Appendix B: Data Extraction Chart

Author	Year of Publi-cation	Title	Data-base	Journal	Study Type	DOI/ URL	Needs Identified	Barriers Identified	Facilitators Identified	Recommendations
Alison Tweed, Andrew Singfield, Julia RA Taulor, Lucy Gilbert, Paul Mount	2018	Creating Allegiance: Leading transformational change within the NHS	EMCARE	BMJ Leader	Qualitative Study	DOI: 10.1136/leader-2018-000088			1) Intrinsic value of leadership - Leaders should be non-partisan integrators rather than assign themselves to an organisation - have an allegiance to the system. 2) Intrinsic value of leadership - Leaders should build high quality relationships involving emotional intelligence and positive role modelling. 3) Organisational Culture - Shared visions (espoused theories) need to be outlined and translated into everyday practice and visions of previous leaders or schemes must be erased. 4) Workforce Management - Connecting through practice: involving frontline staff and all stakeholders in decisions and key pieces of the transformation to integrated care.	1) Intrinsic value of leadership - Connecting is a key theme in managing system or transformational change and occurs through three mediums: relational, with purpose and vision and through practice. 2) Intrinsic value of leadership - To further research the concept of allegiance creation as it appears under-represented within the literature, particularly as part of the process of transformational change, rather than as an outcome of change or behaviours towards leaders.
Anna Charles, Lillie Wenzel, Matthew Kershaw, Chris Ham, Nicola Walsh	2018	A Year of Integrated Care Systems: Reviewing the journey so far	N/A - Snowball	The King's Fund	Report	URL: https://www.kingsfund.org.uk/sites/default/files/2018-09/Year-of-integrated-care-systems-		1) Political - The legislative context does not support system working. 2) Political - Regulation and oversight is not aligned. 3) Organisational Culture - A legacy of competitive behaviours.	1) Inter-organisational Collaboration- Collaborative relationships. 2) Inter-organisational Collaboration- Partnerships with local authorities. 3) Organisational Culture - Shared vision and purpose. 4) Organisational Culture - A meaningful local identity.	1) Inter-organisational Collaboration- Invest in building collaborative relationships at all levels of the system. 2) Intrinsic value of leadership - Promote and value system leadership. 3) Workforce Management - Integrate at different levels of the system,

						reviewing-journey-so-far-full-report.pdf		4) Organisational Culture - Frequently changing language and the lack of a clear narrative. 5) Economic - Leaders face competing demands. 6) Economic - Funding pressures.	5) Intrinsic value of leadership - System leadership. 6) Intrinsic value of leadership - Clinical leadership and engagement. 7) Workforce Management - Established models of integrated working. 8) Economic - Stability of local finances and performance. 9) Economic - Funding to support transformation. 10) Political - A permissive and supportive national programme.	building up from places and neighbourhoods. 4) Workforce Management - Draw on the skills and leadership of frontline staff. 5) Workforce Management - Build governance in an evolutionary way to support delivery. 6) Workforce Management - Develop system-wide capabilities to gather, share and act on public insights. 7) Workforce Management - Develop active strategies to facilitate wider adoption of new care models. 8) Workforce Management - Build robust evaluation into the ICS programme that supports learning and improvement and measures progress.
Axel Kaehne, Alison J Petch, Robin Stewart Miller	2017	Bringing Integration Home: Policy on health and social care integration in the four nations of the UK	BNI	Journal of Integrated Care	Qualitative Study	DOI: 10.1108/JICA-12-2016-0049		1) Inter-organisational Collaboration- Inadequate collaboration continues to result in poor quality, efficiency and effectiveness of care. 2) Organisational Culture - Culture of impatience and cynicism. 3) Workforce Management - Inadequate workforce planning. 4) Inter-organisational Collaboration- Lack of evidence on how the third sector and independent services would be involved.		1) To further research specific policy analysis domains, i.e. investigate policy formation, policy implementation or service delivery outcomes in integrated or co-ordinated health and social care services.

								5) Political - Complex governance arrangements. 6) Economic - Difficulties in agreeing budgets. 7) Political - Lack of understanding of what the drivers and essential requirements are for successful integration between health and social care and how to use policy to steer care organisations through this change.		

Bob Erens, Gerald Wistow, Sandra Mounier-Jack, Nick Douglas, Lorelei Jones, Tommaso Manacorda and Nicholas Mays	2017	Early Evaluation of the Integrated Care and Support Pioneers Programme: Final Report	N/A - Snowball	Policy Innovation Research Unit	Report	URL: https://piru.ac.uk/assets/files/Early_evaluation_of_IC_Pioneers_Final_Report.pdf		1) Political - Pressure by national and local policy-makers to demonstrate the success of new integration initiatives at a stage too early in the programme's implementation. 2) Economic - Acute/community trusts or social services departments suffered from significant financial deficit/and were subject to 'special measures', which diverted senior management attention away from Pioneer activity. 3) Economic - The growing demand for costly A&E services by patients at a time when integration seeks to reduce usage – diverts resources and slows the pace of transformation. 4) Political - Strategic direction from the national government is fragmented. Differences in approach: DCLG reportedly favouring more locally devolved responsibility, while DH/NHSE adopt a more 'command and control' approach. 5) Inter-organisational Collaboration- Health care and social care have different regulatory frameworks and the regulator does not examine systems such as integrated services, instead only	1) Organisational Culture - Trust and shared values that are largely developed locally. 2) Inter-organisational Collaboration- Being part of a national Pioneer programme, which provided an impetus for local professionals to work together to improve care locally. 3) Inter-organisational Collaboration- Building and maintaining good working relationships across organisations and professions at all levels built on trust, so that people could speak frankly, come to understand each other's perspectives, and develop a shared vision and understanding of what the Pioneer was aiming to achieve. 4) Inter-organisational Collaboration- Integrated information system between organisations to enable sharing of patient/service user records or having suitable facilities for cross-agency and/or multi-disciplinary teams. 5) Intrinsic value of leadership - Good leadership and vision was also identified as critical at all levels from local authority councillors through to senior managers, supported by appropriate governance structures. 6) Workforce Management - Experienced staff. 7) Economic - Uncommitted funding.	

