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Title

Implementing an Integrated Acute Response Service: Professional Perceptions of Intermediate Care

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Background and Introduction

The 'Five Year Forward View' (NHSE, 2014) called for decisive steps to break down barriers to how care is provided, specifically the creation of integrated out-of-hospital multidisciplinary teams. Outlined in 'The Long Term Plan' (NHSE, 2019), the vision is for more joined-up and co-ordinated care rather than viewing contact with services as single, unconnected episodes of care. Furthermore, the creation of Integrated Care Systems (ICSs) aim to deliver a 'triple integration' of primary and specialist care, physical and mental health services, and health with social care (NHSE, 2019). This level of integration is set within the context of Sustainable Transformational Partnerships (STPs), which emphasises 'place-based' systems of care (The Kings Fund, 2017). In short, integrated care is widely seen as the way to reduce hospital admissions and improve quality of care (Kumpunen et al, 2019).

Intermediate care was first proposed in the NHS Plan (DH, 2000a). However, the main impetus for expansion was the National Beds Inquiry (DH, 2000b), which found that significant numbers of older people stayed in acute hospitals longer than was necessary or desirable. In addition the National Service Framework for Older People (DH, 2001) reported that older people were being admitted to hospital due to lack of community-based services that would better meet their needs. These reports led to a range of services referred to as intermediate care, the stated aims of which are to: promote faster recovery from illness; support timely discharge from hospital; prevent unnecessary acute hospital admission and maximise independent living. The expectation is for multiagency working, based on comprehensive needs assessment, with short-term interventions to enable users to remain or resume living at home. Key to intermediate care services is the concept of enablement where services aim to help people recover skills and confidence to live at home and maximise their independence. Youde et al (2020) found that an enablement ethos increased the flow of patients through an intermediate care service and resulted in a reduced need for social care packages. However, the difference between active rehabilitation, enablement, and other aspects of intermediate care are not always understood either by practitioners or users (SCIE, 2020).

The Acute Response Team (ART) service is a locally integrated, intermediate care initiative in the South of England. The primary aim is to enhance the level of integration of a range of services including primary and secondary care, the ambulance service, social care enablement and voluntary organisations, to ensure a more timely and appropriate service for:

(i) People in the community who are at risk of attendance/admission to hospital
(ii) People who have arrived in the Emergency Department (ED) and could be cared for in the community

Key drivers for the implementation of the ART service were that people were not always seen by the most appropriate practitioner in the most appropriate place. Some people were being admitted to hospital who could have been cared for in their own home and people were taken to hospital by the ambulance service because there was no alternative option (CCG, 2016). The ART is made up of senior nurses (Grade 7 or above), healthcare support workers (unregistered staff who provide nursing assistance), General Practitioners (GPs) and therapists (occupational and physiotherapists). In addition to the clinical team, a domiciliary care service provide personal and social care. Age UK is a charitable organisation that provides advice and support for older people, for example help with shopping. The operational model for the ART service (Timson et al, 2017) is that all referrals are made direct to the senior nurses via a single telephone number, or face-to-face in the ED or Clinical Decision Unit (CDU) at the hospital. The ambulance service have direct access via a pager system.

The ART has two bases, one at the local acute hospital and one in the community. A package of healthcare and support is put in place for a period of up to five days. Any ongoing needs for support are met by mainstream services. The clinical criteria for referral into the ART service are exacerbation of long term conditions or neurological conditions, worsening frailty, end of life care (crisis management), infections, recurrent falls and poor mobility or unable to cope at home due to one or more medical conditions.

An internal cost analysis of the ART service forecasted an annual saving of between £0.15m and £0.59m primarily due to a reduction in non-elective hospital admissions for older people (Timson et al, 2017). This same report also identified high levels of user satisfaction with the service. To complement this data, the purpose of this study was to explore the implementation experiences and perceptions of professionals and managers of the ART service and external stakeholders in order to gain an understanding of 'what works' in integrated intermediate care, in terms of the execution of the service, care processes, and sustainability, scale and spread.

Methods

The study took place over a one year period from October 2017 to September 2018. The approach was qualitative in order to gain a deep understanding of the experiences and perceptions of the ART professionals, and external stakeholders. External stakeholders were those who the ART received referrals from (GPs, the ambulance service, the local acute hospital) and those who the ART referred to (local authority adult social care and the enablement service, and a private sector care agency). The enablement service, provided by the local authority, aims to support people to maintain independence at home, through skills development and the learning or re-learning of daily life tasks.

