Appendix C: Synthesis of Results

Source of Information		Factors Identified					
Author	**Title**	**Organisational Culture**	**Workforce Management**	**Inter-Organisational Culture**	**Leadership**	**Economic**	**Political**
Alison Tweed, Andrew Singfield, Julia RA Taulor, Lucy Gilbert, Paul Mount	Creating Allegiance: Leading transformational change within the NHS	**Facilitators:** 1) Shared Visions (espoused theories) need to be outlined and translated into everyday practice and visions of previous leaders or schemes must be erased.	**Facilitators:** 1) Connecting through practice: involving frontline staff and all stakeholders in decisions and key pieces of the transformation to integrated care.		**Facilitators:** 1) Leaders should be non-partisan integrators rather than assign themselves to an organisation - have an allegiance to the system. 2) Leaders should build high quality relationships involving emotional intelligence and positive role modelling. **Recommendations:** 1) 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) 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	A Year of Integrated Care Systems: Reviewing the journey so far	**Barriers:** 1) A legacy of competitive behaviours. 2) Frequently changing language and the lack of a clear narrative. **Facilitators:** 1) Shared vision and purpose. 2) A meaningful local identity.	**Facilitators:** 1) Established models of integrated working. **Recommendations:** 1) Integrate at different levels of the system, building up from places and neighbourhoods. 2) Draw on the skills and leadership of frontline staff. 3) Build governance in an evolutionary way to support delivery. 4) Develop system-wide capabilities to gather, share and act on public insights. 5) Develop active strategies to facilitate wider adoption of new care models. 6) Build robust evaluation into the ICS programme that supports learning and improvement and measures progress.	**Facilitators:** 1) Collaborative relationships. 2) Partnerships with local authorities. **Recommendations:** 1) Invest in building collaborative relationships at all levels of the system.	**Facilitators:** 1) System leadership. 2) Clinical leadership and engagement. **Recommendations:** 1) Promote and value system leadership.	**Barriers:** 1) Leaders face competing demands. 2) Funding pressures. **Facilitators:** 1) Stability of local finances and performance. 2) Funding to support transformation.	**Barriers:** 1) The legislative context does not support system working. 2) Regulation and oversight is not aligned. **Facilitators:** 1) A permissive and supportive national programme.
Axel Kaehne, Alison J Petch, Robin Stewart Miller	Bringing Integration Home: Policy on health and social care integration in	**Barriers:** 1) Culture of impatience and cynicism.	**Barriers:** 1) Inadequate workforce planning.	**Barriers:** 1) Inadequate collaboration continues to result in poor quality, efficiency and		**Barriers:** 1) Difficulties in agreeing budgets.	**Barriers:** 1) Complex governance arrangements. 2) Lack of understanding of what the drivers and essential requirements are for successful integration between

	the four nations of the UK			effectiveness of care. 2) Lack of evidence on how the third sector and independent services would be involved.			health and social care and how to use policy to steer care organisations through this change. **Recommendations:** 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.
Bob Erens, Gerald Wistow, Sandra Mounier-Jack, Nick Douglas, Lorelei Jones, Tommaso Manacorda and Nicholas Mays	Early Evaluation of the Integrated Care and Support Pioneers Programme: Final Report	**Barriers:** 1) Differences between the health and social care sectors in terms of language and conceptions of health and wellbeing, professional cultures and working practices. 2) 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. 3) 'Blame culture' within and across local health and social care sectors located responsibility for failures in integration elsewhere in the	**Barriers:** 1) Integration was less of a priority where stakeholders had urgent competing demands (e.g. meeting 4-hour waiting time A&E targets. 2) Multiple challenges of engaging frontline staff. 3) Difficulties recruiting staff particularly in certain areas of the country. 4) High staff turnover (especially following health care reforms) negatively affected longer-term strategic planning and service provision aiming for integration. 5) Existing approaches to training professionals do not produce	**Barriers:** 1) Health care and social care have different regulatory frameworks and the regulator does not examine systems such as integrated services, instead only looking at individual organisations. 2) 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. 3) 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	**Barriers:** 1) Lack of agreement on priorities among local system leaders. **Facilitators:** 1) Good leadership and vision was identified as critical at all levels from local authority councillors through to senior managers, supported by appropriate governance structures.	**Barriers:** 1) 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. 2) 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. 3) PbR incentives for acute providers to increase activity against providing more care outside hospital. 4) 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	**Barriers:** 1) 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) 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. **Facilitators:** 1) Supportive legislation.

