‘Developing a Programme Theory of Integrated Care:

The effectiveness of Lincolnshire’s multidisciplinary Neighbourhood Teams in supporting older people with multi-morbidity’ (ProTICare)

SERVICE EVALUATION

FINAL REPORT: JULY 2017

UNIVERSITY OF LINCOLN

George, T., Ray, M., Walker, J., McKay, S., and Horner, N. (2017)

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Thank you.

The Evaluation Team

Healthy Ageing Research Group (HARG)

HOW SHOULD I CITE THIS REPORT?

You are free to quote from this report. In text citations should be referenced as: (George et al., 2017). A full citation should be referenced as:

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ABBREVIATIONS

A&E	Accident and Emegency
BCF	Better Care Fund
CCG	Clinical Commissioning Group
CDG	Care Design Groups
CHD	Coronary Heart Disease
CMO	Context Mechanism Outcome configurations
COPD	Chronic Obstructive Pulmonary Disease
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
CVD	Cardiovascular Disease
DH	Department of Health
EMAS	East Midlands Ambulance Service
FYFV	Five Year Forward View
GP	General Practitioner
HA	Holistic Assessment
HARG	Healthy Ageing Research Group
HwB	Health and Wellbeing Board
IC	Integrated Care
ICN	Integrating Care in Norfolk
ICP	Integrated Care Pilot(s)
IG	Information Governance
IPC	Integrated Personal Commissioning
IT	Information Technology

LA	Local Authorities
LCC	Lincolnshire County Council
LCHS	Lincolnshire Community Health Services
LHAC	Lincolnshire Health and Care
LTC	Long term conditions
LPFT	Lincolnshire Partnership NHS Foundation Trust
LSSR	Lincolnshire Sustainable Services Review
MCP	Multispecialty Community Providers
NHS	National Health Service
NT	Neighbourhood Team(s)
NTLO	Neighbourhood Team Liaison Officer
MCP	Multispeciality Community Providers
MDT	Multidisciplinary Team
OT	Occupational Therapist
PACS	Primary and Acute Care Systems
PCC	Primary Care Co-ordinator
PCT	Primary Care Trust (Replaced by CCG)
PH	Public Health
ProTICare	'Programme Theory of Integrated Care'
RIF	Research Investment Fund
SHA	Strategic Health Authorities
STP	Sustainability and Transformation Plans/ Partnerships
TSO	Third Sector Organisations
ULHT	United Lincolnshire Hospitals NHS Trust
UoL	University of Lincoln

UNIVERSITY OF LINCOLN

REPORT SUMMARY

SUMMARY

Introduction

This project was a one-year real-time service evaluation of NHS Lincolnshire's four, Phase Two Integrated Neighbourhood Team (NT) sites (Figure 1). The research was carried out between August 2016 and June 2017. It was informed by a realist methodology (see Chapter Two). Research was undertaken with participants who were involved in NT's in Gainsborough, Sleaford, Stamford and Welland, and Skegness and Coast. The main aim of the project was to assess the effectiveness (processes, mechanisms, experiences) of Lincolnshire's Integrated Neighbourhood Teams providing services for typically clinically frail, often elderly people, with co-existing, long-term conditions. The Neighbourhood Teams were conceived as a proactive, community based approach, which supports the needs of their locality, by bringing together various health, social care and third sector organisations (TSO) with the aim of developing integrated – or joined up – care.

Key messages from the literature

- 'Integrated care' is a widely used concept, referred to by many terms, often used uncritically and interchangeably. Integrated care (IC) is often confused with terms such as 'integration, 'partnership working', joined up working', coordinated care' and collaborative care' (Armitage et al., 2009; Shaw et al., 2011)
- 'Integrated Care' is an approach which aims to achieve improved care delivery for patients, service users and carers through seamless care pathways and better coordination of services.
- 'Integration' is a combination of appropriate methods, tools and processes to improve coordination of care for patients and users, and may contain many variations in its approach.
- Integrated care is deemed essential in meeting the challenges associated with: demographic change, disability free years of life, burden of disease and disabilities, risk factors such as inequalities across the life course, public and patient expectations and medical advances (Ham et al., 2012), as well as a government imperative to achieve cost savings.
- Recent research findings have suggested that the Better Care Fund has increased joint working and integrated service provisions. However, it has not achieved the aims identified in national policy. Namely, effective management of growing demand for healthcare, development of out-of-hospital care, consistent evidence of improved outcomes for patients and service users, financial savings in line with government targets (National Audit Office, 2017).

Methods

Our overarching approach to the evaluation of Lincolnshire's NT's was to develop a realist synthesis – a systematic evaluation aimed at assessing 'what works, for whom, and in which circumstances?' (Pawson and Tilley, 1997). The realist synthesis and evaluation comprised four workstreams (see Chapter Two):

- **Workstream One** –A scoping review of existing research was undertaken to develop a testable theory of best practice for implementing integrated care which was subsequently compared with the findings from the Lincolnshire evaluation.
- **Workstream Two** – Qualitative interviews were conducted with 58 key participants and contributed to mapping the processes, structures and outcomes associated with the NT model.
- **Workstream Three** – Four process mapping events were carried out with participants representing each of the neighbourhood teams;
- **Workstream Four**- Questionnaires aimed to evaluate the impact of NT's on older people's quality of life. The workstream did not succeed in obtaining a sufficient number of completed questionnaires and thus, it was not possible to draw any conclusions about the impact of NT's on patient/end user outcome or experience.

Summary of the evaluation project and its findings

- **Workstream One** – 403 Journal articles/ reports were identified within the scoping review. Ten key UK based studies were recognised as highly important to the narrative of integrated care and realist methodology undertaken; 137 articles were identified as important in contributing to the construction and theoretical framework of integrated care; and a further 256 articles were identified as essential for contextual background regarding the NHS and Adult Social Care.

- **Workstream Two** – Participant narratives confirmed a key number of themes reflecting individual, organisational and strategic/ structural factors as a rationale for integrated care; benefits and enablers to the development in integration using NTs as a vehicle for transformation, culture and practice including improved relationships; further barriers and constraints experienced including clarity, awareness and structures; and finally themes around opportunities and challenges in the future development of the NTs.

- ‘Person focused’ or ‘person centred’ care was identified as a central goal of integrated care, particularly a focus on improving outcomes and quality of life for people using the services;
- There was a global assumption that people requiring integrated care were likely to have multiple complex needs (e.g. not just long-term co-existing conditions, clinical frailty) requiring a range of support and interventions;
- Responsiveness to the needs of the whole person was also highlighted as an important goal;
- More effective collaborations between professional and agencies could address the reported challenges expressed with a traditional service model e.g. timely and easy access to navigate services, clarity in the process of seeking and getting help
- The importance of shared access to patient information, to avoid unnecessary repetition and duplication of assessment and patient stories;
- Proactive interventions are key to avoiding unnecessary admissions to hospital and prevent delayed discharge from hospital of individuals identified as being most at risk of deterioration or crisis;
- ‘Self-management’ by patients/ users with complex needs was an emerging theme, particularly with regards to one’s responsibility for their health and taking an active role in condition management;
- The main rationale for developing integrated services reflected the well-rehearsed challenges associated with current practice e.g. duplication, fragmentation, growing frustrations, lack of communication between services and complex, unwieldly and overly bureaucratic services. It was acknowledged that such changes are desirable but require a significant cultural shift, systemic and structural change, and a change in attitudes across all services which must be underpinned by an appropriate strategy;
- NT meetings were essential in bringing people together who may have traditionally been ‘at the end of the telephone’. Such contact fostered mutual respect for one another and relationships which encouraged collaborative practice;
- Furthermore NT meetings also provided opportunities for practitioners, to become more familiar with the array of agencies and resources available in their community.
- The NT model provided a basis for more timely discussions, informal liaison and, by taking discussions to the NT and faster referral processes;
- Reinforced commitment and buy in, at practitioner level, to the NT model clearly enhanced opportunities to deepen integrated practice;

- Patient/end user benefit was identified as key in assessing the benefits of the NT model. Further improvements in outcome for people referred to the NT, were perceived;
- There is currently no provision for systematic evaluation of patient/user outcomes and benefits. Thus, views about the impact on patients'/end users is inevitably based on perception and anecdotal evidence;
- Although at an early stage, the overriding experience of participants was that the NT model was beginning to impact, not just via the NT meetings, but crucially, in collaborations and relationships outside of the meeting;
- Despite positive developments experienced within the NTs, emerging themes from participant narratives indicate low referral rates across all four NTs, a lack of buy in particularly amongst middle managers, low awareness amongst practitioners and evidence of some continued scepticism about the NT model;
- Other barriers focus more on moving beyond Phase One achievements. For example, developing integrated practice beyond the weekly or fortnightly MDT model into daily 'business as usual' with clear strategic direction for deepening integration practice, was an identified priority and concern;
- Most participants agreed that the service, theoretically at least, was for all adults with complex needs, but there was much less certainty about the age range and future foci of priority. It was clear that older adults were perceived as the main beneficiaries of the NTs but aspirations to widen referrals was evident;
- Participants identified uncertainty about the priorities for the NT's in the short, medium and long term, particularly reflecting uncertainty about the ways in which NTs should develop;
- While it is clear that significant progress has been made in raising awareness about the rationale for the NT model in Lincolnshire, a consistent theme was that awareness, participation and buy in, remained patchy;
- Some GP's were strongly committed to the NT model, and/or had colleagues from their surgery who were active participants in the NT model. However overall there was a lack of engagement and understanding from some GPs particularly with one NT site; this was perceived as a significant barrier. However, barriers to GP involvement were also identified (workload, motivation to buy in, other priorities,scepticism of NT model).
- Restructuring was experienced as a fast, changing, unpredictable environment, accompanied by poor communication and uncertainty which resulted in people reporting frustration, anxiety and some cynicism about integration as the next 'big idea';

- Staff change and shortages led to staff becoming more rooted in achieving their 'core' business. Subsequently time pressures and staff shortages impacted on attendance at NT meetings, stakeholder workshops and events planned to publicise and talk about the NT model. Gaps in services particularly focused on mental health for adults;
- Financial investment to develop integration was perceived as limited and concern was expressed by for example, the often temporary nature of posts dedicated to developing the NT model, e.g. CCGs inability to fund a Neighbourhood Team Liaison Officer, a role expressed as essential to the development of the NT model;
- IT systems and governance structures are a major barrier to developing a 360^0 view of patients/users and practitioners accessing records;
- Despite anecdotal evidence of improved patient/user outcomes, the lack of an established framework that relevant parties were signed up to and which assessed and evidenced impact, was identified as a significant weakness in operationalising the current strategy;
- Intractable barriers such as a lack of co-terminus boundaries caused frustration and challenged opportunities for integrated working;
- Participants expressed frustration and scepticism about the expected savings to be achieved by integrated services, reinforced by wider evidence that expected savings were not being achieved at the levels expected in vanguard sites and in a national context;
- Overall, participants shared a similar vision of the purpose and potential benefits of NT's. However, questions about the potential to achieve some of the aspirations accompanying integration were raised by participants. The potential for integration to achieve government cost saving targets was an identified concern amongst a number of participants and points to the potentially divergent views about the core priorities for integration;
- Participants acknowledged the importance of NT's developing to meet the needs of their local community, and that responses which met the needs of one community, may not be relevant for or needed by a neighbouring community. Nevertheless, there was some disquiet about the potential for NT's to develop idiosyncratically and for the key purpose of NT's to become diluted or even, lost;
- Going forward, there were divergent views concerning the extent to which integration brought about fundamental organisational change. For some, the idea of co-location and 'conversations around the water cooler' was perceived as a desirable development, especially in speeding up the process of integrated practice being seen as 'business as usual';

- For others, the notion of co-location was seen as a further and unnecessary distraction from the business of integration and moreover, that such a move could actually delimit integration by confining it within the boundaries of a co-located team;
- The value of multidisciplinary, coordinated care was highlighted as a realistic aspiration for integration and one that was an achievable and workable goal;
- Crucially, participants recognised that NT's needed to develop so that they moved beyond the MDT model, towards the notion of 'business as usual'. This meant that coordinated and collaborative care became integral to practitioner roles and that responsibility widened to incorporate whole teams, rather than assuming that the representative nominated to attend the MDT, was somehow uniquely responsible for integration;
- Underlying future developments is the need for participants to be aware of the strategic priorities aimed at unlocking or removing some of the current barriers that they face on a daily basis. Participants could see that the Care Portal will begin to make a difference to current barriers in information governance and access to shared information, but further work is needed to refine and develop systems so that they can be used by multi-professionals, track the whereabouts of patients/users and provide data which can provide the basis for ongoing evaluation of progress in the evolution of NT's.

- **Workstream Three** – Despite some differences in the ways in which individual NT's were organised, there was a very high level of similarity and overlap in the narratives gathered at the process mapping meetings particularly in perceptions as to who the NTs were for in the present, how inclusion criteria should develop in the future, and debate about risk stratification which was a more contentious issue. However despite such acknowledgments, the intention to focus on people with complex needs, or people with long-term, co-existing conditions, was uncontroversial. Furthermore despite the many challenges and barriers identified with the development of the NT model, the benefits accrued were an important factor in retaining motivation to continue to commit to the NT model.

Conclusion and Discussion

- Integrated care is complex and diverse;
- While Lincolnshire's Integrated Neighbourhood Teams have established excellent working relationships with various healthcare professionals, there is still a large piece of work around risk stratification of local populations; GP engagement; engagement of wider groups of professionals; public engagement and developing a model which constitutes 'business as usual';
- 'You can integrate some of the services for all of the people or all for the services for some of the people, but you can't integrate all the services for all of the people' 'All integration is local'. 'Integration costs before it pays' (Leutz et al., 1999; 2005); these messages from extant research are reflected in the local picture and highlight the importance of thoughtful, strategically developed integration, rather than integration at any price;
- It is too early to say whether the Neighbourhood Team model has had any significant impact on reducing unplanned hospital admissions;
- There was no evidence of achieving other core goals such as reduction in GP visits, avoidance of delayed discharge, and development of comprehensive community resources to avoid admission. At the time of writing, there is no clear evaluation framework in place to assess the impact or otherwise of NT's;
- There is anecodotal evidence that those people who had received a service from the NT, often had positive outcomes;
- Discussion appears to focus on 'phase two' of the NT's.

What do the results mean for policy-makers and key stakeholders?

- There is a need to develop the collaboration of patients/users and carers as a fundamental element in taking forward the NT model;
- Effective channels of communication need to be further developed to ensure that concerns, learning and experiences of operational staff are visible;
- Strategic development for ongoing operationalisation of the NT model is needed;
- Strategy for widening buy in is required;
- If 'self management' is prioritised, attention needs to be paid to its ramifications for the public, core users of services and professionals aligned to the NT model;
- An evaluation framework is imperative to assess and judge the impact of NT's as they develop is required. This must include patient/user benefit.

Chapter 1.0

INTRODUCTION

1.1 SUMMARY

The Programme Theory of Integrated Care project (ProTICare) is a one-year real-time service evaluation of NHS Lincolnshire's Phase Two Integrated Neighbourhood Team (NT) sites carried out by the members of the School of Health and Social Care, University of Lincoln (UoL). The project commenced in August 2016 and concluded July 2017. The purpose of this report is to report on the findings from the workstreams which made up the service evaluation. Based on the project findings, recommendations about the development of the NT model are suggested as well as potentially fruitful areas for further evaluation and investigation.

The overarching aim of the evaluation, was to assess the mechanisms (that is, responses to and experiences of, NT working) and effectiveness of the NT model in supporting each locality to develop integrated care. Four objectives for the evaluation were identified:

1) To develop a programme theory that examines and identifies the components of effective models of integrated care;
2) To examine evidence of NT models elsewhere;
3) To explore the impact of the Neighbourhood Teams on integration and;
4) To assess the effectiveness of the Neighbourhood Teams in improving older people's quality of life.

This first chapter outlines the national and local context for integration, and introduces the four Phase Two Integrated Neighbourhood Teams and their localities

1.2 SUMMARY OF NATIONAL AND LINCOLNSHIRE CONTEXTS

Acknowledging the key themes emerging in the National and local Lincolnshire context are fundamentally important contexts for the development of the Integrated Neighbourhood Teams. See Appendix One for a timeline summarising key policy and legislative developments.

National 'Macro' Context

- Increased national demand and public expectations on services (Ham et al., 2012);
- Ageing national population with long term conditions. The number of people aged 75 and over is projected to rise by 89.3% to 9.9 million, by mid-2039. The number of people aged 85 and over is projected to more than double, reaching 3.6 million by mid-2039. Furthermore the number of centenarians is projected to rise nearly six fold, from 14,000 at mid-2014 to 83,000 by mid-2039. This increase is the number of older people suggests that by mid-2039 more than one in 12 of the population is projected to be aged 80 or over (Office for National Statistics, 2017).
- There has been unprecedented economic restraint since 2010 which has resulted in enormous funding pressures on the NHS (Roberts et al, 2012);
- Aggregate deficit £1.85bn (2015/2016), overall deficit of £2.45bn. £22bn efficiency savings needed by 2020/2021 (NHS England, 2016).
- User experiences of health and social care services highlight a number of deep rooted, systemic problems associated with their experience (e.g. revolving and unnecessary admission to hospital for frail people; numerous, individual appointments, delayed discharge, lack of care close to home and at home).

Lincolnshire 'Micro' Context

- Increased local demand and public expectations on services;
- Ageing local population with long term conditions and multiple needs. The number of people aged 65 – 74 years of age is projected to rise by 23% in 2014 to 112,700 by 2039. The number of people age 75 and over is further projected to rise by 95% in 2014 to 141,000 people by 2039 (Lincolnshire Research Observatory, 2017)
- Budget cuts, lack of resources, and relative difficulty in recruiting staff (staff, facilities, beds) (Lincolnshire Health and Care, 2016a);

- Lincolnshire financial deficit £60m predicted to be £105m in five years (Lincolnshire Sustainable Services Review, 2013);
- Size of the County and population distribution in rural areas; specific areas of deprivation and indequality; difficulties recruiting to health and social care sector.

1.3 PHASE TWO 'NEIGHBOURHOOD TEAM' SITES

Integrated Neighbourhood Teams were developed according to the former Lincolnshire's Sustainable Service Review, now Lincolnshire Health and Care (LHAC), 'A Blueprint for Future Health and Social Care Services in Lincolnshire' (Lincolnshire Sustainable Services Review, 2013). A series of potential interventions, established by Care Design Groups (CDG) under the banner of 'Lincolnshire's Big Brave Ideas', identified four main care agendas. The Integrated Neighbourhood Teams were identified as a core element of LHAC's 'Proactive agenda', amongst 10 other initiatives, intended to address the specific needs of their locality.

Integrated Neighbourhood Teams were conceived as multidisciplinary in nature, comprising a core network of health and social care professionals, including GPs, nursing services, therapy services, social workers, primary care services, mental health services and voluntary sector organisations. Figure 2 illustrates the current NT model. It was envisaged that these services working together, within an NT model, would be responsible for ensuring that frail, often but not solely elderly people with multi-morbidities, are proactively supported, and can maintain or achieve a decent life of quality, retain their independence relative to their needs and circumstances, and only use hospitals services when necessary. It was envisaged that a wider network of community-based services and resources would provide periodic support to the NTs as needed. The purpose of the NTs is to support all organisations to encourage joint working, encourage improved understanding of professional roles and delivering coordinated, effective care. Central to this model is the notion of an integrated network of services around the individual and an opportunity to provide seamless person-centred care. Through risk stratification tools and professional judgement, the NTs would set out to proactively identify individuals within their community, who may require support and care from more than one service, due to their individual health and social needs, and/or be at risk of deterioration in their condition, which could lead to unplanned/emergency hospital admission.

In line with government policy, NT's and health and social care integration more generally, are also expected to support patients/users and the wider community to take an active role in protecting and managing their personal health and wellbeing, choosing appropriate treatments where necessary, and managing long-term conditions (NHS England, 2017). The notion of 'patient activation' describes the extent to which a person has the confidence, knowledge and skills required to effectively manage their own care (e.g. Kings Fund 2014). The approach

suggests a significant culture change in terms of patient/user expectations and the traditional organisation and approach of health services and is in its infancy in terms of realising the meaning and implications of self-management / self-care.

As the NT model has evolved, it has usually been coordinated by a Neighbourhood Team Liaison Officer (NTLO), otherwise known as a Care Liaison Officer. Their role is to manage the work of their locality, promoting the network across various organisations, leading MDT meetings where patient referrals (nominations) are reviewed and discussed, and developing a local directory of services to ensure patients and healthcare professionals are appropriately signposted to services, for example, in the voluntary sector.

Four Phase Two 'Neighbourhood Team' Early Implementer sites were chosen for this evaluation, to reflect the different communities across Lincolnshire's CCG's including: urban, coastal areas, market towns and rural communities. The four sites in question include:

1. **Gainsborough** Neighbourhood Team (Lincolnshire West CCG)
2. **Sleaford** Neighbourhood Team (South West Lincolnshire CCG)
3. **Stamford and Welland** Neighbourhood Team (South Lincolnshire CCG)
4. **Skegness and Coast** Neighbourhood Team (Lincolnshire East CCG)

Figure 1: Lincolnshire's Phase Two 'Neighbourhood Team' sites and Clinical Commissioning Groups (Adapted from Lincolnshire Health and Care, 2016)

Each of the four Neighbourhood Teams are located in areas characterised by ageing populations (aged 65-84) which are higher than the data cited for England in 2011 (Office for National Statistics, 2013 In Lincolnshire County Council, 2014) (See Table 1). Disease prevalence varies between the localities where significant health conditions such as coronary heart disease (CHD), stroke, chronic obstructive pulmonary disease (COPD), lung cancer, mental health, other cancers and obesity have been identified (See Table 2). It is also noted that the percentage of older people experiencing economic deprivation is significantly lower than the national average in Gainsborough, Sleaford and Stamford. However, in Skegness and Coast, the percentage is slightly higher, but not statistically significant when compared with the National average (Communities and Local Government, 2010 cited in Lincolnshire County Council, 2014 a – d).

Table 1: Population by age group 2011 (Aged 65-84 years) of Lincolnshire's localities and CCGs, adapted from Office for National Statistics 2013 cited in Lincolnshire County Council (2014 a – d).

Locality/ CCG	Population by age group 2011 Locality	Population by age group 2011 CCG	Population by age group 2011 England
a)Gainsborough (Lincolnshire West CCG)	15.6%	15.9%	14.2%
b) Sleaford (South West Lincolnshire CCG)	17.1%	17.1%	14.2%
c) Stamford and Welland (South Lincolnshire CCG)	16.6%	18.0%	14.2%
d) Skegness and Coast (Lincolnshire East CCG)	25.1%	21.2%	14.2%

Table 2: Disease Prevalence 2011 of Lincolnshire's CCGs, Adapted from Lincolnshire County Council (2013 a – d).

Locality	Disease prevalence
a) Gainsborough (Lincolnshire West CCG)	CHD, Lung Cancer, COPD and Mental Health are diseases that affect the population in Lincolnshire West mostly in terms of life expectancy, in addition to excess weight and obesity which is higher than England.
b) Sleaford (South West Lincolnshire CCG)	The prevalence of diabetes, CHD, stroke and cancer is higher in South West Lincolnshire than England as a whole. Under 75 mortality rates from respiratory disease is slightly higher than the National rate.
c) Stamford and Welland (South Lincolnshire CCG)	The prevalence of diabetes, CHD, stroke, cancer and obesity (adults and children) is higher in South Lincolnshire CCG than England.
d) Skegness and Coast (Lincolnshire East CCG)	The prevalence of cancer, diabetes, and respiratory diseases are all higher in Lincolnshire East than England in addition to emergency admissions of CHD and strokes.

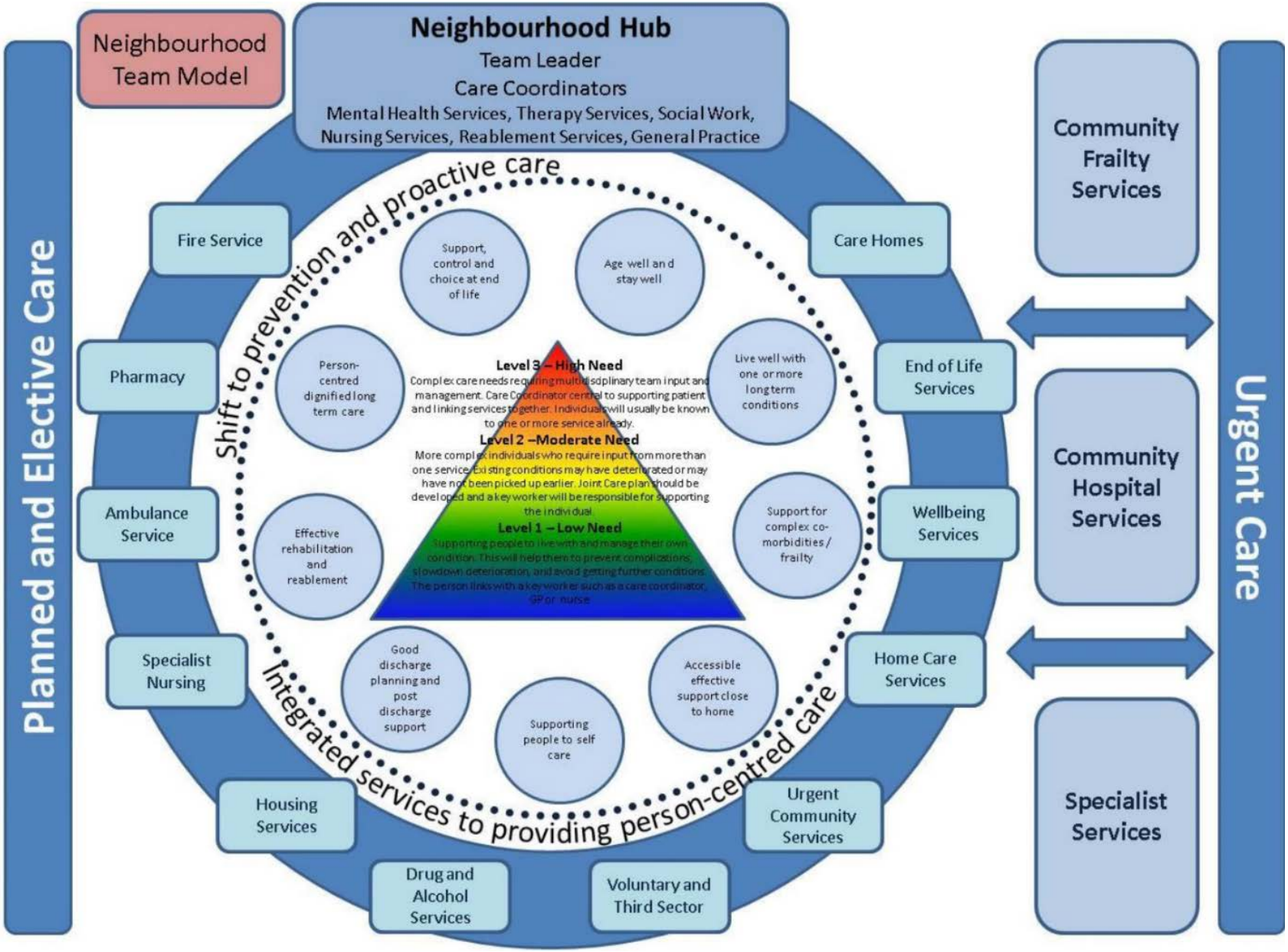

Figure 2: **‘**Neighbourhood Team’ Model (Lincolnshire Health and Care, 2013)

Chapter 2.0

METHODS

2.1 SUMMARY

This chapter highlights the methodological and theoretical approaches undertaken in this project. Four workstreams were proposed. The initial three workstreams were guided by the underpinning contextual framework of 'Realistic Evaluation' (Pawson and Tilley, 1997).

2.2 REALIST METHODOLOGY

Underpinning this evaluation is the development of a 'programme theory' of integrated care. This essentially means that the evaluation set out to ask 'what works, for whom and under what circumstances?' in specified NT's in Lincolnshire (Pawson and Tilley., 1997; Pawson., 2002, 2006, 2013). In order to answer this question each step of the evaluation is broken down into three key components (See Figure 3):

- **Component One - Context** –The context here relates to the political, social, economic and cultural characteristics of the macro environment, for example, increased ageing population; financial pressure on health and social care; austerity measures; long-standing assumptions from the population about how health care is delivered.
- **Component Two - Mechanisms** – The mechanisms here relate to how individuals and stakeholders of an intervention respond, react to and interpret (**reasoning**) the opportunities provided by the programme or intervention e.g. NTs (**resource**)
- **Component three - Outcomes**– The outcomes refer to the intended and unintended consequences of implementing a programme (NT's). Outcomes can be multifaceted, intended or unintended and they can both support or undermine primary objectives of the NT (programme).

The components cited above are more commonly known as 'Context-Mechanism-Outcome' (CMO) configurations and illustrate the 'programme theories' of an intervention (Pawson and Tilley, 1997; Dalkin et al., 2015). Simply written, CMO is a hypothesis of how a programme works or does not work, because of the action of particular mechanisms, which only occur in certain contexts. Therefore, CMOs enable the exploration of assumptions and relationships between the mechanisms of the programme components (responses to the Neighbourhood Model), the context influencing the development of the programme (national government priority, ageing populations, pressures on current public sector services models) and the intended and unintended outcomes of the Neighbourhood Team model.

The project set out to examine four key areas:

1) Evidence of the structures and process of Integrated Neighbourhood Teams and their effectiveness in supporting integrated working;
2) The essential roles and skills necessary to deliver integrated care;
3) Evidence of models that demonstrate improved care outcomes (e.g. changes in health related quality of life; reduction of unscheduled hospital admissions) and;
4) The identification of a programme theory of integrated care for NT's in Lincolnshire

As part of the development of a programme theory of integrated care, an initial programme theory/ hypothesis was established through documentary analysis of the Neighbourhood Teams. Through conducting a scoping review of the literature, qualitative interviews and process mapping emergent, programme theories would be developed. Finally the programme theories developed through these three workstreams would be further refined and synthesised into a final programme theory of integrated care. See Appendix Two, Table i-vi for more details.

