

The Complete Care
Community Programme

THE COMPLETE CARE COMMUNITY PROGRAMME

EVALUATING THE EARLY DEVELOPMENT AND
PROGRESS OF THE PROGRAMME

healthworks



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Executive Summary

How The NHS Can Contribute To Reducing Health Inequalities

This report describes how a new approach and methodology could be adopted by Integrated Care Systems (ICS) to address the challenge of reducing health inequalities in England in a sustainable way; something that numerous past programmes have failed to achieve.

The Complete Care Community Programme (CCCP) is a group made up of clinicians and academics, supported by the University of Central Lancashire (UCLan). In the first 12 months, we have supported 26 “demonstrator sites” across three English regions, each involving one or more Primary Care Networks (PCNs). The programme has now expanded with the support of NHS England to incorporate 46 sites across all their seven regions.

The CCCP’s field work and real-world study has identified poor alignment between local needs, national priorities, and NHS contracts raising tensions over the deployment of resources to tackle health inequalities.

Our hypothesis is that past uncoordinated, disparate, and siloed approaches to tackling health inequalities has resulted in poor adoption and spread of local successful project work, which then becomes unsustainable in isolation.

Our approach espouses taking a grassroots approach to change which demonstrates the reality over rhetoric, and ensures learning is networked, and spread nationally.

In each demonstrator site, we have adopted a consistent methodology which:

- Works with PCNs to clearly identify each and every one in a defined group of people, who are challenged by the same health debilities
- Recognises and investigates the wider determinants of health such as poverty, poor housing and employment, education, crime, social network and many other environmental issues that lead to inequity of access to and poor outcomes from care interventions
- Creates a cross-sector, team-based approach to tackle a deeper understanding of the identified local needs that have not previously been adequately addressed.
- Develops novel solutions to address the unmet need of these population segments.

This results in the CCCP acting like a sector, not a series of independent quality improvement projects. The programme delivers a collaborative cross-sector approach to tackling local health inequalities, the lessons from which can then be shared nationally.

The Department of Health and Social Care has also been supportive in developing a Policy Research Programme to be funded through the National Institute for Health and Care Research.

This high-quality research aims to deliver relevant, timely and accessible evidence to inform national policy decisions in relation to health inequalities. The ambition is to incorporate more formal research into the CCCP construct and our approach in early 2023.

Evaluation for this first report from the CCCP was led by Professor Paul Batchelor who states, “It doesn’t make sense to simply keep trying harder using an approach which has already failed. We need to find out why the NHS in general has found it so hard to manage complex care in disadvantaged groups and reduce health inequalities.

The evaluation of the programme to date is starting to provide answers and our further research we hope will be able to provide the evidence to cement a new approach within the wider community and inform future NHS design.”

“Tackling health inequalities is a key focus for NHS recovery from the COVID-19 pandemic, and a high priority for newly established ICSs, but to achieve lasting change, effective ways which address health inequalities need to be much more transferrable and sustainable.

Our approach uses demonstrator sites with unique characteristics but which share one purpose - which is to reduce fragmentations in service delivery by aligning efforts to foster both comprehensiveness of care and health promotion interventions in their respective communities.”

Foreword - Professor James Kingsland Obe, Clinical Lead, CCCP

The Complete Care Community Programme (CCCP) was created to explore how today's NHS can contribute to a reduction in health inequalities in England as Integrated Care Systems (ICS) become statutory bodies, and as we continue to recover from the COVID-19 pandemic.

The CCCP hypothesis is that previous attempts to nationally reduce the health inequalities gap have failed because of uncoordinated and disconnected approaches.

The aim of the CCCP is therefore to act like a sector, not a series of independent quality improvement projects, to deliver a networked approach to tackling local health inequalities and share the learning.

Such an approach also advocates a consistent methodology to establish what we have termed 'demonstrator sites'. These are anchored within Primary Care Networks (PCNs) and:

- Identify a group of people challenged by the same debilities (a population 'segment' of the combined registered lists of constituent general practices)
- Recognise and investigate the wider determinants of health that have created individual debility and disparity in care outcomes
- Create a cross sector, team-based approach to address the identified needs, and to systematically measure the approach, experience and outcomes for that group of disadvantaged people.

The design of the overall programme and its demonstrator sites is of primary importance in these early stages of the CCCP development.



Every system is perfectly designed to get the results it gets"

W. Edwards Deming

While the CCCP was formally established in April 2021, the motivation for its development originated many years before. It was my experiences as a clinician in the NHS which shaped the construct of the CCCP.

It's a long journey, but I will try to make it a short story.

My career in general practice started as a trainee in Merseyside in 1988.



As it is today, a disproportionate amount of education and training, in both undergraduate and early post graduate medicine, is carried out in hospitals.

It therefore took me a little time, as it still does for many doctors working in the NHS, to understand the nature and primacy of community-based medicine (sometimes pejoratively and condescendingly referred to as 'out of hospital care').

Early in my career, as a principle in general practice, I realised that there were underdeveloped opportunities to improve the benefit of list-based practice, particularly in relation to prevention and early detection of disease.

Registering for NHS care with a GP has been in place since the inception of the NHS in 1948, being replaced in 2004 by registration with a general practice.

Registered lists continue to provide for a locally responsive, first contact service with a continuum of care (and record keeping) in an organisation centred within the community it serves.

The provision of first contact (primary) care was, as it still largely is now, by a partnership of GPs variably supported by practice employed nursing staff and an administrative team.

It quickly became clear to me that the undifferentiated and wide-ranging psychosocial presentations into general practice may not be best delivered by the bio-medical GP-centric model. As a result, in that early part of my GP career, I became increasingly interested in the actual need of my registered population as much as the type of presentations of people choosing to come into my surgery.

Long before the term 'population health' was coined, I thought it a good idea to make better use of the registered list and examine the needs (and wants) of our local population, and then determine how best to design a service based on those findings.

Managing a health service budget (fundholding, total purchasing and then Personal Medical Services Plus contracting between 1991- 2002) allowed me to do this, as well as build a team based on the need of our registered population, rather than continuing to fail in this task through the existing model prescribed by the GMS contract. The Additional Roles Reimbursement Scheme (ARRS) funding, introduced in England in 2019, has some sense of trying to achieve this, albeit with a restrictive mechanistic approach.

The results of analysing the registered population's needs were partly expected but sometimes surprising, and contemporarily remain largely unchanged. Everyone booking an appointment in general practice still needs attention and care, but most do not require this to be provided by a primary care physician (a GP or 'family doctor').

My practice found, for example, that mild to moderate mental health problems, often caused by situational disturbance, constituted a significant need (approximately 40% of all presentations). This is consistent with current research findings. Those people became better served by the development of several practice-based services. Counselling, clinical psychology sessions, occupational therapy, a practice-based community psychiatric nurse and social worker, supplemented by third sector support (Age UK, Citizens Advice Bureau), provided responsive, short wait (or no wait, if required) on site, first contact care. In addition, alcohol and illicit drug abuse services, again provided in practice, made a significant difference to the workload of GPs.

Bringing in physiotherapy (we had first contact physio in 1993), on-site midwifery, health visiting, and district nursing began to develop a comprehensive and coherent Primary Health Care Team (PHCT).

We also worked closely with our local pharmacy and optometrist to improve prescribing management and eye care.

We were able to collectively manage and finish more episodes of care than most other practices in the area, as evidenced by the commissioner's comparative data about referrals, hospital admissions and length of hospital stays.

With a cost neutral approach facilitated by managing budgets at practice level, and therefore from the point at which money started to flow through the system, significant efficiency gains were made, as well as providing responsive and effective treatment closer to the patient's home.

Most importantly, care was provided in relation to the need of the population through a multidisciplinary team-based approach. I could adapt the care arrangements to ensure that the evolving care needs best met my population through the flexibilities the arrangements created.

Fast forward to 2015 where this experience and success translated into developing the 'Primary Care Home', of which I was the co-author. As this concept and set of principles rapidly spread through the NHS in England, NHSE/I recognised the value of such an approach, and hence Primary Care Networks were established nationally.

The CCCP is the next self-evident development in this long journey, created to focus on the most complex of care issues and not least what will be needed to be better manage disparities in health and care in the new environment of Integrated Care Systems (which went live on 1 July 2022).

The CCCP espouses a consistent design approach to address a local complex care need exacerbated by societal inequalities. Only then can the service and the workforce to deliver the care be developed, and a long-term systemised evaluation be undertaken.

We are investigating how a grassroots approach to change can become a national movement. The fieldwork being undertaken by the CCCP demonstrator sites has developed into a real-world study, and this is the first report of what will be an ongoing evaluation of the programme.

With well-structured demonstrator sites built and supported through a consistent design philosophy, we plan that the next stage of the CCCP evaluation will be via a policy research programme, funded through the National Institute for Health and Care Research. This is expected to commence early in 2023.

Tackling health inequalities needs time. The approach is evidence informed. The enthusiasm and energy exists. The potential to create a social movement underpinned by the science of how to scale sustainable models is central to this programme. However, the ultimate appraisal of this programme will be where it works best, and why. How did the CCCP as a component of the NHS contribute to a positive impact on human lives, the same goal as I and the thousands of care workers set out to achieve when we first qualified?

Professor James P Kingsland OBE
June 2022

Introduction

Reducing health inequalities has been at the forefront of most past governmental reforms of the welfare state (Ford *et al.*, 2021, Lewis *et al.*, 2022). This precept still applies, but progress has been variable. Previously reported successful programmes have been localised and rarely sustained or adopted (Lewis *et al.*, 2021).

Health inequalities go against the principles of social justice because they are avoidable and arise from the unequal distribution of social, environmental and economic conditions within societies. They do not occur randomly or by chance. They are socially determined by circumstances, largely beyond an individual's control. Such factors disadvantage people and increase their risk of getting ill, compromise their ability to prevent sickness and ultimately limit their chances of a long and healthy life (Marmot *et al.*, 2020a).

Over the past decade, increasing life expectancy in England has stalled, something that has not happened since the turn of the 20th century (Marmot *et al.*, 2020b). If improvements in population health and well being have similarly regressed, exacerbated by the COVID-19 pandemic, then the signs for civil society are ominous. Life expectancy follows the social gradient: the more deprived an area, the shorter the life expectancy. The gradient has become steeper, and inequalities in health and care have increased in recent times (*ibid.*). There are also marked regional differences in life expectancy, particularly for people living in deprived areas (Corris *et al.*, 2020, Ford *et al.*, 2021, Giebel *et al.*, 2020). The gradient in 'healthy life expectancy' is steeper than that of overall life expectancy. It means that people in more deprived areas spend a greater amount of their shorter lives in ill health. Inequalities in poor health harm individuals, families and entire communities.

The Health and Social Care Act 2012 introduced the first legal duties concerning health inequalities. In addition, the Social Value Act 2012 requires public sector commissioners to consider economic, social and environmental wellbeing in the procurement of services or contracts. The Care Act 2014 also sets out various duties and obligations to 'prevent, reduce and delay' the need for long term care. The law relating to reducing health inequalities is therefore clear.

There is consensus about the importance of analysing health inequalities from the wider determinants of health and wellbeing viewpoint. It is well evidenced that factors such as social isolation, poor housing and low educational attainment impact adversely on affected individuals' health outcomes (PHE, 2021a).

“

The greatest of evils and the worst of crimes is poverty”

George Bernard Shaw

Individuals living in the most deprived communities experience both injurious health and the poorest health outcomes. The social determinants of health have a significantly greater impact on people's health than can be managed by the NHS alone. The principles of a welfare state recognises that the economic and social wellbeing of citizens requires a community structure facilitating access to education, work, shelter, security and social network. So why have we consistently failed as a nation in closing the health inequalities gap?

So why have we consistently failed as a nation at closing the health inequalities gap?

?

The purpose of the Complete Care Community Programme (CCCP) is to examine this question in detail. Its aim is to design an approach through which NHS Primary Care Networks (PCNs), working in association with other community and local council services, can address some of the challenges facing their local populations, especially those associated with the wider determinants of health.

“

There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they're falling in”

Desmond Tutu

The creation of PCNs in July 2019 and ICSs in April 2021, which are now formally established across England, should provide an opportunity to generate a refreshed approach to addressing health inequalities through the improved management of population health. This can be realised by building cross-sectoral partnerships, focused on clearly defined population groups. These partnerships can then also provide the opportunity to address some of the wider determinants of health which lead to these inequalities whilst improving the wellbeing of individuals.



!

The CCCP has been designed to tackle health inequalities through local demonstrator sites,

to be known as *Complete Care Communities*, throughout England. These demonstrator sites aim to establish the evidence and causation

of disparities in the health of local population groups and then design new ways of providing care based on their findings. The approach is not only to test new ideas and approaches and put them into practice, but also to share learning widely across healthcare and local community services.

The longer-term objective is for health and care services, operating within the guidance of their ICS, to continue to work together and co-design projects demonstrating the joint working arrangements required to deliver improved population health and wellbeing through a different team-based approach.

A core component in demonstrator site design is to clearly define the group of people to be served and who are characterised by the debility that this population segment endures in relation to deprivation. An important part of the evaluation of the CCCP is how an overall integrated partnership approach, particularly between PCNs, the local council and other community services approach, can be enhanced.

It has been recognised in the construct of the programme that there are perpetual constraints on local resources and workload pressures in delivering current contractual requirements. It is therefore expected that relatively small groups of people will develop the demonstrator sites and their projects in the early stages. However, this too will form part of the early evaluation.

“

Never doubt that a small group of thoughtful committed citizens can change the world; indeed, it's the only thing that ever has”

Margaret Mead

The above quote has become increasingly pertinent to the evolving approach of this programme. There may also be opportunities to study how local health and care services could be aligned to operate within a defined 'place'. Indeed, a strengthened description of 'place-based care' may be achieved through building the right coalition between statutory and non-statutory services within the boundaries of a local authority.

Historically, many pilot or demonstrator programmes have focused on particular interventions designed to deliver improved outcomes (e.g., The Integrated Care Pilot programme of 2009). However, it has often proved difficult to generalise actionable learning given the widely different contexts, and local objectives of heterogeneous pilots (Lewis *et al.*, 2021). Therefore, this programme has a focus on understanding the cross-sectoral relationships, behaviours and actions that underpin success, and failure, rather than systematically measuring the precise interventions developed. In this way it is hoped this facilitates learning about how effective practice can be disseminated to areas with differing local contexts. Sharing information about the successful interventions themselves, however, may be a helpful secondary objective.

The creation of a learning network for demonstrator sites within the CCCP is to enable the sites to act like a sector, not a series of individual quality improvement projects. The delivery of integrated care through multidisciplinary teams working to provide comprehensive and personalised care to individuals, groups and populations is now a consistent ambition for health and care improvement. However, historically it has been difficult to demonstrate sustainable community-based models of comprehensive care with measurable impact (Lewis *et al.*, 2021).



The CCCP aims to find practical solutions, demonstrate these through bespoke projects and rigorously evaluate the barriers and enablers to reducing health inequalities. In these early stages these demonstrator sites could be

considered as carrying out the field work in a real-world study, and exploring the factors that can lead to transferable learning and the adoption of success.

The recent Fuller Stocktake report, *Next steps for integrating primary care* (NHS England, 2022), examines and advocates a fresh impetus to addressing health inequalities through the application of population health approaches, and by building cross-sectoral partnerships.



The CCCP creates the environment through which PCNs can work towards a high-level goal of reducing health inequalities by delivering improved care to defined 'segments' of their local population (characterised by their debility related to deprivation) in partnership with the local council and other public statutory and voluntary services. This collaboration should also provide the framework through which demonstrator sites can share their learning and identify factors that enables sustainability and then transfer this knowledge to other sites in the country.