Data Collection

   1) *Focus groups*

Two focus groups were conducted by a member of the research team (JM). One focus group was comprised of members of the ART and a second focus group was comprised of social care managers and team leaders from adult social care and the enablement service. Focus groups were chosen as the method of data collection as these teams held regular meetings and so could be accessed together, maximising the number of participants. Focus groups also had the advantage of facilitating group discussion, highlighting similarities and differences in perspectives (Pope and Mays, 2006) and illuminating dynamics of interaction within a group context (Litosseliti, 2003).

The focus groups explored key themes such as communication, roles and relationships, care co-ordination, and the sustainability of service delivery. The focus groups took place at the workplaces and were audio-recorded, with permission.

2) *Interviews*

Other external stakeholders including a GP, paramedic, hospital doctor and care agency staff, were identified by the ART and invited to participate by the researchers. As a result, the sample is not necessarily representative of these groups. Interviews were conducted by members of the research team (JM, SJ, RM). Individual, telephone interviews were chosen as the method of data collection as this was the most convenient method for participants. The interviews were audio-taped with consent. Topic areas mirrored the themes of the focus groups.

Data Analysis

The audio-recordings of the focus groups and interviews were transcribed and analysed thematically using Flick's (1998) approach. This required bringing predetermined templates to the data, in this case the interview and focus group schedules. Quotes were sorted into categories and coded according to their origin. Each category was then organised into themes using the quotes to justify interpretation. The qualitative data analysis software, NViVO11, was used to facilitate analysis.

Ethical considerations

Ethical approval was gained from the University of Kent Research Ethics Committee reference SRCEA 195.

Results

In total, 21 staff took part in either an interview or face-to-face focus group. The majority of the participants attended the focus groups and 5 participants were interviewed (Table 1). Each participant of the focus groups was de-identified and grouped as 'FG1' which represented the focus group consisting of the ART members and 'FG2' which represented the social care and enablement team focus group. *(Table 1)*

Table 1: Characteristics of participants

Data collection method and corresponding code	Total Number	% of Sample	Professionals (n=)
Focus group (ART) (*FG1*)	11	52.4%	General Practitioner (n=2)
			Nurse (n=5)
			Therapist (n=2)
			Support worker (n=2)

Focus group (Social care and enablement) (*FG2*)	5	23.8%	Adult social care team member (n=2)
			Enablement team member (n=3)
External stakeholder interviews (*P1-P5*)	5	23.8%	General Practitioner (n=1)
			Clinical Commissioning Group (CCG) member (n=1)
			Paramedic (n=1)
			Hospital consultant (n=1)
			Care agency worker (n=1)

All members of the ART and social care and enablement teams were invited to take part. However, not all were available at the time. Whilst almost all members of the ART took part, the social care and enablement focus group was attended by a minority of staff.

From the analysis, three main themes were identified: successful and challenging aspects of implementation; care processes; and sustainability, scale and spread. The theme of care processes was further divided into factors affecting referrals into the service and transitions out; the issue of capacity; and teamworking.

Successful and challenging aspects to implementation

Successful aspects of implementation

1) *Co-creation*

The core team developed from an existing 'Rapid Response' service, which provided triaged, rapid nursing intervention in the community. This evolution was beneficial in that it allowed the team to be involved in the development of the new service. This meant that there was an early commitment to implementation and delivery, as this external stakeholder suggests:

> *"The core clinical team who've actually led the delivery of the service, were completely on board from day one [...] in terms of designing and developing the model" (P1)*

As a result of this early involvement, the team were able to try out new ideas and were supported to find creative solutions, as illustrated here by a team member:

> *"We've got the ability to say, 'Right, okay, I think this might work, can we try it?' and 100% the CCG and the GPs are behind us, they're happy for us to trial anything, as part of our role, so that's really beneficial to us" (FG1)*

2) *Financial support*

Financial support from the CCG was essential to the implementation process as this external stakeholder explains:

> *"There was financial support from the CCG, because there were some, you know, significant additional costs. I mean quite a bit of the team has been created within existing resources, so it was about redesigning what some of those staff were already doing, but the GP input into the team has had to be paid for as an additional cost" (P1)*

Aside from this, engagement and support from other service providers was also instrumental for successful implementation:

> *"There was virtually whole system sign-up to the idea of testing the model so it wasn't a question of having to go out and persuade other stakeholders" (P1)*