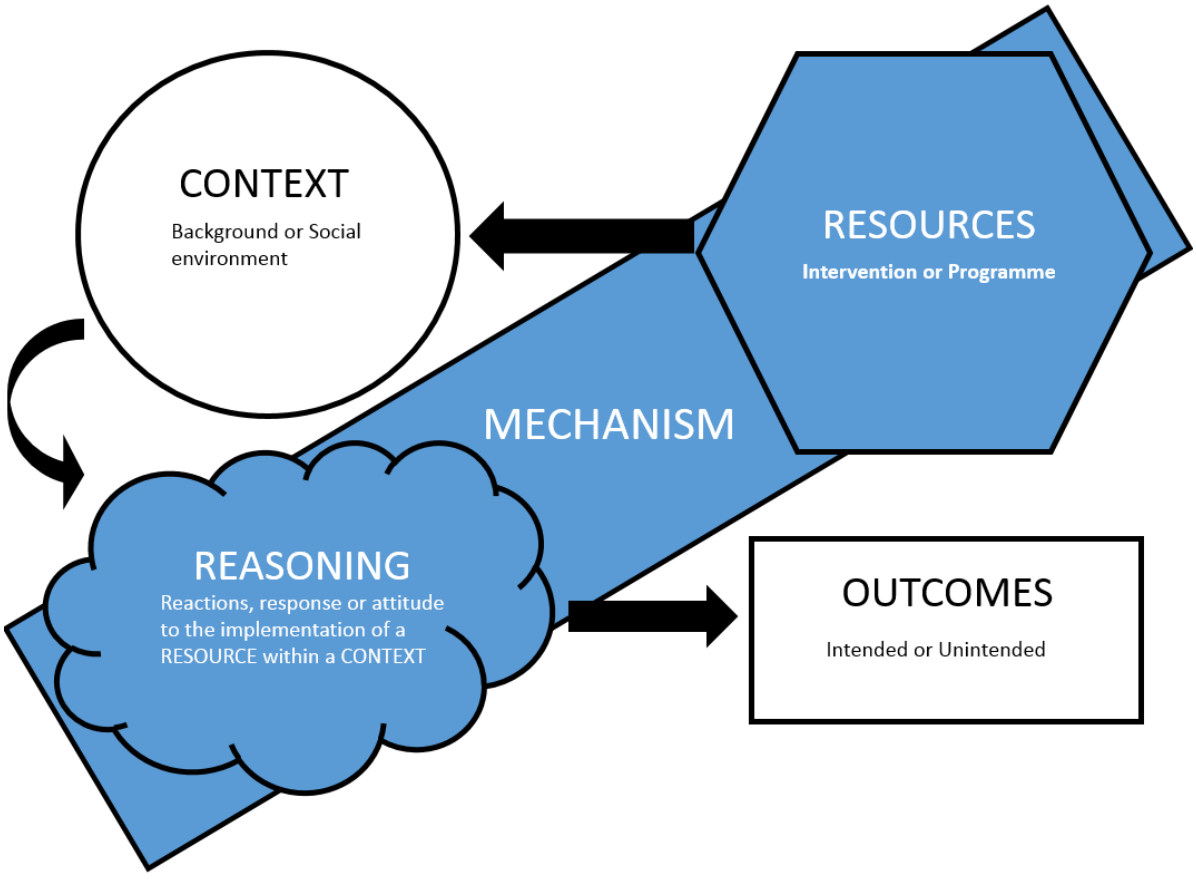

Figure 3: Adapted CMO configuration model, Dalkin et al., (2015).

2.3WORKSTREAM ONE: SCOPING REVIEW

A key element of the realist synthesis (secondary data) was to undertake a scoping review of UK based literature, between 2007 and 2017, about 'integrated care' for people 65 and over, living with multimorbidities. While the inclusion criteria was based on this time period there is some literature preceding this review which provide additional key information; for example, the change from PCTs to CCGs, and findings from pilot sites regarding 'integrated care'.

This scoping review of the literature adhered to Arksey and O'Malley's (2005) literature review framework. Key academic databases (Academic Search Complete; Applied Social Science Index and Abstracts, CINAHL Complete, International Bibliography of Social Sciences, MEDLINE, PsychINFO, SCOPUS and Web of Science) and further grey literature (The KingsFund, The Health Foundation, Nuffield Trust and Google Scholar) were used to obtain the appropriate literature concerning 'integrated care'. The initial screening of the literature, yielded 21,521 hits. These were further screened via analysis of titles, abstracts and where necessary, full text screening in order to exclude irrelevant articles (See Figure 4). The remaining literature was then appraised based on a Wong et al., (2013b) realist synthesis RAMESES training materials quality standards for selecting and appraising documents based on the process of 'relevance and rigour' (Pawson et al., 2004; Wong et al., 2013). Following this process, a total of 403 full texts articles remained, 10 UK based case studies (See Appendix Two Table i-vi), 137 articles relating to theory building and a further 256 background articles.

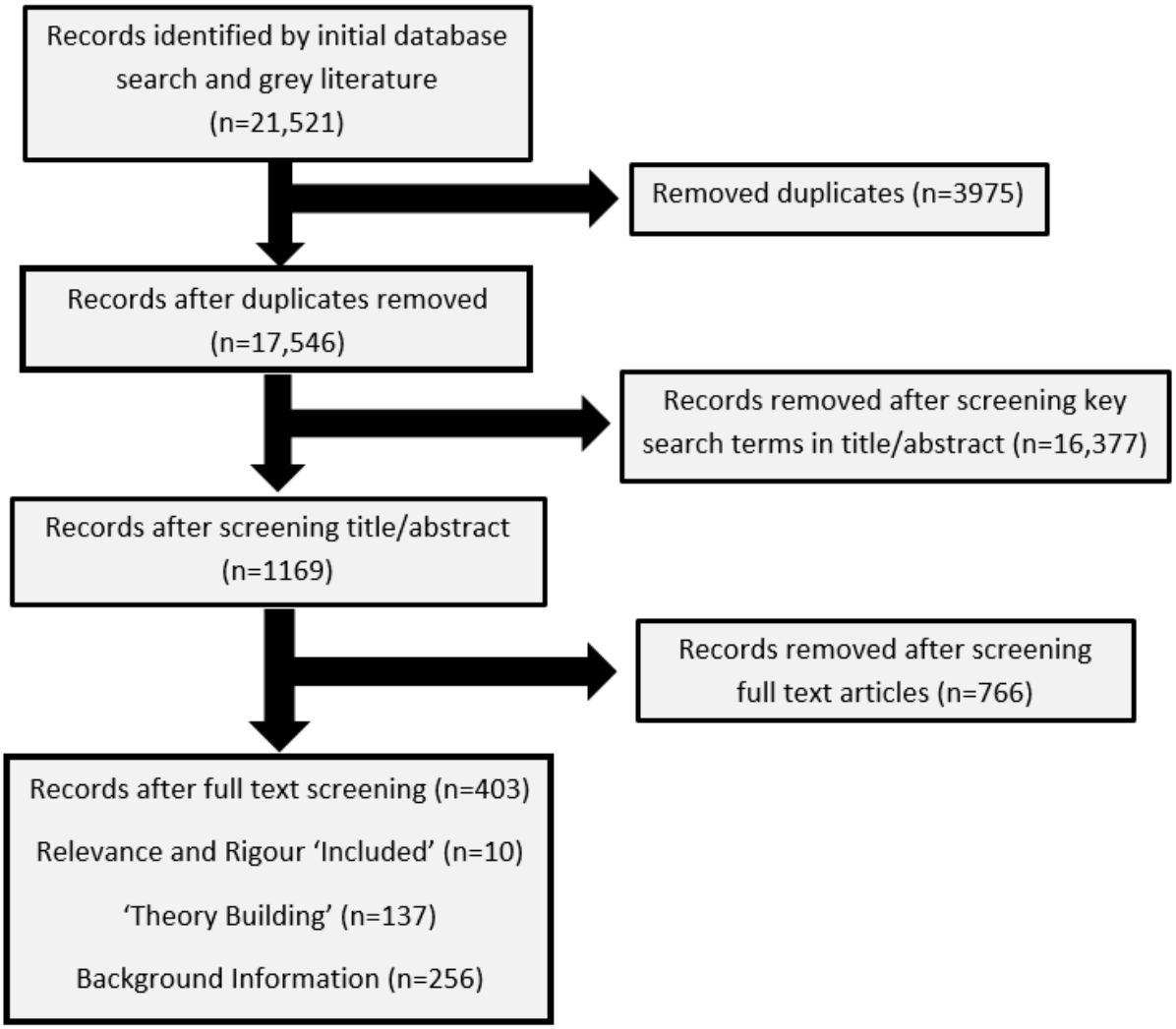

Figure 4: Study flowchart of scoping review of the 'integrated care' literature

2.4 WORKSTREAM TWO: QUALITATIVE INTERVIEWS

Qualitative interviews (primary data) were conducted with various key stakeholders including directors, commissioners, provider and operational staff. The interviews concentrated on the context (for example, roles, skill mix, processes of assessment, facilitators to cross-sector relationships and structural integration), mechanisms (for example, experiences of NT's, benefits, opportunities) and perceived outcomes (for example, changes to user quality of life for end users, reductions in unnecessary admissions, improvements in outcome) of the integration process, in particular participants thoughts about and experiences of the development of 'Neighbourhood Teams' (See Appendices Three).

2.5 WORKSTREAM THREE: PROCESS MAPPING

Participants were invited to map the processes of their Neighbourhood Teams. Four process mapping events (primary data) were conducted with each of the Neighbourhood Teams between January and February 2017. Questions included:

- What are the aims of the 'Neighbourhood Teams'?
- What do you feel you need to help you achieve the aims?
- What part do you play, what is your role in the 'Neighbourhood Teams'?
- Who does the 'Neighbourhood Teams' help? Why these people?
- Mapping of 'Neighbourhood Team' referral process from START to FINISH;
- What part of the process is not working so well? What are the greatest problems?
- Suggestions and improvement?
- What part of the process works well? What are the greatest successes or outcome?

Further organisational documents (documentary analysis) were analysed to explore underlying assumptions guiding the implementation and delivery of the Integrated Neighbourhood Teams in Lincolnshire.

2.6 WORKSTREAM FOUR: SERVICE USER QUESTIONNAIRES

Service-user questionnaires (primary data) were planned in order to evaluate outcomes for a sample of older people referred to Neighbourhood Teams. It was intended that a baseline measure would be collected and a follow up (four months) structured questionnaire via self-completion or, where necessary, telephone interview, with a sample of older people who had been referred to the Neighbourhood Teams. The administration of the baseline questionnaires was supported by the Neighbourhood Team staff. The contents of the questionnaire included validated tools that measured changes in health-related quality of life, social care quality of life, loneliness and social isolation and care outcomes (changes in service use) (de Jong Gierveld and Kamphuis., 1985; Beecham and Knapp., 1992; Bowling., 2002). Insufficient numbers of respondents meant that it was not possible to draw any meaningful conclusions from available data.

2.7 ETHICAL CONSIDERATION

ProTICare was granted ethical approval by the University of Lincoln Research Ethics Committee (19th September 2016), and further ethical approval by the Health Research Authority (HRA) Research Ethics Committee (IRAS Project ID Number: 210575 and REC Reference Number: 16/EE/0385).

Key stakeholders were identified through the external partners on the ProTICare Research Steering Group. Service users as potential particpants were to be identified through the Neighbourhood Teams, as people accessing NT services. Participation in the qualitative interviews, process mapping and service user questionnaires was entirely voluntary and, following receipt of a project information sheet, written consent to participate in the research was given by each participant.

All data obtained throughout this project was stored and managed as required by the Data Protection Act 1998. All interviews and service user questionnaires were coded to ensure anonymity of participants and all documents were password protected and securely stored respectively.

2.8 DATA COLLECTION AND ANALYSIS

A handful of appropriate software packages were used in the data collection and analysis in this evaluation.

Mendeley Reference Bibliography Manager was used to collate and screen all literature obtained from academic databases and grey literature into the final relevant documents.

QSR NVivo 10 was used, in combination with manual coding, to undertake thematic analysis of interviews obtained from individuals and key stakeholders.

Microsoft Visio was used to map the referral processes identified within the process mapping exercises with all four Neighbourhood Team localities.

2.9 CONCLUSION

Table three summarises the workstream methods applied in this project. In summary, a multi-method approach was undertaken which included: a scoping review of the literature (secondary data analysis); 58 semi-structured telephone interviews with participants (Director, Commissioner, Strategic and Operational staff); four process mapping exercises involving 39 operational staff, service user questionnaires (primary data analysis)across the four Neighbourhood Teams.

Table 3: Summary of ProTICare Research methods

Method	Areas of enquiry	Type and numbers
Scoping Review	• Integrated care • Multidisciplinary Teams • Older adults • Multimorbidities/ multiple long term conditions • United Kingdom	Literature • 21,521 articles (without duplicates removed • 17,546 (with duplicates removed) • 1,169 (Title and abstracts screened) • 403 (Full text articles screened): o 10 Included o 137 Theory building o 256 Contextual Background
Qualitative Interviews	• Job role and responsibilities; • Definition of 'integrated care'; • Key aspects and characteristics; • Rationale and objectives underpinning; • Barriers and facilitators to programme; • Value of programme.	Total number of interviews (n=58/90) 64.44% • Telephone Response (n=46) 79.31% • Written Response (n=12) 20.69%
Process Mapping	• Perceived aims and objectives • Role of participants in achieving aims and objectives • Type of individuals being supported • Structures and processes of the work • Barriers and facilitators to implementation	Total number of Process Mapping events (n=4) and attendees (n=39): • Gainsborough (n=9) • Sleaford (n=11) • Stamford (n=15) • Skegness (n=4)
Service-user questionnaires (base-line and four month follow-up)	• Quality of life (Bowling, 2002) • Social Isolation (Lubben social network scale) • Loneliness Scale (de Jong Gierveld and Kamphuis, 1985) • Health-related quality of life (EQ-5D3L) • Individual service use (Beecham and Knapp, 1992) • Demographics (e.g., marital status, accommodation, work/ retirement, benefit receipt, ethnicity, sexuality, faith).	Please refer to section 4 for more detail*
Neighbourhood Team Meetings	Attendance of Neighbourhood Team meetings with all four hubs	(n=4) Neighbourhood Team Meetings
Conferences	Attendance of Neighbourhood Team conferences: • IPC National Board Visit (23rd November 2016) • Home First Event (16th March 2017)	(n=2) Conferences

Chapter 3.0

A REALIST REVIEW OF LITERATURE

3.1 SUMMARY

This chapter clarifies the context of integration, including a working definition, conceptualising model, key drivers of change and finally, the intended of integrated care.

3.2 THE CONTEXT FOR INTEGRATION

Integration of health and care services has been a long-standing policy objective. The acceleration of integration as a government priority has been promoted by a raft of legislation and policy over the past decade (See Appendix Two Table i-vi).

A number of national contexts, reflected locally, contribute significant drivers for health and social care integration (Ham et al., 2012). It is a well-rehearsed, if rather uncritically adopted argument, that an ageing population places a significant 'burden' on the healthcare system. Additional pressures have also been created by unprecedented retrenchment in health and social welfare since 2010, arguably contributing to the 'burden' debate. Increases in the population of people aged 85 and over, are projected to rise to 3.6 million by 2039, and the greater likelihood of people defined as the 'oldest old' using services, contributes to growing anxieties about unsustainable demands on health and social care. The picture is repeated in a local context. There has also been an increase in the numbers of people living with co-existing, long-term conditions, usually termed multimorbidity, (Fortin et al., 2004; Ryan et al., 2015) where such individuals account for around 50% of all GP appointments and a further 70% of all inpatient bed days (DH, 2012). Other factors such as, inequalities across the life course, and contemporary challenges including: growing numbers of people defined as clinically obese or overweight, and the health implications of lifestyles choices associated with harmful levels alcohol intake, poor nutritional profiles and physical inactivity, contribute to the numbers of people seeking medical intervention. Disability free years of life, that is the number of years a person lives without experiencing disabling consequences from long term conditions, has not reduced as life expectancy continues to increase.

Austerity measures have resulted in additional funding pressures with a reported overall deficit of £2.45 billion and £22 billion efficiency savings required by 2020/21 (Roberts et al., 2012; NHS England, 2016) set against an 11% increase in spending by NHS Trusts and NHS foundation trusts between 2015-16 (NAO, 2016). The Lincolnshire deficit for health is assessed currently at £60 million and predicted to increase to £105 million over the next five

years (Lincolnshire Sustainable Services Review, 2013). A similar picture of retrenchment is evident in the social care sector. Local Authorities have reduced spending on adult social care by 10% in real terms between 2009 and 2015/16, resulting in a 26% fall in the numbers of older people receiving local authority funded care (CQC, 2016). The numbers of older people with significant needs in activities of daily living, including personal care, who do not receive help with care, was estimated in 2016 at 1.2 million (Age UK, 2017). Secondary analysis of the English Longitudinal Study on Ageing (ELSA) and the Health Survey for England (HSE) has confirmed the extent of unmet need (Ipsos MORI, 2017). While the CQC (2016) highlight the continuation of good quality adult social care services during the inspection period 2015/2016, they also reflect concern that the sustainability of social care is reaching tipping point. Clearly, additional pressure on the social care sector has serious consequences for health care systems and services and the health and wellbeing of people who are struggling to cope. This is evidenced by, for example, a 14% increase in the number of emergency hospital admissions between 2011 and 2016/17 (NAO, 2017).

Although health and social care services have an important role in improving population health and providing access to care, there has been a growing critique of 'traditional' approaches to health service delivery. Arguably, traditional approaches which respond reactively, work tirelessly to keep pace with growing demand, and tend to operate as separate services, have contributed to uncoordinated and fragmented care, especially for people with complex and high support needs (Ham et al., 2012). Poor coordination of services and fragmentation have a direct impact on patients/end users of services. For example, patients and service users are critical of the experience of repeatedly telling their story or experiencing uncoordinated assessments; returning to the hospital for multiple, uncoordinated outpatient appointments (exacerbated when a person lives with co-existing long term conditions) and experience of delays and blocks in getting the help they need. It is argued that too great an emphasis on acute and primary care has hindered the development of preventative secondary and community services which have the potential to support a more proactive response to community health, and ultimately, reduce service use in the acute and primary care sector.

This is especially true for people who are clinically frail, whose condition can change rapidly and who are at considerable risk of an unhelpful and costly pattern of repeated admission to hospital and discharge home, in the absence of coordinated and well developed community services (Øvretveit, 2011, pg.6). Increasingly, government policy directs attention towards the importance of 'self-management' as a crucial culture change, alongside proposals for service redesign and integration of services.

All of these factors have contributed to the continued attention to, and prioritisation of, integrated health and social care. As well as reducing costs created by unnecessary hospital admissions, delayed discharges and the costs associated with siloed service provision, evidenced for example, by repeated visits from multi-professionals or successive outpatient appointments, integrated care is identified as an important approach to address perceptions and experiences of fragmented care through the application of a 'seamless' care pathway. Ultimately, it is argued that integrated care should lead to improvements in patient/user quality of life through better coordinated and coherent services on a continuum from early preventative interventions to planned care for people with very complex needs. An underpinning assumption of integrated care is that it will lead to a reduction in unscheduled hospital admissions, discharge delays, inappropriate service use and ultimately, cost savings (Curry and Ham, 2010).

3.3 WHAT IS MEANT BY HEALTH AND SOCIAL CARE INTEGRATION?

'Integrated care' is a widely used, yet poorly understood concept. There is a plethora of terms, such as 'partnership working', 'joined up working', 'coordinated care', 'collaborative care' which are often used interchangeably and uncritically to describe or refer to 'integrated care'. This is illustrated in a systematic review by Armitage et al., (2009) who identified 175 individual definitions and concepts relating to 'integrated care'. The diversity of definitions and terms of reference have led to it being coined 'the imprecise hodgepodge of integrated care' (Kodner, 2009: 12). The most commonly cited terms within the literature, depicted in Figure five, highlight the subtle nuances around key definitions. It is evident that 'partnership working' and 'joined up working' are defined by their individual organisational and professional boundaries but become temporarily united to complete a task. Whereas 'integrated care' encompasses working arrangements underpinned by the same boundaries across different services.

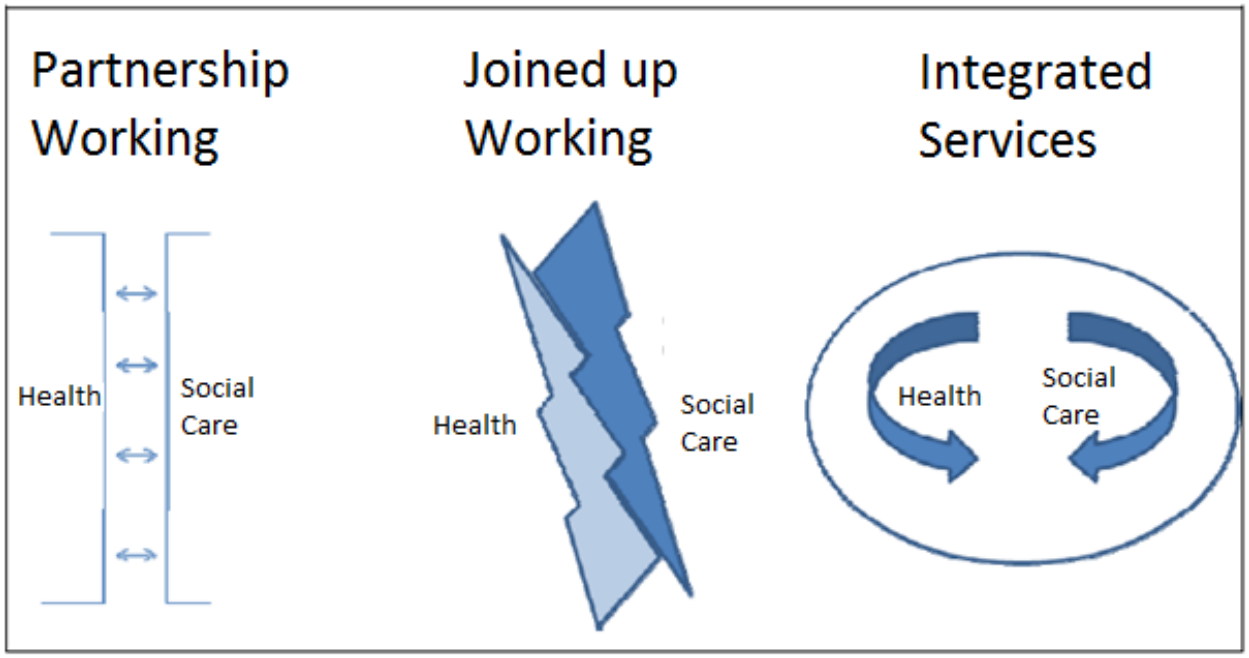

Figure 5: Models of the types of health and social care working arrangements. Adapted from Carnes-Chichlowska et al., (2011).

Similarly, there is underlying confusion in the distinction between 'integrated care' and 'integration' (Shaw et al., 2011). In its' simplest form, 'integrated care' is recognised as an overarching standard, goal or approach with the aim of achieving improved care delivery for patients, services users and carers through seamless care pathways and better coordination of services. Furthermore, there is an emergent emphasis on patient-centred care which underpins the framework of integrated care (See Figure 4). Integration is recognised as a combination of appropriate methods, tools and processes which seeks to provide improved coordination of care for patients and users, and may contain many variations in its approach (Kodner and Spreeuwenberg., 2002). For example, through effective networking (i.e. a method), integration enables various healthcare professionals and systems to communicate and proactively work together. Other models of integration include co-location of care, shared information, single assessment processes (Powell-Davies et al., 2008). Crucially, 'integration' should be a means to an end for better service provision and outcomes for people's lives, not merely and end in itself, becoming part of the wider problem rather than part of the solution (Glasby, 2012).

In summary, the overarching aims and underlying assumptions of integrated care are:

- To improve outcomes for patients, service users and carers, particularly those with possible multi-morbidities and complex long term health conditions, by overcoming issues of fragmentation through seamless care pathways and better coordination of care (Shaw et al., 2011);
- To produce efficiency savings for services through more joined up working;
- Reductions in unnecessary hospital admissions and decreases in the number of admissions to long term care (highly context dependent) (Reed et al., 2005)
- Develop service redesign which responds to the needs of the population and is sustainable.

3.4 CONCEPTUALISING INTEGRATED CARE

It is widely acknowledged that a patient-centred, rather than an organisational focus, should be at the heart of any discussion about 'integrated care', where services through a 'holistic' approach, are wrapped around the patient/user (DH, 2013). The Department of Health have worked with users and collaborating partners to define what integrated care and support means from a patient/end user perspective. At its heart, this definition of integrated care highlights the importance of coordinated, planned care, delivered to achieve the best outcomes for the patient/user and carers. This overarching goal is supported by a process of assessment resulting in clearly identified needs which include: recognition of resources, strengths and aspirations; access to information which is timely and supports self-management and decision-making; agreed care and support with inbuilt reviews; effective communication within and across professional groups, being listened to and responded to effectively; involvement in decisions about care including understanding the care budget available; effective transition planning (DH, 2016). Despite the vision for person centred care, evidence overwhelmingly concludes that it is a rare experience for most people living with long-term conditions (HC Health Committee, 2014).

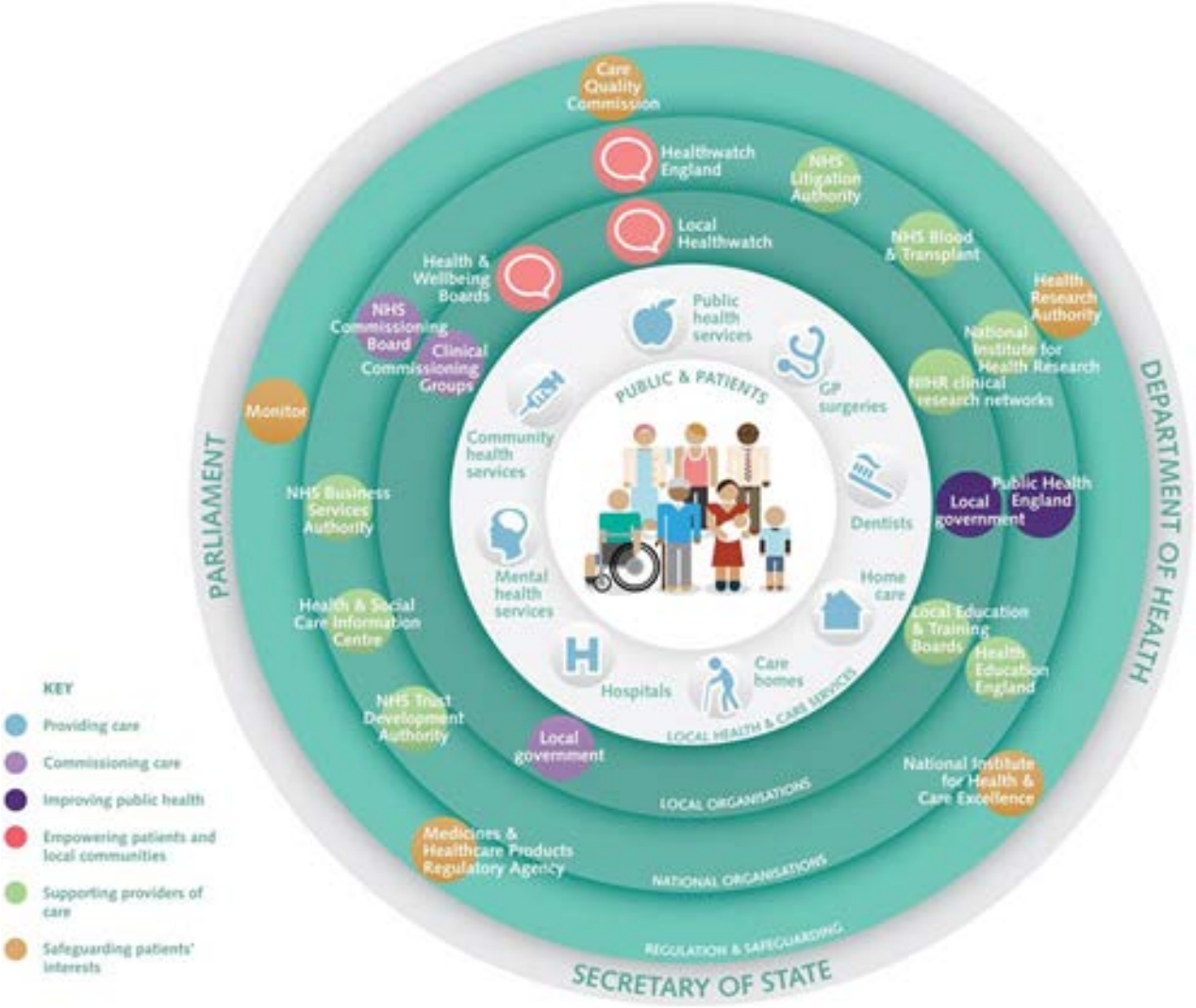

Figure 6: 'Patient –centred care' Health and Social Care System (Department of Health, 2013)

The Department of Health model of health and social care systems (Figure 6) is embedded in an ecological framework demonstrating the different levels of 'integration' in terms of type, breadth, degree and processes (Billings and Leichsenring, 2005; Curry and Ham, 2010; Rosen et al., 2011; Carnes-Chichlowska et al., 2013**;** Valentijn et al., 2013) (See Figure 7). Different levels of integration include:

- **Macro Integration (Strategic)** – is a level of integration which delivers integrated care initiatives across a range of services to their populations (national policy makers/ organisations) e.g. Kaiser Permanente, CQC, Department of Health (Curry and Ham., 2013):
- **Meso Integration** (**Managerial**) – is a level of integration where services deliver integrated care for particular groups of individuals with similar classifications of diseases or conditions e.g. older people, mental health needs and disease management. There are two types of Meso integration:
    - **Organisational (structural) integration** – organisations/ services are merged together possibly through structural change, governance systems, collectives and or virtually through formal provider networks by pooling skills and expertise of different organisations e.g. knowledge exchange networks (Valentijn et al., 2013) e.g. knowledge exchange networks (Valentijn et al., 2013);
    - **Professional integration** – Interprofessional (between) and intraprofessional (within) partnerships with organisations can be conceptualised in terms of vertical and or horizontal integration;
- **Micro Integration (Service delivery/ clinical)** – is a level of integration where services deliver integrated person focused care and improve coordination for individual service users and their carers e.g. care planning (Ham and Curry., 2013).
    - **Clinical integration (patients)** – is a type of micro integration where multiple care processes are integrated into one single, coherent process within and/ or across services e.g. such as shared guidelines or protocols, interprofessional education;
- **Vertical Integration** – is defined as the integration focussed on different stages of care strategic (Macro), managerial (Meso) and delivery levels (Micro) e.g. integration of primary and secondary care such as partnerships of hospitals and community services;
- **Horizontal Integration** – is defined as the integration or cross-sectorial collaboration achieved between one or more services or organisations at all three levels of care e.g. based on good working relationships between services, joined up working and holistic assessments (HA);
- **Diagonal Integration** – is seldom considered however relationships between all levels of services are necessary for managers and practitioners to understand how care is delivered and organised between services (Carnes-Chichlowska et al., 2011).

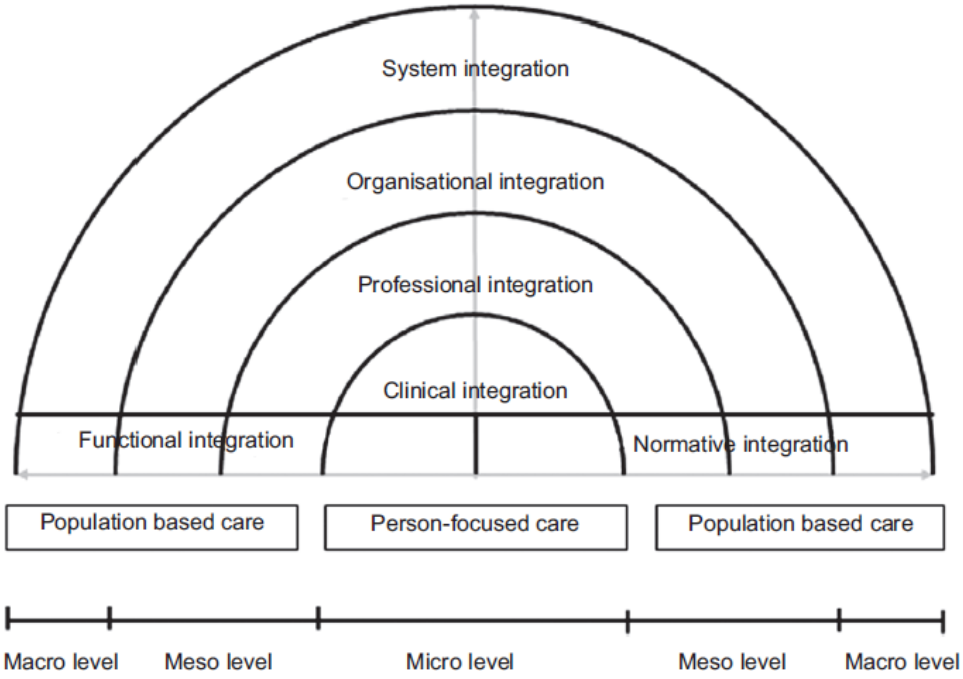

Figure 7: Conceptual framework of integrated care based on the integrative functions of primary care (Valentijn et al., 2013).

