# East INT Learning & Evaluation - Collated Pack

March 2026

Camden

# Contents

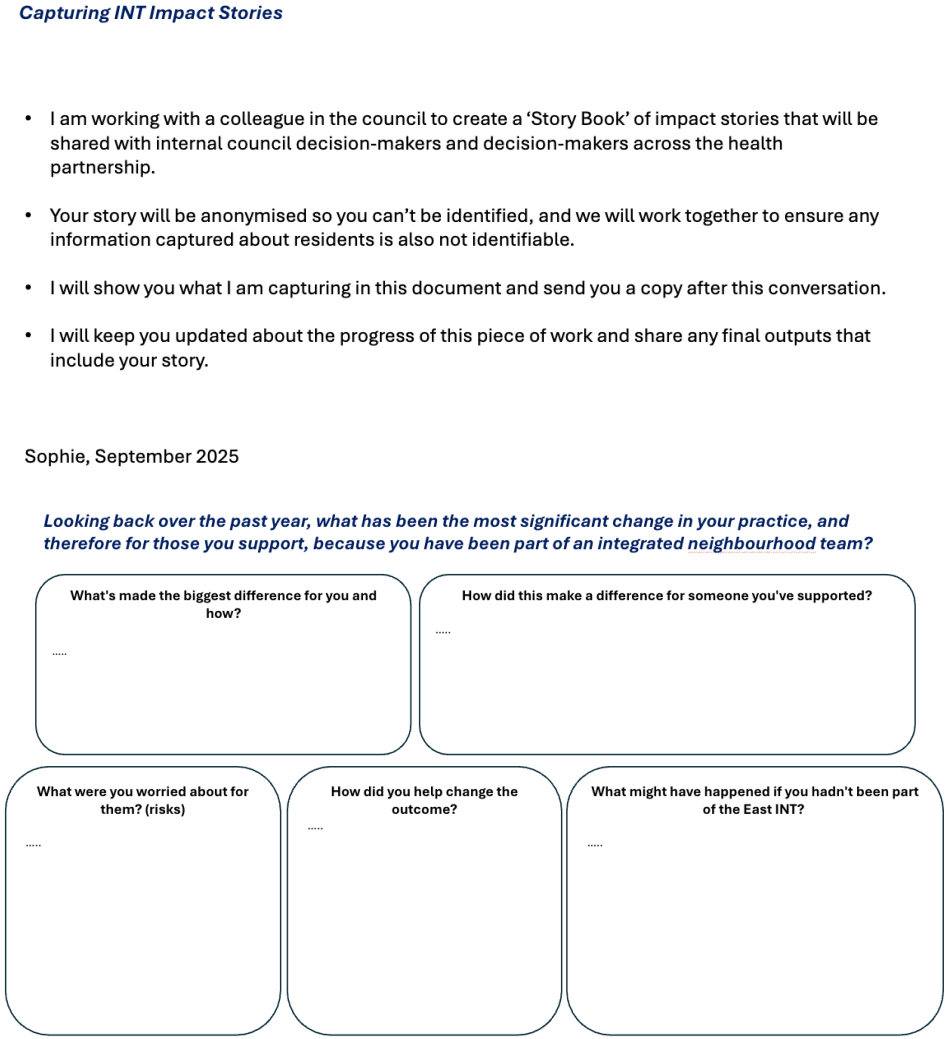
# Overview of approach to evaluation

In the EINT test and learn phase, new ways of working and different 'microinterventions' were added over time through a bottom-up approach facilitated by the Head of INTs and ensuring ownership and buy-in of staff and managers. Due to its iterative nature, attempts to develop a theory of change were challenging, and as a result the evaluation framework also evolved over time. Ultimately evaluation activity was bucketed into 'work packages' to try to capture impact in different ways. The table below and subsequent slides present a summary of the findings – full results can be found in the Appendix .

| Work package | Methods | High Level summary of findings |
|---|---|---|
| **Workforce Stories**<br>*Senior Design Researcher, Head of INTs* | • 12 semi-structures interviews to develop impact stories across roles, asking 'what has been the most significant change' | Collection of stories demonstrating the positive impacts staff have experienced, across a wide range of staff roles. |
| **Case Studies**<br>*Senior Design Researcher, Head of INTs* | • 3 case studies of residents impacted by collaboration in EINT<br>• 2 'Patient theographs' were explored to visualise patient journeys (by PH analyst) | Highlighted the positive impact of multidisciplinary working for a small number of specific complex cases |
| **Quantitative Signals**<br>*Public Health Analyst* | • Service performance indicators that managers expected to be impacted by EINT<br>• Statistical Process Control (SPC) charts to see if trends were significant and unique to East | There were no statistically significant changes seen across the quantitative metrics analysed. |
| **Realist Evaluation**<br>*LSHTM Public Health Registrar* | • 12 semi-structured interviews, meeting observation, field notes, reflexive journal, informal participation<br>• Realist theory driven approach | Highlights challenges to realising EINT goals; such as lack of staff and leadership capacity, infrastructure, structure/process/governance. Overreliance on goodwill and key personalities. |

# Workforce stories - method

- Senior Design Researcher (LBC) conducted **12 staff interviews** at the end of September 2025, using a 'capture template' to guide and standardize data collection. Each interview lasted approximately 30 minutes, conducted in person at the East INT or over MS Teams
- Semi-structured discussion guide was framed **using principles from 'most significant change'** a participatory monitoring evaluation method which elicits narrative accounts of meaningful change as experienced by programme stakeholders
- Narratives were documented in the first person by the researcher, then shared with participants for validation to ensure accuracy, authenticity and ethical representation of their experiences and perceptions of resident experiences
- The resulting stories shared here have been selected to demonstrate nuanced examples of workforce impact



***Capturing INT Impact Stories***

- I am working with a colleague in the council to create a 'Story Book' of impact stories that will be shared with internal council decision-makers and decision-makers across the health partnership.
- Your story will be anonymised so you can't be identified, and we will work together to ensure any information captured about residents is also not identifiable.
- I will show you what I am capturing in this document and send you a copy after this conversation.
- I will keep you updated about the progress of this piece of work and share any final outputs that include your story.

Sophie, September 2025

***Looking back over the past year, what has been the most significant change in your practice, and therefore for those you support, because you have been part of an integrated neighbourhood team?***

**What's made the biggest difference for you and how?**

.....

**How did this make a difference for someone you've supported?**

.....

**What were you worried about for them? (risks)**

.....

**How did you help change the outcome?**

.....

**What might have happened if you hadn't been part of the East INT?**

.....

Capture template used in interviews with staff





Camden

# Workforce stories - summary

- The example story to the right highlights how a GP was able to approach the Duty Desk for support in arranging a mobility scooter for the patient. They were able to get a quick response, which otherwise might have taken weeks to resolve due to being unsure who to approach, saving significant time and energy, and more quickly getting the right support in place for the patient.

- See Appendix 1 for a range of other stories captured from other professionals

- Collectively, the stories highlight the benefits of relational ways of working, understanding referral pathways, appropriate support in other parts of the system, or being able to discuss cases with other professionals more quickly and in a more accessible way.

**General Practitioner (GP)**

I was working at Kentish Town Health Centre when I received a letter from a social worker asking for support in arranging a mobility scooter for their patient. I had no idea how to help with this, so I went upstairs to the duty desk to ask for guidance.

The duty social worker explained that this was actually the social worker's responsibility, and they would get in touch with the original sender to explain how to arrange it themselves.

In the past, I would have been unsure whether this needed to go to another professional—maybe an occupational therapist, a physiotherapist, or even directly to the wheelchair service. I might have sent an email and waited a week, only to be told I'd contacted the wrong service. Then I'd try again, and still end up in the wrong place.

That kind of heart sinking work that takes weeks to resolve can wear you down. It chips away at your resilience and can lead to compassion fatigue. But this time, being able to get a clear answer so quickly meant I could save my energy for things that really require my expertise—like visiting a housebound patient. It also meant the patient got the right support much faster. In the past, they might have fallen through the cracks and lost trust in the system that's supposed to help them. This time, we were able to keep that trust intact.

# Staff Survey - Summary

Results from a staff survey ran with staff participating in the East integrated neighbourhood team in November 2024 and November 2025 have been compared. The survey covered workplace experience, collaboration, understanding, care quality, and elicited open feedback.

- **There were no statistically significant changes.** This is in part due to the small sample size in each survey (not enough people responded for us to draw confident conclusions).

- **However, there are early indications of positive change on several items** (large effect size and, though not significant, close to the threshold for significance: 0.05-0.06). These included: satisfaction that patients/service users are receiving care from the system they need, perception that patients have a 'joined up' experience across different services, feeling part of a multi-disciplinary team in supporting and caring for local residents, sense of trust in other professional/disciplines staff work with.

- In 9 of the 13 items, more people 'agreed' or 'strongly agreed' in the second year than in the first. **This shows that overall, respondents reported feeling more positive about the integrated neighbourhood team this year than last.** These changes are based on percentage differences, not statistical significance, so they should be interpreted as early indicators rather than confirmed improvements.

- Free text responses highlight practical enablers and barriers to integration — **praising co-location, quick access to colleagues, and improved information sharing, while calling for clearer pathways, housing engagement, dedicated collaboration time, and better induction.**

- In future, to improve the reliability of results, surveys should use a non-identifying unique code (e.g. a self-generated identification code, SGIC) so that individual responses can be tracked over time. We should also aim for at least 30 respondents to increase statistical confidence.

