MULTI-PROFESSIONAL WORKING IN THE COMMUNITY: A SCOPING REVIEW

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CONTEXT AND SCOPE

This scoping review forms part of the Community Infrastructure project commissioned by the Strategic Programme for Primary Care (SPPC). The Community Infrastructure Programme is a core part of the SPCC 24/7 work stream regarding the provision of sustainable 24/7 community services and this review sets out to form an evidence base for other components of the project to draw upon.

The review is structured to answer six core questions which address the definitions, existing workforce models, benefits, challenges, patient experiences and health economics of multi-professional working in the community.

METHODS

This review was carried out between June – August 2022. Originally, 357 papers were identified before being screened for relevance against inclusion/exclusion criteria, leaving 74 papers included in the final review.

RESULTS

A wide range of papers discussed the definitions of multi-professional working however there was no overall consensus, but key values are shown in the table below. Similarly, multiple workforce models were identified, the most common of which were regular team meetings and co-location of teams. The patient experience of multi-professional working was largely demonstrated to be positive, provided it is carried out effectively. Literature also suggested that there were several health economic benefits to be found when this type of working was supported. Key benefits and challenges that were identified are also provided in the table below

Values	Benefits	Challenges
Early intervention	Cost-effectiveness	Budgetary restrictions
Trust	Improved outcomes	Staff turnover
Communication	Patient satisfaction	Lack of understanding
Collaboration	Knowledge sharing	Poor communication
Equity	Faster assessments	Mistrust
Empowerment	Improved patient reach	Access to records
Quality improvement	Increased engagement	Differing priorities
Innovation	Fewer admissions	Poorly defined responsibility
Accessibility	Shorter hospital stays	Time restraints
Sustainability	Fewer crisis referrals	“Territorial” behaviour

1. INTRODUCTION

Primary care plays a crucial role in the functioning of the healthcare system. Access to primary care is a fundamental determinant of population health (Voorhees, Bailey, Waterman & Checkland, 2021) and is a vital way of preventing referrals to secondary care (Doran & Roland, 2010), and preventing hospital admissions (Huntley et al, 2014). One way of summarising is provided by Packer (2022, p1), who said that: "High quality primary care is essential to the health of the nation and the world."

However, primary care is not always sufficient to address need. In England, the NHS receives approximately 1.6 million outpatient referrals a month, of which 1 million come from primary care (Levell, 2022), in Wales this figure was 124,073 referrals for May 2022, of which 76,552 were from primary care (Welsh Government, 2022). This leads to increased costs for already stretched healthcare systems (Faulkner et al, 2003), as well as effects on patient outcomes (Park et al, 2020). Clearly, it is vital that primary care works effectively to prevent these outcomes and continue to deliver for the public.

One component of this, is the use of multi-professional working in primary care, and in the community at large. Particularly in the wake of Covid-19, multi-professional teams are being increasingly recognised as crucial for effective service delivery (Parkin et al, 2021; Baranidharan, Connell, Malpus & de C Williams, 2021). The NHS has identified that: "Evidence consistently shows that multi-professional team working delivers better outcomes for patients and more effective and satisfying work for clinicians." (Health Education England, 2017, p2), and in Wales this has been echoed.

As recently as 2019, the Welsh Government discussed the need for a strong multi-professional workforce across healthcare systems (2019). This has led to the Strategic Programme for Primary Care (SPPC) embarking on their Community Infrastructure programme in collaboration with the National Collaborative Commissioning Unit (NCCU) and with the NHS Delivery Unit. The aim of this is to "create collaborative working across community professions and organisations to support recovery and build resilience" (SPCC, 2022, p9).

Additionally, a recent review has even suggested that now may be a particularly apt time to implement multi-professional working, due to the impacts of Covid-19: "It is true that some barriers were taken away overnight at the start of the pandemic, and many took on different roles" (Easterbrook & Blood, 2022, p46). This highlights the ability of professionals to work across barriers when necessary and implies that professionals, now more than ever, may already have an improved understanding of others roles.

As a result, this scoping review has been undertaken to understand the pre-existing literature that describes multi-professional working in the community, and answer key questions to aid with any future implementation.

1.1 REVIEW REMIT AND OBJECTIVE

For the reasons outlined above, this scoping review was commissioned by the Strategic Programme for Primary Care (SPPC). The Community Infrastructure Programme is a core part of the SPCC 24/7 work stream regarding the provision of sustainable 24/7 community services. The programme is wholly aligned to A Healthier Wales, the Primary Care Model for Wales, the Six Goals of Urgent and Emergency Care, Allied Health Professions (AHP) Framework, and supports the SPPC Accelerated Cluster Development Programme (ACD). Specifically, this scoping review aims to establish an evidence base of existing literature from which other elements of the project, including the evaluation framework and the Group Concept Mapping study, may draw from.

A scoping review is "a preliminary assessment of potential size and scope of available research literature. It aims to identify nature and extent of research evidence (usually including ongoing research)" (Grant and Booth, 2009). As such, this review is not a comprehensive examination of literature as would be found in a systematic review but instead aims to conceptualise the boundaries of the review topic; multi-professional working in the community.

1.1.1 REVIEW QUESTIONS

This scoping review was designed to address the following six questions:

1. What literature is there which describes multi-professional working in the community?
    a. Are there differing definitions?
2. What workforce models are in the examples identified in the literature?
3. What benefits are there to multi-professional working in the community?
4. What literature is there which describes the patient experience of multi-professional working in the community?
5. What are the challenges of multi-professional working in the community?
6. What literature is there which explores the health economics of multi-professional models in the community?

2. METHODS

This scoping review was carried out between June and August 2022 with the aim of conceptualising the literature on multi-professional working in the community. Particularly, this review investigated the definitions of this work, workforce models identified, patient experience, benefits and challenges, and health economics relating to community based multi-professional working.

The search comprised academic literature across the following four databases: CINAHL, Cochrane, ProQuest and Social Care Online. Due to the nature of a scoping review and the amount of literature identified from these databases snowballing ,the process by which additional papers are identified through the reference lists and citations of existing papers, did not take place.

A PICO(population/problem, intervention, comparison, outcome) table was developed to assist in searching databases (Appendix 1.). Search terms were limited to those closely aligned to the research questions and, therefore, synonymous with the terms 'multi-professional', 'community', 'health economic' and 'model'. Search terms were kept largely consistent however in some cases terms were adapted (i.e. to add an additional search term) if too large a sample of literature was returned for review (Appendix 2.).

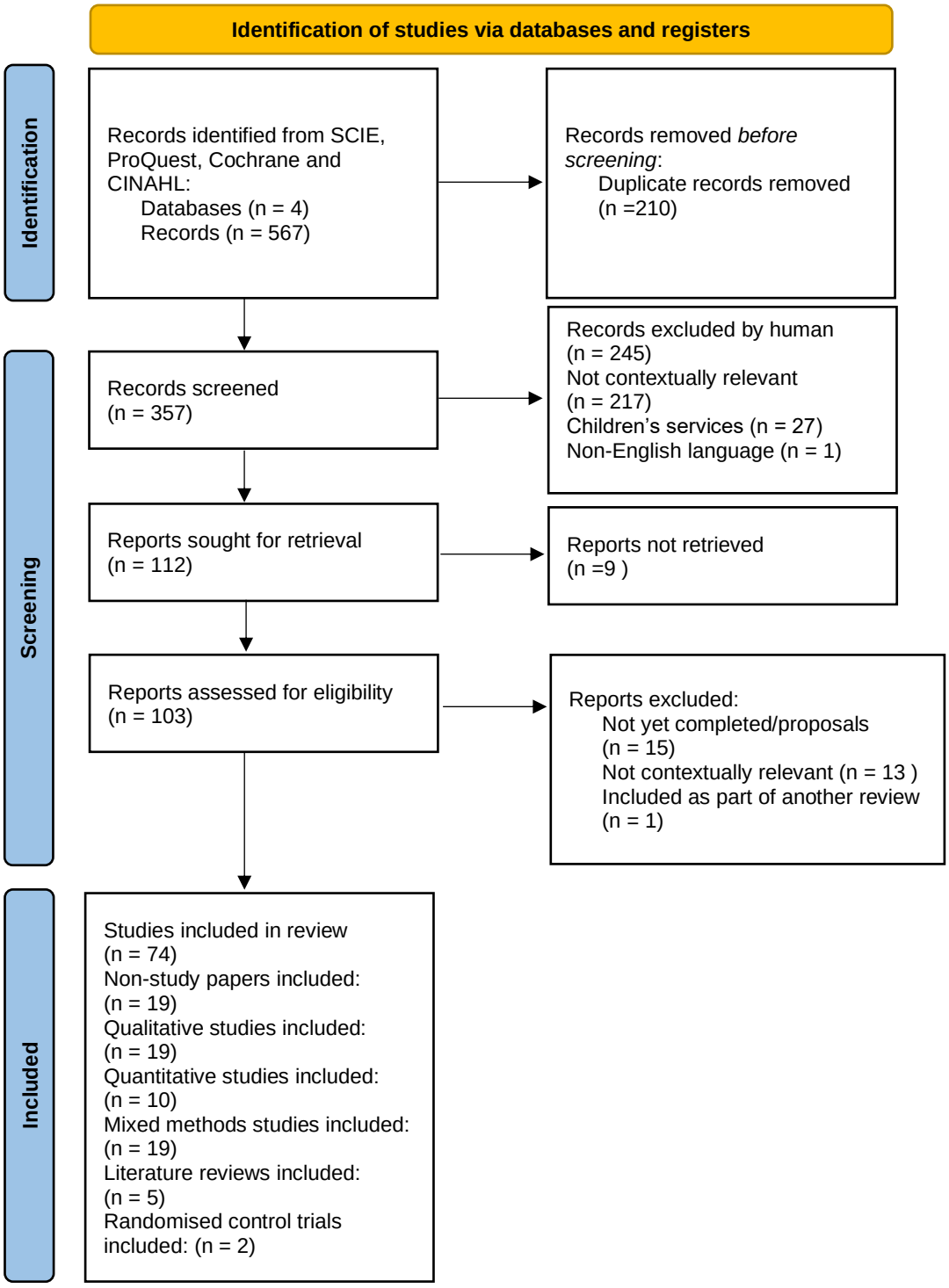
Subject to inclusion and exclusion criteria (Appendix 3), included in the review are all relevant literature published in the English language. Papers were excluded if unrelated to all six research questions and therefore papers were not limited to studies of multi-professional working but could also include policy documents and community guidelines.

The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) diagram below provides detail on the number of records and of papers identified. Following the initial search of databases 567 records were retrieved, 357 following duplicate removal. These were first screened by title however it was found that many of the titles did not accurately reflect the contents of the paper and so all records were screened by their abstract to extract any that were deemed relevant against the inclusion and exclusion criteria. If considered relevant they were rated green and if not considered relevant they were rated red.

A total of 112 records were rated green for potential relevant. Of these, 9 could not be retrieved in full, 15 were study proposals without posted results, 13 were not contextually relevant when read in full and 1 had already been referenced as part of another review. This left a total of 74 papers in the review.

Papers were then screened for quality, using a RAG rating criterion. Papers that were randomised control trials were giving the Green rating, other quantitative and qualitative studies were given the Amber rating. Papers that were not studies were given a Red rating, as it cannot be assumed that they are all supported by a robust evidence base.

Figure 1. PRISMA diagram



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

3. RESULTS

A total of 74 papers are included within this scoping review, drawn from the 357 papers that were screened for possible inclusion. Detail of these papers is provided in Appendix 4. The review was structured around the six questions described above.

3.1 TYPES OF PAPERS

This scoping review includes 74 papers, of which:

- 19 were mixed method studies (Allworth et al, 2018; Baillie et al, 2016; Banerjee et al, 2007; Barraclough, 2019; Beynon and Wafula, 2012; Clarke and Wydall, 2013; Cooper et al, 2021; Davey, 2005; Dugdale et al, 2019; Elias et al, 2021; Elston et al, 2022; Fallows, 2019; Fraser, 2018; Jocelyn, 2018; Kulnik et al, 2017; Leichsenring and Ruppe, 2016; Llewellyn et al, 2021; Miller et al, 2017; Nabhani-Gebara et al, 2020)
- 19 were qualitative studies (Aby, 2020; Barmaky et al, 2018; Beacon, 2015; Beehler and Wray, 2012; Bjørkquist et al, 2017; Burchell, 2022; Dambha-Miller et al, 2021; Franzosa et al, 2021; Gerolamo et al, 2016; Lalani and Marshall, 2022; May-Lill and Ervik, 2022; Pettersson et al, 2019; Rees, 2004; Rugkåsa et al, 2020; Scheele and Vrangbæk, 2016; Smith and Gibb, 2007; Szafran et al, 2018; Wain, 2020; Woodhouse, 2009)
- 19 were not studies (Bonciani et al, 2018; Care Quality Comission, 2022; Daly, 2016; Drysdale, 2017; NHS England, 2015; NHS England, 2019; Fear et al, 2012; Integration and Better Care Fund, 2021; Ljubi et al, 2020; Llewellyn et al, 2022; National Association of Primary Care, 2018; Pitt et al, 2018; Pollard et al, 2014; Roland et al, 2015; Rosen, 2018; Routledge, 2020; Sang et al, 2006; Sinclair, 2017; Venditti et al, 2021)
- 10 were quantitative studies (Anjara et al, 2019 ; Ekelund and Eklund, 2015; Greenberg and Rosenheck, 2010; Ismail et al, 2020; Meyerowitz-Katz, 2017; Michalowsky et al, 2016; Mueller-Stierlin et al, 2017; Sfar-Gandoura et al, 2017; Tachibana et al, 2019; Vestesson et al, 2020)
- 5 were literature reviews (Allen and Rixson, 2008; Greidnaus et al, 2020; Pitchforth and Nolte, 2014; Rawlinson et al, 2021; Reece et al 2022)
- 2 were randomised control trials (Rogers et al, 2016; Uittenbroek, et al, 2017).

Further screening was undertaken to identify which of the research questions each paper was relevant against. The table below shows the number of papers that were relevant for each of the six questions:

Review Question	No. of papers
1. What literature is there which describes multi-professional working in the community? Are there differing definitions?	25
2. What workforce models are in the examples identified in the literature?	29
3. What benefits are there to multi-professional working in the community?	39
4. What literature is there which describes the patient experience of multi-professional working in the community?	18
5. What are the challenges of multi-professional working in the community?	34
6. What literature is there which explores the health economics of multi-professional models in the community?	19

In the sections that follow, key themes that emerged under each of these questions will be presented.

3.2 WHAT LITERATURE IS THERE WHICH DESCRIBES MULTI-PROFESSIONAL WORKING IN THE COMMUNITY? ARE THERE DIFFERING DEFINITIONS?

Twenty five papers were identified that gave specific definitions of multi-professional working in the community. Of these, some were more vague and simply defined multi-professional working in general terms rather than in specific models. For example, papers that gave definitions such as "place based joint vision and ambition" (Integration and Better Care Fund, 2021) or "collaboration, alignment, training and connectivity among social care, health care and community care providers" Ljubi et al, 2020). However, some papers gave very specialised definitions, likely due to specificity of their services such as an integrated diabetes management service that gave the definition of "integrating diabetes, mental health and social care into one service, the Three Dimensions For Diabetes (3DFD) model" (Ismail et al, 2020) or a housing service that defined their multi-professional working as "a way of working where all health and social care professionals work together as a virtual team in each of the five localities of East Lancashire" (Daly, 2016).

Despite the variety of services included in the literature, some core themes were identified in these papers. One of these was place-based working, or co-location, in the context of multiple professionals either working from the same building or meeting in person on a

regular basis (England, 2015; Integration and Better Care Fund, 2021; Pollard et al, 2014; Roland et al, 2015; Sinclair, 2017). In these definitions, place-based work is incorporated into the idea of multi-professional working as a key component and seen as an essential facilitator without which successful multi-professional working would not have been achieved. However, most definitions identified in the literature do not focus on specific facilitators but rather values such as collaboration (Elston et al, 2022; Ljubi et al, 2020; National Association of Primary Care, 2018; Sinclair, 2017) and knowledge sharing to meet patient need (Banerjee et al, 2007; Cooper et al, 2021; NHS England, 2015; Fear et al, 2012; Greenberg and Rosenheck, 2010). Similarly, some definitions are more focussed on outcomes than a specific way in which multi-professional working may be achieved, for example groups of professionals working together to try to improve their cost effectiveness (Elston et al, 2022; Uittenbroek et al, 2017), or achieve shared goals (Care Quality Comission, 2022; NHS England, 2015; Greenberg and Rosenheck, 2010; Integration and Better Care Fund, 2021; National Assiociation of Primary Care, 2018).

Additionally, there are differences in the services named as needed for multi-professional working, which seems to relate to the demographic of people the service is trying to reach. For example, services more related to social difficulties (i.e. housing, drug use etc.) stress the importance of collaboration from the voluntary sector (Beynon and Wafula, 2012; Clarke and Wydall, 2013; Elston et al, 2022; National Association of Primary Care, 2018) whereas services based in healthcare (i.e. mental health, diabetes management) may focus on integration between primary, secondary and tertiary care (Elston et al, 2022; NHS England, 2019; Ljubi et al, 2020; Nabhani-Gebara et al, 2020; Routledge, 2020; Uittenbroek et al, 2017).

As outlined above, there are clearly different ways in which multi-professional working in the community can be described and achieved in the literature. However, it can be generalised within these papers as the coming together of multi-disciplinary professionals to provide a service that benefits patients due to the spread of knowledge this provides.

3.3 WHAT WORKFORCE MODELS ARE IN THE EXAMPLES IDENTIFIED IN THE LITERATURE?

Twenty nine of the papers identified in the review gave descriptions of their workforce models and, as above, these were highly varied due to the scope of services included. However, although specifics (such as which professionals are included) varied significantly, there were two workforce models in particular that emerged repeatedly.

The first of these models were multi-professional services in which professionals worked independently much of the time, but came together regularly for meetings to discuss their

work (Clarke and Wydall, 2013; Elston et al, 2022; Ismail et al, 2020; Meyerowitz-Katz, 2017; Pollard et al, 2014; Tachibana et al, 2019). Within these models, there were differences in time frame with some services coming together several times a week (Elston et al, 2022; Meyerowitz-Katz, 2017), weekly (Ismail et al, 2020), fortnightly (Clarke and Wydall, 2013). or not specifying. However each stressed the importance and value of the multi-disciplinary meetings and the value that these added to their work.

The second and most prevalent workforce model that emerged was multiple services or professionals physically co-locating (Barmaky et al, 2018; Beynon and Wafula, 2012; Eklelund and Eklund, 2015; NHS England, 2019; Greidanus et al, 2020; Lalani and Marshall, 2022; May-Lill and Ervik, 2022; Miller et al, 2017; Rugkåsa et al, 2020; Scheele and Vrangbæk, 2016). Again, there were differences in how this was achieved as some services were newly established and then co-located with an existing service (Beynon and Wafula, 2021; Ekelund and Eklund, 2015; Pollard et al, 2014; Rugkåsa et al, 2020; Smith and Gibb, 2007) whereas in other cases a 'base' or 'hub' for co-location was chosen after services were already established (Barmaky et al, 2018; Lalani and Marshall, 2022; May-Lill and Ervik, 2022; Miller et al, 2017; Scheele and Vrangbæk, 2016). By whichever means co-location was achieved, it was frequently referred to as an effective workforce model due to the ease with which practitioners were able to interact with one another and discuss their work without the need for a formal meeting. Despite this however, one paper (Pollard et al, 2014) specifically described that co-location was "a necessary but not sufficient step towards integration" and continued to detail that "integration also required regularly scheduled provider and clinic operations meetings" showing that these two workforce models may be complementary to one another rather than entirely separate.

Another lesser described, but distinct, workforce model found in the literature was professionals making use of technology either through the delivery of their service (Franzosa et al, 2021; Gerolamo et al, 2016), or in the way that they connect with other professionals (Jocelyn, 2018). In these cases, services were using telemedicine to allow them to attend to more patients in a shorter period of time (Franzosa et al, 2021), to track patient outcomes more efficiently (Gerolamo et al, 2016) or to connect patients and professionals to specialist teams without geographical restriction (Jocelyn, 2018). We may expect to see a development in this in the coming years due to the recent necessary changes in the workforce, e.g. increased home working, regular use of conferencing software etc, though this theme was not identified in the present review.

Other identified workforce models included inter-professional mobile care (Miller et al, 2017), the use of a specified care co-ordinator (Daly, 2016) and the use of smaller "core teams" (i.e. one GP, practice nurse, district nurse, social worker and case manager) (Beacon, 2015).

