

# Why care about integrated care?

## Part 3. Weighing sunlight: delivering integration in practice and measuring success\*

ARTICLE

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### SUMMARY

The first two articles in this series have shown the direction of travel for health and social care in England, and how the status quo in already stressed systems is not viable. It is difficult to disagree with the principles of ‘integrated care’, yet we currently lack evidenced models on which we might build. There is a need for experiential learning and sharing of experiences. This third article describes in more granularity the experiences, positive and negative, of an early-adopting integrating service in south-east London that incorporated aspects of the local authority and secondary care physical and mental health services. It provides structured guidance on which types of integration one might aim for, managing internal and external relationships, and discussion on evaluating progress.

### LEARNING OBJECTIVES

After reading this article you will be able to:

- consider the practical ‘types’ of integration that can occur, from the organisations through to the teams involved, and be aware of their various advantages
- appreciate the professional relationship and developmental opportunities and challenges, both internally within the integrated service and externally with local partners
- describe various mechanisms for evaluating the successes and failures of an integrating service or organisation.

### KEYWORDS

Integrated care; NHS long-term plan; integrated care system; local authority; primary care network.

means that the status quo for already stressed systems is not viable. Part 2 (Tracy 2020b) outlined legislative, policy and structural changes emerging over the past decade. From the Five Year Forward View (FYFV – see part 2 for a full table of acronyms and initialisms) through to the NHS Long Term Plan, reduced bureaucracy and barriers, and better integration of services is a clear message for purported enhanced outcomes and savings, although the Social Care Green Paper remains a key missing element. Integrated care systems (ICSs) are the next evolution of sustainability and transformation partnerships (STPs) linking healthcare commissioners and providers with local authorities to develop long-term local population plans. These will work closely with the emerging primary care networks (PCNs).

At a conceptual level it is difficult to disagree with more ‘integrated care’: you will be able to think of numerous local examples of how teams and services could work more effectively together, how bureaucracy should be reduced and how the complexity of existing systems could be rationalised. However, it is in the operationalisation of integrated care that the real-life challenges emerge. There is a lack of adequate evidence and the literature that does exist typically consists of policy guidelines at a very high level of generality. Pulling together disparate services requires engagement from many partners, and for many reasons, both political and practical, some services might not be able to integrate, even if this is considered optimal. This leaves local services with the problem of what to do, where to start when one considers the issues of sequencing of change, and what might be measured to determine and share success and failure. There has been little robust evaluation of experiences to date, and there exists an important role for ‘learning by doing’ and sharing that experience.

This third article addresses the logistics and real-life challenges of applying these approaches, drawing on the experiences of a mental health service in the early stages of integration (‘early

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\*This is the third of three articles in this issue focusing on integrated care.

Parts 1 and 2 of this three-part series have shown the direction of travel for health and social care in England. Part 1 (Tracy 2020a) outlined the increasing quantity and complexity of need, finances not projected to match this, and a workforce recruitment and retention crisis anticipated to worsen. All of this

integrating’) in south-east London. It will describe the practical issues faced and overcome, early attempts to evidence outcomes and how services might approach this nationally in the future. We will address three major domains: which teams and services might be integrated; the new internal and external relationships that will emerge; and how one might begin to measure and share outcomes.

### Which integration will you have?

What we learned:

- some high-level decisions will be pragmatic and based on senior relationships and priorities, for example the involvement of primary care and the local authority
- ‘integration’ can mean different things: closer working, co-located services or fully merged new teams and functions
- there are no ‘correct answers’ as to which teams might be merged; strengths and weaknesses emerge in all models.

What you might consider:

- map out organisational interfaces; consider what might be optimal and what is possible
- ask what new models are trying to achieve: more efficient cross-working, financial savings, better clinical outcomes? What does not work well currently and, in an opportunistic moment of change, how might new models of care redress this?
- consider structural challenges: from IT and email systems, through human resources and contractual work, to where teams and people might be located
- take time and start early in explicitly considering the impact on front-line staff, particularly practical aspects of change such as travel and car parking; consider the roles and cultures of the teams and involve them early in discussions.

