

‘An Analysis of the Implementation of Integrated Care Teams in Cambridgeshire’

Final Findings Report

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1 INTRODUCTION

Increasing demand for integrated care is driven by an ageing population and increasing numbers of patients with complex needs, which in return require complex clinical skills and knowledge to manage (Wodchis et al., 2015; Sun et al., 2014; Curry and Ham, 2010). Population ageing presents a great challenge to present day healthcare system as incidences of co-morbidity and diseases increase with age and the numbers of patients needing hospital admission is expected to increase further in future (Glasby, 2016; Kassianos et al., 2015; Hartgerink et al., 2013). It is argued that in order to cater to these changing demands, there is a need for a paradigm shift from an episodic acute based care model of care to a long term comprehensive model which spans professions, sectors and political levels (van Rensburg et al., 2016; Lyngso et al., 2014). Irrespective of the causes of fragmentation in healthcare once admitted to hospital, patients are at increased risk for re-admission, increased length of stay and functional decline. Therefore, there is a pressing policy concern to devise and design the structural and organisational innovations to achieve more integration in healthcare delivery and so improve care delivery, patient experience and re-admission costs (Stein et al., 2016; Sims et al., 2015; Sun et al., 2014).

1.1. Local Context of the Project

Cambridgeshire and Peterborough Clinical Commissioning Group CPCCG (2014) state in their outcomes framework for elderly people that the NHS has historically focused on emphasising service inputs and attached processes but patients and their experience of these services have often been neglected. Thus, CPCCG believe that commissioning focused on adopting approaches to deliver coordinated care to elderly people is an appropriate way forward. Following a tendering process Cambridge and Peterborough Clinical Commissioning Groups (CPCCGs) commissioned the Uniting Care consortium to provide a range of services for older people adopting a joined-up services approach in early 2015. After Uniting Care withdrew from the contract in December 2015, services were contracted to Cambridgeshire and Peterborough Foundation Trust (CPFT).

To operationalise the aims of achieving integrated care delivery, 16 neighbourhood teams (NTs) were formed in autumn 2015 with new configurations of professionals working and functioning within these teams, including mental health nurses, occupational therapists, physiotherapists, community and district nurses and integrated care workers. Social care was aligned rather than amalgamated within this model and GP services continued as independent practices.

The aim of these NTs was to provide a wide range of services and support to patients and GP practices.

Each NT was to be provided with a base for the whole team to work from and, in order to ensure that NT members were able to spend more time with patients, they were to be provided with enhanced information technology (IT) that would allow them to work in an agile manner. It was deemed that this approach would not only improve patient care but would also prove to be cost effective.

Consultation with staff regarding the changes were made from April 2015, and then NTs were formed in October 2015.

NTs were expected to work closely with GPs, primary care, social care, and third and independent sector organisations in order to provide expert and responsive care and treatment. They were also expected to work in close collaboration with their integrated care team (ICT) which includes specialist services such as the speech and language therapy service, memory service, dietetics etc.

1.2. Analysis of the First Year of Implementation

This research project was established to make a detailed analysis of the first year of implementation of NTs from the perspective of staff, service managers and service users to ascertain what the key enablers and barriers are for establishing new models of care. Rather than an evaluation of the whole organisational restructure, the study aimed to focus on the processes of bringing different professionals from different disciplines to work in a more coordinated way and the challenges and opportunities involved in this process. In addition, the aim was to understand the way it affects, if at all, the nature of the delivery of care, what we can learn from it about integrated care more generally and what is required in terms of organisation and education to optimise this or similar change.

The study was funded by Health Education England Transformation Funds and Anglia Ruskin University Research Funding.

1.3. Project Synopsis

| | | |
|--------------------|---|--|
| Study Title | An Analysis of the Implementation of Integrated Care Teams In Cambridgeshire | |
| Study Design | Interpretive | |
| Study Participants | Executive and Senior NHS Managers in the Integrated Care services and Stakeholder Organisations; NT managers in Integrated Care services; NT members in Integrated Care services; Adults and Older People receiving services from the Integrated Care Teams in Cambridgeshire and Peterborough Social Care staff aligned with NTs | |
| Sample size | 10 Executive and Senior Staff 9 Team Managers 124 NT Staff 12 Patients and three carers 2 Social workers | |
| Study Period | July-September 2015: Pre-Study Period October – December 2015: Appointment of Research Team January 2016 – LREC and NHS Ethics Approvals January – April 2016: Phase One Data Collection and Interim Analysis May-September 2016: Phase Two Data Collection September/October – December 2016 – Analysis / Final Reporting | |
| | Study Objectives | Outcome Measures |
| Primary | To analyse the process of establishing and implementing integrated care via the newly formed integrated care teams within Cambridgeshire | Identification of strategic and operational enablers and/or barriers for system integration Insights into how the |

| | | |
|---------------|--|--|
| | <p>To identify the implications for workforce planning, education curricula, pedagogy and education commissioning of an Integrated Care system</p> | <p>socio-cultural elements of the new NTs and their professional identities may affect team dynamics and performance</p> <p>Proposals for curricula and education to support integrated working. Recommendations for pedagogic models consistent with supporting education for integrated workforce development.</p> |
| Secondary | <p>To analyse patient perspectives and experiences of these newly implemented models of care and whether they are experienced as integrated or different to other service models of care</p> | <p>Identification of how integrated care is defined and described by patients and which, if any, aspects of care are experienced as indicative of an integrated service</p> |
| Research Team | <p>Dr Anne Devlin – Chief Investigator</p> <p>Corrie Maxwell – Health Education East of England Lead</p> <p>Fiona Chatten - Project Manager</p> <p>Dr Atif Sawar and Dr Guy Shefer - Post Doctoral Research Fellows</p> <p>Elissa Harwood - Research Associate</p> <p>Matthew Pearson – Quality Improvement Fellow, Health Education East of England</p> | |

1.4. Key Messages from National and International Literature

A summary of key points from the comprehensive literature review is presented in this section re integrated care detailing initiatives nationally and internationally; why they are important at present and factors affecting their success in delivering holistic care.

1.4.1. Global Context

- Complex long-term conditions place pressure on most of the health budgets and is one of the most pressing health issues globally (Glasby, 2016; Lyngso et al., 2016; Kassianos et al., 2015; Goodwin et al., 2014).
- Since availability of informal care delivered by spouse or family is on decline, the number of old people living alone with complex conditions is on the rise (Wodchis et al., 2015; Anderson, 2011; Coyte, Goodwin and Laporte, 2008).
- Current healthcare systems around the world are designed to provide care for patients, adopting a single disease approach and this can lead to duplication or waste of resources when patients have more than one need (Barnett et al., 2012).

1.4.2. UK Context

- For 40 years, successive UK governments have attempted to integrate health care and social care. Whilst several policies and financial tools have been used, the output has been patchy (RCN, 2014).
- There are many reasons to this limited success such as varying values and culture of healthcare and social care, different funding and accountability procedures and regulatory protocols that measure their performance at an organisational level but not an a system level (Humphries, 2015).
- There are around 211 clinical commissioning groups responsible for commissioning acute and community health services. Whilst NHS England is responsible for commissioning primary care and specialist health provision, social care is commissioned separately by 152 independent local authorities (Barker, 2014).
- In the UK there are around 15 million people with one or more long term conditions and this number is believed to rise by at least a third over the next 10 years (Naylor et al., 2015)
- While changes in population demographics have led to increased costs for the NHS due to rising admission rates (Blunt et al., 2010), little has been done to devise suitable alternatives to prevent unnecessary admissions for elderly and frail patients (Bardsley et al., 2013).
- Finished consultant episodes rose by 39% between 2002/2 and 2012/3, the rise in finished consultant episodes was 51% for those aged between 65 and 74 and this rise was 61% for those aged 75 and above (Barker, 2014).
- Healthcare in UK suffering from internal and external fragmentation (Glasby, 2016; Kassianos et al., 2015) and commissioners are responsible for developing a sustainable healthcare system working in close collaboration with local authorities (Holder et al., 2015).
- Successive UK governments focusing on developing policies to achieve health and social care integration with limited progress (Humphries, 2015)

1.4.3. Integrated Care Approach

- An integrated approach can aid the quality of life for elderly and frail patients with long-term conditions (Curry et al., 2013; Johnson, 2009; Hofmarcher et al., 2007; Kodner and Spreeuwenberg, 2002) by
 - improving coordination between various health and social service providers (van Rensburg et al., 2016; Goodwin, 2013; Kodner, 2009; Lloyd and Wait, 2005) and

- delivering care in a cost effective manner (Wang et al., 2016; Evans et al., 2016; Glasby, 2016; Berwick et al., 2008, Kodner & Spreeuwenberg, 2002).
- Integration is a complex and multifaceted phenomenon (van Rensburg et al., 2016; Ashton, 2015; Leichsenring, 2012) and there is limited knowledge about key factors that aid its successful implementation across different contextual settings (Bardsley et al., 2013; Stewart et al., 2013; Low et al., 2011; Wodchis et al., 2015; Valentijn et al., 2013; Valentijn et al., 2015).
- Ambiguity remains around the meaning of the term ‘integrated care’ (Lloyd & Wait, 2005; Kodner, 2009; Goodwin, 2016; Kodner and Spreeuwenberg, 2002) and can be conceptualised in different ways (Johnson, 2009; Curry and Ham, 2010; Armitage et al., 2009; Goodwin et al., 2014; Goodwin and Alonso, 2014; Goodwin and Smith, 2012).
- Research on integrated care has shown factors such as leadership, organisational and professional culture, competent professional workforce, resources, and information technology, organisational management of change and innovation and organisational bureaucracy as of high relevance to determining success of integration initiatives (Evans et al., 2016; Miller, 2016; Busetto et al. 2016, Ling et al., 2012; Curry and Ham, 2010, Reeves et al., 2010)

1.4.4. Importance of professional integration

- Professional integration, i.e. improved relationships between health (physical and mental) and social care professionals are of high importance for smooth integration of services (Stein et al., 2016; Sims et al., 2015; Weaver et al., 2015; Fox & Reeves, 2015; Thistlewaite & Dallest, 2014; Reeves et al., 2010; Suter et al., 2009).
- Literature highlighting implementation of ‘Integrated Care’ initiatives suggest that there is need for health and social care professionals to change their practices, values and professional outlooks in order to provide efficient, integrated and holistic care to patients (Hickey, 2008; Suter et al., 2009; Williams & Sullivan, 2009; Nicholson et al., 2013; Sims et al., 2015; Weaver et al., 2015; RCP, 2012; Chreim et al., 2007).
- Inter-professional teamwork and effective leadership are of high importance to achieve integration (Rosen & Ham, 2008; Feachem & Sekhri, 2005).
- A number of research studies have also suggested that inter-professional teams experience challenges when working together (Mitchell et al., 2011).
- Professional identity can act as an enabler or a constraint to facilitating inter-professional teamwork and professional interactions (Mitchell et al., 2011; Fitzgerald & Teal, 2003; Van Dick et al., 2008).

1.4.5. Complexity of evaluating and studying integrated care initiatives

- However integration initiatives are complex activities and rarely run smoothly to its end (Leutz, 1999) and can also have unintended consequences for the integrated care (Rosen et al., 2011).

1.5. Absence of Empirical Research in the Following Areas

- what integrated care is and how it can be achieved (Shaw et al., 2011; Jones & Jones, 2011; Johnson, 2009; Kassianos et al., 2015);
- its impact on clinical outcomes and healthcare delivery (Winters et al., 2016; Rummery, 2009);
- cost efficiency (Naylor et al., 2015; Bardsley et al., 2013; Armitage et al., 2009; Mastellos et al., 2014) and

- operational detail of the process of integration (Sims et al., 2015; Thistlewaite & Dallest, 2014);
- impact on professionals working in an interprofessional environment (Fox & Reeves, 2015; Sims et al., 2015; Chesluk et al., 2012);
- impact on patient experience (Kassianos et al., 2015; RAND Europe, 2012)

This project addresses the latter 3 bullet points predominantly.

1.6. The Value and Contribution of this Research

There are various practical instantiations of integrated care across the globe which have been studied (see Curry and Ham, 2010; Addicott, 2014; Bardsley et al., 2013; Wodchis et al., 2015; Goodwin et al., 2014), however none of the study/evaluation is comprehensive enough to explore this phenomenon from several perspectives and dimensions, highlighting its complexity. Goodwin et al. (2014) highlighting two reasons for lack of robust evaluations contend, that whilst evaluation is a secondary concern for relevant parties as initiatives were not implemented to prove their effectiveness, it is also difficult to evaluate such complex initiatives and associate consequences or outcomes to specific actions or decisions.

