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Rapid Evidence Synthesis: What factors influence service integration and delivery by integrated neighbourhood teams operating across local health and care organisations?

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Rapid Evidence Synthesis

Rapid Evidence Syntheses (RES) use evidence synthesis approaches and draw on the GRADE Evidence to Decision framework to provide rapid assessments of the existing evidence and its relevance to specific decision problems. In the first instance, RES focus on evidence from guidance and existing evidence syntheses. They are undertaken in a real-time context of decision-making around the adoption of health-related innovation and are designed to provide a 'good enough' answer to inform decision problems in a short timescale. RES methods are flexible and adaptive. They have evolved in response to user feedback and differ depending on the nature of the assessment undertaken.

RES were developed by the National Institute for Health and Care Research (NIHR) Applied Research Collaboration Greater Manchester (ARC-GM). The methods used are based on a framework set out by ARC-GM (1) and previously registered on the Open Science Framework.

RES are not intended to serve as a substitute for a full systematic review or rapid review of evidence.

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Summary of findings

Key question

What factors influence service integration and delivery by integrated neighbourhood teams operating across health and care organisations?

What did we do?

Following RES methods, we searched for and summarised existing primary research and evidence syntheses that investigated the key question.

What did we find?

We found 26 eligible articles, including nine primary research studies and 17 evidence syntheses.

Key messages:

- There was **strong agreement** in the literature on key enabling and inhibiting factors for integrated neighbourhood team functioning across local health and care services. While different studies and reviews often used different terms to describe key factors, the underlying concepts that they reference remain similar:
    - clear and shared vision
    - effective leadership
    - strong working relationships powered by trust and mutual respect
    - clarity on interprofessional roles and responsibilities
    - appropriate, sustained resources and funding
    - opportunities for staff learning and professional development
    - co-location
    - dedicated time for multidisciplinary team (MDT) meetings
    - interoperable information technology (IT) systems to support data sharing.
- These was some evidence that these factors were consistent across integrated services for a range of patient groups, e.g., many of the same factors were relevant for integrated team functioning in services for frail older patients as for services for patients with severe mental illness. However, most articles discussed integrated care involving various services for various patient groups, rather than exploring the evidence on team functioning for specific services or groups.
- While we have endeavoured to synthesise evidence related to the functioning of small-scale, local integration initiatives, the included articles used different terms to describe the scope and scale of integration activities. Notably, **only one study explicitly referred to an integrated *neighbourhood* team model** (2). Although there is significant consistency in the synthesised evidence, this needs to be considered when interpreting the evidence base in relation to integrated team functioning at a neighbourhood-level.
- What is less clear from this literature is the **optimum scope and scale** of integration initiatives. Few studies provide evidence on how the size or reach (across different geographic levels or organisational footprints) of an integrated service affects team functioning.

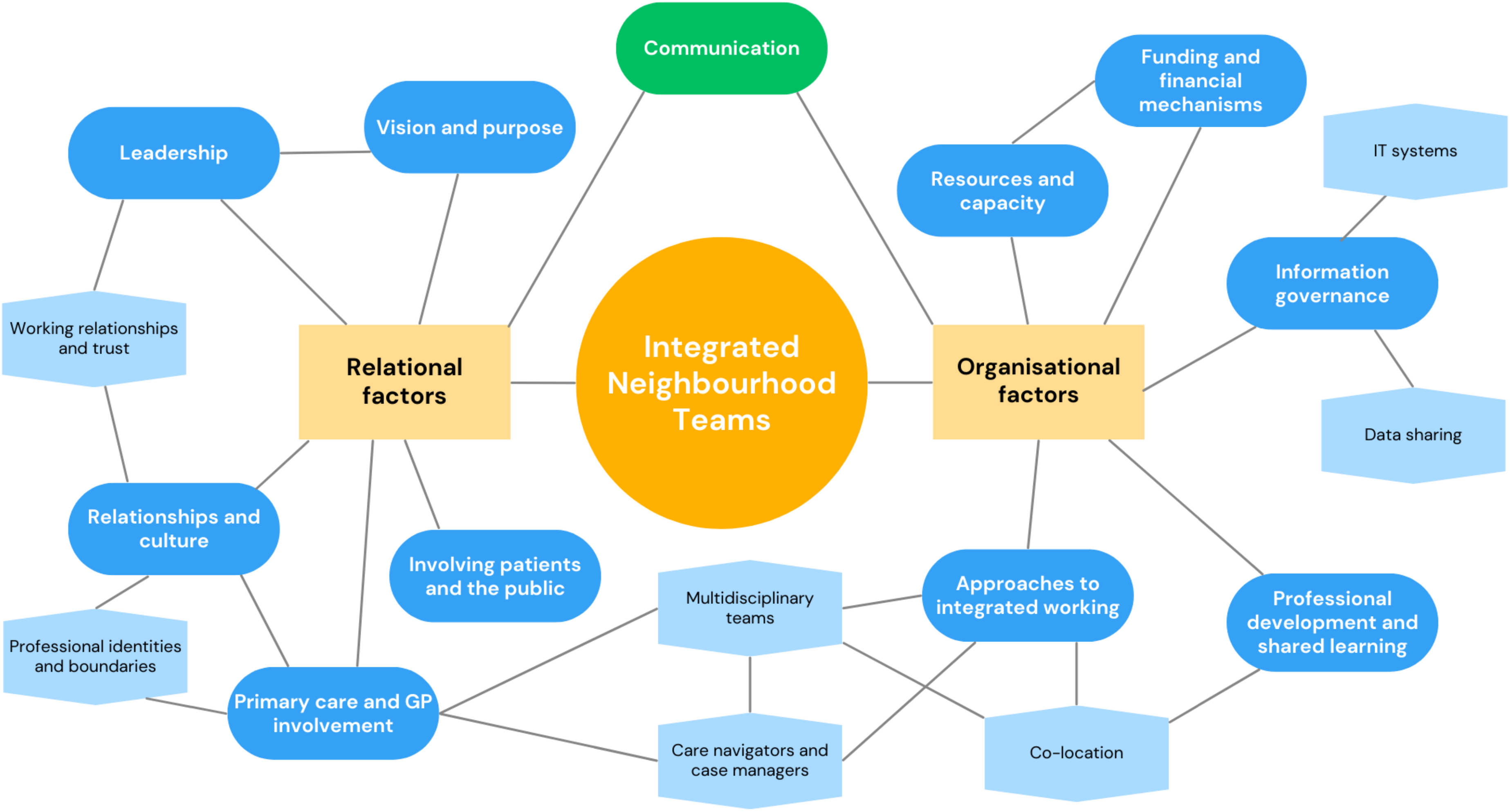

Figure 1. Factors that influence service integration and delivery by integrated neighbourhood teams operating across local health and care organisations.