In summary the overarching goals of the CCCP are to:

- Identify inter-sectoral methods of collaboration that impact on health inequalities
- Identify 'enablers' and 'barriers' to addressing health inequalities
- Collate case studies and thematic reviews that demonstrate how health inequalities may be reduced
- Establish a process by which the approach and learning in demonstrator sites could be adopted across England

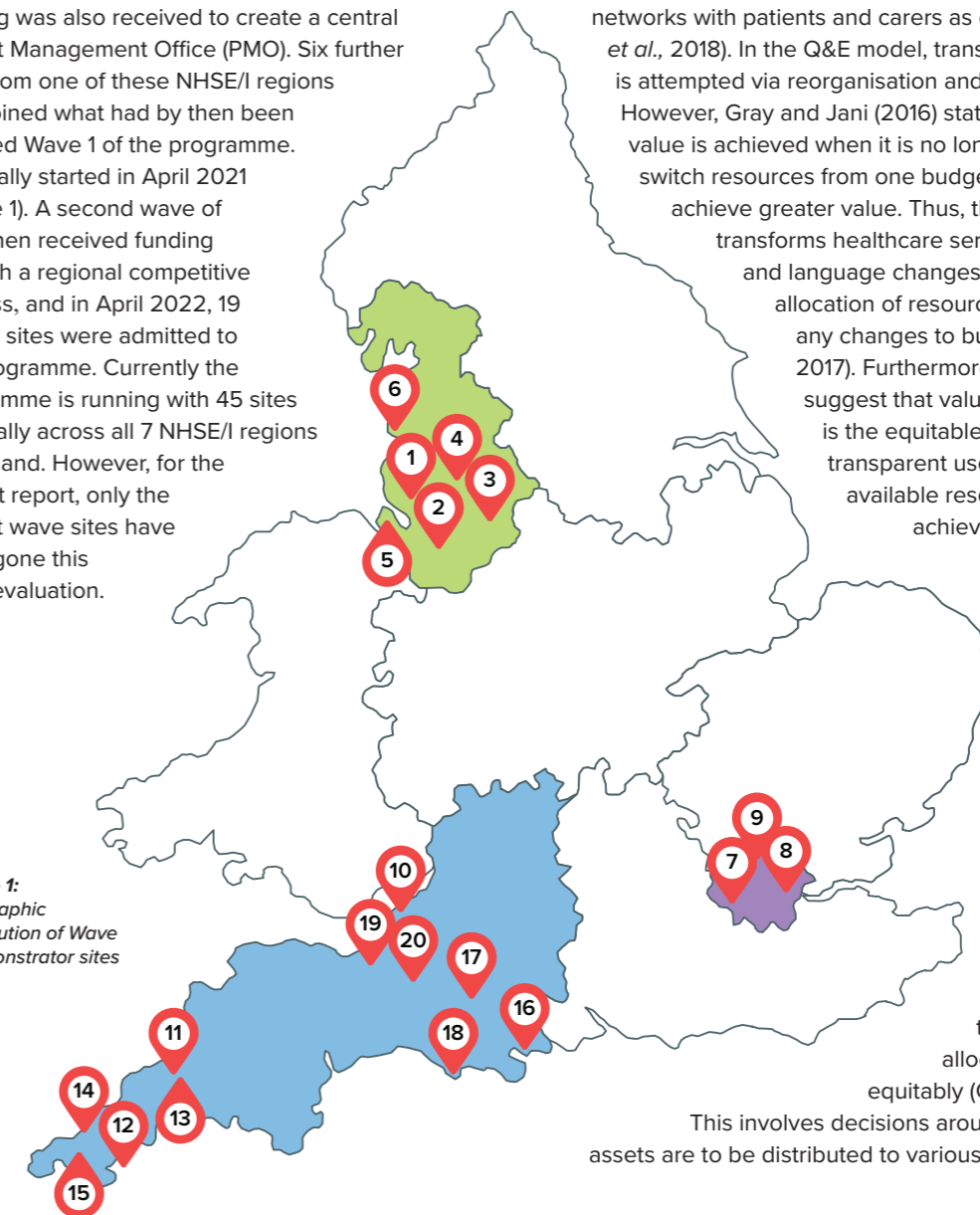
The report explores whether factors exist within the sites which have influenced – or impeded – progress towards the overall goals to date, supplemented by learning from the literature. Indeed, as PHE (2017a) has reported, the timeframe for addressing health inequalities varies for different interventions, but even for the shortest substantial impact it would take 3 to 5 years to achieve. As such, the present evaluation cannot demonstrate the effectiveness of the sites in addressing inequalities, simply on progress towards achieving the environment necessary to do so.

Background

This report presents the current progress of the CCCP and how it is working towards its intended goals. Each demonstrator site is relatively unique. Each has variable contextual settings and incorporate different personnel. They have distinct histories to their project's creation and evolution; albeit the CCCP approach espouses consistency in the overall project design. There are also broader social, economic, political, and physical factors which interact with psychological aspects operating in each site. To better understand these broader factors which have led to the creation of each site's project, it is important for the programme to explore how they were conceived, what shaped them and how they are to be sustained.

In the early months of 2021, the first 20 sites received funding from three NHS England and Improvement (NHSE/I) regions to begin their design work, and funding was also received to create a central Project Management Office (PMO). Six further sites from one of these NHSE/I regions later joined what had by then been deemed Wave 1 of the programme. It formally started in April 2021 (Figure 1). A second wave of sites then received funding through a regional competitive process, and in April 2022, 19 further sites were admitted to the programme. Currently the programme is running with 45 sites nationally across all 7 NHSE/I regions in England. However, for the current report, only the 26 first wave sites have undergone this initial evaluation.

Figure 1:
Geographic distribution of Wave 1 demonstrator sites



The CCCP aims not to just build back better after the COVID-19 pandemic, but to build back fairer, and in a sustainable manner. In order to achieve resilient and sustainable healthcare, Jani *et al.* (2018) suggest that there must be a radical shift in healthcare systems towards triple shift value. Quality, safety, and improvement approaches (the Q&E Model) have been used to address issues in healthcare. These are necessary but not sufficient to meet current and future challenges in healthcare (Gray & Jani, 2016), including the growing and ageing population as well as stagnating resources being invested into healthcare (Jani *et al.*, 2018).

The Quality and Evidence (Q&E) model promotes the improvement of healthcare systems through competition, whereas the Triple Value Healthcare (TVH) model promotes improvement through collaborative systems and networks with patients and carers as equal partners (Jani *et al.*, 2018). In the Q&E model, transformation of services is attempted via reorganisation and more money (*ibid.*). However, Gray and Jani (2016) state that allocative value is achieved when it is no longer possible to switch resources from one budget to another and achieve greater value. Thus, the TVH model transforms healthcare services via culture and language changes, and optimised allocation of resources, rather than any changes to budgets (Gray *et al.*, 2017). Furthermore, Hurst *et al.* (2019) suggest that value-based healthcare is the equitable, sustainable, and transparent use of the already available resources in order to achieve better outcomes.

To achieve greater equity and optimum value, the TVH model aims to optimise three types of value: allocative value, technical value and personal value (Jani *et al.*, 2018). In the TVH model, allocative value refers to the aim of ensuring that resources are allocated optimally and equitably (Gray & Jani, 2016).

This involves decisions around how different assets are to be distributed to various subgroups within

the population as a whole (Jani *et al.*, 2018). This includes developing the best way to allocate finite resources (money, time, space, and carbon) in order to meet the needs of the population. It involves balancing the needs of the individual (personal value) with population needs. It is not possible for everyone to always get what they want, and an open and honest dialogue with the public regarding this is required (*ibid.*).

The NHS must also take into account the inherent tension between individual patient and population needs, and decisions must be made that are proportionate, fair, and equitable (Hurst *et al.*, 2019). Improving allocative healthcare must involve a shift in thinking away from institutional based healthcare which is focused primarily on primary, secondary, and tertiary care, and towards a paradigm known as population healthcare. Population healthcare focuses on populations defined by a common need, these needs could fall under symptoms (e.g., breathlessness), conditions (e.g., arthritis), and characteristics (e.g., frailty in old age).

The aim of population healthcare is to maximise value and equity for those populations and individuals within them (Jani *et al.*, 2018). Decision makers who are responsible for allocating public funds must decide how the set limit of money is spent on health and social care (Gray *et al.*, 2017), and population healthcare provides a structured way in which to think about population value, allowing decision makers to strategically allocate resources (Jani *et al.*, 2018). Currently, the NHS uses programme budgeting, which assumes that people have a diagnosis, and only one diagnosis, which is insufficient (Gray *et al.*, 2017).

Technical value in the TVH model refers to ensuring that resources are being used optimally for all the people in the population who are in need (Gray & Jani, 2016). Technical value can be described as value at the level of intervention. It is concerned with the outcomes: population, patient, and process, delivered by an intervention, and what resources are needed to deliver those outcomes (Jani *et al.*, 2018). It aims to utilise high-value interventions and disinvest in low-value interventions (*ibid.*). Increasing technical value would reduce waste, improve healthcare outcomes, and reduce healthcare inequalities using the existing resources (Hurst *et al.*, 2019). Gray and Jani (2016) explain that high quality and safety (the Q&E model) alone is not enough to guarantee high value. For example, if a highly trained surgeon performs a safe, high quality surgery on a patient who does not need the surgery in the first place, the surgery would be of low value. Healthcare systems currently face the issue of the overuse of resources, such as tests and treatments. This does not add value for patients and can even cause harm (Levinson *et al.*, 2015). The overuse and reliance on antibiotics has led to an increase in antibiotic resistant organisms, for example (Nettleton, 2021). Despite the growing consensus that there is an urgent need to reduce the use of antibiotics for this very reason, global consumption increased by a third between 2000 and 2010 (Van Boeckel *et al.*, 2014). In addition, NHS doctors in England are prescribing more, and stronger opioids, which cannot be explained by patient preference or illness, and there are unwarranted geographical variations in the prescribing patterns of these drugs (Hurst *et al.*, 2019). Overuse of resources can lead to services going beyond the optimal: the balance between



benefit and harm. When resources are wasted by doctors, patients who have their treatments delayed or denied, suffer (Gray & Jani, 2016). A survey of public attitudes found that among people dissatisfied with the NHS, the top three reasons given related to access and resourcing, and 33% identified waste as a reason (Hurst *et al.*, 2019). The NHS must address health inequalities in access and outcomes, improving outcomes for patients presents opportunities for improved clinical stewardship when it comes to managing resources (*ibid.*).

The final key principle of TVH is personal value. This relates to optimising value on the level of the individual patient (Jani *et al.*, 2018). Each patient's values must be used as a basis for decision-making in order to optimise value for the individual (Gray & Jani, 2016). This involves meeting the needs and expectations of each patient, which can include both objective clinical outcomes (e.g., lower blood pressure) and subjective outcomes (e.g., being able to play golf again) (Jani *et al.*, 2018).

Value based healthcare has reached significant levels of interest within the NHS, with several high-profile programmes set up to reduce resource waste and centre patients in the decision-making process (Hurst *et al.*, 2019). The longest running, and most deeply embedded national programme that focused on value healthcare, was The Right Care Programme (Jani *et al.*, 2018), which ran between 2010 and 2015. The Right Care Programme acknowledged that the Q&E model was essential but took things further by raising the issue of whether we

were doing the right things in the right place with the right mix of interventions for the right people – all of which pertain to TVH (Gray & Jani, 2016). However, value-based healthcare is far from fully embedded in the NHS – evidence suggests that the adoption of programmes to increase value has been unsystematic and only partial, and their projected impact may have been exaggerated (Hurst *et al.*, 2019). Greater systemic implementation of value healthcare within the NHS may be achieved with improved communication and a change in culture (Jani *et al.*, 2018). Furthermore, there is a current lack of clarity surrounding what value based healthcare means and how it is applied in decision-making. There is also currently a lack of the knowledge, skills, and training required to develop and deliver value-based healthcare (Hurst *et al.*, 2019). The Right Care Programme found that changing culture is an essential place to start in order to shift to TVH, though it is a challenge. This involves introducing the knowledge and basic concepts of value-based healthcare and posing healthcare workers with the question of who and what they are holding themselves accountable for (Jani *et al.*, 2018). The language and thinking must change in order to achieve culture change; the current language is centred around budgets and institutions which is archaic and problematic (Gray *et al.*, 2017). Language about value is not normalised in the NHS, and there is a common misconception that value-based programmes are simply seeking cost efficiency (Hurst *et al.*, 2019).

The Wicked Problem Of Health Inequalities



Despite the United Kingdom being one of the richest economies in the world, significant variations in the standard of living persist, creating unfair, avoidable and systemic disparities in health across geographies and groups of people.

These can be referred to as the socio-economic inequalities of health, or health inequalities. Essentially, this means that the place one is born, lives, works, and plays can impact manifold life outcomes, such as life expectancy, years lived in good health and morbidity, mental wellbeing, career opportunities and risk of exposure to harmful environments and addiction.

After the Black Report (1980), health inequalities were understood to be inextricably and undeniably linked to material deprivation. The evidence showed that health inequalities had worsened since 1948 and the establishment of the National Health Service, so could not simply be a matter of a failure in the means to manage poor health (Crombie *et al.*, 2005).

The government uses the Index of Multiple Deprivation (IMD) to measure and summarise the extent of deprivation, combining seven domains to provide a comparative

snapshot, the most recent for England being 2019 (IMD2019). There are separate indices for each of the four constituent countries of the United Kingdom. The seven domains are: income; employment; education; health; crime; barriers to housing and services; living environment (MHCLG, 2019a).

The 2019 analysis did not show much improvement from the preceding one. From 2015, only London saw any remarkable positive change including 88% of the most deprived neighbourhoods (MHCLG, 2019b, p. 1). Nine out of the ten most deprived Lower-Layer Super Output Areas (LSOAs) – the small ‘neighbourhoods’ studied for the IMD – were in the North-West of England (second to ninth were in Blackpool). Further, five LSOAs have consistently ranked in the most deprived hundred since 2004: two in Liverpool and one each in Wirral, Rochdale and Middlesbrough (MHCLG, 2019b, p. 5), indicating a lack of positive change in real terms.

The most deprived 10% of neighbourhoods were ranked as ‘highly deprived’, facing multiple forms of deprivation, with 137 neighbourhoods highly deprived in six of the seven domains; and these were not distributed evenly throughout England with the majority being in the North or Birmingham (MHCLG, 2019b, p.7).

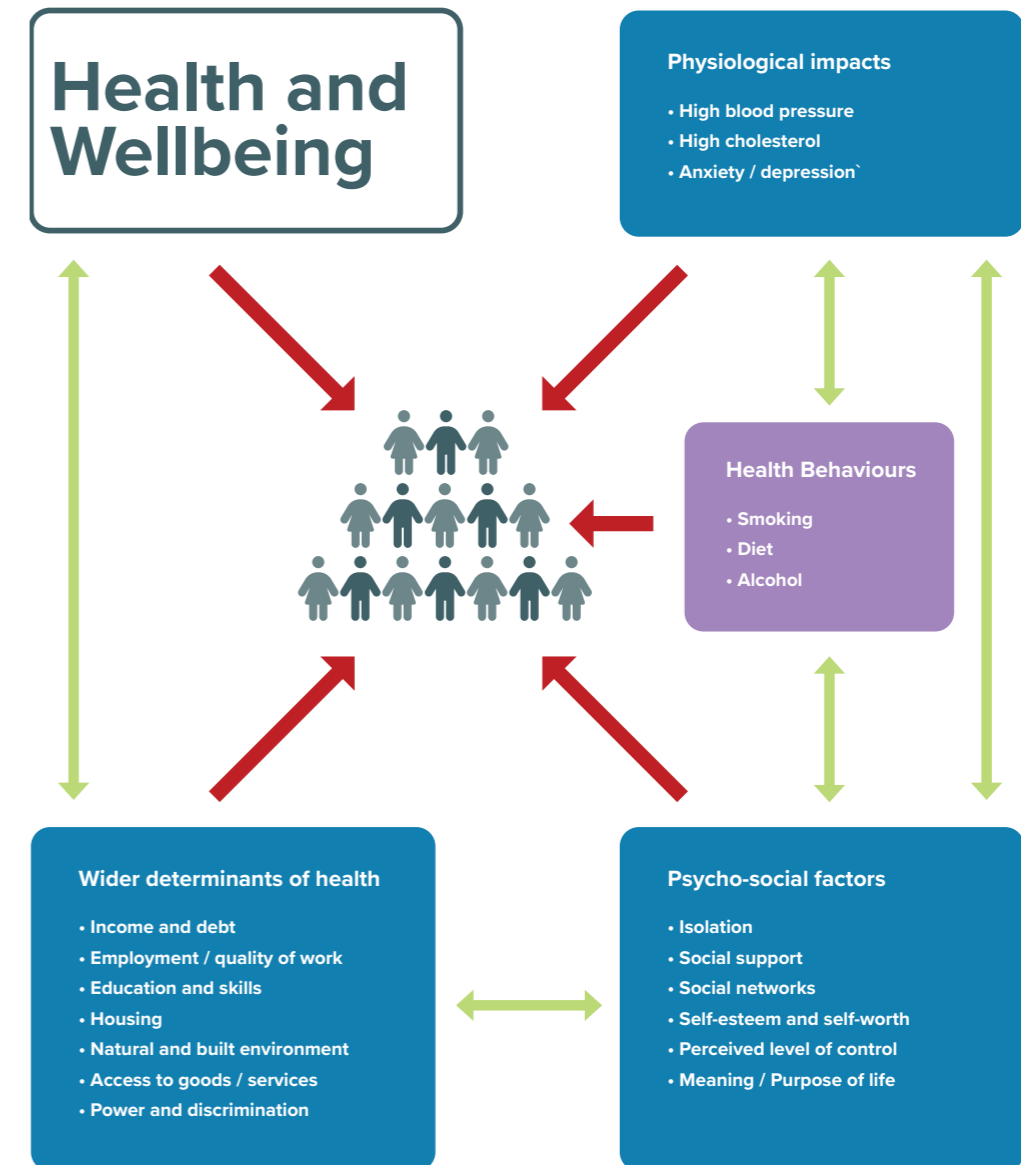


Figure 2. System map of the causes of health inequalities (PHE 2021a)

Contributory factors, which cause health inequalities, are many and varied. Public Health England’s (PHE, 2021a), system map (Figure 2), demonstrates the interrelatedness of such factors. The ‘wider determinants of health’ listed in this model, roughly mirror the domains of the IMD.