Furthermore, the implications of such initiatives are deeply embedded in local context and therefore provides further challenge to theorists and policy makers when adopting evaluation or model from one context to another. Whilst the ultimate ambition is to develop a generalizable model/framework of integrated care, the first step in achieving this is to conduct further studies untangling aspects of local integrated care initiatives.

Best and colleagues (2012) argue that change implementation in healthcare is really tricky and difficult and such change models need significant resources and time to really get embedded. Bardsley et al (2013) argue that it is important to study development and implementation of initiative before evaluating it and one year of operation is not long enough to show results that may aid in evaluating it. After one year, evaluation can only reveal information about initial set-up and implementation of the intervention/initiative. Similar observations were made by Shaw and Levenson (2011) who when evaluating an integrated care initiative also concluded that at least two years are needed for initiative to produce results. They further argue that it is difficult to see results in terms of reduced admission rates or enhanced quality of care delivery within 2-3 years. Goodwin et al. (2012) contend that studying an initiative from day one is risky as interventions usually need more time to overcome barriers and challenges, Pawson and Tilley (2004) argue for the importance of both summative (technique to measure success of an intervention at its end or at a given point in time) and formative (a method to evaluate pilot and use feedback to develop pilot further and develop it further) evaluations.

Whilst this research is focused on studying the process of establishing and implementing the neighbourhood teams (Integrated care teams as these teams are responsible for delivering integrated care), it certainly falls under the formative evaluation category as the initiative itself is just over an year old. It also provides insights into integrated care within a specific local context and will feedback key findings to managers and other stakeholders to inform integrative change going forward within this and other systems.

2. Study Design

This was a qualitative study using non-participant observations, individual and focus group interviews and patient held audio-journals. There were three main sections to the study: NT staff, NT management executive managers and patients receiving care from the integrated services. Written informed consent was gained from all participants in accordance with the Ethics and RM&G approvals – see Appendix 1.

2.1. Team Selection Rationale

The fifteen NTs covering the region differ from each other across geographic, constitutive and functional dimensions of the study. For the purpose of this research, nine NTs were selected to be researched over two phases. The first cycle of data collection ran from February 2016 till June 2016 and the second cycle commenced in August 2016 and finished in October 2016. Our aim when deciding the sample was to select teams which are as diverse as possible in terms of being rural or urban, the professional background of the team manager, team size and the team's professional make-up, as well as current operational details and specifications.

2.1.1. Phase One data collection NTs

Six NTs were selected to be included in Phase One of the data collection. The table below shows the six chosen teams, their classification along the geographic patch covered and the professional background of the NT manager.

| NT Name/Code | Urban/Rural classification | Professional background of NT manager |
|--------------|----------------------------|---------------------------------------|
| RS1 | Urban | Mental Health |
| RS2 | Rural | Nurse |
| RS3 | Rural | Physiotherapist |
| RS4 | Urban | Nurse |
| RS5 | Urban | Nurse |
| RS6 | Rural | Occupational therapist |

RS – Research Site

2.1.2. Phase Two data collection NTs

Data collection and initial data analysis in Phase 1 highlighted two attributes of operational dimension, colocation and agile working, as playing a significant role in shaping the process of NT identity formation and day-to-day level functional effectiveness. In order to gain further insight into the implication of these dimensions on NT dynamics and delivery of care, three new NTs were included in Phase Two of data collection. These newly inducted NTs (RS7, RS8 and RS9) differed from the six NTs of Phase One as they were further along the journey of being colocated and implementing agile working initiatives. These three NTs, when taken in conjunction with the six NTs from Phase One, still presented a good mix along geographic dimension (urban/rural patch classification) and constitutive dimension (professional background of NT manager, NT size and make-up).

In addition to three new NTs, two NTs (RS4 and RS5) were selected from Phase One for a revisit as part of Phase Two of data collection. The reason behind re-selecting these two teams for purpose of

Phase Two data collection was their comparatively unique position in terms of their response to the new initiative of integrated working and associated organisational change. While all six NTs from Phase One were faced with the challenges one could expect with such change initiatives, these two NTs i.e. RS4 and RS5, exhibited a more skewed response (positive and negative respectively) as compared to a more balanced set of responses from the other four NTs.

| Phase Two data collection | | | | |
|---------------------------|----------------------------|---------------------------------------|---|------------------------------------|
| NT name/code | Urban/Rural classification | Professional background of NT manager | Colocation Status | Status of Agile Working initiative |
| RS3 | Urban | Nurse | Not colocated | |
| RS4 | Urban | Nurse | Not colocated with no clear plan or deadline regarding when it will happen | Not commenced |
| RS7 | Urban | OT | Colocated in single building, except for MH everyone is in same office as well. MH is based on a different floor in the same building at the moment | Impending |
| RS8 | Urban | | Colocated in same building | Impending |
| RS9 | Rural | Nurse | Colocated in same building | Piloting |

2.2. Frontline Staff Data collection

Data for this research was collected using focus groups interviews with NT members and semi-structured interviews with professionals from different backgrounds and at different hierarchical levels within the sector and by observation of NT meetings. Interviewees were selected from different units/specialisations working together in the new integrated care model, ensuring that every profession involved in the NT i.e. nursing, mental health, occupational therapy and physiotherapy, were represented either in focus groups or individual semi-structured interviews. In all, 142 health and social care professionals participated in the study via 95 individual interviews and 9 focus groups, 74 healthcare professionals, 2 social workers, 9 NT managers and 10 executives.

2.2.1. Focus groups

Focus group method was selected as it allows participants to express their experiences and insights and also provide them with a platform to reflect and react to opinions and those of other participants (Sargeant et al., 2008) without divorcing from the social context involving interaction with fellow colleagues. This process of reflection and sharing can result in the creation of a new understanding towards issues of importance and the process itself can be informative for professionals. Focus groups lasted from 45 to 60 minutes.

Due to time constraints, work commitments and spatial scattering of professionals, it often proved difficult to get an ideal mix of participants for a focus group across all research sites. Hence in some NTs (e.g. RS1 and RS2), focus groups did not have representatives from all involved professions. In

order to achieve consistency and reduce the impact of this imbalance, additional focus groups were conducted in some NTs (e.g. RS1) with professionals who did not take part in the first focus group activity. The gap left by the absence of some professions from focus groups was filled by semi-structured interviews.

2.2.2. Semi-structured interviews

Semi-structured interviews aid researchers in gathering valuable information by conversing with key personnel (Denzin and Lincoln, 2003; Denscombe, 1998), without compromising on control, capacity and the flexibility it provides (Harris & Ogbonna, 2002). Interviews were mainly conducted at NT bases and lasted anywhere from 60 to 80 minutes. They followed an interview guide that underwent some modifications between Phase 1 and 2.

Due to logistical problems when organising focus groups during phase one of data collection, only individual interviews were utilised in Phase Two.

Details of data collection episodes and participating professionals are presented below.

2.2.3. Data Collection during Phase 1

As mentioned earlier, six NTs were selected to be part of the first phase of data collection out of which two were also part of Phase Two data collection. Phase One data collection took place between the months of March 2016 and June 2016.

Below is a brief description of each of the six NTs that was researched during Phase One with details of team constitution and members that were either interviewed or were part of focus groups.

2.2.3.1. Research Site 1

This NT is attached to seven GP practices. The site is classified as urban and has a total workforce of 36 professionals. This team is managed by a band 7 Mental Health Practitioner.

We conducted a total of 7 individual interviews and 2 focus groups at this site. Data collection started with a focus group which had four participants representing therapy and mental health. The research team decided to organise another focus group at a later date with nursing profession representatives. The first focus group was followed by four individual interviews, two with Band 5 Nurses, one with a Band 5 OT and one with a Band 2 Health Care Assistant or Integrated Care Worker, who was working across both the mental health and nursing team.

This was followed by second focus group which had nine participants from nursing team, including a student nurse. The data collection was rounded off with final three interviews with a Band 5 Community Nurse, a Band 6 District Nurse and a Band 6 Occupational Therapy Specialist Practitioner.

The following table summarises the professionals with their band who were part of the study.

| RS1 | |
|---|--|
| Mode of data collection (number of participants) | Participants (profession and band) |
| Focus group 1 (4) | <ul style="list-style-type: none"> • Band 6 Specialist Practitioner Occupational Therapist • Band 5 Occupational Therapist • Band 4 Assistant Practitioner (Therapy) • Band 2 Integrated Care worker (Nurse/Mental Health) |
| Focus group 2 (9) | <ul style="list-style-type: none"> • 1x Band 6 Nurse • 1x Band 6 Specialist Practitioner – DN |

| | |
|---|--|
| | <ul style="list-style-type: none"> • 5x Band 5 Nurse • 1x Band 3 Integrated Care Workers – District Nurse Assistant • 1x Student Nurse |
| Individual semi-structured interviews (7) | <ul style="list-style-type: none"> • 1x Band 6 Specialist Practitioner District Nurse • 3x Band 5 Nurses • 1x Band 6 Specialist Practitioner Occupational Therapist • 1x Band 5 Occupational Therapist • 1x Band 2 Integrated Care worker (Nurse/Mental Health) |

2.2.3.2. Research Site 2

This NT is attached to 9 GP practices. The site is classified as Semi-Rural with a band 7 nurse as its NT manager. This NT has a workforce of 48 professionals and at the time of the interview different professionals were working in different locations.

We conducted one focus group and seven individual interviews. The focus group had 7 participants and except for one Band 3 therapy Integrated Support Worker (ISW), the other six participants were from nursing background. This was complemented with seven individual interviews with a Band 6 OT, a Band 2 Therapy Health Care Assistant (HCA-therapy), a Band 4 therapy assistant practitioner, a Band 3 therapy ISW, a Band 7 advanced mental health practitioner, a Band 6 mental health nurse and a Band 6 district nurse. The table below summarises the professionals with their band who were part of the study.

| RS2 | |
|--|---|
| Mode of data collection (number of participants) | Participants (profession and band) |
| Focus group 1 (7) | <ul style="list-style-type: none"> • 1x Band 3 Therapy Integrated Support Worker (ISW) • 1x Band 6 Nurse • 4x Band 5 Nurse • 1x Band 3 District Nurse Assistant |
| Individual semi-structured interviews (7) | <ul style="list-style-type: none"> • 1x Band 6 Occupational Therapist • 1x Band 2 Therapy Health Care Assistant • 1x Band 4 Therapy Assistant Practitioner • 1x Band 3 Therapy Integrated Support Worker (ISW) • 1x Band 7 Advanced Mental Health Practitioner • 1x Band 6 Mental Health Nurse • 1x Band 6 Nurse |

2.2.3.1. Research Site 3

This NT is attached to 6 GP practices. The site is classified as rural with staff members colocated on the same site but in different buildings. It had a total workforce of 43 professionals and the NT manager has a Physiotherapist background.

We conducted in RS3 one focus group and eight individual interviews. The focus group only had participants from the therapy profession, and the absence of other professions was made up for by conducting interviews with nursing and mental health professionals along with therapy professionals. The focus group was attended by four professionals i.e. two OTs and two Therapy

ICWs. Eight interviews were conducted with a Band 7 Community Matron, two Band 5 Nurses, a Band 6 Specialist Practitioner Nurse, a Band 6 Specialist Practitioner OT, a Band 7 Specialist Practitioner MH and two Band 4 Therapy Assistant Practitioners.

The table below summarises the professionals with their band who were part of the study.

| RS3 | |
|---|---|
| Mode of data collection (number of participants) | Participants (profession and band) |
| Focus group 1 (4) | <ul style="list-style-type: none"> • Band 7 Specialist Practitioner Occupational Therapist • Band 6 Occupational Therapist • Band 3 Integrated Care Worker (Therapy) • Band 2 Integrated Care worker (Therapy) |
| Individual semi-structured interviews (8) | <ul style="list-style-type: none"> • Band 6 Specialist Practitioner District Nurse • 2 x Band 5 Nurses • Band 6 Specialist Practitioner Occupational Therapist • 2 x Band 3 Integrated Care Worker (Therapy) • Band 7 Specialist Practitioner Mental Health • Band 7 Community Matron |

2.2.3.2. *Research Site 4*

This NT is attached to 7 GP practices and has a workforce of 47 professionals. It is classified as an urban site and is managed by a Band 7 Nurse.