								looking at individual organisations. 6) Workforce Management - Integration was less of a priority where stakeholders had urgent competing demands (e.g. meeting 4-hour waiting time A&E targets). 7) Inter-organisational Collaboration- Some Pioneers were very complex with a large number of stakeholders and/or a large geographic footprint, which made partnership working more complex in terms of size, communication, governance, etc. 8) Collaboration between Organisation - Inadequate local engagement/'buy-in' of the independent, community and voluntary sectors, in part, because they were often required to compete against each other for contracts, making working together particularly challenging. 9) Inter-organisational Collaboration- Inadequate local engagement/'buy-in' of the mental health sector, due in part to the legacy of underfunding and 'Cinderella' status of the sector. 10) Inter-organisational Collaboration- In some Pioneers with multiple partners, a sense that	8) Workforce Management - Staff involvement in developing integration initiatives and encouraging their 'ownership' of new service models. 9) Political - Supportive legislation. 10) Workforce Management - Local champions. 11) Workforce Management - Collecting the right information/indicators so that impact/success can be measured and visible to staff, patients/service users and the local population. 12) Inter-organisational Collaboration- Co-location of operational teams facilitated communication and partnership working between different professionals. 13) Organisational Culture - Freedom to try things out, not having a 'culture of blame' if things go wrong, and piloting new initiatives and sharing the learning before roll-out. Reassuring staff so they 'feel safe' in the face of change.	

								transformation could happen only at the pace of the 'slowest', most conservative or risk averse stakeholder. 11) Economic - PbR incentives for acute providers to increase activity against providing more care outside hospital. 12) Economic - Commissioning organisations were sometimes reluctant to pool budgets as it meant giving up complete control over their own budget in order to have influence over a larger one. 13) Inter-organisational Collaboration- Information sharing was seen as critical, but the level of integration of information and intelligence needed was technically difficult to achieve across multiple IT platforms and with obstructive information governance regulations. 14) Organisational Culture - Differences between the health and social care sectors in terms of language and conceptions of health and wellbeing, professional cultures and working practices. 15) Organisational Culture - Different priorities between professions: e.g. the people of most concern to social workers were not		

								necessarily the same as those of most concern to GPs. 16) Organisational Culture - 'Blame culture' within and across local health and social care sectors located responsibility for failures in integration elsewhere in the system. 17) Intrinsic value of leadership - Lack of agreement on priorities among local system leaders. 18) Workforce Management - Multiple challenges of engaging frontline staff 19) Organisational Culture - Scepticism about NHS initiatives that had previously been seen to 'come and go'. 20) Organisational Culture - Previous initiatives did not live up to expectations leading to demoralisation. 21) Workforce Management - Difficulties recruiting staff particularly in certain areas of the country. 22) Workforce Management - High staff turnover (especially following health care reforms) negatively affected longer-term strategic planning and		

								service provision aiming for integration. 23) Organisational Culture - Promoting a 'play-it-safe' work culture can be detrimental to 'barrier busting'. 24) Existing approaches to training professionals do not produce trainees equipped for integrated working, and not enough trainees to meet demand.		

Carolyn Wilkins	2020	An Allied Approach to Success in Oldham	HMIC	Municipal Journal	Qualitative Study	URL: https://www.themj.co.uk/An-allied-approach-to-success-in-Oldham/216693#			1) Political - Co-operative council with an understanding of communities which helps to target resources and further develop interventions. 2) Organisational Culture - Positive and trusting relationships. 3) Organisational Culture - A culture of innovation, creativity and empowerment and not micro-management based on old fashioned contractual approaches. 4) Intrinsic value of leadership - System leaders who work together to support frontline practitioners to overcome bureaucratic barriers.	
Chris Ham, Judith Smith and Elizabeth Eastmure	2011	Commissioning integrated care in a liberated NHS	Nuffield Trust	Nuffield Trust	Report	URL: https://www.nuffieldtrust.org.uk/research/commissioning-integrated-care-in-a-liberated-nhs		1) Economic - Needs assessment and service specification is time, effort and resource consuming.	1) Economic - Using PMS and APMS contracts to facilitate payments. 2) Intrinsic value of leadership - Managerial leadership in combination with clinician leadership.	

Danial Naqvi, Anam Malik, Mohaimen Al-Zubaidy, Falak Naqvi, Anas Tahir, Ali Tarfiee, Sarina Vara, and Edgar Meyer	2019	The general practice perspective on barriers to integration between primary and social care: a London, United Kingdom-based qualitative interview study	EMBASE	BMJ OPEN	Qualitative Study	DOI: 10.1136/bmjopen-2019-029702		1) Workforce Management - Lack of awareness of roles and services: uncertainty about which roles are carried out by which social service provider and how best to contact these individuals. 2) Inter-organisational Collaboration- Often numbers in practice diaries and on websites are out of date, so staff have to ask the patient directly what social care they receive and how to contact relevant departments, slowing down both communication and any attempts at collaborative working. 3) Workforce Management - Overworked staff: local pressures have led to an increase in workload and time constraints reduce the motivation to collaborate with other sectors to develop new methods of service provision. 4) Inter-organisational Collaboration- Communication between primary care and social care is logistically challenging, as doctors are busy with patients during the day and social care staff are working in the community, making joint conversations about patients nearly impossible.		

								5) Organisational Culture - All participants perceived the current interprofessional culture as a barrier to service integration, since many sensed a lack of mutual respect between social and primary care staff. There is often a siloed working mentality with different teams having different agendas for the patient and a lack of motivation for collaborative decision-making. 6) Inter-organisational Collaboration- Lack of regular contact: most GPs and PMs explained regular contact with social care teams is necessary for effective information transfer and a multidisciplinary approach to patient care. However, currently, contact is through forms and emails with minimal face-to-face contact, which professionals find inefficient and a barrier to continuity of care. 7) Inter-organisational Collaboration- Inefficient MDT meetings. 8) Economic - Low staffing levels. 9) Workforce Management - Inadequate training of staff.		

								10) Economic - Insufficient funding. 11) Inter-organisational Collaboration- Interoperability between information systems: the lack of shared information systems.		
DOH	2008	The Evidence Base for Integrated Care	HMIC	DOH	Report	URL: https://webarchive.nationalarchives.gov.uk/20130124044156/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_089371.pdf				1) Workforce Management - The objectives of integration need to be made explicit. 2) Workforce Management - Begin integration at the frontline, which impacts directly on the patient experience; based on this, the most apt organisational supports for service provision might be identified. 3) Workforce Management - The right incentives: it is important that frontline staff recognise and buy into the integration process. 4) Organisational Culture - A culture of quality improvement. 5) Organisational Culture - A history of trust between partner organisations. 6) Organisational Culture - Personnel who are open to collaboration and innovation. 7) Organisational Culture - Awareness of local cultural differences: organisational cultures evolve separately over decades.