		system. 4) Scepticism about NHS initiatives that had previously been seen to 'come and go'. 5) Previous initiatives did not live up to expectations leading to demoralisation. 6) Promoting a 'play-it-safe' work culture can be detrimental to 'barrier busting'. **Facilitators:** 1) Trust and shared values that are largely developed locally. 2) 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.	trainees equipped for integrated working, and not enough trainees to meet demand. **Facilitators:** 1) Experienced staff. 2) Staff involvement in developing integration initiatives and encouraging their 'ownership' of new service models. 3) Local champions. 4) Collecting the right information/indicators so that impact/success can be measured and visible to staff, patients/service users and the local population.	particularly challenging. 5) Inadequate local engagement/'buy-in' of the mental health sector, due in part to the legacy of underfunding and 'Cinderella' status of the sector. 6) In some Pioneers with multiple partners, a sense that transformation could happen only at the pace of the 'slowest', most conservative or risk averse stakeholder. 7) 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. **Facilitators:** 1) Being part of a national Pioneer programme, which provided an impetus for local professionals to work together to improve care locally. 2) Building and maintaining good working relationships across organisations and professions at all levels built on trust, so that people could speak		larger one. **Facilitators:** 1) Uncommitted funding.	

				frankly, come to understand each other's perspectives, and develop a shared vision and understanding of what the Pioneer was aiming to achieve. 3) 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. 4) Co-location of operational teams facilitated communication and partnership working between different professionals.			
Carolyn Wilkins	An Allied Approach to Success in Oldham	**Facilitators:** 1) Positive and trusting relationships. 2) A culture of innovation, creativity and empowerment and not micro-management based on old fashioned contractual approaches.			**Facilitators:** 1) System leaders who work together to support frontline practitioners to overcome bureaucratic barriers.		**Facilitators:** 1) Co-operative Council with an understanding of communities which helps to target resources and further develop interventions.
Chris Ham, Judith Smith and Elizabeth Eastmure	Commissioning integrated care in a liberated NHS				**Facilitators:** 1) Managerial leadership in combination with clinician leadership.	**Barriers:** 1) Needs assessment and service specification is time, effort and resource consuming.	

						Facilitators: 1) Using PMS and APMS contracts to facilitate payments.	
Danial Naqvi, Anam Malik, Mohaimen Al-Zubaidy, Falak Naqvi, Anas Tahir, Ali Tarfiee, Sarina Vara, and Edgar Meyer	The general practice perspective on barriers to integration between primary and social care: a London, United Kingdom-based qualitative interview study	**Barriers:** 1) 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. 2) Poor interprofessional 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	**Barriers:** 1) 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) 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. 3) Inadequate training of staff.	**Barriers:** 1) 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. 2) 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. 3) 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,		**Barriers:** 1) Low staffing levels. 2) Insufficient funding.	

		different teams having different agendas for the patient and a lack of motivation for collaborative decision-making.		which professionals find inefficient and a barrier to continuity of care. 4) Inefficient MDT meetings. 5) Interoperability between information systems: the lack of shared information systems.			
DOH	The Evidence Base for Integrated Care	**Recommendations:** 1) A culture of quality improvement. 2) A history of trust between partner organisations. 3) Personnel who are open to collaboration and innovation. 4) Awareness of local cultural differences: organisational cultures evolve separately over decades.	**Recommendations:** 1) The objectives of integration need to be made explicit. 2) Begin integration at the frontline, which impacts directly on the patient experience; based on this, the most apt organisational support for service provision might be identified. 3) The right incentives: it is important that frontline staff recognise and buy into the integration process.	**Recommendations:** 1) Effective and complementary communications and IT systems.	**Recommendations:** 1) Local leaders who are supportive of integration.		**Recommendations:** 1) 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	Educating for integrated care	**Needs:** 1) The need to develop a culture in which people are comfortable and competent in working across organisational boundaries to serve		**Needs:** 1) Financial incentives do not encourage collaboration. 2) Lack of shared data.	**Needs:** 1) 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		

