty pathway for example, that goes from community to hospital and from hospital out, I think there’s an increasing recognition that actually what we need to be doing is looking at moving the specialist capacity that sits in [name of local hospital] or [name of local hospital trust], and actually moving that out into the community. So that your care of the elderly service is a community based service and not an acute based service.

AT: And would you say it’s still more based within the acute?

P1: Definitely. We’re still admitting far too many frail elderly people into an acute hospital, who if they had the right care and support wouldn’t be there, shouldn’t be there, it’s not the right place for them.

AT: So in terms of the NTs model and the frailty pathway is still that the NTs are implementing the frailty pathway? How would you define that model and describe how that should be working, or is working?

P1: Well I think one of the things that we’re currently doing now is looking at the work that we’ve done around transitional or intermediate care and some of the pathways that we’ve developed for those. So I think what we’re getting to is that I think we’re reasonably comfortable that the design of NTs is the right design, so the idea of bringing together lots of people with lots of skills, and different professional groups together in a single team, managing a defined cohort of people with a degree of risk, is the right thing to do. And then they need to have within their community, so within their geographic location or locality, a network, a Neighbourhood network, that’s got those lower level support. So whether those are self-help groups, whether they’re community groups, faith groups, different voluntary sectors. You know, particularly around some of the mental health charities etc. that are there to be able to support people when they actually have some need for support and information, education, whatever it is, but they don’t have a clinical need actually.

AT: So more social?
P1: So much more social, much more social and a much more non-medical focus is needed for the Neighbourhoods that we’ve currently got, because it’s all about, today it’s all about the MDT and that’s where I think we’ve lost the focus, because that was never the intention. So the vision was that it was a Neighbourhood, community, social movement, type, approach, and actually the clinical stuff was small it was a tiny part of it, that needed to be expert, so that when people either naturally deteriorated and moved along their pathway and got to end of life or they experienced a sudden on-set crisis situation, that medical team, neighbourhood care team, could respond like that, wrapped round you, sort you out, get you stabilised, and pop you back into the community. And that’s the bit we haven’t done, and that’s because we haven’t got explicit clear pathways for the things. So we haven’t got an explicit transitional care pathway from the neighbourhood team into the care tier, we don’t have an explicit pathway for frailty, so how do you manage somebody that’s frailty and that frailty syndrome, even though everybody knows what it is, it’s not explicit. We haven’t got current, we have got them but not current and again how they then need to change to work into the NT pathways for long-term conditions for example.

AT: Can I just check, is this the model you’re working with, is this the most up to date? You mentioned you’ve got the MDT, is that where the focus is?

P1: More or less yes, and that’s your network.

AT: So it’s become more focused on these bits? (The MDT)

P1: Well I think that it has because for health and for some degree adult social care, this bits easier to do. So but what we’ve got at the moment is we’ve got 12 or 13 of these (NTs) working across the county, most of them, not all of them, only meet every two weeks, they only see a handful of patients at most. They sit together for an hour and a half, they will discuss Mrs x, they will agree a set of actions and then if you’re a CPN you’ll go back to your mental health trust and you’ll work in you’ll become mental health trust or you’ll become community trust or you’ll go to being GP, but actually what we need for them is that that is a unit and that is where they do their day job and that they’re a managed team, whatever the terminology is you wish to use, but that they are there Monday to Friday 8-6.

AT: So at the minute are they all still quite separate?
P1: They are separate and not a team, they don’t function as a team, and that’s the bit, and the reason why that’s really hard is because what they require is organisations to give up from sovereignty. So if I’m a CPN for example, what we’ve never agreed is as a mental health trust we haven’t got them signed up to go actually for the [name of NT2] NT, they need a CPN to be allocated to them, that’s their day job, the manager for that team or the leader for that team is somebody who works for adult social care, so is Fanny Adams from ASC and actually for operational purposes Monday to Friday Mrs CPN is responsible to Fanny Adams, and she gets her clinical supervision back in her organisation, but her today to today operational working is part of that, and that’s where we need to get to, to make that happen and there’s something about co-location which we haven’t cracked, but we’re moving there with our phase 2 sites. So there’s some big system things that need to change around the way organisations perceive themselves and the way they don’t currently work together on any level, no matter what they tell you.

AT: So would you say that’s quite a big barrier?

P1: Yes, at the moment the biggest challenge we have is about how do we get people really integrated and actually do we need an honest conversation about actually are we ever going to get there or are we chasing something that nobody believes in and isn’t actually going to support to happen, or do we need to think of a different way of doing it? Which is out there in the ether, and the other biggest challenge for me is primary care.

AT: Is that still not fully integrated?

P1: Primary care is, so if you go on the basis that none of these (core MDT) are fully integrated.

AT: Is it less integrated?

P1: It’s variable. That’s what I would say. So in some teams it works really well, so in [name of NT2], which is where they’ve got JS working, JS is fabulous and JS has engaged every one of the six GP practices, and they think that JS works for them, but as I said to you before, they work for JS, which always makes me smile whenever I think about that. But JS has educated them and shown them, which is the critical factor, how effective a different way of working can be and that’s the only to show GPs.
## Appendix 11 – Chapter 4: Partnership assessment principles and associated elements

<table>
<thead>
<tr>
<th>Principles</th>
<th>Elements</th>
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</thead>
</table>
| 1: Recognise and accept the need for partnership | • Identify principal partnership achievements  
• Identify the factors associated with successful partnership working  
• Identify the principal barriers to partnership working  
• Acknowledge whether the policy context creates voluntary coerced or mandatory partnership working  
• Acknowledge the extent of partners’ interdependence to achieve some of their goals  
• Acknowledge areas in which you are not dependent upon others to achieve your goals |
| 2: Develop clarity and realism of purpose | • Ensure that the partnership is built on shared vision, shared values and agreed service principles  
• Define clear joint aims and objectives  
• Ensure joint aims and objectives are realistic  
• Ensure that the partnership has defined clear service outcomes  
• Partners’ reasons for engaging in the partnership are understood and accepted  
• Focus partnership effort on areas of likely success |
| 3: Ensure commitment and ownership | • Ensure appropriate seniority of commitment  
• Secure widespread ownership within and outside partner organisations  
• Ensure sufficient consistency of commitment  
• Recognise and encourage individuals with networking skills  
• Ensure that partnership working is not dependent solely upon these individuals  
• Reward partnership working and discourage and deal with those not working in partnership |
| 4: Develop and maintain trust | • Ensure each partner’s contribution is equally recognised and valued  
• Ensure fairness in the conduct of partnership  
• Ensure fairness in distribution of partnership benefits  
• Ensure the partnership is able to sustain a sufficient level of trust to survive external problems which create mistrust elsewhere  
• Trust built up within partnerships needs to be high enough to encourage significant risk-taking  
• Ensure that the right people are in the right place at the right time |
|---|---|
| 5: Create clear and robust partnership arrangements | • Transparency in the financial resources each partner brings to the partnership  
• Awareness and appreciation of the non-financial resources each partner brings to the partnership  
• Distinguish single from collective responsibilities and ensure they are clear and understood  
• Ensure clear lines of accountability for partnership performance  
• Develop operational partnership arrangements which are simple, time-limited and task-orientated  
• Ensure the prime focus is on process, outcomes and innovation |
| 6: Monitor, measure and learn | • Agree a range of success criteria  
• Develop arrangements for monitoring and reviewing how well the partnership’s service aims and objectives are being met  
• Develop arrangements for monitoring and reviewing how effectively the partnership itself is working  
• Ensure widespread dissemination of monitoring and review findings amongst partners  
• Celebrate and publicise partnership success and root out continuing barrier  
• Reconsider/revise partnership aims, objectives, and arrangements |
Appendix 12 – Chapter 4: Paper version of the Partnership Assessment Tool

Developing Integrated Neighbourhood Teams

Individual Code

Lincolnshire West Clinical Commissioning Group
Thank you for taking part in this survey

You have been selected to take part in this research due to your extremely valued work with the development of the Neighbourhood Teams. These integrated Neighbourhood Teams bring together multi-disciplinary professionals in order to provide a wide range of health and social care services for patients. This requires organisations and individuals to work together in partnership in order to provide streamlined and person-centered care. Evidence is currently emerging about the benefits of integration, integrated care, and partnership working for both service users and service providers. However, it is not always clear how these benefits can actually be achieved within specific local contexts.

The research study therefore aims to investigate how the strategies of integration, integrated care, and partnership working have been developed and implemented through the Neighbourhood Teams. In order to do so, we would like you to complete the following questionnaire. This will ask you about your views and experiences of multi-disciplinary working and providing integrated care through partnership working across organisations within the Neighbourhood Teams. For example, through working with partner organisations including:

- Adult Social Care
- Community Health Services – Integrated Community Teams
- Community Mental Health Services
- General Practice
- Age UK
- St Barnabas

The following assessment tool is based on six ‘Partnership Principles’ which have been shown to form the building blocks for successful partnerships. These include:

- Recognise and accept the need for partnership
- Develop clarity and realism of purpose
- Ensure commitment and ownership
- Develop and maintain trust
- Create clear and robust partnership arrangements
- Monitor, measure and learn

The purpose of the tool is to ascertain how far people feel that these building blocks are in place. The assessment is based on individuals identifying and sharing their views of the partnerships developed across the organisations within the Neighbourhood Teams.

Please be as honest and open as you can in your responses. All responses given will be confidential. Many thanks in advance for your time and input!
Some questions about yourself...