										8) Intrinsic value of leadership - Local leaders who are supportive of integration. 9) Inter-organisational Collaboration- Effective and complementary communications and IT systems. 10) Political - Be patient: the time required to implement effective integration is a recurrent theme and is unsurprising given the changes required. It takes time to effect demonstrable changes in organisational structures and processes; and to have these filter down to outcomes.
E Paice, S Hasan	2013	Educating for Integrated Care	PubMed	London Journal of Primary Care	Report	DOI: 10.1080/17571472.2013.11493374	1) Organisational Culture - The need to develop a culture in which people are comfortable and competent in working across organisational boundaries to serve the needs of patients more effectively and strive continuously to improve the quality of care. 2) Intrinsic value of leadership - Staff working within integrated care must have (or develop) emotional intelligence and empathy in dealing with patients and users, be willing to work in teams with shared accountability, and be prepared to take on a leadership role in improving the system of care.	1) Economic - Financial incentives do not encourage collaboration. 2) Inter-organisational Collaboration- Financial incentives do not encourage collaboration. 3) Inter-organisational Collaboration- Lack of shared data. 4) Organisational Culture - Lack of shared accountability.		

Elena Urizar, Roberto Nuño, Caridad Alvarez, Fernández Concepción, Carles Blay, Andrea Quiroga	2018	Barriers and facilitators for the implementation of Integrated Care Pathways ICPs: a systemic perspective	CINAHL	International Journal of Integrated Care	Qualitative Study	DOI: 10.5334/ijic.s2131		1) Organisational Culture - At macro level there is a general lack of strategic vision towards integrated care from a systems perspective. 2) Inter-organisational Collaboration- At meso level, the historical fragmentation of organizations poses a strong challenge towards care coordination. 3) Intrinsic value of leadership - At the micro level a lack of clinical leadership and buy-in hinders the needed multidisciplinary and collaborative work.	1) Inter-organisational Collaboration- Better Information Systems. 2) Organisational Culture - Strategic Alignment. 3) Workforce Management - Improving data collection, continuous monitoring and evaluation, feedback looping to professionals. 4) Workforce Management - Incentives and training healthcare professionals in communication and team-work skills.	
Gerald Wistow, Matt Gaskins, Holly Holder, Judith Smith	2016	Why implementing integrated care is so much harder than designing it: experience in North West London.	CINAHL	International Journal of Integrated Care	Qualitative Study	DOI: http://doi.org/10.5334/ijic.2856		1) Workforce Management - Balance between: collective leadership and local autonomy; integrated commissioning and integrated provision; NHS leadership and local authority engagement; local variation and programme-wide consistency; investment in design and support for ongoing implementation and change. 2) Intrinsic value of leadership - Systems leadership. NHS leaders have relatively little training or experience in managing systems as opposed to organisations.	1) Organisational Culture - Co-design, inclusivity (especially of lay partners), an openness to learning. 2) Workforce Management - A clear, timetabled route map, together with roles of the programme management team and its resources were seen as valuable enablers.	

								3) Inter-organisational Collaboration- Securing data-sharing and information governance. 4) Economic - Developing payment and accountability systems aligned with integrated care objectives. 5) Workforce Management - Maintaining acute provider viability while reducing hospital admissions. 6) Inter-organisational Collaboration- Balancing competition and collaboration.		
Gwyn Bevan ; Katharina Janus	2011	Why hasn't integrated health care developed widely in the United States and not at all in England?	PubMed	Journal of Health Politics, Policy and Law.	Report	DOI: 10.1215/03616878-1191135.			1) Workforce Management - Governance by hierarchy (ownership) or a mode that is close to a hierarchy (through long-term contractual relationships). 2) Inter-organisational Collaboration- Full integration compared with arrangements of different autonomous insurers and providers reduces costs of information, negotiation, contracting, control, and adaptation and is hence more efficient. 3) Economic - Finance by capitation. Payment per member for coverage for all care provided by the IHCDS (typically in an annual contract with monthly payments), as the principal reimbursement method acts as a powerful pricing strategy that generates substantial savings	

									through internal incentives for preventive care. 4) Economic - A commitment to cost control and high-quality care. 5) Workforce Management - Good management and information systems. In a well-organized IHCDS, tight management controls its bureaucratic costs (which can otherwise result in hierarchy failure), sophisticated data management enables it to react quickly to developments in health care and markets, and standardisation in care management facilitates health care provision and thereby economises on transaction costs. 6) Workforce Management - Durability and size.	
Hermina Harnagea, Yves Couturier, Richa Shrivastava, Felix Girard, Lise Lamothe, Christophe Pierre Bedos, Elham Emami	2017	Barriers and facilitators in the integration of oral health into primary care: a scoping review	HMIC	BMJ Open	Scoping Review	DOI: 10.1136/bmjopen-2017-016078		1) Political - Lack of political leadership and healthcare policies and a poor understanding of the population and low prioritisation on the political agenda as well the absence of appropriate policies at the macro level. 2) Economic - The cost of integrated services, human resources issues (workload of personnel, staff turnover, time constraints and scarcity of various trained human resources such as care coordinators, public health workforce and allied professionals) and deficient administrative infrastructure (the absence of health records, cross-	1) Economic - Supportive policies and resource allocation: financial support from governments, stakeholders and non-profit organisations at the macro level. 2) Workforce Management - Interprofessional education. 3) Workforce Management - Three subthemes: perceived responsibility and role identification, case management [including choice and flexibility in service delivery at multiple levels (administrative and/or clinical)] and incremental approach (gradual modification in the workflow based on staff experience and preference). 4) Inter-organisational Collaboration- Geographical	

								domain interoperability and domain-specific act codes) at the meso and macro levels. 3) Workforce Management - Discipline-oriented education and lack of competencies. 4) Inter-organisational Collaboration- Lack of continuity of care and services: unstructured mechanism for care coordination at the micro level and lack of practice guidelines and types of practice at the meso level. Discontinuity in the integrated care process associated with poor referral systems, deficient interface and poor connection between public health section, primary care and academic institutions.	proximity of interdisciplinary organisations. 5) Inter-organisational Collaboration- Partnerships and common vision among governments, communities, academia, various stakeholders and non-profit organisations. 6) Intrinsic value of leadership - The strategic role of the local leader in building teamwork and communities' capacities.	
Jenna M. Evans, Agnes Grudniewicz, G. Ross Baker, Walter P. Wodchis	2016	Organizational Context and Capabilities for Integrating Care: A Framework for Improvement	HSE	International Journal of Integrated Care	Systematic Literature Review	DOI: 10.5334/ijic.2416	1) Workforce Management - Basic Structures and Design: Physical Structures, Human and Material Resources, Organizational Design, Governance, Accountability, and Information Technology. 2) Intrinsic value of leadership - Leadership and Strategy: Leadership Approach, Clinician Engagement and Leadership, Strategic Focus on Improvement,			