		the needs of patients more effectively and strive continuously to improve the quality of care. **Barriers:** 1) Lack of shared accountability.			prepared to take on a leadership role in improving the system of care.		
Elena Urizar, Roberto Nuño, Caridad Alvarez, Fernández Concepción, Carles Blay, Andrea Quiroga	Barriers and facilitators for the implementation of Integrated Care Pathways ICPs: a systemic perspective	**Barriers:** 1) At macro level there is a general lack of strategic vision towards integrated care from a systems perspective. **Facilitators:** 1) Strategic alignment.	**Facilitators:** 1) Improving data collection, continuous monitoring and evaluation, feedback looping to professionals. 2) Incentives and training healthcare professionals in communication and team-work skills.	**Barriers:** 1) At meso level, the historical fragmentation of organizations poses a strong challenge towards care coordination. **Facilitators:** 1) Better information systems.	**Barriers:** 1) At the micro level a lack of clinical leadership and buy-in hinders the needed multidisciplinary and collaborative work.		
Gerald Wistow, Matt Gaskins, Holly Holder, Judith Smith	Why implementing integrated care is so much harder than designing it: experience in North West London.	**Facilitators:** 1) Co-design, inclusivity (especially of lay partners), an openness to learning.	**Barriers:** 1) 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	**Barriers:** 1) Securing data-sharing and information governance 2) Balancing competition and collaboration.	**Barriers:** 1) Systems leadership. NHS leaders have relatively little training or experience in managing systems as opposed to organisations.	**Barriers:** 1) Developing payment and accountability systems aligned with integrated care objectives.	

			change. 2) Maintaining acute provider viability while reducing hospital admissions. **Facilitators:** 1) A clear, timetabled route map, together with roles of the programme management team and its resources were seen as valuable enablers.				
Gwyn Bevan, Katharina Janus	Why hasn't integrated health care developed widely in the United States and not at all in England?		**Facilitators:** 1) Governance by hierarchy (ownership) or a mode that is close to a hierarchy (through long-term contractual relationships). 2) 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	**Facilitators:** 1) 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.		**Facilitators:** 1) 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. 2) A commitment to cost control and high-quality care.	

			facilitates health care provision and thereby economises on transaction costs. 3) Durability and size.				
Hermina Harnagea, Yves Couturier, Richa Shrivastava, Felix Girard, Lise Lamothe, Christophe Pierre Bedos, Elham Emami	Barriers and facilitators in the integration of oral health into primary care: a scoping review		**Barriers:** 1) Discipline-oriented education and lack of competencies. **Facilitators:** 1) Interprofessional education. 2) 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).	**Barriers:** 1) 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. **Facilitators:** 1) Geographical proximity of interdisciplinary organisations. 2) Partnerships and common vision among governments, communities, academia, various stakeholders and non-profit organisations.	**Facilitators:** 1) The strategic role of the local leader in building teamwork and communities' capacities.	**Barriers:** 1) 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-domain interoperability and domain-specific act codes) at the meso and macro levels. **Facilitators:** 1) Supportive policies and resource allocation: financial support from governments, stakeholders and non-profit organisations at the macro level.	**Barriers:** 1) 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.
Jenna M. Evans, Agnes Grudniewicz, G. Ross	Organizational Context and Capabilities for	**Needs:** 1) Social and Psychological Context: Readiness for Change,	**Needs:** 1) Basic Structures and Design: Physical Structures, Human and Material	**Needs:** 1) Processes: Partnering, Teamwork, Delivering Care, and Improving	**Needs:** 1) Leadership and Strategy: Leadership Approach, Clinician Engagement and		

