

**Independent Evaluation of the IoW Vanguard My Life a Full Life [MLaFL] Integrated Locality Services**

**Using the Normalisation Process Theory [NPT] framework to evaluate a new care model [NCM] and its team**

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Disclaimer

This report presents the findings of an independent evaluation comprising a non-participant observation of a multi-disciplinary team meeting, a survey and a focus group undertaken with the ILS teams in South Wight and North East and Ryde. The findings and interpretations in this report are those of the author and do not necessarily represent the views of the ILS teams and other partners involved in the implementation and evaluation of the Isle of Wight Vanguard My Life a Full Life.

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**Abstract**

**Background**

In line with the Five Year Forward View (NHS England, 2014), MLaFL aims to offer person centred care and support based on multi-specialist teams and GP clinical leadership to achieve prevention-based improved health and well-being outcomes that encourages self-care.

**Aims and objectives**

The team evaluation sought to understand the experience of the staff involved in developing and delivering the implementation of ILS to understand the extent to which the team was able to embed the implementation of ILS in daily routine practice in a long term sustainable way and to ascertain the extent to which the team was effective and the goals of the ILS were felt to have been achieved.

**Methods**

The conceptual framework was mixed methods (Plowright, 2015) informed by Normalisation Process Theory (May and Finch 2009), Force Field Analysis (Lewin, 1949; 1951) and Alexander (1985) team effectiveness as well as the MLaFL ILS Logic Model. Data collection took place in 2 different sites South Wight [ILS1] and North East Ryde [ILS2] and took the form of non-participant observation of a regular multi-disciplinary team meeting [MDT] [n=7 and n=11), a focus group that took place directly following the MDT (n=7 and n=8), which included an anonymous survey and brainstorming and a ranking exercise. Data were analysed numerically using the NPT framework (May and Finch, 2009) and thematic analysis (Braun and Clarke, 2006).

**Results**

For both localities a number of key enabling factors were identified: teamwork/joint working with other agencies; person- centred care/helping people and less time from referral to action. Other key factors were progress in clarity of processes [ILS 1] and less time from referral to action [ILS2]. Optimal implementation of ILS was felt to be inhibited by a number of restricting factors: lack of time/capacity re MDT due to competing demands; unclear roles/processes; lack of buy in from other agencies, including little involvement from GPs and nurses [ILS1] and lack of funding [ILS2]. Team members strongly agreed they felt valued as team members, that they communicated effectively with each other, and that ILS meetings were productive with agreed actions. Most goals received positive or highly positive scores with team members agreeing or strongly agreeing that ILS team goals had been met. Although the ILS NCM was *not completely there yet about saying your story only once*, top scores were given for improved identification of safeguarding issues and more opportunity for shared learning from colleagues from different professions. Focus group discussions similarly underlined that ILS NCM had played a key role in supporting multi-agency working across the South Wight and North East and Ryde localities. The very few less positive NPT scores concerned resources, training and support. Most scores were positive. The highly positive scores showed strong agreement that the ILS NCM was worthwhile, team members valued the effect of ILS on their work and were open and willing to work in new ways. Cognitive engagement and reflexive monitoring were the NPT domains with the highest overall average scores showing a very good level of buy in from team members and experiential learning and reflection.

**Conclusion**

This was a pragmatic evaluation of a small pilot implementation of a NCM in a real life setting using a mixed methods approach with a validated conceptual framework demonstrated that, although collective action could benefit from improvement, ILS 1 and ILS 2 appeared to be effective and were on track to become embedded in daily routine practice. Both ILS teams had moved from “fragmentation” to “integration”, demonstrating a good potential for sustainability in the long term and being on track to embed the implementation of ILS in a long term sustainable way.

**Recommendations**

As a matter of priority IT problems should be sorted out with better integration across networks and patients’ records management systems. There should be more of a reciprocal process between ILS and senior leadership. The ILS teams should continue to access all available information about ILS and its effects in order to take steps to optimise the effectiveness and worthwhileness of ICT. ILS would be even more worthwhile if it became more fully integrated with a more pro-active approach and include an even greater range of professionals, including GPs.

**Executive summary**

**Key findings**

**Context** The team evaluation sought to understand the experience of the staff involved in developing and delivering the implementation of ILS to understand the extent to which the team was able to embed the implementation of ILS in daily routine practice in a long term sustainable way. Data collection took place in 2 different sites South Wight [ILS 1] and North East Ryde [ILS 2]: non-participant observation of a regular MDT [n=18 (7+11)]; focus group and survey [n=15 (7+8)].

**Barriers and drivers** For both ILS 1 and ILS 2 taken together (n=15), top key barriers mentioned in both groups were: time/capacity re MDT [26.7%]; unclear roles/processes [26.7%] which made up just over half the votes. Top key barriers for ILS1 were: lack of ‘buy in (from other agencies) [42.8%, lack of time/capacity (competing demands on staff) [23.8%] and unclear processes/roles (especially at the beginning) [23.8%] [just over nine tenth of the votes]. Top key barriers for ILS2 were: time/capacity re MDT (competing demands on staff) [29.1%]; lack of funding [29.1%] and unclear roles/processes (especially at the beginning) [29.1%] just under nine tenth of the votes]. See table 8 and fig 2.

For both ILS 1 and ILS 2 taken together, top key drivers were: teamwork/joint working with other agencies [53.3%]; person- centred care/helping people [28.9%] [approximately four fifth of the votes]. Top key drivers for ILS1 were: team work/joint working with other agencies [57.1%]; helping people [28.5%] and progress with clarity of process [14.3%] [100% of the votes]. Top key drivers for ILS 2 were: Team work/joint working with other agencies [50%]; person-centred care [29.1%]; less time from referral to action (quicker care pathways) [16.75] [nearly 100% of the votes].

**Team effectiveness**  Out of 5 team effectiveness questions, none received an overall score of less than 8.7. The overall average for all five effectiveness question for ILS 1 and ILS 2 together was a highly positive 9 [9.6 and 8.4]. Team members strongly agreed they felt valued as team members [9.2] [10 and 8.3], that they communicated effectively with each other [9.0] [9.4 and 8.6] and that ILS meetings were productive with agreed actions [9.5] [9.7 and 9.2].

**Goals** Most goals received positive or highly positive scores with team members agreeing or strongly agreeing that ILS team goals had been met [8.3] [8.6 7.9]. Although ILS NCM was *not completely there yet about saying your story only once* [7.2] [7.4 and 7.0] top scores were given for improved identification of safeguarding issues [9.1] [9.4 and 8.8] and more opportunity for shared learning from colleagues from different professions [9.4] [10 and 8.8], indicating that through closer working patterns and a more integrated approach, ILS staff were communicating more with and learning more from colleagues from different professions. Focus group discussions similarly underlined that ILS NCM had played a key role in supporting multi-agency working across the South Wight and North East and Ryde localities.

**NPT questions** There were no negative average scores and only three slightly positive scores, all concerning resources, training and support. All other questions were positive with the top 3 questions receiving highly positive scores: team members agree that ILS is worthwhile [reflexive monitoring] [9.4] [9.2 and 9.5]; team members value the effect of ILS on their work [reflexive monitoring] [9.3] [9.0 and 9.5]; and team members are open and willing to work in new ways [cognitive engagement] [8.9] [8.9 and 8.8]

**NPT domains** Reflexive monitoring was the top scoring NPT domain [8.8] for both ILS 1 and ILS 2 followed by cognitive engagement [8.5], coherence [8.3] and collective action [7.2]. This demonstrates a high level of buy in and the ability to turn experiential learning into knowledge which reflects discussion in the focus groups where team members, especially ILS 1, indicated that experiential learning through reflection was the consequence of being left without much guidance and support from senior managers. Bearing in mind that restricting factors about resources, support and training pulled the average down and are not under the control of team, and although collective action could benefit from improvement, ILS 1 and ILS 2 appeared to be effective and on track to become embedded in daily routine practice, thus having moved from “fragmentation” to “integration” and demonstrating a good potential for sustainability in the long term.

**Benefits and limitations** This pragmatic evaluation undertaken with limited resources benefitted from a mixed methods approach with a validated conceptual framework [NPT] and three different data collection methods: non-participant observation, survey and structured focus group, including brainstorming and ranking exercise. Some of team members who took part in the focus group and survey subsequently took part in semi-structured interviews starting one week after ILS 2 and three weeks after ILS1. The team evaluation is likely to have ‘activated’ team members prior to the semi-structured interviews in which up to 9 team members that attended ILS1 or ILS2 also took part.

**Recommendations**

Recommendations based on suggestions from participants for improving/developing ILS are:

* Improve IT and IT support
* Ensure better integration across networks and patients’ records management systems
* Work on achieving the involvement of a wider range of health and social care professionals (especially ILS 1)
* Work towards ensuring that employers of HCPs involved in ILS share the ILS vision
* NHS and the Vanguard programme management should ensure better resources to support ICT.
* Make it more of a reciprocal process between ILS and senior managers
* Work towards making ILS even more fully integrated and adopt a more pro-active approach

The ILS teams should continue to access all available information about ILS and its effects in order to take steps to optimise the effectiveness and worthwhileness of ICT.

1. **Introduction**

**1.1. Background**

**Who is organising and funding the study**

The Isle of Wight Clinical Commissioning Group [IoW CCG] is funding Wessex Academic Health Science Network (Wessex AHSN) to undertake the overall evaluation of MLaFL, including the Integrated Locality Services [ILS]. Wessex AHSN is working with the Centre for Implementation Science at the University of Southampton to undertake the present team evaluation as part of the overall evaluation of the ILS.

**My Life a Full Life [MLaFL]**

My Life a Full Life [MLaFL][[1]](#footnote-1) is an integrated Primary and Acute Care Systems vanguard site [PACS]. Vanguard sites are tasked with improving the health of local people by piloting New Care Models [NCMs] that involve working with partners to see how care can be provided in a better and more sustainable way in the future. Isle of Wight CCG has pockets of deprivation and inequality linked to less favourable health outcomes. In line with the Five Year Forward View (NHS England, 2014), MLaFL aims to offer person centred care and support based on multi-specialist teams and GP clinical leadership to achieve prevention-based improved health and well-being outcomes that encourages self-care. The MLaFL operational model has four key components: integrated commissioning, which consolidates all the commissioning function across the system; integrated provision through a single point of access; support in the community; and integrated corporate functions that support commissioning and provision.