Relational factors

Vision and purpose Relational factor		
What is it?	**What does it look like?**	**What are the barriers to achieving it?**
Clear, shared, and positively framed understanding of the goals and benefits of integration. Developed collaboratively and communicated effectively. Adaptable to local contexts to ensure genuine buy-in from partners as well as sustained progress.	Generate a positive, solution-focused vision co-developed with staff and partners. Generate a flexible and organic vision that is 'bottom up' Staff united over strong narratives around improving quality of care and positive change for patients.	Difficulty of translating 'vision' into concrete strategies and plans; there is need for clear operational detail. Need for effective communication of vision across all partners. Scope and scale of integration activities (smaller, less complex activities more effective) Maintaining staff engagement and motivation when progress is slow

Leadership Relational factor		
What is it?	**What does it look like?**	**What are the barriers to achieving it?**
Strong, engaged local leaders (at all levels) who foster: • Collaboration • Trust • Communication • Innovation While: • Communicating vision • Setting goals • Supporting staff wellbeing • Driving change	Develop flexible, responsive leadership. Foster a leadership attitude that is courageous, with a willingness to take risks. Develop distributed leadership that is prepared to delegate widely, empowering individuals across an organisation to take ownership of leadership responsibilities and share decision-making authority. Support local (clinical) leadership development through funded programmes.	Challenging to 'break the mould', when integration under scrutiny. Difficult to break from tried and trusted patterns instead of working with familiar methods and the same professional contacts. (Lack of) freedom to innovate. Obtaining sufficient input from clinical leadership.

Working relationships and trust Relational factor		
What is it?	**What does it look like?**	**What are the barriers to achieving it?**
Strong, positive working relationships characterised by trust and respect.	Team building activities and regular team meetings strengthened relationships. Longstanding relationships build resilience amid system changes.	(Lack of) trust and respect. It takes considerable time and effort to build and maintain relationships.

Professional identities and boundaries Relational factor		
What is it?	**What does it look like?**	**What are the barriers to achieving it?**
A staff workforce that has clarity on interprofessional roles and responsibilities.	Develop clear frameworks (i.e., protocols, processes) for roles, responsibilities, communication, and data sharing. Joint staff training improves clarity on roles and enables shared learning.	Differences in professional culture and values, communication, attitudes towards risk, ways of working, and governance structures. Lack of clarity on boundaries of role and decision-making authority.

Involving patients and the public Relational factor		
What is it?	**What does it look like?**	**What are the barriers to achieving it?**
The involvement of patient and the public in the design and delivery of patient-centred integration services, and in decisions about their own integrated care.	Establish a local citizens board to inform integration programme. Older patients generally wanted to be involved in decisions about their care and treatment, but their preferred type or level of involvement varied.	Lack of clarity around roles and aims of patient and public involvement. Practical issues included • language translation • bureaucracy • making decisions when the public have opposing views • effective patient and public involvement in

		areas with several community and voluntary groups.

Primary care and GP involvement Relational factor		
What is it?	**What does it look like?**	**What are the barriers to achieving it?**
GP involvement in integrated teams was seen to be a significant benefit to integration.	GP participation in MDT meetings was particularly effective.	Time constraints and competing demands in primary care is a barrier to GP engagement. (Lack of) clarity on available local services, including nature of services and how best to contact services. Suitable infrastructure to host MDTs.

Organisational factors

Resources Organisational factor		
What is it?	**What does it look like?**	**What are the barriers to achieving it?**
Integrated teams required sufficient resources, capacity, and staff capabilities to successfully collaborate and deliver integrated care.	No specific evidence was identified.	Securing sustained and appropriate resources, including staff capacity and capabilities. High staff turnover. High reliance on agency staff.

Funding and financial mechanisms Organisational factor		
What is it?	**What does it look like?**	**What are the barriers to achieving it?**
Having sufficient and sustained funding to deliver programmes and services.	Pooled budgets. Suitable payment mechanisms that do not favour one organisation over another.	No specific evidence was identified.

Professional development and shared learning Organisational factor		
What is it?	**What does it look like?**	**What are the barriers to achieving it?**
Staff skills and capabilities shaped integrated team functioning. It was therefore important for staff to receive and maintain adequate training and education, and possess the necessary knowledge and skills to work effectively within the integrated care programme.	Joint staff training in new practical skills, as well as shared decision-making, patient empowerment, interprofessional collaboration, and communication. Cross-sector rotations to strengthen interprofessional relationships. 'Learning windows' to share experiences and knowledge.	(Lack of) prioritisation by provider organisations to train staff together. Absence of dedicated time for professional development. (Lack of) training opportunities exacerbated by workforce pressures.

Multidisciplinary teams Organisational factor		
What is it?	**What does it look like?**	**What are the barriers to achieving it?**
MDTs comprised of staff from various disciplines, each bringing their own expertise, to meet the complex and diverse care needs of different patients.	Dedicated time (e.g., monthly meetings held at GP practices). Effective MDTs were those with appropriate composition of professionals (to meet patient needs) and consistent attendance from all members.	Finding the most effective management structure (e.g., more hierarchical versus less hierarchical). Conflicting work schedules (e.g., time and location of MDT meetings). Lack of protected time for meetings (e.g., for GPs).

Co-location

Organisational factor

What is it?	**What does it look like?**	**What are the barriers to achieving it?**
The sharing of workspace or close proximity among integrated team members, designed to promote collaboration, build trust, improve communication, share data, and facilitate informal knowledge exchange.	Physical co-location (e.g., sharing office spaces and facilities) or close proximity of teams.	Co-location alone is not a silver bullet. There is need to plan for and provide sufficient space (with funding to maintain it), provide clarity on interprofessional roles, and encourage a willingness to work together. Be mindful of remaining barriers (e.g., professionals are on the same office floor but in different office spaces; data access issues)

Care navigators and case managers

Organisational factor

What is it?	**What does it look like?**	**What are the barriers to achieving it?**
Care navigators and case managers support patients to navigate fragmented complex care systems and offer continuity of care.	Considered the central coordinator in effective MDTs. Service users and carers emphasised a relationship with their care provider characterised by good communication, respect, listening, and trust, and supporting feelings of empowerment, control, and safety.	Organisational barriers included staff shortages, high staff turnover, lack of service user contribution to design of services, and a lack of service user or carer involvement during transition from hospital to community settings.