As such, a public health intervention that focuses on just one area of these determinants, for example a smoking cessation programme which addresses the ‘health behaviour’ alone, without looking at other areas, has little potential to make vast inroads into reducing health inequalities, as it does not account for the competing issues that may be impacting on people’s lives. Impressing onto someone that they should give up smoking to improve their health is going to go unheeded if that person is living in substandard accommodation, with mental health problems and a limited support network.

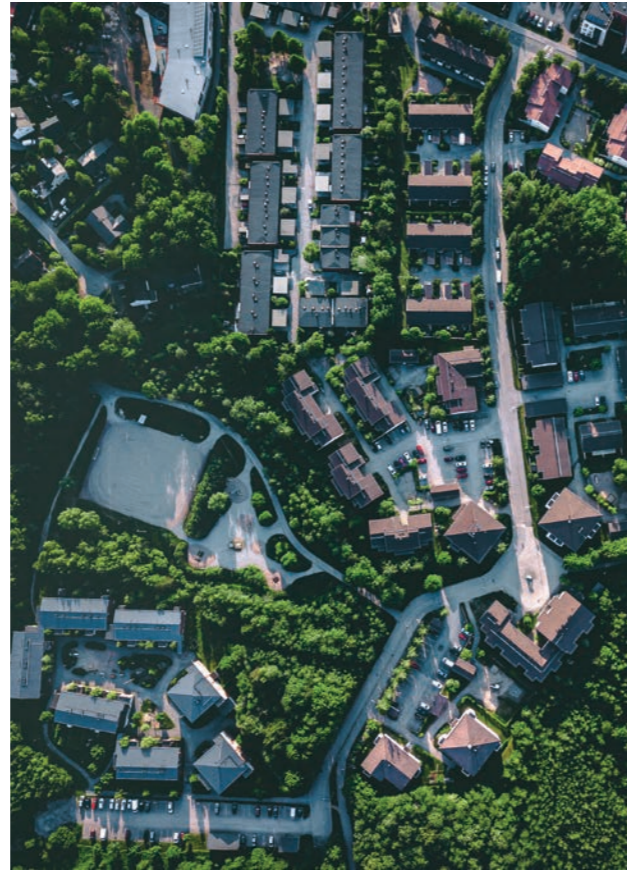
The Public Health England system map outlines examples – undoubtedly missing some entries – and indicates that a holistic approach to public health is required in order to substantially tackle health inequalities.

Consideration of health inequalities is also complex and multifaceted. Relying on one measure such as life expectancy does not give a full picture, though it may be one of the most stark representations. It may be that it is tailored for a specific audience, the gap in life expectancy is headline-grabbing and may create an improvement drive, but healthcare professionals are more likely to respond to individual – and more manageable – measures (Ford *et al.*, 2021). These various measures; roughly aligning with the domains of the index of multiple deprivation and the wider determinants of health; are discussed below with the current context, but the list is not exhaustive.

The issue of health inequalities has, of course, never been too far away from the dispatch box, as a brief look at the priorities of the Health Secretary since the Black Report demonstrates. The 1979 general election brought a change in British politics, with Margaret Thatcher and neoliberalism, financial deregulation, the focus on market forces and the privatisation of public goods and services, voted in on the back of union action in the 1978-79 'Winter of Discontent'. During this political period, the gap in inequalities between the richest and the poorest widened, resulting from high unemployment, lower wages, the retrenchment of the welfare state, the Thatcherism policy of laissez-faire and non-interference. And, while the NHS remained relatively unscathed in terms of privatisation; managerialism and a quasi-market increased the reach of private healthcare within the service (Scott-Samuel *et al.*, 2014).

The Black Report (1980) was commissioned in 1977 by the then Labour government but was published under Thatcher's Conservative government. In December 1982, an Opposition Day in the House of Commons was used to debate '*Inequalities in Health*', dipping heavily into the report to argue that the recommendations be heeded, and that the UK was subject to considerable inequality. Norman Fowler, the Secretary of State for Health and Social Services, and Kenneth Clarke, Minister for Health, were defendants of the current administration, remarking that there had been improvements and seemingly downplaying the role of health inequalities, but Fowler did accept that "*inequalities exist . . . and that action will have to be taken to even them out*" (Hansard, 1982). A better start in life for children, in maternity care and older adults were noted areas in need in Britain. From 1997, New Labour, via a targeted health inequalities strategy, had increased funding to the NHS and public services, leading to the creation of resources such as SureStart. During this time, the gap in infant mortality rates between the most and least deprived areas had reduced (Robinson *et al.*, 2019). Further, the strategy was seen to reduce the gap in life expectancy (Barr *et al.*, 2017). However, austerity measures central to the Conservative-Liberal Democrat coalition of 2010, introduced with the aim of reducing the national deficit, resulted in the closure of many key services, including these SureStart centres, libraries, youth centres and those for older adults.

The ambition to narrow the gap in health inequalities has continued to be claimed in successive maiden or significant speeches by the incumbent Health Secretary. Jeremy Hunt in 2012, the incoming Secretary of State for Health, focused on the successes in public health from the 20th Century, such as the doubling of life expectancy, clean water and sanitation, safer roads and better working conditions. And, yet still was the recognition that inequalities persisted, and that services needed to be better at reaching the poorest, most vulnerable and hard to reach in society (DHSC, 2012).



His successor Matt Hancock, assuming office in 2018, used his first speech to outline his own priorities, and make reference to the wide range of socioeconomic factors that impact on health (DHSC, 2018). His office undertook to raise life expectancy by five years by 2035 and reduce the gap between the richest and poorest. To date, we find the opposite to be true.

Sajid Javid, the Secretary of State for Health and Social Care until July 2022, labelled health inequalities the "*disease of disparity*" exposed by the COVID-19 pandemic, where the unhealthy had become more unhealthy (DHSC, 2021). As expounded by Professor Sir Michael Marmot at a conference, 2021, "*COVID has not muddied the waters, it has made them crystal clear*"; deprived areas saw higher critical hospital admissions due to COVID and more than double the rate of mortality (PHE, 2020a, Ford *et al.*, 2021). Javid outlined his three priorities as the prevention of poor physical and mental health; to tackle health inequalities and improve access to services; and to act on the wider factors affecting health outcomes (DHSC, 2021). This speech was used in part to announce that the Office for Health Improvements and Disparities would be the successor to Public Health England, and drive these ambitions.

Health inequalities are stubborn and seemingly resistant to long term intervention. It may be that improvement in health inequalities, being the domain of the incumbent government, will never see significant improvements due to the nature of what is essentially two party politics in England and a fixed term Parliament based on a five year cycle. Just as one public health intervention could begin to see successful outcomes, there's a potential for a change in government; as noted earlier, it can take years for change to be evident. Though overarching bodies such as Public Health England and now the Office for Health Improvements and Disparities exist, they are subject to the ideological will of the government of the day.



However, regardless of political rhetoric, life expectancy has stalled for the first time since 1900 and has even decreased for the poorest 10% of women in England (Marmot, 2020b). As seen in the IMD, the areas experiencing most deprivation have not been subject to improvement. People are living shorter lives with more years in poor health. This is not evenly experienced throughout the country.

Life expectancy is the most prominent benchmark measure to provide an indication of how healthy a nation is and one which is easily compared across nations. The gap in life expectancy between the most and the least deprived areas is seven and a half years for women, and more than nine years for men, and this gap is steadily widening. Blackpool has the lowest life expectancy for both women and men at 79.5 years and 74.2 years respectively, whereas the highest life expectancies are in London: for women it is Camden (87 years) and men, Kensington and Chelsea, and Westminster (83.8 years). For both, City of London trumps these with life expectancies of 90.2 and 91.1 respectively (all data PHE, 2021b, 2021c). People are also living with ill-health for a greater proportion of their life, with those living in the most deprived areas spending a third of their life in poor health. Those in less deprived areas will spend up to 20 years longer in better health (PHE, 2017b, Raleigh, 2021).

Multimorbidity, that is the coexistence of two or more chronic physical or mental health conditions which require treatment, is predicted to affect two-thirds of those aged 65 and over by 2035, 17% of whom will have four or more conditions, nearly double the prevalence in 2019. Hypertension and chronic pain are among the most common conditions and with a forecasted one-third living with a mental illness, e.g. dementia or depression, aggravated by an ageing population, the challenges ahead in managing population health are evident (Kingston *et al.*, 2018, Pearson-Stuttard *et al.*, 2019).

The link between socioeconomic status and multimorbidity is proven. Not only are long term conditions more prevalent in lower socioeconomic groups, even in less common conditions such as stroke, they are more severe (King's Fund, 2014). A 2018 retrospective cohort study (Cassell *et al.*, 2018) found that multimorbidity prevalence was 27.2%, with this increasing by age, affecting women more than men and that specifically, "*physical-mental comorbidity increased substantially with greater socioeconomic deprivation.*" (p. e428). Those living in deprived areas are affected by complex health issues some 10 to 15 years earlier than those in less deprived areas (King's Fund, 2014).

Cancer will affect one in two people in England with the survival rate for many cancers having increased substantially over the years. However, mortality rates from cancer among those under 75 years of age are not equal. Indeed, they "*are highest in the most deprived areas of England*" (Baker, 2021, p. 12). As with life expectancy, the North and South experience cancer-related mortality differently: Manchester has the highest under-75 mortality rate for cancer at 182 per 100,000 population, for Westminster this is 87 (*ibid.*).

Reduced access to dental services, in part created by the cessation of appointments during the first half of the pandemic, has created a backlog. Public Health England (2021d) found that socioeconomic status impacted on people's use of dental services, tooth decay, tooth loss, oral cancer, health and hygiene; those who are vulnerable and socially disadvantaged were disproportionately affected by poor oral health. This has been evidenced by inequalities in incidences of dental decay in five year old children which has increased in more disadvantaged areas (*ibid.*), with dental surgery being the most common reason for children requiring emergency general anaesthetic in hospital (Levine, 2021).

Numerous studies and reports have investigated the inequality experienced in maternity care and outcomes, specifically in response to the findings of societal and structural racism (Fernandez Turienzo *et al.*, 2021), but also more widely towards the most socially disadvantaged groups. Such findings include less respectful treatment, higher rates of hypertension and diabetes, stillbirth, preterm babies, and maternal morbidity and mortality, that:



Women living in the most deprived areas are almost two and a half times more likely to die than those living in the least deprived areas, and their babies have a 73% higher risk of perinatal mortality.

Webster & NMPA Project Team, 2021, p. 1

The impact of austerity measures start early, indeed as recognised by the MP, Dafydd Ellis-Thomas, forty years ago, “*the inequalities continue from the cradle to the grave.*” (Hansard, 1982)

Poor mental health is both a consequence and cause of health inequalities. Children from the poorest 20% households are four times more likely to experience serious mental health difficulties by age 11, than the wealthiest 20% (Centre for Mental Health, 2020). It is a two-directional relationship: mental health problems often go hand in hand with unemployment and benefits-dependency, poor or insecure housing and homelessness, stigma and discrimination, poor physical health and substance use, all known causes of mental health problems (Mental Health Foundation, 2020). The growing prevalence in poor mental health is partly responsible for the increase in rates of multimorbidity.



“Homelessness can be seen as a measure of our collective success in reducing health inequalities”

PHE, 2020b



“... rough sleeping has increased by 169% since 2010”

St. Mungo's, 2018

Another significant and stubborn indicator of health inequalities, homelessness predicated a host of potentially significant health outcomes, with life expectancy being reduced by as much as 30 years, to 47 for a homeless man and 43 for women. Rough sleepers are more than twice as likely as the general public to experience mental health problems and 13 times more likely to experience psychosis (PHE, 2020b). They are more likely to have alcohol and drug problems, resulting in 35% of deaths among homeless people compared to 2% in the general population (*ibid.*), and are more likely to die from treatable conditions such as tuberculosis (Aldridge *et al.*, 2019).

These issues – and many more – faced by people affected by homelessness, are compounded by unequal access to services and primary care. Though all people in the UK have the right to register and use services with the GP regardless of address, or immigration status, one-third of rough sleepers are not registered. Use of services is low, meaning health issues tend to be undiagnosed or untreated until hospital admission (PHE, 2020b).

There are also economic impacts from health inequalities. Higher use of Accident & Emergency services can be attributed in part to people in more deprived areas being unable to afford to call their GP, whereas a 999 call is free. Greater hospital use in deprived areas alone results in a cost of £4.8 billion to the economy (PHE, 2021a). The high burden of disease due to socioeconomic deprivation, the treatment and care for more people with long term conditions, is estimated to take up around £7 in every £10 of total health and social care expenditure (King's Fund, 2014). Ill-health results in £31 billion in lost productivity and this is felt most in terms of jobs and economy in areas of higher deprivation (Marmot, 2020a).



There are many hidden knock-on effects of socioeconomic deprivation. These often do not exist in isolation, but intersect and are complex. For example, someone on low income may find it hard to afford public transport precluding their access to services, training and employment. Those living in more deprived areas are more likely to live in insecure or unsuitable accommodation, damp and mould, exacerbating health conditions. Living in areas with high crime rates affects individual mental health and community wellbeing. It is very difficult for people to socially mobilise out of poverty, and this potentially creates a cycle of poverty for generations, severely restricting families' and communities' opportunities and life chances. With the cost of living crisis impacting the United Kingdom in 2022, following on from the effects of the COVID-19 pandemic, the situation is set to deteriorate further; reinvigorated action on health inequalities could not be more timely.



Socio-economic status (SES) is one of the primary predictors of health inequalities, and is closely linked to poorer mental and physical health. . . As stated in the Marmot review, an active reduction in health inequalities requires addressing all social determinants of health, including education, occupation, income, the home environment and the community.”

Giebel *et al.*, 2020, p. 2

Humanistic & Social Factors Involved In Creating Momentum & Sustainability



There have been a number of successful national public health interventions in the UK, including the smoking ban, the sugar tax, and mass vaccination (RSPH, 2020). However, it is often the case that individual programmes do not have long lasting

effects on community health, or substantially address health inequalities (Lewis *et al.*, 2022). It may be that one of the major elements contributing to the endurance of the first group of interventions is that they are subject to central government legislation and therefore appropriate resources and funding are made available throughout the country; behaviour change becomes legally regulated.

It is critical therefore, that we understand why some interventions fail after initial interest.

Further, it is clearly a difficult task to address health inequalities. Successive programmes have not had enduring effects as we consider the widening of the gap in health inequalities. Health inequalities may only be eradicated with a concerted effort at multidisciplinary health promotion programmes and discovering ways in which these programmes can become sustainable, as well as fully integrated. This aligns with the aims of the Complete Care Community Programme (CCCP).



The case for tackling health inequalities is clear and overwhelming, and yet attempts to do so in recent decades have had mixed success. Crucially, none of these efforts have translated into the enduring focus on addressing health inequalities that is needed.

Lewis *et al.*, 2022, p. 1

One of the aims of the CCCP is to evaluate the barriers and facilitators to successful public health promotion in order to assemble a body of evidence as to what works. Summarised by McFarlane *et al.* (2016), these will be discussed subsequently.



Enablers included: management support, skilled staff, provision of external support to the organisation, committed staffing and financial resources, leadership and the availability of external partners to work with. Barriers included: lack of management support, lack of dedicated health promotion staff, staff lacking skills or confidence, competing priorities and a lack of time and resources allocated to health promotion activities.

McFarlane *et al.*, 2016, p. 118

The extant literature on public health interventions has allowed identification of a number of behaviours of those working in management, or leadership, that may contribute to a working environment that enhances opportunities for successful delivery. These can be summarised as being supportive; provision of resources; influence; and openness to external expertise.

Supportive leadership is vital. This demonstrates senior-level commitment to a programme, in the style in which they oversee and mentor staff and management, including investment of resources and time. It ensures training is available to all, thus creating flexible staff working practices and shaping workplace culture change (Herlitz *et al.*, 2020, Eriksson *et al.*, 2011, McFarlane *et al.*, 2016). The influence on the culture in the workplace should allow for staff to feel comfortable to question practice and to learn (Horton *et al.*, 2018), and also to create a culture of working collaboratively regardless of position (McFarlane *et al.*, 2016). Further, a positive organisational attitude towards the programme, including the sufficient provision of other resources, such as appropriate information and communication systems and technology establishes further commitment by leadership (Maijala *et al.*, 2016, Rogers *et al.*, 2021). And leadership should not be afraid to bring in external expertise, knowledge, and funding from other

organisations, especially as this may help increase reach and promote longevity (Horton *et al.*, 2018, McFarlane *et al.*, 2016).

With regards to staff 'on the ground' delivering public health promotion interventions, enthusiasm, motivation, and personal interest are some of the most acknowledged grounds for success (Breheny *et al.*, 2020, Herlitz *et al.*, 2020, Rogers *et al.*, 2021). As noted above, staff have competing demands on their time yet must be allowed the time to effectively commit, specifically it must be communicated to them that they are permitted to give these programmes adequate attention. Clinical staff will have to manage their direct work with patients, paperwork and meeting attendance, alongside any intervention work. Thus, a whole team approach is required, where everyone supports each other to provide cover, take on each other's clinics for example, to all be working towards the same aims, creating "a culture of collaboration" (McFarlane *et al.*, 2016). Though directed by management, commitment must come from all staff.