Baker, Walter P. Wodchis	Integrating Care: A Framework for Improvement	Organisational Culture, and Work Environment.	Resources, Organizational Design, Governance, Accountability, and Information Technology.	Quality.	Leadership, Strategic Focus on Improvement, and Performance Measurement.		
John Deffenbaugh	Becoming an integrated (accountable) care system	**Needs:** 1) Common priorities: move from what's in it for their organisation mindset to how they can help other organisations be successful. 2) Getting into the shoes of others. 3) Agreed objectives. 4) Common narrative. **Recommendations:** 1) Stop clashes and set a common goal (no PBR from NHSI conflicting with CCGs from NHSE) - end artificial divides.	**Needs:** 1) Engaging citizens and communities.		**Needs:** 1) Overarching strategy. 2) Leaders who get along. **Barriers:** 1) System leadership is harder than organisational leadership - there are conflicting performance measures. 2) Leaders need to see the larger picture, be more reflective and shift focus from reactive problem solving to co-creating the future. **Facilitators:** 1) Leaders understand the motivation of partners enabling unconditional commitment, collective ownership - debts, income etc. **Recommendations:** 1) Long-term perspective needs to be maintained and the stakeholders must be motivated.	**Needs:** 1) An agreed allocation of resources and risk sharing system to achieve maximum results across the system.	

					2) Leadership roles must change to become facilitators of change (no more competition).		
Judith Smith, Gerald Wistow, Holly Holder & Matthew Gaskins	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.	**Barriers:** 1) Social and cultural differences including those related to knowledge, organisation and power.	**Recommendations:** 1) Define specifically what changes to services are intended. 2) Convene stakeholders to plan for and support implementation continuously. 3) See outcomes as something for which commissioners and providers are jointly accountable.				**Barriers:** 1) 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.

Kasper Raus, Eric Mortier & Kristof Eeckloo	Challenges in turning a great idea into great health policy: the case of integrated care	**Recommendations:** 1) 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.				**Barriers:** 1) 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. **Recommendations:** 1) 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.	**Barriers:** 1) 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) 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 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. **Recommendations:** 1) 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 policy-maker 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) 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) 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. Policy-makers 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. Policy-makers should preferably not only learn about what happened in other places, but instead learn from other places. 4) 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	The core dimensions of integrated care: a literature review to support the development of a comprehensive framework for implementing integrated care.	**Facilitators:** 1) Shared vision and values for the purpose of integrated care. 2) An integration culture institutionalised through policies and procedures. 3) Striving towards an open culture for discussing possible improvements for care partners.	**Facilitators:** 1) Planned/organised meetings.	**Facilitators:** 1) Information sharing	**Facilitators:** 1) Local leadership and long-term commitments. 2) Leaders with a clear vision on integrated care. 3) Distributed leadership. 4) Managerial leadership. 5) Visionary leadership. 6) Clinical leadership. 7) Organisational leadership for providing optimal chronic care.		

		4) Linking cultures. 5) Trust (on colleagues, caregivers and organisations).					
Mahiben Maruthappu	Enablers and Barriers in Implementing Integrated Care	**Barriers:** 1) A change of culture is required, at both clinical and management levels, without which may lead to a lack of shared vision and problems in the long-term sustainability of integration. **Facilitators:** 1) Common values. 2) Changing clinical cultures.	**Facilitators:** 1) Evaluation models.	**Barriers:** 1) 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. **Facilitators:** 1) IT infrastructure. 2) Leadership coalition. 3) Involvement of primary, community and social care.	**Facilitators:** 1) Clinical leadership.	**Barriers:** 1) 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. **Facilitators:** 1) Funding realignment. 2) Identification of target population. 3) Adequate financing.	**Facilitators:** 1) Supportive regulation. 2) Flexible administrative reorganisation.
Martin Bardsley, Adam Steventon, Judith Smith and Jennifer Dixon	Evaluating integrated and community-based care		**Facilitators:** 1) Defining the intervention clearly and what it is meant to achieve and how, and implement it well. 2) Being explicit about how desired outcomes will arise, and use interim markers of success.	**Facilitators:** 1) Generalisability and context are important - each area will have specific success factors but the aim must be the same.	**Facilitators:** **Recommendations:** 1) Blend designated leadership with distributed leadership.		**Facilitators:** 1) Recognising that planning and implementing large-scale service changes takes time e.g. Kaiser Permanente.