# Staff Survey - Methods

**Sampling Design**

- Two surveys with 13 multiple choice questions
- One survey conducted pre-intervention, and one survey 1-year post-intervention
- Small sample sizes: Year 1 (n=17), Year 2 (n=18)
- Not a matched sample: we can't track individual changes between years

**Analysis**

- **Statistical test:**
  - Unpaired Mann–Whitney U (M-W) test: for each question, compares overall patterns of answers between Year 1 and Year 2
  - Common Language Effect Size (CLES): shows the chance that someone from Year 2 scores higher than someone from Year 1
    - *E.g. CLES = 70% → "There's a 70% chance a Year 2 respondent gave a higher score than a Year 1 respondent."*
  - Adjusted p-values using Benjamini–Hochberg (B-H) correction to account for multiple comparisons (13 items).

- **Descriptive change:**
  - Calculated percentage point change in proportion of respondents giving a positive response (*agree/strongly agree*) between years.

# Staff Survey - Results

No changes were statistically significant. Four items show early signs of improvement with moderate effect sizes (CLES > 0.7) and p-values near the significance threshold (p < 0.05).

| Item | Effect size (CLES) | Adjusted p-value (Benjamini-Hochberg correction)* |
|---|---|---|
| I am satisfied that patients/service users are receiving care from the system that they need | 0.77 | 0.0503 |
| Patients have a joined up experience of support across different services | 0.78 | 0.0503 |
| I feel part of a multidisciplinary team in supporting and caring for local residents | 0.75 | 0.0547 |
| I have trust in the other professionals/disciplines who I work with | 0.73 | 0.0596 |
| I am using my knowledge and skills to support colleagues from other professional disciplines | 0.66 | 0.2755 |
| How would you rate your level of understanding of NHS and Council services and resources that are available locally | 0.62 | 0.5110 |
| How often do you work with colleagues from other services or organisations to plan and deliver care? | 0.59 | 0.7900 |
| I feel valued by the colleagues I work with locally | 0.54 | 0.9175 |
| I feel supported and empowered at work | 0.46 | 0.9578 |
| I have access to the information from other services that I need to address the needs of residents I support | 0.46 | 0.9578 |
| How would you rate your level of understanding of the broader offer of support available through voluntary and community sector accessible to residents locally. | 0.47 | 0.9578 |
| I feel connected to the community I serve | 0.51 | 0.9578 |
| I feel motivated and happy at work | 0.47 | 1.0000 |

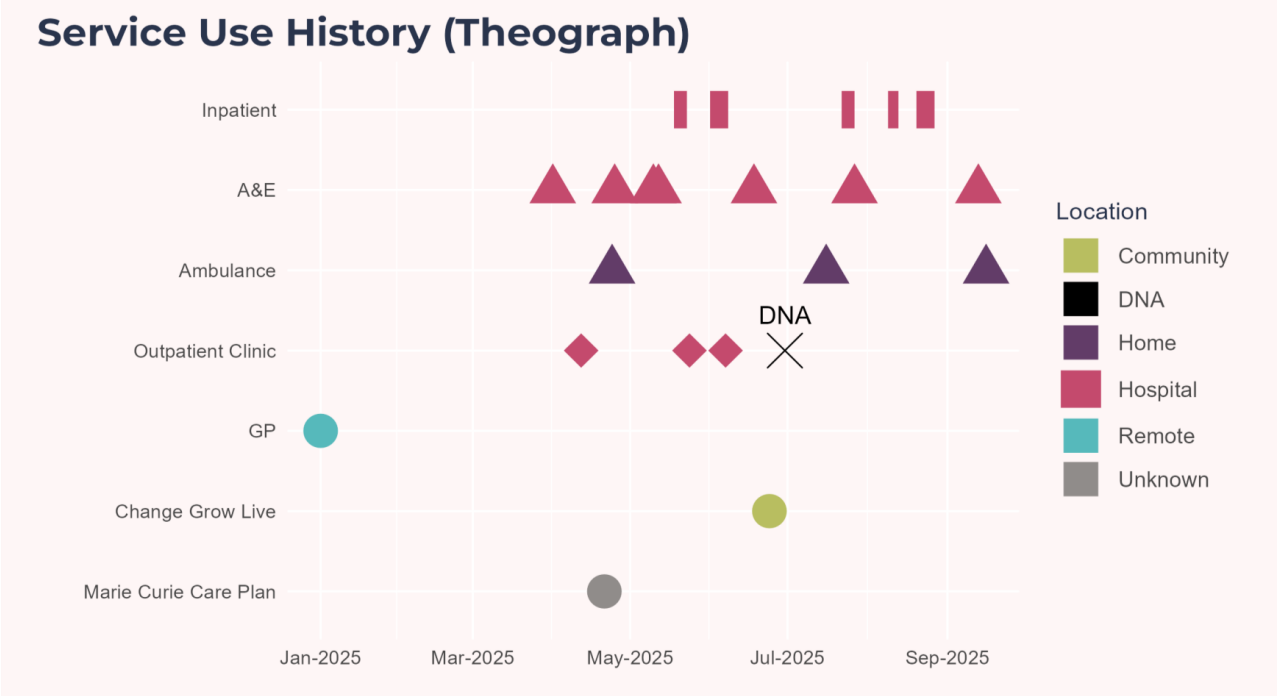
**In this analysis, a result would be considered statistically significant if the adjusted p-value < 0.05*

# Cases Studies - summary

The Senior Design Researcher collated three summaries of patients whose care was improved because of multidisciplinary working in East INT forums. The three cases (Appendix 2) are ‘Miriam’ a patient with mental health needs who was not registered with a GP and not receiving the care she needs, ‘Jason’ a homeless individual with history of mental illness, and ‘Ade’ a substance user who had disengaged with support. All three cases were discussed in the ‘Working Together’ sessions which provides a forum for staff members to bring cases where they feel ‘stuck’, benefitting on the expertise of a multi-disciplinary group of professionals who can advise next steps for addressing the needs of each case. In each case, the advice from the session allowed the case to be better supported in the right part of the system. See Appendix 2 for the full details of each case.

**Theographs:**

Patient theographs were explored as an approach to understanding a patient’s care use across services, including fragmented use of care. Two examples were explored independent of the cases above (see appendix). In one case showing a patient with high levels of A&E and inpatient admissions (right) and a separate case demonstrating more coordinated care in the community. Note these were two separate patients and so did not demonstrate a ‘change’ in care within the same patient. Nonetheless this was viewed as a powerful way of visualising a patient’s journey.



# Quantitative signals

There was a desire from system leaders to include quantitative indicators in the evaluation. Initially, system and population health outcomes were considered. However, without a clear theory of change linking EINT activities to these outcomes, and the long timescales to realise these outcomes, signal indicators were explored which were more likely to be tangibly affected by new EINT ways of working. The indicators below were selected following engagement with service managers on key metrics they would hope to be influenced by the EINT.

**System Flow**

- Number of contacts staff have with patients
- Referrals into service by source
- Referrals from service by destination
- Type of Datix incidents
- Average caseload of staff
- New clients receiving long-term care
- Clients receiving small packages of care

**Workforce (indicators of system efficiency)**

- Non-access visits
- Inappropriate discharge
- Inappropriate referral
- Reablement rate
- Review outturns completed