During Phase One, we conducted two focus groups in RS4. One focus group had 9 participants with representation from nursing (including student nurse), physiotherapy and integrated care workers. The second focus group had seven participants, all of whom belonged to the nursing profession, including another student nurse.

Focus groups were followed by seven individual interviews. Interviews were conducted with two Integrated Care Workers, two Band 5 Nurses, a Band 6 Occupational Therapist, a Band 6 CPN and a Band 7 Advanced Mental Health Practitioner.

The following table summarises the professionals with their bands who were part of the study during Phase One of data collection.

| RS4 – Phase One | |
|--|---|
| Mode of data collection (number of participants) | Participants (profession and band) |
| Focus group 1 (7) | <ul style="list-style-type: none"> • 5x Band 5 Community Nurses • 1x Band 3 Integrated Care Worker • 1x Student Nurse |
| Focus group 2 (9) | <ul style="list-style-type: none"> • 1x Band 7 Physiotherapist • 1x Band 6 Specialist Practitioner – District Nurse • 1x Band 6 District Nurse • 3x Band 5 Nurse • 2x Band 3 ICWs • 1x Student Nurse |
| Individual semi-structured interviews (7) | <ul style="list-style-type: none"> • 1x Band 7 Mental Health Advance Practitioner • 1x Band 6 Specialist Practitioner (Mental Health Nurse) • 1x Band 6 Specialist Practitioner (Occupational Therapist) • 2x Band 5 Nurse • 2x Band 3 Integrated Care Workers |

This site was selected to be revisited during Phase Two of data collection. The aim was to assess the extent of change since the first phase of data collection. Two individual interviews were conducted with a Band 5 Nurse and a Band 6 Nurse. Interviews highlighted that not much has changed at the site since the first phase of data collection and hence the research team decided not to collect more data.

| RS4 – Phase Two | |
|--|---|
| Mode of data collection (number of participants) | Participants (profession and band) |
| Individual semi-structured interviews (2) | <p>1x Band 6 Nurse</p> <p>1x Band 5 Nurse</p> |

2.2.3.3. Research Site 5

This NT is attached to 6 GP practices and has a workforce of 45 professionals. It is classified as a rural site and is managed by a Band 7 Nurse.

One focus group and eleven individual interviews were conducted as part of Phase One data collection. It was a small focus group with only three Band 5 Nurses as participants. But this was compensated by eleven interviews which were conducted with a Band 7 Community Matron, three Band 6 District Nurses, two Band 5 Community Nurses, a Band 7 Occupational Therapist, a Band 7 Physiotherapist Advance Practitioner, a Band 5 MDT Coordinator, a Band 3 Mental Health Support Worker and a Band 2 Integrated Care Worker.

The following table summarises the professionals with their band who were part of the study during Phase One.

| RS5 – Phase One | |
|--|---|
| Mode of data collection (number of participants) | Participants (profession and band) |
| Focus group 1 (3) | <ul style="list-style-type: none"> • 3x Band 5 Community Nurses |
| Individual semi-structured interviews (11) | <ul style="list-style-type: none"> • 1x Band 7 Community Matron • 1x Band 7 Specialist Practitioner (Physiotherapist – Team Lead) • 1x Band 7 Specialist Practitioner (OT – Team Lead) • 3x Band 6 District Nurse • 2x Band 5 Community Nurse • 1x Band 5 MDT Coordinator • 1x Band 3 Mental Health Support Worker • 1x Band 2 Integrated Care Worker |

This was one of the two NTs which were selected to be revisited during Phase Two of data collection. The aim of revisiting this team was to measure the extent of change that team had gone since Phase One of data collection. Two interviews with a Band 6 District Nurse and a Band 5 Community Nurse were conducted as part of Phase Two data collection.

| RS5 (Cambridge City North) – Phase Two | |
|--|---|
| Mode of data collection (number of participants) | Participants (profession and band) |
| Individual semi-structured interviews (2) | <ul style="list-style-type: none"> • 1x Band 6 District Nurse • 1x Band 5 Community Nurse |

2.2.3.4. *Research Site 6*

This NT is attached to nine GP practices and has workforce of 30 professionals. It is classified as rural and is managed by a Band 7 Occupational Therapist. At the time of interview, the team was not colocated.

In order to collect data, we conducted one focus group and seven individual interviews. The focus group was attended by six participants which included one professional from a therapy background (a Band 6 Occupational Therapist) and the rest of the five participants were from the nursing profession. We interviewed one Band 7 Mental Health Advanced Practitioner, a Band 6 Mental Health Nurse (OT), a Band 6 Physiotherapist, a Band 6 District Nurse, a Band 7 Physiotherapist, a Band 7 Community Matron and a Band 5 Community Nurse.

The following table summarises the professionals with their band who were part of the study.

| RS6 | |
|--|---|
| Mode of data collection (number of participants) | Participants (profession and band) |
| Focus group 1 (6) | <ul style="list-style-type: none"> • 3x Band 5 Community Nurses • 1x Band 6 Occupational Therapist • 1x Band 4 Health Care Assistant (Nurse) • 1x Band 3 Health Care Assistant (Nurse) |
| Individual semi-structured interviews (7) | <ul style="list-style-type: none"> • 1x Band 7 Mental Health Advance Practitioner • 1x Band 7 Physiotherapist (Lead) • 1x Band 6 Physiotherapist • 1x Band 6 Mental Health Practitioner (Occupational Therapist) • 1x Band 7 Community Matron • 1x Band 6 District Nurse • 1x Band 5 Community Nurse |

2.2.4. Data Collection during Phase Two

Five NTs were selected to be part of the second phase of data collection, out of which two were revisits from Phase One (see above regarding RS4 and RS5). Phase Two data collection took place between August 2016 and October 2016. Below is a brief description of each of the three new NTs that was researched during Phase Two with details of team constitution and members interviewed.

2.2.4.1. Research Site 7

This team is attached to seven practices and is the biggest NT in terms of its over 65s population. We classified this team as an urban team. It was selected for Phase Two of data collection due to the progress it had made in terms of colocation, where at the time of data collection the whole NT was based in one single office except for the mental health team, who were based in the same building but on a different floor. This was also the team with the biggest number of staff members (67) and its manager had an occupational therapy background. As mentioned earlier, data was only collected by conducting individual semi-structured interviews.

In total six individual interviews were conducted with staff members: two Band 6 Occupational Therapists, a Band 5 Physiotherapist, a Band 6 Physiotherapist, a Band 7 Community Matron and a Band 7 Mental Health Practitioner (who was also attached to RS3 and thus was interviewed twice). A breakdown of research participants from this NT is given below:

| RS7 | |
|--|--|
| Mode of data collection (number of participants) | Participants (profession and band) |
| Individual semi-structured interviews (6) | <ul style="list-style-type: none"> • 1x Band 7 Community Matron • 1x Band 7 Specialist Practitioner (Mental Health) • 2x Band 6 Occupational Therapist • 1x Band 6 senior Physiotherapist • 1x Band 5 Physiotherapist |

2.2.4.2. Research Site 8

This team is attached to five practices and is classified as an urban team. It was selected for Phase Two of data collection due to the progress it had made in terms of colocation, where the whole NT

was colocated at the time of data collection. A breakdown of research participants from this NT follows:

| RS8 | |
|--|---|
| Mode of data collection (number of participants) | Participants (profession and band) |
| Individual semi-structured interviews (10) | <ul style="list-style-type: none"> • 1 x Band 7 Community Matron • 2 x Band 6 District Nurses, • 1x Band 5 Community Nurse • 1 x Band 3 Nursing Health Care Assistant • 1 x Band 7 Mental Health Advance Practitioner • 1 x Band 7 Occupational Therapist (complex house OT) • 1 x Band 7 Physiotherapist • 1 x Band 6 Occupational Therapist • 1 x Band 5 MDT coordinator |

In total, 10 interviews were conducted with a Band 7 Community Matron, two Band 6 District Nurses, a Band 5 Community Nurse, a Band 3 Nursing Health Care Assistant, a Band 7 Mental Health Advance Practitioner, a Band 7 Occupational Therapist (complex house OT), a Band 7 Physiotherapist, a Band 6 Occupational Therapist and a Band 5 MDT Coordinator.

2.2.4.3. *Research Site 9*

This site was attached to four practices and was classified as rural. It was selected for Phase Two of data collection because this team was already colocated in the same offices, because it was also a pilot site for new technology (agile working initiative) and for trail-blazing the complex case multi-disciplinary weekly meetings. The team had a workforce made of 61 professionals including a team manager with a nursing background.

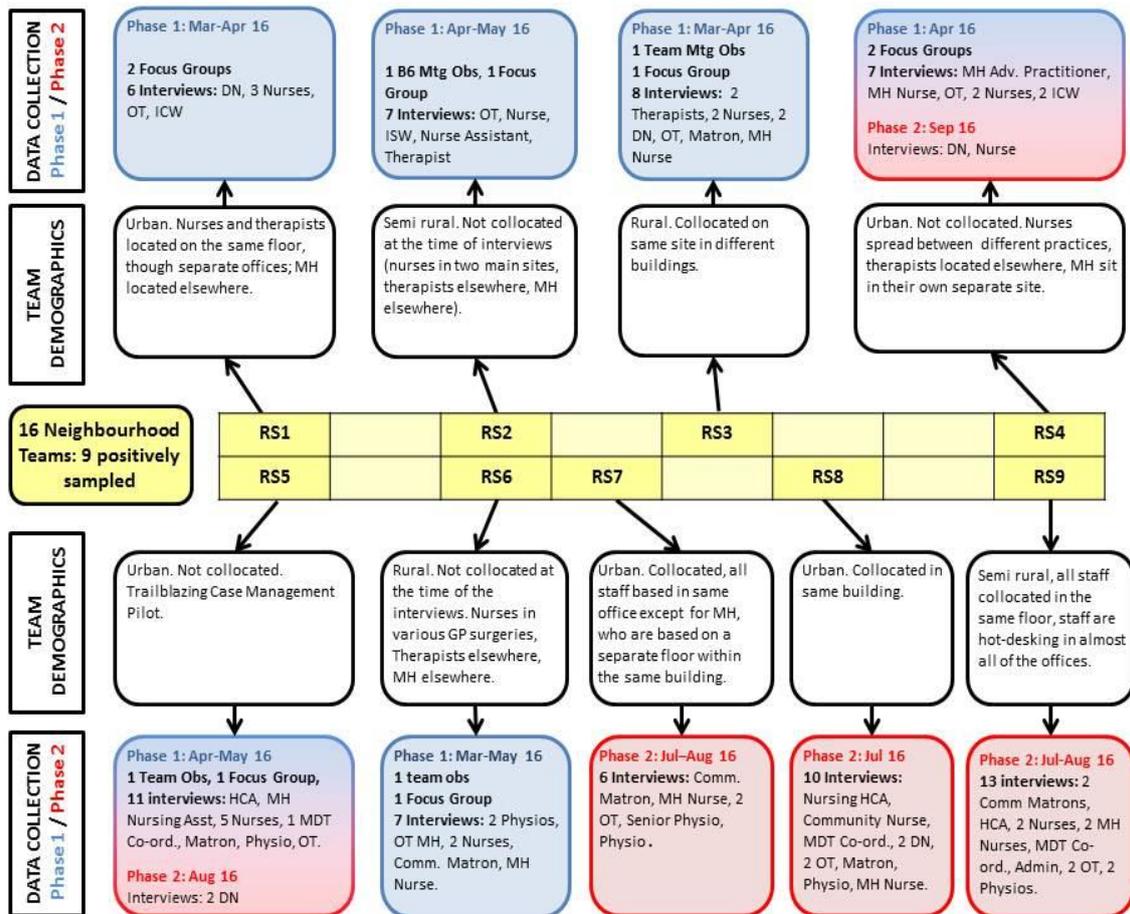
In total, 13 interviews were conducted. Interviews were conducted with two Band 7 Community Matrons, one Band 4 Associate Practitioner (Nurse), one Band 6 Community Nurse, one Band 5 Community Staff Nurse, one Band 7 Advanced Practitioner Mental Health, one Band 5 Mental Health Practitioner, an MDT Coordinator, a Band 4 Senior Administrator, a Band 7 Physiotherapy Team Leader, a Band 7 OT Team Leader, a Band 6 OT and a Band 6 Physiotherapist. A breakdown of research participants from this NT is given below:

| RS9 | |
|--|--|
| Mode of data collection (number of participants) | Participants (profession and band) |
| Individual semi-structured interviews (13) | <ul style="list-style-type: none"> • 2x Band 7 Community Matron • 1x Band 4 Associate Practitioner (Nurse) • 1x Band 7 Physiotherapy Team Leader • 1x Band 6 Physiotherapist • 1x MDT Coordinator • 1x Senior Admin • 1x Band 6 Community Nurse • 1x Band 5 Community Staff Nurse • 1x Band 7 Occupational Therapist Team Lead • 1x Band 6 Occupational Therapist • 1x Band 7 Advanced Practitioner Mental Health • 1x Band 5 Mental Health Practitioner |