Information governance

Organisational factor

What is it?	**What does it look like?**	**What are the barriers to achieving it?**
The integration of interoperable digital systems that allow different professionals and organisations to access, share, and communicate patient information effectively.	No specific evidence was identified.	(Lack of) interoperability between existing platforms and software. Restricted access to IT systems.

		(Lack of) trust between partners hinders data sharing. Concerns around data protection.

End of Summary

Full report

Description of the research area

In England, integrated teams operate at a local, neighbourhood level, comprising healthcare, social care, and voluntary organisations who support communities in different settings. Integrated teams typically cover neighbourhoods of between 30-50,000 residents, involving primary care networks (PCNs), community care, mental health care, non-health and social care teams, who collaborate to share resources, information, and form MDTs dedicated to improving the health and wellbeing of a local community and reducing health inequalities. These teams typically focus on delivering proactive, personalised care and early intervention with populations ‘at risk’ of deterioration and admission (including but not limited to those with multiple long-term conditions) and streamlining service delivery to minimise reliance on acute care services. The exact make up and nature of these integrated teams varies depending on the needs of the local population and the purpose of each team (e.g., an integrated team to support people living with frailty might comprise core primary care professionals from general practice and district nurses from a community service provider).

While integrated, multidisciplinary, and multi-agency team models of care are widely promoted in England, they are complex and multifaceted. Their success depends on various factors, including governance structures, leadership, shared goals, funding arrangements, and local contexts. Understanding the factors that enable or hinder successful collaboration between health and non-health organisations is important for informing local policy and practice. This Rapid Evidence Synthesis (RES) seeks to consolidate the evidence on the key influences on service delivery by local integrated team models, examining both the challenges they face and the conditions that support meaningful, sustainable cooperation.

Key question

What factors influence service integration and delivery by integrated neighbourhood teams operating across health and care organisations?

Methods

Searches

We searched the electronic databases Medline (Ovid) and CINAHL (Cumulative Index to Nursing and Allied Health Literature (EBSCO) on 14th February 2025. The database searches were complemented by searches in Google Scholar and Google search engine. We used search terms based on the key question (above) and adapted from existing relevant umbrella reviews of this literature (e.g., (3)). We searched the reference lists of included articles and conducted selective forward citation searching. We excluded articles not published in English and articles that were not available as full texts.

Eligibility criteria

Participants

We included studies involving integrated neighbourhood care models and teams (defined below) serving any adult or child population in a local area. The focus of eligible studies could include recipients of care, integrated care team staff, or those involved more widely in managing service delivery.

For primary research studies to be eligible, they needed to include participants from the UK. For existing evidence syntheses to be eligible, they needed to include study populations from high-income countries (as defined by the World Bank) to report evidence that is more transferrable to a UK setting.

Intervention

We acknowledge that integrated care is a complex concept. There is no one agreed definition of integrated care or model for integrated teams. Therefore, we adopted an inclusive definition of integrated care. In the NHS, these are sometimes called integrated neighbourhood teams or neighbourhood MDTs (4). To be eligible, research needed to examine integrated teams involving collaboration between two or more distinct organisations, involving (for example) at least two of the following: PCNs, community care, mental health care, non-health and social care teams. Care delivery needed to occur at a local level with the aim of improving health or reducing inequities. We excluded studies where integrated teams were operating within single organisations or were between clinical services only. We excluded collaborations between agencies focused on academic research.

We primarily aimed to identify evidence on factors that influence the service delivery by integrated team models operating at a local, neighbourhood-level. We excluded evidence on higher-level collaborations operating at a national, system-level or regional level (but acknowledge that micro-level care models such as neighbourhood teams necessarily interact with macro- and meso-levels).

Context

A key aim was to understand factors affecting service delivery by integrated care teams. Therefore, we included studies reporting on collaboration or partnership mechanisms, processes, barriers, and enablers affecting the service delivery, success, or functioning of integrated teams (e.g., effective leadership, shared values and goals, clear communication). These outcomes could be measured using either quantitative or qualitative data collection methods.

We excluded evidence on the effectiveness of integrated teams for improving health and wellbeing outcomes (e.g., hospital admission rates) in the local population in cases where these outcomes are not linked to models of delivery. We excluded articles solely reporting on (i) the concept of integrated or collaborative care (including theoretical models and frameworks, when there is an absence of data related to team success or functioning), (ii) the legislation behind integrated care, (iii) formal guidance to integrated care implementation, or (iv) a single disease or focus (e.g., COVID-19).

We included existing evidence syntheses (e.g., systematic, scoping, umbrella, and other review types) of integrated care evaluations and relevant empirical primary research (e.g., quantitative, qualitative, and mixed-methods research) published in the UK. This could include articles reporting the implementation or evaluation of integrated care interventions or programmes for physical and mental health outcomes. Grey or unpublished literature was also eligible if it met the above criteria.

Critical appraisal of the evidence

We did not conduct a formal critical appraisal of each piece of underpinning evidence. Where possible, we considered existing quality assessments (of the primary evidence) from the included reviews. However, most reviews focused their appraisals to studies evaluating the effectiveness of integrated care on health outcomes, rather than on studies reporting contextual evidence on team functioning that is the focus of this RES. As such, it was difficult to get an overall sense of the quality of this evidence base. Therefore, it has not been factored into our evidence synthesis. However, we screened the eligible articles to identify any areas of overlap in terms of included studies. Where possible, we have only reported data from individual studies once.

Synthesis of the evidence

We undertook a rapid qualitative evidence synthesis of the findings and have summarised the evidence narratively to answer the key question. This process had two stages. First, we considered the UK primary research evidence, on the basis that it was likely to be more directly relevant, detailed, and transferrable than evidence from reviews (which report high-level summaries from a body of evidence). We extracted the main findings from the eligible primary studies. The findings were then subjected to a content analysis. This involved coding key influencing factors related to service integration and service delivery. The codes were grouped based on similarity and given overarching theme names. We produced a written narrative to describe the themes.

Second, we incorporated the evidence from eligible reviews. We extracted and coded the main review findings to identify areas of overlap with the primary study evidence. The review findings were integrated into the narrative, effectively reinforcing the primary level evidence and providing further nuance where appropriate.

Results

Search results

We identified 5139 articles (4954 after duplicates were removed). After screening these records, 26 articles were considered eligible for inclusion in this RES.