1. What is your gender?
   Female ☐  Male ☐  Prefer not to say ☐

2. What is your age?
   ______________________

3. Please indicate which organisation you work for:
   General Practice ☐
   Lincolnshire Community Health Services ☐
   United Lincolnshire Hospitals Trust ☐
   Lincolnshire Partnership Foundation Trust ☐
   Lincolnshire County Council – Adult Social Care ☐
   Age UK ☐
   St Barnabas ☐
   Other (please specify)
   ______________________

4. How long have you been working within this organisation?
   ______________________
5. Please select the job title which best describes your role within this organisation

- General Practitioner
- Community Nurse
- Occupational therapist
- Physiotherapist
- Personal Independence Coordinator
- Adult Social Care Professional
- Community Psychiatric Nurse
- Case Liaison Officer
- Case Manager
- Clinical Team Lead
- Other (please specify)

_________________________

6. How long have you been working within your current job role?

_________________________

7. Which best describes the responsibilities of your daily work?

- Operational
- Strategic
- Combination of operational and strategic
- Direct delivery of care or services
- Other (please specify)

_________________________
The Neighbourhood Teams

1. Were you aware that you were working in an organisation which is part of a Neighbourhood Team?
   Yes [ ] No [ ]

2. Were you aware that the Neighbourhood Team initiative is part of the Lincolnshire Health and Care (LHAC) proactive care programme?
   Yes [ ] No [ ]

3. How much of your daily work relates to working with the Neighbourhood Teams?
   - None specifically [ ]
   - Some of my daily work [ ]
   - The majority of my daily work [ ]
   - All of my daily work [ ]

4. Which Neighbourhood Team(s) do you mostly work with?
   - Lincoln South [ ]
   - Lincoln City South [ ]
   - Lincoln North [ ]
   - Lincoln City North [ ]
   - Gainsborough [ ]
   - None [ ]
5. **How often do you attend the multi-disciplinary Neighbourhood Team meetings?**
   - Always [ ]
   - Often [ ]
   - Sometimes [ ]
   - Rarely [ ]
   - Never [ ]

6. **To your knowledge, how often do the multi-disciplinary Neighbourhood Team meetings occur?**
   - Weekly [ ]
   - Fortnightly [ ]
   - Monthly [ ]
   - Every six weeks [ ]
   - Bi-monthly [ ]
   - Less than bi-monthly [ ]
   - Unsure [ ]
   - Other (please specify) [ ]
## Principle 1: Recognise and accept the need for partnership

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>There have been substantial past achievements within the partnership.</td>
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<tr>
<td>The factors associated with successful working are known and understood.</td>
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<tr>
<td>The principal barriers to successful partnership working are known and understood.</td>
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<tr>
<td>The extent to which partners engage in partnership working voluntarily or under pressure/mandation is recognised and understood.</td>
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<tr>
<td>There is a clear understanding of partners' interdependence in achieving some of their goals.</td>
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<td>There is mutual understanding of those areas of activity where partners can achieve some goals by working independently of each other.</td>
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</tbody>
</table>
Principle 2: Develop clarity and realism of purpose

To what extent do you agree with each of the following six statements in regard to the Neighbourhood Team partnership as a whole?
(Please tick the box which best represents your answer. You may wish to add additional comments or observations in the final column)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Our partnership has clear vision, shared values and agreed service principles.</td>
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<tr>
<td>We have clearly defined joint aims and objectives.</td>
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<td>These joint aims and objectives are realistic.</td>
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<td>The partnership has defined clear service outcomes.</td>
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<td>The reason why each partner is engaged in the partnership is understood and accepted.</td>
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<td>We have identified where early partnership success is most likely.</td>
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</table>
Principle 3: Ensure commitment and ownership

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<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>There is a clear commitment to partnership working from the most senior levels of each partnership organisation.</td>
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<tr>
<td>There is widespread ownership of the partnership across and within all partners.</td>
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<td>Commitment to partnership working is sufficiently robust to withstand most threats to its working.</td>
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<td>The partnership recognises and encourages networking skills.</td>
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<td>The partnership is not dependent for its success solely upon individuals with these networking skills.</td>
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<tr>
<td>Not working in partnership is discouraged and dealt with.</td>
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</tbody>
</table>
### Principle 4: Develop and maintain trust

To what extent do you agree with each of the following six statements in regard to the Neighbourhood Team partnership as a whole?

(Please tick the box which best represents your answer. You may wish to add additional comments or observations in the final column)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>The way the partnership is structured recognises and values each partner’s contribution.</td>
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<td>The way the partnership’s work is conducted appropriately recognises each partner’s contribution.</td>
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<td>Benefits derived from the partnership are fairly distributed among all partners.</td>
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<td>There is sufficient trust within the partnership to survive any mistrust that arises elsewhere.</td>
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<tr>
<td>Levels of trust within the partnership are high enough to encourage significant risk-taking.</td>
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<td>The partnership has succeeded in having the right people in the right place at the right time to promote partnership working.</td>
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</tbody>
</table>
**Principle 5: Create clear and robust partnership arrangements**

<table>
<thead>
<tr>
<th>To what extent do you agree with each of the following six statements in regard to the Neighbourhood Team partnership as a whole? (Please tick the box which best represents your answer. You may wish to add additional comments or observations in the final column)</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>• It is clear what financial resources each partner brings to the partnership.</td>
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<tr>
<td>• The resources each partner brings to the partnership (other than finance) are understood and appreciated.</td>
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<td>• Each partner’s area of responsibility are clear and understood.</td>
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<td>• There are clear lines of accountability for the performance of the partnership as a whole.</td>
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<td>• Operational partnership arrangements are simple, time-limited, and task-oriented.</td>
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<tr>
<td>• The partnership’s principal focus is on process, outcomes and innovation.</td>
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</table>
## Principle 6: Monitor, measure and learn

<table>
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<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Comments</th>
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<tbody>
<tr>
<td>The partnership has clear success criteria in terms of both service goals and the partnership itself.</td>
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<td>The partnership has clear arrangements to effectively monitor and review how successfully its service aims and objective are being met.</td>
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<td>There are clear arrangements to effectively monitor and review how the partnership itself is working.</td>
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<td>There are clear arrangements to ensure that monitoring and review findings are, or will be, widely shared and disseminated amongst the partners.</td>
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<td>Partnership successes are well communicated outside of the partnership.</td>
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<td>There are clear arrangements to ensure that partnership aims, objectives and working arrangements are reconsidered and, where necessary, revised in the light of monitoring and review findings.</td>
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</table>
The relative significance of the six principles

1. How would you weight the six principles in terms of their current significance for the Neighbourhood Team partnership – given its nature and stage of development?

Please select the point which you think is most significant for each principle.

<table>
<thead>
<tr>
<th>Principle 1: Recognise and accept the need for partnership</th>
<th>More Significant</th>
<th>Less Significant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principle 2: Develop clarity and realism of purpose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principle 3: Ensure commitment and ownership</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principle 4: Develop and maintain trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principle 5: Create clear and robust partnership arrangements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principle 6: Monitor, measure and learn</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. To what extent do you agree with the following statement in respect of the Neighbourhood Team partnership as a whole?

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The partnership is achieving its aims and objectives</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

2. Please add below any comments on the performance of the partnership.

__________________________________________________________________________
__________________________________________________________________________
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__________________________________________________________________________
__________________________________________________________________________
Appendix 13 – Chapter 4 – Operational plan
Introduction
This report is intended to provide information about referral routes, service requirements and the pathway of patients through the Neighbourhood Team. It uses data gathered by the Case Liaison Officer to monitor time scales and progress of patients.

New Referrals
Since April 2015 to November 2015 NT2 has received 51 referrals, these are shown by month in the table below:

![Chart of New Referrals](image)

Referrals by GP Practice (April to November)
These referrals were for patients registered at the practices below:
From September 2015 onwards the Case Liaison Officers have been developing the database and the additional information below is now available.

**Referral Reason September to November**
Assessments carried out by role September to November

Initial Assessment carried out by role September to November

<table>
<thead>
<tr>
<th></th>
<th>September</th>
<th>October</th>
<th>November</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Nurse</td>
<td>5</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>ILT - Health</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Community Geriatrician</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Primary Care Navigator</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Com. Psychiatric Nurse</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Length of time between referral and assessment -

Avg. wait in days referral to assessment

<table>
<thead>
<tr>
<th></th>
<th>September</th>
<th>October</th>
<th>November</th>
</tr>
</thead>
<tbody>
<tr>
<td>Com. Psychiatric Nurse</td>
<td>5</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Community Geriatrician</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Community Nurse</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>ILT - Health</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Primary Care Navigator</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>(blank)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Primary Services required following assessment September to November

Length of time between assessment and start of service September to November.
In development

Patients admitted to hospital in the reporting months September to November 2015
Patients re-admitted to hospital in the reporting month within 30 days following previous discharge

0 patients were re-admitted to hospital in the reporting month

Patients Admitted to Rapid Response Beds in the month

0 patients were admitted to a Rapid Response Bed in the reporting month.