> *"Thinking about it from the hospital's perspective, I mean they continued to be challenged in terms of their performance in relation to waiting times and the four-hour standard in A&E etc. So, there was support from that quarter to see it work" (P1)*

Alongside this, support from a key individual (GP) was highly valued by the team in the early stages of implementation:

> *"We always knew that the service could be a lot more and we were fortunate that the GP kind of helped to set it up, came in and actually took time to see what the team was doing at that point, and listened to where we thought we could take it" (FG1)*

Challenges to implementation

1) *Lack of referrals from primary care*

There were some early challenges to implementation, particularly around referrals from primary care. The reasons for this are unclear although it may be related to GPs lack of trust in a new, unproven service or a lack of awareness of the service:

> *"In the early stages, and it wasn't unexpected, there was some reluctance in terms of primary care, primarily GPs being reluctant to refer into the service" (P1) (FG1)*

Care Processes

Referrals into the ART service

1) *From the acute hospital and GPs*

There was a perception that the number of referrals into the ART service was sub-optimal. The main reason for this was lack of awareness about the existence of the service. This seemed to be focused around the medical profession (hospital Doctors and GPs). For example, in the hospital, not being aware of the ART service was seemingly related to staff turnover:

> *"The hospital end of the service, it's quite difficult when you've got a rotating […] particularly the medical workforce, a rotating medical workforce which changes every four months" (P17)*

Lack of awareness of the service or reluctance to refer, then created problems accessing people once in hospital, as this ART member explains:

> *"Often I feel that we're going around in circles […] wasting time trying to find patients, when we shouldn't be finding patients, they should be finding us. And I think that that's a fault of*

the consultants and the doctors at the hospital, because I think that there at least should be five patients a day that they're able to put our way, so I almost feel that we're pulling them out of their hands, rather than them actively giving them to us" (FG1)

In the primary care setting, referrals from GPs was slow at first but became more commonplace as the service became more established:

"I think that a good 70% of our patients now come from the community, the hospital is a small proportion of patients, which I think is a really good thing, because ultimately if we were to get the patients whilst they're in the community from an ambulance, from their own GPs, that we're preventing them from getting into hospital in the first place" (FG1)

2) *From the ambulance service*

Aside from the medical profession, the key role of the ambulance service as a gatekeeper to ART seems evident here:

"If a paramedic goes out to a patient's home either via a 999 call or a call from a GP practice, then the theory is that if the paramedic thinks that with the support of the ART that patient could be kept at home rather than being transported to hospital then that's what should happen. And whilst the referrals from the ambulance service have increased significantly, certainly over the last six months, we still don't believe we've reached the potential. There are still patients being transported to hospital that don't need to be" (FG1)

At times, this seemed to be related to issues of professional judgement and risk. For example, GPs may call an ambulance with the expressed intention of taking the person to hospital, which created an unacceptable level of risk for paramedics should they involve the ART service. As this paramedic explains:

"Generally, I think we would take them to hospital, if the doctor said, 'Go to hospital'. I'd be surprised why any crew would put themselves at risk by going against that, because sod's law that would be the patient that deteriorates. You might get a crew that are very comfortable […] and say, 'This might be suitable', but it's very unlikely" (P3)

Transitions out of the ART service

1) *To social care*

In relation to handing over to social services, the main difficulty was the need to make a number of referrals to different services, illustrating a lack of internal integration and co-ordination within social services:

"When we may refer to the enablement team [they] go out and say it's not appropriate for the enablement team, it needs a long-term care package, and then that gets pinged to us to then refer the same paperwork to refer for a long-term care package […] why can't the enablement team pass that on, as it's under the same umbrella? that's quite frustrating" (FG1)

The issue of capacity

1) *Lack of staff*

Lack of capacity, primarily due to lack of staff, was identified by the team and social care staff as the main factor impacting on transitions of care:

> *"At the moment we're lucky enough to have extra staff but that's a temporary measure, we're still over capacity" (FG1)*

> *"Sometimes they haven't got capacity to take. We had a gentleman a fortnight ago […], I immediately phoned the ART, unfortunately they didn't have capacity otherwise they would have taken him" (FG2)*

2) *Lack of social care packages*

Lack of capacity in the wider health and social care economy, particularly social services was a significant factor influencing turnover. This participant from social care explains how capacity/flow is limited by the lack of availability of social care packages which means people remain in both the enablement and ART service for longer than is necessary:

> *"We've got people waiting for care packages that have been requested, it's a knock-on […]. We've identified their needs, we've got it agreed that this is their needs, let's move them on and then we can take more, ART can take more and it's a knock-on effect" (FG2)*

3) *Users with complex medical needs*

Another capacity issue concerned those with medical needs who needed to stay in the service longer than the 'permitted' five days:

> *"Our medical ones are much more of a quicker turnover, but sometimes they can be longer than five days, if there's a change in antibiotics or something that needs continually reviewing" (FG1)*

Teamworking

1) *Communication and information sharing*

Within the ART, frequent handovers were seen as a significant activity necessary for effective co-ordination:

> *"Handover is quite a substantial part of our day really, it's at least an hour in the morning, plus another one at three o'clock in the afternoon, as well as the sort of mini ones at lunchtime" (FG1)*

Other ways in which information was shared were various, but the value of personal communication and feedback was of paramount importance. This ART member and social care representative both describe the process as highly personalised and achieved over the telephone or face-to-face:

> *"We update GPs, we go in person to the hospitals, so you're not just referring, we're talking with the consultants, the nurses, face-to-face, we're part of the ward round […]. We pick up the phone and speak to hospices, we pick up the phone and speak to the GPs, nurses in the practice, we speak to the heart failure team, the respiratory team…" (FG1)*

> *"You can speak to the people that are involved with their care, which is really important […], you can speak to the actual person, the physio that went out or the GP that went out" (FG2)*

However, there was a perceived lack of communication, especially feedback, from the perspective of the paramedics:

> *"We would like more feedback, we would like an honest answer of how many referrals they're making, how many of those patients they're dealing with and able to keep at home and any negatives so we can feedback to staff" (P3)*

Given that paramedics were central to the functioning of ART, this dislocation of communication was a weakness. As in many areas of service collaboration, digital information sharing was also challenging due to a lack of a shared IT system:

> *"What is missing in co-ordination is shared records, you know, if we had shared records across all systems, if we could have more integration with the care teams" (FG1)*

2) Skill-mix

The skill-mix, within the ART was highly valued by the team and external stakeholders, and the benefits to the way holistic care could be delivered were clear:

> *"Age UK has been a real help for the domestic tasks and things, people that need to get their money out to pay various bills, any domestic support if they're in this acute phase, that's been really helpful" (P17)*

> *"That's a good thing about this team, being multidisciplinary, because we've all got our aspects of expertise, but they're not all the same […],we've got a really, really good skillset here" (FG1)*

There was a sense that the support staff were valued for their contribution and listened to, as one support worker explained:

> *"If we bring back something really important, for example, a significant change in somebody's pressure areas, we get listened to, it's really important that everyone listens and they do, and then they [senior nurses] make a decision on that" (FG1)*

3) The value of personal relationships

The development of trusted, personal relationships between members of the ART and other service providers was key to successful teamworking and care co-ordination, as these social care representatives noted:

> *"It's about having really good relationships with that team, wherever they're based, so that things like referrals get processed efficiently, so that the people in each of the respective teams trust each other in terms of assessing patients, that they trust each other to make accurate assessments" (FG2)*

> *"I think both teams [ART and enablement] have grown and now we've got this relationship, this partnership" (FG2)*

Sustainability, scale and spread

Sustainability

In order to continue the existing service, ongoing funding and workforce issues, linked to succession planning, were highlighted as issues to be addressed:

> "Funding that has been invested is based on the rationale that certainly for the CCG, the service is delivering savings. So, the less people going into hospital, costing the CCG less for those patients not to be in hospital, the money is being re-invested in the ART. That's the sort of crude rationale in terms of the funding model" (P1)

> "From a workforce perspective, in terms of the sustainability of the service […], making sure that the service isn't as fragile as potentially it could be. It is very reliant on three or four individuals in terms of the clinicians. We need to be planning anyway for those people, for when those people are no longer around, either through retirement or they leave and get another job" (P1)

Scale

In terms of scaling-up, there was a desire to expand the type of people served by the ART service, specifically those with long-term conditions and more complex health and social care needs. Added to this, an ambition within the team to increase the service hours was evident. Respondents elucidate on these aspects:

> "The next step really is also to try and take over some of the frailty patients, you know, I don't see why a 90 years old patient, who lives alone, if he has falls, cannot be more supported by ART […]. Frailty is certainly something that needs to come out and we need to deliver it because the population is requiring it" (P5)