Additional types of integration include:

- **Functional integration** – key support functions and activities are integrated linking all levels of the system e.g. electronic patient records, financial and information technology management (Billings and Malin, In Billings and Leichsenring (2005);
- **Normative (cultural) integration** – where organisations, services and individuals have a shared set of ethos, values, visions and commitments to integrated working enhancing trust and working relationships, collaboration in delivering care;
- **Systemic integration** – coherence and coordination of rules, policies and guidelines at all organisational levels e.g. Quality and Outcomes Framework, financial incentives;
- **Real integration** – entails agreed guidelines and principles between organisations;
- **Virtual integration** – can occur along a continuum and range from formalised networks with governance arrangements to informal alliances/ federations. Often underpinned by contracts or service agreements between organisations (contractual integration);
- **Social integration** – the strengthening of social relationships amongst the various stakeholders and integration of interests, resources and objectives.
- **Other integration** – e.g. full integration, coordination, collaboration and informal partnerships (Leutz, 1999).

Although initiatives to integrate health and care have largely focused on either horizontal or vertical integration (e.g. Primary Care or Public Health to improve overall health and wellbeing; Torbay PCT through the use of pooled budgets, intermediate care, proactive discharge planning; respectively), it is widely agreed that such initiatives should focus on all levels of care, thus minimising the risk of fragmentation, and the potential for service users and carers 'falling through the net' (Curry and Ham, 2010; Thistlethwaite, 2011). Therefore improvements in coordinated service provisions of care are essential to enhance professional working relationships and better patient outcomes. Furthermore consistent with Valentijn et al., (2013), partnerships across traditional organisational and professional boundaries are required to improve the quality and efficiency of services provided e.g. collaborative work between community nurses and social workers.

Various 'integrated care' initiatives have been reported in the literature, including the use of integrated locality or multidisciplinary community based teams (Lewis et al., 2010; Bardsley et al., 2013; Bennett and Humphries, 2014). This population based model of care aligns with the development of multidisciplinary community providers (MCP) which aim to improve the health and wellbeing of their local population through vanguards such as GP Federations and community based services (Collins, 2016; Naylor et al., 2016; NHS England, 2016). These integrated, multidisciplinary teams (MDTs), which demonstrate horizontal integration, primarily consist of GPs, nurses, occupational therapists (OT), physiotherapists, mental health, social workers and voluntary/charitable sector organisations, typically discussing referrals for people with complex needs characterised by multi-morbidity and requiring intervention from several services. A recent review found that more than 80% of all CCGs groups were involved in integration focusing on MDT's based in primary care that identify and manage patients at risk of hospital admission (Stokes et al., 2015). Stokes and his colleagues conclude that concentrating integrated services on patients/end users with the most complex needs may improve outcomes and health benefits commensurately, however for services themselves, integration is unlikely to contribute to any significant cost reductions or use of service provisions (Stoke et al., 2015). Moreover recent evidence suggests that a substantial focus has been targeted towards services around patients with complex needs, which has correspondingly resulted in a lack of progression in other services over the same time period e.g. Torbay PCT focusing on adult services, whereas children services have been less well developed in the same period (Thistlethwaite, 2011). A more holistic approach is required in order to improve integration across the whole system.

3.5 DOES INTEGRATED CARE IMPROVE OUTCOMES?

While there is a wealth of literature on 'integrated care', with an emerging UK and international based evidence, it is acknowledged that those improvements which have been attributed to integration, have particularly been associated with processes, structures and patient user satisfaction and experience. Despite cost savings and a reduction in hospital admissions being typically cited as key aims or potential outcomes of integrated care, they have rarely been convincingly or consistently demonstrated in research (Powell-Davies et al., 2008; Ham and Curry, 2010; Rosen et al., 2011; Goodwin and Smith, 2011; Humphries and Wenzel, 2015).

Due to the complexity and diversity of integrated care interventions, it is difficult to fully analyse the potential for reduced costs and service use across integrated initiatives. Some studies have indicated potential cost savings and cost effectiveness, including reductions in hospital bed days (Windle et al., 2010; Thistlethwaite, 2011; Tucker and Burgis, 2012), however, others concluded that there was no evidence of a reduction in costs to the NHS and little evidence of a reduction in emergency admissions (Nuffield Trust, 2013).

With a primary focus on UK based studies, an evaluation conducted by Windle et al., (2010) on the Partnerships for Older People Project (POPP) found significant evidence that various care models across 29 local authorities made considerable savings. Savings equating to £0.80 - £1.60 per £1.00 invested throughout the pilot were documented, with additional savings of £1.20 in emergency bed days. It was cited that savings of £2,166 per person were made in reductions in clinic or outpatient appointments. Such cost savings were noted in parallel with a reduction in service use including a 47% reduction in overnight hospital stays, 29% reduction in Accident and Emergency (A&E) departments, further reductions in physiotherapy and occupational therapy. Furthermore due to proactive coordination of services there was a reported 60% reduction in A&E, in addition to a 48% reduction in hospital overnight stays, 28% reduction in in phone calls, 25% reduction in visits to practice nurses and a further 10% reduction in GP appointments. Even though Windle and colleagues noted conclusive savings and reductions in service use, especially initiatives surrounding hospital discharge, the impact that such cost savings had on health and social care budgets was inconsequential**.** Although cost savings were evident at micro level integration, it is essential that specific structures and

strategies at meso and macro level integration should be present if significant cost savings are to be achieved in future.

Another example of potential cost savings were documented by Thistlethwaite (2011) of Torbay PCTs integrated care services. Torbay PCT was able to deliver successfully staged service development through micro level integration changes including, staff buy in at all levels, initiatives focussing on GPs central in the role in the provision of community care, information sharing of data between IT platforms, and the appointment of care coordinators who worked directly with allied health professionals. Additionally meso level integration focussed on service delivery during service redesign while macro level integration had less impact on the delivery of integrated care services. Moreover a reported £250,000 savings was made within the first year of service delivery, where monies were reallocated to develop additional services across the Trust including a number of new social worker posts and local leadership programmes. Furthermore a 33.1% reduction was reported in the daily average number of occupied beds from 1998/99 to 2009/10 including the lowest emergency bed day use for individuals aged 65 and over at 1920 per 1000 population compared with the national average of 2698 per 1000 population in 2009/10. Additional findings reported a 24% reduction in emergency bed day use for individuals aged 75 and over and a 32% reduction in individuals aged 85 and over between 2003 and 2008. It was also evident that delayed transfers of care from hospital, reduced to insignificant numbers which was further sustained for a number of years. Findings suggest that Torbay was also financially responsible for 144 fewer people aged 65 years and over in residential and nursing homes. There was a corresponding increase in the use of home-care services, some of which were being targeted on preventive low-level support. The use of Direct Payments was reported as one of the best in the region. Another important outcome occurring in 2010 was the CQC judging Torbay and its services to be 'performing well'. Finally non-elective bed use by individuals, 65 years and over, has maintained a downward trend in Torbay in comparison to other parts of the region, and home care provision by the care trust has increased in parallel. Also double the regional average of individuals aged 65 years and over now receive some form of social package from Torbay Care Trust. Despite reported positive changes to Torbay services, it was noted that Children's services did not progress as well over the time same period, despite a strong local collaborative culture. This could be largely due to the focus and emphasis on older adults

rather than adopting a life course approach. The impact of services on the level of care experienced by the service user has been monitored using various outcome measures including, increased amounts of social care provided for the over 65s, and reduced number of non-elective bed days occupied by the over 65s. Reported personal outcomes were not featured.

While cost savings and reductions in service use have been periodically reported, findings from an evaluation of Integrated Care Pilots in North-West London, noted inconsistencies in funding resource allocation of the innovation fund amongst multidisciplinary groups during the first year of spending, and negligible changes in emergency admissions across the pilot in comparison to the national level (Curry et al., 2013). Despite this, the pilot was one of the first to monitor clinical outcomes relating to a cohort of people with diabetes. The evaluation detected improvements in clinical outcome measures of cholesterol and blood pressure control, where three months exposure to the pilot's care planning showed a marginal significant increase (p=0.0472) in the percentage of individuals with good cholesterol (high density lipoprotein mmol/L) control in addition to a significant decrease in average cholesterol readings (p<0.0001). Furthermore blood pressure (mmHG) control has shown continual improvements for all individuals with diabetes over the three years, despite the percentages of good control ranging between 50 – 58% among the pilots practice during the final year reportedly falling well behind the national prevalence of good blood pressure control (80%+). Finally there was no significant change in the proportion with good blood pressure control prior to or after the care plan for three months. During the pilot, it is worth noting that blood sugar level (HbA1c) control in individuals with diabetes showed no improvements either (Curry et al., 2013).

An evaluation of Southwark and Lambeth's integrated care (SLIC) programme reported interesting findings with regards to the impact on hospital and care home stays (Wolfe et al., 2016). During a 44 month data collection period, emergency discharges rose by 2% across S&L in 2012 however, reported emergency discharges rose by 23% in other local CCGs. Despite such findings, there was no specific targets reported. A reprofiled target from 2014/ 15 was a -5% reduction in emergency bed days per month for individuals aged 65 years and over. In practice there was a reported -0.6% reduction, although there was a +18% increase in bed days for other local CCGs. Therefore reductions in hospital activity in SLIC were deemed

negligible. Finally, there was a reported 61% reduction in care home placements for individuals aged 65 years and over, where placements were 11.4 per month, 46% below the 19.9 per month target. The impact on demand for services particularly emergency admissions (and discharges) remained relatively stable between 2012 – 2016, for individuals aged 65 years and over, despite increases in other areas. Overall admissions to care homes reduced significantly. Findings also noted an 18% reported shift in the investment of resources available which were transferred from acute care towards more community and primary care settings. Evidence of this shift in resource allocation was demonstrated by increased investment in emergency rapid response teams and reablement services. It was acknowledged that SLIC targets were overly ambitious in their scale and timing, additionally there was no behavioural links of causation in measurements such as volume of holistic assessments and reductions in admissions. The projected financial savings anticipated, based on a 14% reduction of hospital bed days and an 18% reduction of residential placements by 2015, were based on the top 2-3% hospital users or those defined as being most at risk. A further 50% of expenditure and benefits were anticipated by the programme of interventions that remained at SLIC, which was targeted at low risk patients (e.g. falls prevention). Overall, there was a reported difficulty in assessing interventions and wider system change due to a lack of data on inputs and measures of outcomes. Furthermore, while findings concerning emergency discharge and bed days were small and somewhat inconsequential, comparative local CCG figures reflect a more positive outcome, reinforcing and strengthening the more positive changes reported by SLIC.

Finally, Tucker and Burgess (2012) conducted an evaluation of Integrated Care Pilots in Norfolk. Findings reported a decrease of 0.85% in unplanned admissions to the pilots between 2009/10 and 2010/11. Furthermore the impact on admissions to residential care was even greater in this period, with the pilot population recording a decrease of 7.64%, while a 16.7% increase in population was noted across the rest of Norfolk. A more detailed analysis of 12 practices highlighted that there was a 31% decrease in the rates of hospital admissions amongst 60 identified participants. Measured across 180 days before and after the intervention, provided a reduction of 18 hospital admissions which was estimated to have saved the pilot £40,000.

Taken together there are promising indications of improvements in care, particularly across micro level integration, likely to be of direct benefit to older people using services. In terms of the government's stated priority of achieving cost savings though, the evaluations considered here, suggest negligible savings (for example, Torbay, £250,000; Norfolk £40,000) against the identified £22 billion efficiency savings apparently required by 2020/21. Studies have also concluded very limited evidence or an absence of evidence to suggest a reduction in costs and hospital admissions to the NHS and its' services. Findings from the evaluations briefly reviewed here appear to be more concerned about containing costs, rather than reducing costs or reducing the costs per head of delivering care.

Whilst the above studies noted some potential positive changes in cost savings and hospital admissions, overall, the findings represent a rather contradictory picture.

A national evaluation of 16 Integrated Care Pilots (ICP) across England conducted by RAND Europe and Ernst & Young LLP (2012) found a significant and unexpected two percent increase in emergency admissions for patients, despite reported reductions in elective admissions and outpatient attendances by four percent, and 20%, respectively. Furthermore case management sites reported a nine percent increase in emergency admissions in the six months following an intervention, although there was a reduction in outpatient attendances and elective admissions by 22% and 21% respectively. A more detailed evaluation conducted by Nuffield Trust (2013) of Inner North West London ICP monitored both the quality of care and health outcomes of older people with diabetes, and the impact of service use and cost. While it was too early to observe any noteworthy changes in patient outcomes, primarily due to the study examining changes in the processes of care, there was some interesting reported findings about care planning and hospital admissions. From the conception of the pilot in August 2011 to January 2012, there was a marked increase in the diagnosis of individuals with dementia, particularly a 42% increase in the provision of care plans for individuals with dementia in the region. Similarly an increase in the frequency of diabetes testing was documented. However, there was no evidence to suggest improvements in the proportion of patients with adequate control of their condition. Other evidence reported no change in the rates of hospital admissions for individuals with fractures and falls. Due to the short evaluation time frame of the ICP, there was fairly limited analysis concerning the impact of services use and costs. Therefore a longer monitoring period would be beneficial in identifying

such changes. Despite this, the evaluation monitored changes in hospital activity for patients, particularly older people with diabetes. There was a reported 0.8% rise in emergency admissions in practices from July 2011 to March 2012, even though there was a 0.9% fall in other practices across the same region, a 1.1% rise in South West London and 0.4% rise in England across the same time period. Furthermore the evaluation was able to identify person-level matched controls for 1,236 of the initial patients recruited into the ICP. By focusing on this cohort the evaluation was able to evaluate the impact of service use of people requiring care planning interventions in comparison to those registered with a practice. Findings suggested there was no significant difference between the pilot cohort and matched controlled patients concerning changes in A&E attendances, emergency admissions, hospital cost of emergencies or total hospital costs.
A further evaluation of 25 Integrated Care and Support Pioneer sites suggested that there was little evidence of improved cost-effectiveness (Policy Innovation Research Unit, 2015). Overall, there remains an absence of studies examining the evidence for integration and cost-effectiveness (HC Health Committee., 2014; LGA., 2013, NAO., 2017).

A recent report published by the National Audit Office (2017) documented current progress towards integration between health and social care services in England (see Table 3 for a summary of key findings and recommendations). Sixteen significant findings and a further seven key recommendations were identified to ensure that the Better Care Fund (BCF) and the Five Year Forward View (FYFV) achieved their targets concerning long term positive outcomes for both patients and organisations (See Table 4). In summary, the NAO concluded that while there is evidence of the BCF contributing to improvements in joint working and integrated service provisions, thus benefitting patient experience, the achievement of its intended aims of managing the growing demand for healthcare, support out-of-hospital care, improve outcomes for patients and service users, or fundamentally saving money within its first year of delivery, is far from being realised. The NAO report reiterates the importance of robust evidence on the best approaches to improve care and save money through the integration of service provisions.

Table 4: Summary of key findings and recommendations on the current progress of integrating health and social care in England (National Audit Office, 2017).

Key Findings	Recommendations
1. Rising demand for services, combined with restricted or reduced funding, is putting pressure on local health and social care systems;	**1.** Confirm whether integrated health and care services across England by 2020 remains achievable;
2. Nearly 20 years of initiatives to join up health and social care by successive governments has not led to system-wide integrated services;	**2.** Establish the evidence base for what works in integrating health and social care as a priority;
3. The Departments have not yet established a robust evidence base to show that integration leads to better outcomes for patients;	**3.** Review whether the current approaches to integrated health and social care services being developed, trialled and implemented are the most appropriate and likely to achieve the desired outcomes;
4. There is no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity;	**4.** Bring greater structure and discipline to their coordination of work on the three main barriers to integration – misaligned financial incentives, workforce challenges and reticence over information-sharing;
5. The Departments' expectations of the rate of progress of integration are over-optimistic;	**5.** Set out how planning for integration will be on a whole-system basis, with the NHS and local government as equal partners;
6. Nationally, the Better Care Fund did not achieve its principal financial or service targets over 2015-16, its first year;	**6.** Put in place appropriate national structures to align and oversee all integration initiatives as a single, coordinated programme;
7. Local areas achieved improvements in two areas at national level: 1) reduced permanent admissions to residential/ nursing homes; 2) increased proportion of older people at home 91 days after discharge from hospital reablement/ rehabilitation services.	**7.** Complete their development of measures that capture the progress of implementing more patient-centred integrated care.
8. The Departments are simplifying the Better Care Fund's assurance arrangements and will provide more funding from 2017-18;	
9. The Integrated Care and Support Pioneers Programme has not yet demonstrated improvements in patient outcomes or savings;	
10. NHS England's ambition to save £900 million through introducing new care models may be optimistic;	
11. The Departments and their partners are still developing their understanding of how to measure progress in integrating health and social care;	
12. The Departments' governance and oversight across the range of integration initiatives is poor;	
13. The Departments are not systematically addressing the identified main barriers to integration	
14. Without full local authority engagement in the joint STPs process, there is a risk that integration will become side-lined in the pursuit of NHS financial sustainability;	
15. NHS England has not assessed how pressures on adult social care may impact on the NHS;	
16. NHS England is diverting resources away from long-term transformation to plug short-term financial gaps.	

It is apparent from the literature that evaluating the impact of integration has examined a range of professional and organisational perspectives as well as looking at some of the outcomes and impacts for patients/end users. A number of barriers to integration have been noted. For example, from professionals and organisational perspectives, evidence of poor investment and or lack of funding has been noted as a significant barrier. This was noted in the Integrated Care and Support Pioneer sites where limited funds were present to support integration initiatives, and specifically, no dedicated funds for service transformation were allocated (PIRU, 2015). Variability in investment and funding may result in shortages of staff/ capacity to implement change, insufficient money to establish large scale change, and the ability through additional start-up funding to enable community services to relieve pressures on acute care. Furthermore, inherent difficulties in resource allocation between different organisations, particularly during a time of unprecedented economic restraint, could create tensions amongst providers and organisations.

Whilst funding can be seen as a significant challenge towards implementing integrated care initiatives, so too is the lack of evidence of major changes to services or measurable impacts such as, patient experience of care, or patient outcomes (PIRU, 2015). What's more, there has been slow progress in the implementation of initiatives towards integrated care demonstrating difficulties in achieving integration at the scale and pace envisaged by the government. This is argued to be partly due to historical, cultural and professional boundaries across different systems (Syson and Bond., 2010; Wolfe et al., 2016) and the realities associated with culture change in large-scale organisations. The challenge and time taken to support culture change should not be under-estimated.

Despite less positive outcomes being reported, there have too been more encouraging findings which offer evidence of the potential benefits of integration. Findings include improved working relationships (Tucker and Burgis, 2012; Windle et al, 2010), improved collaboration between services and organisations, improved knowledge of each other's roles (Syson and Bond, 2012); and enhanced interprofessional learning (Windle et al, 2010).

It is difficult to generalise findings from existing evaluations, because the sites studies represent a sample of unique, highly context-specific, UK based integration initiatives. It is widely agreed that more research, systematically examining outcomes and actual and potential cost efficiency savings are called for. This should examine for example, the degree to which hospital admission can realistically be reduced, the impact of improved discharges and better community services and the impact on the patient/user of better coordinated care.

Based on a synthesis of the selected literature summarised in this section of the report, a testable hypothesis about integrated care has been developed (Table 5) against which the data derived from the qualitative interviews and process mapping exercises in Lincolnshire will be compared. See Appendix 2, Table i-vi for more details.

Table 5: Testable hypothesis of the literature

CMO	Description	Supporting references
Context	Increased ageing population, increased demands on services, financial restrictions and deficit.	Ham et al., 2012; NHS England, 2016; Roberts et al., 2012.
Mechanism (Resource)	Various interventions have been described in the literature including pre-emptive and planned care, end of life care, telecare, multidisciplinary groups, and integrated locality teams, case-management, falls in over 60s.	Carnes-Chichlowska et al., 2013; Curry et al., 2013; Nuffield Trust, 2013; PIRU, 2015; RAND Europe and Ernst & Young LLP, 2012; Syson and Bond, 2010; Thistlethwaite, 2011; Tucker and Burgess, 2012; Windle et al., 2010; Wolfe et al., 2016.
Mechanism (Reasoning)	Difficulties and frustrations of service users, repeated stories, unwieldy assessment, repeated visits to separate hospital services, inherent delays to transfer of care, lack of joined up care, gaps in existing system, demand and increasing costs in service provision, and significant gaps in the evidence base.	
Outcomes (Successful)	Increased engagement, improved communication and collaborative working, improved trust, improved patient experience, some reduction in hospital bed days, some cost savings, enhanced interprofessional learning, clinical knowledge and skill sharing;	
Outcomes (Unsuccessful)	Professional boundaries and way of working, reluctance to engage by some staff, initial scepticism and mistrust ; vision change over time, IT difficulties, overly ambitious business case, limited referrals, challenged underpinning evidence base of interventions, lack of leadership and strategic direction, constant restricting of services, roles and responsibilities not clearly defined.	

3.6 CONCLUSION

In conclusion, despite increased attention surrounding 'integrated care', to date, there is still little compelling evidence of significant or sustained and significant cost savings or cost-effectiveness achieved by integrated working. Furthermore, due to the complexity and diversity of 'integrated care' initiatives, which are highly context specific, various potential outcomes have been reported largely focusing on improvements in the quality of coordinated delivery of care and user experience. However, this is highly dependent on the approach taken, how the intervention is implemented and the environment in which it was developed (Ovretveit, 2011). This conclusion highlights the importance, reflected in realist methodology of asking 'what works, for whom, and in what circumstances' (Pawson and Tilley, 1997).

Chapter 4.0

EVALUATION FINDINGS

4.1 SUMMARY

This section of the report presents findings from semi-structured, qualitative interviews carried out between November 2016 and February 2017. Fifty eight participants were interviewed, representing clinicians, senior managers, strategic and operational leads, practitioners and Neighbourhood Team liaison officers. Forty-six interviews were conducted on the telephone and lasted between 30 and 90 minutes. Twelve interviews were self-completed as the fieldwork period neared its end.

Completed interviews were subsequently transcribed and analysed using thematic analysis, which is a method for identifying, analysing and reporting themes within data. Our approach to analysis was informed by a realist perspective, that is, a focus on analysis of experience, meaning and realities of participants (Braun and Clarke, 2006). Here, coding and identifying emerging and repeated patterns in participant narratives, is undertaken in conjunction with the research questions which underpin this study. Refer to Appendix Two Table iv for a summary of analytic themes.

The remainder of this section reports on the main themes identified from analysis of participant interviews.

4.2 MAIN THEMES FROM THE QUALITATIVE INTERVIEWS

Defining integrated care

> *'To me the objective is to provide the best care possible to patients in the community. You use the corporate language: patient focused, continuity of care, equality …. A language loved by managers, politicians and similar species, but hated by front line practitioners. This language has numbed the senses of NHS workers, ad nauseum.' (Strategic Leader)*

Participants were asked to give what they considered to be core definitions of integrated care, and the rationale for moving towards integrated care. It was evident that participants were at least aware of, a raft of different terms, used uncritically and often interchangeably, to denote integrated practice similarly expressed by Shaw et al., (2011). For example: 'joined up working'; 'seamless services'; interprofessional practice; multi professional practice;

interprofessional working; interdisciplinary practice; multidisciplinary working; multi-agency collaboration; multi-agency practice; co-located, interdisciplinary teams; neighbourhood teams; integrated teams; coordinated teams. Participants acknowledged the diversity of terms to describe integrated working, and acknowledged that there was a lack of definitional precision in the use of terms, and uncertainty as to whether they were 'current'. The muddle about terminology was mostly seen by participants as a reflection of the state of flux that accompanied the national imperative to integration, reflected in local contexts. Participants expressed a generally pragmatic view that definitions came and went, were perceived as 'buzz words' or the 'term of the moment':

> *'Well, I mean, I think sometimes we get caught up in the language and stuff and we use whatever is the word of that moment.' (Programme Manager)*

The national agenda for integrated care was identified as a key theme underpinning the case for change. National contexts were cited as resonating with local concerns about current models of service delivery:

> *'Well, the rationale was nationally directed, but I also think there was a pressure to do something because of the financial situation that we're facing…as a health and social care community and the big sort of black hole of money. We're not going to be able to sustain health and social care provision in the way that it's currently provided…and `I think the reality is that people became aware that we could not and cannot continue to provide in the way we do, so something's got to be done and we've got to look at how we can …. We've got to do something different now.' (Strategic Leader)*

Individual level

Participant narratives confirmed a number of themes reflecting individual, organisational and strategic/structural factors as a rationale for integrated care. At an individual level, the focus was on the variously described, 'patient', 'person', 'service user', 'client', 'citizen', using health and care services. A key theme related to 'person focused' or 'person centred' care as a central goal of integrated care. Here, patients/users were defined as the person at the centre of assessment, care and support planning and interventions. Responsiveness to the needs of the whole person rather than the needs or problems being treated as a set of single and

unrelated conditions, was highlighted as an important goal. This position also challenged traditional models focusing problems located with or in the individual patient:

> *'Integrated care is about thinking about a whole person's needs – not just their medical needs – or that they are being 'difficult' or causing concern – for example, social, environmental, financial.' (Practitioner)*

> *'So on an individual level it's about that whole person, it's about your….. clinical and your social needs, so they may be able to sort out your gammy leg, but actually what about your social isolation, because that's really impacted on you it's stopping you getting better. So on an individual level, for me, it's about the whole person and about understanding what that whole person's needs are.' (Programme Manager)*

Implicit in participant narratives was the assumption that people needing integrated care services were likely to have complex needs (for example, long-term co-existing conditions, clinical frailty), requiring a range of support and interventions. There was a recognition too, that thinking about the whole person was likely to reveal needs that could have little to do with traditional health care delivery, but be of immense significance to the patient/user's life. Social, environmental and practical circumstances for example, could add layers of complexity to the experience of living with and managing pre-existing medical conditions:

> *'So for instance, the patient can come into hospital, go back out again, but actually it's not just a medical thing that they need. They're probably lonely, they probably – I don't know – need a mental health assessment. I don't know. It's about finding out what else they need apart from just that hospital admission. There's so much more out there that can stop people getting to that point of crisis because there are things out there that they don't know about.' (Neighbourhood Team Liaison Officer)*

Participants highlighted a number of aspects of problematic aspects of patient/user experience. Their view was that developing more effective collaborations between professionals and agencies, could address these often reported challenges within a traditional service model. Timely access to a responsive and easy to access and easy to navigate service, were key themes, as well as clarity in the process of seeking and getting help:

'Integrated care must be rapidly responsive to patients, must address the health and social needs of patients and public, must be timed with the patient needs and requirements, should not waste time of practitioners and patients.' (Strategic leader)

'I think it's as we discussed earlier, really. Making sure that the patient just gets what they need really, without a lot of fuss and a lot of— I think one of the problems we've got at the moment is a patient will come in and, before the neighbourhood team was sort of involved, they just got passed from pillar to post. I think one of the things we also need to concentrate on is sort of local services that are out there.' (Health Care Practitioner)

Ease of access and navigation was linked to the importance of people giving key information once. This implied minimally, shared access to client information, to avoid unnecessary repetition and duplication of assessment, but significantly referred also to shared assessments:

'So on the personal, on the patient level, I think it's around, you know, I only have to tell my story once, one person can support me all the way through my journey, one person then understands me and I build links with that person, and I'm not passed from pillar to post. That's one thing about integrated care.' (Transformation lead)

'I would say sort of working more efficiently and cost effectively, improving the service to customers so that they're not dealing with telling their story to lots of different people and slipping through sort of the gaps in the system.' (Strategic Leader)

'Really, it's something that we should be doing. I think patients expect us to talk to each other, they expect it to happen. They can't understand that we don't. Patients get very frustrated about telling their story again and again to different professionals coming into their homes, or wherever. And so I think, in that way, it's an obvious thing to do.' (Health Care Professional)

Getting a service in the 'right place' referred to well-developed and accessible local services which enabled people to be cared for at home, avoid unnecessary admission to hospital and prevent delayed discharge from hospital. This aspiration had implications for a significant shift towards interventions which are proactive – especially for those people identified as being most at risk of deterioration or crisis:

> *'…If we can prevent people being admitted to hospital when they don't need to be, that will help, and if people are admitted, actually what we can do to support, to kind of pull them back out really. Once you get sucked into the hospital system, it can be quite difficult to get people out again, because the hospital is trying to fix everything, and actually, they don't always need to because there's support in the community for them'. (CCG)*

> *'It's about keeping people at home for as long as we can when it's appropriate. So, supporting people to live independently for as long as possible and how we can keep them out of hospital. So, preventing the need for hospital admissions. Yeah, pre-empting crises.' (Neighbourhood Team Liaison Officer)*

An emerging theme of 'self-management' by patients/users with complex needs, reflects the national policy expectation of patient/ citizen behaviour change in health literacy, responsibility for one's health and taking an active role in condition management. Aspirations for changes in behaviour of this order has significant implications for cultures of practice for practitioners, but crucially too, for citizens using integrated services.

> *'…..so, helping people to know how to manage their illnesses so that they don't end up at a crisis point and giving them the understanding about what there is available, and the families and carers. Yeah, so, keeping fit, etc. Yeah, the walking things and the healthy eating, yeah, that's fairly recent and that's what we're hoping to incorporate as part of the neighbourhood team. But it's how it does that. So that's a work in progress.' (Neighbourhood Team Liaison Officer)*

> *'But some of this actually is about ensuring the patient is equipped to be able to not come back in the system. So for me, one of the issues is, how do we empower those neighbourhood team professionals to be able to do that?' (Programme Manager)*

Overwhelmingly, participants identified that integrated care must, at its core, focus on improving outcomes and quality of life for people using the service.