							and Performance Measurement. 3) Organisational Culture - Social and Psychological Context: Readiness for Change, Organisational Culture, and Work Environment. 4) Inter-organisational Collaboration-Processes: Partnering, Teamwork, Delivering Care, and Improving Quality.			
John Deffenbaugh	2018	Becoming an integrated (accountable) care system	EMCARE	British Journal of Health Care Management	Qualitative Study	DOI: 10.12968/bjhc.2018.24.4.175	1) Economic - An agreed allocation of resources and risk sharing system to achieve maximum results across the system. 2) Organisational Culture - Common priorities: move from what's in it for their organisation mindset to how they can help other organisations be successful. 3) Intrinsic value of leadership - Overarching strategy. 4) Organisational Culture - Getting into the shoes of others. 5) Organisational Culture - Agreed objectives. 6) Organisational Culture - Common narrative. 7) Workforce Management - Engaging	1) Intrinsic value of leadership - System leadership is harder than organisational leadership - there are conflicting performance measures. 2) Intrinsic value of leadership - Leaders need to see the larger picture, be more reflective and shift focus from reactive problem solving to co-creating the future.	1) Intrinsic value of leadership - Leaders understanding the motivation of partners enabling unconditional commitment, collective ownership - debts, income etc.	1) Organisational Culture - Stop clashes and set a common goal (no PBR from NHSI conflicting with CCGs from NHSE) - end artificial divides. 2) Intrinsic value of leadership - Long-term perspective needs to be maintained and the stakeholders must be motivated. 3) Intrinsic value of leadership - Leadership roles must change to become facilitators of change (no more competition).

							citizens and communities. 8) Intrinsic value of leadership - Leaders who get along.			
Judith Smith, Gerald Wistow, Holly Holder & Matthew Gaskins	2019	Evaluating the design and implementation of the whole systems integrated care programme in North West London: why commissioning proved (again) to be the weakest link.	PubMed	BMC Health Services Research	Systematic Literature Review	DOI: 10.1186/s12913-019-4013-5.		1) Organisational Culture - Social and cultural differences including those related to knowledge, organisation and power. 2) Political - The Health and Social Care Act 2012 re-emphasised the role of competition and implicitly encouraged more extensive use of for-profit and third sector providers alongside mainstream NHS-managed services. Yet there has been a parallel emphasis on collaboration and integration so Commissioners have therefore had to explore ways of balancing apparently contradictory pressures: to promote provider competition through contracting and procurement, while simultaneously securing collaborative service delivery through strategic purchasing.		1) Workforce Management - Define specifically what changes to services are intended. 2) Workforce Management - Convene stakeholders to plan for and support implementation continuously. 3) Workforce Management - See outcomes as something for which commissioners and providers are jointly accountable.

Kasper Raus, Eric Mortier & Kristof Eeckloo	2020	Challenges in turning a great idea into great health policy: the case of integrated care	PubMed	BMC Health Services Research	Report	DOI: 10.1186/s12913-020-4950-z.		1) Political - Conceptual challenges: lack of clarity on what constitutes integrated care. When drafting and implementing integrated care, there are three fundamental questions that should be considered by every policy-maker: (1) how the integration will be organised; (2) what kind of integration is intended; (3) what outcome is intended. Because of the conceptual complexity and ideological choices, it is particularly difficult to determine when and to what degree integration of care is a success. 2) Political - Empirical challenges: when drafting policy on integrated care, policymakers are likely to make use of the available empirical evidence. There are at least three different sources of such evidence. First, policymakers might learn from places where policies on integrated care have already been put into place. Second, policymakers can make use of the available research literature. Third, policymakers can gather their own data. However, each of these sources of evidence can pose substantial challenges. Successfully transferring policy requires not just learning about particular policy (such as by reading		1) Political - Reflect on the type and level of integration you want to promote. As we have argued, integrated care is a broad concept that encompasses various sorts of integration and collaboration. It is necessary as a policymaker to be aware of the level of integration that you want to achieve as, without proper prior thought, it will be impossible to determine the success of the policy afterwards. 2) Political - Reflect beforehand on what you hope to achieve with integrated care. We have argued throughout that integrated care should be seen as a means to a number of possible ends (e.g., economic efficiency or increased quality of care). Knowing what one hopes to achieve by promoting integrated care is crucial to being able to later evaluate the success or failure of the policy. This also allows policy-makers to install a mechanism for evaluation, allowing the health policy to be re-evaluated after a period. 3) Political - Tailor policy to the particular context in which it will be implemented. The successful integration of a given policy in a particular health care context might not be automatically transferrable to another health care context. Policymakers should critically assess the available scientific literature and look at examples of places where comparable policies have been implemented. One cannot simply copy policy from somewhere else and expect it to work. Policymakers should preferably not only learn about what happened in other places, but instead learn from other places.

								policy documents), but also learning from particular policies. Policymakers can make use of an increasing amount of existing and published evidence from research, however, how to translate this knowledge into political action is far from evident. Also, while many case studies have been published there may be publication or reporting bias, whereby successful networks are more likely to be published than unsuccessful ones. 3) Economic - Resource challenges: integrated care is often believed to allow for 'improved efficiency of services, and reduced overall cost', however there is research suggesting that creating integrated care and health care collaborations might actually require a great investment of resources before there is any efficiency pay-off. The resources needed are :(1) expertise, (2) time, and (3) funding.		4) Economic - Be committed to investing the resources needed to genuinely run and evaluate a policy. Research shows how successfully promoting integration may require resources such as time, expertise, and funding. As we have argued, policy-makers who fail to invest the necessary amount of money might afterwards incorrectly conclude that a particular policy implementation does not work. 5) Organisational Culture - Provide the stakeholders with sufficient freedom and autonomy. Research shows that successful integration cannot be fully mandated and requires a willingness from stakeholders and a relationship of trust between them. 6) Political - Consider beforehand how the actual implementation of the policy can be evaluated: Despite there being empirical challenges, a lot can be learned from the example of other countries and the experiences of other policy makers. There is also the option of setting up pilot projects or policy experiments to gather relevant feedback. Finally, policy makers should also consider the installation and use of feedback mechanisms to gain insight into the implementation of policy once it is underway.
Laura G. González-Ortiz, Stefano Calciolari, Viktoria Stein, Nick Goodwin	2018	The core dimensions of integrated care: a literature review to support the developmen t of a	HMIC	Internatio nal Journal of Integrate d Care	System atic Literatu re Review	DOI: 10.533 4/ijic.41 98			1) Intrinsic value of leadership - Local leadership and long-term commitments. 2) Intrinsic value of leadership - Leaders with a clear vision on integrated care.	