			Recommendations: 1) Establish feedback loops. 2) Engage physicians, patients and families.				
NHS Future Forum	Clinical advice and leadership: a report from the NHS Future Forum.	**Needs:** 1) A duty to promote research and innovation and the use of research evidence. 2) Strong and visible clinical and professional leadership at all levels, focused on increasing trust and encouraging positive behaviour.	**Needs:** 1) Data about quality and outcomes of care is collected, shared and used in a transparent way to support informed patient choice and continuous improvement. 2) Continuing professional development. 3) Responsible officers continue to be in place to support doctors in improving care and ensuring their fitness to practice through revalidation.	**Needs:** 1) Integrated information systems need to be developed, commissioned and implemented.	**Needs:** 1) 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. 2) All organisations, particularly new ones, should ensure that appropriate leadership development and support are in place.		

NHS Leadership Academy	Leadership in Integrated Care Systems (ICSs)	**Barriers:** 1) Performance management and assurance processes that are not aligned to learning and self-reflection. 2) A sense that the goalposts keep moving with priorities, funding and expectations changing. 3) A culture of blame towards leaders. **Facilitators:** 1) Having the security to make long-term plans. 2) Trust and delegation of autonomy from the centre: a permissive, not prescriptive, approach and national guidance that provides a broad, enabling framework. **Recommendations:** 1) Peer support including mechanisms for 'buddying up'. 2) The creation of	**Barriers:** 1) Strategies and agendas that are imposed by NHS England on local areas rather than being clinically-led and driven by local need. 2) Complex accountability structures and configurations. 3) Insufficient development, support and peer support for leaders. **Facilitators:** 1) Involving staff and service users. 2) Clarity about how performance will be judged. 3) Clarity about how accountability will work, and responsibilities of individual organisations. **Recommendations:** 1) Local champions who will push and progress the work, and 'win hearts and minds'. 2) Skilled external	**Barriers:** 1) Lack of coordination and alignment at national level between NHS England and NHS Improvement. 2) Different performance regimes and cultures, including between the NHS and local authorities. **Facilitators:** 1) Relationships before structures: drawing on established working relationships built over the years.	**Needs:** 1) 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 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		**Barriers:** 1) Lack of a coherent view of whole population needs. 2) Sheer volume of bureaucracy involved in getting service changes through.

		'safe spaces' for leaders to meet with peers and share problems and solutions. 3) More opportunities to learn from other professions and sectors.	facilitation, to help deliver complex programmes. 3) Systems leadership development for middle managers across the system. 4) 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.		frameworks. j) fostering a learning culture across the whole system. **Barriers:** 1) Capacity and capability of local leaders, pressure and stress in these roles, uncertainty about the future. 2) People in leadership roles finding the job lonely and feeling isolated. 3) High turnover of the leadership workforce, resulting in loss of experience and skills. 4) Confusion about where the decision-making power lies. 5) Clinical leadership is especially challenged by bureaucratic constraints. **Facilitators:** 1) Stability in senior leadership positions across organisations. **Recommendations:** 1) Leadership programmes and professional development opportunities.		

Nick Goodwin, Judith Smith, Alisha Davies, Claire Perry, Rebecca Rosen, Anna Dixon, Jennifer Dixon, Chris Ham	Integrated care for patients and populations: Improving outcomes by working together	**Barriers:** 1) NHS management is permission based and has a risk averse approach where innovation is needed.	**Facilitators:** 1) Clear articulation of benefits to patients, service users and carers. 2) Approaches that measure experiences of patients, service users and carers in relation to integrated care. 3) Need for GPs to adapt to provide services at a larger scale	**Barriers:** 1) Divide between primary/secondary, health/social care: different contracts, employment, free/means tested. 2) Absence of robust electronic sharing record.	**Facilitators:** 1) Creating powerful narrative at national and local level. **Recommendations:** 1) Setting a clear, ambitious and measurable goal to improve the experience of patients and service users, implement change at scale and pace.	**Barriers:** 1) 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. **Facilitators:** 1) New payment incentives and local currencies. 2) Commission services based on outcomes rather than items of delivery.	
R Humphries	Integrated health and social care in England – Progress and prospects	**Barriers:** 1) 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.				**Barriers:** 1) 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 implementation styles will play out. **Recommendations** 1) A new settlement that brings together all health	