> "It would be really useful to have a GP till eight o'clock, and also with the staffing that we've got at the moment […], we don't have enough staff for nurses to be on a late seven days a week, and obviously we want to have a cohesive service where we can offer the same service 12 hours a day, seven days a week, so that's where we want to go, maybe even a 24 hour service if you're looking at the best possible care that we can support" (FG1)

Spread

In terms of spreading the service more widely, there was a desire within the ART and external stakeholders from social care, hospitals, and the ambulance service to implement ART across a wider geographical area outside the CCG boundaries. There was multiple reasons for this including the need to reduce variation across the system:

> "ART is not mapped to the hospital […] and that means that if ART can only take, let's say out of 15 patients, if four of them are from [the locality] then only four would be supported, the other 11 we need to find another way, which is either to discharge them at risk or to try and get other services to come in which is really not working very well. Currently the geography […], the hospitals are having a totally different overlap to ART, equally I understand that ART needs to start from somewhere but sadly the other CCGs have not bought into that service" (P5)

Discussion

This analysis has revealed a number of insights around 'what works' in terms of implementation, and what hindered progress. It also highlights the factors necessary to maximise sustainability, scale and spread. This is timely in that NHSE (2020) have recently announced the roll-out of 'Urgent Community Response Teams' which has many similarities with the ART service, for example, rapid access to a range of professionals who can address both health and social care needs.

What works in implementing intermediate care

The key factors for successful implementation were co-creation and the engagement of key external stakeholders at an early stage, a varied skill-mix, effective teamworking and the development and maintenance of personal relationships. These 'ingredients' are echoed by Mitchell et al (2012), recent international projects such as SUSTAIN (2019) and others as factors necessary for integrating care for older people.

Co-creation - In setting up the ART service, the core team was already in place and were given the freedom to develop the service from the 'ground-up', which meant there was already insight into how the service could operate within the local context. The ART service, like many integrated care initiatives is highly localised and context dependent with the type of provision determined to a large extent on the prevailing 'gaps' in the local system (Martin et al, 2004). A review of intermediate care models by SCIE (2020), also found that local implementation and context impact on success. At a strategic level, the co-creation of a new service is, therefore, advocated.

Engagement and support of other service providers - buy-in from key stakeholders, particularly social care and the acute hospital was important. A GP 'champion' who became part of the ART service, was crucial at the design stage. The support of GPs at a planning stage is advocated here and by Wilson and Parker (2003) who argue that provision of medical care by GPs to intermediate care schemes is at risk of becoming their weakest link. Integrated services without medical staff support are also described as vulnerable by Billings et al (2018).

Within the ART service, the engagement of local GPs strengthened over time, which may have been due to an initial lack of awareness of the service but also to scepticism and resistance as described by Gollop et al (2004). Reasons for this include personal reluctance to change or misunderstanding of the aims of a change programme. They argue that sceptical staff can be influenced to change but this takes time and support may be fragile, requiring ongoing evidence of benefits to be maintained. There may be some evidence for this amongst some of the GPs and the hospital doctors, in this study. Facilitating GP participation relied upon regular, direct communication, as there was no financial incentive to refer patients to the ART.

Skill-mix - A varied skill-mix, within the ART was valued by the team and external stakeholders. In contrast with other studies, the ART service seems unique in that as well as nurses, therapists and support workers, the team also includes GPs and voluntary sector workers. Such a skill-mix is also advocated by Nancarrow et al (2005), Pearson et al (2015) and SCIE (2020).

The involvement of support workers, has been linked to improved user quality of life possibly due to better service delivery by allowing for a greater emphasis on service development (Dixon et al, 2010). The National Audit of Intermediate Care (2017) also provides evidence that service user outcomes are improved when users come into contact with a range of staff.

Teamworking and the importance of personal relationships - Information sharing was mostly by personal communication which facilitated the development of relationships. Informal working relationships, especially with acute hospital staff, has been identified as a key component for integrated intermediate care services (Pearson et al, 2015). The ART developed trusted, personal relationships with other service providers which was important for successful teamworking and care co-ordination at a practitioner level. Mitchell et al (2012), identify key components of a high-functioning team including shared goals, clear roles, mutual trust and respect, and effective communication, as demonstrated in the ART model.

Factors hindering implementation of intermediate care

A number of factors were identified which hindered implementation, namely, a lack of awareness of the service, lack of capacity, especially in social care, and lack of an interoperable IT system which limited information sharing.