3.4 WHAT BENEFITS ARE THERE TO MULTI-PROFESSIONAL WORKING IN THE COMMUNITY?

Thirty nine papers were identified that discussed the benefits of multi-professional working in the community. There were several key themes that emerged with the most common being improved service outcomes/improved outcomes for service users (Banerjee et al, 2007; Beacon, 2015; Clarke and Wydall, 2013; Ekelund and Eklund, 2015; NHS England, 2019; Ismail et al, 2020; Rogers et al, 2016; Venditti et al, 2021). As mentioned previously, due to the range of services included in the literature the outcomes themselves differed but examples included reduced depression and anxiety (Beynon and Wafula, 2012), improvements in physical health (Reece et al, 2022) and lowered blood pressure and cholesterol (Meyerowitz-Katz, 2017). Despite this being the most frequently discussed benefit to multi-professional working, the reasons for this may be attributed to some of the other benefits that were described.

For example, some papers identified that multi-professional working increased the confidence of professionals (Baillie et al, 2016; Beacon, 2015) due to the early and effective communication that this way of working afforded them. Many papers also identified that multi-professional working led to earlier intervention (Allen and Rixson, 2008; NHS England, 2019) and faster assessments (Lalani and Marshall, 2022; Rawlinson et al, 2021) due to increased access to specialist services. The improved sharing of specialist knowledge was also discussed in several papers either in terms of practitioners sharing specialist knowledge between one another (NHS England, 2015; Kulnik et al, 2017; May-Lill and Ervik, 2022; Wain, 2020) or increased access to specialist services so that referrals could be made efficiently when needed (Barmaky et al, 2018). When benefits such as these are identified in the literature, it follows that service outcomes are likely to improve as a result.

In addition to the professional benefits of multi-professional working in the community, there were also several direct benefits to service users identified. For example, some papers described that multi-professional services were easier to access either due to rapid access (Rosen, 2018; Rugkåsa et al, 2020), co-location (Sinclair, 2017) or the use of technology to connect multiple professionals with service users at once (Franzosa et al, 2021). As a result of this, some services found it easier to reach previously considered "hard to reach" groups (Kulnik et al, 2017) including people living in the community with a dementia diagnosis (Banerjee et al, 2007) and mothers with a history of drug use (Smith and Gibb, 2007). Furthermore, once service users had access to the service, many papers indicated that they showed increased levels of engagement (Barmaky et al, 2018; Burchell, 2022; Dugdale et al, 2019; Fallows, 2019), again suggesting that they may show improved service outcomes compared to a service without multi-professional working.

Finally, as a result of the improved outcomes and early intervention already discussed, some papers identified that following uptake of multi-professional working there was a reduced need for referrals to secondary care (Beacon, 2015; Cooper et al, 2021), hospital admissions (Drysdale, 2017), or crisis referrals (Barraclough, 2019).

3.5 WHAT LITERATURE IS THERE WHICH DESCRIBES THE PATIENT EXPERIENCE OF MULTI-PROFESSIONAL WORKING IN THE COMMUNITY?

Eighteen of the identified papers described the patient experience of multi-professional working in the community, and the majority of these described a positive experience. By far, the most common theme of these papers was “high patient satisfaction” however this can be broken down into satisfaction with the process as a whole (Beacon, 2015; Cooper et al, 2021; Mueller-Stierlin, 2017; Pettersson et al, 2019; Rogers et al, 2016), satisfaction due to the accessibility of multiple services (Sfar-Gandoura et al, 2017; Uittenbroek et al, 2017), and satisfaction due to the holistic approach that multi-professional working encourages (Smith and Gibb, 2007).

Although a generalised ‘satisfaction’ was the most common theme identified, there were also some smaller themes that emerged . For example, some service users described that following their experience with a multi-professional service they felt more confident in their future self-management and independence (Care Quality Comission, 2022; Kulnik et al, 2017), which could in one case be explained by the feeling that multi-professional working had encouraged service user skill development (Kulnik et al, 2017). Another paper described that service users had particularly valued not needing to repeat themselves when accessing several professionals (Elston et al, 2022), and others felt that being able to access services earlier had led to a better outcome for them (Rugkåsa et al, 2020)

Despite the many positive patient experiences of multi-professional working in the community, there were two papers in particular that highlighted negative patient experiences, particularly when multi-professional working is attempted but improperly executed. For example, in contrast to the lack of repetition described previously, one service user described frustration when communication in multi-professional working is disjointed rather than fully integrated: “We felt that we were having to speak to so many different people. You’d go to one person and they’d deal with that bit, and the next person would deal with another bit, and another person.” (Dambha-Miller et al, 2021).

Another paper gave comprehensive oversight of the challenges to the patient experience of multi-professional working when it is not properly executed. Frustration mostly stemmed from ineffective professional relationships, or non-existent pathways when multi-professional working is supposed to be in place. This was summarised as:

"Respondents described partnership working between social services and health services problematic at best, and in some cases non-existent. This also applies to integrated health and social care teams that social services work with. Ineffective working relationships were felt to be to the detriment of service users and carers." (Llewellyn et al, 2022).

3.6 WHAT ARE THE CHALLENGES OF MULTI-PROFESSIONAL WORKING IN THE COMMUNITY?

Thirty four papers discussed the challenges of multi-professional working in the community and several core themes were easily identified across differing services. The first of these were challenges surrounding resource, particularly time and budgetary restraints. Lack of time was identified (Greidanus et al, 2020; Kulnik et al, 2017; Rawlinson et al, 2021), as when professionals lack time they are unable to commit to the facilitators of effective multi-professional working, such as regular multi-disciplinary team (MDT) meetings. Budget was mentioned more frequently than this (Aby, 2020; Banerjee et al, 2007; NHS England, 2015; Kulnik et al, 2017; Rawlinson et al, 2021) with one paper going as far as to say that "the funding system in effect penalises collaborative work" (Rugkåsa et al, 2020). These challenges are linked as a lack of resource is traced within the papers to a lack of investment from funding bodies (Banerjee et al, 2007) or lack of interest from individuals within senior management, largely due to their own lack of human resource, time and access to appropriately skilled professionals to facilitate implementation (Rawlinson et al, 2021) . Senior leaders are therefore unable to advocate for multi-professional working, and therefore may allocate insufficient resource for practitioners.

Staff difficulties were also frequently discussed within the papers, the first of these was the challenge of high staff turnover (Aby, 2020; Baillie et al, 2016; Kulnik et al, 2017; Szafran et al, 2018). This is seen as a challenge as it can then cause multi-professional working to lose 'momentum' over time (Elias et al, 2021) as practitioners who were at first engaged in this leave services. Another challenge identified, and likely impacted by high turnover, was a lack of understanding amongst staff of the roles held by other staff (Lalani and Marshall, 2022; May-Lill and Ervik, 2022; Nabhani-Gebara et al, 2020; Pettersson et al, 2019; Szafran et al, 2018; Woodhouse, 2009) which can then lead to "mistrust and poor communication" between professionals (Fraser, 2018). As a result of this poor understanding and mistrust, some papers also identified that some staff can become "territorial" (Aby, 2020; Dambha-Miller et al, 2021; Greidanus et al, 2020; Rawlinson et al, 2021; Szafran et al, 2018) and therefore resistant to information sharing and communication with others.

Lack of communication was also identified as a significant barrier to effective multi-professional working. Several papers discussed that there was the potential for multi-professional working to lead to a lack of clearly defined responsibilities (Bjørkquist et al, 2017; Cooper et al, 2021; Wain, 2020) which could be particularly challenging in high-risk scenarios. This was not helped by difficulties in record sharing, particularly when professionals do not all have the same access to the same record keeping system (Bjørkquist et al, 2017; Dambha-Miller, 2021; Greidanus et al, 2020; Lalani and Marshall, 2022; Ljubi et al, 2020), usually due to ethical and confidentiality concerns, but creating a barrier to full integration nonetheless. Furthermore, professionals from different specialities or with different responsibilities can also have different priorities when it comes to what is important (Greidanus et al, 2020; Sinclair, 2017), leading to a "tunnel vision of expertise" in some cases (Ljubi et al, 2020), in direct contrast to the person-centred approach of multi-professional working as a whole.

A lack of shared space was identified as the cause of some of these challenges (Griedanus et al, 2020; Szafran et al, 2018) implying that co-location may aid alleviation of some of the difficulties of multi-professional working. However, this was discussed specifically in one paper that concluded that, although co-location can mitigate difficulties such as lack of understanding and poor communication, it is not always enough without other steps that promote facilitation (Fraser, 2018).

3.7 WHAT LITERATURE IS THERE WHICH EXPLORES THE HEALTH ECONOMICS OF MULTI-PROFESSIONAL MODELS IN THE COMMUNITY?

Nineteen papers were identified that discussed the health economics of multi-professional models in the community. The key theme was that many papers found multi-professional working to be cost-effective overall, if sometimes needing additional funding to be established (Anjara et al, 2019; Beacon, 2015; Drysdale, 2017; Dugdale et al, 2019; Elston et al, 2022; Ismail et al, 2020; Meyerowitz-Katz, 2017; National Association of Primary Care, 2018; Venditti et al, 2021).

Within this theme, there were several identified reasons for the cost-effectiveness observed. The first of these were reduced hospital admissions (Elston et al, 2022; National Association of Primary Care, 2018; Routledge, 2020) with one paper citing that savings in admission accounted for "96% of savings so far" (Beacon, 2015). Related to this, multi-professional working was shown to lead to an increase of discharges from secondary care and fewer required follow ups once discharged (Cooper et al, 2021), or a reduced length of stay in hospital once admitted (Drysdale, 2017).

In addition to this, multi-professional working led to improved general health in some populations (Pitchforth and Nolte, 2014; Routledge, 2020) which could in term save on costs as service users then require fewer appointments in future (NHS England, 2019). There was also an observed increase in service efficiency in one case (Elston et al, 2022) meaning that professionals may have a reduced workload without a decrease in the effectiveness of a service (Reece et al, 2022). Cost-effectiveness was not only observed in health settings, as some papers described improved financial security for service users involved in services working with social difficulties (Reece et al, 2022), which could include a reduction in their personal debt (Allworth et al, 2018). It therefore appears that multi-professional working can provide an economic way of working, with review of case studies going as far as to describe "a budget surplus as well as improvement to services, reduction in hospital referral rates and increased referral speeds" (Beacon, 2015).

However, although there are some clearly demonstrated health economic benefits to multi-professional working in the community, some papers indicate that these should be interpreted with caution. For example, one review outlined that: "Utilization and cost were the most common economic outcomes assessed by reviews but reporting of measures was inconsistent and the quality of the evidence was often low" (Pitchforth and Nolte, 2014). Furthermore, another review considered that: "Maintaining services in the current financial climate means that: service redesign is the key, clinical leaders and managers need to be prepared to take this forward together" (Fear et al, 2012) indicating that support needs to come from higher level stakeholders, as has already been outlined above.

Overall, it appears that there are beneficial health economic outcomes to multi-professional working, however the evidence base is not necessarily strong enough to draw a firm conclusion and it is likely that any benefits would be conditional on the working model being executed efficiently, with many of the facilitators mentioned above.

4. CONCLUSIONS

The results detailed above show that there is a large evidence base from which to draw regarding multi-professional working in the community. As this is a scoping review, results should be interpreted with the restrictions of this type of review in mind, and with reference to the inclusion and exclusion criteria applied. Whilst a systematic review would provide a more definitive picture of the evidence base, the key themes identified here are reflective of the key issues and talking points of the available literature and, were further research undertaken, would likely also be identified during the course of a full systematic review.

The reviewed literature suggested that there was no singular definition of multi-professional working in the community, which was to be expected given the scope of services and professionals that this type of work could apply to. Some services gave very specific descriptions that could not apply more broadly as they specified not only their working model but also which professionals they deemed to be necessary facilitators for multi-professional work. However, some papers gave broader definitions and descriptions that focussed on 'soft' values such as collaboration or knowledge sharing. In papers with more specific definitions, these softer values could also often apply and so, although there was no definitive definition of multi-professional working in the community, it could be said that the collaboration of differing professionals to share knowledge to the benefit of the public appeared to be the commonality amongst differing definitions.

There were also several workforce models identified in the literature, however the overwhelmingly present theme was that of co-location, i.e. of services or professionals that worked together at the same location. Many papers posited co-location as a key facilitator, or in some cases a necessity, to multi-professional working. However, this was not the only model identified and other papers described that a regularly scheduled multi-disciplinary meetings could replace co-location. Other papers pointed toward the role of technology, or of a specified case worker though this was far less prevalent. It seems that, whether through regular meetings, co-location or another strategy, the key aspect of a successful workforce model for multi-professional working was an established method of communication between professionals, however that could be best achieved.

The patient experience of multi-professional working in the community was broadly positive, with many papers discussing patient satisfaction with the process as a whole. Individuals described multiple benefits including feeling they received holistic treatment, had easier access to professionals or achieved better outcomes from services. However, there was literature that described a negative patient experience, especially in the case that multi-professional working was poorly executed. There were a large number of both benefits and challenges to multi-professional working identified that could be linked to

patient experience, for ease these are summarised in figure 2 along with the values that underpinned much of the literature.

Finally, the literature that described the health economics of multi-professional working in the community was also largely positive, with multiple papers describing cost-effectiveness or indirect savings such as fewer referrals to primary care, or shortened hospital stays. Overwhelmingly, the literature demonstrated that multi-professional working is cost effective when executed properly. However, a key caveat to this is that it needs sufficient funding and support to achieve this and can be costly in the short term. A small amount of papers highlighted that, in the current economic climate, this may be difficult to navigate.

Overall, this review demonstrated that there is a wide breadth of literature to draw upon when considering multi-professional working in the community, however due to the nature of the scoping review some topics may not have been identified. Of note was that no literature was identified in this review surrounding the topic of virtual wards, which we had expected due to their prominent role in community based multi-professional working. This may of course be due to the search terms used as opposed to a lack of literature, and would ideally form a valuable topic for future review. This suggests that perhaps where specific models are of interest, they should be specifically sought, as the breadth of the topic means that these may not be identified.

Figure 2. Table of values, benefits and challenges identified in the included literature

Values	Benefits	Challenges
Early intervention	Cost-effectiveness	Budgetary restrictions
Trust	Improved outcomes	Staff turnover
Communication	Patient satisfaction	Lack of understanding
Collaboration	Knowledge sharing	Poor communication
Equity	Faster assessments	Mistrust
Empowerment	Improved patient reach	Access to records
Quality improvement	Increased engagement	Differing priorities
Innovation	Fewer admissions	Poorly defined responsibility
Accessibility	Shorter hospital stays	Time restraints
Sustainability	Fewer crisis referrals	“Territorial” behaviour

REFERENCES

Baranidharan, G., Connell, H., Malpus, Z., & de C Williams, A. C. (2021). 5.9 MULTIDISCIPLINARY TEAMWORKING IN PAIN CLINICS. *CSPMS*, 72.

Doran, T., & Roland, M. (2010). Lessons from major initiatives to improve primary care in the United Kingdom. *Health Affairs*, *29*(5), 1023-1029.

Easterbrook, L., & Blood, I. (2022). Scoping how we can support the development of different workforce and care service models within communities across Wales.

Faulkner, A., Mills, N., Bainton, D., Baxter, K., Kinnersley, P., Peters, T. J., & Sharp, D. (2003). A systematic review of the effect of primary care-based service innovations on quality and patterns of referral to specialist secondary care. *British Journal of General Practice*, *53*(496), 878-884.

Grant, M. J. & Booth, A. (2009). 'A typology of reviews: an analysis of 14 review types and associated methodologies' *Health Information and Libraries Journal*, **26**, pp.91-108.

Heath Education England (2017) Multi-professional framework for advanced clinical practice in England. NHS England, London.

Huntley, A., Lasserson, D., Wye, L., Morris, R., Checkland, K., England, H., Salisbury, C., & Purdy, S. (2014). Which features of primary care affect unscheduled secondary care use? A systematic review. *BMJ open*, *4*(5), e004746.

Levell, N. J. (2022). NHS outpatient secondary care: a time of challenges and opportunities. *Future Healthcare Journal*, *9*(2), 106.

Packer, C. D. (2022). The Importance of Primary Care. In *Excelling in the Clinic* (pp. 1-9). Springer, Cham.

Park, S., Elliott, J., Berlin, A., Hamer-Hunt, J., & Haines, A. (2020). Strengthening the UK primary care response to covid-19. *Bmj*, *370*.

Parkin, A., Davison, J., Tarrant, R., Ross, D., Halpin, S., Simms, A., Salman, R., & Sivan, M. (2021). A multidisciplinary NHS COVID-19 service to manage post-COVID-19 syndrome in the community. *Journal of primary care & community health*, *12*, 21501327211010994.

Strategic Programme for Primary Care. (2022). An All-Wales Health Board-led programme that works in collaboration with Welsh Government and responds to A Healthier Wales End of year update. https://primarycareone.nhs.wales/topics1/strategic-programme/sppc-end-of-year-review-2022/

Voorhees, J., Bailey, S., Waterman, H., & Checkland, K. (2021). Accessing primary care and the importance of 'human fit'.

Welsh Government. (2019). A healthier Wales. Our plan for health and social care. https://gov.wales/sites/default/files/publications/2019-10/a-healthier-wales-action-plan.pdf

Welsh Government, *Referrals by treatment function and month*. Available at: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/Referrals/referrals-by-treatmentfunction-month [Accessed September 7, 2022].

BIBLIOGRAPHY

Aby, M. (2020). A case study of implementing grant-funded integrated care in a community mental health center. The journal of behavioral health services & research, 47(2), 293-308.

Allen, D., Rixson, L. (2008). How has the impact of 'care pathway technologies' on service integration in stroke care been measured and what is the strength of the evidence to support their effectiveness in this respect?. JBI Library of Systematic Reviews 2008; 6(15): 583-632. (50p)

Allworth, K., Miller, E., Hansen, S., & Eastwood, J. (2018). An exploration of models of care coordination to meet the needs of families requiring health and social care in Sydney, Australia'. International Journal of Integrated Care (IJIC), 18.

Anjara, S. G., Bonetto, C., Ganguli, P., Setiyawati, D., Mahendradhata, Y., Yoga, B. H., Trisnantoro, L., Brayne, C., & Van Bortel, T. (2019). Can general practitioners manage mental disorders in primary care? A partially randomised, pragmatic, cluster trial. PloS one, 14(11), e0224724.

Baillie, L., Martin, F., Thomas, B., Scotter, J., & Sykes, S. (2016). Enhancing care transfers from hospital to home for older people with complex needs. International Journal of Integrated Care, 16(6).

Banerjee, S., Willis, R., Matthews, D., Contell, F., Chan, J., & Murray, J. (2007). Improving the quality of care for mild to moderate dementia: an evaluation of the Croydon Memory Service Model. International Journal of Geriatric Psychiatry: A journal of the psychiatry of late life and allied sciences, 22(8), 782-788.

Barmaky, S., Hansen, S., Miller, E., Tennant, E., Ratcliff, S., & Eastwood, J. (2018). A realist evaluation of Healthy Homes and Neighbourhoods' place-based initiative in an inner city public housing estate in Sydney. International Journal of Integrated Care (IJIC), 18.

Barraclough, F. (2019). Exploring the integration of a nurse practitioner led mental health service in rural Australia. International Journal of Integrated Care, 19(4).

Beacon, A. (2015). Practice-integrated care teams–learning for a better future. Journal of Integrated Care.

Beehler, G. P., & Wray, L. O. (2012). Behavioral health providers' perspectives of delivering behavioral health services in primary care: A qualitative analysis. BMC Health Services Research, 12(1), 1-12.

Beynon, R., & Wafula, S. (2012). One charity's approach to perinatal depression and social inclusion. Mental Health and Social Inclusion.

Bjørkquist, C., Forss, M., & Samuelsen, F. (2017). Enablers and Barriers for Collaboration–Introducing Digital Safety Alarms for Elderly Living at Home. International Journal of Integrated Care, 17(5).

Bonciani, M., Barsanti, S., & Roti, L. (2018). Developing shared values for strategies and policies on Primary Care Centres in Tuscany Region, Italy. International Journal of Integrated Care (IJIC), 18.

Burchell, J. Do it: Connecting people to do good things. Do IT | Connecting people to do good things. Available at: https://doit.life/channels/11997/move-findings/file/md/141257/report-2-models-and-frameworks-for-coord [Accessed August 25, 2022].

Care Quality Comission, Bradford Local System Review. Available at: https://www.cqc.org.uk/sites/default/files/20180522_bradford_local_system_review.pdf [Accessed August 25, 2022].

Clarke, A., & Wydall, S. (2013). 'Making Safe': a coordinated community response to empowering victims and tackling perpetrators of domestic violence. Social Policy and Society, 12(3), 393-406.