**Workforce (indicators of culture)**

- Staff sickness
- Staff turnover

**Resident Experience**

- Compliments and complaints
- Family and Friends results

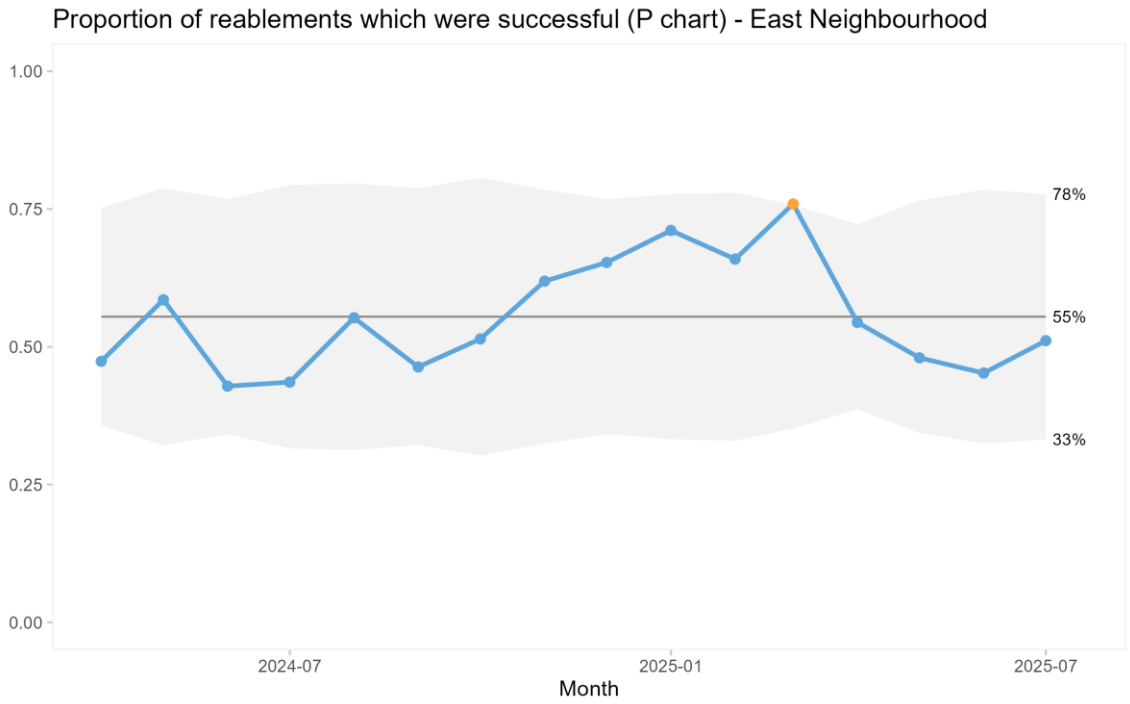
**Safety**

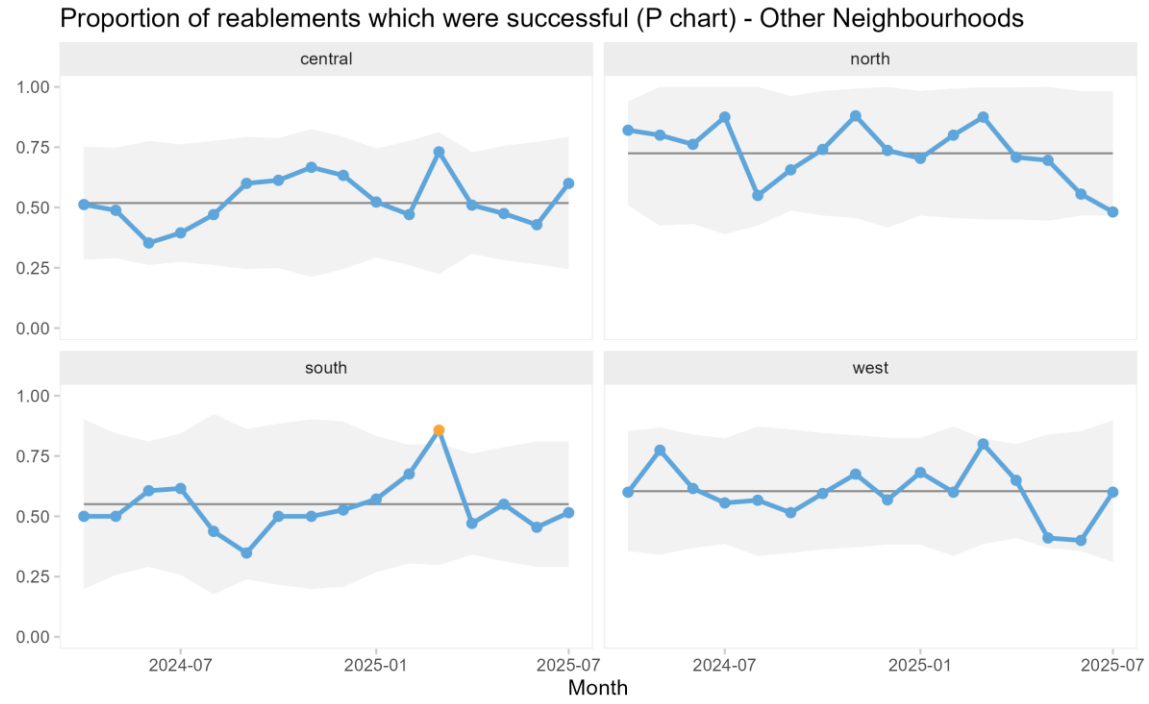
- Datix incidents
- Safeguarding alerts

# Quantitative signals - summary

**Analysis:** Statistical process control (SPC) chart were used to see if signal changes were significant, beyond normal variation that would be expected (grey area in charts below). Data trends for the East (left) were compared to trends for the other neighbourhoods (right) to see if any shifting trends are unique to the East or also seen in other neighbourhoods.

**Results (see Appendix 3):** Across all indicators analysed there were no significant trends in signals (beyond what we would expect to see due to normal variation), that were unique to the East neighbourhood. For some indicators, a pattern was seen in all neighbourhoods, and therefore was unlikely to be associated with the EINT intervention. The lack of clear signal trends could be due to numerous reasons, for example: the timescales, the indicator selection or the scale of the micro-interventions relative to broader service delivery.



# Population Health Management (PHM) – Approach

A PHM approach was planned that avoided a top-down, data-only model. Instead, the aim was to co-develop, iteratively, cohorts and interventions with frontline staff, ensuring ownership, feasibility, and alignment with local assets.

1. Camden-wide introductory workshop
   - Built shared understanding of the aims of the neighbourhood programme
   - Presented initial neighbourhood data to stimulate discussion about population needs beyond services
   - Created connections between staff who may not routinely discuss rarely more strategic working
2. East INT selected as pilot area (due to being the most developed neighbourhood) and a series of workshops planned

**Workshop 1**
- Reviewed INT progress to date
- Explored whether high-level data aligned with staff experience
- Identified priority issues, populations, and potential cohorts
- Introduced the collaborative cohort-development process

**Workshop 2** *(intended)*
- Present refined analysis for shortlisted cohorts
- Discuss feasibility, assets, and intervention options
- Select final cohort for intervention design

**Workshop 3** *(intended)*
- Co-design logic model
- Map pathways and operational processes
- Refine data to support intervention elements

Due to system changes in neighbourhood delivery, the second and third East INT workshops did not take place. However, substantial preparatory work and feedback were gathered from Workshop 1.

# Population Health Management (PHM) – Learning

- **Data pack as conversation starter:** Staff found high-level data useful for initiating discussion but felt it would have benefitted from more linked, multi-agency datasets to better reflect the diversity of INT services and demonstrate the value of integration. This also created challenges to deeper data analysis of cohorts.
- **Strong engagement enabled meaningful dialogue:** High levels of participation reflected the strong relational groundwork already established in the East INT. This accelerated progress and enabled more nuanced, locally meaningful cohort ideas that focused on what could be gained from integration.
- **Value placed on data when it connects to lived experience:** Staff were eager to interrogate data—especially when it either confirmed or challenged their frontline understanding. This reinforced the importance of co-produced analytical insight.
- **Suitability of methods:** Although the process did not progress to logic modelling or pathway redesign, staff saw clear value in these tools for structuring integrated care interventions.

## Feedback from Workshop 1

*“That was the most inspirational thing I've done in a long time. I wasn't expecting to leave feeling like I was a member of a new team."* - Consultant, University College London NHS

*"(This quote) resonates with me and came to mind when in the workshop yesterday: 'There comes a point where we need to just stop just pulling people out the river. We need to go upstream and find out why they're falling in.'"* - Social Prescriber, Caversham GP

*"I thought it was brilliant."* - Manager, Mental Health Core Teams

# Realist Evaluation

An independent external evaluation of the EINT was conducted by Cassie Moore, Public Health Registrar based at the London School of Hygiene & Tropical Medicine, for her Masters degree dissertation.

**The Approach**

Rather than asking "is this successful", realist evaluation asks, **what works, for whom, in what circumstances, and why?**

It does this by looking at the relationship between three things:

- **Context:** The conditions/setting e.g. leadership, local culture, resources
- **Mechanism:** The underlying processes or responses that occur in particular contexts that generate (or not) an outcome, e.g. psychological safety, saving time, trust
- **Outcome:** What actually happens as a result of the context + outcome, e.g. better relationships, more appropriate referrals