### The organisations involved

The first and most fundamental question is which services are integrating. This is likely to be driven as much by practicalities and politics as by preferences or perceived optimal models. Many of these decisions are likely to be taken ‘above’ front-line clinicians and even relatively senior managers, sitting with trust boards, local authorities and commissioning groups. Nevertheless, it is helpful to map this out: it aids understanding of the local model and interpreting data from others (at present, all are likely to describe themselves as ‘integrated/integrating’ systems but be quite different). It is also worth considering the power of shop floor clinicians agreeing on change: if this occurs it is a compelling case for more senior levels of management.

Table 1 gives an overview of the services that might be included. One might consider this across several levels: from primary care through various secondary and tertiary healthcare services, to the local authority and the third sector. Each of these will have numerous subdivisions, some divided by demographic group (e.g. children’s or older persons’ services), some by geographical location and some by function (e.g. psychosis or frailty pathways). This can also occur to different degrees: from merged teams with single management, through merged boards and finances, to co-located but separate services or agreements/memoranda on closer working.

There are many permutations of this: for example, a National Health Service (NHS) trust and local authority might keep their own boards and structures but agree to pool service and team management; they might harmonise human resources processes, but keep finances separate, and so forth. In terms of the NHS and local authority, national challenges include the facts that they use separate email and IT systems; in the short term, work-arounds can be found but at present these systems cannot be merged, inevitably leading to some duplication.

### The specific teams: closer working or merging?

Clinicians and managers are most likely to get involved at a more granular level about which and how specific teams or services within integrating organisations might better work together in novel ways. As an example, let us consider this within the context of a typical mental health trust. At the highest level, one might deliberate major functional groupings within a trust – child and adolescent mental health services (CAMHS), older persons’ mental health (OPMH), intellectual disability, adult mental health (AMH), forensic mental health – and those that might be divided geographically, for example by borough or district. There are thus two broad approaches one might take: integrating functional services (such as CAMHS with children’s social care) and integrating geographical ones that specify merges by location. There is a general move in the UK back towards geographical models, in part to align with integrated structures and local authority boundaries, but clearly there are many variations that this might take.

One might make a cogent argument, for example, to include CAMHS, AMH and OPMH – covering the lifespan and families – in a geographical footprint. However, historical and training boundaries mean that such profound merge is unlikely to occur widely in initial iterations of integrated care. The exemplar organisation discussed in this article has adult and older people’s mental health, secondary

**TABLE 1** An overview of the areas that should be considered by integrating services

Description of degree of integration	Organisations	Teams (sample list)	Support functions
This will vary by domain and the described organisation/service/support function but most crudely might be considered: integrated, partially/hybrid integrated, not integrated, or not included in a model	Primary care Secondary mental health Secondary physical health Social care Tertiary services Third (voluntary) sector	Adult mental health: community mental health teams, in-patient wards, crisis teams, early intervention in psychosis Older persons' mental health: community mental health teams, memory services, in-patient wards Community physical health: district nursing, end-of-life care, physiotherapy, diabetes, respiratory and cardiovascular care Adult social care: housing, safeguarding, public health, education, substance use services	Finance Human resources Information Technology Governance Estates Management structure Professional development and training

Source: adapted from Tracy et al (2019).

care physical health and adult social care within a geographical boundary of a London borough. Fig. 1 maps out the integrated teams in this model; it might be informative to contrast these with the types, numbers and relationships of parallel services where you work.

These questions continue at a more granular level. For example, let us just consider adult mental health in a given district or borough. In the UK today, it is typically divided into a large number of 'functional' teams: home treatment, early intervention, rehabilitation psychiatry, in-patient services and community teams that have most commonly in recent years been split into 'psychosis' and 'non-psychosis' aspects. For some, substance use and intellectual disability might also form part of this, and there will be links to specialist and tertiary services, for example eating disorder services. The question arises as to how these teams might work in a more integrated service with physical health and the local authority. Again, there will be a spectrum of possibilities, from staying structurally similar but working more closely with other teams and services through to physical merging. The general push of integration will be towards fewer teams and more 'local footprint-based' care. In some ways this perhaps models the more old-fashioned generic community mental health team (CMHT) – the difference being presumed enhanced working with the local authority, secondary care physical health and primary care.

The opportunities and problems of integration are exemplified by considering the two ends of the psychosis treatment spectrum: early intervention and rehabilitation services. On the one hand, the populations they serve have much to gain from a novel community team with enhanced social care and physical health input; on the other, the reason these evolved as distinct in the first place was an

awareness that these patients risked getting lost in a wider, larger system. There is no single correct answer as to which teams might merge, and we are again confronted by the lack of evidence or guidance.