To deliver an intervention confidently and expertly requires staff to be suitably trained and knowledgeable; retaining such staff – therefore having a low turnover – is essential (Herlitz *et al.*, 2020, Rogers *et al.*, 2021). Encouraging staff development reinforces the view of the programme as being of value. Protected time for training ensures that staff can attend without concerns over cover or loss of hours (Rogers *et al.*, 2021), investing in career development and recognising the achievements of staff permits "professional growth . . . work well-being" (Maijala *et al.*, 2016, p. 48) ultimately encouraging staff to remain. Limiting staff turnover can impact the success of a programme; loss of staff also means the loss of knowledge and expertise. Further, Herlitz *et al.* (2020), suggests that losing the very people driving the project forward can impact its sustainability by resulting in premature conclusion.

An enthusiastic workforce is universally beneficial. When delivering a bespoke or innovative public health programme, it is evident that the drive of those directing the work will contribute to its future, Breheny *et al.* (2020) insisted: "The subsequent success of an initiative was attributed to enthusiastic staff driving it forward" (p. 5). Herlitz *et al.* (2020) performed a systematic review of health promotion within school settings, identifying a number of transferable factors to promote sustainability, notably "the work of intervention champions" (p. 2). Champions may be staff who become 'the face of' the intervention, who assume responsibility for organisation and promotion, who are persuasive and expert at obtaining an audience with other influential people and those at a senior level.

However, these champions need not be sought and trained from clinical staff alone. Indeed, the co-operation of the community in delivering public health could assist in breaking barriers and allow for proliferation, especially in 'under-served' communities that healthcare services have failed to reach (Fernandez Turienzo *et al.*, 2021, Lee *et al.*, 2019, Liljas *et al.*, 2019, O-Mara-Eves *et al.*, 2015). Importantly, they are key members, either exhibiting a level of authority and expertise that suits the responsibility inherent in driving forward novel interventions; or are central, visible, a strong member of a network within religious or educational settings or charities (Horton *et al.*, 2018).

Development is central to building on innate skills that people suited to being champions possess. The role of a champion is both organisational and inspirational; they facilitate and coordinate important elements of a project, encourage others to develop skills and learning, and oversee the project if it is then adopted elsewhere. Promotion of the intervention, in spreading information, encouraging engagement, encouraging collective action and gaining support requires certain attributes, such as tenacity and resilience. Considerable time is invested and a commitment to the project, fuelled by their belief in it and its importance, fosters dedication.

Qualities champions hold have been categorised in studies and reviews (Bonawitz *et al.*, 2020, Demes *et al.*, 2020, Shaw *et al.*, 2012, Shea, 2021). There is much consensus on personal attributes which I have collated into six areas: enthusiasm and persuasiveness, communication, tenacity, authority, leadership, and risk-taking.

Enthusiasm for, and belief in, the project encourages an ongoing commitment; it is hard to stay invested in something one does not believe in. But this also assists in staying motivated, proactive, and bringing others on board; persuasiveness comes from this investment and belief and in turn, this "contagious passion" (Bonawitz *et al.*, 2020, p. 7) contributes to success. This ability to influence is also linked to ability to communicate. Effective and adaptable communication skills are required in disseminating information about the project to different audiences, and in building relationships for effective working. The effusive nature of a champion's attitude towards their cause tends to inspire others to get involved.

In the early stages of a novel intervention, there will be multiple challenges e.g. around funding and staffing, garnering support and challenging apathy. Someone who aims to champion the intervention will need "grit" (Bonawitz *et al.*, 2020), trouble-shooting skills, and tenacity to overcome and indeed learn and grow from the issues faced. Getting a project off the ground requires resilience as it may be especially vulnerable to failing at the outset, which will affect the team's ability to remain positive.

As champions will be prominent in the team or community, they will have a level of authority which can be a factor in the successful development of the programme. This is associated with influence, and the ability then to mobilise resources, access funding streams, borrow favours and affect agendas. Champions will be seen as responsible, accountable and trustworthy, promoting the programme to management and community alike. Akin to belief in the programme, ownership through their commitment inspires and motivates others to engage and form effective relationship at all levels. The perceived authority of a project champion is further enhanced by leadership skills that are “horizontal and collective” (Demes *et al.*, 2020, p. 1), rather than top-down and over-dogmatic. As such, participative leadership, which allows input and decision-making from all involved, increases the ownership and buy-in by teams and communities and promotes longevity (Bonawitz *et al.*, 2020).



Most surprising of all, a champion may also need to be prepared to take risks. At the outset, those driving a novel intervention may be on their own, with little support and there may well be critics. One may have to risk their reputation to put themselves “out there” (Shea, 2021, p. 5)

on something that may either fail or leave them open to criticism. There are also potential risks to their job and family life as hours are invested. However, champions who possess these qualities, with an intervention they believe in and organisational support and appropriate resources, could be the human factor required to create success and sustainability.

The role of champions is evident in the CCCP where, within each demonstrator site, a small group of people have emerged to take command of the vision, the design and the running of their intervention. The attributes noted above are consistent with this group of local clinicians, professionals and community and other organisation members.

In keeping with the CCCP themes, we could further distil the qualities of champions into being:

- **Connectors:** with their influence and authority they are able to connect with and bring in partners from across healthcare and community; securing funding, venues and other resources, and time with various audiences; *promoting co-production*
- **Credible:** they are trustworthy, reliable, suitably trained and knowledgeable individuals who are keen to widen the reach of a project by encouraging learning in others and ownership and buy-in; *supporting subsidiarity*
- **Charismatic:** their enthusiasm and drive behind the project is compelling; they are skilled persuaders with powerful negotiation and promotional skills who are prepared to take necessary risks; *aligning systems*

These ‘champions’ utilise their in-depth knowledge of local community challenges and use specific content to create local programmes of care delivery that renders their impact meaningful and memorable to local people and providers.

Clinical practice is sensitive to, and strongly influenced by, its environment and peers. An immediate positive impact is dependent on the power of context, case studies, track record and certain types of people disseminating information – and this information needs to be clear, consistent and unambiguous.

Tackling health inequalities across a nation can benefit from the production of a ‘policy epidemic’ which is usually dependent on the involvement of these people with a particular set of leadership and social skills. A relatively small number of ‘champions’ working in local projects that disseminate information, knowledge and enthusiasm are stimulating and creating a cascade of change in the CCCP.

Networking with other interested organisations, including those in the local community, was found to influence sustainability. Forming strong social links allows for pooling of resources, providing support in funding applications and running joint training sessions which are more cost-effective (Herlitz *et al.*, 2020); as can be seen in the ambitions of the CCCP’s learning network and the formation of a ‘sector’.

To help raise the profile of an intervention within a community, as well as the crucial input from community champions, there must be an understanding of the population it proposes to reach. For example, if in the past low numbers have engaged with health services, then providers must reach out into the community. Using existing and well-known community buildings, e.g., religious centres, leisure facilities, football grounds, instead of NHS buildings reduces anxiety, increases visibility, normalises it and embeds into the community (Horton *et al.*, 2018). Furthermore, accessibility should be a primary consideration, from the use of appropriate language and translation, including for those with impaired sight or hearing, to physical access. Public community buildings are likely to provide step-free access, and also be located on public transport routes, or transport must otherwise be provided. Access to transport often creates a barrier to people attending services, especially for disabled people (Disability Rights UK, 2021) and those on low-income or living in more deprived areas (Marmot *et al.*, 2020a).

Delivering activity within community buildings brings in the knowledge, expertise and connections of members of the third sector – the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector, who as mentioned above, should be recruited as champions. These are people who know and are known in the community; they will often facilitate or co-facilitate programmes, and their relationship with the community is vital in the promotion to and engagement of people. As well as their role in delivery, “a peer community, or network of adopters [champions]” (Horton, p. 43) can model behaviour change. It is more likely an intervention will be successful if it is visible in the community, aligning with the now common idiom, ‘you can’t be what you can’t see’, and this can drive a collective commitment. People often find adherence to healthy behaviour easier if they are part of a peer group for support, advice and motivation.

This connection to the community builds on trust-based reciprocal relationships to form and develop strong and equal cross-sectoral teams with a common goal (Bolton *et al.*, 2020), thus, enabling effective public engagement.

Programmes which are co-designed and co-produced, recognising the importance of cultural norms and values, with consideration of the role of language, may prove more acceptable to the public e.g. asking a community-based focus group what to name the service and avoiding over-medicalised or pejorative language such as ‘intervention’, ‘morbidly obese’ or ‘exercise’ (Bolton *et al.*, 2020). Public and patient involvement and engagement (PPIE) should be the standard when planning and designing, making decisions, procuring funding and resources, or delivering any health-related activity. This is even more imperative when reaching out with public health promotions. Again, success in reaching out to a target audience will be stilted if you do not directly engage with and integrate representatives from the population. Those experiencing physical, mental or social services from a non-clinical point of view contribute added value, a different perspective and are more appropriately suited to determine if an intervention is tailored to the population it aims to serve (Lee *et al.*, 2019).

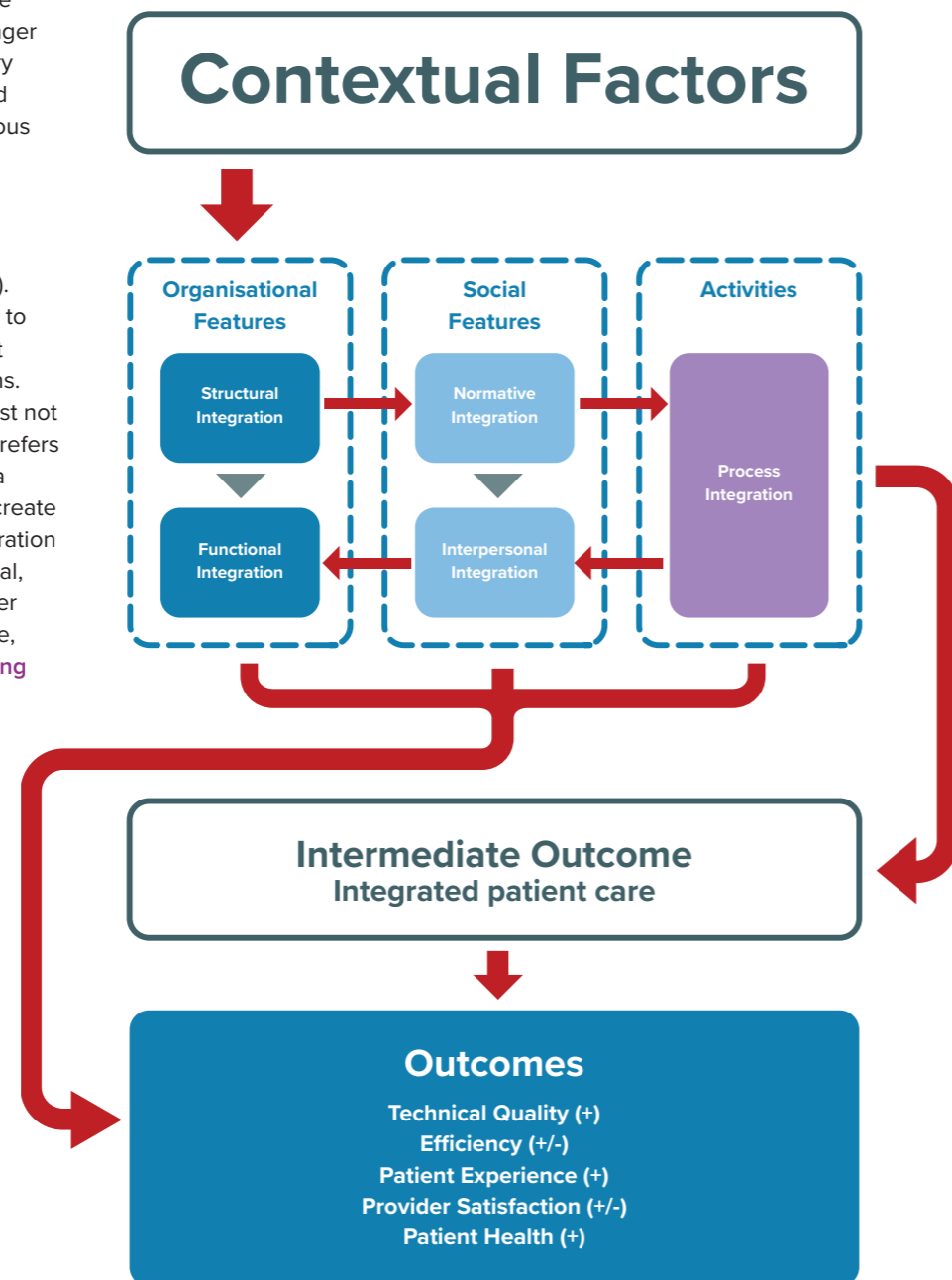
As outlined by McFarlane *et al.* (2016) earlier, the barriers from a humanistic and social approach to understanding the success and sustainability of transformative health programmes are essentially the antitheses of those that contribute to success (see also Herlitz *et al.*, 2020, Horton *et al.*, 2018, Rogers *et al.*, 2021). Therefore, having unskilled and unenthusiastic staff, with a high rate of turnover and the de-prioritisation of the aims and values of the programme, with insufficient management support and incongruence with the organisation’s culture, will have a destabilising effect. Furthermore, large and newly formed health centres can prevent useful staff co-operation and communication. As across the NHS, there are competing demands on budgets, staff are expected to do more with less, and this of course has a significant potential impact on the delivery of preventative or collaborative services that do not fit within core functions of the setting. The humanistic and social factors identified here, which may create and encourage momentum and sustainability in the delivery of transformative projects to benefit public health, will be examined across the Complete Care Communities Programme sites. This aims to elucidate and assemble patterns of good practice, and practitioners, across settings, clinical staff and community co-production to benefit future health and care service design.

Theoretical Approach

CCCP is evaluated using a critical realist approach to studying particular interventions. This is a theory-driven method whereby programmes are assumed to be based on theories, but are also dynamic and embedded in a social context that influences how a programme is implemented, and how various actors in that reality respond to it (Pawson & Tilley, 1997). It aims to identify the outcomes derived from interventions, what mechanisms generate these outcomes and what features of the context affect them. It is based on Context (C), Mechanism (M), and Outcome (O) (Pawson & Tilley, 2004). As such, a realist approach includes a theory-driven evaluation, but also a process as well as outcomes evaluation (Nurjono *et al.*, 2018). The theory-driven evaluation follows Singer *et al.*'s (2020) comprehensive theory of integration, which was developed through a thorough review of previous frameworks of integration in health. Integration in this theory is defined as "the making of a unified whole from distinct and interdependent organizational components" (p. 197). This definition is intentionally broad to encompass the variety of forms that relate to health and care integrations. However, the literature warns against not specifying which sector integration refers to. In this case, the CCCP refers to a diverse set of models designed to create connectivity, alignment and collaboration within and between the health, social, care, and community sectors (Kodner & Spreeuwenberg, 2002). Therefore, its main purpose consists of reducing fragmentations in service delivery and aligning efforts to foster both comprehensiveness of care and health promotion interventions in their respective communities.

Building on the Context, Mechanism and Outcome (CMO) approach to evaluate interventions, Singer *et al.*'s (2020) comprehensive theory of integration depicts a logic chain in which contextual factors influence the processes of integration, which in turn affect the potential outcomes (see

Figure 3). The mechanisms (M) in this theory are presented as five integration types to account for the range of integration arrangements in health care. These types are structural, functional, normative, interpersonal, and process. Structural and functional integration refer to organisational features, while normative and interpersonal integration refer to social features of integration, some of which have previously been discussed. Process integration describes the specific activities used in the course of care delivery, such as shared care plans.



Compared to other models, the difference between social and organisational aspects is what makes this framework the most appropriate when evaluating the CCCP. Previous studies have not paid enough attention to the social aspects of integration and team development (Singer *et al.*, 2020), although it is one of the key determinants in the successful implementation of integrated care as referenced in various guidelines (González-Ortiz *et al.*, 2018; LGA & SCIE, 2019). Table 1 provides a description of the components of Singer *et al.*'s (2020) model, including factors that have been identified in the integrated care literature that relate to each of them. Given the lack of attention to social features in integrated care and the current stage of the CCCP sites, the focus of this particular report relates to the cross-sectoral relationships, behaviours and actions that underpin success in the initiation of integrated care programmes. In this case, particular attention has been paid to interpersonal and normative integration features (coloured in grey). These have been previously discussed given their relevance in ensuring the sustainability of interventions addressing health inequalities.