Patients Discharged in the reporting month September to November 2015

<table>
<thead>
<tr>
<th>Month</th>
<th>Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>September</td>
<td>2</td>
</tr>
<tr>
<td>October</td>
<td>2</td>
</tr>
<tr>
<td>November</td>
<td>14</td>
</tr>
</tbody>
</table>

Patients still on the caseload to September to date

At the end of the reporting 25 patients are active (on the caseload)
Patients time on caseload September to November 2015

The chart below illustrates the number of days patients are on the caseload, from the date of referral to the date of discharge.
### Appendix 15: Chapter 5: Summary of research questions and thematic data

**RQ2: How has a local approach to integrated care been conceptualised and how has it evolved over time?**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The purpose and focus of the integrated concept</strong></td>
<td>Partnership working, developing integrated community teams and a wider neighbourhood network, integrating professional roles and skills within one team, managing a defined cohort of people and the health of the population.</td>
</tr>
<tr>
<td></td>
<td>Unclear model, aims, objectives and outcomes.</td>
</tr>
<tr>
<td></td>
<td>Phase one – identifying core MDT and co-ordinating meetings, establishing referral process, developing relationships, and shaping teams around geographic boundaries. Phase two – proof of concept with a focus on organisations who were not initially integrated, and a whole population health mentality.</td>
</tr>
<tr>
<td></td>
<td>Common goals between CCGs and partner organisations were developed for phase two – normative integration and shared values.</td>
</tr>
<tr>
<td></td>
<td>Need for a focus on patient needs rather than on organisational assessments and processes.</td>
</tr>
<tr>
<td></td>
<td>Variation in understanding of target population (i.e. frailty vs. whole population approach).</td>
</tr>
<tr>
<td></td>
<td>Recent clarity of the concept of integration and how the NT model can achieve this.</td>
</tr>
<tr>
<td></td>
<td>Variation in application and progression of the five NTs.</td>
</tr>
<tr>
<td></td>
<td>Original strategy not to be directive in developing NTs.</td>
</tr>
<tr>
<td></td>
<td>Need understanding of integration strategy to achieve organisational integration.</td>
</tr>
<tr>
<td></td>
<td>MDT should represent functional integration, not the whole integrated concept.</td>
</tr>
<tr>
<td><strong>Multi-disciplinary team working and engagement</strong></td>
<td>Regularly scheduled MDT meetings where case load of patients is discussed – variation in format and frequency between NTs.</td>
</tr>
</tbody>
</table>
Organisational and professional engagement problematic – not integrated yet?

Processes – development of social relationships, and objectives and interests to provide patient-centred care within the NTs.

Primary care integration into the community model deemed essential.

Normative integration and cultural and social processes were key for successful engagement with the NT model, a lack of which had resulted in a particular lack of primary care engagement.

Advanced integration between health and social care – compared to physical and mental health.

Professional, organisational, service/clinical and horizontal integration (communication between staff at the same level) but lack of vertical integration (less communication across different levels).

<table>
<thead>
<tr>
<th><strong>Professional roles and responsibilities</strong></th>
<th>To what extent has professional integration been achieved? Lack of professional and organisational understanding = lack of integration?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specialist clinical role and frailty teams provided clinical and service integration. The frailty teams also provided organisational integration through working with primary care, social care and the voluntary sector.</td>
</tr>
<tr>
<td></td>
<td>CLO role provided important functional integration through administration co-ordination. This role needs to be separate to clinical leadership role.</td>
</tr>
<tr>
<td></td>
<td>PCN role provided organisational and service/clinical integration and support for patients in navigating the complex systems.</td>
</tr>
<tr>
<td></td>
<td>Organisational integration crucial.</td>
</tr>
<tr>
<td></td>
<td>Lack of systemic integration, clinical and professional integration through joint action, and normative integration, despite the joint aim of providing patient-centred care.</td>
</tr>
</tbody>
</table>
| Contextual factors and challenges and integration | Lack of systemic integration - system does not promote and enable trust between organisations (due to separate working practices and accountability).  

Lack of integration with acute services (particular in reference to admission and discharges) – lack of clinical/service integration.  

Over-reliance of functional integration of MDTs as information was not shared if people could not attend the meetings – not effectively integrated if information was not shared if did not attend meetings.  

Lack of infrastructure and workforce. |
|---|---|
| Expectations and the reality of integration | Patients’ assumptions of co-ordination, organisational integration, clinical/service integration, and professional integration, and vertical integration (between primary and secondary care).  

Initial intention was for organisational integration as the meso level (partner organisations working together to provide care for patients with multiple needs).  

Intention that model would operate on a larger scale within a whole population approach (at macro level).  

Need for both a MDT (linkage) and a wider Neighbourhood network (co-ordination).  

Lack of normative integration means that individual interpretations and perceptions of what collaboration means in practice, affects behaviours and engagement with the model.  

Top-end complex patients should not be the focus of the NTs, with a proactive and preventative approach to patients with less complex needs. If NTs can provide community care in a preventative way across organisations and sectors (i.e. organisational integration and vertical integration), this would reduce demands on acute services. |
| Aspirations and future goals of care delivery | Education and training needed on culture and relationships of professional integration and shared responsibility of patients (normative and relational processes). |
Need an all-encompassing approach to care delivery at the macro level, including all age groups, and types of services (service integration) and sectors (vertical integration) e.g. integration of NT into acute hospital setting.

Single assessment process and co-location.

Organisation and professional integration not achieved? – individual perceptions may present barriers to implementation

MCP framework – capitated budgets.

The MDT level should represent the prevention agenda, and should be occurring regardless of a Neighbourhood Team.

RQ3: What are the feasibilities and practicalities of developing and implementing integrated care and integrated working?

<table>
<thead>
<tr>
<th>Theme</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>The purpose and focus of the integrated concept</td>
<td>Frustrations and lack of progress result in the need to relaunch whole NT concept – potentially with STP.</td>
</tr>
<tr>
<td></td>
<td>Lack of understanding of the NT process results in lack of ability for both staff and patients to navigate the system. This results in a time-consuming process and patients not taking up services available.</td>
</tr>
<tr>
<td></td>
<td>Phase two aimed to explore the feasibility of the model and learn from the experiences of phase one. The second phase was implemented due to the initial phase losing momentum and not representing the original vision.</td>
</tr>
<tr>
<td></td>
<td>Loss of focus can be attributed to implementation difficulties, becoming distracted by other initiatives/priorities, and loss of particular roles.</td>
</tr>
<tr>
<td></td>
<td>Model had intentionally become focused on the core MDT, which should be incidental if partnership working had been achieved.</td>
</tr>
<tr>
<td></td>
<td>Model application variation is somewhat inevitable and could be due to the need to adapt to local needs and circumstances, and lack of clarity of the purpose of the NTs. Implementation variation however can result in quality variation.</td>
</tr>
</tbody>
</table>
Driving the model from MDT meetings to a broader delivery of care and services in the community requires substantial and significant changes.

<table>
<thead>
<tr>
<th>Multi-disciplinary team working and engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDT meetings have developed organically due to their ability to adapt to their local NT needs, resulting in variation in leadership, quality, effectiveness, format, attendance and commitment. Some are much more advanced than others.</td>
</tr>
<tr>
<td>Variable MDT meeting attendance (due to workload demands and conflicts of interest) results in inconsistencies and insufficient patient information.</td>
</tr>
<tr>
<td>Even if staff were able to attend MDT meetings, it was not viewed as beneficial or relevant in light of other workload demands.</td>
</tr>
<tr>
<td>Despite critical engagement of primary care and GPs, extreme variation was experienced. As the model and referral processes had not be effectively implemented, this had effected GP engagement (particularly due to their current workloads and demands), which results in sub-optimal outcomes.</td>
</tr>
<tr>
<td>Varying approaches needed to facilitate GP engagement, due to their own interpretation, behaviours, priorities and cultures.</td>
</tr>
<tr>
<td>Engagement and commitment can be affected by partner organisations becoming distracted by other priorities or other agendas and outcomes.</td>
</tr>
<tr>
<td>Lack of leadership and shared ownership make it unclear whose responsibility partnership working was.</td>
</tr>
<tr>
<td>Developing relationships between the desired organisations is difficult due to contrasting cultures and ways of working.</td>
</tr>
<tr>
<td>Trust between organisations would reduce duplication and provide continuity of care, however this is difficult when separate accountability and Key Performance Indicators exist.</td>
</tr>
<tr>
<td>While communication may happen between staff at the same level – there is less communication across different levels (i.e. managers and ground force staff).</td>
</tr>
</tbody>
</table>
While partnership working is desirable it is also difficulty and organisations are not currently functioning or operating as a team, as it requires organisations to give up some sovereignty and power.

<table>
<thead>
<tr>
<th><strong>Professional roles and responsibilities</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability for specialist clinical roles to perform home assessments and administer comprehensive geriatric assessments was feasible and practical within the NT model.</td>
</tr>
<tr>
<td>Workforce changes and a loss of particular clinical roles resulting in a decrease of GP engagement and referrals to the NTs. Also meant that other roles were providing the leadership and making clinical decisions who weren’t best placed to.</td>
</tr>
<tr>
<td>Inconsistency in the requirements of the CLO role.</td>
</tr>
<tr>
<td>Reorganisations and workforce changes create delays in NT progression as new members need the time to develop knowledge of the processes and embed into the team dynamic.</td>
</tr>
<tr>
<td>PCN roles can obtain a different perspective of patient needs which other organisations do not have the benefit of, as they help to break down some of the barriers other organisations experience, and they have the capacity to spend time with patients and build relationships.</td>
</tr>
<tr>
<td>Staff don’t have the time to take a step back from delivering care to understand other professions and organisations roles, however this results in inappropriate referrals.</td>
</tr>
<tr>
<td>Without a clear leadership role, the NTs were not sustainable as a service as people will revert back to habitual and more comfortable ways of working. Appropriate people hadn’t always been given leadership roles, however there is a difficulty of identifying these roles within the current system and resources.</td>
</tr>
<tr>
<td>Difficulty of managing people and facilitating an understanding of the need for change, new roles, and ways of working.</td>
</tr>
<tr>
<td>Staff doing own normal day to day working alongside NT working.</td>
</tr>
</tbody>
</table>
Previous ways of working and separate accountability meant that organisations struggled with joint action and responsibility.