Cooper, C., Liu, H., Rowland, T., Prajapati, R., Hurlock, T., & Owen, A. (2021). An evaluation of the Stratford multiagency, multidisciplinary, assessment clinic. Mental Health Review Journal.

Daly, R. (2016). Integrating Care in Local Neighbourhoods. International journal of integrated care 16.6: 342.

Dambha-Miller, H., Simpson, G., Hobson, L., Olaniyan, D., Hodgson, S., Roderick, P., Fraser, S., Little, P., Everitt, H., & Santer, M. (2021). Integrating primary care and social services for older adults with multimorbidity: a qualitative study. British Journal of General Practice, 71(711), e753-e761.

Davey, B. (2005). Integrating Health and Social Care: Implications for Joint Working and Community Care Outcomes for Older People. Journal of interprofessional care 19.1: 22–34.

Drysdale, C. (2017). Integrated Care in Practice. International journal of integrated care 17.5: 274–. Web.

Dugdale, C. M., Phillips, T. K., Myer, L., Hyle, E. P., Brittain, K., Freedberg, K. A., Cunnama, L., Walensky, R., Zerbe, A., Weinstein, M., Abrams, E., Ciaranello, A., & MCH-ART Trial Team. (2019). Cost-effectiveness of integrating postpartum antiretroviral

therapy and infant care into maternal & child health services in South Africa. PloS one, 14(11), e0225104.

Ekelund, C., & Eklund, K. (2015). Longitudinal effects on self-determination in the RCT "Continuum of care for frail elderly people". Quality in Ageing and Older Adults.

Elias, L., Maiden, G., Manger, J., & Reyes, P. (2021). Teaming up for more comprehensive care: case study of the Geriatric flying squad and emergency responders (Ambulance, Police, Fire and Rescue). Journal of Integrated Care.

Elston, J., Gradinger, F., Asthana, S., Fox, M., Dawson, L., Butler, D., & Byng, R. (2022). Impact of 'Enhanced 'Intermediate Care Integrating Acute, Primary and Community Care and the Voluntary Sector in Torbay and South Devon, UK. International Journal of Integrated Care, 22(1).

NHS England. (2015). MDT Development: Working toward an effective multidisciplinary/multiagency team. Leeds, NHS England.

NHS England. (2019). The community mental health framework for adults and older adults. London: NHS England, NHS Improvement, NCCMH. Accessed on, 23(06), 2020.

Fallows, R. (2019). Integration of Neuropsychology Into Primary Care: A Retrospective Analysis of Outcomes and Lessons Learned From a Single Provider Practice. Professional psychology, research and practice 50.6: 419–426.

Fear, C., Scheepers, M., Ansell, M., Richards, R., & Winterbottom, P. (2012). 'Fair Horizons': a person-centred, non-discriminatory model of mental healthcare delivery. The Psychiatrist, 36(1), 25-30.

Franzosa, E., Gorbenko, K., Brody, A. A., Leff, B., Ritchie, C. S., Kinosian, B., Sheehan, O., Federman, A., & Ornstein, K. A. (2021). "There is something very personal about seeing someone's face": Provider perceptions of video visits in home-based primary care during COVID-19. Journal of Applied Gerontology, 40(11), 1417-1424.

Fraser, M. W. (2018). Elephant in the room: Inter-professional barriers to integration between health and social care staff. Journal of Integrated Care.

Gerolamo, A. M., Kim, J. Y., Brown, J. D., Schuster, J., & Kogan, J. (2016). Implementation of a reverse colocation model: Lessons from two community behavioral health agencies in rural Pennsylvania. The journal of behavioral health services & research, 43(3), 443-458.

Greenberg, G. A., & Rosenheck, R. A. (2010). An evaluation of an initiative to improve coordination and service delivery of homeless services networks. The Journal of Behavioral Health Services & Research, 37(2), 184-196.

Greidanus, E., Warren, C., Harris, G. E., & Umetsubo, Y. (2020). Collaborative practice in counselling: a scoping review. Journal of Interprofessional Care, 34(3), 353-361.

Integration and Better Care Fund. (2021) Top tips for implementing a collaborative commissioning approach to home first. Local Government Association. Available at: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/hospital-discharge/guidance/top-tips [Accessed August 25, 2022].

Ismail, K., Stewart, K., Ridge, K., Britneff, E., Freudenthal, R., Stahl, D., McCrone, C., Gayle, C., & Doherty, A. M. (2020). A pilot study of an integrated mental health, social and medical model for diabetes care in an inner-city setting: Three Dimensions for Diabetes (3DFD). Diabetic Medicine, 37(10), 1658-1668.

Jocelyn, C. (2018). We Have a TIP for You! - Serving Complex Patients through Telemedicine IMPACT PLUS TIP Case Conferences. International journal of integrated care 18.s2 (2018): 98.

Kulnik, S. T., Pöstges, H., Brimicombe, L., Hammond, J., & Jones, F. (2017). Implementing an interprofessional model of self-management support across a community workforce: a mixed-methods evaluation study. Journal of interprofessional care, 31(1), 75-84.

Lalani, M., & Marshall, M. (2022). Co-location, an enabler for service integration? Lessons from an evaluation of integrated community care teams in East London. Health & Social Care in the Community, 30(2), e388-e396.

Leichsenring, K., & Ruppe, G. (2016). Specific approaches to integrating care in Austria-The cases of psychogeriatric coordination and palliative care (SUSTAIN project sites). International Journal of Integrated Care (IJIC), 16(6).

Ljubi, I., Belani, H., & Romac, S. B. (2020). Cloud-based integrated socio-sanitary care e-services in Croatia: Lessons learned. In SHS Web of Conferences (Vol. 85, p. 02004). EDP Sciences.

Llewellyn M., Verity F., Wallace S. and Tetlow S. (2021) Evaluation of the Social Services and Well-being (Wales) Act 2014: Process Evaluation. Cardiff. Welsh Government, GSR report number 2/2021. Available at: https://gov.wales/evaluation-social-services-and-well-being-wales-act-2014-process-evaluation

Llewellyn M., Verity F., Wallace S. and Tetlow S. (2022) Expectations and Experiences: Service User and Carer perspectives on the Social Services and Well-being (Wales) Act. Cardiff. Welsh Government, GSR report number 16/2022. Available at: Evaluation of the Social Services and Well-being (Wales) Act 2014: Expectations and Experiences

May-Lill, J., & Ervik, B. (2022). Talking Together in Rural Palliative Care: a Qualitative Study of Interprofessional Collaboration in Norway. BMC health services research 22.1: 314–314.

Meyerowitz-Katz, G. (2017). Integrated Care of People with Type 2 Diabetes in Western Sydney: A Business Case for Joint Specialist Case Conference (JSCC) with General Practice. International journal of integrated care 17.5: 37

Michalowsky, B., Thyrian, J. R., Wucherer, D., Eichler, T., Hertel, J., & Hoffmann, W. (2016). O2-11-04: Effect of Dementia Care Management on Healthcare Resource Utilization and Cost: One-year follow-Up Results of the Delphi Trial. Alzheimer's & Dementia, 12, P255-P255.

Miller, E., Ratcliff, S., Golightly, H., Tennant, E., & Eastwood, J. (2017). Helping a community to help their kids: Bringing services together in a community hub in inner-city Sydney, Australia. International Journal of Integrated Care, 17(5).

Mueller-Stierlin, A. S., Helmbrecht, M. J., Herder, K., Prinz, S., Rosenfeld, N., Walendzik, J., Holzmann, M., Dinc, U., Schützwohl, M., Becker, T., & Kilian, R. (2017). Does one size really fit all? The effectiveness of a non-diagnosis-specific integrated mental health care program in Germany in a prospective, parallel-group controlled multi-centre trial. BMC psychiatry, 17(1), 1-12.

Nabhani-Gebara, S., Fletcher, S., Shamim, A., May, L., Butt, N., Chagger, S., Mason, T., Patel, K., Royle, F., & Reeves, S. (2020). General practice pharmacists in England: integration, mediation and professional dynamics. Research in Social and Administrative Pharmacy, 16(1), 17-24.

National Association of Primary Care. (2018). Primary Care Home and social care: Working together - NAPC. Available at: https://napc.co.uk/wp-content/uploads/2018/11/NAPC-Social-care-guide.pdf [Accessed August 25, 2022].

Pettersson, A., Modin, S., Hasson, H., & Krakau, I. (2019). Feasibility of referral to a therapist for assessment of psychiatric problems in primary care–an interview study. BMC family practice, 20(1), 1-12.

Pitchforth, E., & Nolte, E. (2014). What is the evidence of economic impacts of integrated care.

Pitt, R., Haire, G., & Patience-Quate, K. (2018). Neighbourhood Care Development in Inverness, Highland, Scotland." International journal of integrated care 18.s2: 77.

Pollard Jr, R. Q., Betts, W. R., Carroll, J. K., Waxmonsky, J. A., Barnett, S., deGruy III, F. V., Pickler, L., & Kellar-Guenther, Y. (2014). a and behavioral health with four special

populations: Children with special needs, people with serious mental illness, refugees, and deaf people. American Psychologist, 69(4), 377.

Rawlinson, C., Carron, T., Cohidon, C., Arditi, C., Hong, Q. N., Pluye, P., Peytremann-Bridevaux, I., & Gilles, I. (2021). An overview of reviews on interprofessional collaboration in primary care: barriers and facilitators. International journal of integrated care, 21(2).

Reece, S., Sheldon, T. A., Dickerson, J., & Pickett, K. E. (2022). A review of the effectiveness and experiences of welfare advice services co-located in health settings: A critical narrative systematic review. Social Science & Medicine, 114746.

Rees, G. (2004). Joint Working in Community Mental Health Teams: Implementation of an Integrated Care Pathway. Health & social care in the community 12.6 (2004): 527–536.

Rogers, E. S., Maru, M., Kash-MacDonald, M., Archer-Williams, M., Hashemi, L., & Boardman, J. (2016). A randomized clinical trial investigating the effect of a healthcare access model for individuals with severe psychiatric disabilities. Community mental health journal, 52(6), 667-674.

Roland, M., Barber, N., Howe, A., Imison, C., Rubin, G., & Storey, K. (2015). The future of primary health care: creating teams for tomorrow: report by the primary care workforce commission.

Rosen, R. (2018) Divided we fall. Getting the best out of general practice, London, UK: Nuffield Trust.

Routledge, R. (2020). Integrating Specialty Care into Primary Care: The Nuka Approach. British Columbia medical journal 62.1: 26–28.

Rugkåsa, J., Tveit, O. G., Berteig, J., Hussain, A., & Ruud, T. (2020). Collaborative care for mental health: a qualitative study of the experiences of patients and health professionals. BMC health services research, 20(1), 1-10.

Sang, B. (2006). Continuity and Connectivity: Who will Stabilise the Systems that Support Health Care Outside Hospital?. Journal of Integrated Care.

Scheele, C. E., & Vrangbæk, K. (2016). Co-location as a driver for cross-sectoral collaboration with general practitioners as coordinators: The case of a Danish municipal health centre. International Journal of Integrated Care, 16(4).

Sfar-Gandoura, H., Ryan, G. S., & Melvin, G. (2017). Evaluation of a drop-in clinic for young people with attention deficit hyperactivity disorder. Nursing Children and Young People, 29(5).

Sinclair, J. (2017). Building connections: co-locating advice services in general practices and job centres. Glasgow: Glasgow Centre for Population Health.

Smith, L., & Gibb, S. (2007). Postnatal Support for Drug Users: Evaluation of a Specialist Health Visiting Service." Community practitioner : the journal of the Community Practitioners' & Health Visitors' Association 80.7: 24–29.

Szafran, O., Torti, J. M., Kennett, S. L., & Bell, N. R. (2018). Family physicians' perspectives on interprofessional teamwork: Findings from a qualitative study. Journal of interprofessional care, 32(2), 169-177.

Tachibana, Y., Koizumi, N., Akanuma, C., Tarui, H., Ishii, E., Hoshina, T., Suzuki, A., Asano, A., Sekino, S., & Ito, H. (2019). Integrated mental health care in a multidisciplinary maternal and child health service in the community: the findings from the Suzaka trial. BMC pregnancy and childbirth, 19(1), 1-11.

Uittenbroek, R. J., Kremer, H. P., Spoorenberg, S. L., Reijneveld, S. A., & Wynia, K. (2017). Integrated care for older adults improves perceived quality of care: results of a randomized controlled trial of embrace. Journal of general internal medicine, 32(5), 516-523.

Venditti, E. M., Steinman, L. E., Lewis, M. A., Weiner, B. J., & Ma, J. (2021). Seeking a pot of gold with integrated behavior therapy and research to improve health equity: insights from the RAINBOW trial for obesity and depression. Translational Behavioral Medicine, 11(9), 1691-1698.

Vestesson, E., Shen, J., Pariza, P., & Wolters, A. (2020). Technical report: The impact of Extensive Care Service and Enhanced Primary Care in Fylde Coast.

Wain, L. M. (2020). Does integrated health and care in the community deliver its vision? A workforce perspective. Journal of Integrated Care.

Woodhouse, G. (2009). Exploration of interaction and shared care arrangements of generalist community nurses and external nursing teams in a rural health setting. Australian Journal of Advanced Nursing, The, 26(3), 17-23.

APPENDICES

APPENDIX 1. PICO TABLE

Population/Problem	Intervention	Comparison	Outcome
Community	Multi-professional working		Benefits
Individual	Workforce model		Challenges
Workforce	Integration		Definition
Organisation	Multi-agency		Experience
System	Inter-professional		Health economics
Patient	Co-location		Economic impact
Primary care	Integrated care		
Adult	Collaborative care		

APPENDIX 2. LIST OF SEARCH TERMS

AB"Multi-professional" AND AB"Community"

AB"Multi-professional" AND AB"primary care" AND Ab"model"

AB"Multi-professional" AND AB"primary care"

AB"Multi-agency" AND AB"primary care" AND "model"

ab("Multi-agency") AND ab("community")

AB"Multi-agency" AND AB"community" AND AB"model"

AB"Multi-professional" AND AB"economic impact"

AB"Multi-professional" AND AB"economic"

AB"Multi-professional" AND AB"health economic"

AB"Integration" AND AB"Community" AND AB"multi-agency"

AB"Integration" AND AB"primary care" AND ab"model" AND ab"benefit"

AB"Integration" AND AB"community" AND "workforce"

ab("Integration") AND ab("Primary Care") AND ab("Community") AND ab("adult")

AB"Integration" AND AB"primary care" AND "organisation" AND "adult"

AB"Integration" AND AB"economic impact"

ab("Integration") AND ab("health economics")

AB"co-location" AND AB"primary care" AND "community"

AB"colocation" AND AB"primary care" AND "community"

AB"co-location" AND AB"primary care"

AB"colocation" AND AB"primary care"

AB"co-location" AND AB"Economic impact"

AB"colocation" AND AB"Economic impact"

AB"co-location" AND AB"health economic"

AB"colocation" AND AB"health economic"

AB"co-location" AND AB"Economic"

AB"colocation" AND AB"Economic"

APPENDIX 3. INCLUSION AND EXCLUSION CRITERIA

Inclusion	Exclusion
Multi-professional	Non English language publications
Multidisciplinary	Age under 16 years
Joint working	Hospital
Interprofessional	Community hospital
Multi-agency	Uni-professional
Interagency	Uni-agency
Integrated teams	
Model	
Team	
Cost effectiveness	
Community	
Primary care	
Economic effectiveness	
Cost effectiveness	
Definition	
English language	

APPENDIX 4: TABLE OF LITERATURE INCLUDED IN THE SCOPING REVIEW

No	Title	Author(s)	Full Reference	Abstract
1	A Case Study of Implementing Grant-Funded Integrated Care in a Community Mental Health Center	Aby Martha.	The Journal of Behavioral Health Services & Research; New York Vol. 47, Iss. 2, (Apr 2020): 293-308.	The US government funds integrated care demonstration projects to decrease health disparities for individuals with serious mental illness. Drawing on the Exploration Preparation Implementation Sustainability (EPIS) implementation framework, this case study of a community mental health clinic describes implementation barriers and sustainability challenges with grant-funded integrated care. Findings demonstrate that integrated care practices evolve during implementation and the following factors influenced sustainability: workforce rigidity, intervention clarity, policy and funding congruence between the agency and state/federal regulations, on-going support and training in practice application, and professional institutions. Implementation strategies for primary care integration within CMHCs include creating a flexible workforce, shared definition of integrated care, policy and funding congruence, and on-going support and training.
2	How has the impact of 'care pathway technologies' on service integration in stroke care been measured and what is the strength of the evidence to support their effectiveness in this respect?	Allen, Davina; Rixson, Laura	JBI Library of Systematic Reviews 2008; 6(15): 583-632. (50p)	Across the developed world, we are witnessing an increasing emphasis on the need for more closely coordinated forms of health and social care provision. Integrated care pathways (ICPs) have emerged as a response to this aspiration and are believed by many to address the factors which contribute to service integration. ICPs map out a patient's journey, providing coordination of services for users. They aim to have: 'the right people, doing the right things, in the right order, at the right time, in the right place, with the right outcome'. The value for ICPs in supporting the delivery of care across organisational boundaries, providing greater consistency in practice, improving service continuity and increasing collaboration has been advocated by many. However, there is little evidence to support their use, and the need for systematic evaluations in order to measure their effectiveness has been widely identified. A recent Cochrane review assessed the effects of ICPs on functional outcome, process of care, quality of life and hospitalisation costs of inpatients with acute stroke, but did not specifically focus on service integration or its derivatives. To the best of our knowledge, no such systematic review of the literature exists.
3	An exploration of models of care coordination to meet the needs of families	Allworth, Kristy; Miller, Erin; Hansen, Sally; Eastwood, John	International Journal of Integrated Care (IJIC), 2018	The Healthy Homes and Neighbourhoods HHAN team provides care coordination for vulnerable families with complex health and social care needs, who are disconnected from key services and require multi-agency support. HHAN care coordination is delivered across inner western Sydney, with staff based at a community health centre and a co-

No	Title	Author(s)	Full Reference	Abstract
	requiring health and social care in Sydney, Australia'.		Supplement2; 18 1-2.	located hub in an identified suburb of disadvantage. Care coordination is provided by Senior Social Workers and Clinical Nurse Consultants. At the commencement of the program staff were instructed to deliver care coordination from their respective sites, in response to community need. The study aims to describe the model of care coordination and the variables contributing to its emergence.
4	Can General Practitioners manage mental disorders in primary care? A partially randomised, pragmatic, cluster trial	SG Anjara, C Bonetto, P Ganguli, D Setiyawati, Y Mahendradhata , BH Yoga, L Trisnantoro, C Brayne, T Van Bortel	PloS one, 2019, 14(11), e0224724	Background For a decade, experts have suggested integrating mental health care into primary care to help bridge mental health Treatment Gap. General Practitioners (GPs) are the first port-of-call for many patients with mental ill-health. In Indonesia, the WHO mhGAP is being systematically introduced to its network of 10,000 primary care clinics as an add-on mental health training for pairs of GPs and Nurses, since the end of 2015. In one of 34 provinces, there exists an integrated care model: the co-location of clinical psychologists in primary care clinics. This trial evaluates patient outcomes among those provided mental health care by GPs with those treated by clinical psychologists in primary care. Methods In this partially-randomised, pragmatic, two-arm cluster non-inferiority trial, 14 primary care clinics were assigned to receive the WHO mhGAP training and 14 clinics with the co-location framework were assigned to the Specialist arm. Participants (patients) were blinded to the existence of the other pathway, and outcome assessors were blinded to group assignment. All adult primary care patients who screened positive for psychiatric morbidity were eligible. GPs offered psychosocial and/or pharmacological interventions and Clinical Psychologists offered psychosocial interventions. The primary outcome was health and social functioning as measured by the HoNOS and secondary outcomes include disability measured by WHODAS 2.0, health-related quality of life measured by EQ-5D-3L, and resource use and costs evaluated from a health services perspective, at six months. Results 153 patients completed the outcome assessment following GP care alongside 141 patients following Clinical Psychologists care. Outcomes of GP care were proven to be statistically not inferior to Clinical Psychologists in reducing symptoms of social and physical impairment, reducing disability, and improving health-related quality of life at six months. Economic analyses indicate lower costs and better outcomes in the Specialist arm and suggest a 50% probability of WHO mhGAP framework being cost-effective at the Indonesian willingness to pay threshold per QALY.