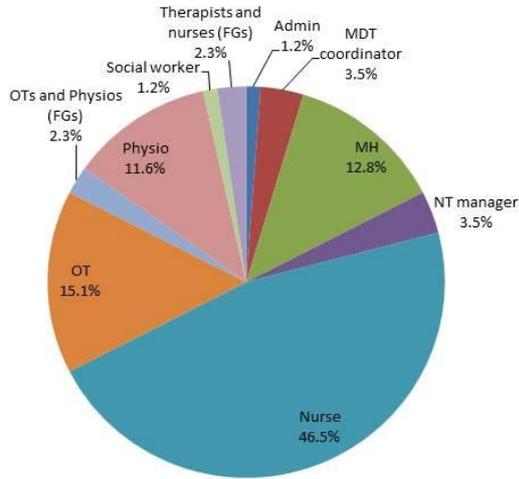
2.2.5. Diagrammatic representation of data collection episodes with frontline staff

Diagrammatic representations of the data collection episodes follow, highlighting their breakdown in terms of data collection method (interview or focus group), in terms of professional background of interviewees, location of NT and by gender.

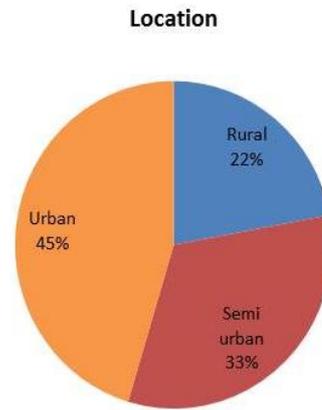
2.2.5.1. NT Phases 1 & 2 Data Collection Summary



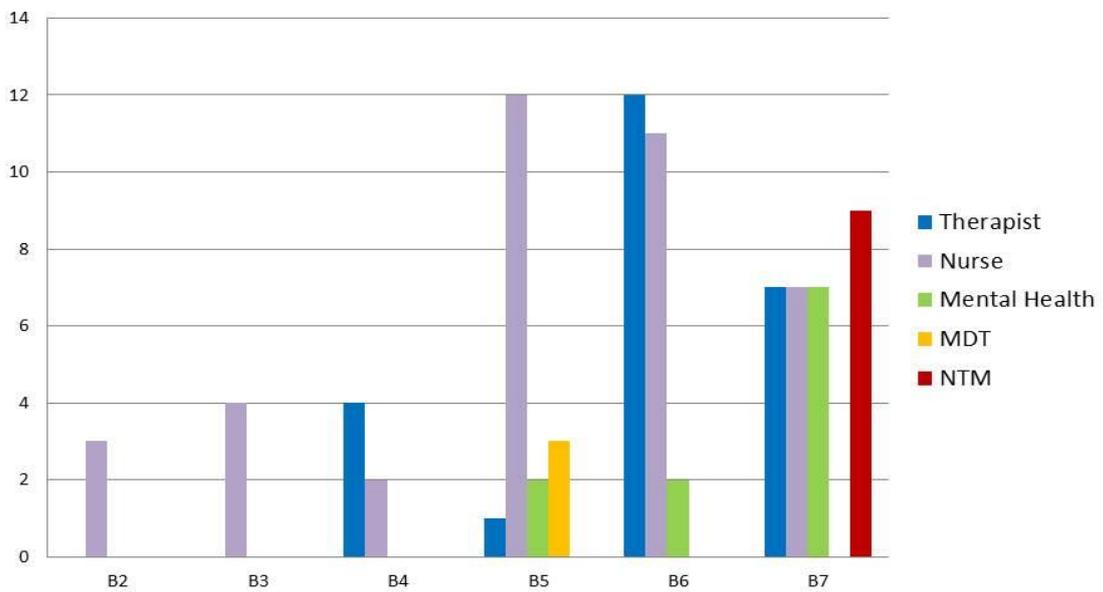
Data Collection Episodes by Profession



Data Collection Episodes: Location



Interviews by Band and Profession



2.3. Patient Data Collection

2.3.1. Recruitment

Patient recruitment commenced in April 2016 via invitation from NT staff already involved in the project. This was required by LREC as it allowed staff to screen patients for eligibility prior to invitation and protected them from undue pressure to participate. Over 300 invitation packs were distributed to staff by the research team and to patients using different methods by the end of July 2016. Nevertheless, patient recruitment proved to be a challenge.

2.3.2. Responses

At the close of the study, 15 patients had been recruited. A number of carers requested participation in the study and therefore an amendment was sent to LREC in September 2016 to expand recruitment to include carers.

Patients are being individually interviewed and if agreeable, provided with audio (written) journals to keep over a one year period.

2.4. Management Staff Data Collection

Interviews were held with all nine of the NTs managers, two of which took part in the second phase of data collection, six months after the first, to examine how things had changed in the intervening period. 10 interviews also took place with senior level managers throughout CPFT and a further one in Social Services. Managers of all levels were recruited via written invitation by the project team.

2.5. Data Analysis

All interviews were recorded and transcribed verbatim. Thematic analysis using NVivo and Atlas Ti software were utilised to manage the large corpus of qualitative text. Given the time scale of the project and in line with common practice in qualitative analysis, we started the analysis process relatively early, soon after starting the data collection, but kept on modifying it as required. After conducting 10 interviews, to increase rigour and validity, four members of the teams read through several transcripts each, and each of them was asked to suggest a coding tree made of codes and sub-codes that would capture the content of these transcripts and collate quotations of the same topic. The suggested coding trees were quite similar to each other with the main differences being the level of code 'resolution' required (how general or specific the codes should be). It was initially agreed that given the number of different coders (three of the team members did most of the coding work), the 'resolution' of the coding tree could not be over detailed. Accordingly, we agreed a list of 35 codes with 11 of them having lists of sub-codes (overall 61 sub-codes).

After conducting 22 interviews and coding them (i.e. indexing quotations to the relevant code which represented specific themes or specific aspects of the NT life), discussion within the project team led to the development and addition of some more codes and sub-codes in order to capture the numerous aspects of the implementation and working of the new integrated care initiative and its impact on staff. We developed eight more codes and 38 more sub-codes were added to the original list. One of the coders then read through the transcripts and reassigned quotations to the new codes and sub codes as required.

Two more similar expansions of the coding tree (including reading of all the transcripts and re-assigning quotations to new codes) followed the second phase of data collection to reflect the fact that we somewhat modified our interview script for this stage (based on our first phase of data collection as mentioned in data collection section) and also some differences between the NTs and their approach to the move. In the end, we had 53 main codes, out of which 24 had (overall) 218

sub-codes (or sub-sub-codes). This iterative process allowed the researchers to develop a detailed, critical but also progressive understanding of the data, (Jones & Jones, 2011). Emerging themes were identified in relation to the primary and secondary research questions and compared with contemporary published research findings. The following section represents the key findings arising from this analysis.

3. Key Findings

3.1. Interprofessional engagement in the first year of integrated neighbourhood team (NTs) implementation

The majority of the respondents (n=81) indicated that the formation of the NTs in October 2015 had had some positive and less positive effects on their interprofessional relationships and on some aspects of how care provision was organised and delivered in their view. It is worth noting however that the staff's experience of implementing integrated care via NTs was not uniform across the nine NTs studied or necessarily similar between the three key professional grouping within the NT, i.e. nurses, therapists and mental health (MH) professionals.

- 77 comments from 36 staff across the nine NTs indicated a positive impact from the new NT on enhanced inter-professional contact. About one-third of these respondents worked in teams that had already colocated at the time of the interview.
- 52 comments from 50 staff indicated there was little or no change in their professional practices or inter-professional work since moving to the NTs.

The project reinforced what is already understood from various national and international studies, i.e. professional role identity, culture and hierarchy pose potential barriers to integrated team working (Mitchell et al., 2011; Fitzgerald & Teal, 2003; Van Dick et al., 2008; Chreim et al., 2007; Stein, 2016; Humphries, 2015; Evans et al., 2016; Miller, 2016; Busetto et al. 2016, Ling et al., 2012; Curry and Ham, 2010, Reeves et al., 2010)

Given how frequently these themes emerged in the data, acknowledging and managing them should not be underestimated within any strategy for establishing new and/or integrated models of working. There were several key factors within the NTs studied that illustrated how complex and at the same time embedded within professional services, cultural and professional differences were and are likely to be within health and social care teams (Evans et al., 2016; Miller, 2016; Busetto et al. 2016, Ling et al., 2012; Curry and Ham, 2010, Reeves et al., 2010). The factors observed in nursing, therapy and mental health professionals within the NTs studied were:

- variations in their understandings of each other's roles
- differences in the number and pattern of contacts between them
- perceived and actual inequities within the NT and workloads
- mixed focus and models of care provision

3.2. Role perception and interface within the NT

53 respondents claimed to have some or a good understanding of the professional responsibilities of other health and social care professionals, although a greater number of nurses and therapists reported knowing more about each other's work and having contact with each other than either understood about the mental health field. Similarly nurses and therapists reported larger numbers of contact with each other than either had with mental health workers.

- 20 comments referred to an increased contact between nurses and therapists while only 12 noted increased contact between nurses and mental health and 9 between therapists and MH professionals.
- Conversely limited contact was also noted and commented upon more frequently, with 43 respondents suggesting limited or no contact between physical and mental health professionals, 29 respondents (39 responses) indicating there was limited interaction between nurses and MH professionals and 10 respondents suggesting interaction between therapists and MH professionals was minimal if achieved at all.

That professionals need to understand the expertise and potential contribution from others within their team to support integrated patient health outcomes and that limited engagement/contact with each other is unlikely to facilitate this is self-evident. It may be that easier understanding and integration between professional groups is achieved where those professionals share and understand aspects and indeed specific goals linked with patient pathways seen more readily in the NTs between nurses and therapists, and are less able to integrate around specific specialist clinical fields, e.g. the acute mental health scenarios that represent the main work of the MH professionals within the NTs studied. Support for this conclusion resides in a range of national and international evaluations of integrated care models which have identified that most success is seen where the integrated care focuses upon specific patient pathways, e.g. integrated diabetes care, as the integrated team members tend to focus on their shared specialist knowledge of diabetes, rather than their original professional role designation.

Clearly limited understanding of each other's expertise and potential for care inputs is a barrier to integrated care services and in addition to limited and/or variable mutual contact, a couple of other contributory factors appeared pertinent within the NT model established in Cambridgeshire. One of these related to individuals' concerns re their clinical competency in less familiar fields.

3.3. Professional role competency, accountability and community

While 33 respondents welcomed the idea of overlapping of professional roles, albeit conditional on appropriate additional training, 37 respondents from the 9 NTs and all professional backgrounds suggested that 'blurring' professional boundaries could be problematic in terms of competency and professional accountability. Likewise some professionals were cautious about accepting/performing tasks that were not covered by their mandated job specifications due to concerns re displacement of where official responsibility lies.

Professional accountability and competency aligned for MH team members with professional supervision which they perceived as less within the NT team. Data indicated that while some mental health professionals embraced the NT model and made an effort to work and engage with other professionals, others were more reluctant to replace their previous wider network of MH support with the NT environment. In two of the NT teams studied, MH staff were particularly reluctant to move to a shared base with the rest of the team.

Q: "How do staff feel about moving into that? Coming out of here, where you are all mental health, and moving into a base where there are a lot of other professionals....?"