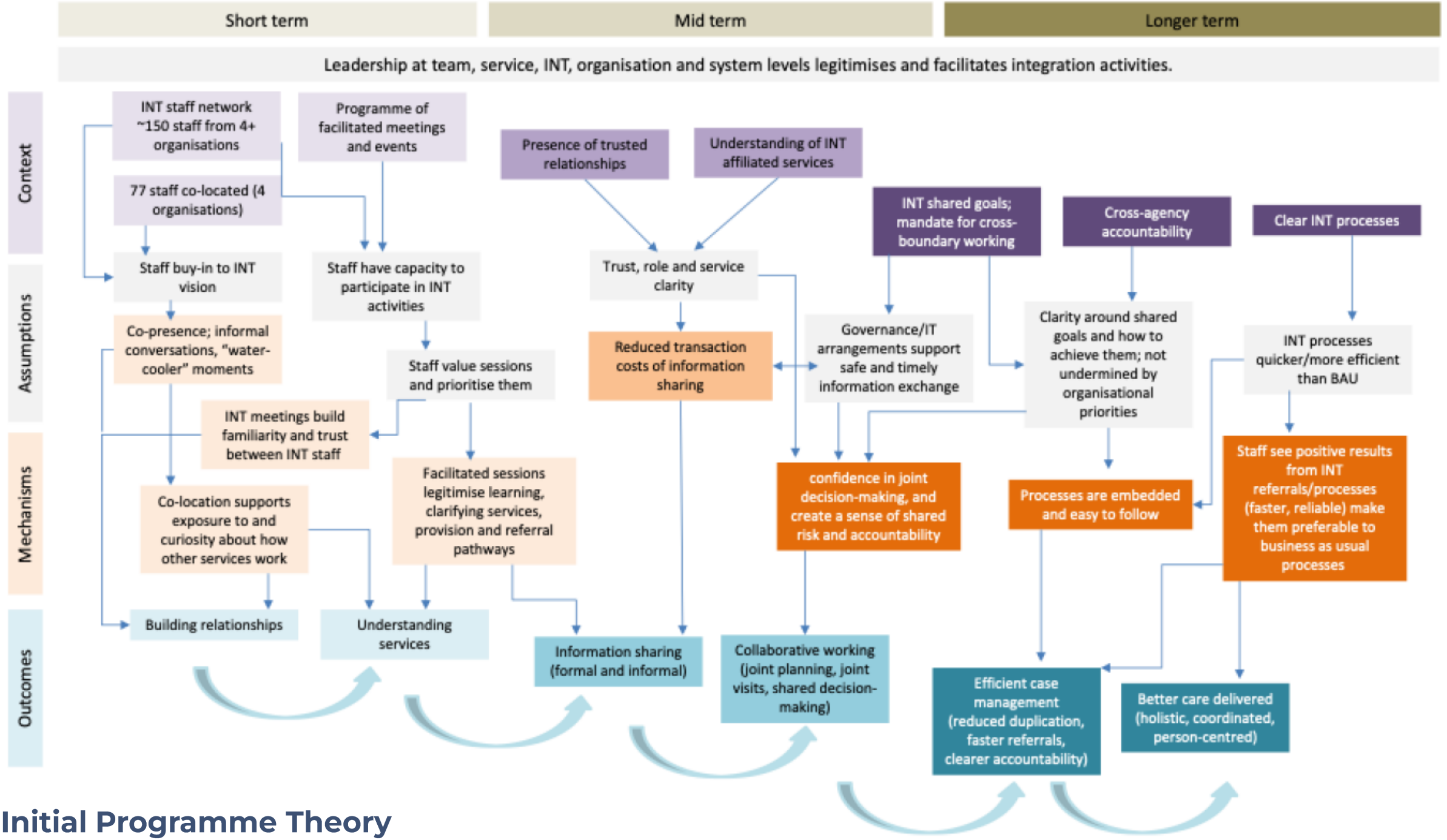
**Key steps** (following RAMESES II reporting standards)

1. **Develop initial programme theory** from Camden's interim theory of change and other evaluations of INTs
2. **Test and refine:** Triangulation of data (interviews, observations, field notes, literature) to test and contest assumptions about how the programme works, and build a picture of what works (or doesn't), for whom, in real life
3. **Refine programme theory** about how an intervention actually works; construction of context-mechanism-outcome configurations (CMOCs)

**DATA COLLECTION**

Adopted a realist approach of using multiple data sources over a three-month period. These included: **non-participant observation of 13 EINT meetings**, **12 semi-structured realist interviews, field notes, a reflexive journal and informal participation** (See Appendix 4 for full details). This approach supported an account of 'what goes on', as well as how staff describe and understand these processes. Emerging context-mechanism-outcome theories were brought into interviews for discussion, testing and refinement.

# Initial Programme Theory



# Realist Evaluation - Summary Themes

Following a realist approach, four overarching CMOCs were developed, each corresponding to one of the study's themes. These capture the central mechanisms at play within each thematic area and how they interacted with context to generate outcomes, offering an interpretive synthesis of the findings.

| Theme | Context | Mechanism | Outcome |
|---|---|---|---|
| **Strategy & Vision** | Vision for integration articulated at a high level, but without clear short-term aims, outcome metrics, or accountability structures to anchor it in daily practice | Staff engage in meetings, pilots, and relational initiatives, but participation is uneven and the absence of visible learning makes these feel optional or symbolic | Integration is perceived as aspirational but intangible, with staff struggling to connect the vision to tangible change in daily work. There is limited sustainability beyond co-location and early relational efforts, that are dependent on individual presence and effort. |
| **Leadership** | Lack of investment in leadership capacity at INT, organisational, and system levels with no cross-organisation authority | Leadership roles are stretched between BAU and "invisible" integration work, leaving little time or authority to sustain or develop integration | Integration stalls at the level of co-location; staff continue siloed working within the same office space. |
| **Infrastructure** | No shared digital systems and limited investment in the INT estate: IT inoperable across organisations, insufficient clinical and meeting space, and basic facilities missing | The absence of fit-for-purpose infrastructure made it difficult for staff to see how integration could work in practice, shaping whether and how they engaged with the INT | Integration was widely experienced as constrained by infrastructure: some staff disengaged or worked elsewhere, others participated despite the shortcomings, but all saw infrastructure as a barrier to the INT model |
| **Institutional maintenance** | Despite policy rhetoric and co-location strategies, organisations retain distinct priorities, professional identities, and service thresholds, with no overarching mandate for joint working | Staff anchor themselves in organisational silos and frame cross-agency collaboration as discretionary or dependent on personal goodwill. Occasional disruptions (e.g. facilitated meetings, duty desk) temporarily suspend these patterns | Integration struggles to become institutionalised, experienced by staff as rhetorical rather than real, enacted through exceptions rather than embedded change |

# Realist Evaluation - updated programme theory

| IPT Outcome | Mechanism(s) | Outcome in practice | Enabling Contexts | Constraining Contexts |
|---|---|---|---|---|
| **Building Relationships** | Visibility of colleagues created opportunities for informal interaction<br><br>Facilitated meetings enabled respectful, curious dialogue across services<br><br>Practical interventions (Duty Desk) legitimised interactions | Some new cross-agency relationships<br><br>Trust and relationship building fragile and dependent on individuals | Co-location (for some staff)<br><br>Facilitated meetings and events<br><br>Relational culture set by Head of INT and Design Researcher<br><br>Operational, work-based (not just relational) interventions legitimised staff contact | Staff turnover<br><br>Inconsistent attendance at meetings due to staff capacity and buy-in<br><br>Gaps in cross-cutting leadership presence |
| **Sharing information** | Duty Desk provided visibility and immediacy, legitimising quick referral discussion<br><br>Occasional ad-hoc exchanges | Some timelier information sharing in co-located teams<br><br>More appropriate, timely referrals into some services | Relational and structural foundations (co-location, relationships, leadership)<br><br>Duty Desk | IT and data governance barriers<br><br>No shared INT messaging/comms platform |
| **Understanding services** | Lunch and Learns and other cross-agency fora provided structured learning opportunities<br><br>Duty Desk interactions clarified service provision and criteria<br><br>Informal exchanges revealed how other services "work" | Some timelier referral discussion and appropriate referrals<br><br>Improved understanding of services and pathways | Relational and structural foundations (co-location, relationships, leadership)<br><br>Structured learning and networking meetings and events<br><br>Duty Desk | Capacity pressures limiting attendance<br><br>Knowledge gains limited to meeting attendees<br><br>Numerous meeting and service forums creating competing demands |
| **Collaborative working** | Duty desk enabled informal cross-agency collaboration<br><br>Some staff went "above and beyond" remits<br><br>Facilitated meetings reduced psychosocial and knowledge barriers | Collaboration patchy, framed as favours<br><br>Dependent on personalities and capacity<br><br>Silos largely persisted | Emerging trust and relationships from earlier stages<br><br>Capacity and desire to "go above and beyond"<br><br>Facilitation to bring people together and encourage relational working | No shared mandate or accountability<br><br>Persisting cultural/professional boundaries<br><br>Reliance on goodwill<br><br>Reliance on Head of INT and Design Researcher facilitation |

# Recommendations from Realist Evaluation

1) **Set a clear vision that translates into tangible objectives**: A shared ethos is not enough; staff need clarity about how being in the INT should change everyday practice. Without this the INT risks being experienced as a concept rather than a reality.
2) **Balance "soft" and "hard" approaches**: Relationship-building, trust and culture change are all vital, but must be matched by structures, processes and resources.
3) **Resource and embed leadership**: Visible, boundary-spanning leaders with cross-organisational mandates are needed to sustain momentum; reliance on "hero" leaders is fragile and unsustainable.
4) **Institutional commitment**: Policy, funding and workforce capacity must be aligned with INT goals; without earnest organisational buy-in staff engagement will remain fragile.
5) **Shared governance**: Create cross-agency accountability and shared risk frameworks are required to move beyond business as usual.
6) **Evaluate culture as well as outcomes**: Evaluation should capture cultural and relational outcomes alongside service indicators.

# Appendix 1: Workforce

Camden's community-based health and care workforce benefit from a collaborative and empowered team culture, embedded within the community they serve.

# Workforce stories

## General Practitioner (GP)

I was working at Kentish Town Health Centre when I received a letter from a social worker asking for support in arranging a mobility scooter for their patient. I had no idea how to help with this, so I went upstairs to the duty desk to ask for guidance.

The duty social worker explained that this was actually the social worker's responsibility, and they would get in touch with the original sender to explain how to arrange it themselves.

In the past, I would have been unsure whether this needed to go to another professional—maybe an occupational therapist, a physiotherapist, or even directly to the wheelchair service. I might have sent an email and waited a week, only to be told I'd contacted the wrong service. Then I'd try again, and still end up in the wrong place.

That kind of heart sinking work that takes weeks to resolve can wear you down. It chips away at your resilience and can lead to compassion fatigue. But this time, being able to get a clear answer so quickly meant I could save my energy for things that really require my expertise—like visiting a housebound patient. It also meant the patient got the right support much faster. In the past, they might have fallen through the cracks and lost trust in the system that's supposed to help them. This time, we were able to keep that trust intact.