		comprehensive framework for implementing integrated care.							3) Intrinsic value of leadership - Distributed leadership. 4) Intrinsic value of leadership - Managerial leadership. 5) Intrinsic value of leadership - Visionary leadership. 6) Intrinsic value of leadership - Clinical leadership. 7) Intrinsic value of leadership - Organisational leadership for providing optimal chronic care. 8) Organisational Culture - Shared vision and values for the purpose of integrated care. 9) Organisational Culture - An integration culture institutionalised through policies and procedures. 10) Organisational Culture - Striving towards an open culture for discussing possible improvements for care partners. 11) Organisational Culture - Linking cultures. 12) Organisational Culture - Trust (on colleagues, caregivers and organisations). 13) Inter-organisational Collaboration- Information sharing. 14) Planned/organised meetings.	
Mahiben Maruthappu	2016	Enablers and Barriers in Implementing Integrated Care	N/A - Snowball	Health Systems and Reform	Report	DOI: 10.1080/23288604.2015.1077301		1) Organisational Culture - A change of culture is required, at both clinical and management levels, without which may lead to a lack of shared vision and	1) Political - Supportive regulation. 2) Political - Flexible administrative reorganisation. 3) Economic - Funding realignment.	

								problems in the long-term sustainability of integration. 2) Economic - For integrative care to be successful, a long-term plan with adequately protected support and funding must be provided. Financial incentives must be directed toward integrated pathways and designed to redistribute incentives to stakeholders. 3) Inter-organisational Collaboration- Without an infrastructure framework, the coordination of care is stifled; for example, robust shared electronic patient record platforms, which can be accessed by all those involved in providing care to the target patient population.	4) Economic - Identification of target population. 5) Economic - Adequate financing. 6) Inter-organisational Collaboration- IT infrastructure. 7) Inter-organisational Collaboration- Leadership coalition. 8) Inter-organisational Collaboration- Involvement of primary, community and social care. 9) Workforce Management - Evaluation models. 10) Organisational Culture - Common values. 11) Organisational Culture - Changing clinical cultures. 12) Intrinsic value of leadership - Clinical Leadership.	
Martin Bardsley, Adam Steventon, Judith Smith and Jennifer Dixon	2013	Evaluating integrated and community-based care	Nuffield Trust	Nuffield Trust	Report	URL: https://www.nuffieldtrust.org.uk/research/evaluating-integrated-and-community-based-care-how-do-we-know-what-works			1) Political - Recognising that planning and implementing large-scale service changes takes time e.g. Kaiser Permanente. 2) Workforce Management - Defining the intervention clearly and what it is meant to achieve and how, and implement it well. 3) Workforce Management - Being explicit about how desired outcomes will arise, and using interim markers of success. 4) Inter-organisational Collaboration- Generalisability and context are important - each area	1) Intrinsic value of leadership - Blend designated leadership with distributed leadership. 2) Workforce Management - Establish feedback loops. 3) Workforce Management - Engage physicians, patients and families.

									will have specific success factors but the aim must be the same.	
NHS Future Forum	2011	Clinical advice and leadership : a report from the NHS Future Forum.	HMIC	N/A	Report	URL: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213750/dh_127542.pdf	1) Inter-organisational Collaboration- Integrated information systems need to be developed, commissioned and implemented. 2) Workforce Management - Data about quality and outcomes of care is collected, shared and used in a transparent way to support informed patient choice and continuous improvement. 3) Organisational Culture - A duty to promote research and innovation and the use of research evidence. 4) Intrinsic value of leadership - Substantial multi-professional clinical leadership embedded within it including visible leadership for key groups and conditions, for example children, women, older people, mental health and learning disabilities. 5) Workforce Management - Continuing professional development. 6) Intrinsic value of leadership - All			

							organisations, particularly new ones, should ensure that appropriate leadership development and support are in place. 7) Workforce Management - Responsible officers continuing to be in place to support doctors in improving care and ensuring their fitness to practice through revalidation. 8) Organisational Culture - Strong and visible clinical and professional leadership at all levels, focused on increasing trust and encouraging positive behaviour.			
NHS Leadership Academy	2018	Leadership in Integrated Care Systems (ICSs)	N/A - Snowball	Social Care Institute for Excellence: Future of Care	Report	URL: https://www.scie.org.uk/integrated-care/leadership/systems#further info	1) Intrinsic value of leadership - Leaders in ICSs need to be skilled at: a) identifying and scaling innovation (e.g. from pilots) b) having a strong focus on outcomes and population health c) building strong relationships with other leaders, and often working with them informally to develop joint priorities and plans d) establishing governance structures which drive faster change, often going	1) Workforce Management - Strategies and agendas that are imposed by NHS England on local areas rather than being clinically-led and driven by local need. 2) Inter-organisational Collaboration- Lack of coordination and alignment at national level between NHS England and NHS Improvement. 3) Workforce Management - Complex accountability structures and configurations. 4) Inter-organisational Collaboration- Different performance regimes and	1) Intrinsic value of leadership - Stability in senior leadership positions across organisations. 2) Inter-organisational Collaboration- Relationships before structures: drawing on established working relationships built over the years. 3) Workforce Management - Involving staff and service users. 4) Organisational Culture - Having the security to make long-term plans. 5) Organisational Culture - Trust and delegation of autonomy from the centre: a permissive, not prescriptive, approach and national guidance that provides a broad, enabling framework.	1) Leadership Style - Leadership programmes and professional development opportunities. 2) Organisational Culture - Peer support including mechanisms for 'buddying up'. 3) Workforce Management - Local champions who will push and progress the work, and 'win hearts and minds'. 4) Workforce Management - Skilled external facilitation, to help deliver complex programmes. 5) Organisational Culture - The creation of 'safe spaces' for leaders to meet with peers and share problems and solutions.