A: "Apprehensive I think is probably the biggest feeling people have. You know when they meet individual team members everybody is very nice and we are all you know good communicators and welcoming etc. ..., we have a lot of concerns because from mental health we had a lot of really good clinical governance structures that have existed and we have worked to keep ..., I think we are

generally very good at supporting each other and working together so one of people's biggest fear is that we lose that that gets diluted and so for us its quite a challenge to integrate but maintain mental health as a speciality to the quality that I think we have had previously.” - MH staff member S11

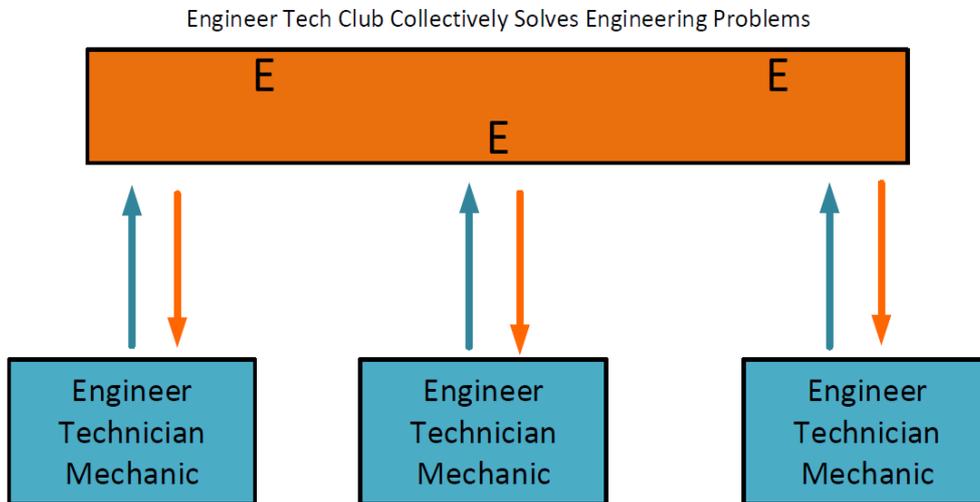
“... and I think there have been there have been sometimes when I have for a whole day it has just been me which is has been a bit daunting at times but [...] part of the challenge has been recognising that there is support available you are just accessing it in a different way [...] one of the adult nurses who is not mental health I actually had a chat about an issue and it was helpful that she was there and she listened and actually she was able to provide, not it wasn't advice about what to do but actually just sort of reinforcing some of the thoughts that I had been having and just about the general challenges of dealing with families” - MH staff member S110.

An important challenge to establishing integrated working within the NTs was that nurses comprised at least 50 per cent of the workforce as the larger professional group within each NT outweighed the other professional groups numerically and culturally in terms of working practices, hierarchy and even the operational management of their work. Non nursing respondents missed the higher level of support from the larger profession specific teams inhabited prior to the change and criticised the NT model for disrupting this. Some maintained that the smaller nursing dominated NT had not only displaced their profession-specific peer support networks emerging from their shared expertise but presented practical operational problems such as finding cover for annual leave or sick leave etc.

In his study of the Daimler-Chrysler car platform Wenger observed a similar situation to that noted in the NTs where vertical and horizontal integration of expert groups was required for efficiency and observed how this was achieved. The operational group, which equates with the individual NT described in this study, worked within departments staffed by technicians, engineers, mechanics etc., whose role it was to collaborate in order to design cars. However each departmental operational group had their own engineers who in addition to working with their design and mechanic colleagues formed a cross-departmental engineers' tech club to solve engineering problems.

DAIMLER-CHRYSLER CAR PLATFORM

Wenger 2004



Operational Group Design Cars

The benefits of forming their own community of practice of engineers included sharing problems, finding faster and better solutions, generating standardised approaches, technical databases, taking risks with the support of the community, liaising with manufacturers to find the most effective products as well as generating a sense of belonging, which can be particularly important in changing and/or uncertain worlds and generating interest and energy together (Wenger, et al., 2002).

We would recommend building resilience into the smaller professional groups/teams within the workforce by encouraging their communities of practice or integrated teams to engage with focused problem solving that uses their expertise to address challenges to care that may be resolved more effectively by taking an integrated approach, and also recognising where specialist intervention reflects the patient/service user needs more effectively-in other words we are suggesting a selective approach to utilising integrated models of care where they are likely to have most impact, rather than approaching integration as a generic idea of principle.

3.4. 'Nurses and the Rest': perceived inequities within the NT

The previous section has highlighted some feelings of marginalisation within the smaller professional teams because of the dominance of nursing within the NT. This had led to a perception that integration was centred around nursing in a way that didn't quite reflect the original intention of the change, e.g. non nursing healthcare professionals deemed that the IT systems (both the number of desktops and the tablet and technical efficiency) suited to the needs of the nurses more than their own, although they did acknowledge that adjustments are being made to improve the suitability of the IT systems to non-nursing professionals. Conversely, caseload numbers and patient visits per day were higher within the nursing group, creating potential tension within the teams and a sense of unfairness in how work was distributed/experienced.

11 respondents said their 'patch size' had increased, predominantly within 2 NTs, while 6 remained the same and 5 reduced. This combined with a change in previously existing support services, e.g. 'Hospital at Home', and some staff vacancies contributed to an atmosphere of needing to 'get the job done' with limited 'space' to address the requirements of this change

Nurses in particular suggested that due to high workload they had less time for 'integration' activities; whether formal (NT meetings) or informal (corridor or office conversations).

3.5. The influence of infrastructure, systems and facilitative staff engagement in enabling integration

Infrastructure and operational facilities such as common/shared office space, and common IT systems were deemed by the majority of the respondents as key factors essential to integrated care delivery and successful implementation of NTs

3.5.1. Co-location

Co-location was the most cited factor in our data, deemed as key to integrated working and appeared 412 times in the transcribed interviews and focus groups. Undoubtedly staff at all levels (including NT managers and senior managers) believed that colocation was an important factor for improved multi-disciplinary and inter-professional working. 36 respondents explicitly cited colocation as a factor that had already made a positive change to their work practices or potential to improve things

"Yes I think it has, I think since we have actually relocated to these buildings, rooms above, and we are now with the nurses, with the adult care teams, JET and the like whatever, we are now beginning to talk to each other and more face to face shall we say." - S120

Staff explained that colocation created opportunities for healthcare professionals to see each other and discuss patients (formally and informally), made it easy to stimulate discussion and seek professional support and understand each other's professional responsibilities and expertise.

"I think the neighbourhood team I must say is much better because everyone is here now, OTs, physios, mental health team, actually they usually sit in this office, they are all here, actually I can talk to them rather than call them ... sometimes it is very difficult to actually get hold of them ... It is very handy to have somebody sitting here you can ask for advice, a lot of the times I don't actually need a referral at all, I just need to speak to OT or physio to see their input and then I can actually I don't actually need them." - S109

"OK so one positive about the neighbourhood team, I like everybody I like the accessibility I suppose you can walk over and speak to somebody whereas often perhaps you would have to leave a message and hope that somebody would get back to you, so I like the networking aspect of it." - S70

Similarly, absence of colocation was considered to be a key factor hindering inter-professional and multidisciplinary working with 21 respondents (30 comments) suggesting that the absence of colocation affected their sense of being part of the NT and was a major obstacle to achieving full integration when delivering care.

There was not always a consensus about how colocation is achieved, e.g. in the same office, same floor, or same building. Professionals in some NTs who complained about not being officially colocated, nevertheless were based within walking distance of each other, either in the same building (and often on same floor) or on the same site. Close proximity was not always enough to facilitate closer working between NT members, but for most respondents it was central to successful integration.

3.5.2. Formal (NT and sub-team meetings) and Informal interaction

Increased multi-disciplinary contact is partially a result of NT meetings and other formal sub-team meetings that allowed staff to meet to discuss not only clinical aspects of their work but also provide collegial support to each other, although there was a tendency for these to focus on NT organisational business rather than service or care provision, a lost opportunity for formal exposure to issues linked with moving to integrated services/care. Professionals complained about the lack of formal measures taken to facilitate inter-professional contact, specifically highlighting the absence of systematic formal changes to areas they felt were critical to providing an integrated service, e.g. referral systems between health care professionals.

Increased informal contact (daily or several times a week) between professionals, i.e. in corridors, kitchen or shared office space were mainly reported in NTs which were colocated. In the teams that were not yet colocated, some NT managers had taken initiatives to facilitate inter-professional and multidisciplinary working by organising formal meetings between senior healthcare professionals (band 6 and 7), by introducing the concept of 'buddies' where a healthcare professional is partnered with a professional holding a different role and facilitating healthcare professionals to initiate contact with each other informally.

The organisational or leadership strategies that made 'space' for and facilitated contact across profession-specific team members were seen as an enabler supportive of moving toward some aspects of integrated service. However, the IT systems and physical resources described below were perceived as unhelpful and therefore potential barriers.

3.5.3. IT systems and other facilities

Of the 56 respondents who highlighted the problem of inadequate IT facilities for integrated working, the majority cited not being able to share patient records as a barrier to achieving integration. Disappointed expectations may have played a part in the strength of feeling apparent within staff groups, as Uniting Care in their original plans had cited a system called *"One View" [that] will bring together summaries of all the different records held by the various health and social care providers about one person, creating a single view of the whole patient record"* (Uniting Care document). However, at the time of the interviews nurses and therapists used the 'System One' IT system while MH had 'Rio'. As the systems did not communicate with each other record sharing with consequent inter-professional working was hindered. Furthermore, mental health patient confidentiality and information governance protocols made it impossible to freely share mental healthcare records of patients with others including social care professionals.

Resources such as on-site computers, office space and telephones were seen as inadequate by the teams presenting practical problems associated with administrative work, especially for therapists and mental health professionals as they appeared to spend comparatively more time on the system, writing patient reports.

3.5.4. Agile Working

This new initiative at first sight would appear to address some of the resourcing issues discussed above. It enabled professionals to update patient records and perform other administrative duties electronically without having to touch base physically by using smart devices such as tablet or I-Phones as well as manage their travel more effectively. In the one team piloting this, 19 respondents, mainly nurses, deemed it a positive change that would facilitate them to increase their efficiency. Some staff, especially those who worked in teams who did not use agile working as yet, were worried that it was inconsistent with the aim of increased integrated working as it encouraged professionals to work remotely.

“ ..., I can't wait to get the iPads so that I don't have to do six continuation sheets and then repeat it on SystemOne ... you know to have it all in one place would be fantastic and also to have the time then and you not having to come back to the office to do it but then that is the whole thing, you are not going to come back to the office, because we are not actually going to come back to the office so it's a catch 22. Yes it's great because it's going to help us and free up some time and you are not having to repeat yourself with paperwork but with the same breath you are then not working with other people.” - S21

“I know that there is a drive towards us doing more work from home and being in the office less which is a concern for supporting each other as therapists - we always come back to the office and ask questions, run through cases because our work is so varied and we are spending thousands of pounds we need to make sure what we are doing is right, and there is a risk that we won't have that opportunity because we won't be in the office as much, so people will just be making their own decisions hoping it is the right one or waiting until they can talk to someone in which case there will be a delay for the patient.” - S41

Overall, the data would indicate that formalised exposure and proximity is conducive with the shared role insight likely to support integrated care provision and shared decision making. Consideration should be given to if and how well infrastructure supports this agenda and the impact and consequences of various initiatives within the overarching integrative strategy, e.g. where one new initiatives such as 'Agile Working' resolves space and resourcing issues but may impact on formalised interprofessional exposure and networking.

3.6. Leadership and Management Culture

There were 21 interviews with managers. 10 were with managers in various senior team roles, the remaining interviews were conducted with the NT managers.

3.6.1. NT Vision and Clinical Model

There was a consistent belief that the vision of the neighbourhood team was the right clinical model. The Neighbourhood Team Model from the management perspective was overwhelmingly positive, despite the fact that the majority of managers had no involvement or influence over designing the model or structures to deliver it.