**Integrated Locality Services**

There have been a number of international and national drivers that support the rationale for the design of services such as ILS. Recommendations have been made internationally and nationally for a more collaborative approach and greater partnership working to provide person centred care, greater efficiency, improved health and well-being outcomes and quality of life for all (Wanless et al, 2004; Cameron and Lart, 2003; Banks, 2004; Williams and Sullivan, 2010; Ham and Curry, 2011; Rand Europe and Ernst and Young, 2012; NHS England, 2014, 2014b; Robertson et al, 2014; NHS Confederation et al, 2016).

Currently, services on the IoW work in structures specific to their profession, with only pockets of services working together to join up a person’s care. The development of a strong and sustainable community service offer is key to supporting people to achieve their desired outcomes in the least intensive setting possible. Health and social care organisations on the Island have therefore committed to the locality model and developed the ‘Integrated Locality Services’ (ILS) to bring together disparate services in the community based around the people they care for. According to the ILS logic model, the aim of the ILS model is to be successful in achieving the five key outcomes below:

* + People will receive improved quality of appropriate and holistic care, as part of ‘business as usual’ for community services.
	+ People will remain independent in their day-to-day lives.
	+ People will have greater involvement in planning their own care.
	+ People will no longer have to repeat information with multiple services.
	+ People will remain in their own home for longer.

The aim of developing and implementing the ILS is to provide more joined-up care by enabling existing community staff to communicate and work in a more integrated effective way. The ILS model of care will provide a more streamlined access route to community health and social care, and result in a more co-ordinated approach from multiple providers.

Benefits to people requiring community services:

* + Review of needs and creation of subsequent care plan carried out simultaneously by all services involved in their care, leading to a more holistic approach and as a result better outcomes.
	+ A more efficient approach to delivery of care, leading to a reduction in the number of times a person has to repeat conversations about their health and wellbeing to professionals.
	+ Reduction in the number of visits from services and the total number of services involved in their care.
	+ One point of contact.

Benefits to the staff already working in the community:

* Staff will have improved sight of who else is involved in delivering care for the people on their caseloads, enabling them to link in with other teams and take a more co-ordinated approach where beneficial.
* Improved identification of safeguarding issues.
* More opportunity to communicate with and learn from colleagues from different professions, through closer working patterns.
* Where an individual requires multiple referrals, the referrer (in the first instance this would be a community staff member or a GP) will be able to refer into a single point of access which encompasses all community services (the current main point of access only encompasses some services and the services not included often have their own point of access).

Implementation will be phased to monitor how the ILS operates in practice and adapt the ILS model as required. Phased implementation across the three localities also provides an opportunity for learnings from one locality to be incorporated into the next. At present the following three phases have been identified:

* + Phase one – core community services required to improve integration and co-ordination of community health and social care.
	+ Phase two – inclusion of a wider range of additional community services over an extended period of time.
	+ Phase three – involves the movement of services currently delivered in an acute settings to the ILS.

**1.2. Purpose of the evaluation**

The team evaluation sought to understand the experience of the staff involved in developing and delivering the implementation of ILS to understand the extent to which the team was able to embed the implementation of ILS in daily routine practice in a long term sustainable way and to ascertain the extent to which the team was effective and the goals of the ILS were felt to have been achieved.

1. **Methods**
	1. **Conceptual framework**

Normalisation Process Theory[[2]](#footnote-2) (NPT) is a validated instrument that has been widely used to evaluate quality improvement interventions in health care. The focus is on factors (beliefs and behaviours) that promote or inhibit (enablers and barriers) the implementation of an intervention, in this case the ILS.

The four key components of the theory are: coherence, cognitive participation, collective action and reflexive monitoring (May and Finch, 2009, p539):

1. **Coherence or sense making**: the mobilisation of a practice – how it is conceptualised and held together in action
2. **Cognitive engagement**: participation in a practice – how members decide to engage and actually engage
3. **Collective action**: enacting a practice – how the work is organised and activities structured and constrained
4. **Reflexive monitoring**: the appraisal of a practice – how it is appraised and the effects of appraisal, i.e how it is ‘understood’ and what changes the team make in response to appraisal and feedback

The starting point of NPT is to understand the embedding of a practice i.e. what people actually do and how they work together. NPT provides an explanatory framework to better understand the routine embedding of healthcare interventions in their social contexts and *why some processes seem to lead to a practice becoming sustained over a long term while others do not* (May and Finch, 2009, p539).

The NPT derived NoMAD instrument [20 NPTquestions] (Finch et al, 2013, 2015). Because of its predictive potential in respect of the extent to which a quality improvement intervention is likely to become routinely embedded, NPT is ideally suited as a framework to evaluate an intervention a few months after the start of its implementation as the ‘diagnostic’ dimension of NPT can provide an effective way to identify enablers and barriers so as to enable taking steps to overcome potential barriers or optimise the intervention.

Although May and Finch (2009) make no claim of absolute predictive power for NPT, within certain limits, the extent of sustainable long term embedding can be projected.

The conceptual framework was also informed by Force Field Analysis (Lewin, 1949; 1951) of enabling and restraining forces (drivers and barriers) in respect of the implementation process and Alexander (1985) team effectiveness as well as the MLaFL goals articulated in the Logic Model.

* 1. **Scope and design, data collection and sampling,**

The design involved mixed methods by way of two primarily qualitative data collection methods (non-participant observation and focus group) and a primarily quantitative data collection method (survey) to help make findings more robust and claims from the findings more warrantable (Plowright, 2015).

On its own or alongside other data collection methods, non-participant observation often reveal characteristics of groups that would have been difficult to discover by other means (Bell, 2002). Using an activity based structured focus group enabled the collection of quantitative data by way of survey and brainstorming and ranking exercise, which will help provide both depth and detail on the questions of interest (Smithson 2007; Hammersley, 2013). The structured focus group was supplemented by non-participant observation which took place before the focus group.

A researcher undertook a non-participant observation of the weekly multi-disciplinary team meeting [MDT] on 9 November in South Wight and on 21 November in North-East Ryde and took notes, focussing on what might provide insights in relation to the four domains of the NPT framework. The MDT on 9 November in South Wight Locality or ILS1 (n=7) lasted one hour. The MDT in North East Ryde Locality or ILS2 on 21 November (n=11) lasted one hour and twenty minutes.

The researcher then facilitated the structured focus group that immediately followed the MDT. The focus group lasted 50 minutes in the South Wight Locality (n=7) and 35 minutes in the North East Ryde Locality (n=8).

*Table 1: Composition of MDT, focus group and survey samples for ILS1*

|  |  |  |  |
| --- | --- | --- | --- |
| **Locality** | **MDT**  | **Focus Group****(+ ranking exercise)** | **Survey** |
| **South Wight****ILS 1****9 Nov 2017** | MDT co-ordinatorManager Adult and Social Care South Wight Locality [chaired MDT] Social workerCare Navigator [CN]Fire and Rescue service [NE Ryde Locality Manager]Adult Safeguarding Local Area Co-ordinator [LAC]  | MDT co-ordinatorManager Adult and Social Care South Wight Locality [chaired MDT] Social workerCare Navigator [CN]Fire and Rescue service [NE Ryde Locality Manager]Adult Safeguarding Local Area Co-ordinator [LAC]  | MDT co-ordinatorManager Adult and Social Care South Wight Locality [chaired MDT] Social workerCare Navigator [CN]Fire and Rescue service [NE Ryde Locality Manager]Adult Safeguarding Local Area Co-ordinator [LAC]  |
|  | **7** | **7** | **7** |

*Table 2: Composition of MDT, focus group and survey samples for ILS1 and ILS2*

|  |  |  |  |
| --- | --- | --- | --- |
| **North East and Ryde****ILS2****21 Nov 2017** | Care Manager NE Ryde Locality [chaired MDT] [laptop]Assistant Manager re-ablement Lead Social Worker NE Ryde Locality Lead Care Navigator [Age UK] Local Area Co-cordinator [LAC]Fire and Rescue service [NE Ryde Locality Manager]Fire and Rescue service officer [Community Fire Safety] Well-Being Advisor Social Work/Adult Safeguarding [NE Locality Manager]Police Community Support officerOT Crisis Response  | Care Manager NE Ryde Locality [chaired MDT] [laptop]Assistant Manager re-ablement Lead Social Worker NE Ryde LocalityLead Care Navigator [Age UK] Local Area Co-cordinator [LAC]Fire and Rescue service [NE Ryde Locality Manager]Fire and Rescue service officer [Community Fire Safety] Well-Being Advisor  | Care Manager NE Ryde Locality [chaired MDT] [laptop]Assistant Manager re-ablement Lead Social Worker NE Ryde LocalityLead Care Navigator [Age UK] Local Area Co-cordinator [LAC]Fire and Rescue service [NE Ryde Locality Manager]Fire and Rescue service officer [Community Fire Safety] Well-Being Advisor  |
|  | **11** | **8** | **8** |

*Table 3: Sample of ILS team members that were also interviewed*

|  |  |  |  |
| --- | --- | --- | --- |
| **ILS teams** | **Locality** | **Range of roles** | **Interview dates** |
| 4 | North East | Fire, Social Work, Safeguarding, LAC, CN, Manager + not disclosed.  | 28.11 – 05.12.2017 |
| 5 | South | 30.11 – 07.12.2017 |

Some of team members who took part in the focus group and survey also took part in semi-structured interviews starting a week following ILS 2 for one week and starting three weeks following ILS1 for one week. See table 3. The focus groups and surveys are likely to have acted as ILS team members’ activation prior to the semi-structured interviews in which up to 9 team members that attended ILS1 and ILS2 also took part.

At the beginning of the focus group participants undertook an anonymous paper based survey based informed by the conceptual framework which took approximately 10 minutes to complete (See appendix 1 focus group schedule and appendix 2 survey questions).

Participants n=7 for South Wight Locality and n=8 for North East and Ryde Locality were asked to rate each question on a scale of 1-10 where 1=not at all agree and 10=completely agree. Negative scores start at 5.4 since 5.5 is the mid-point. Average scores between 5.5 and 6.9 are slightly positive and require attention. Average scores between 7 and 8.9 are positive. Average scores above 9 are highly positive.