Table 1: Detailed description of Singer et al.'s (2020) comprehensive theory of integration

Description		
	Singer et al. 2020	Factors
Organisational features		
Structural integration	Physical, operational, financial, or legal ties among organisations in a health system and teams within organisations.	Power relations Distance Resources Degree of interdependence
Functional integration	Formal, written policies and protocols for activities that coordinate and support accountability and decision making among organisations and individuals.	Confidentiality IT Continuity of meetings Training Commissioning Management Transparent processes and governance Evaluation and accountability
Social features		
Interpersonal integration	Extent of collaboration or teamwork among health care professionals of one or more disciplines and from one or more organisations, as well as nonprofessional caregivers and the patients themselves.	Communication Engagement (community + partners) Previous relationships Background/territories Team functioning
Normative integration	Common culture and a specific culture of integration across units and organisations within a health system.	Cultural distance Mutual understanding Open culture Personalities Leadership (Processual) Trust Shared Vision
Services and context		
Process integration	Courses of organisational actions or activities intended to integrate patient care services into a single process across people, functions, activities, and operating units over time; specific activities that demonstrate care has been or is being delivered in a coordinated way (use of shared care plans)	Multidisciplinary care pathways
Context	Features of the market and organisational context that affect integration types	National policies & regulations Bureaucracy Geographical boundaries Previous history

Although the approach of this model is useful for the evaluation of the CCCP, a key distinction needs to be made to apply to the context of the case studies. The comprehensive model of integrated care mainly relates to a patient-centred conceptualisation of care. Many of the projects included in the CCCP refer to population-level health perspectives and integration strategies, as explained before. In this regard, the outcome of the integration of care in the context of the CCCP is conceptualised as the progressive achievement of TVH.

Methodology

Underpinned by the theoretical framework explained above, the present work has adopted an underlying methodology using what is generally termed 'action research', a concept which aims to improve the links between theory and practice. The underpinning theory behind action research has its basis in the wider field of operational research, which sets out to understand the rationale underlying complex problems, not least those with managerial elements. The basis for such an approach was discussed by Eden and Ackermann (2018) who explored the practical application of action research, highlighting how the methodology can be both rigorous and relevant, not least for strategy development, the central aim of the present work.

The application of action research in the health field has been reviewed by Casey *et al.* (2021). Their review argued that traditional research generally sought to provide answers for abstract thinking as opposed to practical application. Drawing on the work of Coghlan and Shani (2018), the review used a framework based on two key elements: the relationships between context and the quality of relationships. It has a dual focus on the inquiry and implementation process, as well as concern for the actionability and contribution to knowledge creation.

The arguments for the above factors are that they comprise a comprehensive framework as they provide the opportunity to capture the complex cause-and-effect dynamics within and between each factor.

The authors explain the factors as follows:

- **Context:** the context of the action research project refers to individual, organisational, environmental and research/consulting factors. Individual factors include ideas about the direction of the project and how collaboration can be assured. From an organisational perspective, the availability and use of resources, influence of previous history, and the level of congruence between these impacts on the capability for participation. Environmental factors in the global and local economies provide the larger context in which action research takes place. An example of research factors which can have relevance relates to previous research experience and involvement with a similar area or topic.
- **Quality of relationships:** the quality of relationship refers to trust, shared language, concern for each other and equality of influence between members and researchers.
- **Quality of the action research process itself:** this refers to the dual focus on both the inquiry and implementation process as they are being undertaken.
- **Outcomes:** the dual outcomes of action research are some level of organisational improvement and learning, and the creation of actionable knowledge.

The present report has adopted the approach outlined above through three phases. First, the contextual setting for each of the CCCP sites was explored, following the comprehensive theory of integration explained earlier. The aim of this was to understand the key elements behind each project given their uniqueness, and hence variability. This was achieved using a semi-structured interview of the project team at each site. The interview itself was an hour long and covered four topics: the rationale for choosing the project; the level of engagement within the NHS; the level of engagement outside of the NHS (including the target group for whom the project had been designed to help); and the extent to which learning opportunities about the work were occurring.

The second element, conducted at the same time, was a formal questionnaire which the programme site team were asked to complete (Appendix 1). This covered two themes: the sectors involved, and the engagement process. The third element was a follow-up questionnaire on the progress made at each site since the commencement of the programme. For Wave 1 programmes, those which commenced towards the end of 2021, the programmes had been running for approximately 6 months, while for Wave 2 sites, those commencing at the beginning of 2022, the timeframe was obviously far shorter.



Findings

The collected data is presented in two broad categories. First, an overview of the sites is presented. The overview includes the nature of the project and the proposed parties involved in the work. To help understand the contextual setting, the findings from the semi-structured interview are reported. The four themes: the rationale for the work; the engagement within the NHS; the engagement with other parties including the target audience; and education and training aspects, are explored and common themes highlighted. This aspect is referred to as the qualitative element.

The second category reports 'progress to date' of the evaluation and is more quantitative in nature. For each dimension of the project, the project leader was asked to judge how well the programme was working. Aspects reported include overall progress of the project, the level of engagement with the target audience, level of engagement with the NHS sector, that with the sectors outside of the NHS, progress in addressing inequalities, NHS management support and the workload that the project was creating for the respondent.

The results of the two categories are then explored in the third section. In one way, these results are the most important as they provide the opportunity to identify key components required to enable the project to achieve its goals.

The Contextual Setting: Qualitative Aspects of the CCCP Sites.

The CCCP, while having overall common goals, consisted of very differing sites, each one of which was unique. Furthermore, given the timeframe to identify actual changes in health inequalities, the present work can only begin to measure process measures towards that goal.

The qualitative aspects, derived through semi-structured interviews, provide the contextual setting that each site found itself in. This approach provided an opportunity to see whether, despite the unique nature of the site, common elements exist that led to the decision to enter the CCCP and, subsequently, the rate of progress being made.

The overall programme consisted of two waves of entrants. The first saw 20 sites enter the CCCP in early 2021 and the second wave in early 2022. The timings are of importance as the experiences of the Wave 1 may have provided support for the Wave 2 entrants. Furthermore, progress towards the goals of the programme is more likely to be found in Wave 1 simply due to the duration of their activities.

The themes of the project organised by each of the sites showed a high level of commonality. The largest topic of work was mental health with 15 sites undertaking a project in this area. For 12 of these sites the emphasis was on children and young people. For the other sites, the topics included obesity (6 sites), cardiovascular disease management, comorbidity management, working with the homeless, falls reduction, and reducing knife crime.

Rationale for the project

The first element discussed in the interviews was the rationale for the project topic. While some of the sites had recognised the need for the work, the establishment of the CCCP provided an opportunity to actually develop it in what many project leads described as "a supportive environment". Not least, the principles enshrined in the CCCP were those which the project leads shared and as such gave them confidence to progress the work.

Three overriding themes existed; the project had an understanding of the specific needs of the population that the site was engaged in addressing; it was felt that the solutions to helping the target population could not be achieved solely through medical interventions; and that the emphasis given in the current General Medical Practitioners national contract was not always synonymous with meeting the local identified health needs. In addition, site leads frequently mentioned the issue of socioeconomic deprivation as a factor which was linked to health needs. Many site leads commented that, unless these issues were tackled, meeting the needs of the target group, and in consequence, addressing health inequalities, would not happen.

When asked for their rationale regarding the above factors, two issues were mentioned frequently; trust, and continuity of the relationship with the target group, both of which had built up over a period of time. Indeed, a number of the sites had used the project to build on already established links, especially with community and voluntary organisations. The temporal order for the link varied. For some sites, there had been a long history of community engagement which the project lead made efforts to link to. For others the situation was reversed, with the project lead facilitating the development of a bond between the various groups.

In a number of cases, the importance of the social prescriber was identified as facilitating the links. Site leads commented on the value of this role, in particular the strong community links they had either when appointed or created once in post. A further factor in helping provide the understanding of the target group for the project was previous work experiences. A number of the site leads had combined their present work in practice with working in other settings, for example a local Trust, which gave them a greater insight into the issues, in particular for service development. This was a common finding for those sites addressing mental health issues.

But perhaps the single most important factor found at each site was the strength of purpose and leadership. Characteristics of drive and energy, along with recognition of the importance of networking,

were all present. In some sites, this meant challenging the current orthodoxy, whether it be the way that the practice or secondary care operated. For the majority of sites, the lead had or continued to hold a position of Clinical Director. This was seen as important by the holder for a number of reasons. Frequently commented was that the title itself was felt to provide a level of authority within the system when attending meetings, but also gave that individual an increased sense of confidence.

Engagement within the NHS

The financial backing for the projects was to varying degrees provided by the NHS and, as such, the case for the programme had to be made. While at the macro (regional) level the case was accepted, there was variation at both the meso (PCN) and micro (practice) levels. As with the rationale for the project, a common theme centred on relationships. **Where good relationships existed within the NHS systems, the project lead had a sense of confidence on the likely progress of the project.**

NHS relationships operated within several system elements. There were those between management and clinicians, those between secondary and primary care, and those within a practice. While the variation in projects meant that not all projects involved all elements, a common finding was that where relationships were difficult, the work required by the project lead appeared to be substantially greater when compared to projects in which relationships were good. Factors associated with the strength of the relationship included the length of time that the project lead had worked in the area, age of colleagues (particularly important for projects involving secondary care, with younger colleagues seeming to be more willing to explore new models of working), and managing current workload in both the practice and PCN.

There appeared to be a high degree of variation concerning the qualities of management apparent within the NHS structural organisations. Both within a practice and within the PCN, differing project leads noted issues which impacted on the actual project. Where management of high quality existed, the projects had developed with relative ease. For sites where management issues existed, either within a practice, a PCN or both, the project lead came across additional workloads to ensure the project would run smoothly; this proved particularly true for PCNs.

For a number of sites, a tension was evident between national and local priorities. The national targets were identified within the local NHS system as the priority, but these were not necessarily coterminous with addressing local needs. In many of these cases, the project lead also

stressed the need to move away from a medical model of health to a social model, if the determinants of health were to be improved and inequalities addressed. A number of sites reported that management was seeking early goals to help justify the programme, not least if the project did not match the goals which management saw as important.

Throughout the projects the importance of a supportive network was evident. Numerous project leads commented on the value of having medical colleagues to discuss issues with. In some sites there was a sense that some of the project leads were feeling isolated. While the Project Management Office (PMO) was able to offer support, the day-to-day operational aspects of a project did impact on the project lead and where a sense of isolation existed, the additional stresses of the work were evident.

Examples of where projects appeared to be progressing well demonstrated certain leadership traits. For example, a model of delegative leadership allowed the project to maximise opportunities arising through community engagement, in which other team members of the project were given the freedom to work as they saw fit. This highlights the importance of trust and collaboration as factors in this work.

One other important issue that a number of project leads raised centred on the prescriptive use of funding for other health care roles. The leads would have liked to have seen greater freedoms in any appointments to help support the work through what they saw as relevant personnel on contractual agreements, that best suited their needs, as opposed to the inflexibilities in recruitment which existed.

Engagement with the non-NHS sector and target population



In order to succeed in addressing health inequalities, the majority of projects must work with agencies outside of the NHS and, equally, ensure engagement with the very audience the project seeks to help.

Of all the elements explored in the interviews, the contextual setting of the projects when they started is perhaps of most significance. At one extreme, a project had started in which engagement with the target population and non-NHS agencies had yet to commence, and at the other, charitable agencies had been fully converse with the target population over a considerable period of time and were involved with the project from the start.

Perhaps most importantly, irrespective of the current state of the project at the time of the interview, all parties recognised the need to engage. Of particular note, many project leads identified improved data analytics to help support the work although the extent to which the public

health team was engaged varied. Whether this was a lack of appreciation of where and how they could help, or whether the data the project used was limited to that found within the practice, was not explored.

As highlighted above, the historical context was a key factor in the level of engagement. For many projects, the practice project team had formed links over a considerable period of time, a factor seen as of enormous value to the likely success of the project. Examples of key relationships included those with local councils, in particular social care, voluntary and community organisations, and groups such as the faith sector. A number of project leads also commented on the role that these groups had played in the COVID-19 pandemic supporting vaccination uptake.

The relative importance of the role of local councils in any programme was recognised. The majority of the sites had working relationships with the relevant local council, with the project lead valuing how both parties collaborated. Given the positioning of public health teams within local authorities, the data issues above could be easily addressed.

A sense of purpose existed for all the projects in which an underlying theme of 'working with' as opposed to 'doing to' the target population formed the basis of the work. Although one or two sites struggled to establish exactly how this would occur, for many there was a history of understanding the area, knowing which voluntary and community organisations existed and reinforcement of the key role that a social prescribing link worker could play in addressing the problems.

Sustainability

Three dimensions concerning sustainability were explored: the impact of the project on the project lead; the level of engagement from other parties should the project lead step away; and the extent to which educational opportunities arising from the project were being utilised.

While for all project leads the programme was seen of value and progress was being made with enthusiasm, a number noted that their overall workload had increased, and some held reservations about handling both the practice workload and the project (which did not replace the former). All leads were committed to the work, but felt concerned about how work would be managed in the longer term. Linked to this was the financial elements of the work. A small number of partners commented on these aspects of the project due to what they saw as negative financial effects on the practice.

The above issues were not helped by what many project leads saw as current system pressures, with a number saying that the work on the project exacerbated what was already a problem. This was in-part dealt with through

different leadership approaches; if the project was at a stage for passing over to the 'team', doing so could alleviate pressure as coping with many aspects of the project in a team setting was not considered an issue.

A number of the projects were already involved with postgraduate education, most commonly with general practice, but also nursing. Indeed, a number of sites also worked with undergraduate medical schools. However, there was limited engagement with Health Education England on the opportunities that the project created with regards to developing community engagement. While the project leads could see the benefits, not least in highlighting the importance of social determinants and the use of data and local knowledge in influencing health, this was only happening at one site.

Overview

The overall picture gained from the interviews highlighted a remarkable commitment to the project by the project leads. All demonstrated an enthusiasm and energy which the work had given them, although for some the workload was proving challenging. Not least, the programme was seen to be 'in addition to' as opposed to being 'part of' their day-to-day workload within the NHS.

Key factors of the programme that were highlighted as being of importance included trust and collaboration, both of which had been built up over time. The project leads tended to be 'embedded' within their communities, whether in wider society, and hence having an appreciation of the problems that the target group of the programme found itself facing, or as part of the NHS community, showing leadership within the system at practice, PCN or wider level, or working with the various community agencies.

The project leads demonstrated considerable leadership skills. They were committed to 'their' populations and while at times a number found themselves isolated within the NHS for a variety of reasons, engagement with non-NHS bodies was very high. Tensions between the project lead and other NHS parties existed in a small number of the projects. At the macro level, the NHS General Medical Services (GMS) contact was seen as the fundamental driver at both practice and PCN level, and the drivers within it were rarely seen as being congruent with the needs of the target population. At the meso level, while a number of PCNs were supportive of the project, others were less engaged. This picture was also found at the micro and practice level. The positional role within the system of clinical director, was of considerable value in overcoming the challenges that the project leads faced when arguing for support for the project.



While the importance of data to help support the project was recognised, engagement with parties such as public health varied. However, it should be noted that the timing of the interviews for this section of the evaluation was in the early stages of the project's development.

Finally, the long-term sustainability of the projects was of concern to some project leads. While the majority felt that the programme was now embedded in the local environment, with the PMO team being seen of value in helping achieve this, a small number were concerned about the workload that the projects were creating. In some cases, this was having a personal impact on the leads. Moreover, the opportunity for helping create sustainability via the next generation of the NHS workforce was not evident, save for a few exceptions.

Project Progress.

At the time of writing, 19 of the 26 sites had completed and returned the progress report form, a response rate of 73%. The response rate for Wave 2 sites was higher (83%) than that of the Wave 1 sites (60%). Overall, five sites (26%) felt they were making excellent progress (four from Wave 1, one from Wave 2) Five sites felt progress was good, while four sites said that it was satisfactory. Two sites felt that progress was only fair or poor. Both of these sites were part of the second wave entrants. Overall, Wave 1 sites felt that better progress had been made than those sites in Wave 2 (Figure 4).

A key component of the project lay with the level of engagement with the target group of the population, as demonstrated in Figure 5. Only one site reported that engagement was excellent, although eight sites (42%) reported that good progress was being made. Five sites reported that engagement was satisfactory, one site reported this to be fair, and one said it was poor. Wave 1 sites reported a better overall level of engagement when compared to those in Wave 2 (Figure 5).