The organisational level

The organisational rationale for developing integrated services reflected the well-rehearsed challenges associated with current practice: duplication, fragmentation, lack of communication between services and complex, unwieldy and overly bureaucratic services:

> *'And I think there's a bit of detail that sits under that, so that's things like not duplicating visits and kind of, you know, the care planning process and it's kind of like whole seamless system where there's kind of one version of the truth for that individual customer.'(Transformation Leader)*

> *'From my point of view, I would think it means the various health, social services and third sector organisations working together in a direction that we all agree on. The same thing and the same aims and the same objectives, and we're working sort of collaboratively, without some of the barriers and constrictions that we've got currently, for the good of the patients. You know, put the patient at the centre of that. (Team Coordinator)*

> *'On an organisational level I think it's about a better systems approach, it's about moving the barriers that stop organisations or professionals working across systems rather than just within their own system.' (Programme Leader)*

The potential for duplication of effort resulting from fragmented services constituted a significant theme in participant narratives. There was a sense of frustration amongst participants that, in a time of considerable work pressure, staff shortages and financial challenge, work was being repeated and causing unnecessary work for hard pressed front-line staff and was not good for patient/ user experience:

> *'I think that duplication is a huge problem with patients….. For instance, you could have the district nurses seeing the same patient as Age UK, but nobody knows that that other person is seeing them. So it could be that you've got this one patient that lots of different organisations have got a problem with and, in fact, if then we all get together and say, "Well actually, I'm doing this for them, but I need that help," and, "Oh yes, I know that patient. I'm doing this for them," obviously you're all looking together at how you can help that patient rather than lots of individual services going in that the other ones don't have any clue about.' (Neighbourhood Team Liaison Officer)*

Experiences of duplication and fragmentation served as an important motivator to view changes in culture and practice as a necessary and desirable step. Their view was that this kind of change could not only improve services from the end user's perspective, but also potentially, streamline practice to make it more effective. Progress in developing local collaborations as a result of the NT model is evident in this research. However, making the cultural shift that is necessary, at all levels of the system, and to encourage and support further steps to integrated practice, and was identified as an important priority:

> *'So you've got health and care, and other services kind of working in parallel, not necessarily talking to each other, sometimes, working against each other to some extent. Having integrated care is about pulling that together, coordinating all of that support that's available… I think in terms of the aspects around the team it's around flexibility of approach and coordination of approach, like I said earlier, good communication between the people involved and part of the work is kind of about planning as well, so people are clear what their roles and responsibilities are, I suppose clarity for professionals and for non-professionals about who's doing what and making sure that all the things the person needs support with are being delivered and they're not getting stuff they don't need, if that makes any sense.' (Health Sector Leader)*

The rationale for developing integrated practice included agreed protocols for joint or collaborative activities, including assessment, intervention and individual support plans. For many people, a collaborative approach to assessment and support planning was distinct from the 'holy grail' of the single assessment process (SAP), which, despite national policy exhortation, and significant localised efforts over the past two decades, has remained substantially unachieved:

> *'…..so for me integrated care means multiagency, multidisciplinary working. It means shared care records, shared assessment processes and by that I don't mean a single assessment process, because I don't think we'll ever get there, but at least it's a shared and understood assessment process by all the agencies and all the professionals working within that. It also means for me the delivery of an integrated care and support plan, so multi agencies will feed into that but they will ultimately deliver on a shared set of personalised objectives for the individual.' (Strategy Manager)*

Participants accepted and supported the rationale for changes in practice but also acknowledged that this constituted a major cultural shift and systemic and structural change across all services:

> *'I think for a professional I think there's some pros and cons, I think the con is, I may feel disenfranchised if my colleague in the next organisation is dealing with what I class at the moment as my job, but actually I've got to be empowered to be able to understand that. Every conversation I have it's about support the whole person and I don't need to pass it on to somebody else to deal with another bit of that person; so I think that's one bit.' (Programme Manager)*

A consistent theme was that changes in practice and culture should be underpinned by an appropriate strategy setting out objectives for breaking down barriers to integrated care. Participants identified core elements of strategy and change they believed were required in the structure of service delivery. They included:

- Working to a consistent, unambiguous and well publicised message about the vision for integration – purpose, extent and desired outcomes, as well as what would happen to effect change towards better integration;

- Reviewing and refining systems and structures which supported collaboration and removed barriers was an important aspect of participant interviews and highlighted for example, shared digital systems, aligned boundaries and agreed priorities for intervention.
- Effective communication about progress, failure, and learning from both.

Benefits and enablers – developments in integration using Neighbourhood Teams as a vehicle for transformation

> *'The relationships that we've built, I find, are the most important. I know that where it started originally we had an A5 contact sheet of just the people that attended the meetings, and now we've got to the point where people know each other so well that when they've got a problem, they just ring that other person in the team directly. So they're not waiting for me to organise an MDT, they get on the phone and say, "Do you know this patient? Can you help me with this patient?" So, breaking down those barriers between the organisations has been priceless.' (Neighbourhood Team Liaison Officer)*

This section considers the ways in which participants felt that integration had been supported and their perceptions of the benefits that accrued from 'phase one' of the NT model. The themes identified reflect much of the existing literature on the benefits to practice associated improved communication and contact between agencies and practitioners.

Culture and practice – relationships

Neighbourhood Team meetings brought people together, face-to-face, who had traditionally been people 'at the end of the telephone' – often perceived or experienced as inaccessible. Neighbourhood Team meetings also provided opportunities for practitioners, to become more familiar with the often extensive array of agencies and resources that are available in their community. The simple act of regular, face to face contact, and opportunities to talk about specific patients/users, achieved a number of benefits, including, learning about each other's roles. It is often reported that practitioners even when they appear to have opportunities to understand each other's role, make inappropriate assumptions and judgements about what their colleague/s 'should' and can do. Such misunderstanding can

fuel stereotyped assumptions about other professionals and their willingness or availability to help. Participants also identified that it was just as important to learn what other practitioner and agencies did *not* do – as this helped to frame appropriate referrals and requests for help. Participants at the NT meetings reported benefitting from learning more about the resources that were available in the communities and often expressed surprise at the range of services (often in the voluntary sector) that were available to, potentially provide sources of support and help beyond the statutory sectors:

> '*It's changed in the sense that it's given me a greater perspective and understanding of the other services. We've come out of our silos a little bit and had a peep over the top and see what's going on.' (Health Care Practitioner)*

> *'…..like a voluntary car driving scheme, all the different groups in the area that people can attend, what British Red Cross can cover. So, all the voluntary services, and also funding as well. So, the Handyman Service, £250 for this. Yeah, so it's lots of the minutiae that people— So if you automatically assume, okay, they can go to social services for that, well they might not be entitled, so here are the alternatives (Neighbourhood Team Liaison Officer)*

> *'I think, within my experience, it has helped tremendously for people from all of these partner organisations to understand what the other one is doing, what the other one is about, and what they don't do as much as what they do, and where to go for the right sort of help for the right sort of person. You know, right person, right place, right time. So I think it certainly supports and has helped integrated working locally, within my team anyway.' (Team Leader)*

Focused opportunities for collaboration fostered mutual respect for other NT members' expertise and encouraged commitment and buy in to the NT model:

> *'So, to be able to access a social worker there and then is fantastic. I think we're lucky to have a very good older adults' community mental health team and to be able to discuss cases with them and get their advice. But I find it quite interesting, you know, looking at housing and benefits, you know, as I say, you learn something from them every day.' (Health Care Practitioner)*

> *'I think the voluntary sector have really been knocking on the door a little bit and wanting us to get on with it, and they've been very keen to get involved too, and that's been really positive. I think what's often made the difference for people, you know in terms of their care and what we've been able to do around personalisation, has been about linking people into the kind of voluntary sector and use the opportunities that are out there.' (Strategic/Transformation)*

Regular contact via the NT fostered relationships and encouraged other types of collaborative practice. These initiatives began to address some of the challenges associated with a fragmented service, and offered further opportunities to bring shared expertise to bear on complex situations. Not surprisingly, good experiences of collaboration and joint working reinforced motivation and commitment to the NT model:

> **'***One of the things that we quickly developed in the neighbourhood team meetings has been joint visits. So although out badges might say different organisations, you'll have a discussion at a neighbourhood team meeting and the CPN will say, "Well, I'll come out and visit with you and we can do an assessment on capacity," or, you know, the district nurse or the social worker. And I think kind of going together so the patient tells their story once and where people don't see the joins between us all is a starting point. I think there's a lot of work to go because I think those badges do sometimes get in the way.' (CCG)*

> *'But I think it's really down to them and they do a lot without us really knowing about it. As I said before, they will just ring each other up for advice and support and they'll make joint visits together to see patients. And that is a kind of neighbourhood team approach; it's just that it's not recorded as such.' (Programme Manager)*

Regular contact, useful discussions and evidence of achievement, has supported the development of trust between colleagues. It was clear that the NT, as a place for mutual support, including sharing worries or concerns about complex situations with a patient/end user, was an important theme for NT members:

> '*I think sometimes, because of the nature of the patients that we look after, it can be quite oppressive or depressing or, you know, sometimes you think you're just wading*

through treacle, and the fact that you can actually bring a patient and have input from other people and feel supported that actually, you know, you're not far off the mark, it's very supportive (Practice Care Coordinator)

'One of the benefits we found with the MDTs is, obviously as well as talking about patients, it's a really good sounding board for staff. So for instance, if they're frustrated about anything in particular, they can openly come and talk to the rest of the team and say, "This is a real pain and I'm struggling with it." It's not a counselling session but it is a great way for them to see that they're not on their own with this problem and there's people out there that'll help them with it.' (Neighbourhood Team Liaison Officer)

Fostering constructive and positive interprofessional relationships also realised other benefits. The potential for the NT model to support the development of integrated practice is evident in participant narratives about access and streamlining. Here, participants reported the value of reliable access to professionals who, prior to the NT meetings, were experienced as difficult to speak to, with referral processes experienced as cumbersome, slow and bureaucratic. The NT model provided a basis for more timely discussions, informal liaison and, by taking discussions to the NT and faster referral processes:

'I think certainly with Social Services, I've worked just in that particular cases, I mean we've worked very closely with social services. I find the NT very beneficial because trying to – certainly I find trying to access adult social care on the phone is such a lengthy process. I mean it can take me sometimes more than a day to get through to them.' (Health Care Practitioner)

'By working together we can maybe cut through a lot of, sort of red tape sometimes; I can access services quicker, I can liaise with colleagues for some more information. Occasionally, you know, because I've gone with somebody who I felt was urgent and maybe got them a visit quicker, because I know other people in the team, so it's a lot more effectively really for the person involved.' (Care Navigator)

Reinforced commitment and buy in at practitioner level to the NT model, clearly enhanced opportunities to deepen integrated practice. Buy-in as a theme, reflected across all levels of

the various services involved in integration, was identified as a crucial enabler to further integration. Senior buy in was identified as vital in sending messages across the service about the importance of the NT model as a means of transforming service models – and too, for unlocking barriers to further integration.

> *'So it works because the individuals believe in it and make it work, not necessarily because their organisation is supporting it. And I think we've got high level support so at a senior strategic level they absolutely get it and are like, you know, sold on it and bought into it.' (Programme Manager)*

> *'Besides sort of individual personalities, I guess the stuff around [undisclosed area] and the STP saying it's one of the key areas of work, getting that sort of senior buy-in, which we've got to filter that down through the layers, but that's important because if we didn't have senior buy-in we would never sort of – well it would never have got as far as it's got and it wouldn't be able to go to the next stages.' (Transformation)*

Patient/end user benefit was identified as key in assessing the benefits of the NT model. Improvement in outcome for people referred to the NT, were perceived. There is currently no provision for systematic evaluation of patient/user outcomes and benefits built into the NT framework and so views about the impact on patients'/end users are inevitably based on anecdotal evidence. However, a number of consistent themes were identified by participants which suggest that some of the difficulties identified as highly problematic in more traditional service delivery, began at least locally, to be less pervasive. Thinking about the whole person suggested in some instances, a wider, more integrated approach to support planning and intervention:

> *'I remember very early on in the [undisclosed area] meetings there was a discussion about a patient in [undisclosed area] and the GP had said about his health and somebody else had said something. Then I think it was the social worker who said, "Well yeah, this is all true, but actually what their real thing is they want to live in [undisclosed area]. Their family lives in [undisclosed area] and they don't want to live in [undisclosed area] anymore." They've now moved to [undisclosed area].' (Neighbourhood Team Liaison Officer)*

Tracking people and keeping tabs on their whereabouts was identified as a significant improvement on traditional approaches to practice. The time wasted in home visits to people, who were in fact, in hospital, and the potential risk to patients/users of being discharged without community practitioner knowledge and involvement, was at least to some extent, perceived as being mitigated by NT collaboration. There was also anecodatal evidence in some areas of reduction in duplication of effort and better coordinated service delivery.

In conclusion, anecdotal evidence from participants suggested a number of improvements in patient/user care, as a direct result of the NTs. Bringing people together is supportive and developed relationships. Increased opportunities and motivation to develop integrated practice is reinforced by good experience. Although at an early stage, the overriding experience of participants was that the NT model was beginning to impact, not just via the NT meetings, but crucially, in collaborations and relationships outside of the meeting:

> **'***So I think it looks like a small number of people that we're supporting, but actually it's probably a much big number that are just not logged properly. I think that is a huge step and that's what— People didn't know each other before that, and now they do…..they feel comfortable calling into the practice to chat to the practice nurse about somebody they've just been to see and what support they can do. I think that's broken down the barriers. Real or perceived, they seem to have disappeared quite a lot. So I think that's really, really positive stuff.' (CCG)*

Barriers and constraints

> *'I think the stuff around culture is really difficult, so for our many healthcare professionals, and that's across the board, and it is a generalisation because they'll be some that are really into this, clinicians particularly think of the thing that they know best…..but often it only relates to one part of that person's life. So I think that culture shift is really important and when we've tried to change, we've done some things where we've tried to see if that works and one of the huge things that comes up is healthcare professionals are not ready yet, so I think there's an issue there about cultural shift….letting the healthcare professional understand that the patient they*

have has lots of other issues in life as well, as well as the bad leg or whatever, and how do you understand that, how do you work with that.' (Programme Manager)

Despite evidence of developments towards more integrated approaches to practice, participants continued to experience barriers and constraints which hindered getting to first base in some examples, and in others, building on the good progress that had been achieved. This section presents the key themes related to barriers and constraints. It presents a complicated picture, and reflects the complexity of whole system change – and the time required to achieve it – in the context of structures, systems, organisations and individuals embedded in 'traditional' models of service delivery. Some of the barriers relate to what could be defined as located in Phase One of the integration strategy. For example, lack of buy in, low awareness amongst practitioners and evidence of continued scepticism about the NT model. Other barriers focus more on moving beyond Phase One. For example, developing integrated practice into the daily business of health and social care agencies. There was also confusion amongst participants as to what 'stage' in development their NT was at. Higher level barriers, such as the development of comprehensive preventative services, buy in across all areas of health, social care and the citizenry, relate to longer term strategy.

Neighbourhood Teams – its role and purpose

Low referral rates into the NT was a consistent theme in all areas. A number of reasons for low referrals are suggested, including: continued lack of awareness of the NT, lack of buy in, complex referral processes/consent processes and maintaining traditional approaches to practice. Crucially too, there was some uncertainty amongst participants who were fully supportive of, and actively engaged in NT's, about the criteria for referral, and who the NT model should be for, in the immediate, and longer term. There was broad agreement that referrals to the NT prioritised people with complex needs, characterised by frailty. It was also accepted that that the referrals should be for people known to a number of services, and may be causing concern by, for example, repeated admission to hospital, high GP use and frequent use of emergency services:

'I think it was about supporting those people who are, probably either about to go into hospital or just come out of hospital, or in and out of hospital, because it was mostly

focused on acute care. So it was about them avoiding, either going in or going back, in and out all the time.' (Programme Manager)

Most participants agreed that the service, theoretically at least, was for all adults with complex needs, but there was less certainty about the age range. It was clear that older adults were perceived as the main beneficiaries of the NTs although aspirations to widen referrals was evident:

'I mean we look at patients, complex patients. Frailty tends to link in to people that have got comorbidities, but having said that, I mean quite recently I did actually bring a young man to the case conference…..he had complex needs.' (Care coordinator)

'Well I think the majority are sort of older people, that's the common theme. I mean it is over eighteens but most of them are older people, you know, looking at over fifty-five's. Some, you know, it's usually physical disability, mental health really, occasional learning disability.' (Navigator)

'I mean, theoretically, the eligibility is anybody over eighteen can access a neighbourhood team, but obviously not everybody needs the support of a kind of integrated team.' (Social Care Practitioner)

Participants also identified uncertainty about the priorities for NT's in the short, medium and long term and the way they should develop in the future. There was general, but not unanimous, agreement that using risk stratification tools to identify the top two per cent of the population at highest risk was a reasonable initial priority for the NT. However, participant's reported some uncertainty as to whether this should, could, or had already been increased to the top five per cent of the population, cited in risk stratification data. Effectively capturing data about people who were likely be at risk of developing complex needs over the next year or so, was identified as a priority. Identifying people who were some way off from developing complex needs, but who would benefit from effective and timely preventative services, and support to manage their own care to avoid crisis, were perceived as a longer term, but necessary development in integrated care:

'I think this is one of the things we struggled with and that we need to bottom out quite a lot is actually who should we be supporting and how do we identify who we should be supporting. We're looking at the moment at different trigger points. So it might be that somebody's got a certain frailty score, or they've had two or more hospital admissions in the past six months or year, or they've got a certain social care package in place, you know, there's kind of different things that would mean something to the different partner organisations. So they recognise something, then what happens to somebody who's known to social care, how do they know when actually somebody else needs to be involved in the support and care, and who do you go to? And the idea is that we try and prevent them getting into crisis.' (CCG)

'Well I think if we could phase it, if we started it off at the top 5% for people who need intervention, but then we need to think how're we going to get those who are say in the top 15 or 20% who need support but don't need the same types of intervention, but they might need signposting.' (Programme Manager)

'…so for me it's, those neighbourhood teams need to be multi agency, they will predominantly be focused on that top 5% of the users of the health and social care system, but they need to then have a wider network around preventative care, primary, secondary and tertiary prevention through public health so that not only are they focusing on those top 5% of users, there needs to be a process to identify and work with those who are at risk of becoming the top 5% and preventing them from going into it. And so for me, so that requires a cross agency working of community, health, primary care, i.e. GPs and their staff and local authority and public health.' (Team Leader)

In respect of achieving Phase one strategy and developing the NT model beyond the MDT focus, being clear about referral criteria to the NT and have a clear strategic direction for deepening integration practice was highlighted by participants.

Culture and practice

Awareness and buy in

While it is clear that significant progress had been made in raising awareness about the rationale for integrated care and the NT model in Lincolnshire, a consistent theme was that awareness, participation and buy in, remained patchy. Participants found, services that were either completely unaware of the NT or, who had a sketchy understanding of its role in supporting the development of integrated care:

> *'I was part of a stakeholder's meeting and there were quite a few people there, different stakeholders, care homes, etc., and we had to sit on different tables…..Four out of five people hadn't even heard of the neighbourhood team meetings….That's why I'm trying to get them involved. So how can we have a Phase 2 when we haven't rolled out Phase 1? A lot of people still do not know about the neighbourhood team meetings.' (Neighbourhood Team Liaison Officer)*

> *'I did a talk the other day for the district nurses, to their team, their actual team that go out, and I just took a random selection of services that we can offer that's out in the local area and they just hadn't heard of them and they didn't understand that they could nominate patients to the NT. There really is, after two years, still a lack of knowledge there.' (Neighbourhood Team Liaison Officer)*

> *'I think it would be interesting to actually ask people who perhaps work in a surgery, you know, particularly GPs, do they actually know what a neighbourhood team does. I think that can be a problem that I think the concept of a neighbourhood team isn't well embraced by enough people. I think we probably need to try and raise the profile of neighbourhood teams so that they are used to their fullest extent.' (Care Coordinator)*

Some GP's were strongly committed to the NT model, and/or had colleagues from the surgery who were active participants in the NT. But, the overall lack of engagement of GP's was a consistent theme, reflecting a concern from many about a lack of interest in developing integrated care. Certainly, there was worry that if GP surgeries were not engaged in the NT

model, there would be difficulty in widening the reach and impact of the NT and embedding integrated care, as well as developing community services. Arguably, GP's do not have to physically attend NT meetings, as long as there was a commitment from others in the surgery, referrals were made appropriately and GP's understood and bought into the NT approach. Overall, participants identified an urgent need to improve awareness of the NT model with GP's and to encourage and support buy in from them:

> *'Certainly in [undisclosed area] there's a bit of a mix of engagement with GPs, so GPs can see the value of it and find it useful. Other GPs, we've got like practices and groups of GPs who don't make any referrals at all, so there's a bit of a mixed bag really. Some people think it's really useful and understand how it can help and other people don't. In [undisclosed area] that sort of mix kind of plays out then in the number of referrals they get.' (Strategic Leader)*

> *'I think one of the problems though lies in people's understanding of the neighbourhood team. I mean I know within the surgery, although the doctors are aware of the neighbourhood team, they're not always very – I suppose they're not always aware of the benefits that can be achieved by bringing complex patients to the meeting, but then again they give me the complex patients and I suppose I bring them then.' (Care Coordinator)*

Colleagues at team leaders (referred to as 'middle managers') level were also identified as lacking awareness of and commitment to the NT. Concerns were raised about knowledge of the NT model in this layer of management and associated worries about their commitment to supporting team members to participate in the NT and engage with activities towards developing integrated care. This caused consternation amongst participants as a lack of engagement and leadership at this level could effectively block practitioners from knowing about the strategy and plans for integrated care. Team leaders could also block practitioners from attending the NT and making the changes needed to further embed the NT model in daily practice:

> *'I think it's more the management in most of the organisations hear a lot about the neighbourhood teams – it seems to be the buzzword – but I'm not sure whether*

management in most organisations are actually feeding it down enough to the ground level staff. So when I speak to some staff that are on the ground, they've not heard of it. So I don't think there's enough of a level of communication down towards the staff on the ground which are actually, in fact, the staff that need to be doing that particular working on that integration, more so to me than the management. (Neighbourhood Team Liaison Officer)

'And then somewhere in the middle, before you get to kind of the frontline staff who get it and think it's a good idea and some of whom struggle with the capacity issues to kind of be as involved as they'd like, but I think most people on the frontline completely get that if they all join up, it'd be much better. And then in the middle, for whatever reason, the support and that sort of message that this is what's important kind of gets lost. (Transformation Manager)

The need to unblock or foster communication between higher levels of management, team leaders and practitioners about the NT model is clearly an important piece of work. At this stage of development, an emphasis on 'traditional' approaches to practice was evident:

'*There is also often duplication and cross-over between some services. For example, we often visit the same day or even at the same time as the community nurses, despite the fact we are doing similar jobs.' (Team Manager – Clinical Practice)*

'We ran a couple of sessions (personalised commissioning) where we look at the referral pathway for individuals. What we found is that at the moment it is incredibly siloed working, so at the top level of referral patterns from reactive GP or a proactive GP, individuals are referred across agency, whether that be, for example, dementia, into a memory assessment clinic within our primary mental health trust, so [undisclosed name], they're then referred back to the GP service who then do another reactive referral across into social care maybe, or if they see things deteriorate. So what we're seeing is a pattern of siloed referrals based on someone hitting a crisis. What we need to have is a proactive referral process where individuals, once they're picked up and those referrals and diagnoses are made, that they come down through the system into that multidisciplinary team, neighbourhood team working, and there's

then the coordinated support planning process, and at the moment that doesn't exist and that's what I see the neighbourhood teams having to deliver. (CCG)

Ongoing work on culture change needs to take account the diversity in levels of engagement/disengagement that appears around the County. There were evidently colleagues in health, social care and the voluntary sector who remained sceptical about the NT model, as well as teams and colleagues reported to know little or nothing about it. Second, deepening integrated approaches with people who are committed to the NT model, including developing practice outside of the immediate NT meeting, is crucial. Third, engaging with wider systems e.g. hospitals, primary health is also important for developing commitment to the NT model at all levels:

'I think culture within organisations, so you know, [undisclosed names], etc. and they all had different views on neighbourhood teams and whether they think they're a positive thing or not, I think, yeah that'd be my view. You see some of the organisations more engaged, I think also within the organisations having a culture supporting the frontline staff to working this different way, or working in a kind of a neighbourhood team's way, and kind of supporting the development that, that kind of culture as well within the organisation.' (Transformation Lead)

'I think the other thing that's a bit of an issue for us, I think relates back to the culture of organisations, being able to, start to think about how they could work together to deliver the model. We've been very focused on MDT meetings, which are fine, and are useful in terms of discussing cases, but there's only an element of what a neighbourhood team should do, but it provides a focal point, because there's a meeting and you go there with cases and you talk about stuff. But actually, thinking about neighbourhood teams more broadly and that I think is quite difficult at the moment in terms of how people might work together differently.' (Programme Manager)

Systems and structures

> *'I think a lot of the existing processes probably are blockers because they're having to kind of fight the system to do things at the minute.' (Strategy Manager)* The need to remove barriers in order to promote and develop deeper integration within the NT model remains a priority. But the challenge of achieving better integrated care in the context of a pattern of reorganisation and restructuring was identified as a significant barrier. Restructuring was experienced as a fast, changing, unpredictable environment, accompanied by poor communication and uncertainty. This resulted in participants, especially those colleagues on the front line, experiencing messages about integrated practice in the context of organisations in a state of flux. It was not always easy to prioritise integrated care in the context of other reorganisations. People reported frustration, anxiety and some cynicism about integration as the next 'big idea':
>
> *'You know, and I think because of the constant change in both adult care and the NHS, I think some people are naturally sceptical about new developments and, you know, we've seen this all before and we've seen that all before, and maybe that's why, but I can't speak for those people because I've never actually asked anybody.' (Care Navigator)*

Staff change and staff shortages led colleagues to becoming more rooted in achieving their 'core' business. The waiting list, achieving service targets (which did not necessarily relate to improving integrated care), risked taking priority over the NT, even if the people on a service waiting list were substantially the same group as those people referred to the NT. Time pressures and staff shortages were identified as seriously impacting on attendance at NT meetings, stakeholder workshops and events planned to publicise and talk about the NT model. Service shortages, particularly in mental health, were identified as problematic to advancing integrating practice:

> *'Definitely all the staffing changes and the restructuring that's gone on in some organisations, such as [undisclosed name], can make it very difficult because, if there's not enough frontline staff, then it's very difficult for them to attend because, obviously,*

the priority goes to seeing the patients, which is completely understandable. So that is the fundamental, just having the staff available to attend, really.' (Neighbourhood Team Liaison Officer)

Our staffing levels are challenged, we are struggling to deliver core services, whichever organisation you work for, so the fear of something different coming along… and when you've worked in a certain way for a long time, it can be quite hard to change. (CCG)

'We have – I think it's an accepted thing, we have an ongoing difficulty with getting mental health services for younger adults. We do have a representative that does mental health for the older adults, but for the younger adults it's very difficult to get care provision for them.' (Care Coordinator)

There were challenges associated with systems not being effectively coordinated or which operate under different conditions of eligibility. This links in part to being clear about the various levels of service that citizens may be able to access, under specific conditions, and with what tests of eligibility.

Financial investment to develop integration was perceived as limited and concern was expressed by for example, the often temporary nature of posts dedicated to developing the NT model. Perceptions of limited funding also created concerns about the resources needed to roll the model out further and to begin to incorporate a wider range of organisations as well as communicating messages about service transformation to the citizens of the County:

'NT has little real support. There are numerous meetings around the subject, but the small funding limits the possibilities of success. We have been able to demonstrate the benefits at a small scale. How to translate those on the wider population will require a considerable funding…' (Leader – Strategic Transformation)

IT systems and governance structures are a major barrier to developing a 360^0 view of patients/users and practitioners accessing records. There was hope that the imminent launch of the Care Portal system would improve practitioner access to records and that it would help to track patient movements (for example, admission to hospital), as well as giving clear information about who was currently involved with the person. Information governance

(IG) was also experienced as unnecessarily burdensome. This was area that participants believed would benefit from a pragmatic approach, focussed on accessibility and underpinned by appropriate standards of governance. There was a sense of frustration that access to records was meant to improve patient/user care and experience, but that the barriers and hurdles experienced, effectively hindered patient/user care.

> *'For some reason I can't remember, we're not allowed to call it a referral. We call it a nomination. Obviously this is to do with governance to make sure that we're keeping a check on which patients are coming through and what we're doing with them and stuff like that, and there's this whole issue of consent, having to have written consent, which I find a bit ludicrous.' (Team Leader)*

> *'I think what it (IG) should be is that we should have a very flexible system, so we need to deal with things like IG, because that's a real issue; IG is one of the huge barriers at the moment I think, because we need to have the flow of information about people, and if we haven't got that flow of information then we need to deal with that system issue….' (Programme Manager)*

Despite anecdotal evidence of improved patient/user outcomes, the lack of an established framework that relevant parties were signed up to, which assessed and evidenced impact, was identified as a significant weakness in the current strategy. A comprehensive evaluation framework could serve a number of important functions, including assessing positive change for patients/users and assessing the extent to which other criteria for integration were achieved. Participants for example, were interested to know what impact progress in integration might have on staff morale and the nature of the work that they undertook. Publicising evidence could reinforce commitment to deepening integration and assist in identifying and analysing failure as well as success. Sufficiently detailed data could also be used as a basis for further planning. Without the evidence, it is difficult to see how the development of integration and it impact can be confidently asserted:

> *'For me it's got to be… an agreed consistent outcomes framework…. What it is …. I don't really care as long as it's consistent and we're measuring actual outcomes for individuals.' (Programme Manager)*

'You can't write down on a piece of paper how much it's improved somebody's working life to be able to get on the phone instead of having to fill out a two-page assessment and have a fifty-minute phone call. I think, if we're not careful, that part of what we've achieved will be swept under the carpet and missed, and I think it's a really important part of what we're doing.' (Neighbourhood Team Liaison Officer)

'They've not got – well, part of the project work is to try and identify some outcome measures, but they've not got that finalised yet. In fact, the work looking at it has only just started. I don't know what the original measures were when they were first established.' (Transformation Lead)

Intractable barriers such as a lack of co-terminus boundaries caused frustration and challenged opportunities for integrated working. For example, a patient/user could be referred into an NT who is a patient in a local practice, but who has a social worker in another locality. These boundary challenges could prevent the social worker engaging with the NT:

'So at our meetings, the social workers attend. But actually, many of their patients fall under another team for social services. So yeah, there are real issues there. Although they have come along to one meeting and they do give me regular updates, they find it difficult to attend meetings because they're coming from some distance.' (Neighbourhood Team Liaison Officer)

'Geographical areas are an absolute nightmare. I think if we're going to work together as an integrated team, we need integrated geographical areas.' (Neighbourhood Team Liaison Officer)

Business as usual?