Participants then undertook a brainstorming and ranking exercise seeking to identify enabling forces (drivers) and restricting forces (barriers) in relation to their experience of the implementation of ILS. The items were put into categories by the researcher who then asked team members to distribute 3 votes on what they believed to be the most important categories of drivers and then barriers.

As a final opportunity to participate for those who could not attend, after each focus group the electronic link (SurveyMonkey) for the same anonymous survey was circulated to the team by the ILS MDT co-ordinator. This generated no additional responses.

* 1. **Data analysis**

Quantitative data were analysed numerically and trends analysed using SPSS 24. Key themes within qualitative data were identified using NPT (May and Finch, 2009) and thematic analysis (Braun and Clarke, 2006).

* 1. **Ethical issues**

The study obtained ethics approval from the University of Southampton UoS Ethics: 26528. Informed consent, data management, data protection, confidentiality and anonymity are aligned with UoS policy. As this is a service evaluation of the ILS on behalf of IoW CCG, the latter arranged that the researcher could use the usual meeting rooms in which the weekly operational meetings took place to conduct the non-participant observations of the MDTs and structured focus groups. Hence, there was no need for R&D approval to be sought and obtained. The researcher was independent and had no prior relationship with the participants. The researcher satisfied the requirements of IoW CCG including a letter of access for research.

1. **Results**

Both ILS 1 and ILS2 MDTs were chaired by a Locality Manager. In both ILS1 and ILS2 the MDT was based on going through a list of people on the case load or who had been added to the case load or who could be added to the case load. The discussion focussed on providing updates i.e. what was known and who had done what and planning the next steps. All took part in the discussion and asked relevant fact finding questions to clarify matters. All made suggestions in relation to potential next steps.

The chair for ILS 2 or MDT co-ordinator for ILS1 had a computer or laptop to access healthcare information/records about those whose case was discussed during the MDT. In each of ILS1 and ILS2 a Social Worker had access to social care information/records of those discussed. The MDT co-ordinator for ILS1 and the Locality Manager for ILS2 updated information and recorded action points. Approximately 10-12 people were on the case load for each of ILS1 and ILS2. The MDT for ILS1 provided a printed version of information/updates/action points in relation to people on the caseload who were to be discussed during the MDT.

* 1. **Coherence**

Table 4 summarises the survey results for the area of ‘coherence’ or sense-making i.e. how ILS is conceptualised and held together in action. All the average coherence scores were positive for both localities. The overall average score for coherence was 8.3 [8.4 for ILS1 and 8.2 for ILS2]. The range of scores was 7.5-8.9 [8.3-8.9 for ILS1 and 7.5-8.8 for ILS2].

The difference between the highest and lowest individual score for each question was relatively small [3.6pts] [2.5-4.5pts] with a slightly wider range for ILS1 [2-5pts] than for ILS2 [2-4pts], which shows that responses are more united than polarised, especially the responses for the question that obtained the highest score [q4].

Team members had a shared understanding of the purpose of ILS and of specific responsibilities required [8.3] [8.3 and 8.3] and could see the potential value of ILS for their work [8.6] [8.9 and 8.3]. ILS1 had a greater belief in the potential value of ILS. Team members understood how ILS affected the nature of their work [7.9] [7.7 and 8.8]. ILS 2 seemed to have a greater understanding than ILS1.

The greatest difference between the localities was for ILS is distinct from previous ways of working [8.1] [8.7 and 7.5]. Both were positive response. ILS 2 thought ILS was more similar than different from previous ways of working than did ILS 1. Taking ILS 1-2 together the highest average score was for team members see the potential value of ILS for their work 8.6 [8.9 and 8.3], suggesting a good potential for ILS1 and ILS2 and especially ILS 1to become embedded in daily routine practice.

*Table 4*: Survey results for ‘coherence’ [Not at all agree =1 completely agree=10]

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Coherence/****sense-making** | **ILS 1 Average score (n=7)** | **ILS2** **Average score (n=8)** | **ILS 1+2****Average score****n=15** | **ILS 1 Difference****+/- score** **(n=7)** | **ILS2** **Difference****+/- score** **(n=8)** | **ILS 1+2** **Difference****+/- score** **(n=15)** |
| 1. ILS is distinct from previous ways of working
 | 8.7 | 7.5 | 8.1 | 5pts | 2pts | 3.5pts |
| 2. Team members have a shared understanding of the purpose of ILS and of specific responsibilities required  | 8.3 | 8.3 | 8.3 | 5pts | 3pts | 4.0pts |
| 3. Team members understand how ILS affects the nature of their work  | 7.7 | 8.8 | 7.9 | 5pts | 4pts | 4.5pts |
| 4. Team members can see potential value of ILS for their work  | 8.9 | 8.3 | 8.6 | 2pts | 3pts | 2.5pts |
| **Overall averages** | **8.4** | **8.2** | **8.3** | **4.3pts** | **3pts** | **3.6pts** |

Survey results are in line with the findings of the non-participant observation of the MDTs and focus groups and showed a positive level of coherence or sense-making.

During both MDTs [ILS 1 and 2], various team members accessed information by way of laptops about those on the caseload in order to update the rest of the team about progress. Team members who had recently visited those on the caseload i.e. one or two days previously, provided up to date information, some of which was not yet recorded but was added to the notes of the MDT meeting.

To improve clarity of processes, the MDT for ILS1 provided a print out with updates about various type of information in relation to those on the caseload or those who could be added to the caseload (name; place; review date; weekly progress; outcomes; care pathway providers; lead professional; date of referral; actions; care plans; implied consent; and written consent).

Both focus groups indicated that at the beginning there had been a lack of clarity and guidance about ILS roles and responsibilities which had had to be worked out by the team members themselves as the implementation progressed. Communications about ILS from those in senior leadership positions had been muddled and confused and they had offered little in the way of guidance and support. However, *the various roles and the purpose of ILS had become clearer over time as we went along* [ILS co-ordinator, ILS 1].

New team members took time to understand the complexity of the roles and the purpose of ILS. *I don’t have a clear idea of all the roles within ILS and because I have only recently become involved, I am still finding out about roles of various team members* [Fire and Rescue 2, ILS2]. The open and flexible collective approach facilitated their integration into the ILS teams. *Although new to the group, I have found all members to be open in explaining the ways in which they can be involved and in collectively agreeing action plans and roles and responsibilities of members* [Fire and Rescue, ILS1]

Both purpose and roles had evolved to match the needs of those on the caseload who may not always have fitted the expected criteria which were seemingly adjusted or redefined over time. *We’re walking into this more and more. There’s a gap here. We need some funding for this.* [Fire and Rescue 1, ILS2] and *We can’t help much right now. We need to work out pathways so we can take some of these cases forward*. [Care Navigator, ILS2].

The MDT in each of ILS 1 and ILS2 was driven by person-centred approach and, if necessary, a willingness to push boundaries to best meet the needs of the people on the ILS caseload. The potential value of ILS was felt not to have been fully realised insofar at *some team members are yet to be convinced* [Social Work Lead ILS1] and *Coherence would be 10 if team grew to potential i.e. other agencies and organisations joined* [LAC, ILS1].

In neither ILS 1 nor ILS 2 were GPs involved and they did not attend the weekly MDTs. While both ILS 1 and ILS 2 included one or more paramedic professionals, LACs and CNs, social work, adult and social care professionals, ILS 2 had a larger team and a wider range of HCPs or allied professionals than ILS 1 i.e. community police and occupational therapists.

The ILS1 MDT discussed that although there had been a few referrals from Community Pharmacists, to date not much work had been done directly with GPs who were not getting involved with ILS. A GP has recently used a newly introduced referral inbox to refer to ILS someone with eczema. The MDT decided that this person really needed to have been referred to the district nurse for eczema rather than to the ILS. However, the person had anxiety or any other problems beside eczema, the ILS MDT would pick this up. The GP would be informed of this. The set criterion for referral to ILS was: *once patients are stable we need a first response referral and we can pick things up if required.* [Locality Manager, ILS1]

* 1. **Cognitive engagement**

Table 3 shows the results for ‘cognitive engagement’ or how team members decide to engage and actually engage with ILS. All the average coherence scores were positive for both localities with one question highly positive [q6]. The overall average score for coherence was 8.5 [8.5 for ILS1 and 8.5 for ILS2].

The range of scores was 8.1-8.9 [7.8-8.8 and 8.1-8.9]. The difference between the highest and lowest individual score for each question was relatively small but slightly higher than for coherence [4.0pts] [3.5-4.5pts] with a slightly wider range for ILS1 [4-5pts] than for ILS2 [3-4pts], which shows that responses are more united than polarised, especially the responses for the question that obtained the highest score [q6].

*Table 5: Survey results for ‘cognitive participation’* [Not at all agree =1 completely agree=10]

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Cognitive engagement**  | **ILS 1 Average score (n=7)** | **ILS2** **Average score (n=8)** | **ILS 1+2****Average score****n=15** | **ILS 1 Difference****+/- score****(n=7)** | **ILS2** **Difference****+/- score****(n=8)** | **ILS 1+2** **Difference****+/- score****(n=15)** |
| 5. Key individuals drive ILS forward and get others involved  | 8.4 | 7.8 | 8.1 | 4pts | 4pts | 4pts |
| 6. Team members are open and willing to work in new ways  | 8.9 | 8.8 | 8.9 | 4pts | 3pts | 3.5pts |
| 7. Team members believe that contributing to ILS is a legitimate part of their work  | 8.3 | 8.0 | 8.2 | 5pts | 4pts | 4.5pts |
| 8. Team members continue to support ILS | 8.3 | 8.3 | 8.3 | 5pts | 3pts | 4.0pts |
| **Overall averages** | **8.5** | **8.5** | **8.5** | **4.5pts** | **3.5pts** | **4.0pts** |

All the average cognitive engagement scores were positive and some highly positive for both localities. The overall average score for coherence was 8.5 for both ILS1 and ILS2. The range was 8.3-8.9 for ILS1 and 7.8-8.8 for ILS2. This was higher than for coherence [8.3] [8.4 and 8.2].

In both ILS 1 and ILS 2 team members agreed that individuals drove ILS forward and got others involved [8.1] [8.4 and 7.8] and that contributing to ILS was a legitimate part of their work [8.2] [8.3 and 8.0]. The former was also the question that showed the greatest difference between ILS1 and ILS2 with scores of 8.4 and 7.8 respectively. Key individuals driving things forward are associated with effective leadership and a high level of buy in within teams.