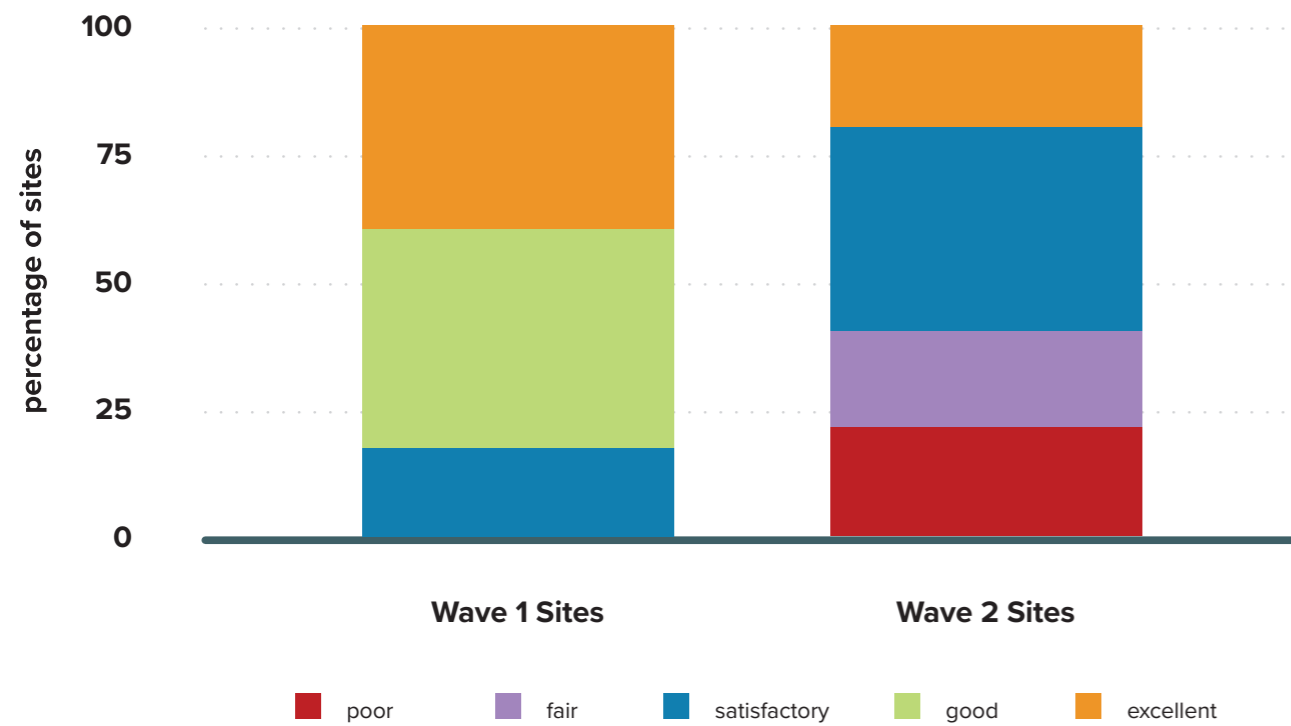


Figure 4. Overall site project progress by Wave

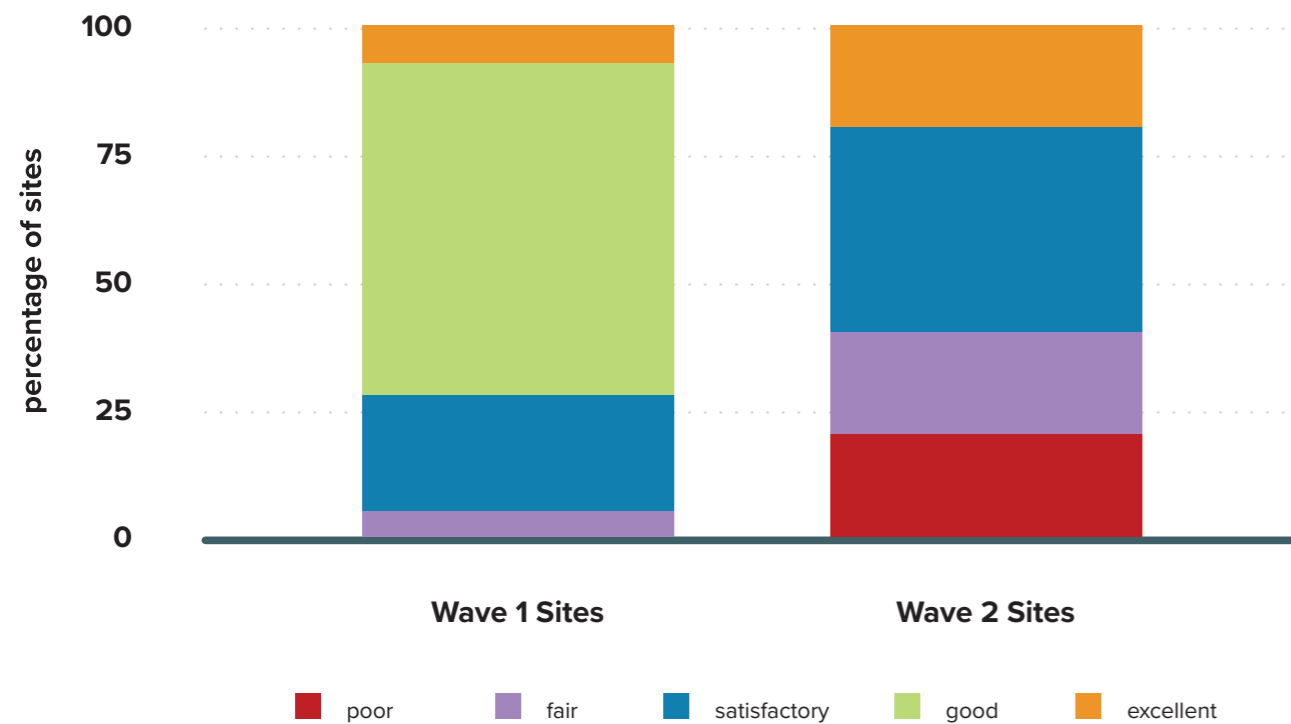


Figure 5. Target population engagement by Wave

A further important element lies with the level of engagement within the NHS sector. Figure 6 shows the level of

engagement within the NHS by wave. Both waves reported a high level of engagement; perhaps unsurprisingly, no site reported poor engagement. As with the previous factors, Wave 1 reported an overall better level of engagement,

with nearly two thirds of sites reporting engagement was either good or excellent. This compared to 40% of sites in Wave 2.

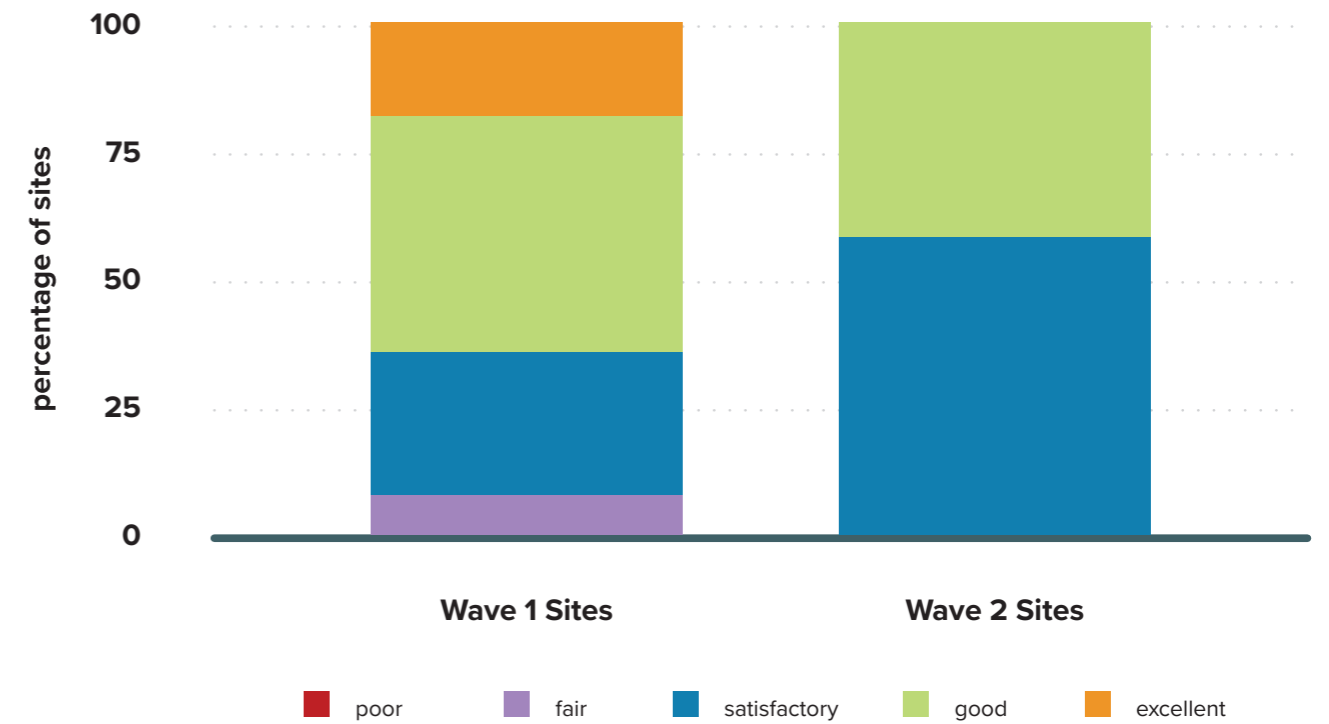


Figure 6. Level of NHS engagement by Wave

With respect to the non-NHS sector, sites in Wave 2 reported a similar overall distribution of engagement as that reported for within the NHS. However, Wave 1 sites were generally more positive. Overall, 45% reported excellent and 27% good engagement, a total of nearly 75%, while for Wave 2 sites, the percentage was 40% (Figure 7).

progress on this element, with 60% of sites reporting that progress was good or excellent. However, a single site felt that progress was only fair, this being one of the Wave 1 entrants.

Figure 8 shows the extent to which progress towards addressing health inequalities was being achieved. Both Wave 1 and Wave 2 sites were similarly positive about

Figure 9 shows the workload impact of the project. The reported workload for Wave 1 sites was greater than that for Wave 2. Over half of the Wave 1 sites reported that the workload was fair, and no sites recorded it as being excellent. This compares with 20% of Wave 2 sites.

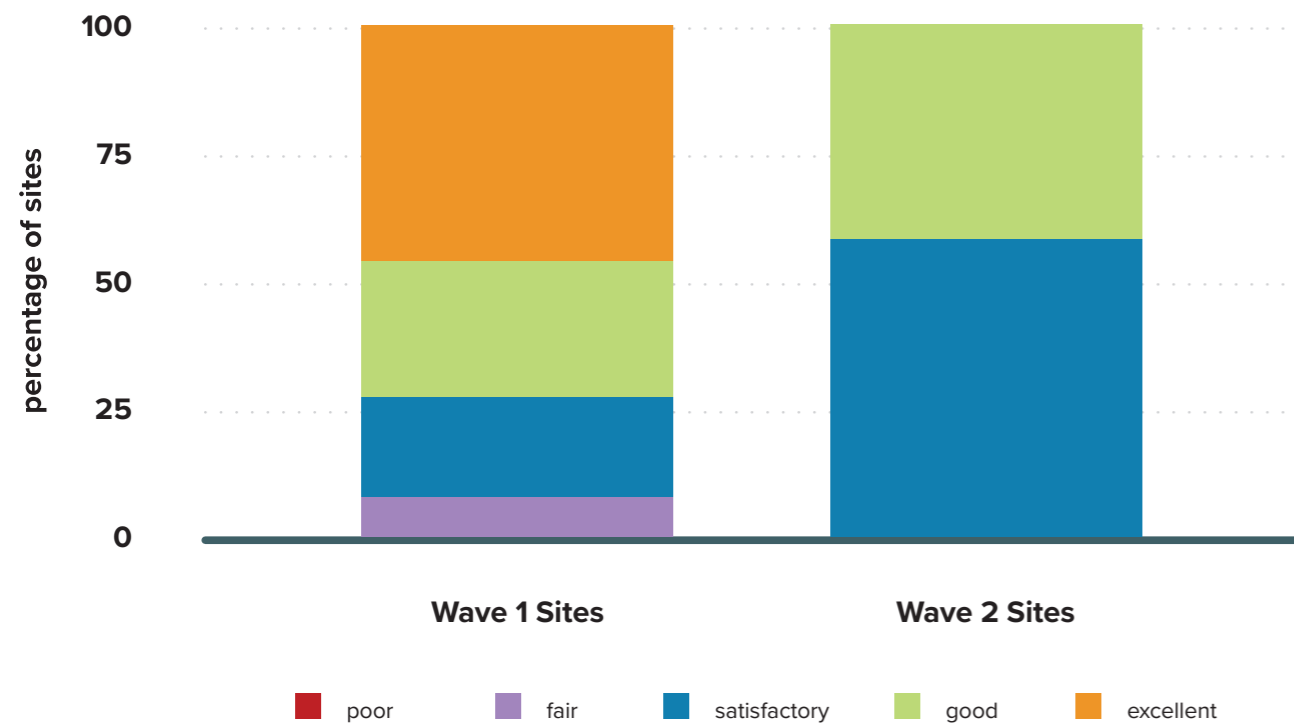


Figure 7. Level of non-NHS engagement by Wave

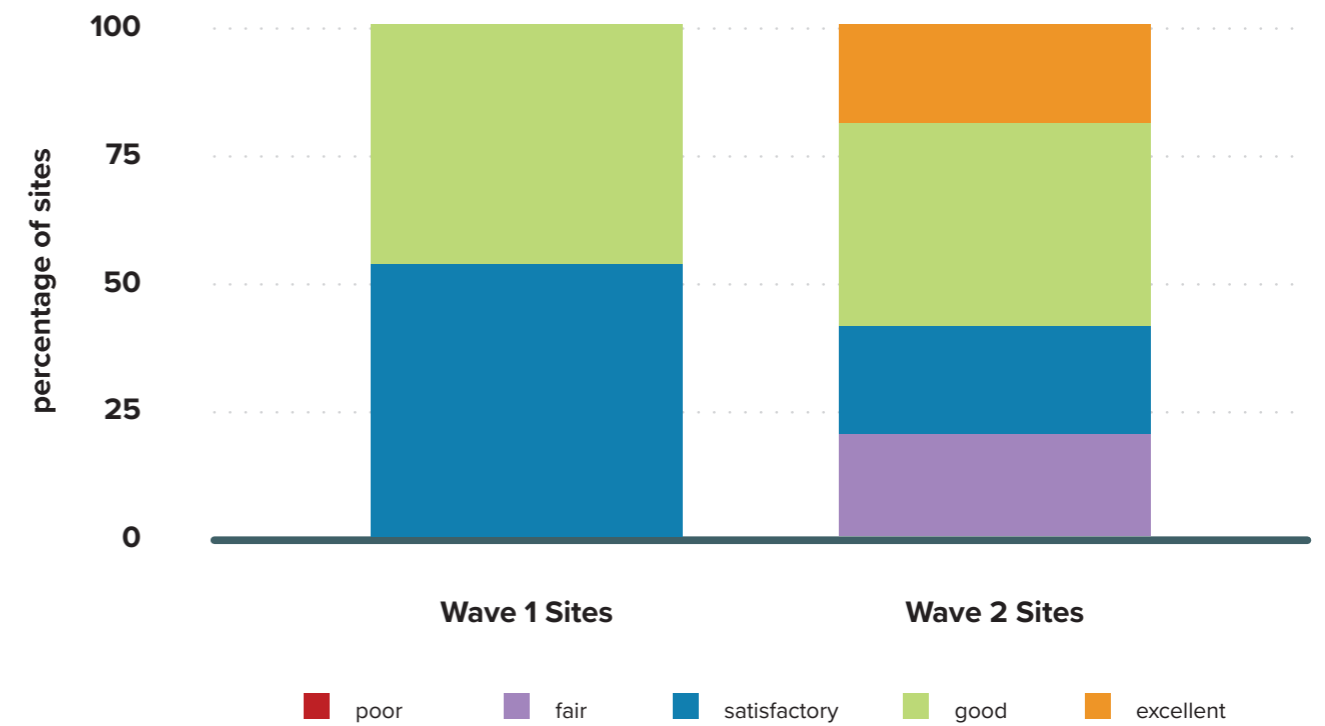


Figure 9. Workload by Wave

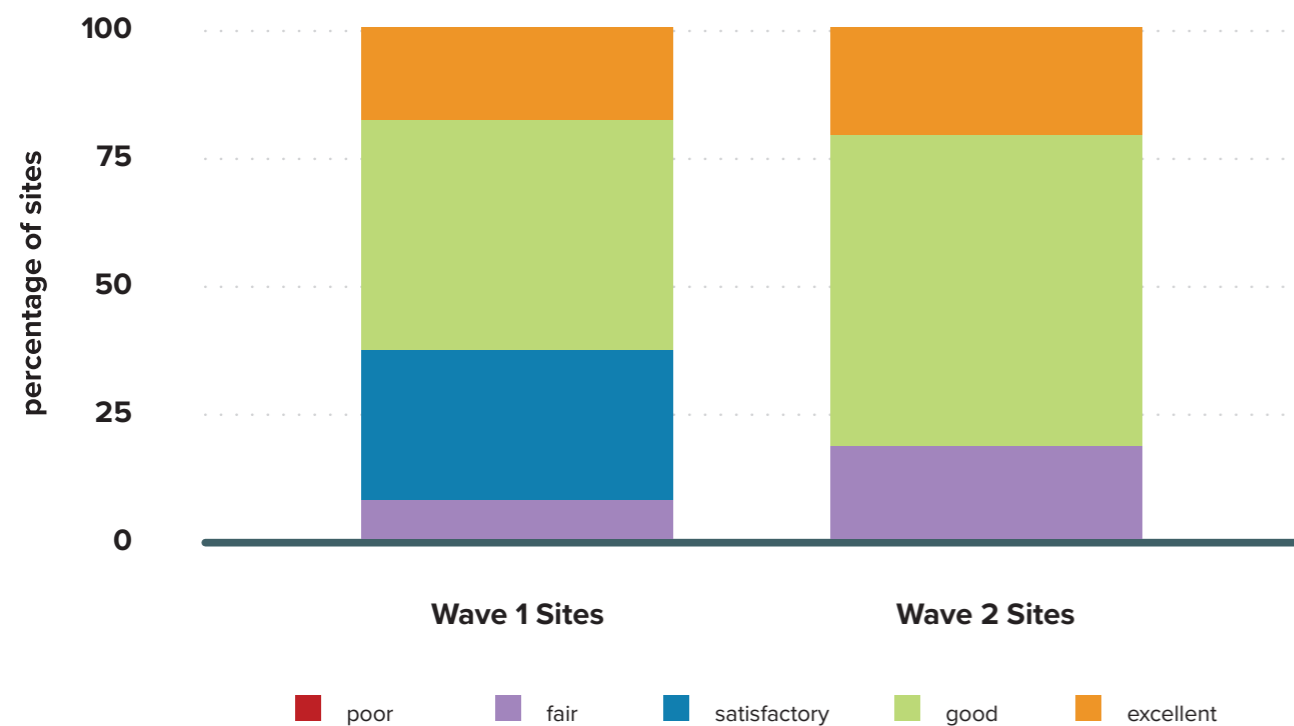


Figure 8. Level of NHS management support by Wave

Overall, these findings suggest a sound level of engagement and support in all of the sites. Variation between Wave 1 sites and Wave 2 is to be expected. For key elements of the project, these being engagement with the three key groupings of the target audience (the NHS and non-NHS sector), and better levels of engagement for those sites which have been running for longer, (i.e., Wave 1 sites), this is to be expected.