## Social Worker

I carried out a Care Act Assessment with a young man on the autistic spectrum who had multiple complex medical issues. He was living alone, had limited family support, and was finding it incredibly difficult to navigate the services available to him — especially the paperwork and coordination between them.

While attending a Lunch and Learn session, I discovered *Reach Out*. The resident was already known to them, so I got in touch to explore how we could enhance the support he was receiving, based on what I'd learned about how he was coping. Together, we helped him better understand where his support was coming from and how the different services interlinked.

Reach Out also referred him to *VoiceAbility*, who assigned him a community advocate. That advocate is now supporting him with housing and employment-related issues.

By working collaboratively with local services to strengthen the support around him, I was able to avoid commissioning an additional package of social care. He's now feeling less overwhelmed by the number of services involved, and his advocate is helping him sort out his medical needs and complaints.

# Workforce stories

### Camden Integrated Community Health Manager

As a CICH Manager, I know our nurses can only accept referrals for patients waiting to be discharged from hospital if those patients are already receiving social care support for daily tasks. That requirement has often created delays and uncertainty.

Now, with the shared duty desk, when one of our staff receives a referral, they can quickly ask our social work colleagues to check their digital system and pull up the latest notes from hospital social workers. It's a small change, but it's made a big difference.

Before this, our duty workers might have waited hours—or even days—for confirmation. That meant patients who were medically fit to leave had to stay in hospital unnecessarily. Given the wider system pressures—rising waiting lists, overstretched A&E departments, delayed ambulance handovers—it's clear that reversing discharge delays is a major priority.

And beyond the system strain, long hospital stays pose real physical risks to patients. In some cases, the hospital might have discharged the patient anyway, without a nurse assigned to support them. That's incredibly risky, especially if something urgent like anticoagulation was needed.

### District Nurse

I'd known this patient for some time and had built up a good understanding of her medical history and risks. The social work team approached me with concerns - she was declining pressure-relieving equipment or a hospital bed. They wanted my clinical opinion on the risks involved, even though I wasn't supporting her any more. The pressure ulcers were worsening, and with her multiple comorbidities, including mild cognitive impairment, the risk of sepsis was very real.

Even though the social worker and her colleagues were offsite that day, we were able to meet on Teams for an MDT with the patient present. Because we'd all worked together before in the INT, the conversation was open and honest. It was powerful — she could hear directly from every discipline involved in her care. From the social worker perspective, there was a real tension around risk. Without the right equipment, the patient might have gone home without the equipment—social care often has to balance autonomy with safety. But now, thanks to our joint working, the patient is clearly informed by every discipline.

She's now in the nursing home, receiving the care she needs, and we're all working together to ensure she stays safe and supported. I feel at peace and satisfied that we've explored every option together. It makes me feel proud of our work; it was nice to come together.

# Workforce stories

## Social Care Practitioner

During a Working Together session, I spoke about a woman in her 80s whose mental capacity seemed to have changed. She wasn't receiving any care or support, and she refused to let anyone into her home—not even her family. They were deeply worried, especially about the fire risk caused by her hoarding and the amount of flammable clutter in the property.

I knew that most mental health service referrals usually needed to come from a GP, but she wasn't registered with one. That felt like a dead end—until a psychiatrist from another team in the meeting mentioned the Older Adults Mental Health Home Treatment team. They don't require patients to be registered with a GP, which was a breakthrough.

I arranged a joint visit with that team and it became clear that she needed urgent help. She was sectioned under the Mental Health Act and later placed in supported living residential care, where she could be safe and properly supported.

I often think about what might have happened if we hadn't been able to act so quickly. She was at serious risk of harm—especially from fire. In fact, deaths and serious injuries from fire were up 161% in Camden in 2024. Without that timely intervention, she could have easily become part of that statistic.

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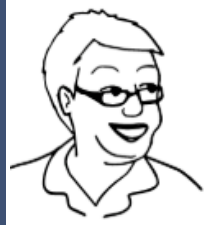
# Workforce stories

## District Nurse

I visited a patient with a pressure ulcer whose brother was physically lifting him to move - a huge safety risk. The patient hadn't had a recent hospital admission, so wasn't suitable for our therapies team. His needs weren't acute or rehab-focussed; they were long-term, so it was clearly a case for adult social care. I spoke to the duty worker in the office, who arranged an assessment quickly. Even if things didn't move instantly, just knowing the case was acknowledged meant I didn't have to chase or worry.

The brother, in his mid-60s, was hurting himself trying to lift someone in his 80s. Because of the difficulty transferring him, the patient was being moved less, which worsened the pressure sore. They tried a hoist, but it wasn't suitable, and the decision was made to nurse him in bed. It wasn't ideal, but it was safe - and options had been explored.

I followed up later and noticed the social worker who'd since taken on the case hadn't managed to progress things quickly. I was able to back and say 'Hey can you make sure this is picked up?' and it was received in a no-blame way. That kind of relationship helps us hold each other accountable. It breaks down the barriers that come with email-only communication. Even if I do have to email or call, I know the person, and that makes all the difference. It's not like the anxiety I feel when calling a GP I've never met, for example - here, we've built trust through good relationships. I am much happier at work and I feel like I've learned so much about other disciplines, so that I have context when I go to ask them questions. It makes me feel more confident and clear of what I need to ask of my colleagues, so interacting with them isn't so anxiety inducing.



## Physiotherapist

I was supporting a woman in her 60s who had recently had a fall. She was registered as blind due to diabetic retinopathy and was very socially isolated. Her confidence in walking outdoors had really diminished because of her visual impairment, and I could see how much that was affecting her overall wellbeing.

As we were nearing the end of our rehabilitation work together, I attended a Lunch and Learn session and found out about Reach Out—a local mental health service I hadn't come across before. I realised it could be just what she needed, so we filled out the referral form together.

She said she was open to one-to-one support for her anxiety and was also interested in learning about community groups focused on visual impairment. I saw her express real hope and curiosity about the future, and I could tell she felt listened to.

If I hadn't known about Reach Out, I would have had to leave her without that extra layer of support. She might have stayed housebound, which would likely have worsened her physical condition and increased the chances of her being re-referred to community health services. Instead, she left our sessions with a sense of optimism—and a plan.

# Staff Survey – Comments

## How has being part of the East INT made a difference?

| |
|---|
| Knowing colleagues from different disciplines and having access for discussion have been very helpful.  Working together sessions, housing and hoarding clinics have been helpful. |
| We have definitively found that working in an integrated way has significantly improved our professional relationships with other agencies. This collaborative approach has given us a better understanding of the working methods of other professionals and enhanced our engagement with various multi-agency partners. Furthermore, we have observed notable benefits for service users resulting from this joint effort. By working together, all professionals involved have been able to respond to and address raised concerns much more quickly and effectively. |
| Being able to meet other colleagues in person |
| I have enjoyed the approach of working closely with NHS and DN. It makes it easier to be able to chat with someone directly rather then going back and fourth on email chains. It reduces the amount of admin time. |
| Having face to face access to the Community Team has meant easier conversations and ease of updates |
| Its nice to get to know colleagues from other parts of the NHS and social care helping my patients. It helps me help patients that I have more of a relationship with these colleagues |
| Able to talk face to face to the team is brilliant. |
| It has been so useful having them in the same building. We can pop upstairs to discuss difficult cases. They come to our meetings. We have faced instead of names and it makes working together for our patients so much easier and more productive |
| Resources available easily and with the ability to have a quick 'MDT' about complex patients when required just by walking upstairs, without complex forward planning and diary rearrangement. Helpful to put faces to names and get instant answers so issues can be solved straight away rather than waiting for an email reply. |
| It seems as this site is very progressive with the intentions to integrate multiple teams and makes you feel like it is a good example for patient centred care |
| Community relations have improved. |
| I really value being able to discuss things face to face or, at least,  put a face to a name when I email queries since EAST INT  have moved into the same building. So much of the work we do as GPs is related to the patients home situation and being able to discuss this with OTs, DNs and S/Ws that know them really helps. Or just being very helpfully signposted after discussing cases.. |
| I like being able to find colleagues to speak with them in person about complex cases. Building these relationships makes the work more rewarding and seems to improve outcomes for patients. |
| It is very much simpler to acess care and coordinate care for my patients. Also to get advice |
| It has made much easier the way we can give care to our services user. The access to other teams has made easier to get the information needed very quick, without waiting days or weeks for a reply about our questions. Making easy to solve problems and doubts in regards patients care. Also, this has been seen in improving a "soon and quick" input to service users somehow avoiding their deterioration as physical, mental, and/ or emotional levels. |
| It has brought a more 'can do approach' to the way we work. A focus on working with partners to find solutions, prevent crises. Better staff collaboration, shared learning and resources |