<table>
<thead>
<tr>
<th>Contextual factors and challenges and integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systemic issues were yet to be grasped in manner which would enable integration – system not designed with integration in mind to allow organisations to successfully work together and the majority of organisations all use different systems. This means that sharing of information is reliant on individuals attending MDTs, which was not always feasible.</td>
</tr>
<tr>
<td>Even if individuals could grasp the benefits of the integrated concept, the system did not enable them to deliver care in this way, which affected the motivation and engagement of staff.</td>
</tr>
<tr>
<td>Although there is national importance placed on system leadership, the system does not promote and enable trust between organisations (due to separate working practices and accountability).</td>
</tr>
<tr>
<td>Lack of resources to support change, in particular from providing care in the acute sector, into the community – not feasible within current resources – haven’t seen sufficient investment.</td>
</tr>
<tr>
<td>Not feasible to provide proactive care and improve care outcomes within current resources, despite commitment from organisations and professionals to do so.</td>
</tr>
<tr>
<td>Such a large scale transformation needs sufficient resources (workforce, budgets, time, and leadership capacity) – a lack of which creates increased waiting times. Insufficient workforce for level of demand (in particular community services). Workforce issues contribute to the lack of recent progress.</td>
</tr>
<tr>
<td>Large workloads of some partner organisations affects the logistics of them being able to attend NT MDT meetings.</td>
</tr>
<tr>
<td>Feasibility of organisations working together in partnership in light of information governance, and separate referral processes and workloads.</td>
</tr>
<tr>
<td>Although middle managers may need to unblock some of the barriers for ground force staff, they have various roles to</td>
</tr>
</tbody>
</table>
juggle (including support, and managing issues with resources and staffing) – feasible within the job role?

Change and restructures can destabilise things and people are unnerved by change.

<table>
<thead>
<tr>
<th>Expectations and the reality of integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>While the integrated concept was appropriate for delivering patient-centred care, the reality of achieving this in a real world setting was much more complex than originally envisaged, despite indications from the evidence base.</td>
</tr>
<tr>
<td>Feasibility and complexity of enabling the NT model to operate on a larger scale than currently doing so. A population based approach had not been delivered as expected – due to variable GP population sizes and implementing NT concept without appropriate infrastructure in place.</td>
</tr>
<tr>
<td>In reality ground force staff concentrate on daily duties – don’t need to engage with wider NT strategy.</td>
</tr>
<tr>
<td>Current system provides a no response to referrals into the NT – effecting engagement with the service.</td>
</tr>
<tr>
<td>Model not currently successfully identifying and accessing patients, who were not being managed effectively, with a lack of infrastructure in place.</td>
</tr>
<tr>
<td>Lack of GP engagement affected the feasibility of integrating primary care into the NT model, despite primary care theoretically being at the centre of the model.</td>
</tr>
<tr>
<td>Is it feasible to achieve the aims and objectives of the NT model amongst the barriers and challenges? A focus on prevention within a stretched system presents a significant challenge. In reality NTs were still spending a lot of time dealing with complex acute patients, which could have been avoidable if the shift in resources had enabled them to focus on proactive care. Double-running costs of the shift from reactive to proactive care, with a difficulty of breaking the cycle of focusing on those with more complex needs. Acute sector was often not the best place for patients, however the difficulty of transitioning care from the acute sector into the community within available resources was acknowledged.</td>
</tr>
</tbody>
</table>
As integration promoted a substantial shift in ways of working, a change in culture and mind-set was needed (normative integration and relational processes).

As integration is a significant change, it doesn’t happen overnight, too high an expectation on what the model could achieve in the timescale set. Within the current system, the NT initiative was far from a fully operating NT model.

Not yet enough down the lengthy implementation process to see an impact and change in ways of working – integration takes a significant amount of time.

Although participants acknowledged a need and expectation of a preventative and proactive approach toward patient care, the reality of the difficulty of the prevention agenda in practice was also acknowledged.

There is the assumption from patients and families that health and social care staff understand each other’s roles and communicate effectively. Patients’ expectations were also considered in reference to patients assuming that their care was being co-ordinated and information shared across organisations.

Aspirations and future goals of care delivery

Considerable work still to be done in order to enable individuals to operate as a team continuously (rather than just in MDT meetings).

Single assessment process a long way from being developed and implemented.

Need support from the system to avoid continued barriers of silos.

Preventative and proactive approach challenging – affects the feasibility of achieving the aims and objectives of the NT in delivering preventative care.

Need for honest and open conversations about realistic implementation of NT amongst challenges.

Front-line staff willing to make the change and work together but need agreements on clinical and organisational governance to work in partnership.
### RQ4: What are the barriers and facilitators to developing integrated teams, and implementing and sustaining integrated care?

<table>
<thead>
<tr>
<th>Theme</th>
<th>Data</th>
</tr>
</thead>
</table>
| **The purpose and focus of the integrated concept** | **Barriers:**<br>Lack of strategic clarity of the Neighbourhood Teams could be a barrier to workforce engagement.<br>Barriers and challenges which had hindered progress had resulted in frustration in response to the strategic vision.<br>The barriers faced are likely to be synonymous across NTs,<br>Lack of leadership and ownership of managing change and new ways of working contribute to implementation variation.<br>Seen as an add on to day job rather than a new way of working in a team.  
**Facilitators:**<br>Need appropriate commitment from appropriate people and a clear understanding of aims and objectives to develop a successful model.<br>Need a level of consistency and a baseline consistent offer. |
| **Multi-disciplinary team working and engagement** | **Barriers:**<br>Lack of any form of leadership leads to lack of perceived importance of the MDT meeting.<br>NT and MDT working seen as an add on to staff normal daily duties and not necessarily relevant.<br>Lack of progress at scale and pace, understanding of the model and perceived relevance were considered to contribute to the lack of GP and primary care engagement. Additional barriers included own interpretation of collaboration, rurality and accessibility, workforce shortages and changes, time-limited nature of GP job role, and anxieties that engagement would increase the level of demand.<br>Partnership working barrier of organisational workload demands promotes territorial and protective behaviours.  
**Facilitators:**<br>MDT meetings facilitate organisational and professional engagement and teamwork, promote an MDT approach for |
patients, enable communication and relationships, and ownership and responsibility.

Lack of specialist clinical leadership facilitates teams developing a shared ownership of the NT process, promoting an open forum of discussion with MDT meetings, and having more organisational engagement.

Change in mind-set that MDT working is viewed as being part of a new team.

GP engagement needs effective communication and organisational buy-in, being able to demonstrate the benefits, building relationships and developing leadership roles.

Engagement attributable to individuals and the relationships formed, including facilitators such as shared ownership and professional respect.

Interpersonal relationships and trust are key to the development of the model and partnership working across organisational barriers. One of the facilitators of this is having the right personalities with the right skills, rather than the appropriate qualifications.

Trust between organisations needed, particularly in reference to assessment processes and discharges.

MDT meetings at GP practices facilitates communication and relationship and professional integration.

MDT meetings promote benefits for staff and patients including teamwork, ownership, responsibilities, and ease of accessing patients.

<table>
<thead>
<tr>
<th>Professional roles and responsibilities</th>
<th>Barriers:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lack of understanding of professional and organisational roles, potentially as facilitating this is time-consuming and complex</td>
</tr>
<tr>
<td></td>
<td>Anxiety associated with change</td>
</tr>
<tr>
<td>Facilitators:</td>
<td>Specialist clinical role – capacity to provide complex community care, clinical leadership and structure to MDT meetings</td>
</tr>
</tbody>
</table>
Dedicated frailty teams working with partner organisations to provide patient-centred care and care planning

PCN role beneficial for delivering patient-centred care, self-management, continuity of care, providing social support and helping patients appropriately use services. A contributory factor is their extensive knowledge base.

Understanding the value of what organisations have to offer patients. Training and education needed to facilitate understanding of professional and organisational roles and responsibilities.

Appropriate leaders in place who commit to driving changes and keeping workforce focused.

Organisational commitment, shared responsibilities, normalised integrated ways of working.