Participants were asked to identify priorities for developing the NT model and overwhelmingly cited the need to move beyond the focus on NT's as an MDT, towards the NT model infused into day to day practice. The value and impact of phase one was not under-estimated but the real challenge was getting the message across that the NT model was relevant to everyone and their practice, and not just to a separate group of people who attend the NT meetings:

> *'(they think) Oh, that person goes to that (NT) meeting, that's not to do with me. And I think that's the real challenge we've got. Is doing that engagement to make them see that they're a key member and they also play a part in it. I'm not entirely sure how we go about doing that yet, but I'm sure we'll figure it out at some point, or we'll still be having the same conversation in another year.' (CCG)*

There were differences of opinion as to how deeper integration, underpinned by an NT model, should be achieved. While some people advocated co-location – the benefit of conversations around the water cooler – and being forced by proximity, shared teams and integrated leadership, to develop integrated working. Others felt that this was an unnecessary diversion, creating further uncertainty in the face of another restructure. Instead, the focus should be on achieving effective coordinated actions/care and that colocation would not serve the interests of deepening integrated care:

> *'….if you have a hub….and you have one person from social care, one person from so-and-so. I think that's restricting it too much again. Think you're saying, again, …. People in this building are the neighbourhood team, and they're not. I think it's much more realistic to say, okay, adult social care can go and work in the district nurses officer and have a half a day there and …. Nurses know they've go someone there for half a day they can go and speak to.' (Team Leader)*

Participants expressed frustration and scepticism about the expected savings to be achieved by integrated services, reinforced by evidence that expected savings were not being achieved at the levels expected in vanguard sites and in a national context. Difficulties in predicting demand, working across multiple sites in situations of complexity and uncertainty, with people, complexities in identifying where savings were being made, lack of evaluative frameworks, a system relatively in its infancy in terms of its development, were identified as reasons:

> *'I am an enthusiastic fan of NT. I don't think they are the answer to the problematic finances of the NHS and LCC and evidence is building to support my opinion. But I believe it is the most important action and transformation in recent times in the NHS. A well planned NT will increase the quality of care and when you increase the quality of care, positive outcomes will follow.' (Clinician)*

Opportunities and challenges in future development of the NT model

This final section reports on participant views about potential opportunities and challenges associated with the future development of the NT model. The benefits of the NT for practitioners has been reported. It was clear too, that benefits reinforced motivation and commitment to continue to develop the NT model and to build on current successes. Recognising and celebrating achievement and success is an important foundation for further development. A focus on challenge and deficit risks draining motivation and alienating colleagues who feel that their efforts and achievements have not been recognised or valued:

> *'But I think the people on the ground get it and they want to do it and they want to not get caught up in the different issues that might be perceived by others. They don't see it as that.' (Neighbourhood Team Liaison Officer)*

> *'So I think we've started doing that and I think, certainly [undisclosed area], they might ….but I think they see themselves as a little team and it is so much down to the individual personalities. We've got a really good group of people in [undisclosed area] who really get it and want to work together.' (CCG)*

Overall, participants shared a similar vision of the purpose and potential benefits of NT's. However, questions about the potential to achieve some of the aspirations accompanying integration were raised by participants. The potential for integration to achieve government cost saving targets was an identified concern amongst a number of participants and points to the potentially divergent views about the core priorities for integration:

> *'I am an enthusiastic fan of NT. I don't think they are the answer to the problematic finances of the NHS and LCC, and evidence is building to support my opinion, but I believe is the most important action and transformation in recent times in the NHS. A well planned NT will increase the quality of care, and when you increase the quality of care positive quantitative outcomes will follow, not vice versa.' (Clinician)*

Achieving personalised services for people living with complex needs was an identified priority for most participants but there was a consistent view that these developments, at least in the short term, did not necessarily lead to cheaper services. Nevertheless, there was an acceptance that savings from across the system could be made, which in turn, could be

put to good use in developing personalised, community responses for people with complex needs:

> *'Okay, so for me I think there's, there are two points, the first one and the most important for me is the fact this delivers better process and outcomes potentially for the individual, so it's not necessarily going to be cheaper, it's not about saving money, it's about making the whole process, the journey through the care system much easier for the individual and their carers. Secondly, it does go down to the money and actually there are potentials there to deliver savings across the system which means that we can then meet the needs of more people, across a year of care for example, so for dementia, if we can get this right for dementia that means more people will go through a year of care package than are currently being prevented from going through the system because of the delays in it.' (Strategic Manager)*

Participants acknowledged the importance of NT's developing to meet the needs of their local community, and that responses which met the needs of one community, may not be relevant for or needed by a neighbouring community. Nevertheless, there was some disquiet about the potential for NT's to develop idiosyncratically resulting in the key purpose of NT's to become diluted or even, lost:

> '*I think it's quite important that everybody works to sort of more or less a standard performer, if you like, because I think with some of the new ones that have been set up, there's been a bit of confusion as to actually what their aims are.' (Care Coordinator)*

> *'Investment, you need to invest to change the system. I think that's one of them. I think the other is that actually because we're trying to do it in four different parts, or actually thirteen different parts across the county the county is different it's not a homogenous being and I think that, there's some challenges with that; because we're trying to structure it, actually what works well in south of the county isn't necessarily going to work in [undisclosed area]. So I think, definitely think there's some challenges around that, that actually, perhaps we need those overarching structures….' (Transformation)*

Going forward, there were divergent views concerning the extent to which integration brought about fundamental organisational change. For some, the idea of co-location and 'conversations around the water cooler' was perceived as a desirable development, especially in speeding up the process of integrated practice being seen as 'business as usual':

'I think it would be about having co-located teams, I think it would be great to have professionals who had a wider range of skills and they could take on potentially health and social care activities to some extent. You might obviously think about the skill mix, so different professionals, what that team would look like for co-located.' (Operational Manager)

For others, the notion of co-location was seen as a further and unnecessary distraction from the business of integration and moreover, that such a move could actually delimit integration by confining it within the boundaries of a co-located team:

> *You know, like they're on about if you have a hub, as such, and you have one person from adult social care, one person from so-and-so, I think that's restricting it too much again. I think you're saying, again, going back to the whole thing of these people in this building are the neighbourhood team, and they're not. I think it's much more realistic to say, okay, adult social care can go and work in the district nurses' office and have half a day there, and when the district nurses have got problems with any patients they've got with adult social care problems, they've got somebody there for half a day that they can go and speak to. And they know that every Tuesday, that person is going to be there for a couple of hours/half a day. Then the next week it can be a different person from adult social care.' (Strategic Lead)*

The value of multidisciplinary, coordinated care was highlighted as a realistic aspiration for integration and one that was an achievable and workable goal:

> *'I think we probably should be looking at specifying coordinated care, multidisciplinary team supported care, so actually it's about individual organisations working together to and working as a multidisciplinary agencies and multi-disciplinary professionals around an individual package of care. I don't think we can expect one agency where it's a very complex case to take the lead and I think we've failed many times to try and*

do that because we're getting to the argument of cost shunting. So I think the idea of multi coordinated care is much more of a concept that we should be pushing. (CCG)

Crucially, participants recognised that NT's needed to develop so that they moved beyond the MDT model, towards the notion of 'business as usual'. This meant that coordinated and collaborative care became integral to practitioner roles and that responsibility widened to incorporate whole teams, rather than assuming that the representative nominated to attend the MDT, was somehow uniquely responsible for integration:

'I think the challenge we've got is we view the neighbourhood team as a group of people that come together for an MDT discussion every couple of weeks and it's how we make that move over to the neighbourhood team and everybody working within those organisations in an area, because I don't necessarily think that everybody who works for [undisclosed name] or adult social care, or whatever, think it's to do with them. I think they sometimes think, oh, that person goes to that meeting, that's not to do with me. And I think that's the real challenge we've got, is doing that engagement to make them see that they're a key member and they also play a part in it. I'm not entirely sure how we go about doing that yet, but (laughs) I'm sure we'll figure it out at some point, or we'll still be having the conversation in another year.' (CCG)

'So I think what we've achieved in two years has been really good, of actually bringing people together and making them feel like they are a team of people. They know who to go to, who to call, how they're supporting each other, but there's a long road ahead still. I'm not sure they entirely see that, but (laughs) I think there's a bigger piece of work to come. But I think we're on the right path.' (Strategic)

Underlying future developments is the need for participants to be aware of the strategic priorities aimed at unlocking or removing some of the current barriers that they face on a daily basis. Participants could see that the Care Portal will begin to make a difference to current barriers in information governance and access to shared information, but further work is needed to refine and develop systems so that they can be used by multi-professionals, track the whereabouts of patients/users and provide data which can provide the basis for

ongoing evaluation of progress in the evolution of NT's. Table 6 details a summary of macro, meso and micro narrative CMO from Qualitative interviews. A further full summary can be found in Appendices Two Table vi. In summary the core findings were:

Table 6: Summary of macro, meso and micro narrative CMO from Qualitative interview

Context	Mechanisms	Outcome
Macro:		
National policy and government agenda for service redesign to include integration of health and social care services	Financial incentives have been made available to support integration (Better Care)	The imperative towards integration has been a major driver of the NT model and associated developments
Integrated care has been identified as a desirable goal which will address fundamental challenges in current systems of delivery	The NT model has been allowed to develop to reflect local needs of the community	Population change, demands on services and critical difficulties with current structures are understood to be the drivers for change
The agenda for change is contextualised by a priority to achieve cost savings and has gathered pace in the context of austerity	The voluntary sector has been supported to engage with the NT model and to varying degrees, become members of the NT meetings	There is a growing expectation that members of the community will 'self-manage', thus using services only when it becomes necessary
The national agenda includes achieving reduction in hospital admission; reduction in delayed discharge; people being cared for in their own home and accessing a range of community services	There has been limited development of community services to support some of the key goals of integration	Buy in to NT's across the system has been variable and key organisations may be unaware of or not engaged with, the NT model and its aims and objectives
Government priorities include moves towards greater self-management by patients and citizens	Coordination of NT models has been supported, but funding has been insecure	Lack of GP engagement seen as a barrier A lack of funding to support NT's is perceived as a significant barrier – especially as NT moves towards its next phase of delivery and 'two services' will operate in the interim

Meso:		
Person centred care / personalised care	Coordinated / seamless care which meets the needs of individuals; recognition that needs are not always health focused	Individual examples of creative practice and joint working to provide 'holistic' care for people
Focus on people with complex needs (long term, co existing conditions; frailty; multiple use of services)		Numbers of people referred to the NT are small and there has not been a systematic means of collecting evidence re: impact and outcomes for individual patients or towards measuring impact on other expected outcomes
NT models delivering integrated care	NT meetings include practitioners and agencies within a defined geographical area	Variability in practices re: eligibility and priorities for NT's (e.g. risk stratification)
	Teams are not collocated	Systems are not in place to support integrated practice and care (e.g. cross agency agreements; barriers removed to access services)
	Referral process has been complex and different referral routes are in operation	Lack of co-located boundaries in some areas is problematic
	Some lack of clarity about eligibility criteria and priorities for NT	Information systems remain problematic; sharing information problematic as is tracking patients/users
	Engagement of the voluntary sector in NT's	NTLO crucial for the NT model as currently developed
	Buy in and awareness from 'middle managers' is perceived as problematic	Difficulties associated with teams engaging with NT's or at times, individual staff members attending NT meetings
	Strategy in place for subsequent phases with 'trailblazers' identified to take integration forward	Oversight and support to the NT's who are not identified as trailblazers
		IT systems have developed to improve access and shared access

Micro:		
Moving beyond the current model to 'the day job'	Relationships between professionals has developed; formal and informal collaborations have enhanced and supported integrated practice; evidence of growth in informal collaborations outside of the main NT meeting Evidence on impact is qualitative and has not been systematically collected	Questions about service provision for people who do not currently fit the NT criteria but whose needs are likely to accelerate Preventative service development Self-management agenda remains a question Responses are limited by barriers outside of their immediate control (e.g. funding; access to services; development of community services)
Improving care for people with complex needs	Changing cultures of care	Improved working relationships Opportunities for collaboration are developing A degree of frustration that effective practice and impact has not been demonstrated systematically Uncertainty about future roles and some resistance / anxiety associated with loss of traditional roles. Some impact on buy in Unrealistic expectations as to outcomes (e.g. cost savings) Pace of change patchy Unrealistic expectations about pace of change

4.3 PROCESS MAPPING

A series of four process mapping events were held in each of the four NTs between January and February 2017. Participants were all involved in NT's in a variety of ways, but predominantly, as members of the NT's who actively participated in meetings and work emanating from the NT process. This meant that participants had a close, operational understanding of the ways in which the NT model was evolving in their areas, personal experience of the benefits associated with NT's, the challenges and what they felt was needed to address some of the experienced barriers and challenges. Below illustrates the number of attendees at each of the Neighbourhood Team Process mapping events (See Table 7).

Table 7: Number of attendees per Neighbourhood Team Process Mapping Event.

Neighbourhood Team Locality	Number of attendees (n)
Gainsborough (Lincolnshire West CCG)	9
Sleaford (South West Lincolnshire CCG)	11
Stamford and Welland (South Lincolnshire CCG)	15
Skegness and Coast (Lincolnshire East CCG)	4

Despite some differences in the ways in which individual NT's were organised, there was a very high level of similarity and overlap in the narratives gathered at the process mapping meetings. Table 8 summarises the narratives gathered in relation to the purpose of NT's as well as considering who NT's are aimed at. There was strong agreement about the overarching aims of the NT's and they reflect national and local priorities for integration. There was differentiation however, in perceptions as to who the NT's were for in the present and how inclusion criteria should develop in the future. On the one hand, the intention to focus on people with complex needs, or people with long-term, co-existing conditions, was uncontroversial. The debate about risk stratification and the value of focusing on a very small percentage of the local population was a more contentious issue. A number of participants, especially in Stamford and Skegness, reflected on the need to widen the net, in terms of the need to increase referrals into the NT but more importantly, to provide an integrated service for people in need and who were identified as 'frequent users' of services, and who would not appear in the top 2 per cent of the risk stratification criteria. People with long-term 'unmet' needs were identified as often being at considerable risk and people who often used

services a great deal, but with little or no discernible benefit. Other participants highlighted that health needs were often not at the forefront of the picture for people with the most complex or intractable needs. In other words, social exclusion, the environment, relationships, behaviour and access to resources were often more pressing needs for the individual and had a deleterious knock on effect on their health and overall wellbeing. The challenges of intervention for people with mental health needs was also identified as a crucial area of inclusion, made more difficult by consistently identified shortages in the system.

Table 8: Summary of process mapping responses; the purpose of NT's and who they are for

The purpose of NT's	Who are NT's intended for?
Overarching aims: • Working with complexity • Patient/end user benefit • Effective use of services • Joined up • Avoidance of unnecessary care (hospitalisation; duplication) • Reduce 000, 111, 999 calls • Cost effective **Patient/user focus:** • Person centred / personalised care • Single care plan • Proactive / planned • Responsive to preferred place of care • Responsive to change / transition (e.g. fluctuating need; deterioration) **Organisational / structural** • Sharing knowledge • Involvement of specialisms as needed • Joined up, effective services and professional input • Service user / patient activation • Networks • Clear pathways • Developed community services	**Adults aged 18 and over** • Complex needs – characterised by the number of health care conditions; stability or instability; fluctuation; uncertainty; high level users of services • Palliative care • Mental health • Older, typically frail people Anyone in the community aged 18 and over, who needs it Predominantly older people The top 2 per cent of the risk stratification data The top 2 per cent of the risk stratification data is the wrong group – too late People with long-term, unmet needs should be a priority Rarely is health at the forefront of peoples' needs – changing the focus and changing the narrative

Participants identified a range of benefits associated with the development of the NT model. They reflect national data on some of the key benefits to emerge from integrated models and based on discussions in the process mapping meetings, and individual interviews, served to motivate, engender and reinforce commitment to the NT model. Table 9 below summarises the main benefits identified by participants.

Table 9: Summary of benefits accrued from participating in the NT model

Team members:

- Improved relationships
- Removing the blame culture
- Better insight into professional roles and responsibilities
- Effective communication
- A forum for discussion
- Troubles shared
- Sharing knowledge, expertise
- Opportunities for creative / joined up thinking
- Increased commitment to working together
- Enjoyment and value e.g. appreciation of 'the team'
- Reinforcing enthusiasm and energy
- Face to face contacts and relationships
- Shared decision making especially with high risk situations
- Good skill mix
- Effective and efficient e.g. faster referrals; getting the job done quickly; calling in favours; informal working; networking
- Benefits of voluntary sector involvement
- Learning about the locality
- New ideas
- Focus on patient benefit

Patient benefits:

- Improved outcomes
- Faster response
- Hospital admissions reduced
- Some creative and innovative solutions / interventions
- Improved information sharing

Organisational / structural:

- Reduction in admissions
- Effective use of resources
- Some reduction in duplication
- The value of the care coordinator role
- Low cost / no cost interventions
- A base line for moving to the next phase
- Working with the voluntary sector

Despite the many challenges and barriers identified with development of the NT model, the benefits accrued were an important factor in retaining motivation to continue to commit to the NT model. The value of sustaining, developing and making professional relationships and alliances in further embedding of the NT model is an important consideration for future developments. Participants expressed significant levels of frustration in trying to overcome the barriers and challenges which participants believed, slowed down the potential for progress and ultimately, impacted on motivation to persevere.

Barriers and challenges were reflected at every level within and across organisations and high level structures, including national government. There is clearly merit in carefully considering how some of the barriers can be overcome and working with stakeholders to identify key priorities for change as well as what achieving change would bring about, is an important factor (See Table 10).

Table 10 Summary of the major barriers and challenges identified by participants as blocks to current integration practice and barriers to further evolution of the model:

Strategic

- Clear, overarching leadership (relationships, communication, accessible)
- Community resources of clear strategy for developing same
- Back office systems not in place
- Funding (e.g. investing in integration; managing a dual system needs funding)
- Public engagement and lack of clear strategy for public engagement
- Strategy re: self-management and its implications
- Continuity – change a feature of daily life with accompanying uncertainty
- Need for a clear strategy for evaluation of NT evolution and development
- Key messages (about integration, service redesign, implications) not being communicated
- Clarity re: eligibility criteria for NT referrals
- Data to demonstrate any impact on key criteria
- Consent process cumbersome
- Strategy for unmet need
- Managing cross boundary complexities
- Waiting lengthy times for referrals to be actioned – accompanied by lack of autonomy to shape the service/look at the current contract
- Recognition that change at this level takes time and cannot be a 'quick fix'
- Focus should be on patients and the community not foregrounding cost savings

Organisational / structural

- Information governance
- Involvement of key organisations and professional groups remain problematic
- Managing across different systems
- Perceived poor buy in / understanding from middle managers who block NT engagement
- Recording unmet need
- Changing entrenched practices

Culture and practice

- Changing traditional modes of delivery
- Time pressures – staff shortages and gaps; managing a dual system
- Losing focus of NT's under pressure of work
- Duplication of work remains a struggle
- Inappropriate referrals
- Bridging different languages and practices
- Who will assess unmet need in a person centred way?
- Changing entrenched practices
- Changing culture not a quick fix

Participants were invited to identify ways in which current good practice and achievements could be further enhanced. Areas identified focused on fundamental areas such as improving digital governance and access to patient/user records. Suggestions were pragmatic, reasonable and reasoned, based on their experiences of the benefits of NT working and the challenges they encountered (See Table 11):

Table 11 suggestions for improving upon current good practice and achievements as well as countering some of the challenges and barriers

Digital governance

- Pragmatic approaches to consent
- Patient/user records and tracking shared
- Accessible data for the benefit of the service user / NT

Investment

- Engagement strategy (statutory sector; voluntary sector and the public)
- Self-management – strategies and investment in engaging with the public about the self-management agenda

Innovation

- Encourage, recognise and reward innovation
- Seeing failure as an opportunity to learn
- Moving away from blame cultures towards learning cultures

Leadership

- Overarching, transparent and consistent leadership on integration
- Recognising that integration will take time
- Developing transparent, achievable milestones and a framework for evaluation and demonstrating achievement (and failures)

While the main findings are summarised above, one key question regarding the referral process was mapped out for each Neighbourhood Team. Fundamentally, all patients are part of the Neighbourhood Teams due to registration with a local GP practice. Patients are identified within the Neighbourhood Teams through either a risk stratification tool or clinical judgement, as an individual with multiple needs who would benefit from a proactive case management of care. The process of the Neighbourhood Team meetings involves the nomination of an individual into the meeting, with their consent, where they are discussed and assessed amongst a multidisciplinary team of health and social care professionals. A plan of action is created and member(s) of the team are responsible for overseeing the care and support for the individual. The action will be discussed in the following meeting amongst the team to evaluate whether the individual has improved or may require additional care and support.

This process may be repeated several times to ensure the individual moves towards a position where they are likely to be capable of self-care and independence with additional support or are further signposted to more specialist or acute services. With this additional support the care plan may be updated to active discharge planning subject to the severity and needs of the individual. Figures 8 a-d represent participant understanding of the referral process for each of the NT's:

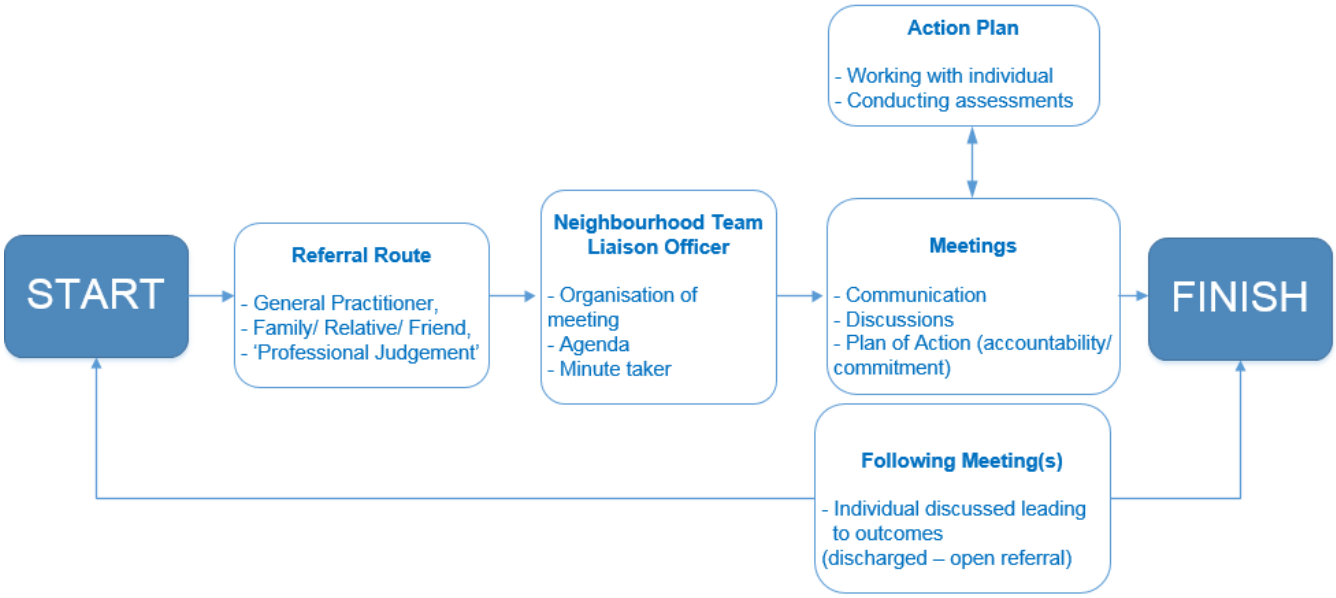

Figure 8a: Referral process Gainsborough (Lincolnshire West CCG) Neighbourhood Team.

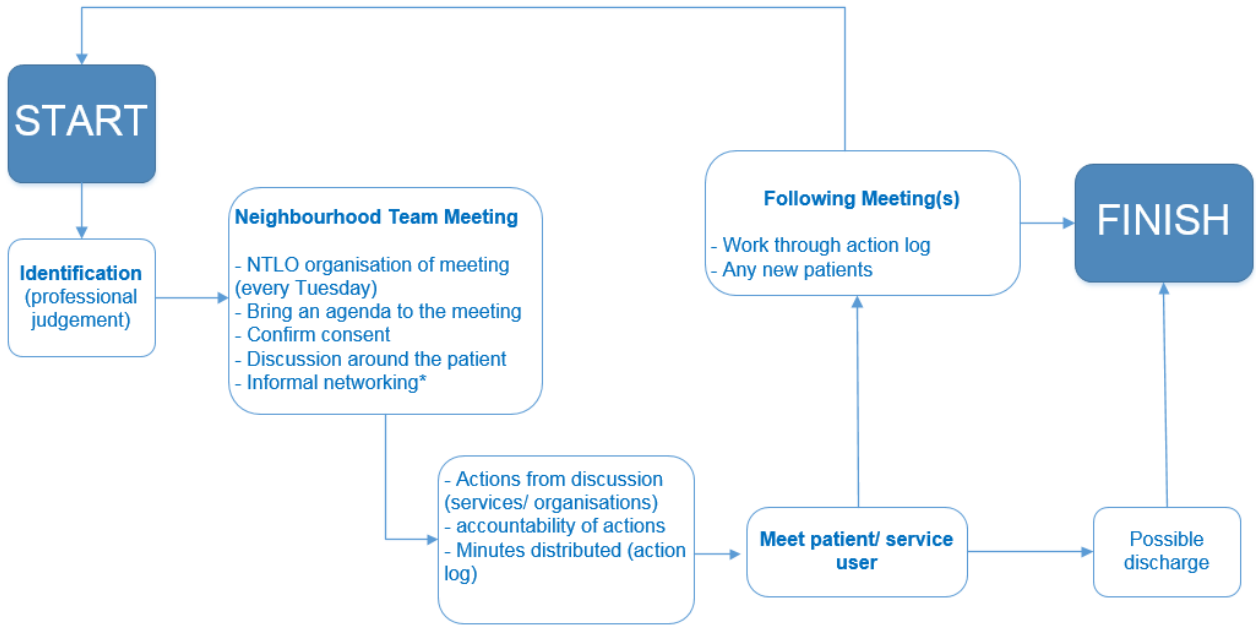

Figure 8b: Referral process Stamford and Welland (South Lincolnshire CCG) Neighbourhood Team.

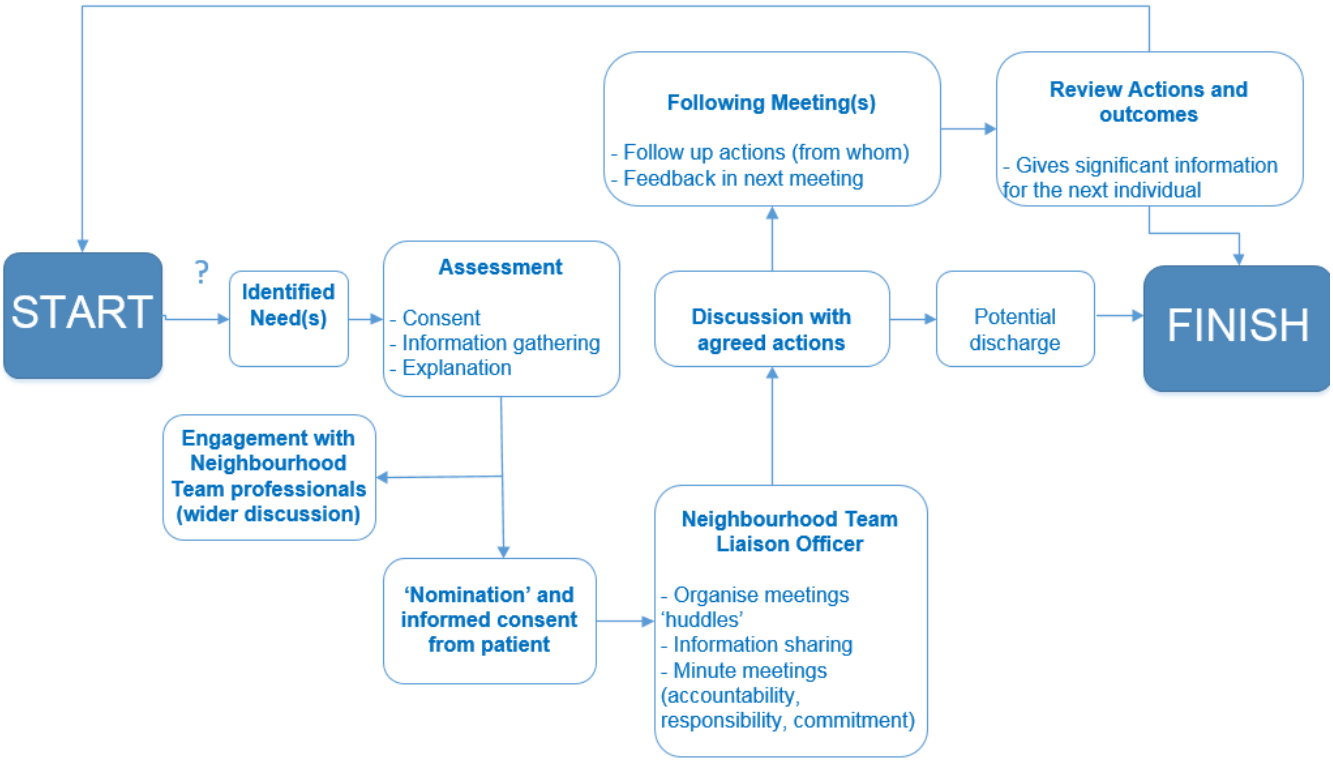

Figure 8c: Referral process Sleaford (South West Lincolnshire CCG) Neighbourhood Team.

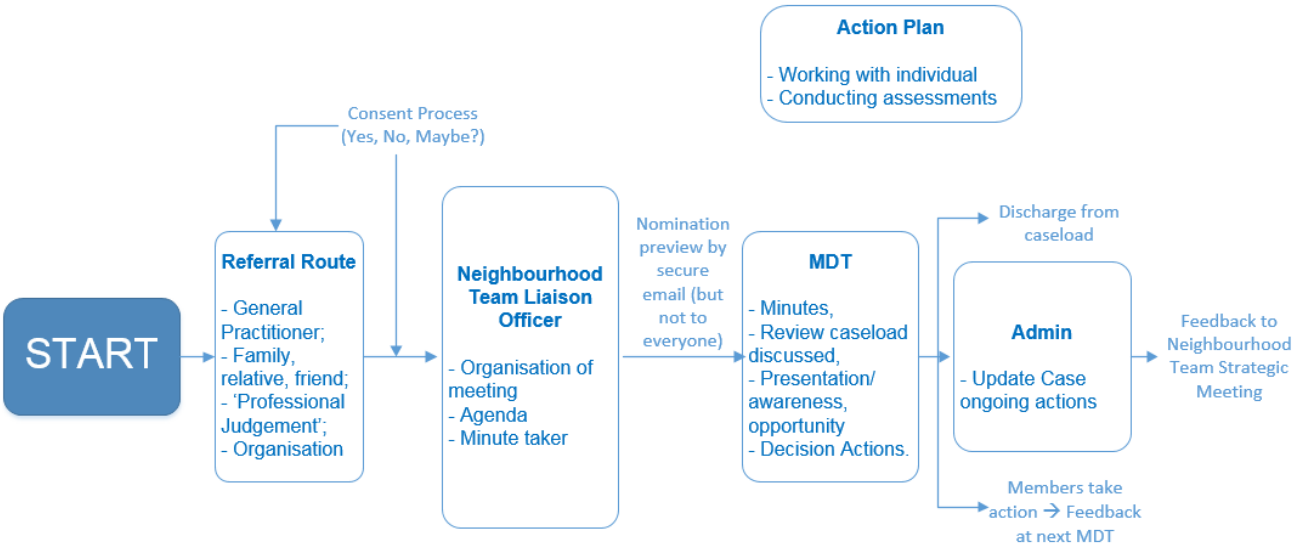

Figure 8d: Referral process Skegness and Coast (Lincolnshire East CCG) Neighbourhood Team.

The evaluation of outcomes for users of the NT have not been systematically collected and the impact of service delivery via the NT model has not been addressed. There is no evidence to suggest that there are better ways of delivering NT's or of developing the NT model to deepen and extend integrated care. Comparing the testable theory developed from the review of literature with the process mapping and qualitative interviews, confirms that based on this evaluation, there are no overarching principles to delivering integrated care via the NT model in Lincolnshire. NT's have had limited impact on the day-to-day realities of front line practice but offer the potential to develop further integration.