# Staff Survey – Comments

## What could improve your collaboration with other colleagues in local services?

| |
|---|
| More information in written and verbal presentation about each services - can be done through monthly whole service meeting.<br>Ability to discuss cases and share ideas with INT colleagues. |
| I think it would be very helpful for us to agree on standardised assessments across the board so all services have the same information. data sharing agreement between all concerned professionals to remove delays, fewer gaps in communication for quicker responses. Joint training would be helpful and enhance communication, improve working relationship based on common understanding. |
| nothing specific |
| Working more closely with Housing and mental health. It would be great to be able to work on the same office as our housing colleagues as I believe this is the hardest service to engage with. It would also be good to have mental health colleagues more present in the office space, to talk out referral in order to service the person more appropriately. |
| A central database of up to date information / contact details would be beneficial |
| Having more funded time to work with them and not having to meet them in my lunch hour |
| social sessions are always nice |
| More face to face interaction options - or direct phone lines for duty teams so we can have real time discussions. |
| more social group meetings to build communication and lunch time shared lunch meet ups perhaps |
| Events with local services promoting what they offer. |
| I think we as GPs need to be reminded of services in the community, especially voluntary services, which often change. Would be good to have another shared meeting where we get to know more about everyones roles |
| Dedicated time to better understand the scope of each service, perhaps through discussion about how specific patients with complex medical and social situations interact with each service and reflection on how this could improve. |
| Some access to their system and service user information can help. As nowadays we have them in the office and the access to the information safe us time. However, if they aren't here the information you will get is null or nearly any. |
| opportunities for learning and innovation |

# Staff Survey – Comments

## What's been the most successful element of our East neighbourhood team so far and why?

| |
|---|
| Sharing the same office makes it easier to have MDT discussion. |
| service users have better care and thier mood has improved additionally some service users mobility has improved. |
| meeting colleagues from other teams |
| The reduction in communication barriers overall. I have been able to build relationships with NHS staff that I would not have otherwise know the role of or how we can collaborate together |
| Getting to know the community team has been very beneficial |
| getting to know colleagues from the wider neighbourhood health and social care services |
| colocation |
| Working together and knowing the people involved |
| Accessibility, speed of response |
| The integration of teams as this is a great example of what the MDMs have been experiencing with multiple teams working well together |
| Being able to liaise face to face with our colleagues. |
| Opportunity to network, and run upstairs to ask questions/discuss patients. The Adult Social Care referral form - is an easier way to refer and seems to generate prompt responses |
| Being able to speak face to face - proximity |
| Being very available |
| We getting together, knowing each other, and having our "Working together sessions". As in the sessions people have been able to get different perspectives and able to identify different teams which can support. Neighbourhood has really been helping our service users in very positive ways receiving care in a more positive and quicker way. |
| A placed based model reflecting Camden's values |

# Staff Survey – Comments

## What hasn't been so successful? Why?

| |
|---|
| More work to be done to make integration successful.  Better induction for new staff and orientation to the office would help. |
| Transport has not been cost effective and it seems in Camden we should do more for transport fo the wheelchair users. |
| not keen on the office setting feels a bit dark and cramped |
| Nothing. I just think it would be helpful to have more disciplines involved, such as housing, GPs and mental health |
| I think it took some time to "settle" into the office environment. |
| Having funded time to integrate |
| When people don't talk to each other |
| nothing has got worse |
| not sure |
| Named people for specific patients might make it easier |
| Not enough dedicated time to understand each other's services and have informal conversations |
| Services are so busy, it is difficult sometimes to keep the momentum up |

# Appendix 2: Case Studies

- Impact Case studies (from July 2025 meeting)
- Patient Theographs (new for this meeting)

Camden

# Impact case study 1: 'Miriam'

**Situation:** A Social Care Practitioner described 'Miriam', a woman in her 80s, who's mental capacity appeared to have changed but was not receiving any care and support. She lived alone and wasn't allowing anyone into her property, even her family, who were concerned for her wellbeing and the risk of a fire due to hoarding in her flat. She had been picked up by the Multi Agency Safeguarding Hub, as she was found wandering by herself late at night in Central London. She had also began abusing her neighbours, who had small children, and throwing stones at them.

**Background:** Miriam had no known history of physical or mental health conditions and had not be registered with a GP for nearly 10 years.

**System Risks:**

**Fire Service Involvement**
High risk of fire in Miriam's property due to her hoarding behaviour and her apparent lack of mental capacity. Deaths and serious injuries from fire were up 161% in Camden in 2024.

**Unplanned hospital admission**
High risk of Miriam presenting at A&E and needing to be admitted due to an accident in the flat because of clutter and/or being picked up by emergency services whilst wandering around late at night. Infectious disease also a risk due to vermin/infestation

**Effects on neighbours & police call out**
High risk of psychological distress/physical injury to neighbours (including small children) due to Miriam's abusive behaviour and hoarding behaviour. Likely police call out for Anti-Social Behaviour.

**Recommendations made in the INT Working Together Session:**

A colleague from the mental health trust suggested a conversation with the Adult Mental Health Home Treatment team. The Social Care Practitioner hadn't been aware that she could approach this team without being registered with a practice. The GP also gave advice on how the family could re-register Miriam and agreed to make a quick call afterwards to speed up the process.

**Outcome:**
Following the Working Together Session, the family was supported to re-register Miriam with her former GP, which happened quickly. Contact was also made with the Older Adults Mental Health Team, who soon undertook a joint visit with the Social Care Practitioner. Following assessment by the Home Treatment Team, Miriam was diagnosed with likely Dementia and taken into hospital under the Mental Health Act. Support is also being put in place to identify suitable sheltered housing or supported living residential care. **As a result, Miriam is in a safe place receiving the care she needs – while her family have greater peace of mind. Meanwhile, Neighbourhood Housing Officers are supporting with cleaning her home.**

# Impact case study 2: 'Jason'

**Situation:** A Neighbourhood Housing Officer described 'Jason', a man in his 30s. Jason is currently homeless and sleeping in a small communal area in social housing, on the doorstep of the property he grew up in with his mother before she died (the property is now vacant). Jason is a Class A substance user and was begging regularly. He was making a lot of noise at night, and disturbing the young family living next door, who share the small communal area. He was urinating in the area and masturbating directly at their Ring video doorbell late at night. He gets food three times a day from staff at local high street who give him leftovers. He had a probation officer who he occasionally engaged with, but was refusing to engage with Routes of the Street or Change Grow Live drug and alcohol service. Professionals were increasingly worried for his wellbeing and neighbours were becoming more and more distressed.

**Background:** Jason experienced sexual abuse as a child and has a history of mental illness. He has a sister but they are no longer in contact.

**System Risks:**

**Unplanned Hospital Admission**
High risk of Jason presenting at A&E needing admittance due to overdose/other physical health issues as a result of Class A substance use or a resulting accident.

**Effects on neighbours and tenants**
High risk of psychological distress to neighbours (including small children) due sleep disturbance due to noise and being exposed to his sexual behaviour.

**Continued effect on local services**
High risk of continued call-outs of Housing, Routes off the Street, Met Police and other services with responsibility for supporting the local population.

**Recommendations made in the INT Working Together Session:**

A consultant psychiatrist advised that there were a number of routes the Neighbourhood Housing Officer could pursue in order for Jason to be assessed by a mental health team, and the criminal justice system was likely to be the place he could get the best support. If he was not detainable by police on a Section 136, the FOCUS team could offer assessments and mental health support for patients who are street homeless. Alternatively, professionals could take him to any A&E to be assessed for mental health support.

**Outcome:**
Following the Working Together Session, the housing and community services team worked with the police and his probation team to get a warrant issued, so they could assess his capacity. Jason was arrested and incarcerated, where he was engaging well with services and taking medication. Prison services began appropriate mental capacity and other assessments with him and found him a placement in supported accommodation outside the borough. **Those involved are now far more confident that Jason is receiving the support he needs. The impact of ASB on his neighbours is reduced.**

# Impact case study 3: 'Ade'

**Situation:** A drug and alcohol worker described Ade, a young man on methadone who she had been working with for a long time. The drug and alcohol worker had supported him into support groups, and recently was pleased to have got him a place at a rehab in a large city away from London. This was his first ever rehab placement. Ade had been making progress and checking in with his support worker, but was unhappy with the Rehab environment and said the food was culturally inappropriate. He subsequently self-discharged. Ade has no known family or friends, and had not contacted anyone including his drug and alcohol worker since leaving the rehab. He had had a really good relationship with his support worker who felt really worried about him and disappointed; she said "I feel like I've failed."

**Background:** Ade is a West African man who is university educated. He's very articulate but by his own admission extremely lonely, with a background of serious drug misuse. He used to attend Alcoholics Anonymous. He has high social anxiety.

**System Risks:**

**Risks to Ade**
High risk of Ade making decisions to the detriment and his health, wellbeing and recovery process. Away from his support network in an unfamiliar urban environment.

**Unplanned hospital admission**
High risk of Ade presenting at A&E needing admittance due to overdose/other physical health issues as a result of Class A substance use or a resulting accident.

**Emergency services call out**
High risk of police or ambulance call out if Ade becomes a missing person following self-discharge from rehab.