<table>
<thead>
<tr>
<th>Contextual factors and challenges and integration</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systemic: System not designed for integrative practice, most organisations are on different systems which creates issues of information governance and sharing information.</td>
<td></td>
</tr>
<tr>
<td>Tensions and frustrations of lack of resources – implementing system transformation within decreasing resources. Insufficient workforce for the level of demand</td>
<td></td>
</tr>
<tr>
<td>Perception of increased workloads barrier to engagement and MDT attendance</td>
<td></td>
</tr>
<tr>
<td>Separate referral processes and workloads</td>
<td></td>
</tr>
<tr>
<td>Professional barriers: cultural change needed – particularly at middle management level who need to unblock some of the barriers ground force level staff experience</td>
<td></td>
</tr>
<tr>
<td>Anxiety and fear associated with change</td>
<td></td>
</tr>
<tr>
<td>County specific barriers – workforce recruitment and professional engagement (e.g. lack of staff available to assign to NTs, difficulty of recruiting GPs), geographical constraints, poor reputation of acute trust</td>
<td></td>
</tr>
</tbody>
</table>

Facilitators
<table>
<thead>
<tr>
<th>Expectations and the reality of integration</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care buy-in essential</td>
<td></td>
</tr>
<tr>
<td>Lack of normative integration and cultural processes – cultural change needed around how organisations perceive themselves and function within designated teams – still operating in silos and focusing on Key Performance Indicators and separate accountability rather than patient needs – not patient focused</td>
<td></td>
</tr>
</tbody>
</table>

| Facilitators: |
| Ground force staff need to see the relevance of the strategy to their daily roles and the overall transformation of services and systems |
| Everyone consistently signed up to a programme of change and committed to the process in order to facilitate successful change |
| Importance of clarity and guidance |
| Start small and build the model up |

<table>
<thead>
<tr>
<th>Aspirations and future goals of care delivery</th>
<th>Barriers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concept not currently tangible and translated into action – hard to sell the benefit to people</td>
<td></td>
</tr>
</tbody>
</table>
Organisational and professional perceptions present a barrier to implementation of successful working

Facilitators:

Consistent organisational commitment

Promote shared ownership and facilitate enabling teams to work together in partnership in a normalised business as usual working mentality and process

Change in mind-set for referral processes

Education, guidance, and training in order to sell the NT vision and facilitate understanding of the concept – engagement events and sharing individual stories

Support from the system in terms of investment and removing barriers

Collaboration and sharing of information between the acute sector and NTs (vertical I) – rich picture of care history and improving staff and patient experience and bring advantageous to the system, as people would be supported to self-manage in a preventative and cost-efficient way.

Roll out of PCN role, co-location (including opportunistic communication, sharing info and collaborating), clear vision, effective leadership, a period of stability in workforce and leadership, giving staff the authority to change.

A better workforce understanding of the concept and model, enabling shared ownership and commitment

Individuals working in the model key to its success

Agreements on clinical and organisational governance to work in partnership

Need a clear vision for everyone to sign up to in order to achieve successful integration
## Appendix 16 – Chapter 6: Participant partnership principle scores

<table>
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### Appendix 17 – Chapter 6: Descriptive statistics

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*a. Multiple modes exist. The smallest value is shown*
Appendix 18 - Chapter 6: Normal distribution considerations

Histograms

**Principle 1**

- Mean = 17.73
- Std. Dev. = 2.864
- N = 30

**Principle 2**

- Mean = 18.70
- Std. Dev. = 3.515
- N = 30
Principle 3

Mean = 15.83
Std. Dev. = 3.425
N = 30

Principle 4

Mean = 17.13
Std. Dev. = 3.381
N = 30
## Test for Normality

### Tests of Normality

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<th>Shapiro-Wilk</th>
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<sup>∗</sup> This is a lower bound of the true significance.

<sup>a</sup> Lilliefors Significance Correction
Box plots
Appendix 19 – Chapter 6: Rapid partnership profiles

Neighbourhood Team 1:

Neighbourhood Team 2&3:
Neighbourhood Team 4&5:

Mental Health Services:
Community Services:

Adult Social Care:
Acute Services:

Third/voluntary sector:
### Appendix 20 – Chapter 6: Partnership principles, scores and explanations

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<td>Very high recognition and acceptance of the need for partnership</td>
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<td>The need for partnership is recognised and accepted</td>
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<td>Only limited clarity and realism of purpose exists</td>
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<td>There is some degree of commitment to, and ownership of, the partnership</td>
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<td>B</td>
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<td>7 - 12</td>
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<td>Partnership monitors, measures and learns from its performance poorly in some respects</td>
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### Appendix 21 – Chapter 6: Interpretation of partner organisation score

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383
### Appendix 22 – Chapter 6: Interpretation of Neighbourhood Team score

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<th>NT1 (n=11)</th>
<th>NT2 (n=8)</th>
<th>NT3 (n=9)</th>
<th>NT4 (n=12)</th>
<th>NT5 (n=10)</th>
<th>Overall (n=30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Very high recognition &amp; acceptance of the need for partnership</td>
<td>Need for partnership is recognised &amp; accepted</td>
<td>Need for partnership is recognised &amp; accepted</td>
<td>Need for partnership is recognised &amp; accepted</td>
<td>Need for partnership is recognised &amp; accepted</td>
<td>Need for partnership is recognised &amp; accepted</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>P2</td>
<td>Some degree of purpose and realism to the partnership</td>
<td>Some degree of purpose and realism to the partnership</td>
<td>Some degree of purpose and realism to the partnership</td>
<td>Some degree of purpose and realism to the partnership</td>
<td>Some degree of purpose and realism to the partnership</td>
<td>Some degree of purpose and realism to the partnership</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>P3</td>
<td>Some degree of commitment &amp; ownership</td>
<td>Some degree of commitment &amp; ownership</td>
<td>Some degree of commitment &amp; ownership</td>
<td>Some degree of commitment &amp; ownership</td>
<td>Some degree of commitment &amp; ownership</td>
<td>Some degree of commitment &amp; ownership</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>P4</td>
<td>Well-developed trust amongst partners</td>
<td>Some degree of trust amongst partners</td>
<td>Some degree of trust amongst partners</td>
<td>Some degree of trust amongst partners</td>
<td>Some degree of trust amongst partners</td>
<td>Some degree of trust amongst partners</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>P5</td>
<td>Partnership working arrangements are reasonably clear &amp; robust</td>
<td>Partnership working arrangements are reasonably clear &amp; robust</td>
<td>Partnership working arrangements are reasonably clear &amp; robust</td>
<td>Partnership working arrangements are reasonably clear &amp; robust</td>
<td>Partnership working arrangements are reasonably clear &amp; robust</td>
<td>Partnership working arrangements are reasonably clear &amp; robust</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>P6</td>
<td>Partnership monitors, measures &amp; learns from its performance reasonably well</td>
<td>Partnership monitors, measures &amp; learns from its performance reasonably well</td>
<td>Partnership monitors, measures &amp; learns from its performance reasonably well</td>
<td>Partnership monitors, measures &amp; learns from its performance reasonably well</td>
<td>Partnership monitors, measures &amp; learns from its performance reasonably well</td>
<td>Partnership monitors, measures &amp; learns from its performance reasonably well</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
</tbody>
</table>

**Code**

|   | B                               | B                              | B                              | B                              | B                              | B                           |

**Total**

<table>
<thead>
<tr>
<th></th>
<th>Partnership is working well enough overall but some aspects may need further exploration &amp; attention</th>
<th>Partnership is working well enough overall but some aspects may need further exploration &amp; attention</th>
<th>Partnership is working well enough overall but some aspects may need further exploration &amp; attention</th>
<th>Partnership is working well enough overall but some aspects may need further exploration &amp; attention</th>
<th>Partnership is working well enough overall but some aspects may need further exploration &amp; attention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
</tbody>
</table>
## Engagement and MDT meeting attendance

<table>
<thead>
<tr>
<th>Positive (n=6)</th>
<th>Negative (n=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Principle 1: From joining the NT at the beginning of the primary care project in 2015 the meetings were well attended.</td>
<td>• Principle 1: After a good start, in the last couple of years there has been a distinct lack of engagement by District Nurses.</td>
</tr>
<tr>
<td>• Principle 1: It (engagement) is well understood by what appears to be the core group.</td>
<td>• Principle 1: A number of partners, most notably GPs are generally (but not exclusively) not engaging in the process well. This is something which will hopefully evolve.</td>
</tr>
<tr>
<td>• Principle 1: This (engagement) is seen with a number of joint assessments and visits which work well for the patient and the practitioner.</td>
<td>• Principle 1: Not all partners appear to be actively involved.</td>
</tr>
<tr>
<td>• Principle 4: Having representation from third sector involvement.</td>
<td>• Principle 1: Poor attendance at the meetings has meant the effectiveness of the service is not working as it did in the beginning. The loss of GP input (name of GP) in the north, was the start of the gradual splintering of the team and the loss of effectiveness of the service.</td>
</tr>
<tr>
<td>• General: The weekly meetings have brought together health and social care professionals who discuss individuals and form and action plan which addresses these needs simultaneously. It saves so much time and is a very efficient medium for problem solving. Quick results are best for patients and staff.</td>
<td>• Principle 2: Plenty of third sector could be more involved.</td>
</tr>
<tr>
<td>• General: Promotes understanding of different organisations, networking and support for service users and professionals/organisations.</td>
<td>• Principle 2: (Reason for partner engagement) should be but isn’t clear.</td>
</tr>
<tr>
<td>• Principle 3: Limited DN (district nurse) commitment.</td>
<td>• Principle 3: Rare to nil involvement from medical professions (e.g. GP).</td>
</tr>
<tr>
<td>• Principle 4: Better attendance could improve partnership working.</td>
<td>• Principle 4: Not really much role for adult mental health, more older adults.</td>
</tr>
<tr>
<td>• General: Plenty of room for improvement, more engagement is</td>
<td></td>
</tr>
</tbody>
</table>
needed from some services to push the team further.

- General: Low or no attendance from some partners.
- General: Needs more recognition to engage continued commitment - despite all having complex, high caseloads - the need to prioritise meetings is required.
- General: Lack of attendance at the meetings has led to lack of performance.
- General: Not 100% commitment from all NT members and referrals number tends to be low (however is rising).
- General: Our meetings have only just started within the last couple of months and so attendance has been variable.
- At the present time were there to be further conferences under that name (LHAC) I doubt I would put aside the time to go... It is certainly not something my colleagues and I discuss very regularly, well, ever.