The mechanisms to facilitate service delivery were the use of a multidisciplinary NT meeting, supported by some shared assessment, decision making and planned and coordinated interventions. Administrative, practice and digital systems are not integrated and so systems can still be unwieldy and rely heavily on the goodwill and skill of individual practitioners and support staff to negotiate. NT's are not collocated and although this may be perceived as a barrier to further integration, there is a view that further restructuring is an unnecessary distraction and may lead to the NT being delimited by the membership of the team. To date there has also been an absence of evidence surrounding the cost effectiveness of the NTs including structures of funding. Finally macro support from 'middle managers' has been reported to be patchy across the NTs inhibiting the progression of integration and collaborative working.

The NT model has delivered in response to the needs of individual localities but at the time of writing, it is not possible to determine what mechanisms produce the best outcomes for service users. Without further robust evaluation it is difficult to say with any certainty, 'what works, for whom and in what circumstances?' (Pawson and Tilley, 1997).

4.4. LIMITATIONS TO THIS EVALUATION

The project was unsuccessful in obtaining a sufficient number of completed service user questionnaires making it impossible to draw any conclusions about the impact of the Neighbourhood Teams on outcome or experience. The lack of success in achieving a satisfactory number of completed questionnaires was due to a number of factors:

- Low referral numbers directly into the Neighbourhood Teams;
- Rigorous inclusion criteria (65 years old and over; are able to consent, can speak, read and write English to a good enough level to complete the questionnaire – any nationality);
- Time frame of the project.

The study was further limited by the absence of any coherent data from which to assess the impact of NT's. However, it is acknowledged that ProTICare is a pilot study and such methodological limitations constitute important learning for future research.

Chapter 5.0

CONCLUSION

5.1 DISCUSSION

The historical context for integration is well documented and the current drivers for service redesign to integrated services is clear. Integration has been positioned as a fundamental development in response to some of the challenges currently facing the health and social care sector, including better delivery of services at a lower cost (Dilnot et al., 2011). Nevertheless, the evidence for this remains equivocal and the most recently published report from the National Audit Office (2017) concluded that while there is evidence of improvements in 'joined up working' and integrated services, the achievement of core aims, such as support for out of hospital care, managing demand for healthcare and saving money is far from being realised. The NAO report reiterates the importance of robust evidence on the best approaches to improve care and save money through the integration of service provisions. Messages drawn from the review of the literature are inconclusive and at times, contradictory. The main messages drawn from the literature and subsequent interviews and process mapping at this stage in the NT development are:

- Current arrangements for care do not work well;
- There are a number of regional and national imperatives driving change;
- The experience of people who use services is often poor and characterised by fragmentation; complexity and delay;
- The NT model has provided important opportunities to enhance communication, build relationships via face to face contact and this has enhanced collaborative practice and motivation to further develop collaborations. In short, the relationships between colleagues is crucial;
- National policy directives are thought to be unrealistic in their expectations about the pace of change required and the outcomes derived from integration (specifically, cost savings);
- The current narrative on self-management is not well understood and public engagement on the topic is at an early stage, despite it being seen as a crucial element in the integration process;
- Integrated service delivery is developed through relationships, collaborations and experiences of success – it is difficult therefore, to force what is a crucial aspect of integration – into a defined time frame;

- Culture change is absolutely fundamental to integration and moving away from traditional service models;
- There is an absence of robust service evaluation and an absence of evaluation of user experience and outcomes;
- There is a need to continue to encourage and support 'buy in' from key players, including GP's and some key agencies;
- Systems remain separate, cumbersome and difficult to negotiate. The current developments in IT are welcomed as crucial steps in addressing some of those difficulties;
- The extent to which integration can address the wider contextual challenges associated with population demand looks unlikely based on current evidence.

Evidence on the impact of NT's for patients/users and carers is anecdotal and robust evidence is absent. Evidence of whether the NT model contributes to cost efficiency is further absent and at this stage in its development, appears unlikely. The desire to support people with complex needs at home and for them to receive care which is easy to navigate, is a shared and important aspiration. It is evident that those front line practitioners involved have largely benefitted from the experience of the NT model and there is a strong view amongst respondents that it has had a beneficial effect on their practice. The support and engagement of management structures is crucial in supporting staff to engage with the NT model rather, that is presently the case, allocating a single staff member to be the 'face' of integration for that team. The expectation of widening the NT model so that it becomes 'business as usual' must clearly be supported by a coherent approach at all levels of institutional working. This evaluation suggests a number of key elements that may support the subsequent development of integrated care via the NT model:

- Work on achieving buy in across institutional and organisational structures (e.g. GP's; middle managers; agencies and staff not yet aware of the NT model);
- The NT model needs to be promoted so that people understand its purpose and careful analysis is needed to plan which approaches are most relevant to specific locations;
- Maintaining the end user as the central focus of concern is essential;

- The progress that has been made should be valued and supported – relationships between colleagues; evolving collaborations; building on trust and motivation – integration is happening in front line practice;
- Easier referral systems and consent processes are crucial as this has been seen as a block to referral and accessing the NT model;
- Vertical, horizontal and diagonal working across sectors is necessary
- Staffing levels need to be secure;
- Investment in integration and the NT model is needed;
- Public engagement in the NT model and its aims and vision is needed;
- A robust system of evaluation is needed to assess impact and outcomes, successes and failures of the NT model;
- There is a lack of consistency and significant change in key personnel responsible for leading on and supporting integration at all levels of organisational structure. This is evidenced for example, by significant challenges in contacting key stakeholders; changed e mail addresses; changes in personnel without notice; similarly, numerous publically accessible websites were out of date or void (refer to Appendix 5);
- From analysis of public reports, websites and other documents, it was noted that there were six different terms to describe the Neighbourhood Teams, six different terms to describe service users, four different terms to describe the Neighbourhood Team Liaison Officer and a further seven different models to explain the Neighbourhood Teams. These inconsistencies should be addressed (Refer to Appendix 5).
- Integration, where all levels of organisational and institutional structures are integrated is not apparent in practice.
- There is no single solution to integrated care, where success is likely to depend on the context in which the integration is introduction, not just the initiative itself (Leutz et al., 1999, 2005; Department of Health, 2012)
- Interventions designed to integrate care are likely to improve processes of care and users' experience of care. Such interventions are much less likely to reduce costs (Goodwin et al, 2012)

Chapter 6.0

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Chapter 7.0

APPENDICES

APPENDIX ONE: NATIONAL AND LINCOLNSHIRE CONTEXTS

Provided in this section is a brief timeline of the NHS which highlights the constantly changing national context and its impact on 'integrated care'.

- **The Health and Social Care Act 2001** – formalises the NHS Plan
- **Lord Darzi's NHS Next Stage Review 2008**
- **The White Paper 'Equality and Excellence: Liberating the NHS' 2010**
- **Primary Care Trusts (PCTs) and Strategic Health Authorities (SHA)** (2001 – 2013) – large administration bodies responsible for commissioning health services from providers. Later abolished in favour of Clinical Commissioning Groups (CCGs).
- **Health and Social Care Act 2012** – (1st April 2012) The most extensive reorganisation and restructuring of the NHS in England
- **Introduction of Clinical Commissioning Groups** (CCGs) (1st April 2013) Clinically led statutory NHS services for their local areas (includes GPs, nurses, consultants etc.)
- **Better Care Fund (BCF)** (June 2013) – £5.3bn to ensure transformation in integrated health and social care (Bennett and Humphries, 2014).
- **Integrated Care Pioneers (ICP) Sites** (1st November 2013) 14 pioneer sites across England were announced**:** South Devon and Torbay, North West London, Worcestershire, Cornwall and the Isles and Scilly, Islington, London WELC (Waltham Forest, East London and City), Greenwich, Leeds, South Tyneside, North Staffordshire, Southend, Cheshire, Barnsley and Kent. Health and Well-being Boards (HwB) were established as a forum for key health and social care leaders to work together to support health and wellbeing of their local population. These proposed sites acted as exemplars (demonstrators), through the use of ambitious and innovative approaches to efficiently deliver integrated care.
- **Care Act: assessment and eligibility** (1st April 2014) – The most significant change in social care law for 60 years, setting out local authorities (LA) duties in relation to assessing people's needs and eligibility for publicly funded care and support.
- **Five Year Forward View** (23rd October 2014) – Sets out a positive vision for the future of the NHS based on seven new models of care: Multispecialty Community Providers (MCPs); Primary and Acute Care Systems (PACS); Urgent and Emergency Care Networks; Viable Smaller Hospitals; Specialised Care; Modern Maternity Services; and Enhanced Health in Care Homes (NHS England, 2014).

- **Additional Integrated Care Pioneer sites** (January 2015) an additional 11 pioneer sites were proposed: Airedale Wharfedale and Craven, Blackpool and Fylde Coast, Camden, Cheshire, Greater Manchester, Nottingham City, Nottingham County, South Somerset, Vale of York, Wakefield, West Norfolk. The main aim of the 25 ICP (pioneer) sites are to develop and test new innovative ways of joining up health and social care services across England, utilising expertise of voluntary and community sector organisations/ third sector organisations (TSO), with the aim of improving care, quality and effectiveness of services being provided.
- **Vanguard sites** (January 2015) 50 vanguard sites were chosen with specific roles: Integrated Primary and Acute Care Systems, Enhanced health in care homes, Multispecialty Community Providers, Urgent and Emergency Vanguards and Acute Care Collaborations. These new care model vanguards are a key element within the Five Year Forward View where there will be partnerships between NHS England, The Care Quality Commission, Health Education England, NHS Improvement, Public Health England and the National Institute for Health and Care Excellence (NHS England, 2016).
- **Integrated Personal Commissioning (IPC) Demonstrator Sites** (1st April 2015) – Nine (demonstrator) sites were elected across the country which join up health, social care and other services at the level of the individual, further empowering the patient to direct combined funding and how it is used. IPC supports people to develop their knowledge, skills and confidence to self-manage through partnership with TSO, community capacity and peer support. IPC works with individuals who have high levels of health and social care needs including: 1) People with LTC, including frail elderly people at risk of care home admission; 2) Children with complex needs; 3) People with learning disabilities, and 4) People with severe and enduring/ chronic mental health problems (Integrated Personal Commissioning, 2016).
- **Moving Healthcare Closer to Home** (Care Closer to Home) (9th September 2015) Monitor – part of the Five Year Forward View (FYFV) encourage efforts to deliver more healthcare out of the acute hospital settings and provide this care closer to home. The aim of providing care closer to home is to provide better care for patients, reducing the number of unplanned bed days and length of stay in hospital, enabling discharge, improving acute pathways and fundamentally reducing the associated net costs (Monitor, 2015)
- **EU Referendum** (Brexit) (23rd June 2016) – Britain voted to leave the European Union.

- **Sustainability and transformation plans (STPs)** (December 2016) – Announced in NHS planning guidance are a five year plan covering all aspects of NHS England spending and represent a shift in the way the NHS England plans its services. Forty four areas have been identified as the geographical 'footprints' where the plans are based, with an average population size of 1.2 million people (ranging from 300,000 – 2.8 million). A named individual is appointed as an STP leader for their area. NHS organisations are now being informed to collaborate, rather than compete, with each other to respond to the emerging challenges facing their local services. This approach in working is known as 'place-based approach' and reflects a growing consensus within the NHS that more integrated models of care with existing health and social care systems are required to meet the ever changing needs of the population, by working together to provide more coordinated services for patients (Alderwick et al, 2016; Ham et al, 2017).
- **National Audit Office Report** (8th February 2017) – Published a significant report on the current Health and Social Care Integration Agenda in England with compelling findings and recommendations (National Audit Office, 2017).
- **EU Referendum** (Brexit) (29th March 2017) - Article 50 Triggered – Britain to leave the European Union.
- **NHS Cyber-attack** (12th May 2017) – The NHS amongst many other organisations were involved in a global cyber-attack by 'Ransomware' which targeted approximately 40 Hospital Trusts across the UK.

Provided in this section is a brief timeline of the Lincolnshire context since 2013.

- **Lincolnshire Sustainable Services Review (LSSR)** (10th December 2013) – The Blueprint document, approved by the Health and Wellbeing Board, sets out a vision for sustainable and high quality health and social care services for Lincolnshire within five years under the four care agendas proposed by the Care Design Group (CDG): Proactive care; Urgent Care (Reactive); Elective Care; Women's and Children's Care. The primary focus is on how Lincolnshire's population can achieve the best health and social care outcomes from the substantial but finite resources available (Lincolnshire Sustainable Services Review, 2013).
- **Lincolnshire and Sustainable Services Review (LSSR) Proactive Care Agenda** – Eleven initiatives were proposed as part of Lincolnshire's 'Big Brave Ideas'. One such initiative, 'Neighbourhood Teams' (NTs), encompasses a multidisciplinary community approach to identifying specific locality needs bringing together various healthcare professionals and third sector organisations (TSO) providing a more joined up approach to care. The development of NT sites across the county were proposed through partnership organisations including Lincolnshire County Council (LCC), United Lincolnshire Hospitals Trust (ULHT), Lincolnshire Community Health Services (LCHS), Lincolnshire Partnership Foundation Trust (LPFT), East Midlands Ambulance Service (EMAS) and Lincolnshire's CCGs.
- **Phase One Integrated Neighbourhood Teams** (November 2013) – The full Blueprint document and executive summary, including the case for change, data analysis, CDG initiatives, initial engagement of key partners and creation of a strategic steering group were provided to every board across NHS providers and commissioners.
- **Phase Two Integrated Neighbourhood Teams** (February 2014) – Development of Phase Two of the NTs commences which starts to develop models of care with enablers. Furthermore preliminary and full consultations will ensure all professionals, patients and public have a voice on the LSSR. The Phase Two sites include (See Figure 1):
    - **Gainsborough** (Lincolnshire West CCG)
    - **Sleaford** (South West Lincolnshire CCG)
    - **Stamford and Welland** (South Lincolnshire CCG)
    - **Skegness and Coast** (Lincolnshire East CCG)

This outcome of the Phase Two NTs sites will dictate the future 'Integrated' framework and model for Lincolnshire, further reflecting the national agenda to be rolled out countrywide by 2020.

- **Care Quality Commission** (10th December 2014) Lincolnshire Community Health Services Quality Report: Good (Care Quality Commission, 2014)
- **Integrated Personal Commissioning (IPC) Demonstrator Sites** (1st April 2015) – Lincolnshire is one of nine demonstrator sites across the country selected to allow individuals, commissioners and the TSO to blend comprehensive health and social care funding, allowing the patient to direct how it is used. Demonstrator lead for Lincolnshire is Wynn Spencer.
- **Lincolnshire Health and Care (LHAC)** (29th June 2016) Published document on LHAC 'Case for Change' highlights the changing health and care environment in Lincolnshire; the challenges facing Lincolnshire and initiatives implemented to improve services.
- **Neighbourhood Team Development Event** (5th October 2016) – Workshop on the discussion of the four Phase Two NTs, the work conducted and challenges encountered.
- **Integrated Personal Commissioning National Board Visit** (23rd November 2016)
- **Lincolnshire Sustainability and Transformation Plan (STP)** (December 2016) – Lincolnshire is one of 44 sites across the country signed up to the National STP agenda. Footprint Lead is Allan Kitt Chief Officer for South West Lincolnshire CCG and LHAC (NHS Lincolnshire, 2016).
- **Home First Conference** (16th March 2017) – The event focused on supporting individuals to remain at home and how as a community we can deliver personalised care through Integrated Neighbourhood working. Key note speaker was Professor Alf Collins, Clinical Lead for Person Centred Care, NHS England; Researcher on self-management support, shared decision making, care planning, co-production, patient activation and patient engagement and visiting Professor in person-centred care from Coventry University and Honorary Fellowships at the Royal College of Physicians and the Royal College of General Practitioners.
- **NHS Cyber-attack** (12th May 2017) – Lincolnshire was one of approximately 40 Hospital Trusts affected across the UK.

APPENDIX TWO SUMMARY OF PROGRAMME THEORIES AND SCOPING REVIEW OF LITERATURE

Table i: Initial 'programme theory' of integrated care

Context	Mechanisms (RESOURCE)	Mechanism (REASONING)	(Perceived) Outcomes
Increased local demand and expectations on services	Integrated Neighbourhood Teams (integrated multidisciplinary locality teams): One of 11 initiatives as part of Lincolnshire's (LHAC, 2013)	Frustrations from patients/ service users and healthcare professionals	Improved patient outcomes and experiences of care through better quality of life and enhanced health and wellbeing
Ever growing ageing population with increasing rates of multimorbidities and long term conditions	Proactive agenda Integrated Neighbourhood Team is a multidisciplinary/ multiagency team consisting of GPs, nurses, therapists, social workers, primary care, community mental health, voluntary sector organisations. Responsible for ensuring frail often elderly people are proactively managed so they can enjoy a good quality of life, maintain their independence, and only use hospital services when absolutely necessary. Neighbourhood Team Liaison Officer appointed to coordinate each of the NTs, organise meetings and collate the appropriate information to be discussed with healthcare professionals.	Duplication of services, resources and assessments	Reduction in unplanned/ unnecessary hospital admissions and A&E attendance
Lincolnshire financial deficit		Financial and funding challenges	Cost savings/ cost effectiveness to services
Budget cuts, lack of resources (Staff, facilities, beds);		Difficulties in pathway navigation	Improved collaboration between local government and health
Relative difficulty in recruiting staff;		Uncertainty of job roles and responsibilities	Care closer to home – 'Home First'
Fewer GPs per 1000 patients in Lincolnshire		Minimise people 'falling through the net'	Greater self-care and self-management
Rurality of Lincolnshire		Lack of connectedness	Better coordination and personalisation of health, social care and other services
Silo-based working		Fragmented care	Reduction in GP visits

Table ii – Summary of 'Included' studies within Scoping Review

Study One	Aims and Objectives	Methods (including sample population)	Results	Relevance and Rigour
Carnes-Chichlowska et al., (2013) A realistic evaluation of integrated health and social care for older people in Wales, to promote independence and wellbeing: Interim report. Welsh Government.	**Aims:** a) To describe the context and the mechanisms used to deliver integrated health and social care service that promotes independent living and wellbeing for the older population in Wales; b) Gather secondary research, policy and other evidence for input into a realist evaluation of the variety of approaches towards integrated care with older people; c) Conduct primary research among local government, health and other stakeholders, in order to better understand the current landscape around service integration and delivery; d) To suggest an integrated health and social care framework for measuring the impact of service delivery. **Objective:** To accumulate examples of good, efficient and effective integrated health and social care practice from literature and stakeholder interviews which will be used to develop a conceptual model of integrated care, with the view to constructing an evaluation framework that can be used to assess the impact of services being delivered to older people.	Realist review of health and social care literature for older people. (n=10) Interviews with stakeholders engaged in delivering health and social care to older people. Questions focussed on five key themes: background; outcomes; impact; leadership and support; and the future.	The current working models of effective integrated care in Wales, described by the programme theories, are a bottom-up approach to delivering care. Facilitating frontline, joint or integrated health and social care. Changes in the way care is delivered gives immediate positive results, both for the service and the service user. Effective integrated structural and organisational development happens as a result of changes to service delivery, not as a precursor to service delivery or changes. Headline findings were expressed: a new silo of care; communication; care in the community; budgeting for care, technology and care; integrating management overseeing integrated care; planning the provision of care and evaluation of care. Future implications for new ways of delivering health and social care were provided.	**Relevance:** Excellent (High) **Rigour:** Yes

Study Two	Aims and Objectives	Methods (including sample population)	Results	Relevance and Rigour
Curry et al., (2013) Integrated Care Pilot in north west London: a mixed methods evaluation. International Journal of Integrated Care.	**Aim:** Conduct an evaluation of an Integrated Care Pilot in North West London to assess integrated care across primary, acute, community, mental health and social care for people with diabetes and/ or those aged 75+ through care planning, multidisciplinary case reviews, information sharing and project management support.	(n=37) Semi-structured interviews with senior leads of the pilot and participating organisations and other health policy experts (n=4) Focus groups with healthcare professionals and managers (n=51) completed in full Surveys of Healthcare professionals (including 31 GPs) (25.5% response rate) (n=405) completed in full Surveys of service users enrolled in the pilot (20.25% response rate) (n=30) hours of Observation of Integrated Management Board (n=20) Hours observation of multidisciplinary group meetings (10 hours were transcribed, coded and analysed in detail) (n=11) semi-structured interviews with GPs about the influence of the integrated care pilot on diagnosis rates.	The pilot had successfully engaged provider organisations, created a shared strategic vision and established governance structures. However, the engagement of clinicians was variable and there was no evidence to date of significant reductions in emergency admissions. There was some evidence of changes in care processes. Although the pilot has demonstrated the beginnings of large-scale change, it remains in the early stages and faces significant challenges as it seeks to become sustainable for the longer term. It is critical that National Health Service (NHS) managers and clinicians have realistic expectations of what can be achieved in the relatively short period of time.	**Relevance:** Good (Moderate) **Rigour:** Yes

Study Three	Aims and Objectives	Methods (including sample population)	Results	Relevance and Rigour
RAND Europe and Ernst & Young LLP (2012) National Evaluation of the Department of Health's Integrated Care Pilots.	**Aims:** Conduct a two-year real time service evaluation of the Department of Health's 16 Integrated Care Pilot (ICP) sites across NHS England that aimed to explore different ways of providing integrated care to help drive improvements in care and well-being across the sites. Main integration/ client groups focussed on programmes including dementia care; end of life care; older people; mental health; falls; chronic obstructive pulmonary disease (COPD); long term conditions.	**Quantitative** Hospital Episode Statistics (HES) used to analyse hospital utilisation using control groups and difference in difference (DiD). Patient/ user surveys in 11 sites in 2 rounds (n=1,650 and n=1,231 respondents). Staff surveys in all sites in 2 rounds (n=510 and n=254 respondents). **Qualitative** Living documents Deep Dives: - Interviews with staff in 2 rounds (n=133 and n=90) - Patient interviews (n=82) - Non-participant observations **Cost Data** Pro formas completed by each pilot Secondary care utilisation assessed to estimate costs; drawing on a difference in difference analysis for 8,691 cases and 42,206 matched control analysed in quantitative data.	Outcomes included improved team working especially for staff closely involved in the piloted activity, with improved communication both within and between organisations; strong leadership; expression of values and professional attitudes were of great importance. Responses to surveys from patients and service users were more mixed. Across all sites (8,691 cases and 42,206 matched controls) findings indicated a significant 2% increase in emergency admissions for pilot patients, with a reduction in elective admissions and outpatient attendances by 4% and 20% respectively. In case management sites (3,646 cases and 17.311 matched controls), findings indicated a significant increase of 9% in emergency admissions in the six months following an intervention and a reduction in outpatient attendances and elective admissions by 22% and 21% respectively. No evidence to indicate a general reduction in emergency admissions, despite reductions in planned admissions and in outpatient attendance.	**Relevance:** Excellent (High) **Rigour:** Yes

Study Four	Aims and Objectives	Methods (including sample population)	Results	Relevance and Rigour
PIRU (2015) Early evaluation of the Integrated Care and Support Pioneers Programme: Interim Report. PIRU.	a) To identify, describe and understand the vision, scope, objectives, priorities, plans and leadership/management of the 14 selected Pioneers; b) Identify and describe the mechanisms and 'intervention logics' (in terms of structures, systems and causal pathways) adopted by the Pioneers to deliver those plans and priorities, and to compare them with other recent integrated care initiatives (e.g. ICP) c) Identify the local and national financial incentives, reimbursement arrangements, contractual forms and budgetary innovations to implement the Pioneers plans; d) Analyse the plans in relation to the Better Care Fund (BCF) put forward by the Pioneers, with particular focus on the alignment with national performance requirements and expectations of the fund in 2015/16 (e.g. investment and disinvestment plans); e) Describe how the Pioneers' BCF plans begin to be implemented in financial year 2014/15 (e.g. budget pooling); f) Make a preliminary assessment of the extent to which Pioneers are able to address previously identified barriers to the integration of care and/or governance, together with the reference to facilitators and barriers; g) Assess the degree to which the BCF focusses local authority and local NHS attention in the Pioneer sites on attempting to design and deliver investment and disinvestment plans intended to make specified improvements in the extent and quality of person-centred coordinated care; h) Undertake an early largely qualitative analysis of the progress of the Pioneers in the first 12 months in relation to their first year integration objectives; i) Distil and rapidly disseminate early learning from the Pioneers relevant to the Integrated Care Policy Programme of DH, NHS England and other partners.	Reviewing documentation for each Pioneer including initial proposal, BCF plan, further plans and team service specifications, including minutes of meetings from CCGs, HwBs and Local Authorities; (n=140) In-depth interviews with key stakeholders in each of the 14 Pioneers; Attending relevant national and local Pioneer meetings; Attending local meetings, e.g. planning, progress or evaluation meetings within specific Pioneer sites; Discussions (or interviews) with the NHSIQ's Delivery Service Managers (DSMs) who keep in regular contact with the Pioneers; Production of published and unpublished reports, and presentation and discussion of these reports with National agencies and the Pioneers.	**Barriers:** **National –** National barriers, leadership and financial issues **Organisational, professional and cultural –** challenges in organisational structures, differences in health and social care language, difficulties in trusting organisations. **Local –** local manifestations of more national/ cultural issues (e.g. financial austerity); size/ complexity of local economies placing high demands on leadership/ governance. **Facilitators:** **National –** advantages of being part of the Pioneer programme **Professional and cultural –** emphasis on the importance of building and maintaining good working relationship across all organisations, MDTs, keeping primary focus on the patient/ service user's perspective. **Local –** good local leadership/ ownership	**Relevance:** Adequate (low) **Rigour:** Yes

Study Five	Aims and Objectives	Methods (including sample population)	Results	Relevance and Rigour
Greaves et al., 2013 Evaluation of complex integrated care programmes: the approach in North West London. International Journal of Integrated Care	**Aim:** Conduct an evaluation of an Integrated Care Pilot in North West London which seeks to improve care for 15,000 people with diabetes and 22,000 over the age of 75 in Northwest London. It seeks to improve the quality of care yet at the same time reduce emergency admissions and the overall cost of care.	**Workstream 1 –** Impacts on service use and costs: Comparison of use of hospital services relative to an external control group; comparison of other health and social care services change over time; **Workstream 2 –** Impacts on clinical service quality (process and outcomes) for patient groups concerning diabetes and the elderly; **Workstream 3 –** Qualitative assessment of the impact of the Pilot including: 1. patient perception of continuity of care; 2. Patient perception of changes in clinical decision making; 3. Provider experience of communication between professional groups; 4. Role of multidisciplinary group meetings in the integrated care change management process. Include a mixed methods design conducting semi-structured interviews with a purposive sample from both patients and professionals to investigate the perceptions of all users; and to develop and implement a survey to record patient and carer experience, and a separate survey of professional experiences. Finally the qualitative component will look to include a novel analysis of patterns in commination within the multidisciplinary group meeting, looking at the nature of and direction of conversation between participants. **Workstream 4 –** Strategic evaluation of the pilot within the national policy context. Unknown sample population	**For more details on findings please refer to** Bardsley et al., (2013) Evaluation of the first year of the Inner North West London Integrated Care Pilot: Summary.	**Relevance:** Adequate (low) **Rigour:** Yes

Study Six	Aims and Objectives	Methods (including sample population)	Results	Relevance and Rigour
Syson and Bond (2010) Integrating Health and Social Care in Teams in Salford. Journal of Integrated Care.	**Aim:** Conduct an evaluation of Salford PCT and to explore the issues around planning, implementation and operation of the pilot, to understand the impact of development of the Walkden team on staff and how the delivery of services for users had been affected, and to identify the lessons learnt. **Objectives:** Identify success factors underpinning better working practices and service delivery and the continued challenges to further improvement arising from new ways of working; Examine staff experience of joint working pre and post integrated care team; Identify organisational/ staff development requirements, lessons of good practice and problems encountered in order to inform how the PCT and City Council could support further implementation.	Qualitative interviews and focus groups with members of the pilot team and key managers. Development and delivery of interventions through tailored workshops to facilitate effective implementation of the new way of working in each locality. Unknown numbers of the sample population (members of the pilot team and key managers)	**Success factors:** Simpler and faster access to services; Increased efficiency; Improved assessment process; Better use of staff time/ improvement organisation; Better understanding of professional roles; Staff skill mix; Better use of resources – improvement information sharing, decision making and risk management; Improved patient experience/ greater ability to deliver person-centred care; Enhanced learning and skill sharing; Hospital admissions/ long term conditions (LTC) management; GP views; Staff experiences; Team functioning. **Obstacles and challenges:** Concerns over professional boundaries; organisational cultures, complex process, accommodation, IT infrastructure and training.	**Relevance:** Adequate (low) **Rigour:** Yes

Study Seven	Aims and Objectives	Methods (including sample population)	Results	Relevance and Rigour
Thistlethwaite (2011) Integrating health and social care in Torbay: Improving care for Mrs Smith. The KingsFund.	**Aim**: To set out how NHS and local government leaders in Torbay together with frontline staff overcome the obstacles to integration that have hindered progress in this direction in other areas, and to distil lessons of wider relevance from their experience. Evaluation of Torbay PCT and how care could be improved for 'Mrs Smith', a fictitious user of health and social care services. Although the paper includes quantitative data demonstrating the achievement of Torbay, it was commissioned to tell the story of what lies behind these achievements. The value of case studies is their ability to get underneath the surface of innovation in public services and to describe in some detail the complexities of bringing about change and the factors that were most important in this process. The focus of what follows is therefore primarily on the interplay of people, relationships and processes in Torbay health and social care community and how these came together to deliver measurable improvements in performance. Central to Torbay story was the receptive context for change based on long term commitment to joint working. Also important were the presence of NHS leaders who had developed a good working relationship overtime and the burning platform of adult social care services that were performing poorly. It was in this context that a compelling shared vision was developed, centred on improving the care of 'Mrs Smith', a fictitious user of health and social care services in her 80s.	Joint enquiry between the evaluator and team to establish the best way to integrate people and services to achieve the vision outlined for Mrs Smith. The evaluation was designed to be a cyclical collective learning process; that is, it involved clarification of initial objectives, monitoring, feedback and then any consequent adjustment of objectives. This cycle happened twice during the pilot period. Progress was shared widely by the evaluator and Brixham staff at the regular staff seminars and in the newsletters. Team managers perceptions of progress through analysing regular questionnaires and focus group discussions (unknown numbers) (n=14) GPs across Torbay were interviewed during the middle stages of the project.	Three wider lessons can be distilled from Torbay's story: **First**, making change happen in public services takes time and requires persistence by local leaders in overcoming obstacles and challenges; **Second**, delivering real results depends on working on several fronts simultaneously while remaining faithful to the vision of improving outcomes for 'Mrs Smith'; **Third**, improvement in this case resulted mainly from the leadership of providers of health and adult social care services, with commissioners having a lesser role.	**Relevance:** Adequate (low) **Rigour:** Yes