Nine primary studies (2,5–12) and 17 evidence syntheses were included (12-27). All primary study articles reported recent (i.e., published within the last 10 years) research evidence on local integrated care teams based in the UK. Only one article explicitly reported evidence on integrated *neighbourhood* teams (who were in the process of co-locating and working together) (2). The remaining primary study articles reported evidence on other types of integrated care models, including evaluations of:

- The Integrated Care and Support Pioneers Programme (hereon Pioneers Programme) operating in local areas in England (5–7).
- An integrated care programme for older people with different frailty levels in Luton (8).
- The barriers to integrated primary and social care for general practitioners (GPs) and practice managers based in London (12).
- Integrated care initiatives in three East London boroughs, which came together to form an Integrated Care Programme comprising local primary, acute, community, mental health, and social care organisations selected by NHS England to act as pioneers in the development of innovative approaches to deliver integrated care (9,10).
- A four-year integrated care programme implemented in South London. The programme attempted to integrate care across primary, acute, community, mental health and social care, with a particular focus on reducing hospital admissions and nursing home placements (11).

The 17 eligible evidence syntheses included six umbrella reviews, and 11 reviews (i.e,. systematic, rapid, and scoping) of primary evidence.

Synthesis of the evidence

The evidence base contained several key themes (see Figure 1 and Table 1). The consistency and overlap of themes across the eligible articles were striking. These are summarised below under two main headings - ‘Relational factors’ and ‘Organisational factors’.

Relational factors

The first overarching factor highlights the critical role of relational factors in integrated teams, including vision, leadership, relationships and trust among partners, organisational culture, professional roles and boundaries, and the potential impacts of these factors on successfully engaging and motivating staff.

Vision and purpose

The evidence suggested that it is essential to have a clear, shared, and positive vision of integration and how integration could improve delivery of health and care services (2,3,6,7,11,13–17). A positive, solution-focused culture was considered important for driving successful integration and sustained progress in quality care and patient experience (7). The vision of integration, and a compelling case for change, needs to be developed with and clearly communicated to all staff, ensuring it is one that all key partners can sign up to and buy-in to at every level – from senior leadership to operational teams (2,6,7,16,17). There was an understanding in the literature that solutions to the challenges of integration would necessarily differ between different local integrated teams, and thus the ‘vision’ needed to be flexible and organic, rather than imposed ‘from above’ (7). An article reported that a ‘lesson learnt’ was that the integrated care programme was too top down, with need for a “bottom up approach” (10).

After a clear vision is agreed, it is necessary to translate the vision into concrete strategies and action plans. The greatest challenges were often identified in this translation and operationalisation process (7). The evidence highlighted the importance of operational detail in integration planning. In particular, while frontline staff reported a clear overarching vision for integration, many expressed concerns over the insufficient detail and communication of this vision during the partnership, highlighting the challenges of translating values and principles into operational detail (2). Similarly, an evaluation of the Pioneers Programme identified that the shared vision had not been effectively communicated to parts of the local health and care system (e.g., among all providers) (7).

Local partners and team members felt united by shared values and a shared commitment to creating positive change for patients (e.g., united by a commitment to reducing health inequalities) (3,17,18). Healthcare professionals were more likely to engage in programmes that presented a strong narrative around quality of care (16). However, sustained motivation was required for this to last, and differences in values could fundamentally undermine integration efforts (3). There were also difficulties motivating staff to become and remain engaged with integration activities, even within the same organisation. For example, a reported barrier within and between partners was the considerable time that it could take to see positive results from integrated care initiatives, and the consequent view that 'nothing changes' leading to demotivation (7). Strategies used to develop shared values and understanding included involving staff in the development of the policies and procedures and providing introductory and ongoing training (15).

Two articles reflected on key 'lessons learnt' from the process of integrating teams (11,14). These articles referred to the importance of starting with smaller, less complex initiatives that are guided by a clear vision and purpose. Overly ambitious programmes were reportedly barriers, hindering progress in achieving objectives (11). Focusing on a limited number of well-executed activities was seen as a more effective approach (11,14). New initiatives often face significant pressures to demonstrate success early on, which can be challenging as it may be too soon to produce measurable results. Therefore, setting short-term milestones may help to demonstrate progress and recognise early successes, helping to sustain morale.

Leadership

Most articles identified effective leadership as an essential factor in successful local service integration and delivery (8,13,15,16,19). A systematic review examining integrated care initiatives within the NHS highlighted leadership as the most critical element, noting its central and enabling role in shaping all other major contributing factors (13). Strong, engaged local leadership was seen to foster pivotal 'enablers' of successful integration (3,7,13,19). These skills and experiences included:

(i) helping to communicate and embed a shared positive vision and purpose,
(ii) setting clear and measurable goals,
(iii) building trust, motivation and commitment,
(iv) building good relationships,
(v) promoting team collaboration and communication,
(vi) supporting the emotional wellbeing of staff,
(vii) identifying and scaling innovation from pilot programmes,
(viii) establishing governance structures that drive faster change.

Effective communication between leadership and frontline staff ensured guidance and support for those working on the ground. While the articles reported the importance of effective leadership at a local team-level, it was recognised that it was necessary at all levels of the system. Leadership was discussed in relation to strong senior management at the macro level, to the involvement of front-line staff as strong clinical leaders at the micro level, together with local author figures acting as local leaders (13).

One article conceptualised effective leadership within integrated neighbourhood teams as having the courage, wisdom, and a willingness to take risks, as integrating health and social care often represents a move into uncharted territory (2). However, it was acknowledged that such leadership was challenging, particularly when integration is under close scrutiny (2). The integrated neighbourhood teams advocated distributed leadership styles, which empowers individuals across an organisation to take ownership of leadership responsibilities and share decision-making authority, fostering collaboration and innovation. Within this vision for distributed leadership, strategic-level staff highlighted the need for senior leaders to adopt new approaches and ‘do things differently’, particularly in budgeting and delegating responsibility (2). These staff stressed that leadership distribution should be flexible, in order to consider differences in team integration, staff expertise, and local contexts. However, while teams perceived distributed leadership to be effective in theory, some noted limitations to this leadership style in practice, as staff either lacked sufficient authority for local decision-making or were unaware of the vision for distributed leadership. Despite fostering distributed leadership, some team members reported that leaders tended to revert to tried and trusted (i.e., less flexible or innovative) ways of working with colleagues they knew (2). A review reported a barrier to integration in the Pioneers Programme was the lack of local freedom to innovate (14).