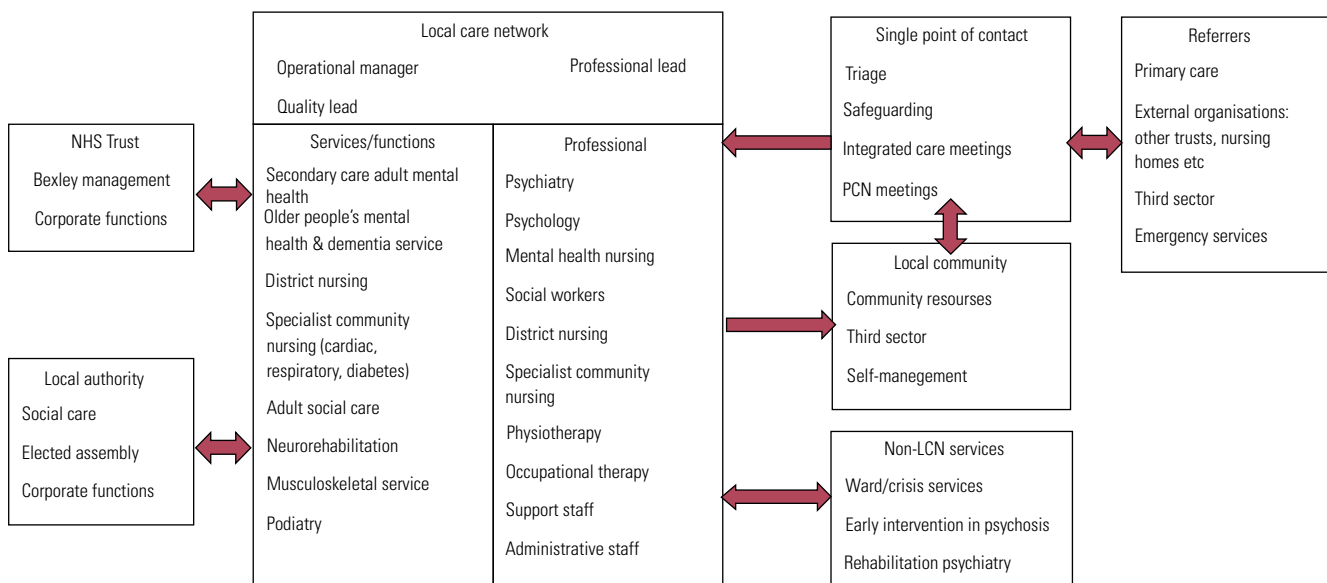
### *Relationships: looking internally – 'laneyards and car parking'*

What we learned:

- the changes that integrated care necessitate are enormous and can be very distressing for staff: people may fear redundancies, loss of role and expertise, and being overwhelmed by increases in quantity and new types of work
- staff will appreciate the concept and values of integrated care, but will also have very practical implementation concerns that must be addressed early – from needing different commutes to work to problems with parking and desk-space
- integrating health and social care presents unique cultural challenges: social care staff can feel a junior partner to, and less valued by, healthcare, and healthcare staff may have strong allegiances to the NHS that can feel threatened.

What you might consider:

- conversations with staff can never start early enough or be frequent enough: engage as soon as possible, including being honest about what is known and not known
- management should lead by example, with a cohesive leadership team from all staff backgrounds and using these senior staff as exemplars of integration
- engage those who use services and their carers
- have a good communication strategy.



**FIG 1** The local care network (LCN), the primary new integrated team in a south-east London borough, which is geographically constituted of three such teams that each map onto a corresponding general practice (GP) primary care network (PCN). This offers a considerably wider range of services and professionals than a typical community mental health team (CMHT) and has fewer interfaces than many such services. In this model, 'secondary mental health' includes general psychosis and non-psychosis care, with the exception of early intervention and rehabilitation, which remain separate. The LCN has a single management team, meaning that there are no internal referrals. There is a matrix management structure, whereby the LCN operational manager and quality lead may be from any professional group, but each profession has a professional lead for development and training. Most referrals come via a single point of contact that will take all mental health, community physical health and social care referrals within the borough. Note that in-patient and crisis services also sit outside the LCNs and work across the three LCNs.