### Impacts and outcomes

<table>
<thead>
<tr>
<th>Positive (n=6)</th>
<th>Negative (n=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principle 1: Results were achieved through networking with health professionals who had previous and ongoing involvement with patients.</td>
<td>Principle 1: Since its implementation I haven't noticed a very real change. Sure enough we talk to the nurses a little more but I haven't noticed an enhanced number of proactive referrals.</td>
</tr>
<tr>
<td>Principle 1: In particular the idea of multi-agency statutory and non-statutory has been the preferred way of working locally as it has enabled us to offer a more timely and integrated response to patient need.</td>
<td>Principle 1: I'm not sure that I have been involved long enough to comment on there being substantial achievements.</td>
</tr>
<tr>
<td>Principle 2: Partnership success as it appears to work very well and</td>
<td>Principle 4: Unable to prioritise patients seen by Neighbourhood Team over own caseload at times.</td>
</tr>
<tr>
<td>Expected success</td>
<td>Challenges and Concerns</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Hopefully it can continue to feed on its own success.</td>
<td>Principle 6: Database is poor and does not reflect true accounts of what is happening in the team.</td>
</tr>
<tr>
<td>Principle 2: It (success) has been down to the members of the NT itself who meet weekly.</td>
<td>Principle 6: I have never seen an outcome measure.</td>
</tr>
<tr>
<td>Principle 4: We have kept some patients at home without significant input which is a positive outcome.</td>
<td>Principle 6: This has been going on sometime and we have not had any feedback/ objective measurement about what has changed.</td>
</tr>
<tr>
<td>General: I am positive about the need to work together even if I feel it is not clear if we are.</td>
<td>General: Where I am an advocate for partnership working, I can’t say that I have found this movement to be an astounding success.</td>
</tr>
<tr>
<td></td>
<td>General: Fundamentally the LHAC programme offered much but it appears to me to have delivered little. Perhaps there has been positive outcomes but we have not been made aware of them. I have heard the ‘better together’ meetings are good. Are these under the same LHAC programme? Was there ever a public consultation on LHAC? What was the results? If it is still moving forward it is doing so with glacial slowness.</td>
</tr>
<tr>
<td></td>
<td>General: It seems like we had a lot of meetings and conferences about how things were going to change. I would say that people’s attitudes have changed but this is a subjective feeling. With regards to objective outcomes I am unaware of any. I am not sure were I an investor that I would be putting money into this as a business.</td>
</tr>
</tbody>
</table>
## Variation and challenges

<table>
<thead>
<tr>
<th>Neutral (n=4)</th>
<th>Negative (n=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Principle 2: More within physical health and older adults though (clear vision and shared values).</td>
<td>• Principle 1: Frequent examples of differing practices between differing organisations. Differing perceptions of key corporate policies can lead to duplication, disagreement and silo mentality. Often patients gets lost in process because process gets in the way.</td>
</tr>
<tr>
<td>• Principle 4: Depends on which team some are better than others.</td>
<td>• Principle 1: On a larger scale, could face barriers.</td>
</tr>
<tr>
<td>• General: Overall it does feel like we work more with our other stakeholders but I wouldn’t want to have to be able to prove it.</td>
<td>• Principle 1: (Barriers include) resources, skill mix retention and geography.</td>
</tr>
<tr>
<td>• General: I do not feel that adult mental health is at the 'core' of the neighbourhood team. We work with services such as mental health social care, housing, addiction, employment services, voluntary services, police, probation etc. We generally do not work with district nurses, [name of local hospice], age UK, physios. So for this to work for adult mental health, shouldn’t we be working more closely with the appropriate teams for our service?</td>
<td>• Principle 1: Individual provider organisation governance issue and concern about risk obstruct effective and efficient joint working.</td>
</tr>
<tr>
<td>• General: I accept that the Neighbourhood team is useful for some people and may be working well for other services.</td>
<td></td>
</tr>
</tbody>
</table>

## Understanding of the process

<table>
<thead>
<tr>
<th>Neutral (n=1)</th>
<th>Negative (n=7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Principle 1: This (mutual understanding) depends whether it is the existing core group, which appear to understand this, or the broader group where there is a feeling involvement is not fully appreciated.</td>
<td>• Principle 3: Across the county, there is still a significant lack of understanding of the concept and how it will positively impact on what we do.</td>
</tr>
<tr>
<td></td>
<td>• Principle 4: Still seems to be widespread referrals to the therapy service of adult social care by patients we have previously seen before. They could call us to speak with us and we could explain why we think a further</td>
</tr>
</tbody>
</table>
referral is pointless but this rarely occurs.

- Principle 5: This (responsibility) depends on the team and who attends, it's not always clear who can do what.

- Principle 6: The team aren’t aware of these processes. I used to be left to get on with it - so it’s not clear.

- Principle 6: Our database/report has not been submitted for the past 10 months - no questions were asked to find out why -therefore is the report even relevant?

- General: It is still very unclear as to the role of adult mental health CMHT. It appears that our role is very limited.

- General: I have no idea (despite repeated +++ requests) what constitutes a patient to be discussed at the meetings and what is just a straightforward therapy referral.

### Relationships

<table>
<thead>
<tr>
<th>Positive (n=5)</th>
<th>Negative (n=1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principle 1: (Factors associated with successful working are known and understood) due to small group, culture of group, professional relationships.</td>
<td></td>
</tr>
<tr>
<td>Principle 4: A high level of trust (within the partnership).</td>
<td></td>
</tr>
<tr>
<td>Principle 4: The level of trust between colleagues is very high.</td>
<td></td>
</tr>
<tr>
<td>General: The successes are due to very effective communication and trust between the team members.</td>
<td></td>
</tr>
<tr>
<td>General: Our hospice team has been involved with the Neighbourhood Team for the last 12 month. In this</td>
<td></td>
</tr>
<tr>
<td>Principle 1: There are major issues in relationships with DN who insist assessments are repeated and are grudging in their acceptance of referrals.</td>
<td></td>
</tr>
</tbody>
</table>
time we have developed our relationships with the other services in the area. This has led to better relationships with these teams, and has also led to a significant increase in referrals to our hospice service in the [name of NT] area. We are soon to co-locate within [name of community hospital] which our service see as a very positive step.

<table>
<thead>
<tr>
<th>Aims and objectives</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive (n=2)</strong></td>
<td><strong>Negative (n=4)</strong></td>
</tr>
<tr>
<td>• General: As it has been working in the [name of NT], I feel it is achieving its aims well.</td>
<td>• Principle 1: More work needed to define common purpose and goals and to also build a corporate trust.</td>
</tr>
<tr>
<td>• General: At the present time the aims and objectives of the neighbourhood team are working well. The team is currently going through a period of transition so I cannot comment if the new aims and objectives are working.</td>
<td>• Principle 2: No aims or objectives have ever been communicated as far as I am aware.</td>
</tr>
<tr>
<td></td>
<td>• General: I am not aware of what the goals of the NHT were/are and I am especially unclear as to how they are being measured.</td>
</tr>
<tr>
<td></td>
<td>• General: We have not discussed any strategic aims/visions/expectations at all (that I am aware of).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Leadership</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neutral (n=2)</strong></td>
<td><strong>Negative (n=2)</strong></td>
</tr>
<tr>
<td>• Principle 1: There needs to be top down guidance.</td>
<td>• Principle 3: Senior levels are only starting to become more visible.</td>
</tr>
<tr>
<td>• General: Needs consistent commitment from management to co-ordinate roles and clarify.</td>
<td>• General: The neighbourhood team meetings used to be better when we had medical leadership. They are a bit vague now.</td>
</tr>
</tbody>
</table>
Appendix 24 – Chapter 8: Neighbourhood Teams meeting attendance field notes

Table 1: Neighbourhood Teams meeting location and number of staff

<table>
<thead>
<tr>
<th>Teams</th>
<th>Location</th>
<th>No of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot Site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT1</td>
<td>Community hospital</td>
<td>10</td>
</tr>
<tr>
<td>South</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT2</td>
<td>GP surgery</td>
<td>6</td>
</tr>
<tr>
<td>NT3</td>
<td>Community Health Services</td>
<td>4</td>
</tr>
<tr>
<td>North</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT4&amp;5</td>
<td>GP surgery</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 2: Neighbourhood Teams meeting profession attending

<table>
<thead>
<tr>
<th>Teams</th>
<th>CLO</th>
<th>ASC</th>
<th>Physio</th>
<th>OT</th>
<th>CPN</th>
<th>Nurse</th>
<th>PIC</th>
<th>GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot Site</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT1</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>South</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT2</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>NT3</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT4&amp;5</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3: Neighbourhood Teams number of patients on caseload

<table>
<thead>
<tr>
<th>Teams</th>
<th>Existing</th>
<th>New</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot Site</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT1</td>
<td>7</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>South</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT2</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>NT3</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>North</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT4&amp;5</td>
<td>13</td>
<td>8</td>
<td>21</td>
</tr>
</tbody>
</table>
Table 4: Neighbourhood Team meeting field notes and comments