**Recommendations made in the INT Working Together Session:**

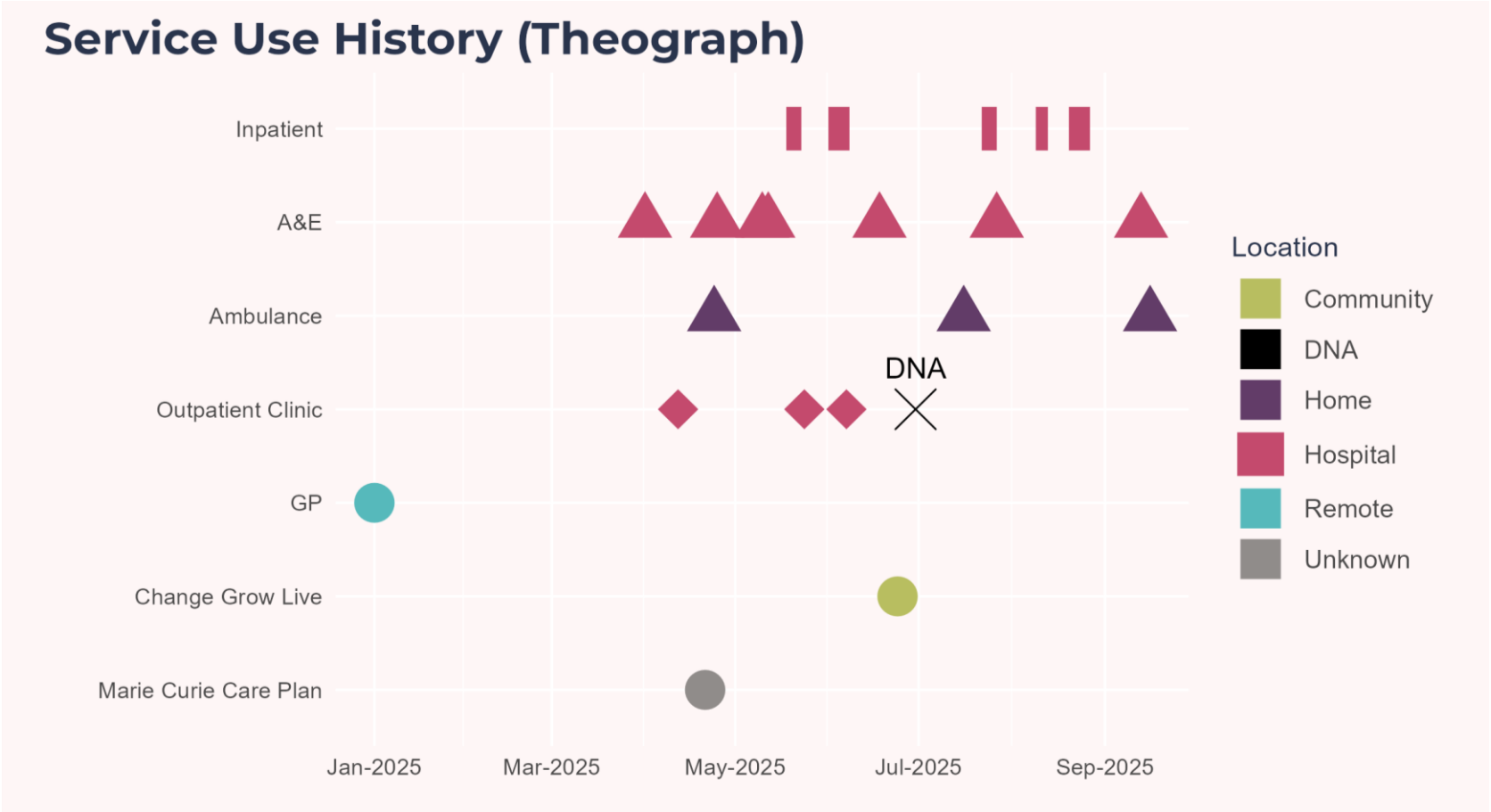
Professionals present in the discussion recommended a number of risk management measures the drug and alcohol worker could take, including calling 111 in the area that he had last been heard from. However the majority of the conversation focussed on helping the drug and alcohol worker to feel supported and celebrate the positive relationship she had forged with Ade so far, so that she would feel ready to support him again when he got back in contact. She was advised to reflect on how he might feel ashamed or embarrassed about getting back in contact as he may also feel that he 'failed'.

**Outcome:**

Following the Working Together Session, Ade made his way safely back to London and got back in contact with the drug and alcohol worker. He came back on his methadone script. She said after the Session she felt ready to work with him in an empathetic way and not let her disappointment take over. **Ade subsequently gave her service a "glowing review" of his experience with her.**

# Resident A

Resident A has a history of cancer and is currently undergoing **oncology care**. She has a **complex set of health challenges**, and a **history of substance abuse**. Despite these challenges, and previously **absconding from wards**, her notes indicate she has **maintained engagement** with the cancer treatment and her cancer is **currently stable**. In recent months, her use of A&E, ambulance and inpatient services has been high.



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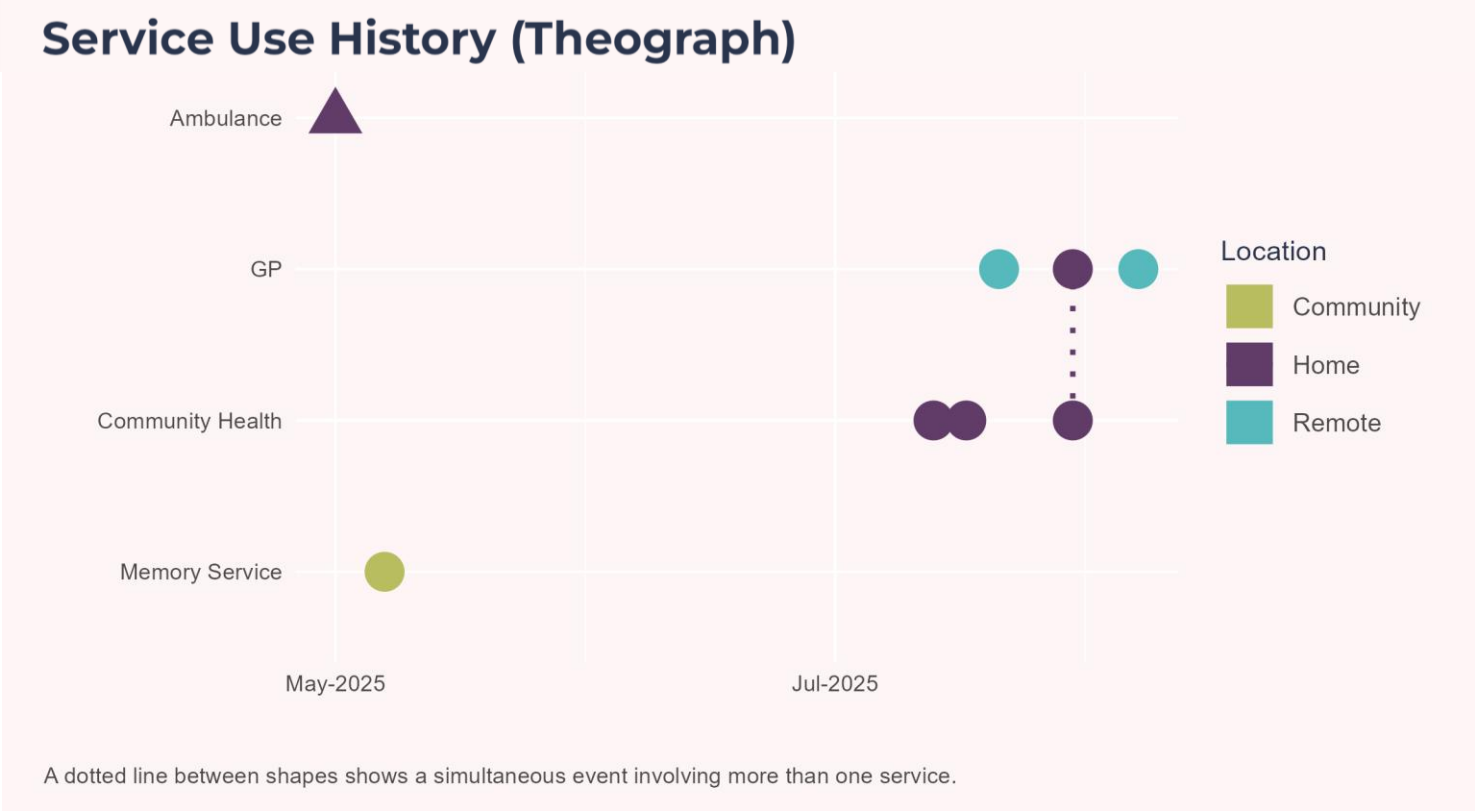
# Resident B

Resident B has a history of **dementia**. He lives alone in **sheltered accommodation** and struggles to manage his **finances and home environment**. His engagement with healthcare has been complex: frequently **forgetting appointments** and exhibiting **reluctance to attend** an MRI scan, although he has demonstrated willingness to engage with **familiar professionals**. More recently, he has been experiencing falls at home and receiving **multidisciplinary care planning** to address his cognitive disorder, mobility issues, and broader support needs.