							where the commitment and energy is strongest e) setting the overall outcomes and expectations on behaviours, but handing day-to-day decision-making to others f) supporting the development of multidisciplinary teams (MDTs) g) designing and facilitating whole-systems events and workshops to build consensus and deliver change h) understanding and leading cultural change i) building system-wide learning and evaluation frameworks j) fostering a learning culture across the whole system.	cultures, including between the NHS and local authorities. 5) Political - Lack of a coherent view of whole population needs. 6) Political - Sheer volume of bureaucracy involved in getting service changes through. 7) Workforce Management - Insufficient development, support and peer support for leaders. 8) Intrinsic value of leadership - Capacity and capability of local leaders, pressure and stress in these roles, uncertainty about the future. 9) Intrinsic value of leadership - People in leadership roles finding the job lonely and feeling isolated. 10) Organisational Culture - A culture of blame towards leaders. 11) Intrinsic value of leadership - High turnover of the leadership workforce, resulting in loss of experience and skills. 12) Intrinsic value of leadership - Confusion about where the decision-making power lies. 13) Intrinsic value of leadership - Clinical leadership especially	6) Workforce Management - Clarity about how performance will be judged. 7) Workforce Management - Clarity about how accountability will work, and responsibilities of individual organisations.	6) Organisational Culture - More opportunities to learn from other professions and sectors. 7) Workforce Management - Systems leadership development for middle managers across the system. 8) Workforce Management - Masterclasses on: co-production theory and practice, finance and risk-sharing, scaling innovation, understanding local government and social care, large-scale and large-group facilitation, working and influencing across multiple layers of governance.

								challenged by bureaucratic constraints. 14) Organisational Culture - Performance management and assurance processes that are not aligned to learning and self-reflection. 15) Organisational Culture - A sense that the goalposts keep moving with priorities, funding and expectations changing.		
Nick Goodwin and Judith Smith	2011	The Evidence Base for Integrated Care	N/A - Snowball	The King's Fund and the Nuffield Trust: Developing a National Strategy for the Promotion of Integrated Care	Presentation	URL: https://www.kingsfund.org.uk/sites/default/files/Evidence-base-integrated-care2.pdf				
Nick Goodwin, Judith Smith, Alisha Davies, Claire Perry, Rebecca Rosen, Anna Dixon, Jennifer	2012	Integrated care for patients and populations: Improving outcomes by working together	Nuffield Trust	Nuffield Trust	Report	URL: https://www.kingsfund.org.uk/publications/integrated-care-patients-and-populations-improving-outcomes-working		1) Organisational Culture - NHS management is permission based and has a risk averse approach where innovation is needed. 2) Inter-organisational Collaboration- Divide between primary/secondary, health/social care: different contracts, employment, free/means tested.	1) Intrinsic value of leadership - Creating powerful narrative at national and local level. 2) Workforce Management - Clear articulation of benefits to patients, service users and carers. 3) Workforce Management - Approaches that measure experiences of patients, service users and carers in relation to integrated care.	1) Intrinsic value of leadership - Setting a clear, ambitious and measurable goal to improve the experience of patients and service users, implement change at scale and pace.

Dixon, Chris Ham						- together		3) Inter-organisational Collaboration- Absence of robust electronic sharing record. 4) Economic - Weak commissioning payment based on episodic care at hospital, PBR incentivises more activity in hospitals, mitigating against other providers, competition within the market and choice and regulation focuses on organisation performance not collective system leading to single outcomes framework	4) Workforce Management - Need for GPs to adapt to provide services at a larger scale. 5) Economic - New payment incentives and local currencies. 6) Economic - Commission services based on outcomes rather than items of delivery.	
R Humphries	2015	Integrated health and social care in England – Progress and prospects	EMCA RE	Health Policy	Report	DOI: 10.1016/j.healthpol.2015.04.010		1) Organisational Culture - In contrast to the 'Pioneer' programme which has encouraged locally driven, bottom-up innovation, NHS England has adopted a much more prescriptive and top-down approach to the delivery of the Better Care Fund which is driven by an imperative to reduce emergency hospital admissions. 2) Economic - The personal commissioning programme is an entirely different approach again which rests on the ability of individuals rather than organisations to integrate their own care. It remains to be seen how the inevitable tensions between these very different policy levers and		1) Economic - A new settlement that brings together all health and care funding into a single, ring fenced budget and overseen by a single local commissioner.

								implementation styles will play out.		
Rebecca Rosen, James Mountford, Geraint Lewis, Richard Lewis, Jenny Shand and Sara Shaw	2011	Integration in action: four international case studies	N/A - Snowball	Nuffield Trust	Case Study	URL: https://www.nuffieldtrust.org.uk/research/integration-in-action-four-international-case-studies		1) Workforce Management - Slow uptake by some physicians due to reluctance to adapt to new methods. 2) Intrinsic value of leadership - Lack of performance management role (indirect influence). 3) Economic - Limited benefit to individuals in the organisations until payment contracts have been redesigned. 4) Inter-organisational Collaboration- Single condition services risk silos for chronic conditions, fragmenting care for those with multiple chronic complex problems. 5) Political - Inconsistencies in national policy. 6) Intrinsic value of leadership - Variable progress in different localities dependent on local leadership.	1) Intrinsic value of leadership - Active medical leadership in charge of developing care standards and resources and raising awareness about expected standards of practice. 2) Workforce Management - Multi-professional teams supporting care coordination and review of high risk patients. 3) Intrinsic value of leadership - Respected medical leaders and high trust in leadership based on track record. 4) Organisational Culture - High level of trust between GPs, specialists, nurses and other stakeholders. 5) Economic - When transfer of work between organisations does not cause issues with payments. 6) Inter-organisational Collaboration- Planned increase in provider competition. 7) Organisational Culture - Joint vision shared by senior officers in health and social care. 8) Workforce Management - Staff commitment and belief that integration is doing the right thing. 9) Workforce Management - Joint training and development across organisations involved in integrated systems.	1) Organisational Culture - Patient-centred culture: focus integrated care on patient needs.