One review presented an alternative view on leadership, citing a lack of evidence on effective leadership and supportive interventions to develop leadership skills to warrant the emphasis on leadership currently given in integrated care models (20). This review highlighted that less visible, more nuanced factors influence effective integrated care, including professional hierarchies, embedded tensions, unconscious biases, and political motivations, all of which drive complex consequences across the system (20). Leaders are expected to recognise these hidden, embedded complexities and offer communication that is both clear and mindful of this, to manage and prevent it, which was believed to be a considerable challenge for leaders (20).

Clinical leadership in primary care, including primary care engagement and leadership on the programme boards, was considered to be of significant benefit (11). In an evaluation of an integrated care progress in two inner-city London boroughs, a charity partner initiated a separately funded primary care ‘emerging leadership’ programme, which was considered a catalyst for the professional development of those leading integrated care (11). Some interviewees highlighted a conflict between management-led and clinically-led models in other teams and questioned whether there was sufficient clinical leadership in integration activities. They also noted a lack of communication between leadership and frontline operations, with executives focusing on high-level strategy but providing little direct support or guidance to those on the ground. The authors reported key ‘lessons learnt’ included the need for stronger clinical leadership and ensuring that future integration proposals originate from and are embraced by primary care (11).

Relationships and culture

(i) Working relationships and trust

The evidence strongly emphasised the importance of building and sustaining effective working relationships across organisations and professions (5,7,8,14–16,19). Integrated teams were more likely to be successful if partners have strong, positive relationships characterised by trust and respect (3,13,15,16). Developing shared vision was dependent upon good working relationships between professionals and partner organisations. Such relationships were essential for enabling stakeholders to speak frankly, understand one another's perspectives, collaboratively problem-solve, and move towards shared values and understandings of what the initiative was aiming to achieve, and the roles of participating organisations (7). A considerable amount of time, skill, effort, and goodwill went into building and reinforcing trusting relationships (5,7,17).

The evidence highlighted the value of longstanding relationships, suggesting that these provide stability and resilience for collaboration amidst changes in staff, systems, and commissioning arrangements (3,7,15,21). Longstanding relationships (whether present or absent, good or bad) shaped how local partnerships developed and functioned (3). A focus on local relationship-building was particularly significant in contexts where no connections existed prior to the integration of teams (7).

However, these relationships could be difficult to establish and maintain – a result of distrust between staff, differences in professional culture, communication styles, and ways of working. In the Pioneers Programme, engaging (new) providers in integrated care initiatives presented significant challenges, as these efforts were often overshadowed by other urgent demands (e.g., meeting local emergency targets like the four-hour A&E waiting time standard) (7). Asking providers to share the 'risk and reward' was described as a radical departure from the previous system, in which providers aimed to gain reward and avoid risk (7). Further, providers were not always invited to be in key discussions, and part of the conversation, which led to tension, trust erosion, and further complicated collaboration (7).

(ii) Professional identities and boundaries: understanding roles and responsibilities

Integrated working fundamentally involves bringing together professionals with different philosophies and values. There was a strong emphasis in the evidence base on the potential impacts of professional and cultural differences on the quality of interprofessional relationships and integrated care functioning (2,3,22,7,10,15–19,21).

Integrated teams generally described the impact of health and social care professionals working closely together in positive terms, and considered it a great benefit of integrated working. Many positive accounts of interprofessional collaboration were shared, with staff anticipating mutual benefits for practitioners, patients, and service users (2). Staff also recognised the value of being able to provide information about another profession's services to better support individuals, patients, and families and to determine when it was appropriate to involve other specialists (2). These discussions were quicker and easier to do when professionals were co-located. Although integrating different organisations was generally viewed as beneficial, staff recognised the complexities involved - particularly in aligning human resources policies, where there were concerns that disparities in grading, pay, and responsibilities between health and social care professionals could lead to animosity and tension between team members.

Despite these positive reflections, interprofessional collaboration was predominantly discussed in the literature in terms of the challenges it introduced for integrated team functioning. Common challenges included differences in language, conceptions of health, professional ways of working, interprofessional tensions, and a lack of mutual understanding, respect, and trust between health and social care professionals (2). For example, perceived differences in terminology between services and providers was a key issue (16). There was confusion around terminology for service users; health and social care staff at both strategic and operational levels expressed uncertainty about whether to refer to individuals receiving care as “patients” or “citizens”, which acted as a barrier to communication (2).

Health and social care professionals shared common concerns about their professional identities and the boundaries of their roles (2,7,10). Both professions noted challenges in developing trust across professional boundaries, partly due to their differing responsibilities and practices (2). There was a shared worry about being held professionally accountable for decisions influenced by another professions’ working methods. Similarly, concerns emerged around being managed by professionals unfamiliar with their specific codes of practice and current evidence-based guidelines.

There were gaps in understanding the roles and responsibilities of different professionals. Representatives from both health and social care groups felt that the other did not fully grasp their specific roles, responsibilities, and governance frameworks (2). For example, healthcare governance was associated with professional bodies such as the Nursing and Midwifery Council, clinical guidelines, and the NHS, whereas social care governance was linked to the Health and Care Professions Council, in addition to local and national government regulations and legal frameworks. This was true for both established roles, such as social workers, and new ‘extended’ roles, such as care navigators (10).

The following tensions between professional groups were evident in the literature:

- **Community-based health and social care staff** often felt undervalued in comparison to acute care services, which were perceived as being better resourced, having better access to information, lacking in understanding of what community care entailed, and given greater priority (2). Many community staff raised concerns about poor discharge processes, where insufficient attention to care handovers created difficult challenges for them to address, in already difficult circumstances (2).
- **Social care staff** perceived themselves as being overshadowed by the larger NHS (2). Social care staff felt there were fundamental differences from their health counterparts, particularly regarding their approach to and application of the Mental Capacity Act (2).
- **Social workers** based in MDTs experienced higher role conflict and more stress compared with their colleagues (15). They felt their social work values were not respected by health professionals, leading to a lack of appreciation of their contribution within MDTs (15). Social workers also expressed frustration at the lack of understanding of their role by district nurses, in particular the nurses’ understanding of the Care Act (2014) (an assessment of people’s needs along with their eligibility for publicly funded care and

support) (10). There was the risk of a blame culture between district nurses and social workers (10), usually as a result of differing organisational priorities, working practices, and communication styles (10,13).

- **GPs and practice managers** perceived interprofessional culture as a barrier to service integration, since many sensed a lack of mutual respect between social and primary care staff. There was often a siloed working mentality with different teams having different agendas for the patient and a lack of motivation for collaborative decision-making. This culture can lead to a diffusion of responsibility and a lack of clarity on who is performing which service for the patient, further delaying quality care provision (12).