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5	Enhancing care transfers from hospital to home for older people with complex needs.	Baillie, Lesley; Martin, Fiona; Thomas, Beth; Scotter, Judy; Sykes, Susie	International Journal of Integrated Care (IJIC), 2016 Supplement; 16(6): 1-2.	Care transfers for older people with complex needs should be person-centred with effective multi -disciplinary teamwork (MDT) across hospital and community settings (Bolsch et al. 2005). This paper presents a project to enhance care transfers within Southwark and Lambeth Integrated Care (SLIC), which is a federation that promotes integrated care in south London, through bringing together general practices, acute hospitals, mental health care, social care providers and commissioning groups. This project comprised: Phase 1: Literature review of best practice in care transfers of older people; Phase 2: Scoping staff educational needs through: meetings with key individuals and teams, observation of MDT meetings; analysis of a local patient discharge survey; Phase 3: Development, delivery and evaluation of a one day interprofessional simulation course ('Good to go: enhancing care transfers for older people') for health and social care professionals
6	Improving the quality of care for mild to moderate dementia: an evaluation of the Croydon Memory Service Model	BANERJEE Sube, et al	International Journal of Geriatric Psychiatry, 22(8), August 2007, pp.782-788.	The large majority of people with dementia receive nothing in the way of specialist assessment and care at any stage of their illness. There is a particular lack of services focussed on early identification and intervention in dementia where there is the possibility of long-term harm reduction for people with dementia and their family carers. The authors have developed a model of care that is complementary to local systems of health and social care (The Croydon Memory Service Model [CMSM]). This is a low-cost, high-throughput, generic service to enable early identification and intervention in dementia. It is a multi-agency approach with joint ownership by health services, social services and the voluntary sector with embedded specifically-tailored approaches to primary care and minority ethnic communities. This article presents the findings of a service evaluation of the introduction of the CMSM in a single borough in South London. Six predefined service goals were set: high acceptability; high appropriate referral rate; successful engagement with people from minority ethnic groups; successful engagement with people with young onset dementia; focus on engagement with mild cases to enable early intervention; and an increase in the overall number of new cases of dementia seen. Mixed qualitative and quantitative methodologies were used including a description and 6-month follow-up of a cohort of 290 consecutive referrals. All key predefined service goals were met: 95% acceptability; 94% appropriate referrals; successful engagement with minority ethnic groups (two-fold greater number compared with that expected from general population demographic data); 17% of referrals under 65 years of age; 68% referrals with mild or minimal dementia severity; and an estimated 63% increase in the

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				number of new cases of dementia seen in Croydon. At 6-month follow up, those referred to the service had decreased behavioural disturbance and increased quality of life compared with baseline. It is concluded that specific services for early dementia, which deliver diagnosis and care, can be established. These services can increase the numbers of people with early dementia identified and provided with care. Those receiving such services appear to improve in terms of quality of life and behavioural and psychological symptoms of dementia.
7	A realist evaluation of Healthy Homes and Neighbourhoods' place-based initiative in an inner city public housing estate in Sydney.	Barmaky, Salwa; Hansen, Sally; Miller, Erin; Tennant, Elaine; Ratcliff, Suzanne; Eastwood, John	International Journal of Integrated Care (IJIC), 2018 Supplement2; 18 1-2	Introduction: The Healthy Homes and Neighbourhoods HHAN Integrated Care Program seeks to enhance vulnerable family access to and engagement with health and social services through a care coordination model. In addition to servicing families living in inner west Sydney, HHAN has also established two place-based initiatives PBI in areas of heightened disadvantage - one of which is located in Redfern. The Redfern PBI co-locates HHAN with housing, drug and alcohol services, financial and legal services. This integration aims to facilitate service access and provide multi-agency support for vulnerable families in the Redfern area and improve health and social outcomes for individuals and the community. This study aims to evaluate the role and impact of HHAN's Redfern PBI and explore whether a place-based model and co-location translates into improved patient, service and community outcomes. Theory/Methods: The project utilised a critical realist methodology to undertake a qualitative evaluation of the impact of the PBI on clients, services and community health and social outcomes. Purposive sampling was used to identify 20 participants including HHAN clients, HHAN employees and stakeholders involved with the Redfern PBI. In-depth, semi-structured interviews were audio-recorded, transcribed, coded and analysed using NVivo. Results: Preliminary thematic analysis found that the PBI provided varied benefits for clients and other services. Positive outcomes for clients included better engagement with services, increased trust in health services, empowerment, improved outlook and planning for the future. Positive outcomes for services included easier referral pathways, knowledge transfer and increased integration with other services. Mechanisms by which these outcomes were achieved included whole of families participating in decision making, flexibility, establishing trust, building connections and proximity. Discussion: The HHAN place-based model has achieved early subjective successes in terms of individual client health and social outcomes and service outcomes. Whether this translates into objective health improvements and overall community benefit is yet to be determined. Co nclusion key findings: The delivery of an integrated care program via a place-based model has

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				resulted in early positive outcomes for individual clients and other services. Lessons learned: This early qualitative evaluation provides an insight into the potential role that place-based initiatives can play in improving health and social outcomes in disadvantaged communities. Limitations: The applicability of the findings of the study in areas outside of the Redfern community is unknown, however, learnings could be applied when establishing PBI in suburbs with a similar demographic profile. Participant bias should also be considered given the most vulnerable clients or clients in crisis were unlikely to be suitable for participation. Suggestions for future research: A comprehensive evaluation of the HHAN initiative will require a mixed-methods approach. As such a quantitative review will provide further insight in regards to client outcomes and cost-benefit analysis. Additionally, given HHAN is a whole of family service, further investigation into family outcomes is required. Examining the role that a place-based initiative plays in improving overall community outcomes would also be beneficial.
8	Exploring the integration of a nurse practitioner led mental health service in rural Australia.	Barraclough, Frances	International Journal of Integrated Care (IJIC) (INT J INTEGR CARE), 2019Annual Conference Supplement; 19(S1): 1-2.	The integration of Mental Health services is a prominent feature of government health policies. Whilst there is a substantial literature promoting the benefits of rural integrated mental health services, there is little detail of how those services function, or how and to what extent those services are integrated. This research described a rural Nurse Practitioner (NP) led primary healthcare mental health service within the context of rural mental health (MH) service policy in Australia and the literature on integrated mental health services
9	Practice-integrated care teams – learning for a better future	BEACON Angela	Journal of Integrated Care, 23(2), 2015, pp.74-87.	Purpose – The purpose of this paper is to present a case study of one element of the integrated work which has taken place in Central Manchester, the development of multi-disciplinary Practice-Integrated Care Teams (PICT). The paper will show how working together has become a practical reality for members of these teams, and is forming the building blocks for further integration across neighbourhoods. Design/methodology/approach – This paper draws on the author's experience of working in the PICT project from 2012 to 2014. The report will draw on the evaluation work which took place during the project, and will include reflections from others involved in the project and members of the teams. Findings – The integrated care teams which have been developed in Central Manchester have started to make significant changes to the ways that professionals work together, to the experience that patients have and to the costs of urgent care provision. Whilst there is still a long way to go, there has been

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				significant learning from the PICT. This includes improved patient outcomes and experience. There has been an overall reduction in secondary care activity for patients the teams have been working with, with the largest reduction being in emergency admissions. Alongside this, patient feedback has reinforced the value of this personalised approach and increased overall satisfaction with the care and advice received from health and social care professionals and an improved professional experience. Evaluation has demonstrated that amongst professionals involved in the team there is a strong commitment to the principles of integrated care and that the confidence, skills and capacity of the teams have strengthened since this way of working has been introduced. As monitoring of financial impact continues to develop, cost savings from secondary care, particularly around emergency unplanned care, are encouraging. Originality/value – This paper draws on the recent experience of designing and delivering integrated care across a range of multi-agency, multi-professional partners. The model which has been developed centres around the role of general practice, and has enabled primary care to take a key role in the development of an out-of-hospital integrated care system. This has enabled community professionals such as nurses and social workers to build a much stronger relationship with general practice and enable system linkages which will be essential to the delivery of joined-up health and social care in the future. The project has been accompanied by thorough and ongoing evaluation to support the validity of the learnings which have been reported.
10	Behavioral health providers' perspectives of delivering behavioral health services in primary care: a qualitative analysis.	Beehler, Gregory P; Wray, Laura O	BMC Health Services Research (BMC HEALTH SERV RES), 2012; 12(1): 337-337. (1p)	Background: Co-located, collaborative care (CCC) is one component of VA's model of Integrated Primary Care that embeds behavioral health providers (BHPs) into primary care clinics to treat commonly occurring mental health concerns among Veterans. Key features of the CCC model include time-limited, brief treatments (up to 6 encounters of 30 minutes each) and emphasis on multi-dimensional functional assessment. Although CCC is a mandated model of care, the barriers and facilitators to implementing this approach as identified from the perspective of BHPs have not been previously identified.Methods: This secondary data analysis used interview data captured as part of a quality improvement project in 2008. Fourteen BHPs (48% of providers in a regional VA network) agreed to participate in a 30-minute, semi-structured phone interview. The interview included questions about their perceived role as a CCC provider, depiction of usual practice styles and behaviors, and perceptions of typical barriers and facilitators to providing behavioral healthcare to Veterans in CCC. Interviews were transcribed verbatim into a text database and analyzed using grounded theory.Results: Six main categories

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				emerged from the analysis: (a) Working in the VA Context, (b) Managing Access to Care on the Front Line, (c) Assessing a Care Trajectory, (d) Developing a Local Integrated Model, (e) Working in Collaborative Teams, and (f) Being a Behavioral Health Generalist. These categories pointed to system, clinic, and provider level factors that impacted BHP's role and ability to implement CCC. Across categories, participants identified ways in which they provided Veteran-centered care within variable environments.Conclusions: This study provided a contextualized account of the experiences of BHP's in CCC. Results suggest that these providers play a multifaceted role in delivering clinical services to Veterans while also acting as an interdependent component of the larger VA behavioral health and primary care systems. Based on the inherent challenges of enacting this role, BHPs in CCC may benefit from additional implementation support in their effort to promote health care integration and to increase access to patient-centered care in their local clinics.
11	One charity's approach to perinatal depression and social inclusion	Beynon, Rhian; Wafula, Simon.	Mental Health and Social Inclusion; Brighton Vol. 16, Iss. 4, (2012): 206-210.	Purpose - The purpose of this paper is to present an example of effective multi-agency working between the statutory health services and the voluntary sector in the field of perinatal mental health. Design/methodology/approach - The Perinatal Support Project (PSP) is an example of an innovative voluntary sector solution to the twin problems of perinatal mental health and social exclusion. The paper explores the structure of the PSP in the context of perinatal mental health research before explaining the significance of the role of volunteer "befrienders" in alleviating maternal depression and reducing social isolation. The paper then presents data from the latest independent evaluation into the PSP before calling for more services of this nature. Findings - The paper highlights the individual success of the PSP model in alleviating maternal depression, improving mother-baby attachment and reducing social isolation. It attests to the benefits of effective multi-agency partnerships more generally. Originality/value - There is a scarcity of truly early interventionist services for vulnerable families. This case study serves as an independently evaluated example of good practice for community practitioners and commissioning groups.
12	Enablers and Barriers for Collaboration - Introducing Digital Safety Alarms for Elderly Living at Home.	Bjørkquist, Catharina; Forss, Maria; Samuelsen, Finn	International Journal of Integrated Care (IJIC); 2017 Supplement; v.17. 1-2	Introduction: This study aims to identify structural and cultural factors for collaboration across multi-professional departments in primary care with regard to the implementation of telecare technology, here digital safety alarms in a Norwegian municipality. Collaboration on services to elderly users living at home will often cross organizational and professional boundaries. This is also the case when it comes to digital alarms where the purchaser office, the home care services and the emergency ward were

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				involved. Theory/method: The analysis is based upon an organizational perspective on the process. Furthermore, in the analysis we apply an analytical scheme to identify different forms of co-ordination which can be placed on a scale of intensity from simple to complex forms and finally, theories on profession. Seven managers from different departments were interviewed individually twice. 17 front line staff members were interviews in groups twice. All interviews were recorded and transcribed. The content analysis centres on participants' descriptions of information, competence and collaboration and proceeded according to the principles of systematic text condensation. Results: Findings suggest that interagency meetings every week or every second week between the purchaser office and the home care services enables collaboration. There are few examples of enablers other than the use of inter-office memoranda that are mostly related to questions on specific users. We find, however, that in general, information flow and information sharing are challenges and barriers to collaboration. This applies to both the implementation of the digital alarms and relating change processes. Employees have, to some extent, an unclear understanding of the division of responsibilities and tasks between the involved departments and their employees. Furthermore, there are few meeting points between the acute ward who respond to set off alarms – and talk to the user and the home care service who attend to the user.
13	Developing shared values for strategies and policies on Primary Care Centres in Tuscany Region, Italy.	Bonciani, Manila; Barsanti, Sara; Roti, Lorenzo	International Journal of Integrated Care (IJIC), 2018 Supplement2; 18 1-2.	Introduction comprising context and problem statement: In Italy, Tuscany Region implemented since 2010 Primary Care Centres PCCs - in Italy known as "Case della Salute"- Health Homes in order to provide the population with a single point of access to primary care services, promoting integration and coordination of care. The present contribution describes the consensus building process promoted by Tuscany Region in order to renew the PCC policy based on shared values among the different stakeholders. Description of policy context and objective: After a first pilot implementation, in 2016 the Tuscan Regional Health Authority established a regional act providing guidelines for the PCC model. This act focused mainly on the structural characteristics of PCCs, such as the number and type of professionals involved, opening hours, technological tools and equipment. The Tuscan Regional Health Authority promoted also to monitor the effective implementation of PCCs in terms of their structural mapping and impact evaluation. After two years, a research monitoring report pointed out a great variability in the implementation of PCCs model in the local context. Particularly there was evidence of the lack of a common vision on functions and core domains of PCCs among policy makers, professionals and citizens. Therefore, during 2017 a consensus conference has

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				been organised with the aim of reviewing of regional guidelines and relaunching them through a participating process involving the different stakeholders. Targeted population: The consensus conference involved more than one hundred stakeholders regional and local health managers, policy makers, GPs, nurses, social workers, specialists, community organisations and citizens in a process that included residential meetings, group works and web sharing of ideas and expression of agreement on specific themes through structured questionnaires. Highlights innovation, Impact and outcomes: This experience is innovative for two key aspects: 1 the participative method adopted for renewing the regional policy on PCC, 2 the shift of PCC paradigm from a structural approach to a focus on PCC objectives and its specific interventions addressing the local community
14	MoVE report 2: models and frameworks for coordinating community responses during COVID-19	BURCHELL Jon, et al	University of Sheffield 2020	This is the second of three reports from phase one of the MoVE (mobilising volunteers effectively) project, exploring the models and frameworks utilised by local authorities (LAs) across the UK to coordinate community responses. The report presents the second set of findings from 49 semi-structured interviews with a range of stakeholders from England, Scotland and Wales, about their responses to the COVID-19 pandemic. It identifies a number of core underlying themes at the heart of response frameworks and processes; classifies three different response models; begins to sketch out potential post-COVID models of social action and community partnership; and offers some reflections for LAs wishing to retain learning from the pandemic and take these models forward. The data highlights three main frameworks that were utilised to coordinate volunteer and community support. These are: Model 1 – response cells utilising a VCS local infrastructure organisation as the primary coordinator/broker; Model 2 – response cells channelling support through a series of hubs; Model 3 – multi-agency response cells working directly with community networks and new informal movements. The report also identifies the key areas that shape what post-lockdown models of social action and community partnership could look like, including: flattened structures and greater decentralisation; the importance of established local infrastructure organisations; building on co-production models; enhanced role for community hubs; the role of informal volunteering and mutual aid.
15	Bradford: local system review report	CARE QUALITY COMMISSION	CARE QUALITY COMMISSION 2018	One of 20 targeted reviews of local authority areas looking at how older people move through the health and social care system, with a focus on how services work together. Specifically, it reviews how the local system is functioning within and across three areas: maintaining the wellbeing of a person in their usual place of residence, crisis

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				management, and step down, return to usual place of residence and/ or admission to a new place of residence. The review found there was a clear shared and agreed purpose, vision and strategy described in the Happy, Healthy at Home plan, which was articulated throughout all levels of the system. Most staff were committed to the vision and agencies were also working together to keep older people safe at home rather than hospital. Reviewers also identified examples of some good joined up interagency processes, particularly the Bradford Enablement Support Team (BEST) for reablement, the MAIDT (multi-agency integrated discharge team) and The MESH team (the medicines service at home). Overall, people who lived in Bradford were supported to live in their own homes and their communities for as long as possible and received holistic assessments that took into account all of their social and health needs based around their strengths. Suggested areas for improvement include: for system leaders need to address issues around quality in the independent social care market with a more proactive approach to contract management and oversight; clearer signposting systems to help people find the support they need, particularly for people who funded their own care; and less reliance on paper based systems when people are discharged from hospital.
16	'Making Safe': a coordinated community response to empowering victims and tackling perpetrators of domestic violence	CLARKE Alan, WYDALL Sarah	Social Policy and Society, 12(3), 2013, pp.393-406.	This article describes an exploratory study of the Making Safe Scheme, which is a multi-agency initiative operating in North Yorkshire designed to provide a coordinated and integrated response to domestic violence by focusing on both victims and perpetrators. The service involves twelve statutory and voluntary sector agencies, including the police, the probation service, Foundation Housing and specialist domestic abuse services, including child support workers. The voluntary scheme comprises three main strands: the provision of advocacy workers for adult victims, support for children and young people, and accommodation and key worker support for perpetrators whilst they attend the IDAP programme. It enables victims to remain in their own homes, provided it is considered safe to do so, and re-houses perpetrators. Consequently, the wrong-doer leaves the home and practitioners can work with families in their established communities to prevent further abuse. In 2008, the project was awarded the Butler Trust Public Protection Award for its innovative work with victims and offenders. The findings from this study focus on a number of themes: perpetrator accountability, the changing balance of power in abusive relationships and the increased opportunities for victims and their families to engage in recovery work whilst remaining in the family home.
17	An evaluation of the Stratford multiagency,	COOPER Catherine, et al	Mental Health Review Journal,	Purpose: This study aims to assess a novel clinic whereby new patients were discussed in a multi-agency, multi-disciplinary panel and given feedback on the same day. The

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	multidisciplinary, assessment clinic		26(4), 2021, pp.392-402.	objectives were to determine the impacts on time to commencing treatment, need for further assessment, discharges and staff and patient experiences. Design/methodology/approach: Outcomes from the new assessment clinic were compared to previous individual assessments. Feedback questionnaires were given to patients, while a focus group was conducted with staff. Findings: There was a significant reduction in the time to agreeing a treatment plan (34 days to <1 day), the need for further assessment (61%-023.2%) and a significant increase in the proportion discharged from secondary care (26.9%-49.8%). Clinician and patient feedback on the clinic was positive. Practical implications: The model of a multi-agency, multi-disciplinary clinic could be used for assessing new referrals to community mental health teams. Originality/value: The use of a multi-agency, multi-disciplinary clinic is a novel approach within community mental health teams which led to improvements in efficiency, while demonstrating positive patient and clinician feedback.
18	Integrating care in local neighbourhoods.	Daly, Richard; Demaine, Rebecca; Logan, Catriona; Beech, Paul	International Journal of Integrated Care (IJIC), 2016 Supplement; 16(6): 1-2.	NHS East Lancashire Clinical Commissioning Group (CCG) along with its partners is driving the development of integrated care. Integrated care is a means by which we can co-ordinate care around the needs of individuals in our communities, residing in five localities, with over 382,000 residents. Successful delivery of integrated care will reduce inappropriate and unnecessary demand on services and support independence, effective outcomes and self-care. East Lancashire is an area with significant deprivation, poor quality of life, and poor health. The consequence of this, is a larger than average proportion of people with multiple health conditions and some of the highest rates of unplanned admissions to hospital in the country. Our challenges locally include an ageing population, increasing population diversity, extremes of socioeconomic deprivation and disadvantage, rising expectations and demand. Health and social care services for complex and long term conditions, as currently configured are not sustainable in the face of future projected need and increasing financial constraints. The case for integrated care as an approach is well evidenced. Additionally, the integration of health and social care services potentially offers further means of supporting people with complex health and social care needs to live well in the community. Locally, work is underway to establish the foundations for co-ordinated delivery across health, social care, public health, third sector and other local services however more needs to be done to ensure scale and pace of transformation. The model for integrated care consists of three elements: Integrated neighbourhood working, an Integrated Home Support Service (IHSS) and an Integrated Discharge Service. A critical element of the approach is the