Team members in both ILS1 and ILS2 provided very similar scores for contributing to ILS is a legitimate part of their work [8.2] [8.3 and 8.0] and team members continue to support ILS [8.3] [8.3 and 8.3]. The question that received the highest level of agreement in both groups and also very similar scores was team members are open and willing to work in new ways [8.9] [8.9 and 8.8]. The scores for this question are highly positive and are likely to reflect flexibility and adaptability to change which makes embedding the ILS new care model [NCM] in routine practice more likely than not.

The results of the survey are in line with the findings of the non-participant observation of the MDT and focus group and showed positive to very positive levels of cognitive participation.

Contributing to ICT meant attending the weekly MDT on the same day, same time and same place each week. Most of those on the ILS caseload were on-going cases and suffered from one or more of anxiety, depression, eating disorder and or/drinking problem, not taking medication and from more than one chronic or long term conditions. All team members were involved in providing information, discussion, asking questions, making suggestions for the next steps and undertaking actions which usually involved one key team member, but at time the team member would be supported by other team members, if a joint visit or other joint action was required.

In both ILS 1 and ILS2 there was very detailed reporting of those discussed with carefully considered input from all, trying to piece together all information and deciding on what would be the possible and achievable next steps. Team members had in some cased been directly involved in providing practical help to those on the case load i.e. finding warm clothes or in clearing/cleaning up homes. Being involved in ILS meant working in flexible and informal ways. Discussion during the MDTs in both ILS1 and ILS2 demonstrated creative thinking and a breaking down of traditional barriers in order to work towards a more integrated approach.

The localities worked in slightly different ways. ILS1 had a smaller team and the team operated on a consensual basis. ILS 2 had more people attending and they were from a wider variety of backgrounds, including Community Police Support, OT Crisis Response, and Well-Being Advice. It took longer for a consensus to be arrived at.

The flexible nature of ILS and willingness to step in when and as required as well as the responsiveness to the needs of people on the ILS caseload was evidence that team members believed that contributing to ICT was a legitimate endeavor in which they were fully engaged.

* 1. **Collective action**

Table 4 outlines the results for ‘collective action’ or how team members enact the ILS i.e. how the ILS work is organised and activities structured and constrained. For both localities, the average scores for collective action [7.2] [7.4 and 6.9] were less positive than for coherence [8.3] [8.4 and 8.2] and cognitive engagement [8.5] [8.5 and 8.5]. The range of scores was 5.3-8.3 [4.9-8.7 for ILS1 and 5.3-8.3 for ILS2]. The difference between the highest and lowest individual score [5.4pts] [2.5-7.0pts] was bigger than for coherence [4.0pts] [3.5-4.5pts] and cognitive engagement [3.5pts] [3.5-4.0pts] with a wider range for ILS 2 [5.6] [2.0-9.0pts] than for ILS 1 [5.1] [3.0-8.0pts]. This shows that responses for collective action were far less united and far more polarised.

Questions about resources and training obtained the lowest average scores for cognitive engagement with ILS 1 giving a lower (and negative) score than ILS 2 for sufficient resources are available to support ILS [5.3] [4.9 and 5.6] and sufficient training is provided to staff [6.5] [6.3 and 6.6]. The response for the former question obtained the lowest scores for cognitive engagement and the lowest out of all the 20 NPT NoMAD questions for both ILS 1 and ILS2. The response for the latter question was less negative, but only somewhat positive and likewise for the NHS/ Vanguard programme management team adequately supports ILS 6.6 [7.0 and 6.1].

*Table 6*: Survey results for ‘collective action’ [Not at all agree =1 completely agree=10]

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Collective action**  | **ILS 1 Average score (n=7)** | **ILS2** **Average score (n=8)** | **ILS 1+2****Average score****n=15** | **ILS 1 Difference****+/- score****(n=7)** | **ILS2** **Difference****+/- score** **(n=8)** | **ILS 1+2** **Difference****+/- score** **(n=15)** |
| 9. a. ILS can easily be integrated into existing work  | 8.0 | 7.8 | 7.9 | 5pts | 5pts | 5pts |
| 9.b. Team members can easily perform the required tasks | 8.3 | 7.5 | 7.9 | 3pts | 2pts | 2.5pts |
| 10. ILS does not disrupt working relationships | 8.0 | 6.0 | 7.0 | 4pts | 6pts | 5pts |
| 11. Team members maintain their trusts in ILS and in each other | 8.7 | 7.9 | 8.3 | 3pts | 9pts | 6pts |
| 12. ILS work is seen as appropriately allocated to staff who with required skills | 8.0 | 8.3 | 8.2 | 5pts | 3pts | 4pts |
| 13. Sufficient training for ILS is provided to staff | 6.3 | 6.6 | 6.5 | 5pts | 9pts | 7pts |
| 14. Sufficient resources are available to support ILS | 4.9 | 5.6 | 5.3 | 8pts | 5pts | 6.5pts |
| 15. NHS/ Vanguard programme management team adequately support ILS | 7.0 | 6.1 | 6.6 | 8pts | 6pts | 7pts |
| **Overall average** |

|  |  |
| --- | --- |
| **7.4** | 6.9 |

 | **6.9** | **7.2** | **5.1pts** | **5.6pts** | **5.4pts** |

Team members agreed that team members could *easily perform the required tasks* for ILS [7.9] [8.3 and 7.5] and that ILS work could e*asily be integrated into existing work* [7.9] [8.0 and 7.8]. Both ILS1 and ILS2 believed that *work was appropriately allocated to staff who with required skills* [8.2] [8.0 and 8.3]. This question generated the highest average score for collective action for ILS 2. Good scores for these questions make the likelihood of ILS becoming embedded in daily routine practice more likely.

ILS 1 agreed that ILS did not disrupt working relationships [7.0] [8.0 and 6.0] to a far greater extent than did ILS 2. Although both ILS 1 and ILS 2 were of the opinion that team members maintained their trust in ILS and in each other [8.3] [8.7 and 7.9]. ILS 1 agreed to this to a far greater extent than ILS 2. Taking ILS 1 and ILS 2 together, out of all the statements for collective action, maintaining trust in ILS and in each other generated the highest extent of agreement [8.3] and also the highest score for ILS 1 [8.7].

For both ILS 1 and ILS 2, the focus group brainstorming and ranking exercises and discussion mirrored the results of the survey.

**Focus group ILS 1 (n=7) [South Wight locality]**

Table 7 and figure 1 outline the key barrier and driver categories generated during the focus group by the brainstorming and ranking exercise i.e. the number of votes and the percentage of the total number of votes that they represent. Figure 1 illustrates the interplay of key barriers and drivers and the percentage of allocated votes for the top four or five categories. See also appendices 3 and 4 for more details.

The top or most important driver category was ‘Teamwork and joint working’ [57.1% of the votes and 63.7% of items]. The top or most important barrier category was ‘lack of buy in’ [42.8% of the votes and 28.8% of items].

*Table 7: Results of ranking exercise about barriers and drivers for ILS 1*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Driver** **Categories ILS1** | **Number of votes** | **% of votes** | **Barrier** **Categories ILS1** | **Number of votes** | **% of votes**  |
| Team work/joint working with other agencies | 12 | 57.1 | Lack of ‘buy in (from other agencies) | 9 | 42.8 |
| Helping people | 6 | 28.5 | Lack of time/capacity re MDT (competing demands) | 5 | 23.8 |
| Progress with clarity of processes | 3 | 14.3 | Unclear processes/roles (especially at the beginning) | 5 | 23.8 |
|  |  |  | Lack of clarity from senior leadership | 1 | 4.8 |
|  |  |  | IT issues | 1 | 4.8 |
|  | **21** | **100** | **Total**  | **21** | **100** |



*Fig 1 Drivers and barriers ILS 1*

***Restricting factors or barrier categories***

Lack of buy in (from other agencies) [9 votes out of 21 or 42.8% of the votes and 6 out of 21 or 28.8% of the items]

This was the top barrier category or top key barrier. It was about the fact that GPs were not involved and professionals from other agencies/community development *eg* police and mental health who were not involved in ILS 1, but had some involvement in ILS 2. The lack of advertisement and lack of information about what community and community services could offer and the fact that there was no real dedicated or devolved budget to tap into prevented buy in*.* It was disappointing that *wider support and understanding outside of the ILS team seems lacking* [LAC, ILS 2] and the *support of senior managers to attend the MDT and acknowledge the value of ILS had not been secured* [Social worker, ILS1]

Lack of time/capacity[5 votes or 23.8% of the votes and 19% of items]

This barrier category was in second position and received far fewer votes. Discussion focused on competing demands on time consequent to the capacity of existing workloads, running several roles at once and fitting in regular weekly attendance with an already busy calendar led to some team members only been able to attend one MDT every 3 weeks.

Lack of clarity of processes [5 votes or 23.8% of the votes and 23.8% of items]

The referral process had also been unclear and there had been poor planning prior to starting the ILS and much confusion with team members feeling left to their own devices and having to work through making sense of things and establishing processes and procedures. Team members had struggled with the lack of clarity of processes, especially at the beginning. There was also confusion because ILS and Case Management Process for those at High Risk [CMPHR] were running alongside each other and had a number of elements in common, although GPs were more involved in CMPHR than in ILS.

Lack of clarity from senior leadership[1 vote or 4.8% of votes and 4.8% of items]

Senior leaders had not helped either clarify issues that were confusing or clarify their commitment to ILS in terms of allocation of dedicated resources. ILS 1 had operated largely *through a leap of faith*, especially at the very beginning. Senior managers were not involved on the ground to monitor things and were not well informed of the benefits of the ILS NCM.

IT issues [1 vote or 5% of votes and 19% of items].

IT issues some general and some more specific to ILS 1 were discussed. The IT systems between health and social care were not compatible with team members having limited access. Some team members could access all records and some only GP records or while others could only access health and social care records. The MDT enabled sharing information about those on the ILS caseload, but full access for all team members to all records would have been better. There were also problems with IT equipment and processes, including IT issues in the ILS meeting room, not to mention the difficulty in accessing the building/room.