<table>
<thead>
<tr>
<th>Field Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The purpose and focus of the integrated concept</strong></td>
</tr>
<tr>
<td><strong>NT1</strong></td>
</tr>
<tr>
<td>• The process has not been thought through properly.</td>
</tr>
<tr>
<td>• They are concerned that as pilot site they have developed the team to work for them and their population, but that this might not work for other Neighbourhood Teams.</td>
</tr>
<tr>
<td>• While the overall vision was that there will be co-location, staff are not sure what’s happening with that (but desks keep arriving). <strong>Uncertainty/ lack of awareness of the type of integration being developed and implemented.</strong></td>
</tr>
<tr>
<td>• It was considered that as the CCG vision wasn’t that the Neighbourhood Team concept would be the MDT meeting, they want to phase it out as it had become unnecessarily focused on it. However the practitioner level staff found the meeting beneficial and necessary to formalise referrals. They were confused as to why they would want to get rid of something which was working. There was great anxiety associated with getting rid of the meetings. It was also unclear what will they would be replaced with. <strong>Unintentional focus on MDT. Disconnect between strategic and practitioner level. Resistance to change. Lack of understanding of decision being made and change creates anxiety. Massive disparity between strategic and practitioner vision – how do you then implement change successfully? Key issue. Not on board with strategic plan.</strong></td>
</tr>
<tr>
<td>• Staff did not want to get rid of meetings as it was what worked for them, even though it is the CCG vision to phase them out.</td>
</tr>
<tr>
<td>• Staff see the CCG input as interference as they’ve only recently shown an interest in the team. <strong>Resistance.</strong></td>
</tr>
<tr>
<td>• The CCG think that the vision is colocation, but what works is the meeting. <strong>Disconnect/ contrast in what was appropriate/works.</strong></td>
</tr>
<tr>
<td>• There is no clear vision. The CCG want to change the structure of the Neighbourhood Teams and the NT1 team does not. <strong>Disconnect/ contrast in what was appropriate/works. Resistance to change.</strong></td>
</tr>
<tr>
<td>• Bottom down approach being utilised rather than bottom up which was needed.</td>
</tr>
<tr>
<td>• One staff member didn’t like being called a project and found it insulting.</td>
</tr>
</tbody>
</table>
• Staff feel like they have no idea what’s going on – do not know what the vision is/lack of awareness.

• Staff are unsure about how everything fits together. Lack of clarity/understanding.

• Staff felt the need to be reassured that the core group remains solid. Uncertainty in times of change. Over-reliance of core group?

NT2
• One staff member commented that patients often decline help/support until they get to crisis level. Hard to implement prevention agenda.

NT3
• Unclear what the referral process is. Questioned what the contact centre’s role is.

• Observation: The format of the meeting is that they go through updates of patients on the caseload then discuss new referrals. Staff also bring new referrals to the meeting.

NT4&5
• Staff were unsure about referring into the well-being service with a lack of awareness of who can refer to whom. Unawareness of referral process.

• Open discussions were had about outcomes for patients. Patient focus.

• It was considered that everyone knows the concept of the NTs works

• Inappropriate referral had come in for a sprained ankle. Staff member was told to tell the referrer that it has to be multidisciplinary / to ask for more information.

• There was an awareness that they were piloting Personal Care Plans in the pilot site.

---

**Multidisciplinary team working and engagement**

NT1
• All professions in attendance apart from GPs. CLOs leading the meeting. Ten in attendance.

• There is a lack of clarity and awareness of what’s going on outside of the MDT meeting. Integration is not business as usual.
• Some staff only dedicated time of one and a half hours for the MDT meeting, as they had no more time to give as this would take away from their daily work. However, they do communicate outside of the meeting. Seen as an add on. Time constraints/ other priorities. But communication/MDT working outside of meeting (Contradiction).

• One staff member reflected that in light of a the lack of commitment from staff to attend meetings, you only have to go to one or two MDT meetings where there is low attendance, before you then think it’s not worth your while and don’t then attend either. An implication of a lack of commitment/engagement was considered to be a perception that it was not worth your time to make the effort to go to the MDT meeting, due to the lack of attendance.

• It was considered that if the MDT meeting was taken away (as strategic leads wanted) there would be more demoralisation and staff won’t engage with the process. Fatigue and disillusion. Demoralisation. Implications of the resistance to change, lack of sense of ownership,

• There are concerns and confusing about the widening the NT model in the future. Will the core team remain the same or widen to the whole network? Fear/uncertainty of a network approach.

• Mental health staff member was the most vocal (they had been involved since the start). More of a sense of ownership? Other mental health professionals don’t feel as integrated in other teams.

• Staff felt that the real MDT working occurred when discussing patents in the MDT meeting. MDT represents real integration in action. Only happening in meetings?

• Observation: Staff are fighting against the vision and are not engaged. They either don’t understand the vision or don’t think that it is appropriate for their MDT working within the Neighbourhood Teams.

• Need commitment from staff to attend the MDT meetings.

• The Neighbourhood Teams work based on relationships formed, communication, and professional respect. Success due to individuals and relationships.

NT2
• CLO, Age UK, Adult Social Care, and GPs attended (6 staff members). Led by CLO. Engagement from GPs. No mental health, community services.
• Observation: GP attended then left once their patients had been discussed. They didn’t say much just mentioned one new patient. Referring patients into

• Observation: Partnership working within the meeting with staff offering to go see patients. A joint visit was also suggested for patient. Great partnership working between Adult Social Care and Age UK. 
Organisational/professional integration between ASC and Third sector

• There was a discussion between staff of whether organisations were aware of certain patients. Lack of organisational integration.

• Adult Social Care asked MDT colleagues for advice as they were unsure what to do with a certain case. Open to input/support and asking for cross-pro knowledge.

• Another GP dropped in to the meeting to discuss a patient that they had just been to see, and asked what support the Neighbourhood Team could provide. Staff commented that this scenario ‘is how it should work’, where they can all offer their services. However, there is often a lack of awareness/engagement from GPs. Doesn’t often happen like this. Benefit for this GP seeing it work in practice and quick results.

• Staff updated each other on patients they had been to see. Evidence of MDT working and patient focus.

NT3
• CLO, Adult Social Care and Physiotherapist (Community Services) in attendance (4 members of staff). Led by CLO. Attendance low.

• It was explained that District Nurses and Age UK usually attend but they had to send their apologies. They never have CPN or GP representation. Organisational commitment/attendance variable.

• Social care staff commented on lack of integration/PW with health

• Observation: Evidence of joint working instigated by staff suggesting joint visits to patients. There was also an open discussion referrals and a willing to take on patients.

• Adult Social Care staff member commented that integration wasn’t working, as health do not want to engage with the process. They explained that they had tried in the past to integrate but it hadn’t worked. They did not identify the NTs as successful integration. Not worked yet. NT not perceived to be integration – lack of shared vision. Disconnect between
health and social care – lack of integration and willingness to work together.

- Need the representation/presence of GPs within in the meeting.

- Adult Social Care staff member commented on the commitment of their line manager who recognised the importance of the Neighbourhood Teams and made it clear that they had to attend the MDT meeting and have a presence. They asked for volunteers but knew that if nobody did, someone would have to go. They considered that other organisations seem less committed. They questioned the reasons for other organisations not attending the meeting, and why District Nurses weren’t there today. If ASC can make the time, why can’t everyone else? Variation in organisational commitment/engagement and understanding of the importance of NT working.

- If GPs are busy, the Neighbourhood Teams still need a primary care representative /link person. Importance of primary care.

**NT4&5**

- CLO, Age UK, Adult Social Care, Community Services (Occupational Therapy & Physio) initially in attendance, CPN and District Nurse joined later (7 in attendance). Led by CLO.

- Feedback was needed from staff who were not there. One member of staff mentioned that they had not been able to get hold of the CPN (the CPN then arrived later on and the patient was discussed). Barrier to PW when professional can’t/don’t attend. Opportunity to discuss patients with other professionals in the meeting, don’t get that opportunity outside of the meeting- difficult to get hold of.

- They commented that there was no point of contact for well-being services and that they didn’t attend meetings. Lack of MDT working with some services – as they don’t attend meetings.

- Observation: Staff were happy to take patients and work in partnership, with good partnership working between everyone.

- A lot of patients were discharged during the meeting. Process

- The comparison was made with the pilot site where they meet weekly, so it was easier for team members to get to know each other and build relationships. However, this team only met fortnightly and meetings are often cancelled. Variation – not all NTs have the opportunity to build relationships – which was seen as important.
Integration and partnership working is all about building relationships. Key

GP asked for timescale once a patient is referred into the Neighbourhood Teams, but we couldn’t give one as it always varies dependent on the patient, but they said they needed one now. Lack of understanding/awareness.

<table>
<thead>
<tr>
<th>Professional roles and responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NT1</strong></td>
</tr>
<tr>
<td>• There is a lack of clarity and leadership. For example they have recently lost the project manager for the Neighbourhood Teams, and they were unsure as to who would be taking over the role. There was a variation of awareness of this management change, as it had not been communicated effectively to the whole team. Staff were rolling their eyes and commented that right at the end before they go live with phase two of the development of the Neighbourhood Teams, the project manager ‘jumps ship’. Loss/changes of important role. Affects staff motivation/engagement? Lack of support when crucial.</td>
</tr>
<tr>
<td>• There was confusion about whether the new STP project lead would also be the new Neighbourhood Team project lead. Leadership and lack of clarity.</td>
</tr>
<tr>
<td>• There was a lack of leadership roles for the changes being developed and implemented.</td>
</tr>
<tr>
<td>• It only works with the correct attitudes and personalities. However, these elements are not quantifiable, and success is due to who you’ve got round the table. Success due to individuals and issues with measuring success.</td>
</tr>
<tr>
<td>• Staff talked openly about what each profession/organisation had the ability/capacity to do, and they understood each other’s roles clearly. Understanding of roles and cross-organisation integration.</td>
</tr>
<tr>
<td>• They commented that they were looking to the matron to give them direction on risk stratification and caseloads. Leadership/guidance.</td>
</tr>
<tr>
<td><strong>NT2</strong></td>
</tr>
<tr>
<td>• They was uncertainty of whether services can refer to other services (e.g. for home fire check). Unawareness of other roles/services.</td>
</tr>
<tr>
<td><strong>NT3</strong></td>
</tr>
<tr>
<td>• Nurses blanket refer to physio. It was commented that District Nurses need to explain to patients what to expect from physio, so that physios then do</td>
</tr>
</tbody>
</table>
not go out and explain treatment process and patients say they don’t want that, as this is a waste of time. We need to educate professions on what other professions do. Discussions were had regarding who to refer to for what, and how, with an evident lack of understanding of the process. Lack of understanding of other org/professional roles. Lack of understanding of the referral process. Also managing patient expectations?