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				Integrated Care Assessment Team (ICAT). ICAT is a multi-disciplinary team who take referrals from a range of health and social care disciplines in the community and acute sector and allocate short term community care. This can be both, step up and step down. Integrated neighbourhoods are a way of working where all health and social care professionals work together as a virtual team in each of the five localities of East Lancashire. The result is improved coordination and communication between GPs and the range of professionals that support patients in the community. The integrated neighbourhood consists of GPs, practice nurses, therapy staff, social workers, mental health teams, intensive home support staff and voluntary sector staff. Care is co-ordinated by a care co-ordinator who ensures that all aspects of a patients care is integrated, smooth and well managed. IHSS consists of a team of clinical staff who provide responsive assessment, monitoring, investigations and support to help patients avoid unnecessary admissions and to help patients return home from hospital wherever possible. This support is delivered in patients' homes and working with the integrated neighbourhood approach, ensures that the right support is allocated to patients to live at home independently and safely. The IHSS model is co-designed with key partners to try and reverse the following trends: - Inpatient high prevalence of frailty - High frail elderly A&E attendance - Longer length of stay for frail older patients - High readmission rates - High mortality rates. The underpinning model of care for Intensive Home Support rapid response which is an established tool in integrating services around the needs of individuals with long term conditions. This supports commissioning intentions, harnessing resources across the community infrastructure regardless of agency boundaries or culture ensuring that patients are treated and managed in an appropriate place of care which is closer to home. There is a need to work across health and Social care boundaries in partnership with mental Health Services to achieve this. The IHSS service ensures the speedy delivery of a high quality service that meets the needs of those at risk of a potentially avoidable admission. It supports and empowers patients to manage their long term conditions in their home environment. It improves patient experience and minimising cause for complaint. The service works with GP Practices within neighbourhoods to identify frail elderly patients that require a multi-agency approach to case management. In addition, it works with health, therapy services, social care and voluntary sectors to identify suitable patients for the service caseload. It provides holistic assessment of need and necessary support, equipment and interventions to promote stability in the patient's condition and enable them to remain in

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				their own home. Ultimately it works with partner professionals, agencies and organisations to enable the patient to be managed safely at home, and to support the discharge process when caseload patients attend or are admitted to Acute Services.
19	Integrating primary care and social services for older adults with multimorbidity: a qualitative study	DAMBHA-MILLER Hajira, et al	British Journal of General Practice, early cite 17 May 2021,	Background: Growing demand from an ageing population, chronic preventable disease and multimorbidity has resulted in complex health and social care needs requiring more integrated services. Integrating primary care with social services could more efficiently utilise resources, and improve experiences for patients, their families and carers. There is limited evidence on progress including key barriers and drivers of integration to inform large-scale national change. Aim: To elicit stakeholder views on drivers and barriers of integrated primary care and social services. and highlight opportunities for successful implementation. Design and setting: A qualitative interview study. Method: Semi-structured interviews with maximum variation sampling to capture stakeholder views across services and professions. Results: Thirty-seven interviews were conducted across England including GPs, nurses, social care staff, commissioners, local government, voluntary and private sectors, patients and carers. Drivers of integration included groups of like-minded individuals supported by good leadership, expanded interface roles to bridge gaps between systems and co-location of services. Barriers included structural and interdisciplinary tension between professions, organisational self-interest and challenges in record-sharing. Conclusions: Drivers and barriers to integration identified in other contexts are also present in primary care and social services. Benefits of integration are unlikely to be realised if these are not addressed in the design and execution of new initiatives. Efforts should go beyond local and professional level change to include wider systems and policy-level initiatives. This will support a more systems-wide approach to integrated care reform, which is necessary to meet the complex and growing needs of an ageing multimorbid population.
20	Integrating health and social care: implications for joint working and community care outcomes for older people.	Davey B; Levin E; Iliffe S; Kharicha K	Journal of Interprofessional Care (J INTERPROF CARE), Jan2005; 19(1): 22-34. (13p)	In England, the theme of promoting collaborative working between social and primary health care remains high on the policy agenda. The underlying assumption, largely untested, is that a greater degree of structural integration benefits service users. This paper reports the findings from a feasibility study comparing two models of joint working and examining the relative impact of personal characteristics, service use and co-location on the likelihood of older people remaining in the community. Baseline standardised interviews with 79 older people aged 75 + with complex needs in two social services departments were carried out following referral, covering social circumstances, physical and mental health and services received, with follow-up interviews after six months.

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				Contacts between social workers and primary care were tracked. The findings suggest that co-location does not necessarily lead to substantially closer interprofessional working in terms of greater contact between social workers and GPs or social workers and community nurses. Factors affecting outcome were degree of cognitive impairment, intensity of home care received and whether the older person lived alone. Whatever the model of collaborative working, its effects on remaining in the community must be assessed in the wider context of the characteristics and services received by older people.
21	Integrated care in practice.	Drysdale, Caroline	International Journal of Integrated Care (IJIC); 2017 Supplement; v.17. 1-3. (3p) (Abstract) ISSN: 1568-4156 AN: 131980905	System integration to achieve sustainable systemic change is not a new concept and something that has been around in International practice for a number of years. Experiential, comparative exploration of system models in Alzira, Boston and Washington DC (via an AQuA fellowship) highlight significant similarities with that of the Oldham economy, at the same time as identifying the stark difference in progress to develop and deploy sustainable system models in the UK. Oldham has taken learning from International best practice and used the intelligence and information to better shape the system in Oldham, aligned to the greater Manchester Devolution mandate. By deploying the same strategic approach as International models to the urgent care system in Oldham (via a multi agency alliance partnership) we are able to demonstrate sustained quality improvements for people and system flow via a number of innovative, transformational approaches that have sustained positive impact on a reduction in unplanned admissions in excess of the National expected average (3.5%). This achievement has received National recognition (NHS England) and also shortlist for two HSJ awards (integration and quality improvement).
22	Cost-effectiveness of integrating postpartum antiretroviral therapy and infant care into maternal & child health services in South Africa	CM Dugdale, TK Phillips, L Myer, EP Hyle, K Brittain, KA Freedberg, L Cunnama, RP Walensky, A Zerbe, MC Weinstein, EJ Abrams, AL Ciaranello	PLoS ONE, 2019, 14(11)	Background: Poor engagement in postpartum maternal HIV care is a challenge worldwide and contributes to adverse maternal outcomes and vertical transmission. Our objective was to project the clinical and economic impact of integrated postpartum maternal antiretroviral therapy (ART) and pediatric care in South Africa. Methods: Using the CEPAC computer simulation models, parameterized with data from the Maternal and Child Health-Antiretroviral Therapy (MCH-ART) randomized controlled trial, we evaluated the cost-effectiveness of integrated postpartum care for women initiating ART in pregnancy and their children. We compared two strategies: 1) standard of care (SOC) referral to local clinics after delivery for separate standard ART services for women and pediatric care for infants, and 2) the MCH-ART intervention (MCH-ART) of Co-located maternal HIV and pediatric care, integrated in MCH services throughout

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				breastfeeding, is a cost-effective strategy to improve maternal and pediatric outcomes. Trial-derived inputs included: 12-month maternal retention in care and virologic suppression (SOC: 49%, MCH-ART: 67%), breastfeeding duration (SOC: 6 months, MCH-ART: 8 months), and postpartum healthcare costs for mother-infant pairs (SOC: $50, MCH-ART: $69). Outcomes included pediatric HIV infections, maternal and infant life expectancy (LE), lifetime HIV-related per-person costs, and incremental cost-effectiveness ratios (ICERs; ICER <US$903/YLS considered "cost-effective"). Results: Compared to SOC, MCH-ART Diagnosis rates of familial hypercholesterolemia (FH) are low in the United States, despite multiple guidelines and recommendations for screening and treatment of high cholesterol, to prevent heart attacks in those affected. Using a stepped-wedge design, the investigators plan to utilize tools from implementation science to improve uptake, acceptability, and sustainability of FH diagnostic programs in primary care settings. If successful, this study will provide tools generalizable to other health care systems to improve FH diagnosis rates. (SOC: 25.26 years, MCH-ART: 26.20 years) and lifetime costs (SOC: $9,912, MCH-ART: $10,207; discounted). Projected pediatric outcomes for all HIV-exposed children were similar between arms, although undiscounted LE for HIV-infected children was shorter in SOC (SOC: 23.13 years, MCH-ART: 23.40 years). Combining discounted maternal and pediatric outcomes, the ICER was $599/YLS. Conclusion: Co-located maternal HIV and pediatric care, integrated in MCH services throughout breastfeeding, is a cost-effective strategy to improve maternal and pediatric outcomes and should be implemented in South Africa.
23	Longitudinal effects on self-determination in the RCT “Continuum of care for frail elderly people”	EKELUND Christina, EKLUND Kajsa	Quality in Ageing and Older Adults, 16(3), 2015, pp.165-176.	Purpose: An intervention “Continuum of care for frail elderly people” was designed to create an integrated care from the hospital emergency department (ED) to home. The purpose of this paper is to evaluate longitudinal effects in terms of self-determination in daily life for community-living frail older persons. Design/methodology/approach: A non-blinded, controlled trial with participants randomised to the intervention group or a control group with follow-ups at three, six and 12 months. The intervention involved collaboration between a nurse with geriatric competence at the ED, the hospital wards and a multi-professional team in the community with a case manager as the hub. The intervention’s person-centred approach involved the older persons in all decisions. Inclusion criteria: 80 years and older or 65-79 years with at least one chronic disease and

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				dependent in at least one daily activity. Analyses were made on the basis of the intention-to-treat principle and outcome measure experienced self-determination in daily life measured by Impact on Participation and Autonomy for Older persons (IPA-O). The analysis was made using Svenssons' statistical method. Findings: There were significant differences in favour of the intervention at three months in self-determination concerning activities at home and at three and six months concerning social relationships. Originality/value: Self-determination seems to deteriorate over time in both groups, and the intervention "Continuum of care for frail elderly people" seemed to slow the rate of decline in two dimensions; activities in and around the house at three-month follow-up, and at three and six months concerning social relationship. Thus, the intervention has the means to support them in exercising self-determination and aging in place, a valuable benefit both for the individual and for society. (Edited publisher abstract)
24	Teaming up for more comprehensive care: case study of the Geriatric flying squad and emergency responders (Ambulance, Police, Fire and Rescue)	Elias, Lynda; Maiden, Genevieve; Manger, Julie; Reyes, Patricia.	Journal of Integrated Care; Brighton Vol. 29, Iss. 4, (2021): 377-389	Purpose The purpose of this paper is to describe the development, implementation and initial evaluation of the Geriatric Flying Squad's reciprocal referral pathways with emergency responders including New South Wales Ambulance, Police and Fire and Rescue. These innovative pathways and model of care were developed to improve access to multidisciplinary services for vulnerable community dwelling frail older people with the intent of improving health and quality of life outcomes by providing an alternative to hospital admission. Design/methodology/approach This is a case study describing the review of the Geriatric Flying Squad's referral database and quality improvement initiative to streamline referrals amongst the various emergency responders in the local health district. The implementation and initial evaluation of the project through online survey are further described. Findings Sustainable cross-sector collaboration can be achieved through building reciprocal pathways between an existing rapid response geriatric outreach service and emergency responders including Ambulance, Police, Fire and Rescue. Historically, emergency services would have transferred this group to the emergency department. These pathways exemplify person-centred care, underpinned by a multidisciplinary, rapid response team, providing an alternative referral pathway for first responders, with the aim of improving whole of health outcomes for frail older people.

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				Practical implications Enablers of these pathways include a single point of contact for agencies, extended hours to support referral pathways, education to increase capacity and awareness, comprehensive and timely comprehensive assessment and ongoing case management where required and contemporaneous cross-sector collaboration to meet the medical and psychosocial needs of the client. Originality/value The Geriatric Flying Squad reciprocal pathways are a unique model of care with a multi-agency approach to addressing frail older people's whole of health needs.
25	Impact of 'enhanced' intermediate care integrating acute, primary and community care and the voluntary sector in Torbay and South Devon, UK	ELSTON Julian, et al	International Journal of Integrated Care, 22(1), 2022, p.14. Online only	Introduction: Intermediate care (IC) was redesigned to manage more complex, older patients in the community, avoid admissions and facilitate earlier hospital discharge. The service was 'enhanced' by employing GPs, pharmacists and the voluntary sector to be part of a daily interdisciplinary team meeting, working alongside social workers and community staff (the traditional model). Methods: A controlled before-and-after study, using mixed methods and a nested case study. Enhanced IC in one locality (Coastal) is compared with four other localities where IC was not enhanced until the following year (controls), using system-wide performance data (N = 4,048) together with ad hoc data collected on referral-type, staff inputs and patient experience (N = 72). Results: Coastal showed statistically significant increase in EIC referrals to 11.6% (95%CI: 10.8%–12.4%), with a growing proportion from GPs (2.9%, 95%CI: 2.5%–3.3%); more people being cared for at home (10.5%, 95%CI: 9.8%–11.2%), shorter episode lengths (9.0 days, CI 95%: 7.6–10.4 days) and lower bed-day rates in ≥70 year-olds (0.17, 95%CI: 0.179–0.161). The nested case study showed medical, pharmacist and voluntary sector input into cases, a more holistic, coordinated service focused on patient priorities and reduced acute hospital admissions (5.5%). Discussion and conclusion: Enhancing IC through greater acute, primary care and voluntary sector integration can lead to more complex, older patients being managed in the community, with modest impacts on service efficiency, system activity, and notional costs off-set by perceived benefits. (Edited publisher abstract)
26	MDT development: working toward an effective multidisciplinary/multiagency team	NHS ENGLAND	NHS ENGLAND 2015	One of three handbooks to support commissioners, GP practices and community health and care professionals in planning and providing personalised care for people living with long term conditions. The handbook brings together information about multi-disciplinary and integrated teams and looks at the types of teams that need to be in place to deliver integrated healthcare. It provides definitions of multi-disciplinary and multi-agency

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				teams and also sets out a tool, the MDT Continuum, that describes different types of care team functioning. Four models or stages of multidisciplinary teams are presented, ranging from from unidisciplinary to transdisciplinary team working. Good practice examples representing each of the stages or models. The final section provide information to help integrated commissioning. Other handbooks published separately cover risk stratification and case finding and personalised care and support planning.
27	The community mental health framework for adults and older adults	NHS ENGLAND, NHS IMPROVEMENT, NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH	NHS England 2019	This Framework describes how the NHS Long Term Plan's vision for a place-based community mental health model can be realised, and how community services should modernise to offer whole-person, whole-population health approaches, aligned with the new Primary Care Networks. The integrated approach will provide benefits for both service users and staff, though integrated assessment, fewer referrals and more direct contact time between staff and service users. The Framework includes links to resources and good practice examples. It has been in partnership with an Expert Reference Group drawn from a range of disciplines and professions across health, social care, the VCSE sector, community groups, and users and carers.
28	Integration of Neuropsychology Into Primary Care: A Retrospective Analysis of Outcomes and Lessons Learned From a Single Provider Practice.	Fallows, Robert	Professional Psychology: Research & Practice, Dec2019; 50(6): 419-426	Neuropsychology is increasingly being integrated into different care settings, with primary care representing a newer area for integration. Although models of neuropsychology integration into primary care have been proposed, there has not yet been a study examining outcome of integration. This is a retrospective analysis of the effects of integration on neuropsychologist productivity, provider referral rates, and the impact of warm handoffs on patient's being lost to follow-up. Exploratory analysis of shifts in reason for referral was also conducted while qualitative data examining patient and provider perception of integration were gathered. Statistical analysis revealed that patients were 3.2 times more likely to complete evaluation if the neuropsychologist was integrated, whereas those referred by warm handoffs were 5.7 times more likely to complete evaluation compared to referrals received through traditional routes. Productivity significantly increased by 3.2 work relative value units (RVUs) per day, or 64.3 RVUs per month. Visual inspection of data showed increases in referral rates from primary care providers when the neuropsychologist was integrated into the clinic. Further, although the integrated neuropsychology services are valued by providers and well received by patients, there are shifts within practice model that occur when integrating into primary care. This article provides preliminary evidence for the benefit of neuropsychology's being integrated into primary care, most notably with higher utilization by primary care providers but also lower rates of patients' being lost to follow-

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				up. Future research may focus on the factors that influence these findings, possibly including destigmatization of service. Many health services, including psychology, are integrating into primary care clinics to provide greater access and improved outcomes for patients. This study examined referral completion trends for a neuropsychology clinic across two time points, being located in mental health (Time 1) and primary care (Time 2). Outcomes revealed several promising trends for neuropsychology integration in primary care, including increased utilization by primary care providers, increased likelihood of patients' completing evaluation, and increased productivity by neuropsychologists.
29	'Fair Horizons': a person-centred, non-discriminatory model of mental healthcare delivery	FEAR Chris, et al	Psychiatrist (The), 36(1), January 2012, pp.25-30.	Access to mental health services is currently determined primarily by age and intellectual function. This has resulted in an approach that discriminates against the over 65s and people with intellectual disabilities. This article describes the development of Fair Horizons, a local non-discriminatory mental health service model in Gloucestershire. A major change programme using this model commenced in September 2011. In developing this model, the views of people who use services, carers, commissioners and local politicians were sought. The Fair Horizons model is person-centred, with all referrals coming to the service through a single access point. Their details are captured and algorithms used to assign patients to the most appropriate care pathway for their needs. The model involves the use of interdisciplinary teams which are extensions of the multidisciplinary community mental health team. Interdisciplinary teams are integrated multi-agency multiprofessional teams that work in and across silos of services, such as adults of working age, older people, children, and learning disability. The paper argues that this approach provides opportunities to reduce overheads, increase capacity, drive up quality, and enhance the patient experience.
30	"There is something very personal about seeing someone's face": provider perceptions of video visits in home-based primary care during COVID-19	FRANZOSA Emily, et al	Journal of Applied Gerontology, early cite July 2021,	The rapid deployment of video visits during COVID-19 may have posed unique challenges for home-based primary care (HBPC) practices due to their hands-on model of care and older adult population. This qualitative study examined provider perceptions of video visits during the first wave of the COVID-19 crisis in New York City (NYC) through interviews with HBPC clinical/medical directors, program managers, nurse practitioners/nurse managers, and social work managers (n = 13) at six NYC-area practices. Providers reported a combination of commercial (health system-supported) and consumer (e.g., FaceTime) technological platforms was essential. Video visit benefits included triaging patient needs, collecting patient information, and increasing scheduling capacity. Barriers included cognitive and sensory abilities, technology access,

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				reliance on caregivers and aides, addressing sensitive topics, and incomplete exams. Effectively integrating video visits requires considering how technology can be proactively integrated into practice. A policy that promotes platform flexibility will be crucial in fostering video integration.
31	Elephant in the room: Inter-professional barriers to integration between health and social care staff	Fraser, Martin William.	Journal of Integrated Care; Brighton Vol. 27, Iss. 1, (2019): 64-72.	Purpose The purpose of this paper is to report on the findings of the first stage of a project seeking to evaluate and overcome inter-professional barriers between health and social care staff within a single, co-located, integrated community team. The project seeks to answer the following questions: first, Do inter-professional barriers to integrated working exist between health and social care staff at the interface of care delivery? Second, If inter-professional barriers exist, can joint health and social care assessments help to overcome them? The paper develops the current evidence base through findings from a staff questionnaire and the initial findings of a pilot study of joint health and social care assessments aimed at overcoming inter-professional barriers to integration. Design/methodology/approach The first stage of the project involved running an anonymous, online questionnaire with health and social care staff within a single, co-located community adult health and social care team. The questionnaire aimed to explore staffs' perceptions of inter-professional collaboration when assessing the health and care needs of service users with a high degree of complexity of need. The second element of the study presents the initial findings of a small pilot of joint health and social care assessments. A second staff survey was used in order to provide a "before and after" comparative analysis and to demonstrate the effect of joint assessments on staffs' perceptions of inter-professional collaboration at the interface of care delivery. Findings Health and social care staff value joint working as a means of improving quality of care. However, they also felt that inter-professional collaboration did not occur routinely due to organisational limitations. Staff members who participated in the pilot of joint assessments believed that this collaborative approach improved their understanding of other professional roles, was an effective means of enabling others to understand their own roles and helped to better identify the health and care needs of the most complex service users on their caseloads. Initial findings suggest that joint assessments may be a practical means of overcoming inter-professional barriers related to a lack of communication and lack of understanding of job roles.