									10) Intrinsic value of leadership - Skilled leaders with ability to win hearts and minds of frontline staff. 11) Organisational Culture - Taking an incremental approach on progress. 12) Inter-organisational Collaboration- Involvement of all relevant health care providers to create broad support.	
Richard Gleave	2009	Across the pond - Lessons from the US on Integrated Healthcare	Nuffield Trust	Nuffield Trust	Case Study	URL: https://www.nuffieldtrust.org.uk/research/across-the-pond-lessons-from-the-us-on-integrated-healthcare				1) Intrinsic value of leadership - Integrated governance models must be built on strong clinical leadership, must be combined with a culture that prompts delivery of integrated care. 2) Inter-organisational Collaboration- Risk needs to be shared in Inter-organisational Collaborationrather than assigned individually.
Sara Shaw, Rebecca Rosen and Benedict Rumbold	2011	What is integrated care?	Nuffield Trust	Nuffield Trust	Report	URL: https://www.nuffieldtrust.org.uk/files/2017-01/what-is-integrated-care-	1) Economic - Situate performance measures within wider health and care systems: acknowledge the level and combination of strategies used based on the challenges faced in obtaining appropriate			

						report-web-final.pdf	quality care for local communities and user groups and consider the contextual factors that affect development and delivery. 2) Workforce Management- Standardised, validated tools and indicators that measure integration across different settings relative to a set of models, structures and processes. 3) Workforce Management - Improvement through audit of medical records, analysis of register data on hospitalisation rates, self assessment for managers, annual surveys, questionnaires for clinical leaders, qualitative interviews with executives, leaders, staff and managers.			
Sara Shaw, Ros Levenson	2011	Towards integrated care in Trafford	Nuffield Trust	Nuffield Trust	Report	URL: https://www.nuffieldtrust.org.uk/files/2017-01/towards-integrated-care-in-trafford-web-final.pdf				1) Organisational Culture - Recognise that major change is needed, ensure a clear and agreed vision from GPs to specialists. 2) Economic - Work simultaneously with commissioners and service providers so that quality and budgeting is fulfilled. 3) Workforce Management - Make a clear case for change 4) Workforce Management - Engage with stakeholders when developing integrated systems

										5) Intrinsic value of leadership - Facilitate local leadership that has good knowledge of the workings of the local systems.
Sheena Asthana, Felix Gradinger, Julian Elston, Susan Martin, Richard Byng	2020	Capturing the Role of Context in Complex System Change: An Application of the Canadian Context and Capabilities for Integrating Care (CCIC) Framework to an Integrated Care Organisation in the UK.	PubMed	International Journal of Integrated Care	Case Study	DOI: 10.5334/ijic.5196.			1) Economic - Size/structural factors were key to integration success: the area was sufficiently small (n=36,251) to allow triage, assessment and referral in one multi-disciplinary team (MDT), whereas in the largest locality had 72,692 registered residents so the single MDT initially had much more caseloads which became unmanageable. 2) Organisational Culture - The small size allowed relationships to develop over time; indeed, there is a history of collaboration there (e.g. between GPs and community hospital teams and between health and social care). 3) Intrinsic value of leadership - A strong role of shared, bottom-up leadership. Frontline clinicians in the Coastal Locality were notable for having trusting and friendly relationships between team leads (Physio, Nurses and Matrons, Social Care). 4) Inter-organisational Collaboration- The integrated system appointed GPs as locality clinical directors, which was a key factor as they helped link the GP community directly into the ICO, thereby overcoming barriers between the acute and primary sectors. 5) Organisational Culture - There was a commitment to learning by leaders. The Coastal leads	

									insisted on collecting their own performance data despite being asked to discontinue doing so and devised their own performance management system (measuring performance). Priority to measure performance; there was a willingness in Coastal to genuinely question the process and outcomes of integrated care. 6) Inter-organisational Collaboration- The partnering and the organisation of inter-professional teamwork and joint care planning as critical determinants of success, especially informal partnership which relies on trusting relationships at all levels. A balance of top-down and bottom-up committees and system-wide steering functions facilitated the emergence over time of trusting relationships and iteratively evolving teams at locality level. This in turn allowed for better service delivery.	
Sian E. Maslin-Prothero. Amy E. Bennion	2010	Integrated team working: a literature review	HSE	International Journal of Integrated Care	Systematic Literature Review	URL: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2883237/	1) Political - The need for clear governance arrangements: there is a need for successful management of the tension between structure and culture at a local and national level, and a recognition of the fundamentally different principles of governance. 2) Organisational Culture - Need for a shared understanding of the purpose of the joint venture and a mutual understanding of, and	1) Inter-organisational Collaboration- Divide between social care staff medical staff: differences in geographical boundaries, communication boundaries, and status inequalities. 2) Organisational Culture - The mismatch in cultures, behaviours and understanding of services creates a divide between the disciplines. Organisational boundaries resulted in staff feeling pressured, and the process		

							commitment to, the vision of the venture across the organizations involved. 3) Inter-organisational Collaboration- It is important for integrated services to work together across agency boundaries; this has been facilitated by the removal of structural constraints through the Health Act 1999, which permitting pooled budgets and integrated provision. 4) Inter-organisational Collaboration- Integrated teams must be able to exchange knowledge easily between agencies; effective shared information technology (IT) systems are key to the success of integrated working. 5) Organisational Culture - Need for the development of a shared culture. 6) Workforce Management - Establishment of new roles to support new ways of working 7) Inter-organisational Collaboration- Exhibiting a past history of joint working. 8) Political - Recognition of grey areas in policy and organizational terms	of collaborative working led to unrealistic expectations being placed on staff. 3) Workforce Management - A lack of clarity of purpose for integration, and a failure to agree partnership outcomes. 4) Workforce Management - The lack of understanding and clarity of others' roles, leading to conflict between team managers. 5) Workforce Management - Imbalance of power and poor communication. 6) Workforce Management - Short-term contract working, lack of clear career structure, and limited opportunities for promotion (unless they left the service) created a dilemma: a trade-off between present job satisfaction and future career progression for staff in integrated care teams. 7) Economic - Financial limitations as to what can be addressed with the resources available.		

							and encouraging local agencies to work together in those areas. 9) Organisational Culture - The promotion of professional values of service to users and socialisation into the immediate work group.			
Stephanie Best	2016	Facilitating integrated delivery of services across organisational boundaries: Essential enablers to integration	HMIC	British Journal of Occupational Therapy	Qualitative Study	DOI: 10.1177/0308022616688019	1) Inter-organisational Collaboration- Horizontal communication.	1) Intrinsic value of leadership - Lack of support. 2) Intrinsic value of leadership - Overestimated expectations. 3) Intrinsic value of leadership - Autocratic leadership style	1) Inter-organisational Collaboration- Communication: Intra- and Inter-professional; staff kept informed; spontaneously shared knowledge across organisations; top-down communication is acknowledged with the need to set a vision and strategic direction identified within leadership; bottom-up communication is seen as essential to actively supporting new ways of working and to sharing a common understanding of operational circumstances. 2) Intrinsic value of leadership - Setting direction, setting the vision. 3) Intrinsic value of leadership - Accessibility through visibility both within and across organisations. 4) Intrinsic value of leadership - Joint decision-making. 5) Intrinsic value of leadership - Authority to influence across organisations. 6) Inter-organisational Collaboration- Joint training offers an opportunity to build	