***Enabling factors or driver categories***

Team work and joint working with partner agencies [12 votes out of 21 or 57.1% of the votes and 14 out of 21 items or 63.7% of items]

Joint working with partner agencies was found to be highly rewarding and motivating. Those who regularly attended the MDT were seen as enthusiastic and dedicated which enabled relationship building between disciplines and collaborative working relationship. All team members believed strongly in the shared vision of preventative person centred work*.* The weeklyMDT was seen as enabling putting faces to names which helped build good working relationships with other agencies and also to facilitate the team’s resilience to the far from ideal amount of ‘buy in’.

Helping people [6 votes or 29% of the votes and 22.7% of items]

Team members believed that undertaking person-centred care working with people who sit outside normal criteria to achieve good outcomes also brought about something beneficial for the whole community. Team members derived great satisfaction from having achieved some great outcomes for individuals. Team members were getting a better at understanding the priority needs of IoW individuals i.e. overall trends may be different to what is known from working in individual services and agencies.

Progress re clarity of processes [3 votes or 14% of the votes and 13.6% of items]

Meeting on a weekly basis round a table for verbal communication about helping achieve good outcomes for people on the ILS caseload did enable meaning and clarity about processes and also enabled to better understand the role of other services or agencies to enable realistic expectations for interventions. Over time the team had put more structured processes in place.

**Focus group ILS 2 (North East and Ryde locality]**

Table 8 and figure 1 outline the key barrier and driver categories generated during the focus group by the brainstorming and ranking exercise i.e. the number of votes and the percentage of the total number of votes that they represent.

Figure 1 illustrates the interplay of key barriers and drivers and the percentage of allocated votes for the top four or five categories. See also appendices 3 and 4 for more details.

The top or most important driver category was ‘teamwork and joint working with other agencies’ [50% of the votes and 50% of items]. The top or most important barrier category was ‘lack of time/capacity’ [29% of the votes and 40% of items]. See table 6 and appendix 4.

*Table 8: Results of ranking exercise about barriers and drivers for ILS 2*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Driver** **Categories ILS2 9n=8** | **Number of votes** | **% of votes** | **Barrier** **Categories ILS2 n=8** | **Number of votes** | **% of votes**  |
| Team work/joint working with other agencies | 12 | 50.0 | Time/capacity re MDT(competing demands on staff) | 7 | 29.1 |
| Person centered care | 7 | 29.1 | Funding (lack of) | 7 | 29.1 |
| Less time from referral to action (quicker care pathway) | 4 | 16.7 | Unclear roles/processes (especially at the beginning) | 7 | 29.1 |
| More freedom (flexibility and autonomy) | 1 | 4.2 | Consent/data management  | 2 | 8.3 |
|  |  |  | IT issues | 1 | 4.2 |
|  | **24** | **100** | **Total**  | **24** | **100** |



*Fig 2 Drivers and barriers ILS2*

***Restricting factors or barriers***

Time/capacity re MDT (competing demands on staff) [7 votes out of 24 or 29.1% of the votes and 6 items out of 24 or 40% of the items]

This key barrier category reduced the optimal value of the ILS NCM. Discussion was about time constraints leading to non-attendance and the difficulty of regularly attending MDTs in view of competing demands on workload due to a very full timetable.

Funding (lack of) [7 votes or 29.1% of the votes and 13.3% of items]

There was no dedicated ILS budget as such and uncertainty of future funding especially in a context of scarce resources (as evidenced in the survey). Another issue was that funding streams for adult social care and health were still separate.

Unclear roles/processes (especially at the beginning) [7 votes or 29.1% of the votes and 26.7% of items]

It was discussed that processes linked to ILS could be confusing and difficult to understand without any induction and training. There was a need for more training and education around ILS and its function. Shared experience of attending the MDT helped, but not all team members could attend on a regular basis. Optimal implementation was felt to be inhibited by insufficient resources. It was emphasised that there was a lack of resources to properly support ILS and that funding streams for adult social care and health were still separate and hence not properly aligned with the more fully integrated ILS approach.

Consent/data management [8.3% of votes and 13.3% of items]

There was uncertainty about how to deal with issues in relation to consent and shared information. There were various types of consent verbal and written consent and explicit and implied consent which were not always straightforward and could lead to confusion.

IT issues [4% of votes and 6.7% of items]

There was a lack of clarity around issues of consent, data sharing and data management as well as inappropriate referrals. The main difficulty was the slow progress on improving processes between health and social care. Difficulties with IT and poor IT support (e.g. problems with Wi-Fi connection) as well as a lack of integration across networks and patients’ records management systems were an on-going issue.

***Enabling factors or driver categories***

Teamwork and joint working with other agencies [12 votes out of 24 or 50% of the votes and 8 out of 16 items or 50%]

The focus was on the benefits derived from this new care model and in particular the MDT partnership to enhance person-centred care. The MDT enabled greater communication and joined up supportive working to provide joint solutions to cases which enabled shared learning about other team members’ roles within and outwith ILS 2. Team members’ primary role was often felt to be improved by better education through shared learning acquired via the ILS work.

Person-centred care[29% of votes and 25% of items]

Team members had a strong belief in person centred care seen as the best way to resolve issues and keep people in their own homes. It also allowed people on the caseload not to have to duplicate their story. However, this was not yet achieved, but was a key aim.

Less time from referral to action [16.7% of votes and 18.8% of items]

By establishing new referral networks /contacts and increasing the understanding of other agencies’ rules and therefore what kind of interventions were possible, the ILS NCM enabled issues to be dealt with in a shorter time frame for the benefit of patients.

More freedom (flexibility and autonomy) [4% of votes and 6.3% of items].

Discussion highlighted that the ILS NCM provided some freedom from the healthcare traditional way of working and especially from the usual adult social care processes. Team members were also able to decide when they would visit people. Therefore, ILS work paradoxically enabled more flexibility and autonomy even though there was more joint multi-agency working for joint solutions.

* 1. **Reflexive monitoring**

Table 9 shows the results for ‘reflexive monitoring’ or how ICT is represented via verbal and written feedback and hence how it is ‘understood’ and the changes the team can make consequent to feedback.

*Table 9*: Survey results for ’reflexive monitoring’ [Not at all agree =1 completely agree=10]

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Reflexive monitoring**  | **ILS 1 Average score (n=7)** | **ILS2** **Average score (n=8)** | **ILS 1+2****Average score****n=15** | **ILS 1 Difference****+/- score****(n=7)** | **ILS2** **Difference****+/- score****(n=8)** | **ILS 1+2** **Difference****+/- score** **(n=15)** |
| 16. Team members can access information about ILS and are aware of the effects of ILS | 7.9 | 7.6 | 7.8 | 6pts | 3pts | 4.5pts |
| 17. Team members agree that ILS is worthwhile | 9.2 | 9.5 | 9.4 | 3pts | 1pt | 2pts |
| 18. Team members value the effect of ILS on their work | 9.0 | 9.5 | 9.3 | 3pts | 2pts | 2.5pts |
| 19. Feedback about ILS can be used to improve it in future | 9.2 | 8.5 | 8.9 | 2pts | 7pts | 4.5pts |
| **Overall average** | **8.8** | **8.8** | **8.8** | **3.5pts** | **3.3 pts** | **3.4pts** |

For both localities, the average scores for reflexive monitoring were higher than for all the other NPT domains. The overall average was a very positive 8.8 [8.8 and 8.8]. The range of scores was 8.7-9.5 [9.4-10 for ILS1 and 7.9-9.2 for ILS2]. The difference between the highest and lowest individual score was very small and far smaller the for the questions about NPT domains [3.4] [2.0 to 4.5pts] with [3.5] [2.0-6.0] for ILS 1 and [3.3pts] [1.0-7.0pts] for ILS 2. This shows that responses for reflexive monitoring are far more united and far less polarised than for the other NPT domains and especially collective action.

Team members could access information about ILS and were aware of the effects of ILS [7.8] [7.9 and 7.6] through attending the MDT and monitoring the progress of those of the caseloads and being aware of the positive impact of their work on those on the caseloads. Although team members agreed that feedback about ILS can be used to improve it [8.9] [9.2 and 8.5], it was felt that ILS was still in the initial stages, so it was perhaps *too early to be engaged in reflection* [LAC, ILS1].

Team members strongly agreed that they valued the effect of ICT on their work [9.3] [9.0 and 9.5] and that ILS was worthwhile [9.4] [9.2 and 9.5]. These two questions obtained the highest scores out of all 20 NPT NoMAD questions.

The worthwhileness of ILS was due in part to getting a better understanding of the priority needs of people and a better understanding of overall healthcare trends on the Isle of Wight. Team members indicated that there were gaps to be addressed where people did not fit the established criteria. Both ILS teams wanted fuller integration and more engagement from nursing staff and GPs as well as from senior management.

* 1. **Team effectiveness**

Table 10 shows the results of the non NPT questions. For both localities, the average scores for team were higher than the highest NPT NoMAD scores for cognitive engagement and reflexive monitoring. The results were highly positive with an overall average of 9.0 [9.6 and 8.4]. Average scores ranged from 8.7 to 9.5 [9.4-10 for ILS 1 and 8.7-9.5 for ILS 2]. The overall average score for team effectiveness [9.0] [9.6 and 8.4] was higher than that of any of the average scores for the NPT domains 8.3 [8.4 and 8.2] for coherence, 8.5 [8.5 and 8.5] for cognitive engagement, 7.2 [7.4 and 6.9] for collective action 8.8 [8.8 and 8.8] for reflexive monitoring.

The difference between the highest and lowest individual score for team effectiveness was smaller than for all other NPT domains [1.5pt] [1pt to 2.5pts] with [1.2pts] [0.0-2.0] for ILS 1 and [1.8pts] [1.0-3.0pts] for ILS 2 indicating more united responses and more team members being on the same page in relation to team effectiveness.

Team members agreed that they could work through and resolve issues [8.8] [9.7 and 7.9] and that the team communicated effectively with other providers [8.7] [9.4 and 7.9]. These questions obtained the greatest unanimity of responses [1pt difference] (except for ILS 1 in responding to I feel valued as a core/extended member of ILS [10]).

Team members strongly agreed that ILS meetings were productive with agreed actions [9.5] [9.7 and 9.2]. Taking ILS 1 and ILS 2 together [9.0], ILS 1 team members strongly agreed that they communicated effectively with each other [9.4] but ILS 2 team members only agreed [8.6]. Taking ILS 1 and ILS 2 together [9.2], ILS 1 team members very strongly i.e. completely agreed [10] and ILS 2 team members agreed [8.3] that they felt valued as team members.