Study Eight	Aims and Objectives	Methods (including sample population)	Results	Relevance and Rigour
Tucker and Burgess (2012) Patients set the agenda on integrating community services in Norfolk. Journal of Integrated Care.	**Aims:** This paper aims to demonstrate the approach taken in Norfolk, UK, to engage patients and staff to develop and improve services by stimulating improvements in integrated working. The two year programme focused on making specific improvements that patients highlighted they wanted to see by working with staff who volunteered to take part in the programme.	**Patient experience and satisfaction:** (n=10) Patients were interviewed face to face in their homes on their views and experience of the service. A semi-structured questionnaire was implemented tracking the project objectives and patient pledges. (n=26) Patients and representatives from patient organisations within a facilitated workshop **Staff experience and views:** (n=29) Online semi-structured questionnaire for interviews completed; Two Focus Groups were held yielding (n=44) and (n=37) respectively. **Service Changes:** To assess the impact of changing practice on the way the services were utilised, a data analysis of activity based on practice populations was undertaken, and compared to the rest of Norfolk.	**Patient experience and satisfaction:** Patients were asked their views on care over five topic areas; communication, access and personalised care, care management, coordination and service improvement. Mixed response was expressed. **Staff experience and views:** Staff expressed all 32 GPs had become actively engaged and had practice-based multidisciplinary teams; improved communication; patient benefits which made their jobs more satisfying; relationships with other services improved. **Service Changes:** Decrease in unplanned admissions by 0.85% whilst the rest of Norfolk recorded an increase of 2.54%; Decrease in residential care admissions by 7.64% whilst the rest of Norfolk recorded an increase of 16.7%; For 60 identified patients, their hospital admission rate decreased by 31% following ICN intervention and was measured by 180 days before and after the intervention, giving a reduction of 18 hospital admissions saving an estimated £40,000 to the local NHS.	**Relevance:** Good (moderate) **Rigour:** Yes

Study Nine	Aims and Objectives	Methods (including sample population)	Results	Relevance and Rigour
Windle et al., (2010) National Evaluation of Partnerships for Older People Projects: Final Report. PSSRU.	**Aims:** National evaluation of the POPP bringing together findings from across 29 sites, 146 core projects set up within them and data gathered from numerous clinical, statutory, strategic and operational staff, as well as the participating older people themselves. Building on interim and annual reports and specific outputs from the different parts of the overall evaluation, it presents the evidence on the extent to which the programme succeeded in achieving its aims: • Provide a person centred and integrated response for older people; • To encourage investment in approaches that promote health, wellbeing and independence for older people;	(n=1529) respondents across 62/ 142 core projects The National Evaluation involved 15 different methods of data collection and analysis: The evaluation addressed questions both on outcomes, such as the extent to which projects improved the quality of life of older people or were cost effective, and on process, such as the nature of the opportunities and challenges experienced in the course of implementing the programme. A first phase involved the collection of baseline information, including documentary analysis, key informant questionnaire and user focused standardised questionnaire across the 29 pilot sites. A second phase involved substantial data collection via interviews and focus groups with both local staff and older people across five case study sites. A third phase involved further interviews across the 29 sites.	Two-thirds of the POPP projects were primarily directed to reducing social isolation or promoting healthy living (Community Facing) and one-third focused on avoiding hospital admission or facilitating early discharge from acute or institutional care (Hospital Facing); The projects were widely thought to have delivered a greater range of services for older people, improving their quality of life and well-being; The projects were reasonably successful in developing good working relations with a range of partner organisations with some variation across areas; Reduction in hospital emergency bed days resulted in considerable savings, to the extent that for every extra £1 spent on the POPP services, there has been approximately a £1.20 additional benefit in savings on emergency bed days. This is the headline estimate drawn from a statistically valid range of an £0.80 to £1.60 saving on emergency bed days for every extra £1 spent on the projects; Overnight hospital stays were reduced by 47% and use of Accident & Emergency departments by 29%. Reductions were also seen in physiotherapy/occupational therapy (OT) and clinic or outpatient appointments with a total cost reduction of £2,166 per person;	**Relevance:** Excellent (High) **Rigour:** Yes

	• Prevent or delay the need for higher intensity or institutional care.		A practical example of what works is pro-active case coordination services, where visits to A&E departments fell by 60%, hospital overnight stays were reduced by 48%, phone calls to GPs fell by 28%, visits to practice nurses reduced by 25% and GP appointments reduced by 10%; Efficiency gains in health service use appear to have been achieved without any adverse impact on the use of social care resources; The overwhelming majority of the POPP projects have been sustained, with only 3% being closed – either because they did not deliver the intended outcomes or because local strategic priorities had changed; PCTs have contributed to the sustainability of the POPP projects within all 29 pilot sites. Moreover, within almost half of the sites, one or more of the projects are being entirely sustained through PCT funding – a total of 20% of POPP projects. There are a further14% of projects for which PCTs are providing at least half of the necessary ongoing funding POPP services appear to have improved users' quality of life, varying with the nature of individual projects; those providing services to individuals with complex needs were particularly successful, but low-level preventive projects also had an impact All local projects involved older people in their design and management, although to varying degrees, including as members of steering or programme boards, in staff recruitment panels, as volunteers or in the evaluation; Improved relationships with health agencies and the voluntary sector in the locality were generally reported as a result of partnership working, although there were some difficulties securing the involvement of GPs.	

Study Ten	Aims and Objectives	Methods (including sample population)	Results	Relevance and Rigour
Wolfe et al., (2016) Southwark and Lambeth Integrated Care Programme: Evaluation. King's College London.	**Aim**: Evaluation of Southwark and Lambert Integrated Care (SLIC) supported by Guy's and St Thomas's Charity (GST). Produce a clear, quantified and detailed account of the value of spend of the GST of their £10.6 million? What worked and what didn't work in improving value and why, for whom and in what circumstances? What lessons have been learnt from the programme? Sub questions: a) How replicable are these lessons and for whom? b) To what extent have the anticipated benefits of the programme (as a whole and individual projects/ work streams) being achieved/ not achieved? c) To tell a clear story of how the Older People's Programme developed into a more ambitious programme of total system transformation.	Quantitative: Costs and Activity Documents: Interventions and Decisions Literature: Theoretical Context Interviews: Key stakeholders (n=31) Focus Groups: Citizens Meetings: SLIC Team Meetings: Governance Boards (n=4)	**What worked well:** Vision – Common goal; Business Case – a range of tangible interventions; Impact on demand for services – emergency admissions (and discharges) have remained broadly stable (flat-lined) of people aged 65+; Citizen Engagement – championed as one of the successes of SLIC; Clinical Engagement and Leadership – increasing engagement of primary care; Strong leadership and accountability; Increased trust and communication leading to improved relationships; **What did not work well:** Vision – changed over time; Business Case – targets were overly ambitious in the scale and timing; Clinical Evidence Base of Interventions – Clinicians challenged the underpinning evidence base; Impact on Demand for Services – difficulty in assessing attribution of cause and effect between individual interventions and wider system change – lack of data inputs and measures of outcome; Clinical Leadership and Engagement – involvement of clinicians is a continuing challenge.	**Relevance:** Adequate (low) **Rigour:** Yes

Table iii: 'Programme Theory' of Integrated Care from 'Included' studies in the Literature

Context	Mechanisms (RESOURCE)	Mechanism (REASONING)
Increased ageing population, particularly over 65s, with multimorbidities and long term multiple conditions	13 examples of Integrated Services across Wales including transitional care, preventative/ pre-emptive and planned care, non-acute medical service intervention and social care, hospital-facing services, community facing services.	Difficulties and frustrations of service users
	Multidisciplinary groups	Repeated stories, repeated information
	16 ICP initiatives: Structured care for dementia, End of life care, Older people at risk of admission, mental healthcare, rapid access medical assessment clinic with reclassification of acute hospital as community hospital, moving services closer to home, fuel poverty intervention, improved transport to services, older people's mental health, people at risk of admission to hospital (long term conditions), structured care for dementia, long term conditions, Falls in over-60s, COPD. People at risk of CVD, prevention of admission of older people to hospital, enhanced discharge planning, people in nursing homes with COPD/ Congestive cardiac failure, services for low-level dementia, structured care for diabetes, substance misuse.	Separate assessments
		Inherent delays, suffered delays to transfer of care
		Complexity of the system
		Lack of joined up care, lack of coordination, lack of connectedness
Increased demands on primary, secondary, social care agencies and third sector organisations	Integrated Care and Support Pioneer programme, 14 Pioneers with similar initiatives including different combinations of risk conditions, telehealth and telecare, hospital discharge planning, GP networks providing a wider range of services, multidisciplinary teams, rapid response services to reduce avoidable admissions, personal health (and social) care budgets, joint-commissioning, developing community assets resilience and an increase use of volunteers and more support to carers.	Systematic failings in care for people with multiple issues
	North-West London ICP contains several intervention using the combined predictive model, care planning across care settings; multidisciplinary group meetings, new financial incentives for participating organisations, new information technology (IT) systems to facilitate sharing of information and patient records between providers.	Gaps existing in systems
		Patients do not feel sufficiently involved in their care
Time of unprecedented economic restraint (austerity)	Integrated Health and Social Care team supporting older people and vulnerable adults	Demand and increasing costs in the provision of health and social care are unsustainable
	Integrated Locality Teams	
	Integrated Care Pilot in Norfolk, multidisciplinary practice-based team, case finding system to identify patients with complex care who need community, social and primary care services, creation of a database for patients, collating timely information on patients between hospital and community services, recruitment of a coordinator for each locality hub.	Significant gaps in the evidence base on initiatives around integrated care
	29 POPP Pilot sites set up with 146 core local projects, ranging from low level services (lunch clubs), to more formal preventative initiatives (hospital discharge, rapid response, co-located and 'virtually' integrated multiagency teams).	
Enormous financial deficit across service provisions	SLIC Interventions – Enhanced Intermediate Care and Enablement; ERR, Home Ward, Case management, Holistic Assessments (HAs), Community MDTs, falls, infection, nutrition, asthma, Rapid Dementia Respite, Care Home Support, Primary Care Registers, Home Care worker training, Roll out of AMBER care bundle, EoLC in residential homes, Urgent Care and triage in general practices, Consultant opinion by phone, Geriatrician-led MDT alongside A&E, Simplified Discharge.	Considerable uncertainty (scepticism) about the best way to secure the anticipated benefits of integrated care or whether integrated care is the right way for the NHS.

'Programme Theory' of Integrated Care from 'Included' studies in the Literature continued

Successful Outcomes (Benefits/ Facilitators)	
Communication: - Increased face-to-face contact - Confidence	- (Intangible benefits) Enhanced trust and level of (open) communication between partners leading to improvements in relationships - Pre-existing goof relationships between individuals was an important factor in some sites in making early progress with pilot; implementation.
Engagement: - Commitment - Receptive to change/ openness	**Staff experience:** - Staff spoke of benefits to patients, which in turn made their jobs more satisfying (anecdotal stories);
Vision: Shared (common) vision, values and beliefs	
Patient experience: - Improved patient experience	- Positive feedback from patients - Enthusiasm towards integration and involvement with care plans
Some reduction in use and admissions to services: - Emergency bed days, Overnight hospital stays, A&E use, Physiotherapy and OT outpatient appointments, GP phone calls and appointments, Practice nurse visits	
Cost savings: - Some cost savings of services redirected elsewhere – better use of resources - Appointment of specific positions e.g. Discharge Liaison Officer.	- Simple/ faster access to services – increased efficiencies; - Shift in investment towards community and primary care services;
Leadership/ Management: - Identifying good leadership as facilitating success - Greater coordination of management of the case work supporting people with LTCs;	
Collaborative working: - Improved team working - Mutual cooperation	**O10 Governance:** - Well established governance
Care at Home: - Needs are being assessed and responded to earlier using pre-emptive preventative home improvement adaptation services; - Improved assessment process;	
Knowledge and understanding: - Enhanced interprofessional learning, clinical knowledge, skill sharing; - Improved understanding of local health economy;	- Clear role definitions enabling a sense of ownership - Better/ improved understanding of professional roles, expectations and pressures the different professions face and what they could deliver.

'Programme Theory' of Integrated Care from 'Included' studies in the Literature continued

Unsuccessful Outcomes (Barriers/ Challenges)	
Professional Boundaries: - Initially some wariness and friction over the demarcation of professional boundaries/ activity - Culture shift – way of working;	- Some obstruction to local level to the acceptance and value of community care; - The discourse and language reflects a shift in terminology. E.g. from patient to citizen. The rationale is clear but there is a risk, articulated by some, of clinicians/ professionals becoming less integrated.
Engagement: - Attendance/ engagement – reluctance to engage was also seen where staff noted fatigue due to constant structural change and policy reform; - Active engagement among clinicians were reported to be variable – continuing challenge;	- Initial scepticism and mistrust; - GPs and other healthcare professionals – lack of confidence in system and some services; - Co-location; - Others voiced dissatisfaction with the number of meetings and the time commitment and questioned the opportunity cost of their involvement.
Vision: Changed over time e.g. strategic vision is not universally owned or understood.	
Patient experience: - Patient/ service user surveys/ feedback – some were not satisfied and felt they needed more help than was being offered, some had negative experiences with hospital discharge which influenced their confidence in services overall;	- Difficulties in seeing a doctor or contacting someone about treatment after leaving hospital; - Perhaps too early to look for changes in quality of care and health patient outcomes; - Care planning initially slow.
IT and Information Sharing: - IT difficulties, data sharing and communication (set up initially slow);	- Strategic implementation and the policy context: Design and roll out of the IT tool for care planning have been slower and more complex than anticipated – led to some frustrations.
Costs: - Overly ambitious business case in the scale, timing and cost-savings; - Ambitious aims: concerns raised around being too ambitious, risking disengagement amongst those who may be disappointed that aims around reduced admissions and financial savings have not be adhered to in the first year.	**Evidence:** - Clinicians challenged the underpinning evidence base of interventions e.g. No evidence of general reduction in emergency admissions, but some reductions in planned admissions and in outpatient attendance. - Capturing data/ data availability; - Limited referrals e.g. coming from GPs and District Nurses.
Leadership/ Management: - Lack of leadership, strategic direction, progress – leadership structure unclear; - Coordination of staff/ services - Recruitment delays and challenges;	- A challenge is the disconnect observed by some between strategy and delivery; - Policy is too distant from practice. - NHS bureaucracy –chains of managerial approval among multiple organisations and slow decisions about resource distribution, were perceived as unnecessarily time-consuming;
Restructuring of services/ personnel: - Constant restructuring of services can be disruptive to care, thus slowing potential progress of service development. - Changes in personnel were also identified by many sites as problematic e.g. most common challenge was departure of staff heavily involved in management of the ICP.	**Understanding:** - Roles and responsibilities not clearly defined; - A lack of training sometimes led to staff being unclear whether they were permitted to take on particular tasks or feeling unprepared to take on new roles; - Concerns over lines of accountability and clarity of decision making.

Table iv: 'Programme Theory' of Integrated Care from Interviews

Context	Mechanisms (RESOURCE)	Mechanism (REASONING)
	Integrated Neighbourhood Teams (integrated multidisciplinary locality teams) Integrated Neighbourhood Team is a multidisciplinary/ multiagency team consisting of GPs, nurses, therapists, social workers, primary care, community mental health, voluntary sector organisations. Responsible for ensuring frail often elderly people are proactively managed so they can enjoy a good quality of life, maintain their independence, and only use hospital services when absolutely necessary. Neighbourhood Team Liaison Officer appointed to coordinate each of the NTs, organise meetings and collate the appropriate information to be discussed with healthcare professionals.	**Macro:** - Government policy/ direction - Cost savings - Reduce duplication - Streamlining services - Clear pathways - Reduce hospital admissions and delayed discharge - Increase self-care and person centred care - Changing structures (NHS) - Avoiding silo's (practice) **Meso:** - Better use of local resources - Working together – shared data - Sharing practice, skills and knowledge - Developing area specific responsibilities - Increased creative solutions - 360 degree view - Improving collaboration and relationships - Managing risk **Micro:** - Patient record - Solution focused - Improved quality of life - Integrated care - Avoid repetition/ duplication - Accessing services - Pathways and signposting - Health literacy - Whole system (patient, carer, family)

'Programme Theory' of Integrated Care from Interviews continued

Successful Outcomes (Benefits/ Facilitators)
Culture and practice: - 'Reinforced the awareness that integration is the way forward, this is what we need. I think it will have benefitted these individual patients who've received joined up care, but it has got a lot more to deliver yet'. - Growing buy in and senior buy in - Sustainability and Transformation Plans (STPs)
Neighbourhood Team: -Very open and progressive platform
Technology/ IT: - Care Portal – snapshot of patient background - Cayder – Patient Flow
Roles: - Neighbourhood Team Liaison Officer (NTLO) – evolving role, lynchpin in connecting people together, enthusiasm, hardworking) - Practice Care Coordinators (attached to GP practices) - Both roles are pivotal/ critical team members
Relationships: - Improved access to people, systems and expertise/ professionals - Improved communication - Improved knowledge exchange, information sharing, skill sharing, limitations and a range of others services (voluntary sector organisations) - Improved awareness and understanding - Improved networking including informal support, where to go, reduced barriers, and increased creativity - Improved trust/ invaluable (safe spaces to discuss patients and move forward with their care needs), sharing worries, risk share, advice, sounding board) suggestions, sound - Joint working - Challenged – stereotypes and assumptions - New partnerships – new role models, creativity, ways of working - Outcomes – increased referrals (earlier, quicker, wider referrals, better access) - Patient benefit – success stories/ anecdotal stories, good outcomes, tracking, renewing - Face-to-face – out of meeting, increased referrals, increased collaborations, increased informal contacts, worked well together, meeting frequency (quicker referral time, feedback, enabling) - Engaged – commitments to NT and integration

'Programme Theory' of Integrated Care from Interviews continued

Unsuccessful Outcomes (Barriers/ Challenges)		
Changing Practice: New way of working – reluctance, fear, leadership, challenge		
People on board: - Low number of GPs and middle managers on-board	- Hierarchies - Tribalism	- Lack of evidence - Lack of buy in from some individuals - sceptics
Technology/ IT: - Care Portal? – high expectations	- Information Governance – confidentiality - Frustrations/ staff	- Wi-Fi in buildings is poor/ poor internet connection
Duplication/ crossover: Services and assessments		
Geography: Rurality of localities	-Boundaries (working)	-Geographical areas (massive)
Referrals: Low, limited, late number of (inappropriate) referrals		
Lack of Communication: - Largely clinical systems don't talk	- Care Portal? - Each organisation (vertically)	- Strategic/ middle management - Secondary care
Terminology: - Surrounding individual/ patient/ service user etc. - Surrounding NT/ MDT/ Integrated NT	- Acronyms (alphabet soup) - Surrounding 'Integrated Care' - definition	
Systems/ Structures: - Restructuring – change (staffing – loss of NTLO [Stamford] – hole in team, lack of funding), fear of change, uncertainty, staff churn; organisations. - Staff – work pressures, lack of services (Mental Health)	- Non-aligned boundaries - Non-aligned digital presence – no 360 degree view, viable to trade, governance (nomination referral route)	
Attendance/ engagement: - Poor meeting attendance – some organisations e.g. GPs, third sector, mental health - time pressures, Information governance, capacity, workload/ resources		
Poor Understanding of the NTs: - Knowledge - Message/ vision - Buy in - At sign up – participation - Pace was slow	- Referral process – inappropriate referrals - Misunderstanding - Poor promotion/ communication/ advertising - 'Patchy'	- Aspirations were too low (not aspirational enough) - Role/ purpose/ aims/ objectives not clearly defined - Possible gains - Reduced continuity (reduced evaluation) - Leadership non-visible, lack of ownership – team, principles, identity, vision ('LHAC Fatigue')
Macro: - Funding/ investment/ Financial – tensions/ restrictions, conversation and who is responsible for it? - Lack of business case to identify possible savings to enable to invest in the new model e.g. elderly care and Mental Health	- Lack of prime funding at the moment where they can see cash efficiency savings - Digital barriers – national issue - Funding silo's - Limited evidence base - Limited public engagement - Public understanding – self-management, integration, service restrictions	

Table v: 'Programme Theory' of Integrated Care from Process Mapping

Context	Mechanisms (RESOURCE)	Mechanism (REASONING)
	Integrated Neighbourhood Teams - multidisciplinary/ multiagency team consisting of GPs, nurses, therapists, social workers, primary care, community mental health, voluntary sector organisations. Responsible for ensuring frail often elderly people are proactively managed so they can enjoy a good quality of life, maintain their independence, and only use hospital services when absolutely necessary.	Avoid duplication
		Prevent/ reduce unnecessary hospital admissions
	Neighbourhood Team Liaison Officer appointed to coordinate each of the NTs, organise meetings and collate the appropriate information to be discussed with healthcare professionals.	Financial and funding challenges - cost efficiency savings
		Proactive rather than reactive (crisis)
		Fragmented care – more joined up working

‘Programme Theory’ of Integrated Care from Process Mapping continued

Successful Outcomes (Benefits/ Facilitators)
Relationships: - Team cohesion - Improved communication and enthusiasm - Commitment/ dedication of team members - Joint working across traditional boundaries - Sharing information knowledge ideas/ information sharing with other professionals - Informal face-to-face discussions in an MDT meeting
Roles: - Neighbourhood Team Liaison Officer (NTLO) – lynchpin, glue to the team, oracle, essential to the day to day organisation of the NTs, link between statutory and voluntary services; - Mutual respect/ good understanding of each other’s roles and what services can provide; - Appointment of a Care Coordinator role at GP surgeries.
Neighbourhood Teams: - Helping people stay in their own home in a safe environment and remaining independent - NT has been an enabler/ facilitator to working - Quicker more efficient process - Good level of supervision - More proactive - Third sector organisations e.g. Evergreen Care - Personalised care and support

'Programme Theory' of Integrated Care from Process Mapping continued

Unsuccessful Outcomes (Barriers/ Challenges)	
Relationships: - Lack of trust by some	
Understanding and Awareness: - Lack of clarity of roles and responsibilities	
Communication: - Poor communication - Limited information sharing with wider public – needs more advertising - Lack of clarity of language, confusion around terminology	
Referrals: - Referral rates - Lack of clarity on referral criteria and referral process - Call centres – process of referring through call centres	
Attendance and Engagement: - Capacity to do job, time and pressures to respond, send representative to attend meeting - Poor GP engagement (some e.g. Gainsborough) - Poor engagement/ attendance at meetings – by some organisations e.g. EMAS, LPFT (adults)	
Changing Practice: - Constant service changes - Cultural shift – slow process/ takes time - Lack of community resources/ services	- Boundaries of work and services - Information – not knowing the latest pathway - Loss of Neighbourhood Team Liaison Officer (Stamford December 2016)
Leadership: - Lack of leadership across the whole system - LHAC were leading NTs – lack of definition and people taking up the banner - Lack of higher level leadership/ ownership from senior management – still gaps amongst services/ management;	
Vision: - Unrealistic expectations	
Technology/ IT: - Different technologies/ systems/ databases	
Duplication/ crossover: - Duplication of services and assessments	

Table vi: Final 'Programme Theory' of Integrated Care

Context	Mechanisms (RESOURCE)	Mechanism (REASONING)
Increased local demand and expectations on services	Integrated Neighbourhood Teams (integrated multidisciplinary locality teams): One of 11 initiatives as part of Lincolnshire's (LHAC, 2013) Proactive agenda Integrated Neighbourhood Team is a multidisciplinary/ multiagency team consisting of GPs, nurses, therapists, social workers, primary care, community mental health, voluntary sector organisations. Responsible for ensuring frail often elderly people are proactively managed so they can enjoy a good quality of life, maintain their independence, and only use hospital services when absolutely necessary. Neighbourhood Team Liaison Officer appointed to coordinate each of the NTs, organise meetings and collate the appropriate information to be discussed with healthcare professionals.	Government Policy/ direction
Ever growing ageing population with increasing rates of multimorbidities and long term conditions e.g. Expected increase in the number of 65s (2013/2018) between 11.66 - 13.36% (LHAC, 2014);		Financial and funding challenges – increasing demands and costs in the provision of care which is unsustainable
		Duplication of services, resources and assessments
		Increased rates of hospital admissions and delayed discharge
		Constant changing and restricting of services (NHS)
		Difficulties and frustrations from patients/ service users and healthcare professionals
Lincolnshire financial deficit £60m predicted to be £105m in five years (LSSR, 2013);		Difficulties in pathway navigation (system complexities)
		Uncertainty of job roles and responsibilities
		Minimise people 'falling through the net'
		Lack of connectedness
Budget cuts, lack of resources (Staff, facilities, beds)		Fragmented care – lack of joined up care and coordination – silo based working
		Repeated patient stories (information)
Relative difficulty in recruiting staff;		Patients/ service users do not feel sufficiently involved in their care/ lack of involvement
Fewer GPs per 1000 patients in Lincolnshire;		Inherent delays in discharge, transfer of care, assessments etc
		Existing gaps within health and social care services;
Rurality of Lincolnshire The Health and Social Care Information Centre, 2014).		Systematic failings in care for people with multiple issues;
		Significant gaps in the evidence base and we have not yet to understand the full dynamics of more widespread and long lasting efforts of such initiatives;
Silo-based working		Considerable uncertainty (scepticism) about the best way to secure the anticipated benefits of integrated care or, indeed, whether integrated care is the right way for the NHS

Final 'Programme Theory' of Integrated Care continued

Successful Outcomes (Benefits/ Facilitators)	
Relationship: - Improved access to people, systems and expertise/ professionals; - Improved networking, informal support, signposting, reduced barriers, increased creativity; increased mutual respect; - Improved trust/ invaluable (safe spaces to discuss patients and move forward with their care needs), sharing worries, risk share, advice, sounding board) suggestions; - Challenged – stereotypes and assumptions;	- Outcomes – increased referrals (earlier, quicker, made, referrals, better access); - Increased face-to-face – out of meeting, increased referrals, increased collaborations, increased informal contacts, worked well together, meeting frequency (quicker referral time, feedback, enabling); - Some pre-existing good relationships between individuals was an important factor in making early progress and implementation; - New partnerships – new role models, creativity, ways of working;
Roles: - Appointment of Neighbourhood Team Liaison Officer (NTLO) – evolving role, lynchpin in connecting people together, glue to the team, oracle, essential to the day to day organisation of the NTs, link between statutory and voluntary services,	- Appointment of Practice Care Coordinators (attached to GP practices); - Both roles are pivotal/ critical team members (enthusiasm, hardworking)
Attendance/ Engagement: - Commitment/ dedication of team members to the NTs and integration;	- Most individuals receptive to change/ openness
Vision: - Shared (common) vision, values and beliefs	
Communication: - Enhanced level of (open/ improved) communication and trust between partners leading to improvements in relationships (intangible benefits);	- Increased face-to-face contact (informal contact); - Confidence/ enthusiasm; - NT – very open and progressive platform.
Staff experience: - Felt they received good level of supervision; - Simple/ faster access to services – some increased efficiencies and processes	- Staff spoke of benefits to patients (good outcomes), which in turn made their jobs more satisfying (anecdotal stories) however no survey/ assessment of patient feedback/ voice; - Improved assessment process, more proactive way of working.
Technology/ IT: Cayder – Patient Flow	
Collaborative working: - Improved team working/ team cohesion/ mutual cooperation;	- Joint working across traditional boundaries; - NT has been an enabler/ facilitator to working
Care at Home: - Needs are being assessed and responded to earlier;	- Helping people stay in their own home in a safe environment, remaining independent; - Personalised care and support
Knowledge and understanding: - Enhanced interprofessional learning, clinical knowledge, skill/ information sharing; - Improved knowledge exchange, limitations and a range of others services (voluntary sector organisations e.g. Evergreen Care) with other professionals;	- Improved awareness and understanding e.g. of local health economy; - Clear role definitions and enabling a sense of ownership of new skill-sets required; - Better/ improved understanding of professional roles, expectations and pressures the different professions face and what they could deliver/ provide
Culture and practice: - 'Reinforced the awareness that integration is the way forward…it will have benefited these individuals…but it has got a lot more to deliver yet'.	- Growing buy in and senior buy in (particularly voluntary sector organisations) - Sustainability and Transformation Plans (STPs)

Final 'Programme Theory' of Integrated Care continued

Unsuccessful Outcomes (Barriers/ Challenges)		
Professional working boundaries: - Initially there was some wariness and friction over the demarcation of professional boundaries and appropriate activity for different members of staff relating to inter-professional working;	- The discourse and language reflects a shift e.g. from patient to citizen. The rationale is clear but there is a risk, articulated by some, of clinicians and professional expertise becoming less integrated; - Some obstruction to local level to the acceptance and value of community care;	
Restructuring of services/ systems and personnel (changing practice): - Constant restructuring/ change of services can be disruptive to care E.g. staff perceived the differing priorities of those organisations to cause progress to be slower than it would have been otherwise. - Changes/ loss of personnel were also identified as problematic (staffing – loss of NTLO [Stamford] – hole in team, lack of funding); - Slow service development; - Fear of change, uncertainty, staff churn; organisations.	- Staff – work pressures, lack of services (Mental Health) - Non-aligned boundaries - Non-aligned digital presence – no 360 degree view, viable to trade, governance (nomination referral route) - New ways of working – reluctance, fear, leadership, challenge; - Cultural shift – slow process/ takes time - Call centres – process of referring through call centres; - Lack of community resources/ services	
Costs: - Overly ambitious business case in the scale, timing and cost-savings; - No proof/ evidence of cost savings	- Ambitious aims: concerns raised around being too ambitious, risking disengagement amongst those who may be disappointed that aims around reduced admissions and financial savings have not be adhered to in the first year;	
Attendance/ Engagement: - Reluctance to engage was also seen where some staff noted fatigue due to constant structural change and policy reform within the NHS; - Active engagement among clinicians were reported to be variable and a continuing challenge in some areas; - GPs and other healthcare professionals – lack of confidence in system/ services - Co-location; - Tribalism	- Others voiced dissatisfaction with the number of meetings and the time commitment and questioned the opportunity cost of their involvement; - Poor meeting attendance – some GPs (Gainsborough), some voluntary sector organisations, services EMAS, LPFT (adults), Mental Health; – time pressures to attend meetings/ send representatives, linked to Information governance, capacity to do job, workload/ resources; - Low number of GPs and middle-managers on-board - Sceptics – some lack of trust still exists (initial mistrust and scepticism)	- Hierarchies
Lack of Communication: - Largely clinical systems don't talk - Strategic/ middle management	- Each organisation (vertically) - Secondary care	- Limited information sharing with wider public – needs more advertising! - Information – not knowing the latest care pathway
Terminology: - Lack of clarity of language, confusion around terminology	- Individual/ patient/ service user etc. - Integrated Care – multiple definition(s)?	- NT/ MDT/ Integrated NT - Acronyms (alphabet soup)
Vision: - Changed over time e.g. NT seek to address over 65s now everyone?	**Referral rates:** - Low, limited, later number of (inappropriate) referrals e.g. from GPs, District Nurses - Lack of clarity on referral criteria and referral process	

Technology/ IT/ Information Sharing:
- IT difficulties, data sharing and communication (set up initially slow)
- Different technologies/ systems/ databases – don't talk to each other
- Strategic implementation and the policy context: Design and roll out of the IT tool for care planning have been slower and more complex than anticipated – led to frustrations;
- Care Portal? – high expectations
- Wi-Fi in buildings is poor/ poor internet connection
- Information Governance – confidentiality
- Frustrations/ staff

Leadership/ Management:
- Poor coordination of staff/ services
- NHS bureaucracy – necessary chains of managerial approval among multiple organisations and slow decisions about resource distribution were perceived as unnecessarily time-consuming.
- Recruitment delays and challenges
- A challenge is the disconnect observed by some between strategy and delivery;
- Policy is too distant from practice
- Lack of leadership and strategic direction across the whole system – unclear/ lack of definition – LHAC were leading on it when I started off – people taking up the banner – we'll make it happen. Evidence of local leadership but higher levels there are gaps and there are still gaps amongst services and management

Cultural/ Practice:
- Confined to NT/ MDT meetings – not the day job
- What happens beyond meetings?