Levels of management support were similar, although for both waves the degree of variation may be indicative of other issues which will be explored in more depth in the subsequent section. Finally, workload aspects, with Wave 1 sites scoring lower overall satisfaction, should be noted.

The Relationship Between Progress And The Contextual Setting.

In the previous section, the progress that sites felt they were making was reported. The question that arises is whether there is an association between the contextual setting of each project identified at the start of the programme and the issues found, and also whether it affects approaches taken to develop the work.

The overall picture of progress was very positive, with the exception of two Wave 2 sites. Where progress was felt to be most successful (i.e., where project leads were awarded the highest overall score), three of the factors assessed also scored highly; engagement with the non-NHS sector,

engagement with the NHS sector, and perhaps most importantly, engagement with the target population. When ranking the progress elements, engagement with the non-NHS sector was the most successful aspect, while progress towards inequalities the lowest. This is to be expected as the results of addressing inequalities are unlikely to be seen for a considerable time, while engagement with the target population had been highlighted as a precursor in the interviews as a necessary step towards it.

Both of the Wave 2 sites that felt progress was weak reported developmental issues in the contextual interview. In one the lead considered communication between parties to be poor, while in the other site additional external evaluation arrangements were taking place for the present report. This created unnecessary and inappropriate time pressures. Conversely, where the project site had reported good collaborative working, progress was rated high.

Contextual factors linked to engagement with the NHS sector highlighted the importance of management in helping ensure that project leads felt supported. In the contextual interviews, some project leads expressed a view that the PCN had 'other priorities' to concern itself with, especially issues with the national contract, marginalising the project and ultimately hindering progress. This was particularly apparent in a site in which the clinical director was not linked to the project.

The site with the lowest scores across the measures assessed reinforced this issue. While the clinical director was involved, engagement was limited. Relationships within the PCN were poor and management weak. The national targets were seen as having overriding importance, despite concerns about their immediate relevance to the site.

Finally, feelings about the workload created by the project were inversely correlated with those expressed about project progress. Where progress was reported as very good, the workload was felt to be fine while for those where progress was challenging, workload was seen as demanding.

Discussion

The report of The Primary Care Working Group (Oldham *et al.*, 2012) identified seven challenges that had to be overcome if the potential of primary care was to be achieved (pp. 8-10). The challenges were:

- Poor patient access and perception
- Insufficient coordination and integration
- Low professional prestige and workforce availability
- Lack of infrastructure investment
- Misaligned incentives
- Under-utilisation of information and technology
- Variable quality standards and regulation

The CCCP has concentrated on the second element, that of coordination and integration. It set out to establish the potential for locally based care arrangements, known as demonstrator sites, to tackle both the consequences and causes of disparities in ill health. It recognised that its approach needed to be more inclusive of other agencies that shaped the determinants of health and, not least, the importance of relationships with all parties. This is especially true for the project target group, the very group who were struggling to maximise their health potential through existing delivery programmes. The underlying question can therefore be framed by exploring the necessary elements for a pilot site to succeed for beneficial system reform, as well as the potential issues.

Addressing the issues of coordination and integration.

When addressing the issues of coordination and integration, two aspects that need to be considered are the organisational and cultural or social issues, as explained in the theoretical approach.

Overall, the qualities of the contextual setting in which the project had commenced provided an indication of the reported rate of progress of the work. If elements such as limited collaboration were apparent at the start of the project, then progress towards its goals proved more challenging. While this is entirely to be expected, the above analyses have highlighted several key factors which can be developed and which, if present, are likely to lead to a more positive rate of progress and successful outcome of the project.

Organisational features

Structural integration:

Structural integration refers to physical, operational, financial, or legal connections between those actors participating in integrated care (Singer *et al.*, 2020). A key success factor for structural collaboration relates to the presence of compatible organisational structures and working arrangements to improve collaboration, which has also been discussed in the findings of this work with regards to management. Moreover, collaboration, particularly mandated schemes, must align with the political and economic interests of all organisations involved (Auschra, 2018). In this regard, power asymmetries between disciplines and sectors need to be addressed because these relations can lead to decreased pooling of resources and slow planning and implementation (Aushra, 2018). A possible solution has been to provide adequate resources to initiatives to ensure financial stability. Research has shown that pooled resources can increase transparency and equitable distribution, and thus address some of the issues discussed previously, securing long-term engagement (Cameron *et al.*, 2014, Duggal *et al.*, 2021, González Ortiz *et al.*, 2018). Eventually, measures to create interdependence, such as pooled resources and formal contracts, are argued to improve integrated care (Singer *et al.*, 2020). In particular, partnerships across the entire care continuum are needed, including beyond health care, to improve quality and efficiency (Valentijn *et al.*, 2013); a key aspect of integrated care that has also been identified through this work. As seen in the findings, the formation of partnerships beyond the NHS sector can depend on the historical context of where projects are developed.

Another important aspect is distance; team members must be brought together either physically or virtually to ensure ongoing collaboration. Mechanisms need to be put in place for this to happen (Choi & Pak, 2007), for example instigating changes regarding implicit requirements of practices, performance evaluation, incentives and reward system (Choi & Pak, 2007). However, as seen in the findings, this can be constrained by tensions between national and local priorities.



Functional integration:

With regards to functional integration, which facilitates the coordination and decision-making among organisations and individuals, the literature identifies several aspects that facilitate its successful design and implementation. Previously, studies have demonstrated that special attention must be given to IT-infrastructure and confidentiality issues, so as to enable interoperability and ongoing information exchange across sectors (Auschra, 2018, Cameron *et al.*, 2014, Choi & Pak, 2007, González Ortiz *et al.*, 2018, Lewis *et al.*, 2021). As seen in the findings, there is a need for improved data analytics to help support the work of CCC projects.

Moreover, at initial stages of integrated care projects, there is a need to clarify roles and ensure motivation beyond initial design, as also identified in this work. For this, research suggests rotating roles so that ongoing learning is in place (Cameron *et al.*, 2014, Schot *et al.*, 2020). Learning is a key aspect of improving the quality of integrated care, as integrated care requires new types of competencies. These skills include teamwork, people-centred and population care, quality assurance and governance management (Borgermanns *et al.*, 2017). Thus, factoring training into the design of integrated care projects becomes salient (Cameron *et al.*, 2014). This also means that an adequate workforce in health inequalities should be prioritised to ensure that key principles of the population intervention triangle and triple value health care are present, from design to implementation. As Miller (2018) suggests, this means freeing up specific people to carry out, monitor and review integrated projects.

Besides the factors discussed above, the literature suggests that clear standards and systems for evaluation and monitoring (accountability) need to be designed. Although not necessarily identified in this work due to the stage of the CCC projects, this topic requires further attention. Evaluating the outcomes of integration, as well as the process, by developing a system of ongoing reflection and assessment of new directions, helps ensure the sustainability of interventions (Maslin-Portero & Bennion, 2010). In agreement with the literature, the findings suggest that process steering at the beginning of a partnership is key in integrated primary care partnerships (Valentijn *et al.*, 2015). Thus, research argues that specific methodologies are required that guide improvement throughout the project e.g. a detailed action plan agreed by all partners and team building mechanisms at the outset (Miller, 2018).

Social features

Interpersonal integration:

Interpersonal integration refers to multidisciplinary teamwork among organisations that collaborate to improve care within a locality (Singer *et al.*, 2020). As seen here and in the literature, a key aspect for successful interpersonal integration is effective communication between team members, which should be transparent and aim for cohesiveness and knowledge transfer (Auschra, 2018, Choi & Pak, 2007, Cameron *et al.*, 2014, Schot *et al.*, 2020). Communication should not only be between team members, but also involve the targeted population group (Duggal *et al.*, 2021). Indeed, participation of the targeted population by providing input on various levels is key for a successful project (Nurjono *et al.*, 2018, Seaton *et al.*, 2018). Moreover, ensuring that all relevant partners are included should be a consideration at the beginning of any integrated care project so as to avoid possible barriers in the future. This should account for ongoing

engagement with influential political and organisational leaders to address anxiety about the development and implementation of the project on the part of team members and target population (Auschra, 2018, Duggal *et al.*, 2021).

Overall, interpersonal integration should aim to develop bottom-up collaborative ties across partner organisations, targeted populations and relevant influential actors so that those involved take ownership of the project (Ahgren & Axelsson, 2007, Miller *et al.*, 2021). For this to work, professionals need to see beyond their own interests and professions and focus on the common good (Axelsson & Axelsson, 2009). A key consideration here is clarifying the terms used in the project, ensuring that all agree on what is being discussed, and building a respectful atmosphere (Lewis *et al.*, 2021, Valentijn *et al.*, 2013). Significantly, as seen through this work, engagement within and outside the core working group should be a point of consideration in integrated care projects to ensure long-term sustainability.

Normative integration:

Normative integration, at its core, refers to the social features needed to advance integrated care. In particular, it focuses on developing common culture and values that prioritises bringing together efforts to address population health needs (Singer *et al.*, 2020, Valentijn *et al.*, 2013, Van Kemenade *et al.*, 2022). Building a common culture would mean that organisational members should be willing to accept the changes needed in order for integrated care to work (Aucshra, 2018). In this regard, besides a common culture, a culture of acceptance and openness needs to be fostered to ensure collective reflexivity (González Ortiz *et al.*, 2018, Schot *et al.*, 2020). In this work, this has been identified as an issue around building trust across all levels of the integrated care project. In particular, integrated care members should ‘reflect-on-action’ and values to facilitate the creation of both the project and a shared long-term vision (Valentijn *et al.*, 2015a, Van Kemenade *et al.*, 2022). In other words, effective integrated care is “often related to social relationships in which people interactively assign, re-interpret and re-negotiate their identities, values and working methods” (Borgermanns *et al.*, 2017, p. 5). This enables the building of relational capital (Valentijn *et al.*, 2015a, 2015b) which, as seen in this initial evaluation, also depends on reliability and dependability, transparency, competency and sincerity.

Research shows that in order to construct this culture it is important that leaders enable it to flourish (Singer *et al.*, 2020). Thus, leadership becomes a key determinant in ensuring the success of integrated care. As seen in this work, leaders should be able to ensure that collaborations do not divert from the shared vision of the members, and ensure constructive feedback about the collaborative process and the project can be provided; this helps to build trust-based relationships among members, inspire

members to work together, and aids members to take a systemic view (Borgermanns *et al.*, 2017, Cameron *et al.*, 2014, González Ortiz *et al.*, 2018, Sims *et al.*, 2021). In particular, leaders should be able to adapt to changing circumstances and thoroughly understand the complexity of factors required to ensure the success of the integrated project. This might mean creating conditions to work together, balancing multiple perspectives, and navigating the power dynamics present in integrated care projects (Sims *et al.*, 2021). This has been defined in the literature as processual and altruistic leadership (Axelsson & Axelsson, 2009, Sims *et al.*, 2021). In other words, leadership should be transformational, which as seen in this project, is present when the clinical director is involved.

Lessons for producing a sustainable complete care community site

The underpinning evidence base that informed the programme’s development suggested a number of ‘enabling’ key factors are helpful for development, not only in the initial phase, but equally importantly for sustainability in the longer term. The NHS has seen a number of programmes hoping to achieve similar goals and, while initially seeing positive outcomes, fail in their adoption at scale. Perhaps the most recent example is that which has become known as ‘The Wigan Deal’. As the report by the King’s Fund (2019) noted:



Importantly, Wigan shows that asset-based working should not be seen as a technocratic quick fix – it is not a tool to be adopted, but rather a culture to be grown.

When addressing the issue of replicability, the report highlighted that skilled leadership at all levels in the system was required both strategically and operationally. If there is a single factor that highlighted the vigour existing within the CCCP, it was the purposeful leadership of the leads. This is in line with the report produced by the Social Care Institute for Excellence (2018) titled *Leadership in integrated care systems*. The factors the report identified are similar to those identified in the present work. The site leads showed an innovative approach to addressing the problem. They relied on relationship building and connecting to other parties identified as relevant; they were remarkably committed and effective in their ways of working, and a key theme of the work was capacity-building.

Combining the literature review and the present evaluation findings highlight some general principles which would help create a sustainable environment to allow a CCCP site to flourish and achieve the overarching goal of contributing to reducing health inequalities. These are summarised in Box 1 below.

- 01 Good governance: inter-organisational, interprofessional, multilevel, data governance, accountability, formal arrangements, clarification of roles and responsibilities
- 02 Financial stability: pooled resources, long-term financing of projects, invest in strategic capacity and capability, structural change related to triple value healthcare
- 03 Structures for collaboration: change of rules, requirements, incentives
- 04 Continuous motivation: ongoing learning, communication, team building
- 05 Horizontal engagement and participation: bottom-up collaboration, community involvement
- 06 Trust-based relational capital: horizontal relations, trust, shared values
- 07 Collective long-term vision: co-construction, long-term goal clarity
- 08 Altruistic and processual leadership: prioritise collaboration success, tackle barriers and power dynamics, understand non-linearity of integrated care process

Box 1: General principles for helping create a sustainable Complete Care Community Demonstrator Site

A number of authors have highlighted the importance of leadership and capacity building. Edmonstone (2020), in addition to arguing that health and social care should be viewed as a single arrangement, identified several locations where success in systems leadership was occurring. In common with Hughes *et al.* (2020), he wrote that arrangements for integrated care requires systems leadership, and viewed “. . . as an emergent set of practices intrinsically shaped by local contextual factors, and not as an intervention to achieve predetermined outcomes” (Edmonstone, 2020, p. 359). This report would add that the system is wider and that voluntary and community organisations should be included given the innovative arrangements that were being created by those involved in the CCCP.

The work exploring the development of the CCCP to date highlights three key aspects which have been identified as being influential for successful progress. These are; the clinical director role; the issue of trust; and the tension between local freedoms and national priorities.

The Clinical Director Role

To help progress the leadership argument, the current work identified how the position of clinical director had a major part in supporting a site’s progress. It not only gave the site lead confidence to argue for the project and the subsequent resources allocated to it, but the post provided in a number of cases, a far better understanding of the NHS environment in which they worked.

Prior to 1990, management in the NHS was only performed by managers, who were separate from clinicians and medical professionals (Thorne, 1997). The purpose of managers in the NHS was to shape and control clinicians. However, in practice, they had little success gaining this control (Harrison & Pollitt, 1992). After 1990, the ideology of managerialism was applied to the NHS, shaping ideas of how it ought to be organised.

Managerialism is based on the concepts of hierarchy, rationality, and providing managers with the freedom to manage, aiming for effectiveness and efficiency. This has resulted in the creation of league tables, wait times, and charters to compare organisations (Thorne, 1997). Critics of managerialism in the NHS argue that the ideology is inappropriate for the complex organisation and ethos of public services. The risk is that the NHS becomes too preoccupied with transparent but meaningless data. Furthermore, critics claim that performance indicators are most likely measuring managerial performance rather than healthcare performance – which is difficult and complex to measure (*ibid.*).

The theory of managerialism in the NHS does not match up the reality. Doctors tend to take it upon themselves to manage, make decisions, allocate resources, determine priorities, and organise their clinical teams. This may be why doctors think of the role of clinical director as a leadership role, rather than a management role (Thorne, 1997). A common assumption is that the role of clinical director is a traditional managerial role, with a focus on planning and setting objectives. However, clinical directors are distinct from management. They are clinical professionals who undertake the role as clinical director on a part-time, rotational basis (Willcocks, 1992). They balance both corporate and front-line expectations for the delivery of healthcare (Cragg *et al.*, 2008).