*Table 10: Team effectiveness* [1 not at all agree and 10 completely agree]

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Non NPT questions: team effectiveness** | **ILS 1 Average score (n=7)** | **ILS2** **Average score (n=8)** | **ILS 1+2****Average score****n=15** | **ILS 1 Difference****+/- score****(n=7)** | **ILS2** **Difference****+/- score****(n=8)** | **ILS 1+2** **Difference****+/- score** **(n=15)** |
| 1. I feel valued as a core/extended member of ILS
 | 10 | 8.3 | 9.2 | 0pts | 2pts | **1pt** |
| 1. The ILS team communicate effectively with each other
 | 9.4 | 8.6 | 9.0 | 2pts | 3pts | **2.5pts** |
| 1. ILS meetings are productive with agreed actions
 | 9.7 | 9.2 | 9.5 | 1pts | 1pt | **1pt** |
| 1. The ILS team can work through and resolve issues
 | 9.7 | 7.9 | 8.8 | 1pts | 1pt | **1pt** |
| 1. The ILS team communicates effectively with other providers
 | 9.4 | 7.9 | 8.7 | 2pts | 2pts | **2pts** |
| **Overall average** | **9.6** | **8.4** | **9.0** | **1.2pts** | **1.8pts** | **1.5pts** |

The greatest difference in scores between ILS 1 and ILS 2 was for the ILS team could work through and resolve issues [8.8] [9.7 and 7.9].

The smallest difference and the highest overall score for team effectiveness was for ILS meetings are productive with agreed actions [9.5] [9.7 and 9.2]. Team members underlined that team effectiveness applied to those who regularly attended the MDT.

* 1. **ILS team goals**

Table 11 shows the results of the ILS team goals which also included two questions about benefits to people requiring community services [q2 and q3] as such were key aims of the ILS NCM rather than just focussing on benefits to staff already working in the community. The results were positive with an overall average score of 8.3 [8.6 for ILS 1 and 7.9 for ILS 2].

*Table 11: Extent of achieving ILS team goals* [1 not at all agree and 10 completely agree]

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Non-NPT questions:****ILS team goals** | **ILS 1 Average score all (n=7)** | **ILS2** **Average score all (n=8)** | **ILS 1-2****Average score****n=15** | **ILS 1 Difference****+/-****(n=7)** | **ILS2** **Difference****+/-****(n=8)** | **ILS1-2****Difference****+/-****(n=15)** |
| 1. Community staff communicate and work in a more integrated/co-ordinated way
 | 8.9 | 7.8 | 8.4 | 4pts | 3pts | 3.5pts |
| 1. People have a greater involvement in planning their own care
 | 7.0 | 6.8 | 6.9 | 4pts | 8pts | 6pts |
| 1. People no longer have to repeat information about health and well-being to professionals from multiple services
 | 7.4 | 7.0 | 7.2 | 4pts | 7pts | 5.5pts |
| 1. Ability to refer to a single point of access for all community services
 | 8.0 | 7.8 | 7.9 | 6pts | 5pts | 5.5pts |
| 1. Improved knowledge of who else is involved in delivering care of patients
 | 9.4 | 8.3. | 8.9 | 2pts | 4pts | 3pts |
| 1. Improved identification of safeguarding issues
 | 9.4 | 8.8 | 9.1 | 4pts | 1pt | 2.5pts |
| 1. More opportunity for shared learning from colleagues from different professions
 | 10 | 8.8 | 9.4 | 0pts | 3pts | 1.5pts |
| **Overall average** | **8.6** | **7.9** | **8.3** | **3.7pts** | **4.4pts** | **3.9pts** |

Average scores ranged from 6.9 to 9.4 [7.0-10 for ILS 1 and 6.9-9.4 for ILS 2], in other words from somewhat positive to highly positive. The difference between the highest and lowest individual scores ranged from 0-6pts for ILS 1 and 1-8pts for ILS 2, indicating that some questions generated more of a polarised response and some more of a united response.

The two lowest but still positive scores were for people have a greater involvement in planning their own care [6.9] [7.0 and 6.8] and people no longer have to repeat information about health and well-being to professionals from multiple services [7.2] [7.4 and 7.0].

These two questions focussed on benefits to people requiring community services and show that ILS staff believed that people were more involved in planning for their own care and no longer had to give information about health to multiple professionals and hence that ILS had met the aim of reducing the number of times a person had to repeat conversations about their health and wellbeing to professionals. This suggests that ILS is on the road to achieving amore efficient approach to delivery of care.

The other questions were about benefits to staff already working in the community.

Team members agreed but not completely agreed that the aim of referring to a single point of access for all community services had been met [7.9] [8.0 and 7.8]. Where an individual required multiple referrals, ILS staff often, but not always, refer to a single point of access which included all community services. The focus group discussions in both ILS 1 and ILS 2 underlined that ILS were *not completely there yet about saying your story only once*.

Team members agreed to a greater extent that the goal of communicating and working in a more integrated/co-ordinated way was achieved [8.4] [8.9 and 7.8] and even more so that the goal of having an improved knowledge of who else is involved in delivering care of patients [8.9] [9.4 and 8.3]. Focus group discussions underlined that ILS team members know who else is involved in the care of the people on the ILS caseloads and even interact with them directly and regularly due to being able to to link in with other teams and, where beneficial, take a more co-ordinated approach.

The top scores were for improved identification of safeguarding issues [9.1] [9.4 and 8.8] and more opportunity for shared learning from colleagues from different professions [9.4] [10 and 8.8] which were highly positive scores indicating a strong agreement that through closer working patterns and a more integrated approach, ILS staff were communicating more with and learning more from colleagues from different professions. Focus group discussions similarly underlined that ILS NCM had played a key role in supporting multi-agency working across the South Wight and North East and Ryde localities

1. **Conclusion**
	1. **Summary of key findings**

**Key barriers and drivers**

Key barriers and drivers for ILS 1 and ILS 2 considered together as an entity (n=15) are outlined in table 12 and figure 3.

*Table 12: Key barriers and drivers ILS 1 and ILS 2 together*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Driver** **Categories ILS 1 +2****(n=15)** | **Number of votes** | **% of votes** | **Barrier** **Categories ILS 1 +2 (n=15)** | **Number of votes** | **% of votes** |
| Team work/joint working with other agencies | 24 | 53.3 | Time/capacity re MDT | 12 | 26.7 |
| Helping people/person centred care | 13 | 28.9 | Unclear roles/processes | 12 | 26.7 |
| Less time from referral to action [ILS 2] | 4 | 8.9 | Lack of buy in from other agencies | 9 | 20.0 |
| Progress re clarity of processes [ILS 1] | 3 | 6.7 | Funding [ILS 2] | 7 | 15.6 |
| More freedom [ILS 2] | 1 | 2.2 | Consent/data management  | 2 | 4.4 |
|  |  |  | IT | 2 | 4.4 |
|  |  |  | Lack of clarity from senior leadership [ILS 1] | 1 | 2.2 |
|  | **45** |  | **Total**  | **45** |  |



*Fig 3 Drivers and barriers ILS 1-2*

Top key barriers for ILS1 were: lack of ‘buy in (from other agencies), lack of time/capacity (competing demands on staff) and unclear processes/roles (especially at the beginning) [just over nine tenth of the votes]. See table 7 and fig 1.Top key barriers for ILS2 were: time/capacity re MDT (competing demands on staff); funding and unclear roles/processes (especially at the beginning) [just under nine tenth of the votes]. See table 8 and fig 2.

Top key drivers for ILS1 were: team work/joint working with other agencies; helping people; and progress with clarity of process or 100% of the votes. See table 7 and fig 1.Top key drivers for ILS 2 were: Team work/joint working with other agencies; person-centred care; less time from referral to action (quicker care pathways) which made up nearly 100% of the votes. See table 8 and fig 2.

**Team effectiveness**

Out of 5 team effectiveness questions, none received an overall score of less than 8.7. The overall average for all five effectiveness question for ILS 1 and ILS 2 together was a highly positive 9 [9.6 and 8.4]. Team members strongly agreed they felt valued as team members [9.2] [10 and 8.3], that they communicated effectively with each other [9.0] [9.4 and 8.6] and that ILS meetings were productive with agreed actions [9.5] [9.7 and 9.2].

**Goals**

Most goals received positive or highly positive scores with team members agreeing or strongly agreeing that ILS team goals had been met [8.3] [8.6 7.9]. Although ILS NCM was *not completely there yet about saying your story only once* [7.2] [7.4 and 7.0] top scores were given for improved identification of safeguarding issues [9.1] [9.4 and 8.8] and more opportunity for shared learning from colleagues from different professions [9.4] [10 and 8.8], indicating that through closer working patterns and a more integrated approach, ILS staff were communicating more with and learning more from colleagues from different professions. Focus group discussions similarly underlined that ILS NCM had played a key role in supporting multi-agency working across the South Wight and North East and Ryde localities.

**NPT questions**

There were no negative average scores and only three slightly positive scores, all concerning resources, training and support. All other questions were positive with the top 3 questions receiving highly positive scores: team members agree that ILS is worthwhile [reflexive monitoring] [9.4] [9.2 and 9.5]; team members value the effect of ILS on their work [reflexive monitoring] [9.3] [9.0 and 9.5]; and team members are open and willing to work in new ways [cognitive engagement] [8.9] [8.9 and 8.8]

**NPT domains**

Reflexive monitoring was the top scoring NPT domain [8.8] for both ILS 1 and ILS 2 followed by cognitive engagement [8.5], coherence [8.3] and collective action [7.2].

*Table 10: Overview of NPT four domains for ILS 1, ILS 2 and ILS 1+2*

|  |  |  |  |
| --- | --- | --- | --- |
| **NPT domain** | **Overall average ILS1 (n=7)** | **Overall average ILS2****(n=8)** | **Overall average ILS 1 +2****(n=15)** |
| Coherence | 8.4 | 8.2 | 8.3 |
| Cognitive engagement | 8.5 | 8.5 | 8.5 |
| Collective action  | 7.4 | 6.9 | 7.2 |
| Reflexive monitoring | 8.8 | 8.8 | 8.8 |
| **Total**  | **8.3** | **8.1** | **8.2** |

This demonstrates a high level of buy in and the ability to turn experiential learning into knowledge which reflects discussion in the focus groups where team members, especially ILS 1, indicated that experiential learning through reflection was the consequence of being left without much guidance and support from senior managers. Bearing in mind that restricting factors about resources, support and training pulled the average down and are not under the control of team, and although collective action could benefit from improvement, ILS 1 and ILS 2 appeared to be effective and on track to become embedded in daily routine practice, thus having moved from “fragmentation” to “integration” and demonstrating a good potential for sustainability in the long term.