						and care funding into a single, ring fenced budget and overseen by a single local commissioner.	
Rebecca Rosen, James Mountford, Geraint Lewis, Richard Lewis, Jenny Shand and Sara Shaw	Integration in action: four international case studies	**Facilitators:** 1) Joint vision shared by senior officers in health and social care. 2) Taking an incremental approach on progress. 3) High level of trust between GPs, specialists, nurses and other stakeholders. **Recommendations:** 1) Patient-centred culture: focus integrated care on patient needs.	**Barriers:** 1) Slow uptake by some physicians due to reluctance to adapt to new methods. **Facilitators:** 1) Multi-professional teams supporting care coordination and review of high risk patients. 2) Staff commitment and belief that integration is doing the right thing. 3) Joint training and development across organisations involved in integrated systems.	**Barriers:** 1) Single condition services risk silos for chronic conditions, fragmenting care for those with multiple chronic complex problems. **Facilitators:** 1) Involvement of all relevant health care providers to create broad support. 2) Planned increase in provider competition.	**Barriers:** 1) Lack of performance management role (indirect influence). 2) Variable progress in different localities is dependent on local leadership. **Facilitators:** 1) Active Medical leadership in charge of developing care standards and resources and raising awareness about expected standards of practice. 2) Respected medical leaders and high trust in leadership based on track record. 3) Skilled leaders with the ability to win the hearts and minds of frontline staff.	**Barriers:** 1) Limited benefit to individuals in the organisations until payment contracts have been redesigned. **Facilitators:** 1) When transfer of work between organisations does not cause issues with payments.	**Barriers:** 1) Inconsistencies in national policy.
Richard Gleave	Across the pond - Lessons from the US on Integrated Healthcare	**Recommendations:** 1) Risk needs to be shared in collaboration between organisations rather than assigned individually.			**Recommendations:** 1) Integrated governance models must be built on strong clinical leadership, and must be combined with a culture that prompts delivery of integrated care.		

Sara Shaw, Rebecca Rosen and Benedict Rumbold	What is integrated care?		**Needs:** 1) Standardised, validated tools and indicators that measure integration across different settings relative to a set of models, structures and processes. 2) 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. 3) Longitudinal methods that move beyond simple snapshots of integrated care and follow integrative processes through time, allowing evaluators to assess not only the long-term implications for integrated delivery, organisation and outcomes, but also the way in which planned change is actually experienced for those with long-		**Needs:** 1) Focused, 'off-the-shelf measures' that suit a specific purpose or aspect of integrated care which can be applied by decision-makers and planners across diverse health and care systems and settings.	**Needs:** 1) 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 quality care for local communities and user groups and consider the contextual factors that affect development and delivery. 2) Qualitative and mixed methods approaches (such as comparative case study research and/or realistic evaluation) that facilitate understanding of which integrative processes work, for whom, and in what circumstances.	

			term conditions.				
Sara Shaw, Ros Levenson	Towards integrated care in Trafford	**Recommendations:** 1) Recognise that major change is needed, ensure a clear and agreed vision from GPs to specialists	**Recommendations:** **1) Make a clear case for change** **2) Engage with stakeholders when developing integrated systems**		**Recommendations:** 1) Facilitate local leadership that has good knowledge of the workings of the local systems.	**Recommendations:** 1) Work simultaneously with commissioners and service providers so that quality and budgeting is fulfilled.	
Sheena Asthana, Felix Gradinger, Julian Elston, Susan Martin, Richard Byng	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.	**Facilitators:** 1) 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). 2) 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		**Facilitators:** 1) 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. 2) 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	**Facilitators:** 1) 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).	**Facilitators:** 1) 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.	