One senior manager expressed “ I don't think anyone has questioned that the model is the right way to go...we are an integrated directorate” another said “ the clinical model is the right model I evangelically believe that”. This was also reflected in the NT managers view point, one said “ I don't think I could do the job if I didn't believe that the end product worthy or worth working towards”. Another said “ I think the neighbourhood team model is sensible and good”

NT managers described a positive appreciation of the expertise and professionalism across the physical and mental health teams but many felt the volume of patients requiring both mental and physical health joint case working was not in reality what the original model anticipated. Most could identify that the model could see an improvement in shared understanding between mental and physical health professionals as the model offered the opportunity to increase exposure between the two perspectives. This was captured by one statement from a NT manager

“The cross over is a bit less because they (MH) are quite narrow in who they will see, but having them attend the meetings and discuss cases with us gives us a different perspective and I think that has been quite enlightening to a lot of staff about what they do”

Many managers articulated that shared problem solving which crossed professional and sector boundaries was a positive aspect of the vision and although the number of jointly worked cases between mental health and physical may be small having the opportunity to discuss and solve patient care problems would and was having a positive impact on how the teams worked together, especially within therapy and nursing. This was captured by one NT manager

“ There has been some really good examples of joint visits as well which they will come back and they’ll explain about the mental health nurse that’s been out with the district nurse for somebody who they are worried about dementia and that had a really good outcome, they came back bubbling with it, so that to me says its working”

This activity was perceived to minimise the infrastructural barriers. One NT manager described an example of this *“ The strength of being able to walk down the corridor and knock on your mental health door and say “right I need to talk about this person” without doing a referral that would be brilliant.”*

Case management was seen as a fundamental concept to the integrated vision. One NT manager expressed it succinctly by saying *“integration won’t work unless we look at case management”*. However overall there were three main reasons for a lack of confidence in its potential to be effective. The reasons expressed were:

- The approach to implementing case management was viewed as being unstructured and inconsistent around both method and tools. This was expressed by one NT manager *“ The problem is that meetings are somewhat ad-hoc not in the time or the people represented there but in the way we case manage because its practitioners bringing their cases to the table we don’t have a structured case management model which would be invaluable” A senior manager said” We cannot get any case finding methodology in place and that is a big gap”*
- The evidence base which underpinned the original decisions for the case management model was questionable. This is illustrated by two senior managers, one said *“ under the UC model case management was envisaged at 15% , now nowhere else is doing 15% that is just made up, somebody just made that up, you can see them sitting in a room and thinking oh I have to earn my money we will make it 15% rather than just 2.5%”* The other said *“ even now we are looking at things like case management with a view to decreasing emergency admissions improving care at home but the evidence on case management broadly for older people that are selected is there and it doesn’t work”*
- The original model called for a significant increase in workforce to deliver the vision and that was no longer available. One NT manager described this situation as *“ Part of that contract (UC) is to do this case management, this case finding all of this extra work but obviously now we don’t have the extra bodies on the ground floor to do that”*. When discussing the long term view for case management a senior manager put it more dramatically *“ We are working out this case management model with social care and the voluntary sector so those discussions are going really well but what I know will happen next is we are doing a separate piece of work around productivity to try and work out do we have slack in our system. If we don’t have slack we are doomed”*

Towards the end of the study there was some positive benefit around relationship and team building being reported from the case management early implementer sites. However there was still a firm

belief that more evaluation and research around patient outcomes would be required to be confident around impact.

3.6.2. Delegated Authority

A consistently recurring theme from a manager's perspective was that integrated teams required an authority to make decisions locally. However, managers from neighbourhood teams expressed a sense of powerlessness to make those decisions. There were many reasons offered for the sense of disempowerment.

NT managers described a feeling of incredible responsibility within the role but a lack of authority to design and apply their own solutions. A 'Top Down' decision making culture was experienced as restrictive to teams wanting to change things in response to local issues. There were a minority of NT managers who did not feel this restriction but in the main there was a significant theme of "hands being tied", "no control" "hierarchy" and "loss of flexibility". One NT manager described integration as *"a freedom to grow. A freedom to look outside the box and I don't think we have that here"*. Another described a top down decision making process by saying:

"Often they [the team] will come to me and say 'why can't we do this?' and I have to take it up the chain and get told 'no' and then it comes back to me to take it down".

Another reason for the sense of disempowerment which emerged through the data from both NT managers and managers in a more senior role was a fear of making mistakes. One NT manager articulated this by saying:

"I have noticed the worry about doing things wrong, about making mistakes and not taking risks and I think when you are working in an integrated way you have to take risks and ...learn from mistakes"

Another NT manager described senior clinicians coming and expressing that:

"I no longer know what I am allowed to do and what I am not allowed to do".

However the reasons for the restrictions on the NT managers decision making autonomy was not rooted in a poor opinion of the NT manager's abilities or performance. In fact there was overwhelming evidence that the senior managers held the NT managers in extremely high regard. One senior manager expressed "I think they are extraordinary"; another said "I think they are doing a brilliant job". There was also a strong desire and recognition from the NT managers that they needed and wanted to take the authority to make the decisions to achieve integration, but only a very few managers felt that the current conditions enabled them to do so.

What clearly emerged from the data was that senior managers also recognised that the hierarchy of decision making was disempowering staff and NT managers. As one senior manager articulated it:

"...that it's the staff on the ground who have the GP saying to them 'you have to take these five patients' and they are having to say 'well I will have to talk to my manager'"

Another expressed:

"I think for our NT managers there is a little bit of uncertainty about who is doing what. The NT managers need to rely on their senior managers for their expertise and knowledge about how to manage that resource but without them actually just taking over, so it is still not a comfortable fit"

Senior managers were able to recognise a paternalistic decision making culture, which was captured by reflective statements from both a senior manager and a NT manager. The senior manager asked *“when does mummy stop holding them so tight?”* and the NT manager recognised that *“it was almost like I was waiting for approval ‘is it ok if?’ Rather than it is in my power”*.

So although there was positive regard, willingness and awareness there was still an absence of delegated authority behaviours and this is a barrier to integrated care.

3.6.3. Collective Approach – organisational level

There is a consistent and strong expression of an absence of shared identity at organisational level with deep division in how the physical and mental health characteristics are perceived within the new personality of the organisation. Managers describe a dynamic of “separateness” and “lack of understanding” between the two cultures. This came from both sides of the organisational experience at practitioner, manager and divisional level. There were expressions of injustice between both communities of practice about the amount of focus and understanding the other received. This is illustrated by two senior managers from opposite perspectives:

“It’s galling to hear ‘oh nobody thinks about physical health’ and I think well actually in our directorate nobody thinks about mental health”

The other expressed:

“...this fluffy stuff, the candle waving stuff around people with mental health, you have a cosy visit and maybe write it up two a day and I think that will bring tension... you have to have equity of work-load”.

There was also a sense that the identity at Board level was still very much a mental health organisation identity. *“What is this directorate’s (Integrated Care Directorate) real fit in this organisation?”* one senior manager expressed; *“so the Board is still focussing on mental health....but there is a lot that isn’t mental health and that needs addressing”* said another. There was recognition that integrating mental and physical health was probably progressing faster at team level than at organisation level.

3.6.4. Collective Approach – system level

The ability to cross professional, organisational or sector boundaries towards a shared objective was a key theme from the manager data. The managers acknowledged that a shared commitment to solving integration issues was critical in enabling integrated care and that responsibility needed to transcend professional, organisational, commissioning and sector boundaries. But as one manager put it there was still no “single truth” across agencies. The need for but the absence of a collective or shared integrated culture was strongly expressed in the data. This was expressed regarding Primary Care, Local Authority, Clinical Commissioning Groups (CCG) and inter-organisationally.

Managers expressed friction associated with the relationship with General Practice. Some explained that as having been damaged by the fact that GPs were *“sold Utopia”* in the Uniting Care model and that they were *“promised a lot of things that were never delivered”*. This has now put a strain on the partnerships within General Practice. Staff in NTs expressed that GPs were discontent about nursing staff and MDT co-ordinators leaving their primary care bases. Managers acknowledged that this was hard on GPs but that the tension between commissioned and non-commissioned work meant community teams were experiencing demand pressures which were a direct result of picking up work that they were *“not getting paid for”*. However managers expressed that getting GPs *“to engage”* or *“work with us”* in finding new service models to address this was difficult. One manager thought the reason for this was achieving agreement between the GPs themselves:

“You get six GPs in a room and you have got at least ten opinions to get an agreement”

GPs were recognised as the key partner in delivering integrated care but there was concern at the deep rift about negotiating over resources.

It was viewed as a *“big mistake”* by Uniting Care that Social Care teams were not included as critical contributors within the original model. Limited involvement of social workers as an organic part of the NTs was seen as a barrier to achieving the goal of delivering integrated care. Neighbourhood staff and managers suggested that care provision was better when they had worked together in fully integrated teams as they had in recent years. This is well evidenced in other studies which suggest that care provision improves when health and social care works closely together. However it was recognised that some progress was being made in the aligning of social care colleagues to neighbourhood teams, with the joint work on case management and re-ablement *“going really well”* but one senior manager described this work as being a:

“...delicate balance that needs to be struck between trying set out ‘this is what I do and this is what I know’ and ‘this is what you do and what do you know?’”

However managers could identify that this balance will be all the more fragile as the pressure on resources within social care had the potential to create a split of agendas between the two sectors. Worries were expressed that this was creating a situation where the CCG and Local Authority had started *“playing hard ball around money”* and was a state of affairs which was *“only going to get worse”*.

Managers described overwhelming tensions and frustration with the commissioning approach within the system. Trust or confidence in the commissioning capability of the CCG has been damaged. Recent decisions are viewed as *“big mistakes to regret”* or as *“short sighted”*. There is a lack of faith in their ability to understand what is required to achieve integrated care and it was felt that the system was taking a retrograde step towards micro / silo commissioning. Doubt that the CCG could recover their position presented heavily throughout the data. However, managers recognised that integrated care would need to be enabled by an effective commissioning system.

There was acknowledgment of the divide between the demand on acute care and the pressures in the community sector. There was a belief that poor discharge practice was a core issue which was not being addressed. There was a recurring view that the management in the acute sector was a barrier to preventative practice within the community although there was acknowledgment that some acute trusts were working hard. But this was unlikely to change whilst the finance and contract arrangements remained unchanged. One senior manager described it as *“Giving the finances to an acute trust is like giving the keys for the wine shop to an alcoholic”*.

This evidence suggests that a collective approach to integrated care is still a significant challenge, as one senior manager put it *“one of the issues in the structure of the system is that we are all doing different things. Social Care do their thing, broadly speaking health do their thing, the GPs do their thing and we are all nicely disintegrated.”* Any system change such as the work initiated by the Sustainable Transformation Plans will need to address the fact there appears more that divides the system than unites it.

3.7. Patient Perspectives

3.7.1. Staff perspectives on patient's experience

Some staff observed the impact of the organisational restructure on patients was the introduction of new professionals coming in to provide care which was generally perceived as an unwelcome change for patients.

- 32 staff respondents highlighted the issue of lack of continuity that often proceeds such organisational restructuring when implementing integrated care initiatives. Staff described investing time in developing relationships with patients, however all this changed with the restructuring.
- In contrast, one respondent highlighted a potential positive aspect of the new model, arguing since the restructure, there is a group of staff members seeing the patient, which is able to provide continuity as a group, rather than one individual person.
- Patients confirmed the concerns raised by staff regarding lack of continuity. While staff described concerns in losing the investment in building rapport and relationships, patients described their concerns in more nuanced terms such as trust, and confidence in clinical abilities and knowledge of treatment preferences.

14 staff respondents made 25 comments about care provision taking a turn for worse since the new changes/implementation of the new model. With increasing caseload, professionals (nurses and therapists) were finding it difficult to see patients on time, which does not sit well with patients and if given the option, patients would place timely visits from the professionals as an important future change. In their responses, patients (and particularly those receiving daily or more visits) stressed the importance of visits being predictable, but also acknowledged the need to have some flexibility in arrival time to allow for delays. Giving prior notice (communicating) to patients and carers when visits would be was important, as one patient described it, her entire life revolved around these visits.

Overall though 39 staff respondents made 48 comments about things having not changed much for patients which corresponded with the views of many patients. Patient and carer awareness of organisational restructuring and geographical changes was generally limited, indicating these issues were rarely discussed between staff and patients, however patients were more aware of when staff seemed stressed or short-staffed.

3.7.2. Patient's perspective on 'New Model' and current care delivery

Patients tend not consider their care as integrated in a 'community team' or 'neighbourhood team' sense, but generally perceive integrated care in a broader sense, i.e. to include links to GPs, hospitals and in some cases social care. When describing care experiences in the home, exposure to services varies widely, therefore we acknowledge that there is a range of conditions and treatments delivered by community staff and patient's views of service reflect this. For example, some participants were receiving daily or twice daily visits from nurses, others had monthly/bi-monthly visits from a physiotherapist.