The evidence indicated that different attitudes to risk led to differences in practices (e.g., related to the discharge of patients) (15). These differences were identified as potential obstacles to building trust and sharing responsibilities. Interviews with integrated neighbourhood team members suggested that social care professionals appeared more at ease with people making "unwise" choices and managing higher levels of risk compared with health staff (2). A review reported that different attitudes towards risk management evident between GPs and social workers led to inappropriate referrals to residential care (15). Staff in other professions suggested that GPs' focus on risk management sometimes resulted in solutions that were less patient-centred or less aligned with the best outcomes for patients (7).

At an operational level, it is important that all parties understand the roles and responsibilities of individual professionals and partners (15–17). Having clarity on and understanding each other's roles and responsibilities was believed to enable better joint working, closer collaboration, joint decision making, and programme implementation and functioning (3,16–19,21,22). A lack of clarity reportedly contributed to power struggles (e.g., concerns about power), protectionism, and an underuse of particular skills or services within a partnership (3,15). It is also important to have clarity on who has the authority to make decisions; health and social care staff reportedly differed with regards to the type and level of decisions they could make, which could dilute the effectiveness of joint working (15) (16,17). Staff believed it was important to be comfortable in the scope of their role and respectful of the role of others (16). To improve clarity on organisational roles, the evidence suggested establishing clear frameworks (including protocols and processes) for collaboration and joint training for staff between partners (3,15,17,23). Greater role clarity also supports patient care-coordination (e.g., by providing clarity on who is responsible for the physical health needs of people with several mental illness) (23). As a caveat, one article suggested that role clarity may not be necessary for all types or levels of partnership (e.g., keeping a level of flexibility may support MDT functioning) (3).

There were several suggestions to improve collaboration, such as sharing knowledge, educating others about distinct roles, and participating in joint training (17). The evidence suggested that team-building activities and regular team meetings promoted mutual understanding between professional roles and built trust and rapport between different groups. These meetings helped to establish a shared sense of purpose, facilitated case discussions, and enabled effective information sharing, all of which contributed to better team functioning, while a lack of such collaborative opportunities was shown to impede integrated working (15). Further, the evidence suggested that keeping a focus on the patient or service user perspective was a successful way to minimise the barriers and reduce tensions between professional groups, in the interests of integrated working for patient benefit (7).

Involving patients and the public

Several articles discussed the involvement of patients and the public in the design and delivery of ‘patient-centred’ integration services (7,11,20,21,24) and in decisions about their own integrated care (22,25).

Co-production with communities was reportedly a facilitator of integrated care delivery (20). Local citizen involvement was largely seen as a success, with citizens actively contributing to decision-making in integrated team activities (7,11). In one study, many team members praised the initiative to establish a citizens board to inform their activities, stating that citizen voices were central and their engagement had been a significant achievement (11). However, some team members questioned whether the citizens’ board was truly representative and expressed concerns about the clarity of citizens’ roles. Additionally, there were concerns raised about potential conflict between the roles and agendas of citizens and service users as patients, with some highlighting a lack of focus on the patient journey, experience, and shared agenda. A key takeaway was the need for a clearer, more defined role for citizens within the programme (11).

In the Pioneers Programme, all sites involved patients and the public in the design and implementation of services to some degree (7). Some Pioneer teams enthusiastically supported patient and public involvement, particularly the involvement of patients and service users (there were fewer references to working with the public more broadly). Pioneer teams discussed the ways in which the patient and service user voice were helpful in ‘building a case’ for the need to improve the quality of services, perceiving this as adding greater weight to the ‘case’ for care integration (7).

However, some articles highlighted that, while public engagement is often seen as important, it can be difficult to achieve and the benefits hard to evidence (24). The exact role that public engagement should play in integration initiatives remains unclear (24). In the Pioneers Programme, there were several challenges related to patient and public involvement. These included issues with language translation during multilingual meetings, bureaucratic processes that hindered meaningful engagement from patients and the community, complicated decision-making processes when different or opposing views exist within the public, a lack of clarity around what input was wanted from patient and public involvement (and across different sites), and the challenges of effective and meaningful patient and public involvement in areas with large numbers of community and voluntary groups (7). Some interviewees believed that the scope of patient and public involvement activities needed to be clarified and felt that, while patient views need to be considered, their direct involvement in service design may not always be appropriate, particularly as their primary interaction with patients is when they are in a stressed environment (7). Others felt that the potential drawbacks of patient and public involvement were outweighed by the substantial greater positive impacts (7).

Two reviews reported on the benefits of involving older frail patients and their informal carers in decisions about their care from the perspective of healthcare professionals (22,25). Their active involvement was seen to enhance the quality of their care (25), and to be important for setting up tailor-made, individual care plans, developing a hospital discharge plan, managing medical treatment, and planning follow-up support (22). Further, the evidence suggested that providing health education and training for older people and their carers could enable their active involvement in their care, leading to a better understanding of each other and a greater understanding of the importance of his or her treatment (22). Healthcare professionals believed that limited involvement of service users and carers in care decisions hindered effective transitions of care between hospital and community settings for older patients (25). Time constraints were reportedly a barrier to involving patients during their transition of care (25).

A further review explored older patients' perspectives on integrated care (26). Participants generally wanted to be involved in decisions about their care, treatment, and medications, in ways that matched their individual needs, preferences, and abilities. While most expected a person-centred approach, many felt their care did not reflect this. Some preferred to leave decisions (particularly about referrals) to their GP. Others preferred to be consulted and informed in order to make their own decisions following professional guidance. Participants felt they had fewer opportunities to make their own decisions when dealing with specialists or when planning for hospital discharge (26).

Primary care and GP involvement

The involvement of GPs was seen to be a significant benefit to integration (2,6–8,22). Securing GP buy-in and their involvement in integrated neighbourhood teams – in particular, their participation in team meetings – was deemed crucial for achieving seamless integrated care (2).

However, other professions suggested that GPs were at risk of viewing involvement in integration as contributing to an increasing and already unmanageable workload (2,7). This was supported in studies of integrated care with GPs in London (12) and Luton (8). Participants described how local pressures have led to an increase in their workload and time constraints, which together have reduced the motivation to collaborate with other sectors (8,12). GPs emphasised a reluctance to accept new responsibilities (e.g., supporting care integration) when there is no immediate reward (12). These challenges were further compounded by the primary care landscape, particularly in Pioneer sites with numerous small general practices (7). Single-handed practices often lacked the infrastructure to host MDTs, and practices overall were reportedly finding it increasingly difficult to assume strategic and developmental roles amidst growing clinical service demands (7).