Duplication/ crossover:
- Services, assessments and patient stories

Geography:
- Rurality of localities
- Geographical areas (massive)

No evidence or assessments conducted on patient experience/ voice:
- Quality of care and health outcomes: too early to observe changes in patient outcomes
- Care planning initially slow

Macro:
- Funding/ investment/ Financial – tensions/ restrictions, conversation and who is responsible for it?
- Lack of business case to identify where savings can be made immediately to enable to invest in the new model e.g. elderly care and Mental Health
- Lack of prime funding where cash releasing efficiency savings are being made
- Digital barriers – national issue
- Funding silo's
- Limited evidence base
- Limited public engagement
- Public understanding – self-management, integration, service restrictions;
- Unrealistic expectations.

Poor Understanding/ misunderstanding:
- Lack of clarity and or awareness of roles/ responsibilities/ purpose (not clearly defined)
- Aims/ objectives not clearly defined
- Referral process and criteria – inappropriate referrals
- Possible gains
- Reduced bed in
- Reduced continuity (reduced evaluation)
- Lack of ownership – senior management, team, principles, identity, vision ('LHAC Fatigue')
- A lack of training sometimes led to staff being unclear/ unprepared to take on tasks or new roles;
- Pace was slow;
- Concerns over lines of accountability and clarity of decision making;
- Knowledge
- Buy in
- Participation/ engagement
- Poor promotion/ communication/ advertising
- Leadership non-visible
- 'Patchy'
- At sign up
- Aspirations were too low (not aspirational enough)
- Message/ vision

No evidence in the reduction in use and admissions to services:
- Emergency bed days, Overnight hospital stays, A&E use, Physiotherapy and OT outpatient appointments, GP phone calls and appointments, Practice nurse visits;
- Clinical evidence base of interventions: clinicians challenged the underpinning evidence base;
- Capturing data/ data availability;

APPENDIX THREE QUALITATIVE INTERVIEW TOPIC GUIDE

The purpose of this interview is to explore the contexts, mechanisms and perceived outcomes of integrated care from the perspective of individual operational, provider, clinical and commissioning staff across Lincolnshire.

1. **Could you first give me a brief description of your job role within Lincolnshire?**

- How long have you been in your current post for? What did you do prior to your current post? Role within the Neighbourhoods Team?

2. **Could you tell me what 'integrated care' means to you OR how would you define 'integrated care'?**

- 'Integrated Care' and 'Integrated working' are these buzz words at the moment, are there, if any, other words which may elicit the term 'integrated care'?
- What are the strategic priorities for embedding integrated care?
- What are the barriers and opportunities for integrated care?
- In your opinion how much of a priority is 'integrated care' in the context of the wider NHS agenda?

3. **What are the key aspects or characteristics of the 'Neighbourhood Teams'?**

- Who does the 'Neighbourhoods Team' seek to address (demographic/ population)?
- What type of healthcare professionals and individuals are involved in the 'Neighbourhoods Team'?

4. **Could you explain to me how service user's needs are identified within the 'Neighbourhood Teams'?**

- How does the assessment and referral process work? How is discharge from your service organised?

5. **What was the rationale was for putting in place the Neighbourhood Teams in Lincolnshire?**

- Were there particular gaps in services? If so, what were these gaps?

- Was the programme put in place to strengthen preventative care across Lincs? If so, what areas were weak?
- Improve patient care and experience through improved co – ordination?
- Reduce fragmentation and duplication of care across services?
- Provide a more cost – efficient healthcare system for patients with LTM conditions and complex needs?
- Reduce unnecessary health and social care service use? If so, which services?

6. What are the overarching objectives of the Neighbourhood Teams?

- To optimise care and treatment for service users?
- Ensure a person – user focused system?
- Promote co – ordination and continuity of care?
- Equality of access and public health?

7. Have there been any barriers or challenges to the 'Neighbourhood Teams' and this integrated way of working?

- Difficult organisations/ services? Partnership? Communication? Referral pathway? Management? Equipment?

8. Have there been any benefits or indeed facilitators to the 'Neighbourhood Teams' and this integrated way of working?

- Great organisations/ services? Partnership? Communication? Referral pathway? Management? Equipment?

9. Do you perceive that the 'Neighbourhoods Team' has (or will) improve 'integrated' working?

- If so, how do you think the 'Neighbourhoods Team' is likely or unlikely to improve 'integrated' working?

10. How well do you think the 'Neighbourhoods Team' has progressed

- What has worked well?
- What has perhaps worked not as well? Perceive as the rationale behind some things working better than others?

11. What are you hoping the long term outcomes of the 'Neighbourhood Teams' will be (and the integrated care pathway)?

- To improve quality of life for older people? How will this be measured? To reduce unnecessary service use in primary and community care?
- To ensure that older people in the community are appropriately supported prior to a crisis? (Can you expand on these points?)

12. Overall, what would you say is the value (impact) of the 'Neighbourhoods Team' so far in Lincolnshire?

APPENDIX FOUR: EVALUATION TEAM OBSERVATIONS

Whilst analysis of the three key workstreams was essential to the overall report, the evaluation team also made some valid observations which may be worth noting for future considerations. Such observations concern consistency in communication, websites, terminologies and models.

1. Consistency in communication

It was evident from this evaluation that there were inconsistencies amongst healthcare professionals, within and across organisations, regarding their email signatures and contact details. It was noted from the ProTICare evaluation team that emails were incorrectly provided or changed without notifying the team which led to the occurrence of 'mail delivery sender failure'. Furthermore obtaining contact details required numerous pathways and various actions including 1) enquiries, 2) switchboard, 3) reception, 4) social media, 5) public documents and 6) other members of the team.

In summary the number of actions required to speak to the appropriate person was absurd. If the Neighbourhood Teams and organisations involved are to improve communication it is highly recommended that all health professionals notify individuals of new contact details and have an email signature which indicates more than one additional contact detail whether that be an additional mobile number, colleagues contact detail or an alternative email. Key findings from the interviews have suggested 'silo' based working still exists across the county despite the Neighbourhood Teams being designed to ensure integrated working across all health professionals.

One suggestion which is fundamental to tackling this 'silo' based working is having a constantly updated staff directory for each organisation which is further accessible to the public via the appropriate websites. A staff directory is simple, effective and can save an enormous amount of time and actions required.

2. Websites

Secondly it was noted from the evaluation team that numerous public websites are out of date or were void (error messages) including old news, staff details, contact details (or no contact details) e.g. phone number and email addresses.

List of websites include [Accessed 21 January 2017]:

- Lincolnshire Health and Care – Care Closer to Home: Integration and Neighbourhood Teams - http://lincolnshirehealthandcare.org/en/transforming-healthcare/care-closer-to-home/
- Lincolnshire Health and Care – Integrated Neighbourhood Care Teams - http://lincolnshirehealthandcare.org/en/lhac-initiatives/neighbourhood-teams/
- Neighbourhood Team Podcast - https://www.youtube.com/watch?v=qu9rTUHPmqE
- Lincolnshire West CCG website - http://www.lincolnshirewestccg.nhs.uk/search/text-content/introducing-neighbourhood-teams-542 http://www.lincolnshirewestccg.nhs.uk/neighbourhood-teams
- South West Lincolnshire CCG - https://southwestlincolnshireccg.nhs.uk/about-us/lincolnshire-health-and-care/neighbourhood-teams
- Lincolnshire East CCG - https://lincolnshireeastccg.nhs.uk/index.php/about-us/lincolnshire-health-and-care
- South Lincolnshire CCG - https://southlincolnshireccg.nhs.uk/index.php/about-us/lincolnshire-health-and-care/neighbourhood-teams
- https://southlincolnshireccg.nhs.uk/index.php/about-us/lincolnshire-health-and-care
- Stamford Resource Centre - http://www.nhs.uk/Services/clinics/Overview/DefaultView.aspx?id=105877
- Lincolnshire Community Health Services- https://www.lincolnshirecommunityhealthservices.nhs.uk/content/new-teams-health-champions-launched-lincs

3. Terminology –

The evaluation team also identified several variations on terms regarding the 'Neighbourhood Teams', the service users and the Neighbourhood Team Liaison Officers across multiple online platforms and public documents; despite the many aims of integrated care to reduce duplication and repetition.

a. **Neighbourhood Teams**

i. Integrated Neighbourhood Teams
ii. Integrated Neighbourhood Working
iii. Integrated Neighbourhood Care Teams
iv. Integrated Neighbourhood Community Teams
v. Community Based Neighbourhood Teams
vi. Multidisciplinary Neighbourhood Teams

b. **Service user:**

i. Patient
ii. Person
iii. Individual
iv. Citizen
v. Customer
vi. Service user

c. **Neighbourhood Team Liaison Officer:**

i. Neighbourhood Liaison Officer
ii. Care Liaison Officer
iii. Liaison Officer
iv. Care Co-ordinator

4. Models of NTs

Finally the evaluation team also identified several variations on the 'Neighbourhood Team' models which were further identified across multiple online platforms and public documents (See Appendix Figure 9 - 15)

Seven models of the Neighbourhood Teams were identified within various documents between 2013 and 2016. Although there were slight nuances across these models, the importance of consistency and effective publicity is key, particularly if the model is revised or changed to communicate that with your audience.

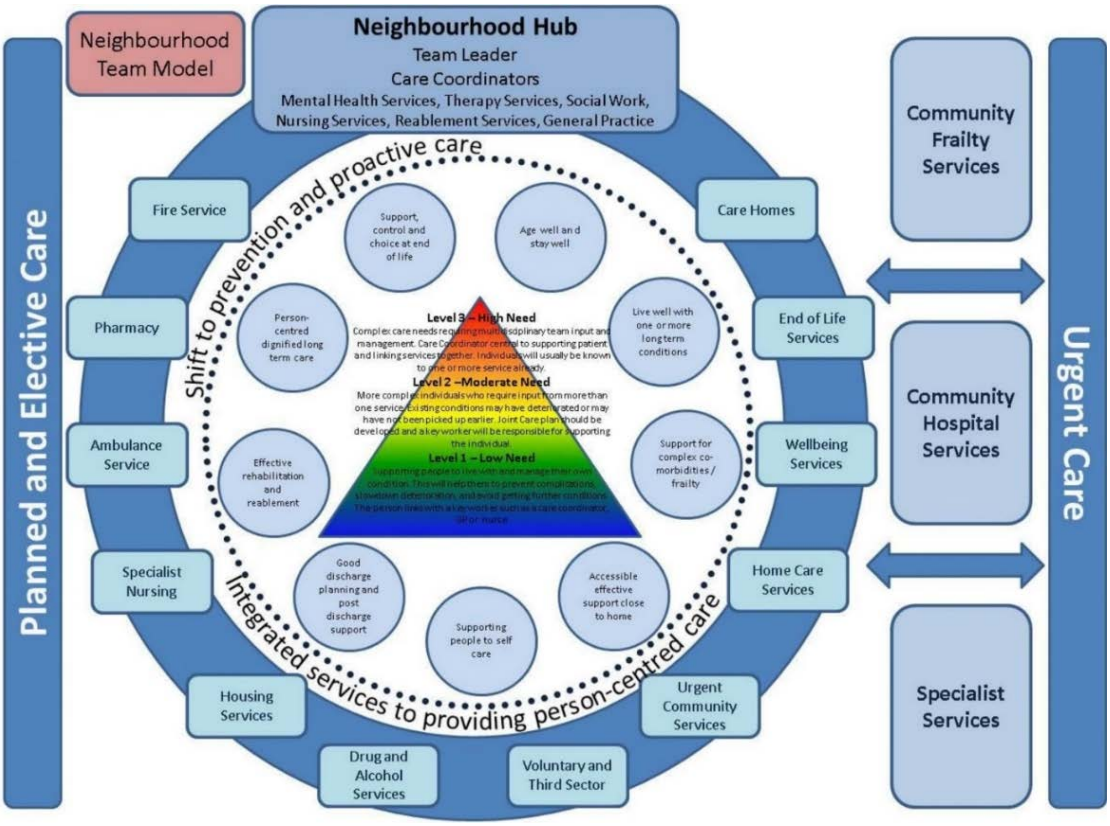

Figure 9: **'**Neighbourhood Team' Model (Lincolnshire Health and Care, 2013)

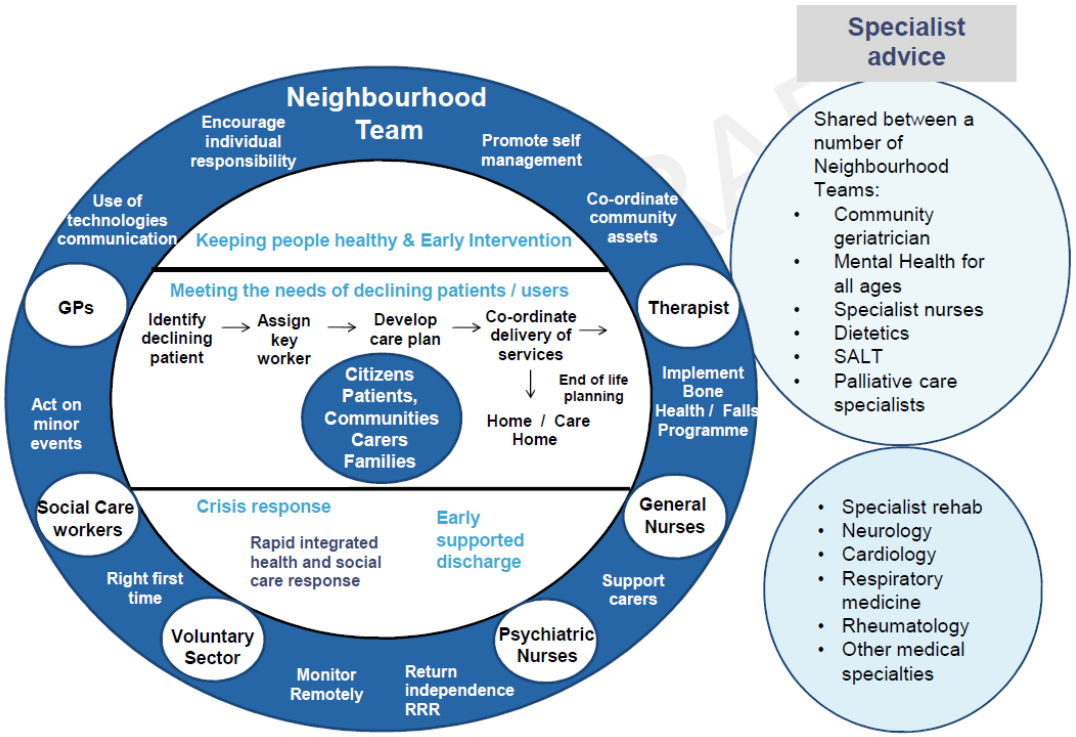

Figure 10: Future Proactive Care Model (Lincolnshire Sustainable Service Review, 2013)

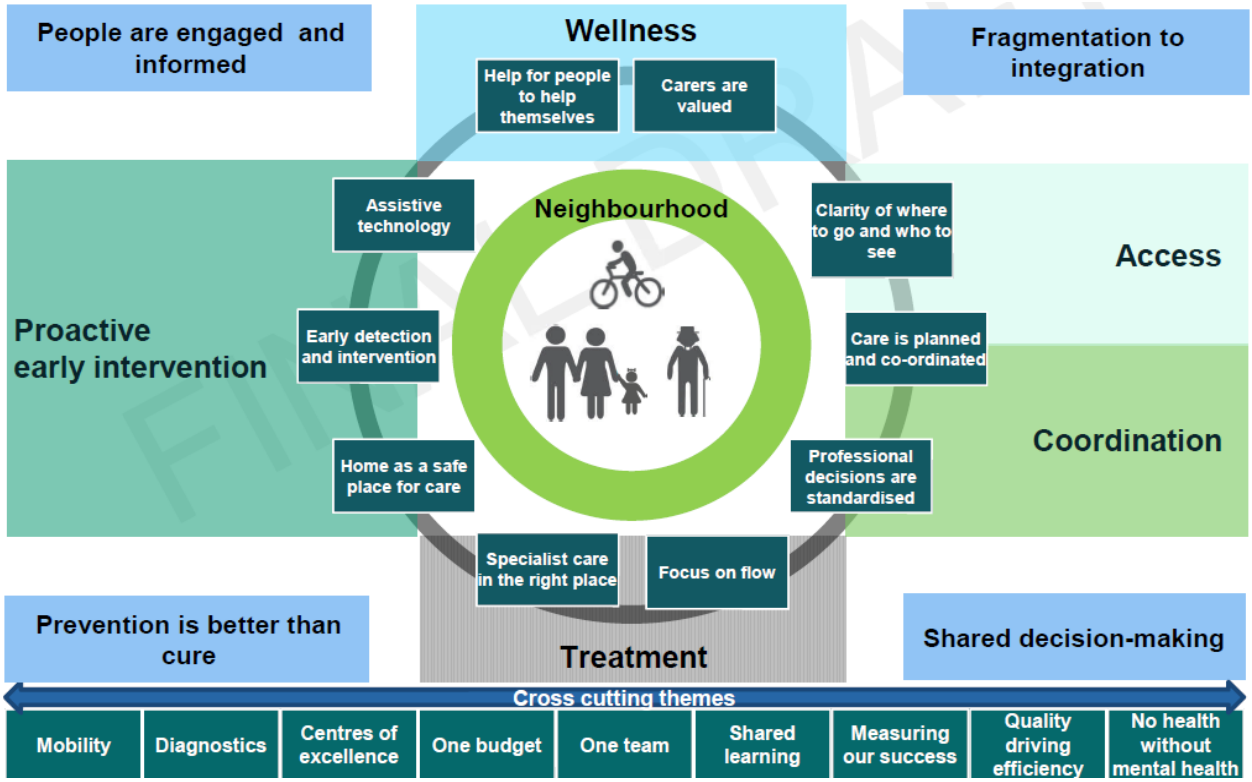

Figure 11: 'Neighbourhood Team' Model (Lincolnshire Sustainable Service Review, 2013)

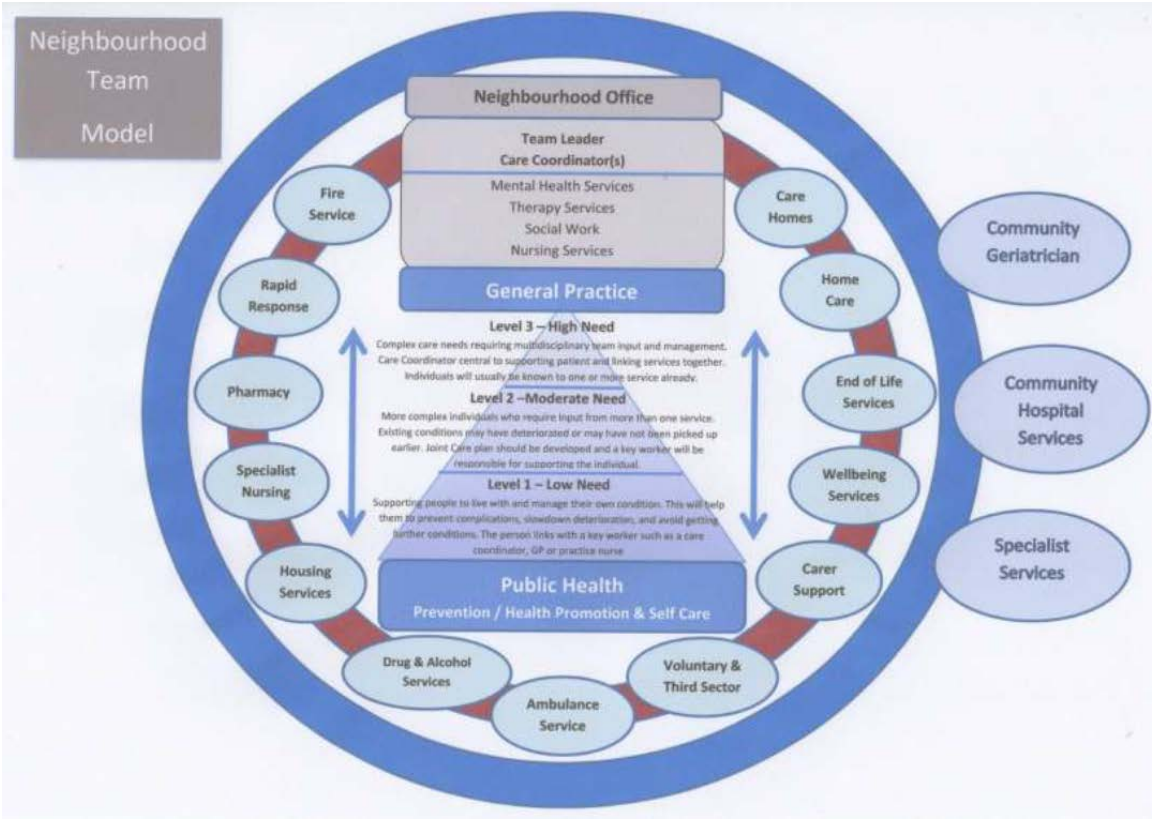

Figure 12**: '**Neighbourhood Team' Model (Lincolnshire Health and Care, 2015)

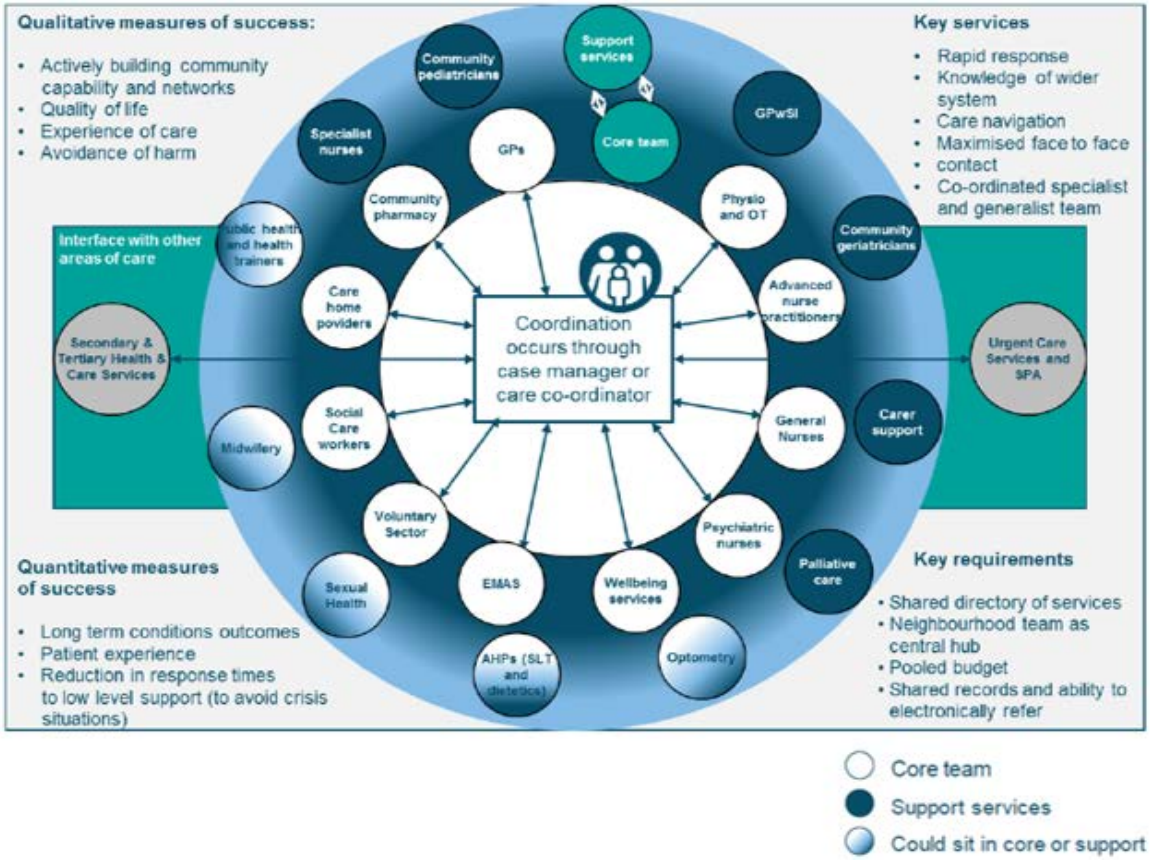

Figure 13: Emerging **'**Neighbourhood Team' Model (Lincolnshire Health and Care, 2015)

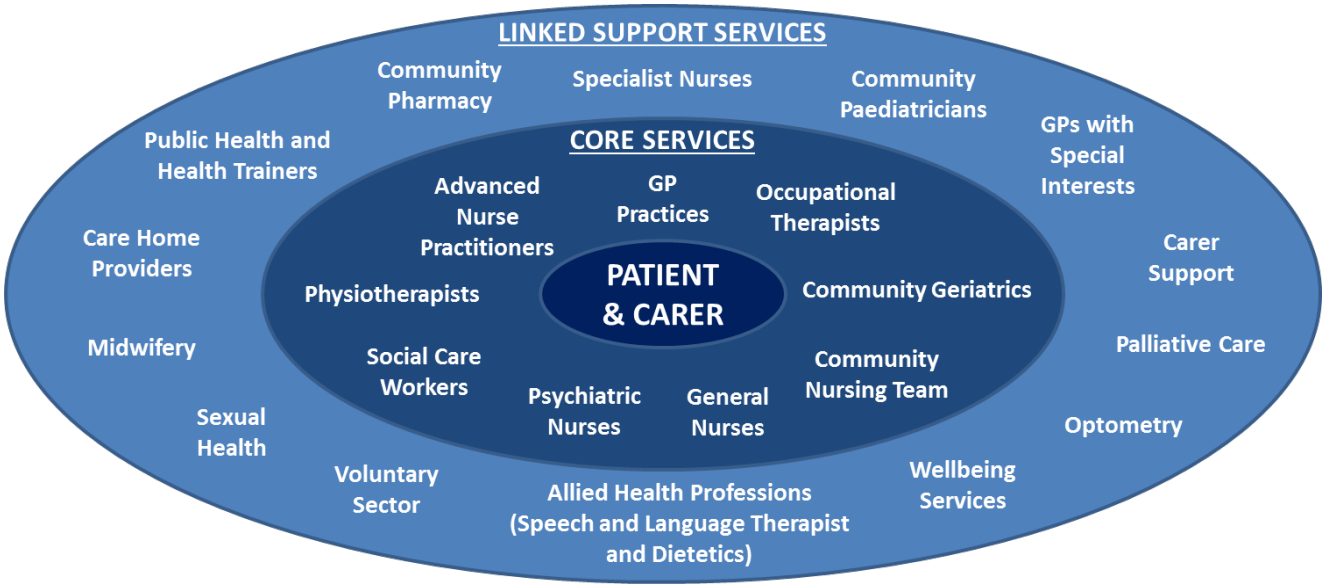

Figure 14: 'Neighbourhood Team' Model (Lincolnshire Health and Care, 2016)

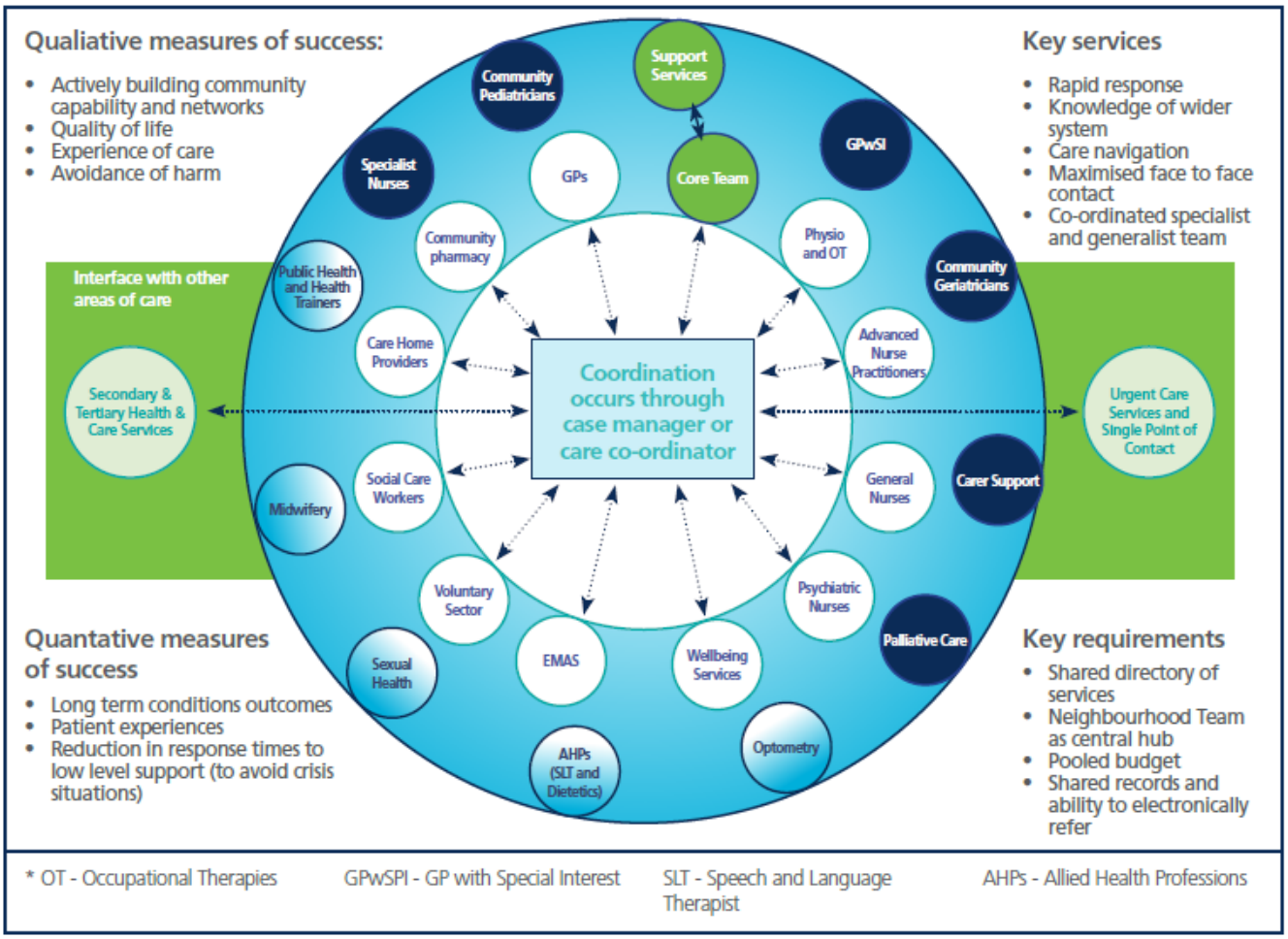

Figure 15: Emerging 'Neighbourhood Team' Model (Lincolnshire Health and Care, 2016)