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				Practical implications The questionnaires highlighted the need for integration strategies that are aimed at facilitating collaborative working between staff of different professions, in order to achieve the aims of integration, such as a reduction in duplication of work and hand-offs between services. Originality/value To date, few studies have explored either staff perceptions of collaborative working or the effectiveness of joint assessments as a means of overcoming inter-professional barriers. This paper adds new data to an important area of integration that legislators and researchers increasingly agree requires more focus. Although the findings are limited due to the small scale of the initial pilot, they provide interesting and original data that will provide insight into future workforce integration strategies.
32	Implementation of a Reverse Colocation Model: Lessons from Two Community Behavioral Health Agencies in Rural Pennsylvania	Gerolamo, Angela M, PhD, APRN, BC; Kim, Jung Y, MPH; Brown, Jonathan D, PhD; Schuster, James, MD, MBA; Kogan, Jane, PhD.	The Journal of Behavioral Health Services & Research; New York Vol. 43, Iss. 3, (Jul 2016): 443-458	This qualitative study examined the implementation of a reverse colocation pilot program that sought to integrate medical care in two community behavioral health agencies. To accomplish this, each agency hired a registered nurse, provided training for its staff to function as wellness coaches, and implemented a web-based tool for tracking consumer outcomes. The findings from two rounds of stakeholder discussions and consumer focus groups suggested that agencies successfully trained their staffs in wellness coaching, integrated nurses into agency functions, developed integrated care planning processes, and increased awareness of wellness among staff and consumers. Similar to other complex interventions, the agencies experienced challenges including difficulty establishing new procedures and communication protocols, discomfort among staff in addressing physical health concerns, difficulty building collaborative relationships with primary care providers, and modest uptake of the web-based tool. The study offers insights into the practical aspects of integrating care and makes recommendations for future efforts.
33	An evaluation of an initiative to improve coordination and service delivery of homeless services networks	Greenberg GA; Rosenheck RA; Greenberg, Greg A; Rosenheck, Robert A	Journal of Behavioral Health Services & Research (J BEHAV HEALTH SERV RES),	This study examines system changes associated with the implementation of the Collaborative Initiative to Help End Chronic Homelessness, an 11-site multi-agency intervention for chronically homeless adults. Data obtained from key informants on community-level interventions and interorganizational relationships were gathered from an average of 6.6 agencies at each site in four yearly waves. Hierarchical linear modeling was used to examine time trends and bivariate relationships between measures. There were significant increases over the full study period in the use of practices designed to encourage system integration, as well as in interorganizational measures of joint

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			Apr2010; 37(2): 184-196. (13p)	planning and coordination, and of trust and respect, although in later waves of the study these measures leveled off. There were also highly significant and positive cross-sectional associations between the use of practices designed to encourage system integration and direct measures of service system integration as well as between measures of change in these system characteristics.
34	Collaborative practice in counselling: a scoping review	GREIDANUS Elaine, et al	Journal of Interprofessional Care, 34(3), 2020, pp.353-361.	Collaborative care (interdisciplinary/interprofessional teamwork) in mental health is emerging as best practice in primary care, hospitals, and government agencies. Counsellors have much to offer and benefit from working with other professions in service of their clients. While most health professions are well on their way integrating collaborating with one another in practice, it is yet unclear how often, and in what ways, counsellors are included in these teams. This scoping review of the literature on collaborative practice in counselling addresses the question: "What is the role of Professional Counselling and Clinical/Counselling Psychology in a collaborative model of mental health care?" This scoping review looks at 40 studies published between 2012 and 2015. Counsellors are often included on multidisciplinary teams in diverse roles. Specific collaborative activities are discussed along with ethical and educational implications. (Publisher abstract)
35	Top tips for implementing a collaborative commissioning approach to Home First	LOCAL GOVERNMENT ASSOCIATION, et al	Local Government Association	These top tips seek to enable health and care systems to identify what they need to commission to enable people to remain living independently at home, avoiding unnecessary admissions to hospital and enabling a safe and timely discharge home after a hospital stay. The top tips are divided into five categories, as follows: developing system priorities; governance and joint funding arrangements; partnership and integration opportunities; enablers for partnership working; collaborative commissioning to deliver Home First. There are many partnership and integration approaches which can support Home First: collaborative, joint, aligned or integrated commissioning; single points of access and integrated discharge teams; joint rehabilitation and reablement teams; continuing health care – jointly commissioned and provided; adult mental health – jointly commissioned and provided; integrated learning disability service – jointly commissioned and provided; senior responsible officer for hospital discharge and flow – system appointment; jointly funded posts, working across one or more partner; shared or integrated record systems with primary care, and community and acute trust(s).
36	A pilot study of an integrated mental health, social and medical model	K Ismail, K Stewart, K Ridge, E	Diabetic medicine, 2020,	Aims: We examined the effectiveness of a service innovation, Three Dimensions for Diabetes (3DFD), that consisted of a referral to an integrated mental health, social care and diabetes treatment model, compared with usual care in improving biomedical and

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	for diabetes care in an inner-city setting: three Dimensions for Diabetes (3DFD)	Britneff, R Freudenthal, D Stahl, P McCrone, C Gayle, AM Doherty	37(10), 1658-1668	health economic outcomes. Methods: Using a non-randomized control design, the 3DFD model was offered in two inner-city boroughs in London, UK, where diabetes health professionals could refer adult residents with diabetes, suboptimal glycaemic control [HbA1c ≥ 75 mmol/mol (≥ 9.0%)] and mental health and/or social problems. In the usual care group, there was no referral pathway and anonymized data on individuals with HbA1c ≥ 75 mmol/mol (≥ 9.0%) were collected from primary care records. Change in HbA1c from baseline to 12 months was the primary outcome, and change in healthcare costs and biomedical variables were secondary outcomes. Results: 3DFD participants had worse glycaemic control and higher healthcare costs than control participants at baseline. 3DFD participants had greater improvement in glycaemic control compared with control participants [-14 mmol/mol (-1.3%) vs. -6 mmol/mol (-0.6%) respectively, P < 0.001], adjusted for confounding. Total follow-up healthcare costs remained higher in the 3DFD group compared with the control group (mean difference £1715, 95% confidence intervals 591 to 2811), adjusted for confounding. The incremental cost-effectiveness ratio was £398 per mmol/mol unit decrease in HbA1c , indicating the 3DFD intervention was more effective and costed more than usual care. Conclusions: A biomedical, psychological and social criteria-based referral system for identifying and managing high-cost and high-risk individuals with poor glycaemic control can lead to improved health in all three dimensions.
37	We have a TIP for You! - Serving Complex Patients through Telemedicine IMPACT PLUS TIP Case Conferences.	Charles, Jocelyn; Pariser, Pauline; Pham, Thuynga; Moira, Stewart	International Journal of Integrated Care (IJIC), 2018 Supplement2; 18 1-3.	Context and Problem Statement: The number of Canadians with chronic conditions is growing. Often patients have serial visits with disconnected specialists and community providers, focused on single diseases not patient goals. Access to interprofessional resources and proactive coordinated care planning are needed to assist primary care providers address chronic disease burden and social determinants. Description of Practice Change: Telemedicine IMPACT PLUS TIP, an innovative secure videoconferencing model, connects patients and their family physicians with interprofessional teams, internal medicine and psychiatry, for goal-directed care planning. An advanced practice community nurse prepares the patient and family physician, identifying what is important and key care concerns, and facilitates post-TIP care plan implementation. Aim and Theory of Change: TIP leverages existing academic and family health teams to support complex patients and their solo family physicians in patient-present real-time planning. Targeted Population: Family physicians are invited to refer “patients who keep them up at night” for synergistic problem-solving to address risk

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				issues. The case conference includes the patient and family caregiver: helping focus everyone on what matters to the patient; ensuring the patient fully understands and commits to their plan; equipping family physicians with local resources; and boosting confidence in managing complexity. Timeline: This program was launched in 2013 in three city regions and now involves 12 teams in all regions.
38	Implementing an interprofessional model of self-management support across a community workforce: a mixed-methods evaluation study	KULNICK Stefan Tino, et al	Journal of Interprofessional Care, 31(1), 2017, pp.75-84.	The importance of implementing self-management support (SMS) is now widely accepted, but questions remain as to how. This article reports on the implementation of an interprofessional model of SMS (Bridges Self-Management) for people with complex multiple long-term conditions through community rehabilitation and social care services in one Southeast England locality. Over 90 professionals and support workers from this workforce received interprofessional training to integrate SMS into their care and rehabilitation interactions. This gave an opportunity to explore how SMS can be implemented in practice. The authors conducted a mixed-methods study with unequal weighting (qualitative emphasis), concurrent timing, and embedded design. Staff provided written feedback and case reflections, participated in group discussions, and completed a survey of self-management beliefs and attitudes. The authors recruited a convenience sample of 10 service users and conducted qualitative interviews and standardised questionnaires. Findings showed that staff appreciated and benefited from the interprofessional learning environment. Staff reported changes in their interactions with service users and colleagues and had gained knowledge and confidence to support individuals to self-manage. Data also highlighted the need to facilitate SMS practice at the level of service organisation. Service user data illustrated the impact of interactions with staff, and how SMS had increased service users' confidence and encouraged different skills to manage life with their conditions. This project has shown how multi-agency community teams can benefit from interprofessional training to enhance SMS for people living with long-term conditions, build a shared understanding of SMS, and integrate effective SMS strategies into everyday practices.
39	Co-location, an enabler for service integration? Lessons from an evaluation of integrated community care teams in East London	LALANI Mirza, MARSHALL Martin	Health and Social Care in the Community, 30(2), 2022, pp.e388-e396.	In an attempt to support care integration that promotes joined up service provision and patient-centred care across care boundaries, local health and social care organisations have embarked on several initiatives and approaches. A key component of service integration is the co-location of different professional groups. This study considers the extent to which co-location is an enabler for service integration by examining multi-professional community care teams. The study presents findings from a qualitative evaluation of integrated care initiatives in a borough of East London, England,

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				undertaken between 2017 and 2018. The evaluation employed a participatory approach, the Researcher-in-Residence model. Participant observation (n = 80 hr) and both semi-structured individual (n = 16) and group interviews (six groups, n = 17 participants) were carried out. Thematic analysis of the data was undertaken. The findings show that co-location can be an effective enabler for service integration providing a basis for joint working, fostering improved communication and information sharing if conditions such as shared information systems and professional cultures (shared beliefs and values) are met. Organisations must consider the potential barriers to service integration such as differing professional identity, limited understanding of roles and responsibilities and a lack of continuity in personnel. Co-location remains an important facet in the development of multi-professional teams and local service integration arrangements, but as yet, has not been widely acknowledged as a priority in care practice. Organisations that are committed to greying care boundaries and providing joined up patient care must ensure that sufficient focus is provided at the service delivery level and not assume that decades of silo working in health and social care and strong professional cultures will be resolved by co-location.
40	Specific approaches to integrating care in Austria - The cases of psychogeriatric coordination and palliative care (SUSTAIN project sites).	Leichsenring, Kai; Ruppe, Georg	International Journal of Integrated Care (IJIC), 2016 Supplement; 16(6): 1-2	Integrated care has gained importance over the past decade in Austria with a strong focus on integration and coordination within the health care system, e.g. by implementing discharge management in hospitals and sporadic disease management initiatives. Alongside these developments, long-term care (LTC) has progressively been shaped as a sector, with distinct funding mechanisms and by creating new links with the health system, e.g. by new types of job profiles. Still, generally fragmented structures have been identified as barriers to person-centred care, continuity and systemic prevention. These difficulties culminate when it comes to care at the end of life as palliative care was 'delegated' to specific wards or hospices, rather than being integrated across sectors to extend possibilities for dying at home. There is growing awareness that improvements to current practice are necessary, in particular in view of the rising number of older people suffering from multimorbidity and dementia. In response to these challenges, many local initiatives have evolved, two out of which will be presented in this contribution. The 'Palliative Care Coordination' (PCC) in Styria and the 'Geropsychiatric Centre' (GPZ) in Vienna were chosen as sites for further organisational development in the context of the EU Horizon 2020 Project SUSTAIN. The following description refers to the baseline assessment at these sites between September 2015 and April 2016.

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41	Cloud-based integrated socio-sanitary care e-services in Croatia: Lessons learned	Ljubi, Igor; Belani, Hrvoje; Suzana Belosevic Romac	SHS Web of Conferences; Les Ulis, Vol. 85, (2020).	Among many other services, modern governments offer both healthcare and social care to their citizens. Traditionally built in a silo structure and often using separate funding schemes, these two services offer limited possibilities for integration. Therefore, a novel approach is needed which will enable the integrated provisioning of both social and healthcare services to the citizens. This paper describes a platform for collaboration on multiple levels, provided to connect actors from healthcare and social care services – from primary care medical doctors to hospitals, and from home caregivers and/or family members to emergency centres for the elderly. Utilizing the cloud-based ICT tool, we have developed an integrated e-care model and introduced personalised care pathways for the elderly people suffering from various health problems (including heart failure, cardio-vascular diseases, diabetes and mental health issues). This model employs a patient-centric approach to care delivery, giving the patient (or the person acting on behalf of the patient) in power to control (and to share) any data relevant to treat patient's health condition. For the socio-sanitary care providers the benefit is the ability to influence clinical outcomes by remotely monitor and coordinate care initiatives. Using this approach, government has an effective aid to meet quality thresholds, generate clinical outcome metrics and improve satisfaction of the citizens using health and social care services.
42	Evaluation of the Social Services and Well-being (Wales) Act 2014: process evaluation	LLEWELLYN Mark, et al	Wales. Welsh Government 2021	This report present findings from the process evaluation phase of the study. The evaluation will examine the implementation and outcomes of the Social Services and Well-being (Wales) Act 2014 through its five principles (and the financial implications of each) and five domains as determined by the study team: service users; carers; families and communities; workforce; and organisations. The aim is understand how the legislation has been implemented at a national, regional and local level, looking particularly at the role that the wide range of organisations that are impacted by the Act have had in this implementation. Key findings and messages include: there was a recurring view that the principles of the Act form an important values-based framework for action; there are some positive examples of prevention models and practices, but this is seen by some as patchy; while there were positive examples of co-production, challenges were noted in securing greater leadership support for co-productive ways of working; wellbeing seen as integral to social care, but as a concept is contested and subject of much discussion; fragmentation and overlap of advocacy services was reported, along with the need to keep raising awareness of the importance of advocacy; there is fragility, gaps and inconsistencies in multi-agency working; the Act has enabled

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				new ways of working including practice change, and developing and strengthening partnerships; however, lack of public awareness and understanding of the Act has created challenges to asset-based way of working. To realise the full potential of the Act, the importance of an open dialogue between Welsh Government and local authorities, and reciprocal working relationships was highlighted. Data monitoring and capture to evidence outcomes and impact were also seen as a priority.
43	Expectations and experiences: service user and carer perspectives on the Social Services and Well-being (Wales) Act	LLEWELLYN Mark, et al	Wales. Welsh Government 2022	The evaluation examines the implementation and outcomes of the Social Services and Well-being (Wales) Act 2014 through its five principles (voice and control, wellbeing, co-production, multi-agency working, prevention and early intervention) – and the financial implications of each. These are being evaluated through a consideration of how the Act has impacted on five domains (citizens, families and carers, communities, workforce, organisations), and is informed by Michael Patton's (2018) Principles-Focused Evaluation (P-FE) approach which we are using as the framework for the study. The report considers three specific issues for service users and carers that were raised in the original Welsh Government project specification for the evaluation: to what extent they feel that services worked in partnership with each other, were fully integrated and were streamlined to ensure the best possible care was provided to them; to what extent they feel involved in decisions about their care and support; their quality of life and their wellbeing. The evaluation found that many of the services were being delivered and experienced in line with the aspirations laid out by the legislation. However, there is ample evidence from this study that the experience of service users and carers was sub-optimal. There are a number of significant structural factors that help to explain this, not least of which are the global pandemic, budgetary pressures and growing demand, challenges over workforce sustainability, and the relative 'newness' of the Act.
44	Talking together in rural palliative care: a qualitative study of interprofessional collaboration in Norway.	Johansen, May-Lill; Ervik, Bente	BMC Health Services Research (BMC HEALTH SERV RES), 3/7/2022; 22(1): 1-9. (9p)	Background: Caring for people with palliative care needs in their homes requires close collaboration within and between primary and hospital care. However, such close collaboration is often lacking. Transitions of care are potentially unsafe and distressing points in a patient trajectory. Few studies have explored the experiences of healthcare professionals in the community who receive patients from hospital care and provide them with palliative care at home.Objective: To explore how rural health professionals experience local and regional collaboration on patients in need of palliative care.Methods: This was a qualitative focus group and interview study in rural Northern Norway involving 52 primary care health professionals including district nurses, general practitioners, oncology nurses, physiotherapists, and occupational therapists. Five uni-

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				professional focus group discussions were followed by five interprofessional discussions and six individual interviews. Transcripts were analysed thematically.Results: "Talking together" was perceived as the optimal form of collaboration, both within primary care and with specialists. Nurses and GPs had similar perceptions of their worst-case scenario in primary palliative care: the sudden arrival after working hours of a sick patient about whom they lacked information. These situations could be the result of a short notice transfer from secondary care or an emergency presentation after a crisis in patient management locally, the latter often resulting in a hospital admission. Participants missed timely and detailed discharge letters and in complex cases a telephone call or conference. Locally, co-location was perceived as advantageous for crucial communication, mutual support, and knowledge about each other's competencies and work schedule. Because local health professionals belonged to different units within the primary health care organisation, in some places they had limited knowledge about each other's roles and skill sets.Conclusions: Lack of communication, both locally and between specialist and primary care, was a key factor in the worst-case patient scenarios for GPs and nurses working in primary palliative care in rural Northern Norway. Co-location of primary care professionals promoted local collaboration and should be encouraged. Hospital discharge planning should involve the receiving primary care professionals.
45	Integrated Care of people with Type 2 diabetes in Western Sydney: A business case for Joint Specialist Case Conference (JSCC) with General Practice.	Meyerowitz-Katz, Gideon; Manoharan, Manimegalai; Jayaballa, Rajini; Bramwell, Sian; Corless, Ian; Nesire, Victoria; Prior, Emily; Schlesinger, Nathan; Maberly, Glen	International Journal of Integrated Care (IJIC); Ubiquity Press 2017 Supplement;	Introduction: Type 2 diabetes is the leading burden of disease in Australia, particularly in Western Sydney, with 960,000 people and one of the fastest growing populations. Approximately 15% of the population have diabetes, 35% are at high risk of diabetes and 50% are overweight/obese. Western Sydney Diabetes (WSD) initiative was established in 2012 by Western Sydney Local Health District (hospital care) and Western Sydney Primary Health Network (primary healthcare) with a range of partners. Aim, theory, targeted population and timeline: The business case identified support to primary care through a hospital-led Joint-Specialist Case-Conference (JSCC) service with a focus on prevention and management of patients with diabetes at an individual and practice level. WSD has run a JSCC service since 2014. A diabetes specialist, resident medical staff, and diabetes nurse educator attend General Practice (GP) to conference with the GP and the patient to develop a management plan. In a session, we see up to 12 patients, 30 minutes each. With four teams doing six sessions a week, JSCC has seen over 1000 patients, and over 150 GPs. JSCC aims to keep people with diabetes well, with fewer complications and reduce the demand on hospitals. It achieves this by empowering GPs to develop their

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				capacity to manage their patients in the long term after 10 sessions with JSCC. Highlights: We demonstrated significant benefits for the patient, including (at 3-6 month follow-up) an average HbA1c concentration reduction of 0.87% (95% CI -1.31, -0.44), mean reduction in systolic blood pressure of 6.45mmHg (95% CI -11.48, -1.41) and non-significant reductions in mean weight, total cholesterol and diastolic blood pressure. We also found a significant reduction in hospital waiting times for specialist services, from 12 to 2.5 weeks. These investigations are repeated at the 18 month follow-up. The JSCC program has high acceptance among GPs. Over 90% of GPs agree/strongly agree that JSCC was useful to their practice to build their capacity to manage patients with diabetes and would recommend it to their colleagues. The PEN Clinical Audit Tool (PENCAT) was used to track the management of patients with diabetes. Early results indicate that GP practices experienced significant reductions in mean HbA1c of all patients with diabetes (not only those who had been case conferenced) and reductions in BMI, blood pressure and indicators of care integration. Looking forward; conclusions, sustainability, and transferability: A cost-benefit analysis found that for every dollar spent on JSCC, we would see a return of over A$3. More broadly, across a number of interventions targeting diabetes prevention and management, it found that, over seven years, a $68m investment would deliver a net benefit of $124m. The flexibility of JSCC and the cultural diversity of Western Sydney (50% of the population born overseas) means the program will be easily transferrable to other primary/tertiary care environs. Discussion and lessons learned: JSCC is a cost-effective method to empower GPs to provide enhanced management of chronic diabetes care, across healthcare and community settings at a low cost to the healthcare system. We have identified a successful business model that can easily be exported to different locales and across differing types of chronic disease to better support care integration and practice.
46	Effect of dementiacare management on healthcare resource utilization and cost: one-year follow-up results of the delphi trial	Michalowsky B, Thyrian JR, Wucherer D, Eichler T, Hertel J, Hoffmann W	Alzheimer's & dementia, 2016, 12(7), P255-	Background: Dementia syndrome is associated with substantial healthcare cost, which adds to making dementia a healthcare priority. Since causal treatment is still out of sight, there is a need for more efficient ways of manegement and care. In Germany, Dementia Care Management (DCM) aims to provide “optimum care” by integrating multi-professional and multimodal strategies to individualize and optimize treatment and care within the framework of the established healthcare system. The health economic impact of the DCM needs to be evaluated. The objective is to analyze the effect of DCM on healthcare resource utilization and healthcare costs of community-dwelling primary care patients screened positive for dementia. Methods: The present analysis is based on the