In this study, GPs and practice managers cited one of the most significant barriers to service integration is the uncertainty about what local services are available, which roles are carried out by which social service provider, how best to contact these individuals, and how long each service takes to arrange (12). Often phone numbers in practice diaries and on provider websites were out of date, so staff had to ask patients directly what social care they received and how to contact relevant departments, slowing down both communication and any attempts at collaborative working. Due to time pressures, GPs were more likely to default to familiar options for decisions about care and onward referrals, unaware of the full range of available resources (7).

Organisational factors

The second overarching factor relates to the impact of organisational issues, such as appropriate resources and capacity, funding, professional development and shared learning, approaches to integrated working, and information governance.

Resources and capacity

Integrated teams require sufficient resources, capacity, and staff capabilities to successfully collaborate and deliver integrated care (14,15,18,21,25,27). A lack of these components was recognised as a common barrier to collaboration, often resulting in increased staff workloads (3,18). Further, staff highlighted the importance of supportive leadership and recognition from management regarding the demands faced by frontline staff. A lack of support from leadership contributed to feelings of being overworked, with some expressing concerns about the impact of these conditions on their mental wellbeing (9).

Many Pioneer sites faced significant challenges due to limited resources and capacity (5–7). Their integration efforts were often managed by small teams with limited time, which became even more problematic when key staff members left (5–7). In larger, more complex Pioneer sites, resources were stretched further by the need to work across multiple Clinical Commissioning Groups (CCGs) and/or local authorities, diverting attention and resources from local initiatives where meaningful change could occur (7). Key partners struggled to allocate staff time and resources, which made it difficult to maintain momentum, while relying on volunteers came with additional recruitment efforts. For providers, the sheer volume of meetings related to integrated care posed another obstacle, as attending these sessions conflicted with the demands of delivering patient care (7). High turnover and staff shortages, particularly among GPs, clinicians, and community nurses, further hindered the capacity to implement new initiatives effectively.

Funding and financial mechanisms

The issue of funding is closely related to resources. Integrated teams depended on having sufficient funding to deliver programmes and services (8,21,22). Key enablers were appropriate, consistent, and sustained funding, which helped to incentivise partner collaborations, ensure sufficient staffing and staff resources, and support long-term planning (24), while short-term or uncertain funding hindered collaborations (3,15). A review of 10 years of integration activities in the NHS highlighted how inadequate funding over time (and declining funding as programmes progressed) impeded integration activities and progress (14). Facilitating integrated working and care provision requires collaboration from organisations that receive funding through different mechanisms, as well as appropriate means to transfer funding between partners (13,24).

Sharing resources through pooled budgets was thought to be particularly beneficial for facilitating integrated working, partly by creating a route to accessing additional resources and adding additional value by enabling activities that would have been otherwise unfeasible (3,7,13,23). This approach was seen to foster a more unified and patient-centred allocation of resources. Combining funds enabled the focus to shift entirely to meeting patient needs, without concerns over whether the resources were coming from health or social care budgets. Separate or fragmented funding were cited as undermining integrated care. However, it was acknowledged that pooled budgets was a ‘big ask’ (7) and could be detrimental if pooling led to a fragmentation of service responsibilities (15).

Payment mechanisms that do not favour one organisation over another were also highlighted as beneficial. Compensating one sector based on activity while providing a fixed budget to another could reportedly create imbalances and distort service delivery (24). Payment methods such as payment by results (PbR) that incentivise activity in hospitals over other providers were identified as barriers to the continued functioning of integrated care (7).

A solid financial foundation and the need to devise long-term plans with an appropriate level of funding was considered essential for driving innovation, offering the flexibility to invest in new ideas and initiatives that can ultimately lead to long-term savings (5–7,13). There was a call in the evidence for financial frameworks that support and encourage, rather than fragment, attempts at integration, where the inability to integrate financially and unify budgets is seen as a barrier (24).

Professional capabilities, development, and shared learning

The skills and capabilities of staff shaped integrated team functioning (15,16,21). Receiving adequate training and education, and possessing the necessary knowledge and skills to work effectively within the integrated care programme, were identified as enabling factors (16). This included, for example, training in shared decision-making, patient empowerment, interprofessional collaboration, and communication (22), as well as new practical skills. In an evaluation of the implementation of an integrated health and social care assessment, nurses requested more training related to the practical skills required to complete the assessment (e.g., asking about personal finances, which they had not previously considered) (15). However, health and social care professionals highlighted the absence of dedicated time for professional development and reflection on practice, which hindered opportunities for learning (21). These challenges were exacerbated by workforce pressures, including difficulties with staff retention and recruitment, reliance on agency workers, and a widespread sense of constantly “firefighting” amid constrained resources (9).

Staff suggested cross-sector rotations to strengthen interprofessional relationships and understanding of the various dynamics of care provision. However, interviewees also expressed the view that multiprofessional learning (via joint training and rotations) were not a priority for provider organisations.

One article described learning ‘windows’ (i.e., formal or informal opportunities that enabled the sharing of experiences and knowledge) in the local boroughs where integrated teams were based (9). In one borough, the community health care provider organisation offered reflective practice sessions, focusing on reducing task-orientated care in favour of more holistic care practices. Additionally, borough-wide staff engagement events provided a platform for sharing experiences and networking between different professional groups. These were well attended, although scepticism remained as to their lasting impact in terms of fostering relationships across the different care sectors. Fostering an ethos of learning and self-reflection was shown to have positive benefits for staff, particularly as they collaborate over the long term (13).

In addition to professional capabilities and skills, one article highlighted the need for education and training in mental health issues for the healthcare workforce to reduce the stigma of severe mental illness (23). The article cited evidence that primary care practitioners may find it difficult to deal with the complexity or relatively slower pace of working with people with severe mental illness (compared with the wider primary care population). Service users and field experts reported that GPs and non-mental health specialists can appear reluctant to tackle severe mental illness, believing this was due to a perception of non-attendance of appointments and non-compliance with treatment advice by those with mental illness (23).

Approaches to integrated working

(i) Multidisciplinary teams

Creating multidisciplinary teams (MDT) was a key enabler of integrated care (7,10,23,25,28). Some approaches to this involved a single management structure co-located on a single site. Others were less formally hierarchical, instead prioritising building trust and shared values among team members.