		performance; there was a willingness in Coastal to genuinely question the process and outcomes of integrated care.		iteratively evolving teams at locality level. This in turn allowed for better service delivery.			
Sian E. Maslin-Prothero and Amy E. Bennion	Integrated team working: a literature review	**Needs:** 1) Need for a shared understanding of the purpose of the joint venture and a mutual understanding of, and commitment to, the vision of the venture across the organizations involved. 2) Need for the development of a shared culture. 3) The promotion of professional values of service to users and socialisation into the immediate work group. **Barriers:** 1) 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 of collaborative working	**Needs:** 1) Establishment of new roles to support new ways of working. **Barriers:** 1) A lack of clarity of purpose for integration, and a failure to agree partnership outcomes. 2) The lack of understanding and clarity of others' roles, leading to conflict between team managers. 3) Imbalance of power and poor communication. 4) 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	**Needs:** 1) 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. 2) 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. 3) Exhibiting a past history of joint working. **Barriers:** 1) Divide between social care staff medical staff: differences in geographical boundaries, communication boundaries, and status inequalities.		**Barriers:** 1) Financial limitations as to what can be addressed with the resources available.	**Needs:** 1) 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) Recognition of grey areas in policy and organizational terms and encouraging local agencies to work together in those areas.

		led to unrealistic expectations being placed on staff.	teams.				
Stephanie Best	Facilitating integrated delivery of services across organisational boundaries: Essential enablers to integration			**Needs:** 1) Horizontal communication. **Facilitators:** 1) 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) 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	**Barriers:** 1) Lack of support. 2) Overestimated expectations. 3) Autocratic leadership style **Facilitators:** 1) Setting direction, setting the vision. 2) Accessibility through visibility both within and across organisations. 3) Joint decision-making. 4) Authority to influence across organisations.		

				relationships, as this has the potential to lead to a 'fluidity in thinking' when managing difficult or complex situations.			
Sue Mackie, Angela Darvill	Factors enabling implementation of integrated health and social care: a systematic review	**Facilitators:** 1) 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.	**Facilitators:** 1) 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.	**Facilitators:** 1) 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.	**Facilitators:** 1) 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) 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.	**Facilitators:** 1) 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. 2) 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.	**Facilitators:** 1) 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.

Tom Ling, Laura Brereton, Annalijn Conklin	Barriers and facilitators to integrating care : experiences from the English Integrated Care Pilots	**Barriers:** 1) Feelings of being sidelined, or uninvolved with planning from the beginning. 2) Reluctance to engage was a major barrier. 3) Poor organisational culture which included local perceptions of professional boundaries. 4) A lack of openness which was part of a wider NHS 'blame culture'. **Facilitators:** 1) Widespread agreement and shared values among participating staff promoted engagement and motivation. 2) Feelings of being involved with planning from the beginning. 3) Willingness to engage. Creating shared beliefs about the benefits of change was described by staff as	**Barriers:** 1) 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) 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) Lack of training led to staff being unclear whether they were permitted to take on particular tasks or feeling unprepared to take on new roles. **Facilitators:**	**Barriers:** 1) 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. 2) 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. 3) Lack of ongoing, planned communication between senior executives in the partner organisations. 4) Lack of co-location: lack of working together face-to-face in the same building decreased the quality and frequency of communication, and exacerbated problems by reducing access to	**Barriers:** 1) Failure when senior management or team leaders were perceived to be weakly committed to implementing lasting change. 2) 'Poor' leadership blamed for lack of shared beliefs about the benefits of change. **Facilitators:** 1) Success when senior management or team leaders were perceived to be strongly committed to implementing lasting change. 2) 'Good' leadership.	**Barriers:** 1) Staff cuts.	**Barriers:** 1) Chains of managerial approval among multiple organisations and slow decisions about resource distribution were perceived as a barrier to innovation.

		critical to progress. 4) 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. 5) Staff feeling permitted to take risks.	1) Size and complexity: simple, smaller integration made more rapid progress and had the ability and authority to come to quick decisions. 2) Staff were motivated when there was clear and consistent communication from leaders within organisations about what work was required and contribution needed from participants. 3) 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. 4) External facilitation has been very helpful in getting two organisations to work together, which is a method well rehearsed in the wider literature on	colleagues' professional knowledge. **Facilitators:** 1) Compatible IT systems and good management of the sharing of private data. 2) 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. 3) Ongoing, planned communication between senior executives in the partner organisations. 4) 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. 5) Shared data systems or other information technology that aided communication and knowledge transfer.			

			managing change.				