Figure 4-6 show a visual overview of all four NPT domains for ILS 1 and ILS 2 separately and as an entity. The responses away from the centre confirm that things are on track and that ILS has in all likelihood become embedded in daily routine practice in all likelihood in a long term sustainable way.



*Figure 6: Overview of the 4 NPT domains [ILS 1 and ILS 2]*



*Figure 4: Overview of the 4 NPT domains ILS 1*



*Figure 5: Overview of the 4 NPT domains ILS 2*

* 1. **Benefits and limitations of the evaluation**

A main benefit was a mixed methods approach with a validated conceptual framework [NPT, Force Field analysis, team effectiveness and extent of meeting team goals as per the logic model] and three different data collection methods: non-participant observation, survey and structured focus group, including brainstorming and ranking exercise.

This was a pragmatic evaluation of a pilot implementation of a new model of care in a real life setting undertaken with limited resources (without a control group to see what things were like in for similar context re demographics and burden of illness profiles that do not benefit from ILS. The overall sample was small with 18 attending the MDTs during which non-participant observation [n=7 and n=11] was undertaken and 15 [n=7 and n=8] taking part in the focus group and undertaking the survey. It is not known to how many HCPs the electronic survey was circulated by the ILS co-ordinator, but no responses were received.

Some of team members who took part in the focus group and survey subsequently took part in semi-structured interviews starting one week after ILS 2 and three weeks after ILS1. The team evaluation is likely to have ‘activated’ team members prior to the semi-structured interviews in which up to 9 team members that attended ILS1 or ILS2 also took part.

1. **Recommendations**

Recommendations based on suggestions from participants for improving/developing ILS are:

* Improve IT and IT support
* Ensure better integration across networks and patients’ records management systems
* Work on achieving the involvement of a wider range of health and social care professionals (especially ILS 1)
* Work towards ensuring that employers of HCPs involved in ILS share the ILS vision
* NHS and the Vanguard programme management should ensure better resources to support ICT.
* Make it more of a reciprocal process between ILS and senior managers
* Work towards making ILS even more fully integrated and adopt a more pro-active approach

The ILS teams should continue to access all available information about ILS and its effects in order to take steps to optimise the effectiveness and worthwhileness of ICT.

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**Appendices**

**Appendix 1**

**Survey**

Version 1 - 19/04/2017 **UoS Ethics**: 26528

**What is your role in ILS? e.g GP, matron, nurse, other healthcare professional etc.** …………………………………………………………………………………………………………………………....................................

**Item 1 - NPT NoMAd questionnaire** (Finch et al, 2013, 2015)

To what extent do you agree with the following statements?

|  |  |
| --- | --- |
| *Not at all**1 2 3 4 5* | *Completely**6 7 8 9 10* |

*Coherence*

1. ILS is distinct from previous ways of working 1 2 3 4 5 6 7 8 9 10
2. Team members have shared understanding/collectively agree *re* the purpose of ILS and of specific responsibilities required –roles clearly defined 1 2 3 4 5 6 7 8 9 10
3. Team members understand how ILS affects the nature of their work 1 2 3 4 5 6 7 8 9 10
4. Team members can see/construct potential value of ILS for their work 1 2 3 4 5 6 7 8 9 10

Coherence free text box if you want to make comments …………………………………………………………………

*Cognitive participation*

1. Key individuals drive ILS forward and get others involved 1 2 3 4 5 6 7 8 9 10
2. Team members are open and willing to work in new ways 1 2 3 4 5 6 7 8 9 10
3. Team members believe that contributing to ILS is a legitimate part of their work 1 2 3 4 5 6 7 8 9 10
4. Team members continue to support ILS 1 2 3 4 5 6 7 8 9 10

Cognitive participation free text box if you want to make comments………………………………………………

*Collective action*

1. ILS can easily be integrated into existing work 1 2 3 4 5 6 7 8 9 10

Team members can easily perform the required tasks 1 2 3 4 5 6 7 8 9 10

1. Work for ILS is seen as appropriately allocated to staff who have the required skills 1 2 3 4 5 6 7 8 9 10
2. ILS does not disrupt working relationships
3. Team members maintain their trusts in ILS and in each other
4. Sufficient training for ILS is provided to staff 1 2 3 4 5 6 7 8 9 10
5. Sufficient resources are available to support ILS 1 2 3 4 5 6 7 8 9 10
6. The programme management team and learning and development provider, if applicable, adequately support ILS 1 2 3 4 5 6 7 8 9 10

Collective action free text box if you want to make comments …………………………………………………………

*Reflexive monitoring*

1. Team members are aware of [informal and formal verbal or written feedback/evaluation, if applicable] about ILS and its effects 1 2 3 4 5 6 7 8 9 10
2. Team members agree that ILS is worthwhile 1 2 3 4 5 6 7 8 9 10
3. Team members value the effect of ILS on their work 1 2 3 4 5 6 7 8 9 10
4. Feedback about ILS can be used to improve it in future i.e. team members have the opportunity to reflect and modify how they work with ILS 1 2 3 4 5 6 7 8 9 10

Reflexive monitoring free text box if you want to make comments……………………………………………………

**Item 2: Team Effectiveness questions** (Based on Alexander, 1985)

Extent of agreement with the following statements?

1. I feel valued as core/extended [cross out as required] member of ILS 1 2 3 4 5 6 7 8 9 10
2. ILS team communicate effectively with each other 1 2 3 4 5 6 7 8 9 10
3. ILS meetings are productive with agreed actions 1 2 3 4 5 6 7 8 9 10
4. ILS can work through or resolve issues 1 2 3 4 5 6 7 8 9 10
5. ILS team communicate effectively with other providers 1 2 3 4 5 6 7 8 9 10

Team effectiveness questions free text box if you want to make comments ………………………………………

**Item 3: Goals of ILS**

Extent of meeting each goal –

1. Community staff communicate and work in a more integrated/co-ordinated way 1 2 3 4 5 6 7 8 9 10
2. Patients have a greater involvement in planning their own care 1 2 3 4 5 6 7 8 9 10
3. Patients no longer have to repeat information about health and well-being to professionals from multiple services 1 2 3 4 5 6 7 8 9 10
4. Ability to refer into a single point of access for all community services 1 2 3 4 5 6 7 8 9 10
5. *I*mproved knowledge of who else is involved in delivering care of patients 1 2 3 4 5 6 7 8 9 10
6. Improved identification of safeguarding issues 1 2 3 4 5 6 7 8 9 10
7. More opportunity for shared learning from colleagues from different professions 1 2 3 4 5 6 7 8 9 10

ILS goals free text box if you want to make comments ……………………………………………………………………...

**Appendix 2**

**Focus group schedule**

**Individual activity**

1. Complete survey [i.e. NPT (Finch et al, 2013, 2015), Alexander (1985) and extent to which goals of ICT were met]

**Individual then collective activity**

1. Force Field Analysis exercise [4 drivers and 4 barriers identified and ranked]
2. Identity up to four enablers or barriers re ICTs – write a few words re each enabler on up to four post-its
3. Categorise post-its, then distribute your 5 votes on most important categories i.e 1 for each of five categories or all post-its on one category because it is such an important category. See what ranking looks like. Brief discussion.
4. Identity up to four barriers or enablers re ICTs – write a few words re each enabler on up to four post-its
5. Categorise post-its, then distribute your 5 votes on most important categories i.e 1 for each of five categories or all post-its on one category because it is such an important category. See what ranking looks like. Brief discussion.

**Discussion of drivers and barriers and what could be done to overcome barriers**

**Appendix 3**

**Barriers and Drivers ILS1**

|  |  |
| --- | --- |
| **Barriers ILS 1** | **Number of items****[% of total items** |
| **Lack of ‘buy in’/advertisement** * Those missing
* Buy in from other agencies/organisations eg police and mental health etc.
* Lack of organisational/community development e.g. no police
* Lack of advertisement
* Lack of information to community and community services
* No real dedicated or devolved budget to tap into
 | **6 [28.5%]** |
| **Lack of clarity of processes*** Confusion of process MDT CMHR and ILS running alongside each other
* Poor planning prior to launching i.e. buildings, resources, parking
* Lack of clarity about the referral process
* Securing the support of senior managers to attend
* Consent issues
 | **5 [23.8%]** |
| **Lack of time/capacity** * Capacity of existing workloads and running several roles at once
* Fitting in regular attendance to 2 2 hours meetings each week with an already busy calendar
* Initial start: lengthy timescale very slow
* When it happens: regularity of meeting can only attend 1 every 3 weeks
 | **4 [19%]** |
| **IT*** IT systems between health and social care
* It systems and equipment
* IT equipment/processes
* IT issues in the ILS room
 | **4 [19%]** |
| **Lack of clarity from senior leadership** * Still some lack of clarity about senior leadership commitment and allocation of dedicated resources – leap of faith
 | **1 [4.8%]** |
| **Other*** Hard to access the building/room
 | **1 [4.8%]** |
| **Total**  | **21** |

|  |  |
| --- | --- |
| **Drivers ILS 1** | **Number of items****[% of total items** |
| **Team** * People’s enthusiasm and commitment
* Putting faces to names and building good working relationships with other agencies
* Enthusiasm and commitment of those [team members] involved
* Relationship building between disciplines
* Collaborative working relationship
* Shared vision: preventative person centred work
* Ethos of ILS
* Team’s resilience to amount of ‘buy in’
* Development day (training)
* Team working
* Staff believing in the process – engagement in South Locality
* Great feelings of team approach
 | **10 [45.5%]** |
| **Help people** * Have achieved some great outcomes for individuals
* Whole community benefit
* Helping more people
* Work with people who sit outside normal criterial
* Getting a better understanding of the priority needs of IoW individuals i.e. trends – may be different to what my service experiences
 | **5 [22.7%]** |
| **Joint working with partner agencies** * Joint working with partner agencies
* Support network in the locality
* Putting faces to names and building good working relationships with other agencies
* Relationship building between disciplines
 | **4 [18.2%]** |
| **Progress and clarity re processes*** Understanding the role of other services to enable realistic expectations for interventions
* More structured processes in place
* Everyone round a table for verbal communication which provides meaning and clarity
 | **3 [13.6%]** |
| **Total**  | **22** |