									relationships with colleagues across organisations and recognise each other's areas of expertise. Overall, participants expressed a wish to see improved working relationships, as this has the potential to lead to a 'fluidity in thinking' when managing difficult or complex situations.	
Sue Mackie, Angela Darvill	2016	Factors enabling implementation of integrated health and social care: a systematic review	CINAHL	British Journal of Community Nursing	Systematic Literature Review	DOI: 10.12968/bjcn.2016.21.2.82			1) Intrinsic value of leadership - Management and leadership support was identified as an enabler in four of the seven studies, with Coupe (2013) suggesting that leadership support was essential for the successful implementation of integrated health and social care teams. 2) Workforce Management - Change management can be complex, and Thomas et al (2006) suggest that changes are more likely to be adopted when the change meets an identified need. Ling et al (2012: 4) support this belief, as they reported that 'where staff felt that change was being forced upon them then they were less likely to support the new activity. 3) Organisational Culture - Ling et al (2012) further reported that pilot sites were more successful when there was evidence of a shared vision, along with a commitment from management in relation to longevity of the change. 4) Intrinsic value of leadership - Thistlethwaite (2011) partially attributed the success in Torbay to the stable leadership within Torbay and the ongoing	

									managerial support to deliver on the integration project. 5) Economic - Resources and capacity have been identified as a key enabler in five out of the seven studies. Coupe (2013) attributed the main cause of under-performance of the integrated health and social care teams to a lack of investment in the teams, which is required to embed the change into practice. Ling et al (2012) also reported that the lack of resources in the integrated health and social care teams resulted in an increased workload, which had an adverse effect on staff motivation. 6) Political - National policy was considered an enabler in four of the studies. Coupe (2013) identified that the NHS payment systems, such as payment by results and block contracts, do not incentivise the delivery of care in the community, and thus pose a barrier to integrated health and social care teams. 7) Economic - Sheaff et al (2009) also referred to the NHS financial system, suggesting that paying hospitals for each case treated was an actual incentive to increase admissions, which completely conflicts with the aims of integrated health and social care teams. 8) Inter-organisational Collaboration- Shared information technology (IT) systems were identified as an enabler in two studies. This may pose a concern for a number of organisations	

									considering data sharing owing to issues with information governance and maintaining patient confidentiality.	
Tom Ling, Laura Brereton, Annalijn Conklin	2012	Barriers and facilitators to integrating care : experiences from the English Integrated Care Pilots	HMIC	International Journal of Integrated Care	Qualitative Study	DOI: 10.5334/ijic.982		1) Workforce Management - Size and complexity: multiple components in integration reported greater challenges of managing change, and they were often greater and longer to implement than they had anticipated. Difficult to communicate the details to all parties and identify the role of each participant group. 2) Workforce Management - Staff demotivated when an absence of clear and consistent communication from leaders within organisations about what work was required and contribution needed from participants. Where staff felt the change was being forced upon them, they were less likely to support the new activity. 3) Workforce Management - Lack of training led to staff being unclear whether	1) Workforce Management - Size and complexity: simple, smaller integration made more rapid progress and had the ability and authority to come to quick decisions. 2) Inter-organisational Collaboration- Compatible IT systems and good management of the sharing of private data. 3) Inter-organisational Collaboration- Good existing relationships between individuals and/or organisations with clear communication about the contributions required from different participants and the rules governing how the partnership should work. 4) Organisational Culture - Widespread agreement and shared values among participating staff promoted engagement and motivation. 5) Intrinsic value of leadership - Success when senior management or team leaders were perceived to be strongly committed to implementing lasting change. 6) Inter-organisational Collaboration- Ongoing, planned communication between senior executives in the partner	

								they were permitted to take on particular tasks or feeling unprepared to take on new roles. 4) Inter-organisational Collaboration- Different IT systems in partner organisations caused difficulties in data-sharing and communicating, especially across health and social care teams. On occasions, these difficulties were not caused by the IT itself but by how their introduction was managed, such as failure to address privacy concerns where organisations were reluctant to share patient data. 5) Collaboration Between Organisations: Absence of relationships between individuals and/or organisations. Poor communication and disagreement about the contributions required from different participants and the rules governing how the partnership should work. 6) Inter-organisational Collaboration- Lack of ongoing, planned communication between senior executives in the partner organisations. 7) Inter-organisational Collaboration- Lack of co-location: lack of working together face-to-face in the	organisations. 7) Inter-organisational Collaboration- Co-location: working together face-to-face in the same building improved the quality and frequency of communication, and expedited problem-solving by allowing quicker access to colleagues' professional knowledge. 8) Organisational Culture - Feelings of being involved with planning from the beginning. 9) Workforce Management - Staff were motivated when there was clear and consistent communication from leaders within organisations about what work was required and contribution needed from participants. 10) Organisational Culture - Willingness to engage. Creating shared beliefs about the benefits of change was described by staff as critical to progress. 11) Intrinsic value of leadership - 'Good' leadership. 12) Workforce Management - Thorough training led to staff being clear whether they were permitted to take on particular tasks or feeling prepared to take on new roles. The provision of training specific to the service change was important, particularly when the work involved required new or changed roles of participants. 13) Organisational Culture - Supportive, transparent organisational culture: the ability to modify existing systems and practices and to create new ones was especially dependent on organisational culture which included local perceptions of professional boundaries. 14) Workforce Management - External	

								same building decreased the quality and frequency of communication, and exacerbated problems by reducing access to colleagues' professional knowledge. 8) Intrinsic value of leadership - Failure when senior management or team leaders were perceived to be weakly committed to implementing lasting change. 9) Intrinsic value of leadership - 'Poor' leadership blamed for lack of shared beliefs about the benefits of change. 10) Organisational Culture - Feelings of being sidelined, or uninvolved with planning from the beginning. 11) Organisational Culture - Reluctance to engage was a major barrier. 12) Organisational culture - Poor organisational culture which included local perceptions of professional boundaries. 13) Organisational Culture - A lack of openness which was part of a wider NHS 'blame culture'. 14) Political - Chains of managerial approval among multiple organisations and slow decisions about resource	facilitation has been very helpful in getting two organisations to work together, which is a method well rehearsed in the wider literature on managing change. 15) Organisational Culture - Staff feeling permitted to take risks. 16) Inter-organisational Collaboration- Shared data systems or other information technology that aided communication and knowledge transfer.	

								distribution were perceived as a barrier to innovation. 15) Economic - Staff cuts.		