Despite this variation, patients and carers across different conditions and treatments share some commonalities. These tended to focus on the predominately relational aspects of care: continuity and communication. However patient 'centred' or 'directed' care and clinical aspects also featured in their responses. Patients and carers had mixed relational and clinical experiences within each domain, but the main message was that the relational were considered as broadly important and notable if absent.

The majority of participants noted the importance of continuity of care. This tended to be expressed in preferences for an individual or group of individuals, with an interest in the patient and/or understanding of their condition to consistently provide care to them. Continuity could be seen as highly valued in descriptions of staff recalling knowledge of the patient's previous health, i.e. precluding patients from revisiting explanations with every new contact and the extent of the engagement staff had with the wider remit of their health and well-being, e.g. looking beyond the physical illness and considering isolation and loneliness for patients living alone. Not supply patients and carers often described the importance of being listened to and staff spending time with them as part of understanding their needs in terms of health and wellbeing, but contextual information such as personal aspirations and limitations were also indirectly referenced as important. As well as being listened to, communication was an important aspect of care with patients saying they valued receiving advice about their health in clear and appropriate language. Carers and family members were also grateful to be involved in patient care, and some gave examples of where they were able to provide staff with information about the patient's condition.

The above findings do not differ from those studies of patient perspectives already published and represent patient and carer perspectives of care per-se, rather than experience of integrated services. There is little in the data that indicates awareness of the change, except some comment re changes in and/or disruption to the staff who had been visiting prior to the change. However there were not an overwhelming number of comments from patients regarding this. Emerging themes from the patient data do not offer particular insights or feedback that could be linked with patient perspectives of integrated care, rather they reflect patient feedback congruent with generic health and social care services. Main themes emerging include:

- **Communication between health professionals** (e.g. different members of the community team, staff from different Trusts) was generally positive, citing examples such as participants who had been included in written communication (e.g. a copy of a letter between professionals). One participant praised a community nurse for supporting a patient's medical concern, after being initially dismissed by the GP. In contrast, there were also examples where communication between team members appeared to be poor, such as conflicting wound care advice between nurses.
- **Patients approaches to managing their care** ranging from passive techniques which rely heavily on staff to identify patient needs or initiate changes to care (P11), or more active techniques where patients or their carers pursue care through other means (P07, P10). Some staff made general statements to indicate they felt patients were often either all one way, or the other. The participants in this study indicate the truth is much more variable and how engaged an individual is with their own health may also fluctuate over time depending on their health and a number of other factors.
- Of those participants who did feel the need to proactively coordinate their own care by 'chasing' or following-up, many of their frustrations were directed towards the wider 'system' and inherent processes and operational barriers (such as obtaining appointments). In this respect, community services appeared to perform comparatively better than primary care and hospitals, however the size of our sample means these findings are purely suggestive and not generalisable.
- Specific areas for improvement for community services were around expected appointments (e.g. arriving within a specified window), continuity on weekends (e.g. staff less likely to be 'regulars' as specific times) and training around clinical knowledge (e.g. improved understanding of specific conditions).

- Examples of where care was good or improved could be found where staff had provided a hard copy (letter) regarding treatment to the patient (e.g. details regarding assessment) (C20), where staff acted as advocates for patients (e.g. phoning for an ambulance, contacting a GP on behalf of the patient) (P18, P21) and staff who were perceived to be approachable and accessible 'if needed'.

4. CONCLUSION

This research project was commissioned to make a detailed analysis of the first year of implementation of integrated care services in Cambridgeshire via the NTs, from the perspective of staff, service managers and service users, and to ascertain what the key enablers and barriers are for establishing new models of care. National and international research has established that impact evaluation is unlikely to be revealing within the first two years of establishing a major new initiative involving significant service reorganisation, hence this early analysis falls under a 'formative analytic category' and focuses upon what can be learned from this implementation going forward, both within this service and to inform new initiatives in the early stages of their implementation.

Rather than an evaluation of the whole organisational restructure, the study focused on the processes of relocating different professionals from several disciplines into integrated neighbourhood teams to facilitate coordinated working. This research has analysed the challenges and opportunities involved in this process and considered what is required in terms of organisational strategy and education to optimise this change.

A comprehensive literature review undertaken as part of this work established that integrated care has been an aspiration of the health and social care sectors nationally and internationally for many decades. However the conceptualisation of it is ambiguous to the point of no longer facilitating clarity of understanding or purpose. The intentions and mechanisms of establishing integrated care within Cambridgeshire however, were described by Uniting Care as Neighbourhood Teams working together with other services to provide 'planned and rapid response services to meet the needs of patients' (UCP WebPage;2015). The key findings of this study have led to recommendations which should further facilitate, possibly strengthen the focused element of planning, to achieve integrative, responsive services.

Conducive with formative analytic studies, this research adopted an interpretive methodology which enabled an in-depth insight into the perspectives of those most closely engaged with the change. Nine of the fifteen NTs established across Cambridgeshire were selected to participate in the study representing the geographic, constitutive and functional dimensions seen within the teams across the patch. 142 health and social care professionals and managers participated in the study via 95 individual interviews and 9 focus group interviews. There have been 22 individual interviews with patient and carer participants and 5 of these have opted to keep audio and/or written journal about their care for one-year (until autumn 2017).

4.1. Key Findings of the Study

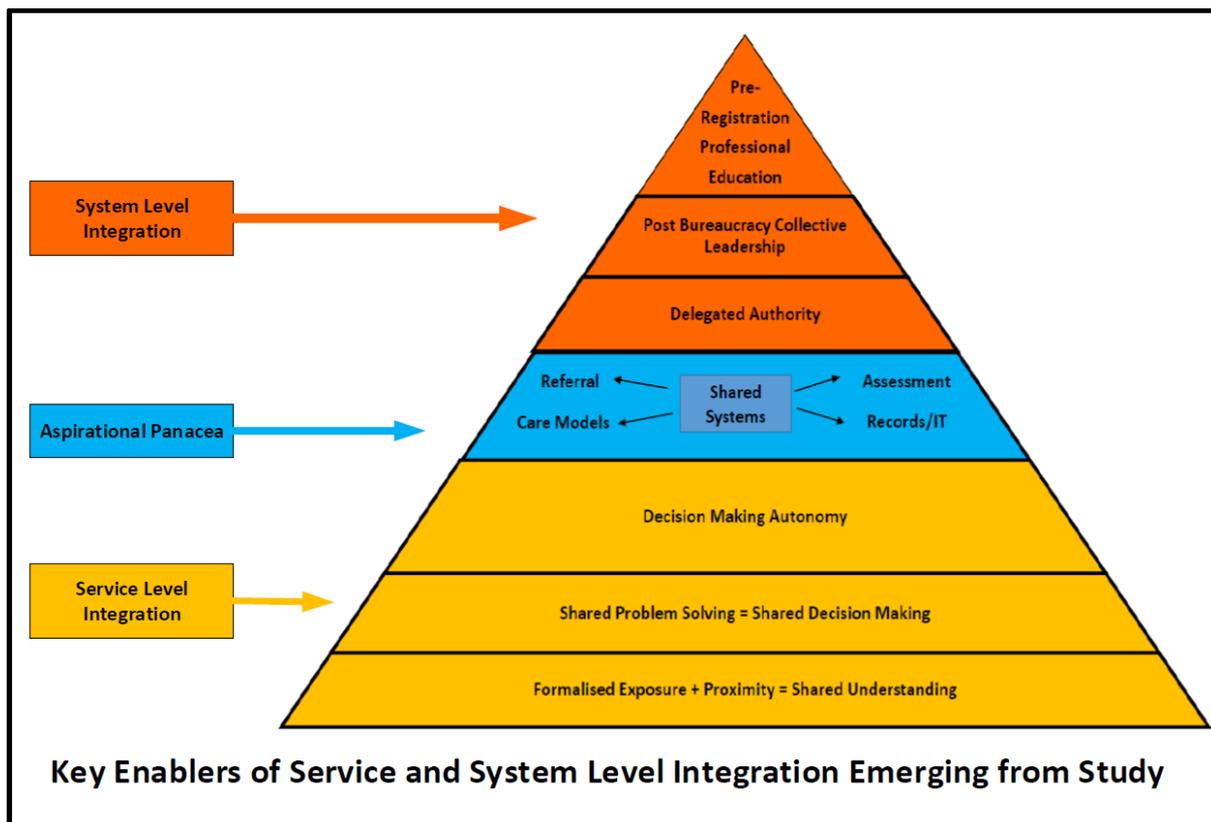
There was strong agreement in principle at all levels of the integrated teams with the idea and philosophy of integrated care linked with service efficiency and better patient outcomes, but this

potential had not been fully realised by the end of the first year. Given the nature and size of the service change undertaken in Cambridgeshire, it was anticipated that this study would report on a 'work still in progress' rather than complete. However, the study findings do provide insights into strategic and operational endeavours that have the potential to support and/or facilitate continuing and possibly more rapid transformation from this point on.

There was a consistent belief that the vision of the neighbourhood team was the right clinical model, but within the NTs studied, integration was hampered by professionally influenced barriers. These prevented staff from productive interactive engagement that would enable them to appreciate and capitalise on expertise now available within the NT. In turn this limited the team's ability to work differently and collectively and to own and offer autonomous solutions to care situations with potential to benefit from an integrated input.

The data also indicated a number of enablers in achieving effective cooperative engagement within the NTs, evidenced most clearly within those teams where formalised exposure and proximity was facilitated by specific strategic approaches such as colocation, agile working and 'buddying'. Clearly professionals need to understand the expertise and potential contribution from others residing within the newly integrated team to develop and operationalise integrative care solutions for patients and service delivery. Limited engagement or electing to remain within professionally-exclusive domains will not achieve this.

A number of key enablers for service-level integration detailed in the model overleaf, focused on deliberate strategic interventions at team level which explicitly promote interprofessional interactions. Possibly 'mandating' cross team engagement will enhance role understanding and alignment more effectively. This may help overcome the barriers that initial professional domain specific identity appeared to pose for the NTs studied here and is nationally acknowledged as embedded within health and social care teams generally (Evans et al., 2016; Miller, 2016; Busetto et al. 2016, Ling et al., 2012; Curry and Ham, 2010, Reeves et al., 2010).



A significant range of literature identified the ambiguity associated with the ‘idea’ of integrated care, generally perceived as a good notion with many having a strong view of what this means in practice. The model adopted within the NTs as the hub of integration within Cambridgeshire Adult and Community Services is, by comparison with many others, unusual, focusing as it does on nursing, therapy and MH professionals. The disparate nature of their expertise and working practices prior to integration precludes adopting a generic, i.e. ‘one cap fits all’ approach to integration. This was especially evident in the scenario observed within the mental health field and how it aligned less easily with the nursing and therapy services. This study indicates a selective model of care provision should be considered. It would involve staff coming together for focused problem solving and care delivery centred on particular care challenges or parts of patient pathways where integrative solutions are likely to show positive impact.

Significant consideration needs to be given to extending the embryonic, but nevertheless optimistic integrative practices beyond those developing within the neighbourhood teams. At the time of data collection, team members were uncertain regarding how GP services and social care, in particular would be incorporated into their integrative approach. Clearly a topic of much national debate, solutions often focus on system infrastructures, referred to ‘aspirational panaceas’ within our model overleaf. The term is not selected to indicate that these solutions are unimportant or even ineffective, rather it reflects an awareness of a multiplicity of problems associated with their implementation. Other potential infrastructure and resource barriers identified by the NTs were being addressed toward the end of the study period via new initiatives such as, ‘Virtual Team’ or the ‘Clinical Network’. These have the ability to address resourcing or capability issues, but will require strategies which can mitigate lack of proximity.

The Neighbourhood Team Model from the management perspective was overwhelmingly positive, despite the fact that the majority of managers had no involvement or influence over designing the model or structures to deliver it. The organisational or leadership strategies that made 'space' for and facilitated contact across profession-specific team members were seen as an enabler supportive of moving toward some aspects of integrated service. However if integration requires individuals to cross normative care boundaries and work differently, those practitioners should be equipped with a different type of leadership skills. Integration is a localised collective endeavour that requires professionals to be empowered with autonomous decision-making. Top down management, which is the normative culture within the NHS, is the antithesis to integrative working and greater delegated authority across the system.