### *From the conceptual to the practical*

It has been our experience that one of the greatest challenges has been engaging the hearts and minds of staff working in proposed novel services. For obvious reasons, integration appeals to service users (see the section 'Matrix management and culture' below regarding terminology), their carers and relatives, and the public, none of whom would design the professional siloed services we have today. The potential gains of reduced bureaucracy, avoiding delays in referral and repetition of one's story, and more joined-up care and a better experience are self-evident (whether or not delivered in practice). For managers, those factors equally ring true, added to by the allure of being able to deliver services on often static or reducing budgets through better efficiency.

Front-line staff will appreciate and understand these factors – we have yet to meet anyone conceptually against 'more integrated care'. However, a core tension can be a sense that the oft-mentioned demographic, workforce and financial stresses on health and social care are what matters and are leading service redesign, rather than a philosophical drive to provide better care. Of course, these are not exclusive concepts, but there is the danger with integrated services that it can feel like 'the money' (or lack of it) is driving everything.

Staff will, understandably, immediately identify the practical challenges they will face in delivering integrated services. These factors are multifaceted and real, and need to be inquired about and addressed as early as possible. Conceptually 'simple' but practically highly important factors rapidly emerge, such as the upheaval of physically changing site and determining car parking, particularly for staff who do home visits. Discussions should involve potential real-world issues such as: school runs, traffic congestion, and personal life commitments around the geography of our home and work.

All existing teams have defined roles, from home treatment through to early intervention. Staff will recognise and value the unique inputs their teams provide and will be concerned that this might be lost in bigger systems. Merging teams, beyond the physicality of any geographical move, challenges staff identities and this is often not welcomed. A common, understandable, refrain went along the lines of 'integration is a good idea locally but won't work for my team'.

It has been our experience that although fear that specialism will be lost in a bigger team was common and one of the biggest concerns, this has not been borne out in practice. However, initial feedback from staff about this risk was so powerful that it was explicitly considered from the start and clear lines of clinical accountability and opportunities

for interaction with appropriate clinical groups were carefully included in the design.

### *Multi-skilled working or overworked generic jobs?*

All staff will recognise the unwelcomed duplication, bureaucracy and delays that come from existing models and will favour their reduction. Equally, all will be in favour of enhancing their own training, skill mix and services for those with whom they work. New integrated services might assist with all these points, but they also raise clear and understandable challenges.

Some tasks might be relatively universal, such as documenting the core features of ‘presenting complaints’ and difficulties, and it would seem reasonable that most staff could begin to document these, including a range of mental health, physical health and social care needs. Common electronic assessment forms afford the opportunity to capture this information, reducing time and effort for both service users and staff. However, anyone who has tried to design a form to capture everyone’s (service users’, carers’ and professionals’) concerns and areas of importance will realise how quickly and burdensome these can grow.

It is perhaps a less explored aspect of health and social care that the barriers against which we all complain undoubtedly act, even if unintentionally, to reduce or manage demand. Integrated reduced bureaucracy also means fewer barriers to accessing already overworked services. This will apply for both ‘true’ need (e.g. in part 1 we noted how only a minority with a mental illness received any care at all; Tracy 2020a) and ‘false’ or inappropriate need (e.g. a district nurse picks up a possible case of mild depression in someone whose wound dressing they were changing and books the person into a consultant psychiatry clinic). In either case, the integrated system might be perceived as ‘creating’ more work, which will inevitably concern many staff. There are arguments that such systems should tackle need more appropriately at an earlier stage and thus actually reduce workloads, but the general lack of evidence at this time is problematic.

Integrated services offer staff the opportunity to learn new and even very novel skills from other professional groups with whom they might otherwise not ordinarily interact. This might be through observational learning, joint working, shared teaching or clinical discussion, and more formal education and skills development. We have found this to be very fruitful, for example in our south-east London service we started with areas common to most professionals, such as substance use or safeguarding work.

Conversely, ‘multi-skilled working’ might feel like ‘doing someone else’s job’ (which perhaps was lost through ‘financial efficiencies’). Most of us have specialist skills and we might worry about losing them through less exposure in more generic services, and indeed that such services might get cut. Trainees’ competency development and continuous professional development of established clinicians will need to find ways to work with this. There are no fundamental reasons this cannot occur and the Royal College of Psychiatrists has issued largely supportive guidance on integrated care systems (Royal College of Psychiatrists 2019): it will be incumbent on local trainees, trainers, deaneries and the RCPsych to work together to ensure that this happens and indeed taps into new development opportunities.