**Appendix 4**

**Barriers and drivers ILS 2**

|  |  |
| --- | --- |
| **Barriers ILS 2** | **Number of items****[% of total items** |
| **Time/capacity constraints*** Lack of time x2
* Time constraints leading to non-attendance
* Other professionals not regularly attending meetings
* Non regular attendance
* Capacity
 | **6 [40%]** |
| **Unclear processes*** Education around ILS and its function is still confusing to some
* Personal knowledge
* Understanding of processes, i.e. no induction or training
* Unclear processes
 | **4 [26.7%]** |
| **Consent** * Issues with consent
* Shared date/information
 | **2 [13.3%]** |
| **Funding** * Funding streams for adult social care and health still separate
* Resources
 | **2 [13.3%]** |
| **IT issues*** IT issues
 | **1 [6.7%]** |
| **Total** | **15** |

|  |  |
| --- | --- |
| **Drivers ILS 2** | **Number of items****[% of total items** |
| **Team work** * Knowledge of other persons’ roles
* Knowledge of colleagues
* Partnership working
* Multi-agency working
* Joint solutions to cases
* Greater communication and joined up working
* Support from other workers with person
* Improved my role by better education
 | **8 [50%]** |
| **Person centered care*** Person-centred care
* Resolving issues
* Keeping people in their own homes
* The person being involved in own care/support not having to duplicate story
 | **4 [25%]** |
| **Less time from referral to action** * Issues are dealt with in a shorter time frame
* Establishing new referral networks /contacts
* Increased understanding of other agencies rules and therefore what kind of interventions are possible
 | **3 [18.8%]**  |
| **More freedom*** Some freedom from the usual adult social care processes
 | **1 [6.3%]** |
| **Total** | **16** |

**Appendix 5**

**Ranking of overall scores for NPT questions ILS 1(**In bracket in left column NPT domain number)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NPT NoMAD questions** | **ILS 1 Average score all (n=7)** | **ILS2** **Average score all (n=8)** | **ILS 1 Difference****higher/lower score all (n=7)** | **ILS2** **Difference****higher/lower score all (n=8)** |
| Team members agree that ILS is worthwhile [q17 reflexive monitoring] | **9.2** | 9.5 | 3pts | 1pt |
| Feedback about ILS can be used to improve it in future [q19 reflexive monitoring] | **9.2** | 8.5 | 2pts | 7pts |
| Team members value the effect of ILS on their work [q18 reflexive monitoring] | **9.0** | 9.5 | 3pts | 2pts |
| Team members can see potential value of ILS for their work [q4 coherence] | **8.9** | 8.3 | 2pts | 3pts |
| Team members are open and willing to work in new ways [q6 cognitive engagement] | **8.9** | 8.8 | 4pts | 3pts |
| ILS is distinct from previous ways of working [q1 coherence] | **8.7** | 7.5 | 5pts | 2pts |
| Team members trust ILS and trust each other [q11 collective action] | **8.7** | 7.9 | 3pts | 9pts |
| Key individuals drive ILS forward and get others involved [2] | **8.4** | 7.8 | 4pts | 4pts |
| Team members have a shared understanding of the purpose of ILS and of specific responsibilities required [q2 coherence] | **8.3** | 8.3 | 5pts | 3pts |
| Team members believe that contributing to ILS is a legitimate part of their work [q7 cognitive engagement] | **8.3** | 8.0 | 5pts | 4pts |
| Team members continue to support ILS [q8 cognitive engagement] | **8.3** | 8.3 | 5pts | 3pts |
| Team members can easily perform the required tasks [q9b collective action] | **8.3** | 7.5 | 3pts | 2pts |
| The intervention does not disrupt working relationships [q10 collective action] | **8.0** | 6.0 | 4pts | 6pts |
| ILS can easily be integrated into existing work [q9a collective action] | **8.0** | 7.8 | 5pts | 5pts |
| Work is seen as appropriately allocated to staff who with required skills[q12 collective action] | **8.0** | 8.3 | 5pts | 3pts |
| Team members can access information about ILS and are aware of the effects of ILS [q16 reflexive monitoring] | **7.9** | 7.6 | 6pts | 3pts |
| Team members understand how ILS affects the nature of their work [q3 coherence] | **7.7** | 8.8 | 5pts | 4pts |
| NHS/ Vanguard programme management team adequately supports ILS [q15 collective action] | **7.0** | 6.1 | 8pts | 6pts |
| Sufficient training is provided to staff [q13 collective action] | **6.3** | 6.6 | 5pts | 9pts |
| Sufficient resources are available to support ILS [q14 collective action] | **4.9** | 5.6 | 8pts | 5pts |

**Appendix 6**

**Ranking of overall scores for NPT questions ILS 2(**In bracket in left column NPT domain number)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NPT NoMAD questions** | **ILS 1 Average score all (n=7)** | **ILS2** **Average score all (n=8)** | **ILS 1 Difference****higher/lower score all (n=7)** | **ILS2** **Difference****higher/lower score all (n=8)** |
| Team members agree that ILS is worthwhile [q17 reflexive monitoring] | 9.2 | **9.5** | 3pts | 1pt |
| Team members value the effect of ILS on their work [q18 reflexive monitoring] | 9.0 | **9.5** | 3pts | 2pts |
| Team members are open and willing to work in new ways [q6 cognitive engagement] | 8.9 | **8.8** | 4pts | 3pts |
| Team members understand how ILS affects the nature of their work [q3 coherence] | 7.7 | **8.8** | 5pts | 4pts |
| Feedback about ILS can be used to improve it in future [q19 reflexive monitoring] | 9.2 | **8.5** | 2pts | 7pts |
| Team members can see potential value of ILS for their work [q4 coherence] | 8.9 | **8.3** | 2pts | 3pts |
| Team members have a shared understanding of the purpose of ILS and of specific responsibilities required [q2 coherence] | 8.3 | **8.3** | 5pts | 3pts |
| Team members continue to support ILS [q8 cognitive engagement] | 8.3 | **8.3** | 5pts | 3pts |
| Work is seen as appropriately allocated to staff who with required skills [q12 collective action] | 8.0 | **8.3** | 5pts | 3pts |
| Team members believe that contributing to ILS is a legitimate part of their work [q7 cognitive engagement | 8.3 | **8.0** | 5pts | 4pts |
| Team members maintain their trust in ILS and trust each other [q11 collective action] | 8.7 | 7.9 | 3pts | 9pts |
| Key individuals drive ILS forward and get others involved [q5 cognitive engagement] | 8.4 | **7.8** | 4pts | 4pts |
| ILS can easily be integrated into existing work [q9a collective action] | 8.0 | **7.8** | 5pts | 5pts |
| Team members can access information about ILS and are aware of the effects of ILS [q16 reflexive monitoring] | 7.9 | **7.6** | 6pts | 3pts |
| ILS is distinct from previous ways of working [q1 coherence] | 8.7 | **7.5** | 5pts | 2pts |
| Team members can easily perform the required tasks [q9b collective action] | 8.3 | **7.5** | 3pts | 2pts |
| Sufficient training is provided to staff [q13 collective action ] | 6.3 | **6.6** | 5pts | 9pts |
| NHS/ Vanguard programme management team adequately supports ILS [q15 collective action ] | 7.0 | **6.1** | 8pts | 6pts |
| The intervention does not disrupt working relationships [q10 collective action 3] | 8.0 | **6.0** | 4pts | 6pts |
| Sufficient resources are available to support ILS [3] | 4.9 | **5.6** | 8pts | 5pts |

**Appendix 7**

|  |  |  |
| --- | --- | --- |
| **NPT/NoMAD questions in descending order** | **ILS 1-2****Average score****n=15** | **ILS 1-2 Difference****higher/lower score all (n=15)** |
| Team members agree that ILS is worthwhile [q17 reflexive monitoring] | 9.4 | 2.0pts |
| Team members value the effect of ILS on their work [q18 reflexive monitoring] | 9.3 | 2.5pts |
| Team members are open and willing to work in new ways [q6 cognitive engagement] | 8.9 | 3.5pts |
| Feedback about ILS can be used to improve it in future [q19 reflexive monitoring] | 8.9 | 4.5pts |
| Team members can see potential value of ILS for their work [q4 coherence] | 8.6 | 2.5pts |
| Team members have a shared understanding of the purpose of ILS and of specific responsibilities required [q2 coherence] | 8.3 | 4.0pts |
| Team members continue to support ILS [q8 cognitive engagement] | 8.3 | 4.0pts |
| Team members maintain their trusts in ILS and in each other [q11 collective action] | 8.3 | 7.5pts |
| Team members believe that contributing to ILS is a legitimate part of their work [q7 cognitive engagement] | 8.2 | 4.5pts |
| ILS work is seen as appropriately allocated to staff who with required skills [q12 collective action] | 8.2 | 4.0pts |
| ILS is distinct from previous ways of working [q1 coherence] | 8.1 | 3.55pts |
| Key individuals drive ILS forward and get others involved [q5 cognitive engagement] | 8.1 | 4.0pts |
| Team members understand how ILS affects the nature of their work [q3 coherence] | 7.9 | 4.5pts |
| ILS can easily be integrated into existing work [q9a collective action] | 7.9 | 5.0pts |
| Team members can easily perform the required tasks [q9b collective action] | 7.9 | 2.5pts |
| Team members can access information about and are aware of the effects of ILS [q16 reflexive monitoring] | 7.8 | 4.5pts |
| ILS does not disrupt working relationships [q10 collective action] | 7.0 | 5.0pts |
| NHS/ Vanguard programme management team adequately support ILS [q15 collective action] | 6.6 | 7.0pts |
| Sufficient training for ILS is provided to staff [q13 collective action] | 6.5 | 7.0pts |
| Sufficient resources are available to support ILS [q14 collective action] | 5.3 | 6.5pts |

1. Isle of Wight Clinical Commissioning Group [IoW CCG] website <http://www.mylifeafulllife.com/> [↑](#footnote-ref-1)
2. May and Finch 2009; Finch et al 2015 [↑](#footnote-ref-2)