The evidence suggested that a key aspect of effective integrated care coordination was monthly MDT meetings held at GP practices (10,23). MDT composition was an important factor (12,28), needing staff from various disciplines, each bringing their own expertise, in order to meet the complex and diverse care needs of different patients (22). In one study, these meetings brought together GPs, Extended Primary Care Teams, Integrated Care Team professionals, and social workers (10). For integrated mental health care, teams included GPs, practice nurses, practice managers and the local community mental health team (23). When working with frail older people and their informal caregivers, optimal teams reportedly included case managers, GPs, geriatricians, advanced nurse practitioners, and professionals with expertise in hospital discharge planning, (22). Team success relied on consistent attendance from all professional groups. In one article, the community physical health coordinator maintained a definitive list of lifestyle services and liaised with GPs and practice managers between MDT meetings (23). Overall, these meetings were viewed as valuable for sharing knowledge and addressing complex patient needs.

The value of scheduled team meetings was further underscored in a study with GPs in London, in which participants described communication between primary care and social care as logistically challenging, often with no standardised method for contacting the other sector (12). GPs were busy with patients during the day while social care staff are working in the community, making joint conversations about patients nearly impossible (12). The main criticism from GPs was that there is often no protected time for these meetings, which often clash with patient clinics, so often the GPs cannot attend themselves. They also acknowledged geographical barriers, since these meetings are held in GP practices, often community teams are unable to attend between home visits (12).

In a further London-based study, participants described their MDT meetings as inefficient (11). Social workers often struggled to attend meetings and, when present, were not always able to contribute relevant information, citing limited capacity and high staff turnover (10,12). This was reported to frustrate other professionals, and meant that conversations regarding care did not conclude in action points. The evidence suggested that a reliance on agency staff across the sector further impacted the effectiveness of care coordination at MDT meetings.

(ii) Co-location

Several articles proposed co-location to be a necessary element in integrated teams (2,3,10,14–17,23). Physical co-location (e.g., sharing office spaces and facilities) or close proximity of teams was seen by many to promote integration, build trust, strengthen relationships, and encourage collaborative working. It was also thought to potentially enhance confidence in data sharing (2). Co-location encouraged more effective communication and created informal opportunities, such as 'corridor conversations,' to share knowledge, experiences, and information about patient care (10). For instance, in one local team site, the close proximity of Extended Primary Care Teams staff to the Rapid Response team was considered essential for coordinating care for their shared patients (10).

However, it was acknowledged that co-location alone was inadequate without proper investment and support for integration. Simply sharing a location did not necessarily result in cohesive professional teams (2). Staff must understand their roles and responsibilities and work willingly and collaboratively together (23), emphasising that people (rather than specific approaches to integrated working) are essential to successful integrated care. Even with co-located teams, challenges remained, such as the separation of Extended Primary Care Teams or Integrated Care Teams by professional group into distinct offices on the same floor, which limited opportunities for partnership working and mutual learning (10). Territorial behaviour among staff using shared spaces was a reported barrier, whereby staff placed personal items and labels on shared spaces, contributing to a perception of space ownership and siloing (27). In one article, social workers were not co-located with healthcare teams, and when they visited they faced difficulties due to inadequate workspace and limited access to their own data systems (10). Consequently, there is need to plan for and provide sufficient physical space for, for example, primary care services to be located in a mental health clinic (23).

Furthermore, interviewees did not always agree on what facilitated integration, as approaches deemed effective in one context might not be viewed the same elsewhere (7). For example, in Pioneer sites, while some participants emphasised the importance of co-located teams (e.g., of community health and social care workers) under a unified management structure, others saw this as either unnecessary or even counterproductive, particularly if it created concerns among staff about their roles within the reorganised framework (7).

(iii) Care navigators and case managers

The evidence endorsed the idea of care navigators, care coordinators, or case managers in integrated care. These dedicated individuals support patients to navigate fragmented complex care systems (e.g., between physical and mental health services, between primary and secondary care) and offer continuity of care (16,23,25,28). They were considered the central coordinator in effective MDTs (17). The value of such individuals was particularly evident in the literature on integrated care for people with severe mental illness (23) and frail older populations (25,28). Service users and carers placed importance on the continuity of care offered through one-to-one relationships with a care coordinator, case manager, or community key worker (25). Such relationships improved the transition of care from hospital to community settings, facilitated personalised care, and enabled access to appropriate information and support. Organisational factors such as staff shortages, high staff turnover (particularly among care workers), a lack of service user contribution to the design of integrated services, and lack of service user or carer involvement during transitions from hospital to community settings were all cited as barriers to effective care coordination and continuity (25). Service users and carers highlighted that a positive relationship with their care provider – characterised by good communication, respect, listening, trust – enhanced their experience of care coordination and continuity, supporting them to feel empowered, in control, safe and secure (25).

However, service users raised questions about the extent to which navigators should engage in advocacy for patients, particularly when dealing with services less accustomed to severe mental illness (e.g., when people with severe mental illness have dental care withdrawn due to missed appointments) (23). This is made more difficult when specialist care coordinators lacked sufficient authority to exert control over other care professionals to ensure care is properly integrated (23).

Information governance: IT systems and data sharing

The evidence consistently highlighted the central role of IT interconnectivity and shared platforms in facilitating the integration and delivery of services, while also underscoring the challenges posed by incompatible IT systems (2,10,13,16,18,21). The success of integration initiatives was compromised by significant barriers to information sharing, including restricted access to IT systems and a lack of interoperability between existing platforms (15,17,18). Effective communication and information sharing were dependent upon access to patient data and records. However, inadequate information systems (particularly the use of disparate IT systems for human resources and clinical tasks across professions and organisations) were reported to be significant barriers to accessing clinical data and streamlining working practices. GP practices and social care teams used different software; there were no direct and user-friendly methods of transferring patient information (12). This lack of interoperability between systems meant staff communication was limited to emails and phone calls, often causing delays in sharing notes and raising concerns about patient confidentiality (12). The absence of a unified clinical IT system for community services negatively impacted data sharing among healthcare, social care, and partner services, such as GPs, mental health providers, and emergency responders, all of whom maintained separate information about individuals' care needs.

At an individual (patient) level, concerns arose about what information could be shared and with whom. Data protection concerns were linked to a perceived lack of trust between acute and community services, as well as between health and social care sectors. This fragmented approach to data access was seen as a potential risk to safeguarding and individual safety. For example, effective data sharing could enhance staff safety by ensuring awareness of dangerous social situations, enabling appropriate risk assessments during lone-working or home visits. It was also recognised that sharing comprehensive data on individuals could reduce unnecessary referrals to other services.

There was a belief that fostering stronger relationships between services and professionals could build trust, leading to greater confidence in data sharing. Integration was seen as an opportunity to address these issues, though it was acknowledged that fully streamlined IT systems across all services were unlikely in the near future.

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