A potentially wider range of service users within an integrated team risks staff being anxious about missing important factors or dealing with emergencies outside of their skill set: for example, those from social care managing someone feeling suicidal, or mental health staff documenting intermittent problems with respiration. Of course, this can happen with non-integrated models and without the resource of the wider groups of professionals. Clear local systems to triage such instances are required.

### *Matrix management and culture*

Integrated teams will contain, by design, wider groups of professionals. However, that might mean that there are relatively fewer of those with whom one is used to working, and for many staff direct line management might now be from someone of a different professional background. In principle, this is not organisationally unreasonable, but it may bring up the question of ‘what does profession X know about my work?’. Our model is of ‘matrix management’, wherein ‘operational’ management of how teams run can be via any appropriately skilled and qualified staff, but ‘professional’ management that considers career training and development must be done by someone of the same background.

The cultural issue of ‘identity’ is also critical and can be quite complex. In our experience, social care can often feel a ‘junior partner’, with healthcare driving and leading changes (and indeed this is correct insofar as the NHS Long Term Plan is the driver). Recognition needs to be made that we are not necessarily ‘all NHS’ anymore. Conversely, in one of our integrating organisations, as we were merging with adult social care, staff lanyards were changed to remove the NHS lozenge to foster cohesion. Yet so many staff in healthcare identify passionately with being part of the NHS and reacted

strongly against this move. Within the NHS side, both physical and mental health staff can feel that the ‘other’ is leading or receiving emphasis: this is typically not the case, but the perceptions matter and need to be explored and opened up.

Language matters and is often used quite differently across organisations. Social care will correctly remind us that they do not see ‘patients’ – in keeping with BJPsych Advances journal style guidelines and RCPsych guidance on the topic, we have generally kept to that phrase in these three articles, but integrated systems will raise interesting variation in perspectives and thinking on this and related issues. More subtle differences can arise, resulting in often profound differences in understanding even when using the same words. One seemingly simple example we found, which had significant impact on an individual’s care until the difference was realised, was how differently health and social care staff understood and had been using the phrase ‘trauma-informed care’.

Nevertheless, it has been the experience of several of us that one of the most profound but least recognised or discussed gains of integration is also cultural. Our training gives us different, and often complementary, views and perspectives, as well as variation in factual knowledge or skill sets. We have found these to offer very significant gains. At a very elemental level, social care brings a valued strengths-based enablement approach and philosophy that works from the perspective of getting people to live their lives as independently as possible and focusing on their strengths. Conversely, many in social care have valued the evidence-based evaluative approach brought by healthcare.

### Relationships: looking externally

What we learned:

- integrated care typically brings existing external stakeholders closer: this affords opportunities to build stronger relationships and care models
- external partners, notably primary care and clinical commissioning groups, are going through their own significant changes, which might bring conflict or pressure with internal models
- the multiple changes and acronyms are confusing, even for staff involved in delivering change, and often bewildering for those not involved.

What you might consider:

- use this opportunity to enhance relationships and clinical models, particularly with primary care
- try to keep all staff updated on local changes, for example to primary care networks and the surrounding integrated care system

- try to keep staff informed of the roles of the different partners and why they matter to local care
- keep the focus on outcomes for service users, not staff or institutions.

### Primary care

Most existing teams and services have relationships with primary care, whether or not they accept direct referrals. In the integrated landscape, individual teams/services might retain direct access/referral but might introduce single assessment hubs covering a wider range of services. For example, in the described model, an overarching single point of contact has been established that allows primary care access to all secondary care mental and physical health services as well as adult social care (Fig. 1). A challenge in this model has been that once open to any part of the integrated care system, it might seem reasonable that ‘all relevant problems’ are thereafter dealt with internally. Depression is perhaps a good case in point: the local system noted is such that, as per National Institute for Health and Care Excellence guidelines, mild to moderate depression is initially dealt with in primary care, even if the individual is receiving care from the local care network (LCN) for other health and social care reasons. That opens up the potentially counterintuitive situation for a service user and general practitioner (GP) that someone being seen in an integrated team setting for their physical health might be asked to see their GP about their low mood, despite that team already having a full complement of mental health professionals. An analogy for the individual and GP would be that if one was admitted to an acute general hospital with a specific illness, it would not necessarily follow that any other identified healthcare problem would be managed by other in-patient teams.