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				general practitioner (GP)-based, cluster-randomized, controlled, interventional trial DelpHi-MV (Dementia: life- and person-centered help in Mecklenburg-Western Pomerania). The trial is designed to test the efficacy and efficiency of implementing a subsidiary support system for persons with dementia who live at home. Patients in the intervention group received DCM, control group received “care as usual”. The study started 01/2012, recruitment ended 01/ 2014 and the one-year follow-up will be finished 03/2016. N=516 patients were assessed at baseline (socio-demographics, clinical variables and the utilization of medical treatments, formal and informal care and caregivers productivity losses). The effect of DCM on resource utilization and costs will be analyzed using multiple linear and logistic regression models comparing intervention and control group. Results: There were no significant differences in resource utilization and costs between intervention and control group at baseline. Cost valuated to be $6.606 for medical treatments, $1.800 for formal care, $18.146 for informal care and $1.412 for caregivers productivity losses due to informal care, resulting in mean total healthcare cost of $27.965 at baseline. Effects on resource utilization and costs after one year of intervention will be presented at the conference. Differences in the hospitalization and institutionalization between intervention and control group will be analyzed and presented in more detail. Conclusions: Due to optimum care and a better integration into routine care, hospitalization and institutionalization could be lower in intervention group, resulting in lower total healthcare cost.
47	Helping a community to help their kids: Bringing services together in a community hub in inner-city Sydney, Australia.	Miller, Erin; Ratcliff, Suzanne; Golightly, Helen; Tennant, Elaine; Eastwood, John	International Journal of Integrated Care (IJIC); 2017 Supplement; v.17. 1-2.	Introduction: The suburb of Redfern is identified as having some of the highest rates of intergenerational family disadvantage in the Sydney district. Many families are disconnected from key services, and require multi-agency input to remain healthy and safe. Short description of practice change implemented: Health district family care coordinators are co-located in an interagency hub on a social housing estate, led by the local housing department. At this hub, staff from government and non-government organisations have partnered to provide an integrated service providing health and social support to residents with complex needs such as psychological trauma, mental health issues, substance abuse, chronic health problems, child protection and parenting issues. Aim and theory of change: By co-locating family care coordinators with partners in the community, we aim to: Bring services directly to the community. Connect care and bridge gaps for families. Provide a "Team Around the Family" model of intervention to increase a family's capacity to independently manage their complex health and psychosocial needs. Support families to seek antenatal support earlier in pregnancy. Work in partnership with

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				families, other services, General Practice and the community. Break down service silos. Targeted population and stakeholders: Families with children aged 0-17 years, where the parents or carers have complex health or psychosocial needs which impact on their ability to care for their children. Stakeholders include drug health services, mental health services, legal aid, financial management assistance, public housing and child and family health services. Timeline: This program commenced in July 2015 and implementation and evaluation is ongoing. Highlights: The model of care evolved in line with local family and community needs, and includes extended family members to align with the Aboriginal definition of kinship. This has empowered families to identify solutions that work for them. Trust has increased at two levels: families who have traditionally shown a mistrust of government services are now approaching staff for support; staff from different organisations are now working in partnership and share care for families. Families are now receiving the support that they require before situations turn into crises, and the adult family members' needs are being addressed. Comments on sustainability: As this model utilises existing services, sustainability is realistic. Comments on transferability: This model could be implemented in other suburbs with high rates of family disadvantage. Elements may be adapted to suit local families and communities. Conclusions: Preliminary analysis indicates that co-location of health and social services is powerful in building trust between service providers and transferring of knowledge and skills. When a hub is located within a community, those services are able to build trust in the community, coordinate services for families and help families to achieve optimal outcomes.
48	Does one size really fit all? The effectiveness of a non-diagnosis-specific integrated mental health care program in Germany in a prospective, parallel-group controlled multi-centre trial	AS Mueller-Stierlin, MJ Helmbrecht, K Herder, S Prinz, N Rosenfeld, J Walendzik, M Holzmann, U Dinc, M Schutzwohl, T Becker, R Kilian	BMC psychiatry, 2017, 17(1) (no pagination) |	Background: The Network for Mental Health (NWpG-IC) is an integrated mental health care program implemented in 2009 by cooperation between health insurance companies and community mental health providers in Germany. Meanwhile about 10,000 patients have been enrolled. This is the first study evaluating the effectiveness of the program in comparison to standard mental health care in Germany. Methods: In a parallel-group controlled trial over 18 months conducted in five regions across Germany, a total of 260 patients enrolled in NWpG-IC and 251 patients in standard mental health care (TAU) were recruited between August 2013 and November 2014. The NWpG-IC patients had access to special services such as community-based multi-professional teams, case management, crisis intervention and family-oriented psychoeducation in addition to standard mental health care. The primary outcome empowerment (EPAS) and the secondary outcomes quality of life (WHO-QoL-BREF), satisfaction with psychiatric treatment (CSQ-8),

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				psychosocial and clinical impairment (HoNOS) and information about mental health service needs (CAN) were measured four times at 6-month intervals. Linear mixed-effect regression models were used to estimate the main effects and interaction effects of treatment, time and primary diagnosis. Due to the non-randomised group assignment, propensity score adjustment was used to control the selection bias. Results: NWpG-IC and TAU groups did not differ with respect to most primary and secondary outcomes in our participating patients who showed a broad spectrum of psychiatric diagnoses and illness severities. However, a significant improvement in terms of patients' satisfaction with psychiatric care and their perception of treatment participation in favour of the NWpG-IC group was found. Conclusions: Providing integrated mental health care for unspecific mentally ill target groups increases treatment participation and service satisfaction but seems not suitable to enhance the overall outcomes of mental health care in Germany. The implementation of strategies for ameliorating the needs orientation of the NWpG-IC should be considered.
49	General practice pharmacists in England: Integration, mediation and professional dynamics.	Nabhani-Gebara, Shereen; Fletcher, Simon; Shamim, Atif; May, Leanne; Butt, Nabiha; Chagger, Sunita; Mason, Thuy; Patel, Kunal; Royle, Finlay; Reeves, Scott	Research in Social & Administrative Pharmacy, Feb2019; 15(2):	Background: A number of key publications in recent years have advocated a more integrated vision of UK primary care involving increased multi-professional communication and understanding. This has resulted in a marked change in the roles being undertaken by pharmacists. Community pharmacists have traditionally provided a medicine supply function and treated minor ailments in addition to delivering a suite of locally commissioned services; however these functions have not necessarily been part of a programme of care involving the other clinicians associated with the patient. An integrated model of care would see much closer working between pharmacy and general practice but also with pharmacists not only working with, but in the practice, in an enhanced patient-facing role, trained as independent prescribers. This has implications for the dynamics amongst professionals in this environment. Objectives: This exploratory multiple case study attempts to explore these changing dynamics across ten GP surgeries throughout the South-East of England. Methods: Semi-structured, in-depth interviews were conducted with one nurse, one pharmacist and one physician from each clinic, and survey data was collected from 38 patients who had appointments with a pharmacist. Results: The data suggested that the pharmacists who had enhanced roles perceived some uncertainty about their professional role and identity, which resulted in instability and insecurity and that this uncertainty led to both professional and interprofessional tension with their primary care colleagues. The survey data revealed that n = 35 (92%) patients stated they were 'very satisfied' or 'satisfied' with their appointment. And n = 37

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				(97%) were 'very comfortable' or 'comfortable' discussing their medications with the pharmacist. In addition, 36 patients (95%) reported that they strongly agreed or agreed with the clinical recommendations made by the pharmacist. Conclusions: These findings are discussed in relation to role expansion and professional/interprofessional relations before key practical suggestions are offered.
50	Primary care home and social care: working together	NATIONAL ASSOCIATION OF PRIMARY CARE, ASSOCIATION OF DIRECTORS OF ADULT SOCIAL SERVICES	National Association of Primary Care 2018	Based on evidence and practice from across England, this guide shows how adult social care and primary care can work more closely together through the primary care home (PCH) model. It provides an overview of the different landscapes of each service and the national policy developments that make closer working more desirable and more important. It suggests ways in which barriers to integration can be overcome and presents opportunities for greater collaboration at the level of the individual patient, the local population and the wider system. It includes case studies of areas where primary care and social care have successfully started to integrate services with local communities benefitting from the approach. The case studies are Workingham Integrated Partnership on Health and Social Care, Larwood and Bawtry Primary Care Home, Greater Manchester Health and Social Care Partnership; and West Devon Primary Care Home. (Edited publisher abstract)
51	Feasibility of referral to a therapist for assessment of psychiatric problems in primary care – an interview study.	Pettersson, Agneta; Modin, Sonja; Hasson, Henna; Krakau, Ingvar	BMC Family Practice, 8/19/2019; 20(1): N.PAG-N.PAG.	Abstract: Background: Depression and anxiety disorders are common in primary care. Comorbidities are frequent, and the diagnoses can be difficult. The Mini-International Neuropsychiatric Interview (MINI) can be a support in the clinical examination of patients with complex problems. However, for family practitioners (FPs), time and perceptions about structured interviews can be barriers to the MINI. An inter-professional teamwork process where FPs refer a patient to a therapist for a MINI assessment represents one way in which to address the problem. The results are fed back to the FPs for diagnosis and treatment decisions. The purposes of this study were to explore if the process was feasible for FPs, patients and therapists in Swedish primary care, and to identify factors influencing the process, using the COM-B model. Methods: FPs at two primary care centers (PHCC) in Stockholm were offered the opportunity to refer patients to in-house therapists. Semi-structured interviews or focus groups were conducted with 22 patients, 17 FPs and three therapists to capture their experiences and perceptions. Inductive content analysis for each group of participants was followed by triangulation across groups. Finally, the categories obtained were fitted to the components in the COM-B. Results: Therapists at both PHCCs conducted the MINI. The intended process was adopted at one PHCC. At the second PHCC, the responsibilities for the diagnosis and

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				treatment of patients referred were transferred to the therapist. The patients were satisfied, as they appreciated multi-professional examinations. The FPs' competence in psychiatry, actual access to therapists, beliefs that the referrals saved the FPs time and effort, and established habits influenced whether patients were referred. Existing routines and professional expectations for work content influenced the degree of cooperation between the therapists and the FPs. Conclusions: An inter-professional diagnostic process where FPs refer patients to a therapist for assessment and the results are fed back to the FPs can be feasible. Feasibility depends on access to a therapist, the perceptions of roles and competences among FPs and therapists, and strategies for supporting teamwork.
52	What is the evidence on the economic impacts of integrated care?	NOLTE Ellen, PITCHFORTH Emma	World Health Organization. Regional Office for Europe 2014	This rapid evidence review summarises evidence on the economic impacts of integrated care approaches, that is initiatives which aimed to improve the outcomes of people with complex chronic health problems and needs by linking or coordination of services of different providers along the continuum of care. Systematic searches on Pubmed, Embase and Cochrane Library retrieved 963 references, of which 19 met the reviews inclusion criteria. A wide range of interventions were included, such as older people in the community who were considered frail, who had medical or social care needs, or were about to be discharged from hospital, and adults with dementia or memory loss. Initiatives included those targeting the interface between hospital and primary care or community care services, often in the context of discharge planning or care transition. None of the reviews identified explicitly defined integrated care as the topic of review. Analysis was carried out for three economic outcomes: utilisation, cost-effectiveness and cost or expenditure. Data were also extracted for health outcomes such as health status, quality of life or mortality. Utilisation and cost were found to be the most common economic outcomes assessed by reviews, but reporting measures were inconsistent and the quality of evidence was often low. There was evidence of the cost-effectiveness of some integrated care approaches but the evidence remains weak. (Original abstract)
53	Neighbourhood Care Development in Inverness, Highland, Scotland.	Pitt, Rhiannon; Haire, Georgia; Patience-Quate, Kate	International Journal of Integrated Care (IJIC), 2018 Supplement2; 18 1-2.	Introduction: NHS Highland is responsible for the delivery of all adult health and social care services in this area with the Highland Council responsible for the delivery of children's services under a Lead Agency model developed as part of health and social care integration in 2012. Whilst integration had brought together adult health and social care services into a single organisation the real benefit was not realised in Inverness due to the comparatively large size of the teams this created. There was an extended length of stay in hospital and waiting lists for assessment and commencement of care packages.

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				Description of practice change: From 2 large district teams 7 community neighbourhood teams were formed with a single referral route to each team. The teams are responsible for all aspects of caseload management with decision making supported by multi-professional huddles. Work in progress to support the teams includes the introduction of an electronic record MORSE, the inclusion of independent care at home providers in huddles, community asset building with Inverness Community Planning Partnership, coaching development for managers and the development of team performance and governance information. Aim and Theory of change: The change is based on the principles of the Buurtzorg model of neighbourhood care in the following ways, Autonomous team decision making and caseload management Neighbourhood teams with a community asset approach to delivering and sustaining care. Coaching enabling team function and efficiency. The aim is to prevent unnecessary admission to hospital and care homes, prevent delay in hospital, provide palliative, preventative and rehabilitative treatment for the neighbourhood population through the effective use of combined team and community resources. We aim to improve staff and patient experience by increasing face to face time between staff and patients and reducing bureaucracy and duplication. Targeted populations and stakeholders: All adults requiring health or social care support in Inverness. Stakeholders are community team members, managers, GPs, independent sector care providers, acute and community hospitals in Inverness. Timeline: The model has been developing since 2016 with further supporting changes planned over the next year.
54	Integrating primary care and behavioral health with four special populations: children with special needs, people with serious mental illness, refugees, and deaf people.	Pollard Jr., Robert Q.; Betts, William R.; Carroll, Jennifer K.; Waxmonsky, Jeanette A.; Barnett, Steven; deGruy III, Frank V.; Pickler, Laura L.; Kellar-	American Psychologist, May/Jun2014; 69(4): 377-387.	Special patient populations can present unique opportunities and challenges to integrating primary care and behavioral health services. This article focuses on four special populations: children with special needs, persons with severe and persistent mental illness, refugees, and deaf people who communicate via sign language. The current state of primary care and behavioral health collaboration regarding each of these four populations is examined via Doherty, McDaniel, and Baird's (1996) five-level collaboration model. The section on children with special needs offers contrasting case studies that highlight the consequences of effective versus ineffective service integration. The challenges and potential benefits of service integration for the severely mentally ill are examined via description of PRICARe (Promoting Resources for Integrated Care and Recovery), a model program in Colorado. The discussion regarding a refugee population focuses on service integration needs and emerging collaborative models as well as ways in which refugee mental health research can be improved. The section on deaf

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		Guenther, Yvonne		individuals examines how sign language users are typically marginalized in health care settings and offers suggestions for improving the health care experiences and outcomes of deaf persons. A well-integrated model program for deaf persons in Austria is described. All four of these special populations will benefit from further integration of primary care and mental health services.
55	An overview of reviews on interprofessional collaboration in primary care: barriers and facilitators	RAWLINSON Cloe, et al	International Journal of Integrated Care, 21(2), 2021, p.32. Online only	Introduction: Interprofessional collaboration (IPC) is becoming more widespread in primary care due to the increasing complex needs of patients. However, its implementation can be challenging. This study aimed to identify barriers and facilitators of IPC in primary care settings. Methods: An overview of reviews was carried out. Nine databases were searched, and two independent reviewers took part in review selection, data extraction and quality assessment. A thematic synthesis was carried out to highlight the main barriers and facilitators, according to the type of IPC and their level of intervention (system, organizational, inter-individual and individual). Results: Twenty-nine reviews were included, classified according to six types of IPC: IPC in primary care (large scope) (n = 11), primary care physician (PCP)-nurse in primary care (n = 2), PCP-specialty care provider (n = 3), PCP-pharmacist (n = 2), PCP-mental health care provider (n = 6), and intersectoral collaboration (n = 5). Most barriers and facilitators were reported at the organizational and inter-individual levels. Main barriers referred to lack of time and training, lack of clear roles, fears relating to professional identity and poor communication. Principal facilitators included tools to improve communication, co-location and recognition of other professionals' skills and contribution. Conclusions: The range of barriers and facilitators highlighted in this overview goes beyond specific local contexts and can prove useful for the development of tools or guidelines for successful implementation of IPC in primary care.
56	A review of the effectiveness and experiences of welfare advice services co-located in health settings: a critical narrative systematic review	S Reece, TA Sheldon, J Dickerson, KE Pickett	Social science & medicine (1982), 2022, 296, 114746	We conducted a narrative systematic review to assess the health, social and financial impacts of co-located welfare services in the UK and to explore the effectiveness of and facilitators and barriers to successful implementation of these services, in order to guide future policy and practice. We searched Medline, EMBASE and other literature sources, from January 2010 to November 2020, for literature examining the impact of co-located welfare services in the UK on any outcome. The review identified 14 studies employing a range of study designs, including: one non-randomised controlled trial; one pilot randomised controlled trial; one before-and-after-study; three qualitative studies; and eight case studies. A theory of change model, developed a priori, was used as an analytical framework against which to map the evidence on how the services work, why

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				and for whom. All studies demonstrated improved financial security for participants, generating an average of £27 of social, economic and environmental return per £1 invested. Some studies reported improved mental health for individuals accessing services. Several studies attributed subjective improvements in physical health to the service addressing key social determinants of health. Benefits to the health service were also demonstrated through reduced workload for healthcare professionals. Key components of a successful service included co-production during service development and ongoing enhanced multi-disciplinary collaboration. Overall, this review demonstrates improved financial security for participants and for the first time models the wider health and welfare benefits for participants and for health service from these services. However, given the generally poor scientific quality of the studies, care must be taken in drawing firm conclusions. There remains a need for more high quality research, using experimental methods and larger sample sizes, to further build upon this evidence base and to measure the strength of the proposed theoretical pathways in this area.
57	Joint working in community mental health teams: implementation of an integrated care pathway.	Rees G; Huby G; McDade L; McKechnie L	Health & Social Care in the Community (HEALTH SOC CARE COMMUNITY), Nov2004; 12(6): 527-536. (10p)	Integration of community mental health services is a key policy objective that aims to increase quality and efficiency of care. Integrated care pathways (ICPs) are a mechanism designed to formalise multi-agency working at an operational level and are currently being applied to mental health services. Evidence regarding the impact of this tool to support joint working is mixed, and there is limited evidence regarding the suitability of ICPs for complex, community-based services. The present study was set in one primary care trust (PCT) in Scotland that is currently implementing an ICP for community mental health teams (CMHTs) across the region. The aim of the study was to investigate professionals' experiences and views on the implementation of an ICP within adult CMHTs in order to generate learning points for other organisations which are considering developing and implementing such systems. The study used qualitative methods which comprised of individual interviews with three CMHT leaders and two service development managers, as well as group interviews with members of four adult CMHTs. Data was analysed using the constant comparison method. Participants reported positive views regarding joint working and the role of an ICP in theory. However, in practice, teams were not implementing the ICP. Lack of integration at higher organisational levels was found to create conflicts within the teams which became explicit in response to the ICP. Implementation was also hindered by lack of resources for ongoing support, team development and change management. In conclusion, the study suggests that operational systems such as ICPs do not address and cannot overcome