Organisational and system development strategies should deliver a plan to enable a culture of delegated authority. This will need to demonstrate commitment to develop values where autonomous decision making are enabled, encouraged and supported. However different professional groups, teams and organisations will have different developmental needs with regards to adopting /enabling autonomous decision making behaviours and skills and so analysis and intervention design should be tailored around the professional or team's needs.

To achieve a collective leadership culture at a system level, leadership development strategies, programmes and interventions will require complete transformation. Attribute and position based programmes alone will be unable to equip the system with integrated leadership skills, values and behaviours. Hence the implications for education from this study are significant, spanning as they do, a skills enhancement to culture change continuum. For example continuing professional development is required to extend the skills-based competency within and across professional groupings and enable flexible utilisation of workforce expertise. More fundamentally or possibly difficult to achieve is education attempting to change embedded cultural norms, e.g. management and leadership within the public sector. Seeking partnerships with education providers to input into CPD redesign, including the use newer pedagogies congruent with cultural change should be considered.

The nationally recognised challenges posed by professional role identity, culture and hierarchy have been alluded to earlier in this section and should not be underestimated in establishing integrative services. Therein is our rationale for indicating the necessity for professional pre-qualifying education as an important vehicle for change. Mindful that some may question their ability to influence what is directed by a collective of professional statutory bodies, we have nevertheless included this within the key enabler's model. This is partly to reflect the role of pre-qualifying education in the professionalisation of the future workforce, but also as opportunities to influence the professional educative agenda are presently stronger than they have been, given the significant changes in this sphere linked with apprenticeships and trailblazers, provider and commissioning led-initiatives and 'new-roles' development.

Patient participation, for understandable reasons, has been more difficult to elicit than anticipated. However 22 individual interviews have taken place since April 2016 and 5 patient/carers are keeping an audio journal of their experiences of services for up to a year. At this juncture it would not be appropriate to leap to conclusions ahead of completed data-analysis, however having seen patients data it would seem evident that emerging themes are concerned with care and not integrated care.

Prior to listing our recommendations the research team want to thank Health Education England for their sponsorship and support throughout this project. We remain grateful to the patient and carer participants who have also welcomed us into their homes and are continuing to do so. Most especially we would like to extend a special thanks to the staff of the neighbourhood teams and their managers for engaging with us in this study and for taking time out of their busy worlds to share their experiences with us. Undoubtedly this has not been an easy transition for some and has led change for all engaged in the reorganisation. Nevertheless, many staff participants continued to express optimism regarding the opportunities offered by integration.

5. RECOMMENDATIONS

Implement **Formalised Exposure and Proximity**, for integrated team members to **foster shared understanding across professional boundaries**.

- “Step into my shoes” and similar shadowing programmes should be integrated into staff and team appraisal processes. This should be demonstrated across different professional groups and different sector partners working within the common care pathway. This could be applied locally to mandate that individuals need to have taken one day out 4 times a year to work / shadow a practitioner who delivers care from an alternative perspective or part of the patient pathway.
- Staff Performance metrics should be applied which focus on transitioning to an integrated model of working where staff evidence of shared understanding and decision making around the integrated pathway are explicit within appraisal and staff development strategies.

Develop **networks, opportunities and proximity to facilitate focused shared problem solving and shared decision making across professional groupings**, e.g. this could incorporate staff development and team engagement strategies.

- Commissioning for CPD programmes could prioritise those which incorporate and include understanding of other professionals within an integrated pathway and intra-professional learning focused on integrated patient pathway outcomes.

Build **resilience into the professional groups/teams within the workforce** and encourage shared problem solving focused on a **common purpose, issues, mission or patient scenario/pathway**.

- The scheduling of formal / informal meetings or team development opportunities should be adjusted according to the proximity of the individuals within the team. If a team does not have the ability to be co-located, the number of opportunities for exposure should be increased to take account of the lack of proximity.
- Professional and or peer groups should have protected time to connect and problem share with their contemporaries, these sessions should focus on the use of professional identity expertise to resolve issues relevant to the group or local community.

- Network, team meetings or work agendas should have dedicated time which is protected for a group to take a flexible approach to solve a local patient, pathway or service problem. This is not 'Any Other Businesses' this is 'Integrated Care Quality Improvement' and should have dedicated time and foster the ability **to make, own and implement a real change**.

Culture and Organisation Development Plans should be redesigned to enable a system shift towards a **culture of delegated authority**. This will need to demonstrate a commitment to develop **the skills, values and behaviours which enable, encourage and role model autonomous decision making**.

- Different professional groups, teams and organisations will have different development needs with regards to adopting autonomous decision making confidence. Therefore an assessment of self-efficacy should be conducted across different disciplines.
- Education and Training should be commissioned which includes autonomous decision making skills and behaviours within the curriculum.
- Leadership development programmes need to be radically redesigned to be underpinned by collective or shared leadership theory rather than attribute theory.
- Collective Leadership organisation / network / system assessments should be introduced and performance metrics adopted.
- Leadership development programmes should be commissioned which are designed around an integrated patient pathway and move away from role and position based products.
- Organisations and Networks should commission development and training on how to facilitate solution focused groups as this will require different skills and behaviours to cascade communication approaches.

Consideration should be given to how **infrastructure supports integrated teams** and the delivery of integrated services.

- For example shared referral strategies, an integrated record systems and assessment processes would undoubtedly support integrated working, and once established have potential to deliver workforce and cost efficiencies as well as a more cohesive patient experience.
- Governance processes that have been developed in relation to profession-specific agendas should be reviewed to ensure they reflect an integrated agenda.
- New initiatives such as 'Agile Working', while highly appreciated by users to resolve some resourcing issues, should be monitored to ensure they do not have unintended consequences that detract from an overarching interprofessional and integrated agenda.

Pre-qualifying professional education should seek to embed **an appreciation of professional roles within an integrated/multi-faceted system focused on outcomes related to patient/client well-being** and mitigate an historic over-emphasis on professional role identity.

- Pre-registration curriculum should be designed, influenced or commissioned so that understanding and behaviours conducive to integrative practices are explicitly part of a students' evaluated progress, e.g. influence into Professional Statutory Body Requirements; the organisation of practice-learning-the hours allocated to interprofessional working practice; via summative assessment.
- New opportunities for providers and commissioners to shape and influence the professional education milieu should be fully recognised and utilised, e.g. offered by developments such as apprenticeship, and similar work-based and/or flexible approaches to pre-qualifying professional education.

The national and international literature indicates that the conceptualisation, implementation and impact of integrated services are not empirically well researched. Empirical analysis of process or impact should form an integral part at the planning stage of service level or system level integrative initiatives and/or new models of care at the planning stage.

- Where case management is integral to a system or service transformation, funding should be invested into conducting research and structured analytic inquiry into its efficacy and impact. Every opportunity should be taken to contribute to the evidence base on patient outcomes.

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7. APPENDIX ONE: ETHICS APPROVAL LETTERS

7.1. Ethical Approval



Health Research Authority

East of England - Cambridge East Research Ethics Committee

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839209

13 January 2016

Mrs Corrie Maxwell
Strategic Development Lead
Health Education East of England
2-4 Victoria House, Capital Park, Fulbourn
CB21 5XB

Dear Mrs Maxwell

| | |
|-------------------------|---|
| Study title: | An Analysis of the Implementation of Integrated Care Teams In Cambridgeshire |
| REC reference: | 15/EE/0419 |
| Protocol number: | v2.12 |
| IRAS project ID: | 185157 |

Thank you for your response of 12th January 2016. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 26 November 2015

Documents received

The documents received were as follows:

| <i>Document</i> | <i>Version</i> | <i>Date</i> |
|--|----------------|------------------|
| Interview schedules or topic guides for participants [Exec Management Interview Schedule] | 2.2 | 03 December 2015 |
| Participant consent form [Exec Interview Consent Form] | 1.2 | 12 January 2016 |
| Participant consent form [Patient Consent Form] | 5.3 | 12 January 2016 |
| Participant consent form [Team Focus Group Consent] | 1.2 | 12 January 2016 |
| Participant consent form [Team Interview Consent] | 1.2 | 12 January 2016 |
| Participant consent form [Manager Consent] | 1.2 | 12 January 2016 |
| Participant information sheet (PIS) [Exec Management PIS] | 2.1 | 03 December 2015 |
| Participant information sheet (PIS) [NT Staff PIS] | 2.1 | 03 December 2015 |
| Participant information sheet (PIS) [Patient Audio Journal PIS] | 1.1 | 03 December 2015 |

| <i>Document</i> | <i>Version</i> | <i>Date</i> |
|--|----------------|------------------|
| Copies of advertisement materials for research participants [Patient Recruitment Poster] | V2 | 22 October 2015 |
| Covering letter on headed paper [Covering Letter] | 1 | 26 October 2015 |
| Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [ARU Insurance] | 1 | 20 July 2015 |
| Interview schedules or topic guides for participants [Manager FG Interview Schedule] | 1 | 15 October 2015 |
| Interview schedules or topic guides for participants [Team FG Interview Schedule] | 1 | 13 October 2015 |
| Interview schedules or topic guides for participants [Exec Management Interview Schedule] | 2.2 | 03 December 2015 |
| Letters of invitation to participant [Patient Invitation Letter] | 1.3 | 22 October 2015 |
| Letters of invitation to participant [Patient Invitation Reminder Letter] | 1.3 | 22 October 2015 |
| Letters of invitation to participant [Patient Recruitment Poster] | 22/10/15 | 22 October 2015 |
| Letters of invitation to participant [NT Staff Interview Invitation Letter] | 1 | 12 October 2015 |
| Letters of invitation to participant [NT Staff 2nd Interview Invitation Letter] | 1 | 13 October 2015 |
| Letters of invitation to participant [NT Staff Focus Group Invite 1] | 3 | 13 October 2015 |
| Letters of invitation to participant [NT Staff Focus Group Invite 2] | 1 | 13 October 2015 |
| Letters of invitation to participant [NT Manager Focus Group 1] | 1 | 13 October 2015 |
| Letters of invitation to participant [NT Manager Focus Group 2] | 1 | 13 October 2015 |
| Letters of invitation to participant [NT Manager Interview 1] | 1 | 13 October 2015 |
| Letters of invitation to participant [NT Manager Interview 2] | 1 | 13 October 2015 |
| Letters of invitation to participant [Exec Interview Invitation] | 1 | 13 October 2015 |
| Non-validated questionnaire | | |
| Other [Fiona Chatten Student CV] | 1 | 22 October 2015 |
| Participant consent form [Patient Consent Form] | 5.3 | 12 January 2016 |
| Participant consent form [Team Focus Group Consent] | 1.2 | 12 January 2016 |
| Participant consent form [Team Interview Consent] | 1.2 | 12 January 2016 |
| Participant consent form [Manager Consent] | 1.2 | 12 January 2016 |
| Participant consent form [Exec Interview Consent Form] | 1.2 | 12 January 2016 |
| Participant information sheet (PIS) [Exec Management PIS] | 2.1 | 03 December 2015 |
| Participant information sheet (PIS) [NT Staff PIS] | 2.1 | 03 December 2015 |
| Participant information sheet (PIS) [Patient Audio Journal PIS] | 1.1 | 03 December 2015 |
| Participant information sheet (PIS) [Patient PIS] | 2.5 | 12 January 2016 |
| REC Application Form [REC_Form_03112015] | | 03 November 2015 |
| Research protocol or project proposal [Research protocol] | 2.12 | 26 October 2015 |
| Summary CV for Chief Investigator (CI) [CI CV] | 1 | 14 October 2015 |

| | | |
|--|---|-----------------|
| Summary CV for student [Corrie Maxwell CV] | 1 | 22 October 2015 |
| Summary CV for supervisor (student research) [Supervisor CV] | 1 | 14 October 2015 |

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

| | |
|-------------------|---|
| 15/EE/0419 | Please quote this number on all correspondence |
|-------------------|---|

Yours sincerely



Carolyn Halliwell
REC Manager

E-mail: NRESCCommittee.EastofEngland-CambridgeEast@nhs.net

Copy to: *Ms Rachel Kyd, Research and Development Department, Cambridgeshire and Peterborough NHS Foundation Trust*