Primary care practices are undergoing their own changes, moving into primary care networks (PCNs, explained in part 2; Tracy 2020b) of practices covering ‘natural populations’ of about 30 000. The aim is to balance personalised care with some scale up of facilities. The PCNs will face analogous issues to the integrated teams in terms of what they might wish to manage internally in a single PCN (covering several practices) or whether they might wish to share resources for more complex issues, for example frailty pathways, across a group of PCNs in a local district or region.

The increased scale and scope of PCNs offers new ways of working in primary care and new potentials for interfacing with secondary care. There is a national trend towards greater psychosocial and preventive work, for example with more community pharmacists and ‘social prescribing’. Some of this

will augment and should link well with secondary care, but one can also envisage overlap that might cause confusion. Equally, a PCN that clusters several primary care practices offers a similar population scale to that typically seen by a community mental health team. This can offer a more efficient interface for both sides. In the described south-east London service, the PCNs map onto the LCNs in three borough-divided footprints (there is actually a fourth PCN that traverses the LCNs, but for management purposes those practices fit into the three LCN:PCN governance/interface meetings). This affords them the opportunity for regular interface meetings that explore and rectify governance or systems issues, as well as ‘integrated case management’ (ICM) meetings where patients with complex multiple needs are reviewed and optimal care decided. However, it is important to note that PCNs are not obligated to map onto the boundaries of mental health integrated teams and mismatches risk interface difficulties.

### *The local authority*

One primary drive of integration is to enhance the relationship with the local authority. As with healthcare, local authorities divide into ‘directorates’, for example, children’s services, adult services, public health, substance use services and so forth. Local authorities face different targets, at least at present, from those in healthcare, for example the Adult Social Care Outcomes Framework (ASCOF).

The local authority, secondary care and commissioners, via the CCG, traditionally come together to review provided services. The general merger and expansion of CCGs to map onto an ICS means that in many instances this interface, as it has historically existed, will be lost. This is a concern to many, not least as such relationships have often been built up over many years and the new enlarged ICSs will have a larger perspective that might miss or be in conflict with the smaller population covered by the local authority. New ‘place-based boards’ will replace these relationships, but they have not been tested in practice. In the described exemplar site, the local authority and secondary care functionally merged, but this is a less common model at this time.

### *The third-sector and external agencies*

Opportunities exist for new ways of working with external and third-sector agencies. A principle of integrated systems is place-based care – see part 2 (Tracy 2020b) – and being part of local communities. Although this is currently less explored in the first iteration of services, there are obvious novel opportunities to work with resources such as cultural, sporting and faith-based organisations.

### *The integrated care system*

Integrated care systems (ICSs) were described in part 2 (Tracy 2020b). It is intended that ICSs will allow long-term planning (and commissioning via the matched CCG) over a considerable geography and demography, aiming to minimise duplication and inefficiencies. However, there are numerous overlaps that will bring about inherent tensions that need to be resolved: for example between different NHS trusts, NHS England and NHS Improvement, local integrated care partnerships and so forth.

## **Implementation and measuring success and failure**

### *The science of implementation*

The science of implementing change is large and varied. A full description of both theoretical and empirical aspects is beyond the remit of this article; for those interested in more detail we refer to works such as Greenhalgh (2017). Briefly, literature often divides obstacles and facilitators to overcoming barriers at several stages – from initiating through to maintaining (Table 2) – and at different levels: organisational, team and leadership.

### *Organisational factors*

Implementation requires a capacity and receptive context for change, involving and engaging staff, patients and carers. A nine-component model on the spread – or failure to spread – of organisational change has been proposed (Robert 2010):

- the relative advantage of the proposed innovation
- identification of potential adopters
- utilisation of social influence through opinion leaders
- the structure of the organisation, its receptivity to absorbing new knowledge and the local context for change
- the organisation’s readiness for the specific change and whether supporters are in the majority and with greater influence
- innovation assimilation by the organisation
- implementation and ‘routinisation’ within the organisation: can be done well or badly; devolution to teams; hands-on input from leaders; bespoke training; targeting resources; communications
- external context/environment; behaviour of other organisations in similar situations
- dynamic linkage between the previous eight factors.