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				wider organisational barriers to integration of mental health services. Integrated care pathways need to be developed with strategic input as well as practitioner involvement and ownership. Team development, education about integration and change management are essential if ICPs are to foster and support joint working in integrated teams.
58	A Randomized Clinical Trial Investigating the Effect of a Healthcare Access Model for Individuals with Severe Psychiatric Disabilities	Rogers ES, Maru M, Kash-MacDonald M, Archer-Williams M, Hashemi L, Boardman J	Community mental health journal, 2016, 52(6), 667-674	We conducted a randomized trial to examine a model for integrating primary care into a community mental health setting. Two hundred individuals were recruited and randomly assigned to receive primary care delivered by a nurse practitioner (n = 94) or services-as-usual (n = 106), assessed on health and mental health outcomes, and followed for 12 months. Intent-to-Treat and exposure analyses were conducted and suggest that participants who engaged with the nurse practitioner experienced gains in perceptions of primary care quality. Health benefits accrued for individuals having receiving nurse practitioner services in a mental health setting to address primary care needs.
59	The future of primary care: creating teams for tomorrow	PRIMARY CARE WORKFORCE COMMISSION	Health Education England 2015	Sets out a vision for the future of primary care calling for greater collaboration across organisations and sectors and a broader range of staff involved in the delivery of healthcare. The report focuses on: the delivery of primary care, increasing capacity and up-skilling staff and teams; making better use of technology; maintaining quality and safety of care; population groups with particular needs, including care for people with mental health problems and learning disabilities, people with challenging health and social care needs, people in nursing and residential homes and care at the end of life; integrated care and joint working; and better use of data and evidence based innovation. The report recommends that there should be a single point of access to community services and social services for urgent assessments. To facilitate effective multi-disciplinary assessment (for example, acutely ill older people, discharge planning), staff from the necessary range of healthcare disciplines and from social services should be co-located and develop a team-based approach.
60	Divided we fall: getting the best out of general practice	ROSEN Rebecca	Nuffield Trust, 2018	This report explores the effect of recent policy to segment general practice into different types of service tailored to the needs of different patients. These include easy access schemes like walk-in centres for those who prioritise speed and convenience, and for the sickest patients with multiple conditions, multi-professional teams linked to GP practices are starting to offer a combination of clinical consultations, community therapies, care planning and care coordination. The report considers the implications that this 'segmentation' has for the traditional 'medical generalist' model of general practice, where professionals take a holistic view of an individual's symptoms and manage them

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				with knowledge of their wider social and family context. It argues that having the ability to see patients 'in the round' helps doctors to manage their care in the community and to avoid making referrals that may have limited benefit. The report concludes by setting out a new vision for general practice that combines the best of the old and the new, and describes what local and national NHS leaders could do to support this.
61	Integrating specialty care into primary care: The Nuka approach	Routledge R	BCMJ, vol. 62, No. 1, January February 2020, Pages 26-28 Premise	An overview of the Southcentral Foundation's gradual approach to integrating specialty services with primary care.
62	Collaborative care for mental health: a qualitative study of the experiences of patients and health professionals	J Rugkåsa, OG Tveit, J Berteig, A Hussain, T Ruud	BMC health services research, 2020, 20(1), 844	Background: Health policy in many countries directs treatment to the lowest effective care level and encourages collaboration between primary and specialist mental health care. A number of models for collaborative care have been developed, and patient benefits are being reported. Less is known about what enables and prevents implementation and sustainability of such models regarding the actions and attitudes of stakeholders on the ground. This article reports from a qualitative sub-study of a cluster-RCT testing a model for collaborative care in Oslo, Norway. The model involved the placement of psychologists and psychiatrists from a community mental health centre in each intervention GP practice. GPs could seek their input or advice when needed and refer patients to them for assessment (including assessment of the need for external services) or treatment. Methods: We conducted in-depth qualitative interviews with GPs (n = 7), CMHC specialists (n = 6) and patients (n = 11) in the intervention arm. Sample specific topic guides were used to investigate the experience of enablers and barriers to the collaborative care model. Data were subject to stepwise deductive-inductive thematic analysis. Results: Participants reported positive experiences of how the model improved accessibility. First, co-location made GPs and CMHC specialists accessible to each other and facilitated detailed, patient-centred case collaboration and learning through complementary skills. The threshold for patients' access to specialist care was lowered, treatment could commence early, and throughput increased. Treatment episodes were brief (usually 5-10 sessions) and this was too brief according to some patients. Second, having experienced mental health specialists in the team and on the front line enabled early assessment of symptoms and of the type of treatment and service that patients required and were entitled to, and who could be treated at the GP practice. This

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				improved both care pathways and referral practices. Barriers revolved around the organisation of care. Logistical issues could be tricky but were worked out. The biggest obstacle was the funding of health care at a structural level, which led to economic losses for both the GP practices and the CMHC, making the model unsustainable. Conclusions: Participants identified a range of benefits of collaborative care for both patients and services. However, the funding system in effect penalises collaborative work. It is difficult to see how policy aiming for successful, sustainable collaboration can be achieved without governments changing funding structures.
63	Continuity and connectivity: who will stabilise the systems that support health care outside hospital?	Sang B	Journal of Integrated Care (J INTEGR CARE), Feb2006; 14(1): 38-43. (6p)	The success of the forthcoming policy promoting health care outside hospitals will depend on achievement of fully integrated services, especially for individuals at risk of hospitalisation. Using as a case study the evaluation of a community response team, this paper argues that past attempts to achieve such service integration with frail elderly people have been short-lived because of the impact of restructuring of the major commissioning organisations. While the effectiveness of integrated service developments can be demonstrated, the positive benefits have not been sustained, and valuable learning has been lost. By identifying key aspects of organisational memory, the paper proposes a more relationship-focused approach to reform in which multi-agency teams are given the time to establish personal services for vulnerable people.
64	Co-location as a Driver for Cross-Sectoral Collaboration with General Practitioners as Coordinators: The Case of a Danish Municipal Health Centre.	Scheele, Christian Elling; Vrangbæk, Karsten	International Journal of Integrated Care (IJIC); Ubiquity Press Oct-Dec2016; v.16 n.4, 1-11. (11p)	The issue of integrated care and inter-sectoral collaboration is on the health policy agenda in many countries. Yet, there is limited knowledge about the effects of the different policy instruments used to achieve this. This paper studies co-location as a driver for cross-sectoral collaboration with general practitioners (GPs) acting as coordinators in a municipal health centre. The purpose of the health centre, which is staffed by health professionals from municipal, regional and private sectors, is to provide primary health services to the citizens of the municipality. Co-locating these professionals is supposed to benefit e.g., elder citizens and patients with chronic diseases who frequently require services from health professionals across administrative sectors. Methodologically, the analysis is based on qualitative data in the form of semi-structured interviews with the health professionals employed at the health centre and with administrative managers from municipal and regional government levels. The study finds that co-location does not function as a driver for cross-sectoral collaboration in a health centre when GPs act as coordinators. Cross-sectoral collaboration is hampered by the general practitioners' work routines and professional identity, by organisational factors

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				and by a lack of clarity concerning the content of collaboration with regard to economic and professional incentives.
65	Evaluation of a drop-in clinic for young people with attention deficit hyperactivity disorder.	Sfar-Gandoura, Hanah; Ryan, Gemma Sinead; Melvin, Gail	Children & Young People, Jun2017; 29(5): 24-32.	Aims To implement and evaluate a nurse-led, multi-agency drop-in clinic for young people with attention deficit hyperactivity disorder (ADHD). Method A repeated measures observational study over 12 months exploring clinic attendance and user satisfaction, crisis management and did not attend (DNA) rates, consultant time spent with patients, benefits to quality of care, and service flexibility. Results A total of 62 service users participated. A significant improvement in service user experience was observed (P=0.001). Crisis management attendances significantly increased (P=0.005). DNA rates did not reduce significantly (P=0.057). Service users attended for their medication review before or on their due date (P=0.011). Those who needed to were able to spend more time with the staff (P=0.001). Conclusion The clinic improved service accessibility and flexibility. It allowed adherence to clinical guidance, including uptake of psychosocial interventions. There was an overwhelmingly positive improvement in service user experience. Importantly, as contact with the ADHD nurse specialists increased, this significantly reduced the amount of time consultant community paediatricians spent with service users. Further research should examine the cost-effectiveness and longitudinal effect of the drop-in model.
66	Building connections: co-locating advice services in general practices and job centres	SINCLAIR Jamie J.	Glasgow Centre for Population Health, Joseph Rowntree Foundation 2018	This report presents learning from the Building Connections programme, which developed a series of collaborative projects to improve social and economic outcomes for people living in poverty in Glasgow. The findings are based on an evaluation different approaches of delivering advice financial, social security, housing and debt advice in two general practices and two job centres in Glasgow. Partners also delivered specific support for lone parents, ethnic minority communities and for people seeking alcohol and addictions advice. The report presents an assessment of the impact of the services and learning on the practicalities of collaborative working, particularly approaches which adopted co-located models. The report concludes that Building Connections was successful in both improving social and economic outcomes for a significant number of people and acting as the catalyst for the development of relationships across the public and third sectors. A series of recommendations for future work are also provided.
67	Postnatal support for drug users: evaluation of a specialist health visiting service.	Smith L; Gibb S	Community Practitioner (COMMUNITY	Women who misuse drugs require a high level of support during their pregnancy and in the postnatal period. A service to provide additional support to such women in the postnatal period was developed in Scotland, through the integration of a specialist

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			PRACT), 2007 Jul; 80(7): 24-29. (6p)	health visitor (SHV) working within the existing multi-agency drug support team (DST). This paper reports on a study to identify views and experiences of both the women who use the service, and the health and social care professionals working with the SHV service, of its effects. Results revealed that specific aspects of the SHV service were viewed positively by women and professionals. However, potential for confusion over lines of accountability between professionals could exist. Also, meeting the complex needs of these women in a sustained way in the community may remain problematic.
68	Family physicians' perspectives on interprofessional teamwork: Findings from a qualitative study.	Szafran, Olga; Torti, Jacqueline M.I; Kennett, Sandra L; Bell, Neil R	Journal of Interprofessional Care (J INTERPROF CARE), Mar2018; 32(2): 169-177. (9p)	The aim of this study was to describe family physicians' perspectives of their role in the primary care team and factors that facilitate and hinder teamwork. A qualitative study was conducted employing individual interviews with 19 academic/community-based family physicians who were part of interprofessional primary care teams in Edmonton, Alberta, Canada. Professional responsibilities and roles of physicians within the team and the facilitators and barriers to teamwork were investigated. Interviews were audiotaped, transcribed and analysed for emerging themes. The study findings revealed that family physicians consistently perceived themselves as having the leadership role on in the primary care team. Facilitators of teamwork included: communication; trust and respect; defined roles/responsibilities of team members; co-location; task shifting to other health professionals; and appropriate payment mechanisms. Barriers to teamwork included: undefined roles/responsibilities; lack of space; frequent staff turnover; network boundaries; and a culture of power and control. The findings suggest that moving family physicians toward more integrative and interdependent functioning within the primary care team will require overcoming the culture of traditional professional roles, addressing facilitators and barriers to teamwork, and providing training in teamwork.
69	Integrated mental health care in a multidisciplinary maternal and child health service in the community: the findings from the Suzaka trial	Tachibana Y, Koizumi N, Akanuma C, Tarui H, Ishii E, Hoshina T, Suzuki A, Asano A, Sekino S, Ito H	BMC pregnancy and childbirth, 2019, 19(1)	Background: Perinatal mental health problems such as mood disorders are common. We propose a new multidisciplinary health service intervention program providing continuous support to women and their children from the start of pregnancy till after childbirth. The aim of this study was to examine the effects of the program with respect to making women's mental health better in the postpartum period and improving the state of care for women and their children in the perinatal period. Methods: We performed a controlled study to investigate the effectiveness of the program in Suzaka City, Japan. The women's mental health status was assessed using the Edinburgh Postnatal Depression Scale (EPDS) 3 months postpartum. Of 349 women, 210 were allocated to the intervention group and 139 to the control group. From April 2014 to March 2015, the number of the pregnant women who were followed-up by the

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				multidisciplinary meeting in the intervention and control groups were 60 and 4, respectively. In the same period, the number of the pregnant women who were identified as requiring intensive care were 21 and 2, respectively. Results: The total EPDS score, which was the primary outcome of the present study, differed significantly between the intervention and control groups (Mean [SD] = 2.74 (2.89) and 4.58 [2.62], respectively; $p < 0.001$). The number of the women receiving counseling from a public health nurse (5.3% in intervention group, 0.7% in control group, $p = 0.02$), attending maternal seminars (attendant ratio: 46% whereas 16%, $p = 0.01$), and receiving home visits by public health nurses (home visit ratio: 93.8% whereas 82.6%, $p < 0.001$) was significantly higher in the intervention group compared to the control group. Conclusions: The present study indicates that continuum support provided by integrated mental health care through a multidisciplinary maternal and child health service in the community can make women's mental health better in the postpartum period and help women and their children receive more health services from public health nurses. Trial registration: Name of registry: Research for the effectiveness of a multi-professional health service intervention program of continuum supports for mother and child which starts for pregnancy periods to enhance maternal mental health.
70	Integrated Care for Older Adults Improves Perceived Quality of Care: results of a Randomized Controlled Trial of Embrace	Uittenbroek RJ, Kremer HPH, Spoorenberg SLW, Reijneveld SA, Wynia K	Journal of general internal medicine, 2017, 32(5), 516-523	BACKGROUND: All community-living older adults might benefit from integrated care, but evidence is lacking on the effectiveness of such services for perceived quality of care. OBJECTIVE: To examine the impact of Embrace, a community-based integrated primary care service, on perceived quality of care. DESIGN: Stratified randomized controlled trial. PARTICIPANTS: Integrated care and support according to the "Embrace" model was provided by 15 general practitioners in the Netherlands. Based on self-reported levels of case complexity and frailty, a total of 1456 community-living older adults were stratified into non-disease-specific risk profiles ("Robust," "Frail," and "Complex care needs"), and randomized to Embrace or control groups. INTERVENTION: Embrace provides integrated, person-centered primary care and support to all older adults living in the community, with intensity of care dependent on risk profile. MEASUREMENTS: Primary outcome was quality of care as reported by older adults on the Patient Assessment of Integrated Elderly Care (PAIEC). Effects were assessed using mixed model techniques for the total sample and per risk profile. Professionals' perceived level of implementation of integrated care was evaluated within the Embrace condition using

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				the Assessment of Integrated Elderly Care. KEY RESULTS: Older adults in the Embrace group reported a higher level of perceived quality of care than those in the control group (B = 0.33, 95 % CI = 0.15-0.51, ES d = 0.19). The advantages of Embrace were most evident in the "Frail" and "Complex care needs" risk profiles. We found no significant advantages for the "Robust" risk profile. Participating professionals reported a significant increase in the perceived level of implementation of integrated care (ES r = 0.71). CONCLUSIONS: This study shows that providing a population-based integrated care service to community-living older adults improved the quality of care as perceived by older adults and participating professionals.
71	Seeking a pot of gold with integrated behavior therapy and research to improve health equity: insights from the RAINBOW trial for obesity and depression	EM Venditti, LE Steinman, MA Lewis, BJ Weiner, J Ma	Translational behavioral medicine, 2021, 11(9), 1691-1698	More than one third of adults in the United States (U.S.) live with multiple chronic conditions that affect their physical and mental health, functional outcomes, independence, and mortality. The COVID-19 pandemic has exposed not only an increased risk for infection, morbidity, and mortality among those with chronic conditions but long-standing health inequities by age, race, sex, and other social determinants. Obesity plus depression represent one such prevalent comorbidity for which few effective integrated interventions exist, prompting concern about the potential for secondary physical and mental health pandemics post COVID-19. Translational behavioral medicine research can play an important role in studying integrated collaborative healthcare approaches and advancing scientific understanding on how to engage and more effectively treat diverse populations with physical and mental health comorbidities. The RAINBOW (Research Aimed at Improving Both Mood and Weight) clinical trial experience offers a wealth of insights into the potential of collaborative care interventions to advance behavior therapy research and practice. Primary care patients with co-occurring obesity and depression were assigned to either Integrated Coaching for Mood and Weight (I-CARE), which blended Group Lifestyle Balance (GLB) for weight management and the Program to Encourage Active Rewarding Lives (PEARLS) for depression, or usual care, to examine clinical, cost-effectiveness, and implementation outcomes. This commentary highlights the empirical findings of eight RAINBOW research papers and discusses implications for future studies, including their relevance in the U.S. COVID-19 context. Organized by key principles of translational behavioral medicine research, the commentary aims to examine and embrace the heterogeneity of baseline and intervention response differences among those living with multiple chronic conditions. We conclude that to prevent health and healthcare disparities from widening further, tailored engagement,

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				dissemination, and implementation strategies and flexible delivery formats are essential to improve treatment access and outcomes among underrepresented populations.
72	Technical report: the impact of Extensive Care Service and Enhanced Primary Care in Fylde Coast	VESTESSON Emma, et al	Health Foundation 2020	An evaluation of the early impact of two complementary integrated care team initiatives developed in the Fylde Coast NHS vanguard, the Extensive Care Service (ECS) and Enhanced Primary Care (EPC), aimed at adults with complex chronic care needs. ECS focuses on serving older people with more comorbidities, requires patients to de-register with their GP and subsequently replaces usual GP care with a coordinated and specialist multidisciplinary team. EPC supports an individual's existing GP relationship, where they have been identified as potentially benefiting from wrap-around multidisciplinary care such as health coaching. The two services were designed to be complementary, serving somewhat different patient populations and with EPC serving as a 'step-down' bridge between ECS and routine primary and community care. The analysis has found that ECS and EPC patients were admitted to hospital in an emergency respectively 27% and 42% more often compared with their matched control group. Similar trends have been also found across other measures of hospitalisation. However, due to observable differences remaining between these groups, the study could not conclude that this was a direct causal effect of the new initiatives. The findings are consistent with previous studies and experience of ICTs in the UK and in other developed health care settings. Implementation of such services may require a longer time period to reduce population-wide admissions and attendances, as unmet medical need is initially identified and treated among high risk patients by MDT professionals. As more multidisciplinary teams are established across England, further research is needed to understand why they are not having the anticipated effect on emergency hospital use.
73	Does integrated health and care in the community deliver its vision? A workforce perspective	Wain, Linda Marie	Journal of Integrated Care; Brighton Vol. 29, Iss. 2, (2021): 170-184.	Purpose The purpose of this paper is to explore and capture workforce perceptions, experiences and insights of the phenomena of integrated care (IC) in a community health and care NHS trust in England; including whether there are any associated factors that are enablers, barriers, benefits or challenges; and the level of workforce engagement in the process of integrated health and care. Design/methodology/approach A qualitative design based on an interpretivist research paradigm was used with a purposive sampling technique. Five in-depth semi-structured interviews were conducted with community nursing, social workers and allied health professionals. Colaizzi's (1978) descriptive phenomenological seven-step method was applied to analyse data, with the

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				emergence of 170 significant statements, 170 formulated meanings and 8 thematic clustering of themes to reveal 4 emergent themes and 1 fundamental structure capturing the essential aspects of the structure of the phenomenon IC. Findings This study revealed four interdependent emergent themes: (1) Insight of IC and collaboration: affording the opportunity for collaboration, shared goals, vision, dovetailing knowledge, skills and expertise. Professional aspirations of person-centred and strength-based care to improve outcomes. (2) Awareness of culture and professionalism: embracing inter-professional working whilst appreciating the fear of losing professional identity and values. Working relationships based on trust, respect and understanding of professional roles to improve outcomes. (3) Impact of workforce engagement: participants felt strongly about their differing engagement experience in terms of restructuring and redesigning services. (4) Impact of organisational structure: information technology (IT) highlighted a barrier to IC as differing IT platforms prevent interoperability with one system to one patient. Shared positivity of IC, embracing new ways of working. Originality/value This study proposes considerations for future practice, policy and research from a local, national and global platform, highlighting the need for any IC strategy or policy to incorporate the uniqueness of the “voice of the workforce” as a key enabler to integration developments, only then can IC be a fully collaborative approach.
74	Exploration of interaction and shared care arrangements of generalist community nurses and external nursing teams in a rural health setting	Woodhouse G	Australian Journal of Advanced Nursing (AUST J ADV NURS), Mar-May2009; 26(3): 17-23. (7p)	Objective The purpose of this pilot study was to determine the understanding of nurses within a shared care model and the degree of interaction evident in their practice in the shared care nursing environment in a rural care setting. Sharing of care between different nursing teams can allow for the improved use of minimal resources available in rural communities. The objectives of the research were firstly, to identify the interactions of nursing teams in a shared care model and secondly, to determine how shared care is evident in their practice. The final objective was to draw attention to the importance of shared care models in rural health settings and to develop recommendations to support shared care models. Design A qualitative, non experimental, grounded theory descriptive study was used in this research. Setting Primary care Subjects The sample comprised the generalist community health team, which consisted of registered nurses with more than 5 years post registration experience in community health nursing and two external nursing teams, comprised of a palliative care team and an aged care team. Main Outcome

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				Measures Identification of the nursing interactions and shared care practices in order to develop recommendations to foster and support shared care models in changing health structures. Results The study generated four themes: a lack of understanding of each teams' roles; difficulties in communication of information; the importance of setting shared goals in care planning; and the need for collaboration to ensure clarity in case coordination. Conclusion Results suggest that confusion around role, skills, communication, care planning and coordination of care within a shared care model are creating barriers to effective sharing of care. Co-location of services should enhance sharing of care. These results should facilitate the development of care approaches that maximise health outcomes and contribute to a better understanding of collaborative processes that can assist in the provision of health care in rural settings.