Lack of awareness of the new service - The number of referrals into the ART service was seen as sub-optimal, primarily due to lack of awareness of the service at the interface between the ART and mainstream services. Medical staff rotation, especially through the ED further exacerbated this and has been documented elsewhere (Glasby et al, 2008). These authors advocate proactive case-finding and in-reach into hospital, which is a feature of the ART service, although referrals from primary care and community settings were seen as more successful. Integrated care services need to ensure visibility through the development of an effective information and communication strategy which could include face-to-face meetings, or written information, targeted at different organisations. The different geographical footprints of services within the locality also hindered awareness of the service due to a lack of a common 'whole system' approach (Glasby et al, 2008). Consistency of service provision across a geographical patch is therefore important at a strategic level, for integration, and may be addressed by the move to Integrated Care Systems and Partnerships within the NHS Long Term Plan (NHSE, 2019)

Lack of capacity - Time in the ART service varied and went beyond the five day maximum at times, especially for users with complex social needs. Extended time in the service was less common for users with acute medical conditions. This differentiation between health and social care needs was also found by Kaamba et al (2008). For the ART service, lack of capacity in mainstream social services, specifically lack of available care packages, impacted on the turnover of ART users and consequently impacted on the ability to take new referrals. This lack of provision of social care is a significant limiting factor on intermediate care services. Issues of capacity in intermediate care were also found by Regen et al (2008) and given that this is over a decade ago, still appears to be enduring and may be worsening due to continued resource constraints (Alderwick et al 2019). Findings by SCIE (2020) on intermediate care, support the needs for capacity to be planned across the whole patient flow. In addition, streamlining the process of referrals through different social services is advocated as a way of potentially speeding up the transition process.

Incompatible IT systems - It came as no surprise that digital information sharing was difficult due to the lack of a shared IT system. This has been identified as challenging in several other studies where a shared, single patient record is recommended to improve communication (Hutchinson et al, 2011).

Sustainability, scale and spread

Sustainability - To ensure sustainability of the ART service and other integrated intermediate care services, continued resources, especially skilled staff are necessary and there is a need for succession planning as the service may be overly-reliant on a small number of key individuals. The close,

effective teamworking within the ART relies on the personal characteristics of its members which may be difficult to replicate if the team changes. However, to ensure the ART and other initiatives are sustainable, a focus needs to be retained on the main purpose to avoid being 'all things to all people', maintaining clear objectives and purpose (SCIE, 2020). At a system level, ongoing funding is, of course, necessary for the sustainability of care services. Given the reliance on social care provision within integrated, intermediate care, services are particularly vulnerable to further reductions in social care funding (Alderwick et al, 2019).

Scale and spread - The ART has ambitions to scale-up the service such as extending opening hours and extending the eligibility criteria. There is also a desire to extend the service to other geographical areas, which would require buy-in from other CCGs and service providers at a strategic level. Reducing variation in intermediate care across the regional health and social care system would also reduce the number of care processes and potentially maximise referral rates.

Limitations of the study

This study is limited in that it considers a single service, within a specific locality with a relatively small sample size. The sample consisted of a small proportion of the total number of external stakeholders and were identified by the ART so the sample cannot be considered representative. We were unable to access staff from the ED so the analysis lacks this perspective. A limitation of using focus groups as a method is that they may give a false consensus in that participants who disagree with the majority perspective may choose not to voice their opinions. The study is also limited in that it is confined to the experiences of the professionals and does not report service user experiences, clinical outcomes or health economic data.

Future Research

Future research should focus on examining the effectiveness of different models of intermediate care in terms what can be achieved, at what cost and over what timescales.

Conclusion

In conclusion, the ART service has made substantial strides towards integrated, intermediate care working. The service has managed to transcend many of the difficulties associated with integrated care through an ability to stay focused on providing rapid interventions to people who are acutely ill. Despite some improvements needed including increasing awareness of the service, and an interoperable IT system, the ART service has many of the essential ingredients for successful integrated care including: good co-ordination, collaboration and teamworking both within the ART and with other agencies. This has been assisted by the team's intrinsic influence in the early stages of implementation and the co-creative way this was operationalised. Integrated care is all about relationships and this is a strong feature in this analysis. There is effective leadership provided by key individuals, namely the senior nurses and GPs which are central to swift decision-making. However, this also creates some vulnerability if staff change or funding is not maintained.

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