### *Team factors*

Clearly, multiple factors within teams will determine the success or otherwise of change. The PARiHS

**TABLE 2** Characteristics of innovations

Stage	Intervention	Potential barriers	Overcoming barriers
Orientation	Promote awareness	Unfamiliar with literature	Multichannel messages; approach key figures/networks
	Stimulate interest	No sense of urgency, seems irrelevant	Attention-catching literature; personal approach; confront regarding performance
Insight	Create understanding	No knowledge; information too complex	High-quality but concise messages; information based on practice problems; repetition
	Develop insight into own routines	Limited insight; overestimates own performance	Audit and feedback; compare with peers
Acceptance	Develop positive attitude to change	See disadvantages, have doubts, not attracted to it	Adapt innovation to wishes of target group with local consensus; good scientific arguments; involve key opinion leaders
	Create positive intentions/decision to change	Doubts about feasibility and own efficacy	Peers demonstrate feasibility; detect bottlenecks, seek solutions
Change	Try out change in practice	Not starting, no time, lack of skills, does not fit into routine	Extra resources, support, training; redevelopment of care processes, temporary support, information for patients
	Confirm value of change	Insufficient success, negative reactions of others	Plan with feasible objectives for change, inventory of bottlenecks, seek solutions
Maintenance	Integrate new practice into personal routines	Relapse, forgetting	Monitoring, feedback and reminder systems; integration in routine care, local protocols
	Embed new practice into organisation	No support, no budget	Provide resources, support from senior management team, organisational measures, rewards; payments

Source: adapted from Grol & Wensing (2004).

framework ('promoting action on research implementation in health services') (Kitson 2008) proposes three-way interactions between any evidence, the context of the change and facilitation required by the interplay of these first two. A quality improvement (QI) approach might work quite well at the team level, both by acknowledging the need for ongoing iterative change that is unlikely to get things 'right' the first time and also engaging front-line staff to determine what is working and not working and having them lead necessary change.

### Leadership factors

Conventional taxonomy divides leaders into several subtypes (Elwyn 2000): charismatic, where a powerful confident personality can engender loyalty and gather followers; inspirational, setting and leading high standards and motivating others to commit to and work hard for a cause; transformational, facilitating a democratic approach and getting others to step forward; and laissez-faire, giving little direction. There is no 'right' style (though the final one is of debatable utility), but it can help the leaders themselves, the teams and the organisations to recognise the different styles, strengths and weaknesses that individuals bring to different problems and situations. Our organisations have tried to work on culture and ideas such as joy in work and psychological safety

### Measurement: what to weigh?

Three major issues present themselves when considering how one might measure success and failure in an integrated service. First, integrated models, as we have seen, will vary widely and thus cross-

comparison between them is difficult. Second, organisations often lack 'before' data with which to make subsequent comparisons. Third, in a complex changing system that has numerous inputs, many coming from outside of the integrating system, ascribing causality to the new model can be very difficult, particularly in the absence of a 'control model' for comparison. These issues should not preclude integrating organisations from trying to measure change: the above-mentioned lack of evidence on the topic makes it ever more important for early sharing of 'learning from doing'. Describing one's integration model is a key first step, as this will also allow other organisations to make fairer comparisons with their own. Is it geographically or 'functionally' based, which age groups and population types does it serve, which organisations and teams are involved, and how closely aligned or merged are they? A typography of integration has not yet been established to allow a universally agreed description of these factors, although it is likely to emerge in one form or another in the coming years.

### 'Process' markers of care

Most policy work on integrated care talks of reduced bureaucracy and increased efficiency, and many aspects of these are open to measurement: referral times, numbers of assessments and time between appointments, crisis or emergency admissions and delayed discharges and so forth are all typically already measured by organisational business offices. These issues also lend themselves to QI interrogation, once again offering the opportunity to allow staff to name and rectify the issues of most importance.