The leadership found in clinical directors differs from management, as leadership focuses on strategy and direction, using vision to align and mobilise commitment to take action (Kotter, 1992). Whilst managers can exercise authority over their subordinates, leaders rely on influencing others to want to follow them. Clinical teams and clinical directors have a strong mutual interdependence, rather than a sense of managerial hierarchy. Doctors respond well to other doctors, which

allows clinical directors to have influence over their colleagues (Thorne, 1997). Clinical directors are expected to be transformational, leading and shaping service changes. They are agents of change who influence others to follow a vision or a desired course of action (*ibid.*). Of course, this could be applied to tackling healthcare inequality – if a clinical director influenced their clinical team to follow the appropriate set of ideals, that team could be mobilised into action. However, clinical directors tend to undertake a substantial clinical workload as well as their leadership role in order to maintain credibility with colleagues and ensure a smooth transition back into full-time practice once their rotational part-time role as clinical director has been put on hold (*ibid.*). This may mean that clinical directors have little time for undertaking or establishing healthcare inequality projects, as they take on this large workload.

Additionally, clinical directors face the challenge of being largely cut off from the decision-making and planning processes. This is in spite of the fact that clinical directors are keen to work with managers as equal partners in order to deliver quality healthcare and improved patient experiences in the face of reduced resources (Giordano, 2010). This could be an additional barrier faced by clinical directors who may wish to tackle the problem of healthcare inequality; if their authority is restricted to the clinical front-line, with their ability to make decisions and allocate resources absent, their ability to create change is limited.



Clinical directors are confident in their ability to negotiate, communicate, influence, and allocate resources, and feel they should be given more freedom to do so (*ibid.*). Formal deputy positions would increase clinical leadership capacity within the directorate, giving clinical directors the time to lead rather than simply representing their peers, as is often the case (Cragg *et al.*, 2008).

The role of clinical director often has no job description, and little direction as to what the role is constitutes. They are expected to learn the role independently as they work, with little support or training (Willcocks, 1992). The risk of having such an elusive, vague role is that clinical directors may be perceived as an inefficient token, jeopardising the value these individuals bring to improving the quality and efficiency of healthcare delivery. Additionally, more training and support is needed for clinical directors to reach their full potential in providing effective leadership (Cragg *et al.*, 2008).

Given the importance that the present study identified in helping progress the site's activities, this is an area which should be developed further.

The Issue of Trust

The impact of trust on health outcomes is well documented (Birkhäuser *et al.*, 2017). A higher level of trust is associated with patients having more beneficial health behaviours, fewer symptoms and a higher quality of life. While there is ongoing work to study the nature and level of trust between patients and healthcare providers (Rasiah *et al.*, 2020) the majority of sites have identified its importance. Numerous project leads commented on the need for continuity of relationships between the parties and organisations involved and the time needed to build it. Indeed, some site leads noted that, having been embedded in the community prior to medical school, they understood the issues that their target population faced.

However, for the present work there is a need for trust, not simply at the patient and care provider level within the NHS, but between individuals and other community organisations, as well as between organisations. This is particularly apparent currently when local authorities (responsible for social care) and the NHS (responsible for health care), are tackling the care needs of individuals within a local area, not least when both parties face financial constraints. A key factor in helping build trust between the two sectors lies in making sure each party understands the context that the other operates in; the two are very different. Through aiming to understand each sector's history, culture, and perspective there is a statement of intent to develop the relationship.

A number of factors influence trust. While time has been identified, there are other issues such as reliability and dependability, transparency, competence and sincerity;



all issues which the interviews with the project site leads commented on. This again raises the issue of the importance of ensuring that the NHS takes full advantage of being a 'learning organisation' (Scobie & Castle-Clarke, 2019). How the opportunities from where success is occurring can be transferred to the wider care system for the future workforce to help create sustainability is key. The same issue has also been raised by Vandergrift and Christopher (2021) in their work exploring health and the criminal justice system.

At present, the opportunities to support such developments are not being utilised. While some of the sites reported links with educational bodies, the vast majority had none. The CCCP provides an environment in which developing the importance and benefits of collaboration between public health, community and voluntary organisations and primary medical practice could occur, especially given the role of Health Education England in training a wide range of personnel.

A further element which sites had seen as playing a role was through the use of social prescribers. Those sites which had adopted social prescribers to aid the work of the project spoke very positively of them helping to achieve the goals of the project. The findings here are in agreement with that of Pescheny *et al.* (2018) who, when reporting on their systemic review of enablers and barriers to delivering services, wrote that they were related to "... the implementation approach, legal agreements, leadership, management and organisation, staff turnover,

staff engagement, relationships and communication between partners and stakeholders, characteristics of general practices, and the local infrastructure" (p. 1). The description could equally apply to many of the demonstrator sites and their relationships to the wider environment. A further factor which a number of the sites commented on was the central direction of funding. This created difficulties in appointing to these roles, which raises the third key aspect, the balance between local and national imperatives.

The Tension between Local Freedoms and National Priorities

The present work identified a tension between local and national priorities, perhaps nowhere better exemplified than in the role and relevance of the national NHS GMS contract in influencing the system at the local context. Many sites found a tension between the work they needed to undertake to achieve the GMS contract goals and that required to help address the targeted local population. This conflict existed at numerous levels, albeit to differing extents: within the individual, within the practice, and within the PCN.

Such conflicts are not unique to the care sector. Bundy *et al.* (2017), when trying to address the question of how mutually beneficial partnerships emerge, change, and grow, the very themes embedded in the CCCP, proposed a two-dimensional framework to help address possible tensions. This framework consisted of value congruence and strategic complementarity (Figure 10).

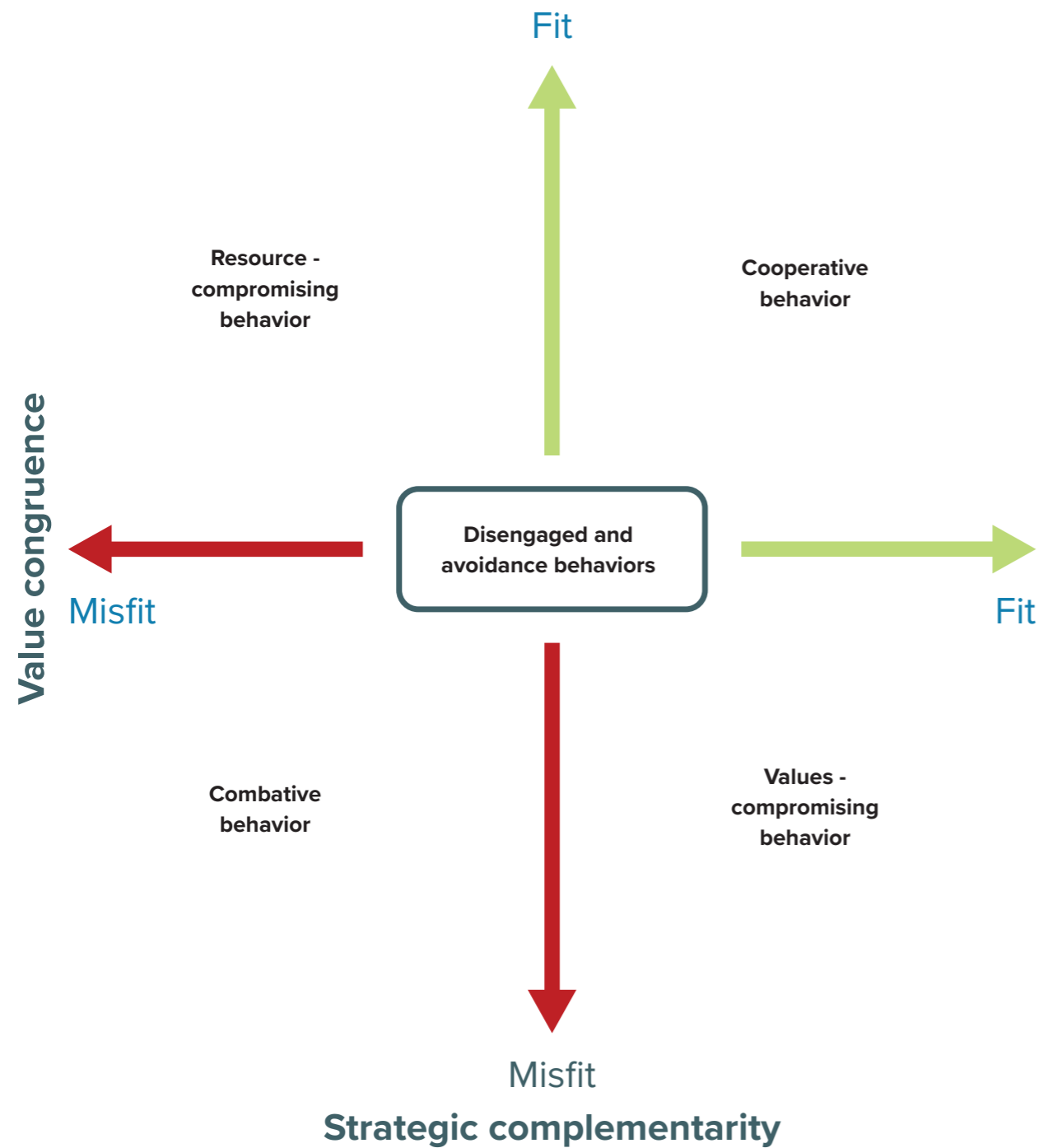


Figure 10. An organisational-stakeholder framework for relationship behaviours (Bundy et al., 2017)

Value congruence consisted of the values and principles between the parties, the basis for which was intrinsically motivated co-operation. Four relational factors helped facilitate the necessary co-operation; character-based trust, relational predictability, mutual liking, and affinity and socioemotional communication.

Strategic complementarity centred on strategic resources and needs, and had as its basis extrinsically motivated co-operation. The factors that facilitated this were competence-based trust, environmental predictability, material exchange and reciprocity and instrumental communication.



What Next? Principles For Scaling Up

The present work has highlighted several areas, which those working on policy to help ensure the success of integrated care and ensure the values of the CCCP work is sustainable, may find the approach useful. Not least, it helps make explicit where issues lie and the rationale behind them, which in turn contributes to improving better working relationships and trust. A key issue to address, however, is how to scale up the lessons learnt from initial evaluation of the CCCP and its subsequent development to address health inequalities. The following section discussed key aspects to take into account in the further progress of the programme to meet the aim of creating a learning network to implement successful integrated care programmes.

Many experimentally tested programmes fail to deliver their promises when they are implemented at a larger scale (Al-Ubaydli et al., 2020a). When the effectiveness of a programme diminishes significantly once the programme is rolled out to a greater scale, this is known as the voltage effect (Kilbourne et al., 2007). The voltage effect can undermine the optimism generated by the results of the original research, which can cause policymakers to hesitate and delay the adoption and implementation of models and programmes (Al-Ubaydli et al., 2020a). Fidelity (how closely implementation follows the initial study) is often cited as the key to solving the voltage problem. However, Al-Ubaydli et al. (2020a) suggest that fidelity is important, but a plethora of additional variances can disrupt scalability. In order to tackle the complex task of successful scalability, the following must also be considered: firstly, statistical inference, which involves posing the question “when is evidence actionable?” (Al-Ubaydli et al., 2020b, p. 5). Secondly, there is the representativeness of the experimental population to consider. This refers to how accurately the subject pool of the initial study represents the population upon which the programme will be scaled and implemented (Al-Ubaydli et al., 2020b). And finally, representativeness of the experimental situation, which

explores which situational features (of both the original study and the scaled implementation), may be threats to scalability (Al-Ubaydli et al., 2020a).

Fidelity is a key aspect of attempting to ensure the scalability of a programme, as it involves retaining all of the main components and quality of the original trial. To optimise the fidelity of a programme, not only should it maintain all of the core components of the initial study when it is scaled, but the facilitators must also understand why the programme is being implemented and why it is done in a particular way. It is better still if the researchers from the original trial are heavily involved in the rollout of the programme at scale (Al-Ubaydli et al., 2020a). When a programme is scaled and does not retain the same quality or key components as the initial trial, this is known as programme drift (Al-Ubaydli et al., 2020b).

In order to address the issue of statistical inference, Al-Ubaydli et al. (2020a) recommend that a post-study probability (PSP) standard be adopted before initial research results are advanced to the policy making stage. PSP refers to the probability that a research finding is true (Maniadis et al., 2014). Al-Ubaydli et al. (2020b) recommend a PSP of 0.95 before enacting policies on the back of research trials. This translates to three or four well-powered independent replications of the original findings. This change would naturally lead to an increased demand in a greater number of replications, which would mean more money for the replication of results from funding bodies. This would counteract the issue of budget constraints and would mitigate the demands for great, as opposed to more accurate, results. Currently, publishers and funders are often inclined to support studies with more effective results, and this incentive can cause researcher bias (Al-Ubaydli et al., 2020a, Al-Ubaydli et al., 2020b). Overall, if incentive was given to replicate results, researchers would be motivated to provide accurate results, as opposed to results which seem more ground-breaking.

Researcher bias and incentives can also have an impact on the representativeness of the population pool in their original studies. Because researchers are encouraged by publishers and funders to produce amazing results, they may be inclined to select subject samples that are likely to yield the best results and benefit most from the programme, giving the model the very best chance of working (Al-Ubaydli *et al.*, 2020a). Another possibility when the model is scaled up is that the population may have different characteristics than the original study participants, including observables such as demographics (Al-Ubaydli *et al.*, 2020b). It is also possible that subjects who know they will benefit the most from the programme will be more likely to volunteer for the initial study, and are likely to be selected because they may not require financial compensation (Al-Ubaydli *et al.*, 2020a). Overall, the representativeness of the population may be affected by researcher choice or bias, participation costs, and selection bias.

Although the literature on the topic of scalability is usually focused on programme fidelity, the situational features in practice are much richer and crucial – arguably, the

representativeness of the situation is even more important than the representativeness of the population (List, 2006). When a programme is implemented and scaled, the context and environment may differ to that of the initial trial, causing a change to the effectiveness of the programme. This is known as context dependence, and various differences to the context can cause this issue, including a difference in infrastructure, how relevant the environment is to the policy, and local constraints (Al-Ubaydli *et al.*, 2020b). In order to detect potential threats to scalability, researchers must have a detailed understanding of the ‘sites’ – the site (or setting) of the initial study and the environment in which the programme is to be implemented. Researchers must comprehensively describe the environment in which the initial study is conducted in order to detect any contextual variables that could have an impact on scalability (*ibid.*). An example of a variable could be that the scaled environment where the programme is implemented could hold many more distractions and other responsibilities for implementers (Paulsell *et al.*, 2010). This could cause a lack of fidelity to the original framework and cause the scaled version to be less effective.

Closing Comments

While the overall aim of the CCCP is to help identify how to contribute to addressing health inequalities, the timeframe for this initial report limits the work to process measures of progression. Outcome measures on the extent to which reductions have occurred cannot be made. What the present work has done is highlight the necessary attributes that personnel require, and the system must consider, if the value of the programme is to be achieved. While resources, especially time and support from within the NHS, are required already, there are exemplars developing through which performance and the values of the system can be assessed and improved. As the programme expands and if it is to be scaled up and sustainable, policy makers need to take note of the above findings.

Meneer *et al.* (2019) have suggested a framework for evaluating what they termed *value-creating learning health systems* (p. 4). The framework is based upon elements including core values, infrastructure, systems and resources that provide the foundational supports for the programme to be studied, the very features of the CCCP which have been explored in the present work. As the report published by the NHS Providers (2018) exploring progress on integrated care stressed, “*although systems are important, the action is really in neighbourhoods and places* (p. 17).” This report agrees with the sentiment but would add that it is the embedding of committed, charismatic and caring personnel working in a collaborative environment that is equally important for success. The NHS needs to be embedded within local population for the local population through collaborative arrangements; the very goals of the CCCP.



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If you require any further information about this programme of work, please contact Arden & GEM PMO:

agcsu.transformation@nhs.net

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Alternatively, please visit Healthworks:

www.healthworks.uk

Appendix 1

Complete Care Community Programme Programme Evaluation Form

SITE Name and lead contact	
Programme Commencement (mm/yy)	
Date form completed (mm/yy)	

Below are a series of dimensions that the program can be assessed on.

For each one question please indicate the extent to which you feel that the program is currently operating as you would like it to. Choose a single option by selecting an answer for each of the 7 questions.

	Poor	Fair	Satisfactory	Good	Excellent
1: Overall programme progress:					
2: Engagement with target audience:					
3: Engagement within NHS sector:					
4: Engagement within non-NHS sector parties:					
5: Progress towards addressing inequalities in health of site population:					
6: NHS management support for programme:					
7: Overall, how do you feel about your workload for the programme:					

If you answered "poor" or "fair" to any of the above, please indicate your reasons why below:

Answer:

Any other comments:



The Complete Care
Community Programme