- One staff member explained that there was a comment on a referral that an Occupational Therapist would not work with patient until they’d had physio input. The physio commented that they found this strange, as they are short staffed, OTs and Physios aren’t therapy specific and have the same waiting lists. Staff therefore do a lot of dual tasks when they go and see patients. Task shifting between professionals – some resistance – some more protective of professional identity?

- Staff were unsure who was responsible for updating staff, sharing information re referral processes, what the plan is for the Neighbourhood Teams. Lack of leadership clarity.

- Difficulty for CLO that they are aware of the changes happening within the teams but the practitioners are not. They are unsure of what to communicate to the team regarding changes and the way forward (i.e. stopping the NT meetings). Not sure what info they can share, variation in communication between NTs of key changes – NT1 aware meetings are to be stopped NT2/3 not.

- Staff commented that some GPs question the clinical input that the NTs now have following the retirement of the community geriatrian. They don’t see nurses as having a clinical input. Only recognising one role as clinical input.

- There was a comment that NT1 feel they have a right to be involved with the development of their team, as they have developed theirs together from the beginning. However, other teams have less ownership of this process, as haven’t been involved from the start.

**NT4&5**

- Discussed whether some staff had capacity to do anything in certain situations. Developing understanding of roles

- Explanation that Occupational Therapy and Physiotherapy are currently sharing job roles due to shortages. Implications of workforce shortages. Task shifting and loss of professional identity.
• One staff member commented that they were not aware of what services organisations and professionals offer. Lack of awareness of other pros/orgs.

• An Adult Social Care member of staff asked what was happening with the role as they found it to be beneficial and was unaware that they were now PICs and where that was the same job role.

• It was considered that while there was commitment from people on the ground working in the Neighbourhood Teams, there was a need for proper commitment of funders which was considered to be lacking. Commitment/responsibility and strategic level needed to fund NT to make the changes they needed and work in the way they are being asked to.

• The constant changes and new people coming into the team meant that the relationships which had been built were lost. Implications of the loss/change of workforce.

• There are pockets of people doing different things. For example not everyone is aware of what the frailty team are doing and there is not a lot of communication about which patients they are taking responsibility for. For example, there is a lack of communication between CPNs and the frailty team. Variation – everyone doing their own thing.

• The CPN job role is based around GP practices, they don’t cover areas like Adult Social Care do. Differences in org/pros

Contextual factors and challenges of integration

NT1

• There are so many layers of staff and high level boards, who don’t actually communicate between themselves. Lack of communication at different levels – hierarchy

• Practitioner level concerns don’t get fed back to the strategic level. Disconnect between operational and strategic.

• They are trying to fit the strategic level agenda into the Neighbourhood Teams, but this is not necessarily appropriate. The staff feel that the teams work well the way that they are. Disconnect and resistance to change. Trying to shoehorn NTs into strategic agenda, NT considered appropriate. They were working in this way before they were told to. So they are bought into the concept but are resitant to change and think that they know better.
• Staff were working in this integrated way even before they were told to. For example, they are being asked to undertake training on person centred planning, but that was what they were doing anyway – deflection? Felt that they were already working towards integration before the strategic level got involved. Feel like they’re being patronised?

• Discharging patients back to the care of GPs is **time consuming** as they have to send letters.

• There are too many layers within the NHS, and too many routes to go through to get to the person you want to talk to. When you finally do they then say that they have no capacity and you have to ring contact centre etc. It is hard for staff to navigate and a lot of time wasted trying to navigate the system. Barriers and resources and pathways, no straight forward route. If staff mind in hard to navigate, it will be even harder for patients. Time consuming

**NT2**

• Staff needed updates about a patient from staff members who were not present. **Barrier – lack of engagement/commitment/logistics of attending a meeting/key patient info not being able to be shared.**

**NT3**

• It was explained that District Nurses and Age UK usually attend but they had to send their apologies. **Barrier – can’t always attend meetings. Organisational commitment/attendance variable.**

• As all organisations are on different systems, they have to go through GPs for information. However, it was questioned as the weather this was appropriate as GPs are so busy. Staff questioned whether GPs were doing jobs they shouldn’t be.

• Physio commented that they are losing four out of the seven band 6 physios, which means that as there will only be three. The implication of this is that they can no longer be aligned to Neighbourhood Teams and they are unsure about whether they will be able to attend the meetings. They also haven’t been told what will happen. **Loss of workforce/capacity affects logistics of attending meetings/alignment/engagement with NTs.**

**NT4&5**

• It was highlighted that there was a big waiting list for Physiotherapy and Occupational Therapy. **More demand? Lack of workforce? Lack of resources?**

• June meeting cancelled as the lead of the meeting (the CLO) was needed at the pilot site. **Implication of other priorities.**
• Easier to work in Neighbourhood Teams in summer rather than winter as it was too busy in winter, so there was no time to breathe or think about anything else. Barrier to engagement – other priorities – don’t have time to think about change.

• While the meeting started at 13:00, one staff member arrived at 1:45 as that was the time they were told and another arrived at 2:00. Lack of communication and logistics of attending

• CCG funding had ended for the PCN role a couple of months previous, and this role was now funded by the third sector until the end of the next month. Not enough resources to fund a role which was perceived to be beneficial for both staff and patients.

• As there is no directory of services and what they offer, it might be helpful for organisations to know what other organisations offer, as there is a lot of duplication. Duplication – implication of the lack of awareness of what services offer.

Expectations and the reality of integration

NT1
• While they were sold the vision that the strategy would be practitioner led, it does not feel like it is. Leadership

• Staff had no idea about what was happening with ‘going live’ with phase two (for which this team was the pilot site for).

• There is the expectation that you can roll out NT1’s approach to the other NTs, however staff are sceptical and worried that their approach won’t work in other areas. Needs to be specific to the health needs in each area. Transferability – needs to be specific to the context/local needs

• The care portal has not been delivered as promised. Virtual integration, delays, things not be delivered as quickly as intended.

• Trying to do too much too soon still and there are unrealistic time scales. Not learnt from previous mistakes.

• It feels like it’s losing its spirit. Losing momentum/initial positives

• The idea was that NT1 would be the blueprint for the other Neighbourhood Teams, however it was considered that you can’t necessarily apply what works in NT1 to other ideas, due to population needs. There was the suggestion that you might need a different blueprint for each
Neighbourhood Team. Transferability, theory vs practice. Concerns of rolling out the pilot site to other teams.

- What would be business as usual here, won’t work elsewhere.

NT4&5

- Neighbourhood Teams were considered to be a long way away from being where they want them to be. Reality – slow progress. Lack of understanding from strategic about the reality of integration and how long things take to change.

- It was considered that everyone knows the concept works but without proper commitment from funders, it’s not going to work in the long-term. The concept is not sustainable if it keeps changing all the time. Too many changes – lack of stability. Theory vs practice – reality is it’s not going to work without investment and commitment from a higher level. This investment links to strategic.

- Staff don’t have the authority to push what the priorities should be. Decision makers need to be on the ground. Don’t have the authority to make key changes/decisions.

- The pilot sites CLO is only contracted to do on 16 hours so they don’t have sufficient hours to keep on top of everything and coordinate. South and North have 32 hours each. They are trying to increase the hours for this CLO role. Lack of commitment from funders. Funding, recognition of importance of role.

Aspirations and future goals for care delivery

NT1

- Clarity needed for the plan going forward. Progression, what is the way forward? No shared vision.

- The staff feel that they do not get any feedback or praise. Lack of useful motivators/ outcomes

- The future seems very uncertain, which is very unnerving and unsettling. Fear/anxiety.

- Decision makers need to be closer to the ground. Hierarchy and levels of leadership
NT3
- Staff commented that they were worried that referrals weren’t being accurately reported. For example, when physiotherapy referred a patient to Adult Social Care via telephone, the receiver played down the urgency of the referral when passing it on to Adult Social Care colleagues and used their own judgment of urgency. It was only picked up that it was an urgent case because the patient and situation was already known to Adult Social Care staff who intersected. A new approach to referrals was therefore advocated. Referrals – subjective rather than objective – new process needed?

- Physios are now triaging and not going by the referral information received, and therefore making their own judgement about what’s urgent. Individual/professional behaviour.

- Referrals were considered to be increasing.

- Adult Social Care staff were asking about the referral process because their colleagues had been asking them and they wanted to feed back to the Adult Social Care colleagues who didn’t attend the meetings. Sharing learning with colleagues – unawareness even though attend meetings and committed/engaged.

NT4&5
- Consistency is needed or we’re just going to go round in circles.

- The CLO felt that it was strange that the project manager who works for the CCG though that the Neighbourhood Teams were working well, even though meetings kept being cancelled, and reports had not been sent for 9 months. Lack of communication/understanding with higher levels/key roles – not a lot of awareness high up as to what the reality and progress is.