### Clinical outcome measurements

Ultimately services are provided for the benefit of patients. Measures which capture overall experience such as the NHS 'friends and family test' are key indicators of how the service is performing from a patient perspective. Clinical outcome measurements tend to be most attractive to healthcare staff, though of course this raises again the fact that social care is not 'clinical' and will have a range of different factors to measure. Outcome measurements vary from patient-reported (PROMs) through clinician-reported (CROMs) to patient-reported experience (PREMs). A wide range of validated tools are available. Tensions for integrating services will be what is more generalisable across a range of inputs (e.g. the Clinical Outcomes in Routine Evaluation – CORE – instruments are not diagnosis specific, although limited to mental health) versus what might be more specific and sensitive to a given intervention. This is also influenced by the fact that there is a growth towards national consensus and implementation of similar scales across the country (e.g. the DIALOG tool in psychosis services). 'Activation measurements' might also be helpful: rather than looking at a clinical change, they evaluate an individual's sense of their ability to engage with the intervention offered. Clinically one sees individuals who, for various reasons, cannot work with a treatment type, and it is therefore not the 'treatment' that fails. Speculatively, one might imagine that a well-functioning integrated service would make individuals feel more empowered to engage in managing their difficulties. Other challenges include the ability or otherwise to digitise the relevant tools and embed them in electronic patient records and to link them with clinical interventions, not least as individuals often have multiple 'inputs' (consider someone with out-patient appointments, care coordination and psychological therapy) and there is an issue of 'regression to the mean' or people getting well 'by themselves'. As before, these important caveats need to be kept in mind, but should only serve to help optimise outcome measurement, not hinder it.

### Local and national targets

Health and social care are required to measure against some externally set targets: CQUINs (commissioning for quality and innovation) and the ASCOF (adult social care outcomes framework) are notable examples, but there are others. These, or versions of them, will continue, although their fitness for novel services might face challenge and they might lack the specificity to assign change to integration. One might speculate that integrated systems offer novel opportunities. Consider the mental health

targets of staff flu vaccination and physical health monitoring of those patients with serious mental illness: a team now including district nurses might be better placed to manage these, although this is currently without evidence, and of course there would be an opportunity cost for taking district nurses away from their existing full roles.

### Workforce data and cultural factors

In an era of a workforce recruitment and retention crisis, new models of care that purportedly enhance care and provide novel training and development opportunities might stand out as a way of tackling these problems and enhancing satisfaction. Human resources data and staff sickness records would provide indirect markers, and quantitative and qualitative staff surveys might give more direct feedback.

### Conclusions

In part 1 (Tracy 2020a) we noted the King's Fund's four pillars of a true population health system as: integrated health and social care; places and communities we live in; our health behaviours and lifestyles; and wider determinants of health such as income, environment and education (Buck 2018). Clearly, even an optimally funded and functioning integrated health and social care system – and none of us have one of those – is thus limited in what it can achieve. However, optimistically, being one of those pillars might allow health and social care to better contribute to people in their lives.

There is a very clear, unavoidable national move towards more integrated services. These offer potentially significant gains in the face of predicted increases in population need at a time of workforce decline. They are the types of service people intuitively would design, pulling together wrap-around care with minimum duplication, bureaucracy and multiple referrals. However, there are considerable challenges: the drive for 'localism' has left us without a road map; practical factors and local politics are most likely to determine which services will come together; staff will have understandable concerns despite the putative gains; and we lack evidence of what works, or even detail on what we should evaluate.

In our opinion these need to be taken on directly as issues with which we all need to engage. This is a time for sharing early learning and experiences. We hope that this series of articles will assist this process.

### Author contributions

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**MCQ answers**

1 c 2 d 3 a 4 e 5 b

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**Declaration of interest**

None.

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**MCQs**

Select the single best option for each question stem

**1 The detail of service integration is most likely to be determined by:**

- a the NHS Long Term Plan
- b the Social Care Green Paper
- c the local NHS trusts
- d the local clinical commissioning groups
- e the local authority.

**2 Which of the following has not been a clear concern of staff in pilot integrating sites?**

- a concerns about deprofessionalisation and skill loss
- b taking on inappropriate responsibilities
- c increase in referral numbers
- d decrease in take-home pay
- e loss of service identity.

**3 As regards partner organisations to mental health services:**

- a clinical commissioning groups (CCGs) will need to align with the local integrated care system (ICS)
- b primary care networks (PCNs) will need to align with community mental health team (CMHT) boundaries
- c children's social care will need to integrate with child and adolescent mental health services (CAMHS)
- d local authorities are being merged to align with the local ICS
- e third-sector organisations are excluded from closer integration.

**4 Which of the following is not one of Grol & Wensing's characteristic stages of innovation?**

- a orientation
- b maintenance
- c acceptance
- d insight
- e reflection.

**5 Which of the following has not been proposed as a potential marker or measurement of change in an integrating system?**

- a clinical outcome measurements
- b service funding
- c staff sickness rates
- d CQUINs
- e rates of unplanned admissions.