# Appendix 3: Quantitative Metrics

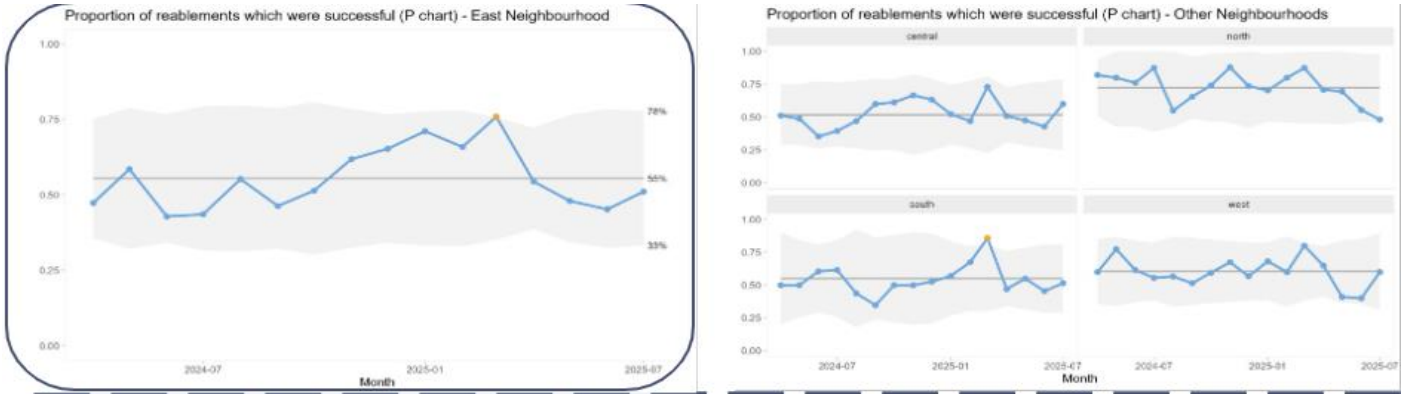
Camden

# Signals: Interpreting the data (SPC charts)

## What are SPC Charts

SPC charts help us to understand whether changes in the data are likely to be part of normal random variation, or whether they may reflect a non-random shift in the signal. They cannot be used to attribute causation.

## Chart Elements




- **Grey area:** represents the expected range of variation.
- **Coloured dot:** suggests special cause variation – a change in the signal.
- **East neighbourhood:** highlighted by a square box.
- **Comparison neighbourhoods:** shown alongside East to help identify whether patterns are unique or shared across other places in the system.

# Signals: Interpreting the data (SPC charts)

## Signals of Change

We are monitoring for **two elements** that, when observed together, may suggest that the move to INTs in the East neighbourhood is associated with a change in the signal:

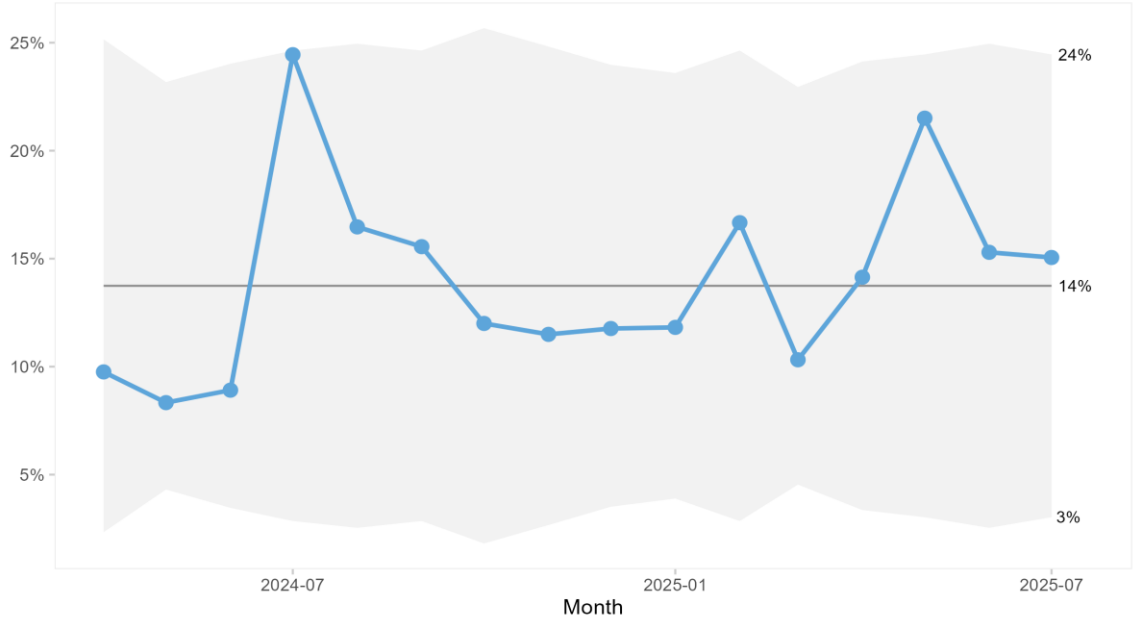
- **Special cause variation**: represented by a coloured dot (orange/blue/purple) outside the grey area, indicating a non-random change.
- **Absence of a similar pattern in other neighbourhoods**: if the same pattern of special cause variation is observed in another neighbourhood, it is less likely to be associated specifically with the East INT and may instead reflect external factors.

## Results so far

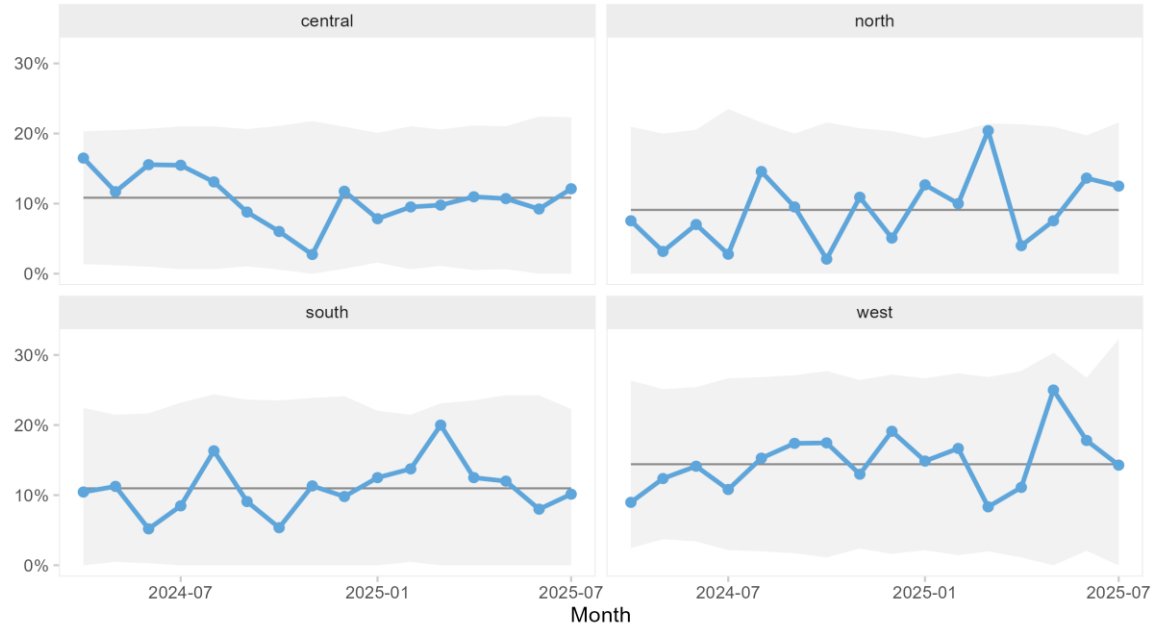
- In most signals, no special cause variation is observed in the East INT.
- A few signals do display special cause variation in the East, but similar patterns are also seen in the other neighbourhoods, suggesting these changes may not be linked to the EINT.

Long-term support

Proportion of residents receiving a long-term package of support (P chart) - East Neighbourhood

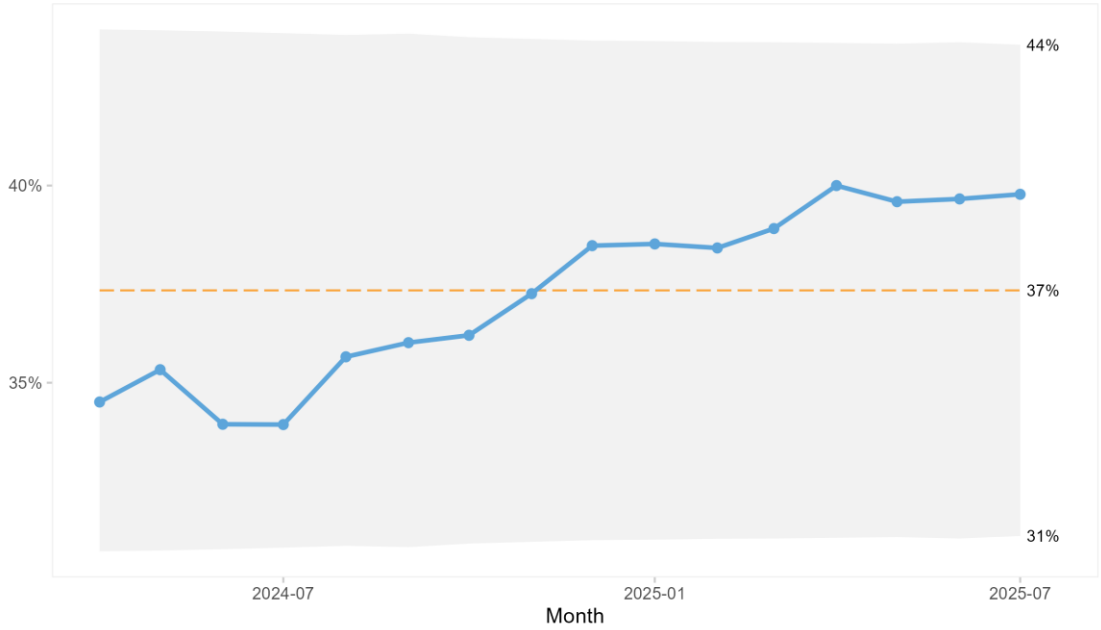



Proportion of residents receiving a long-term package of support (P chart) - Other Neighbourhoods

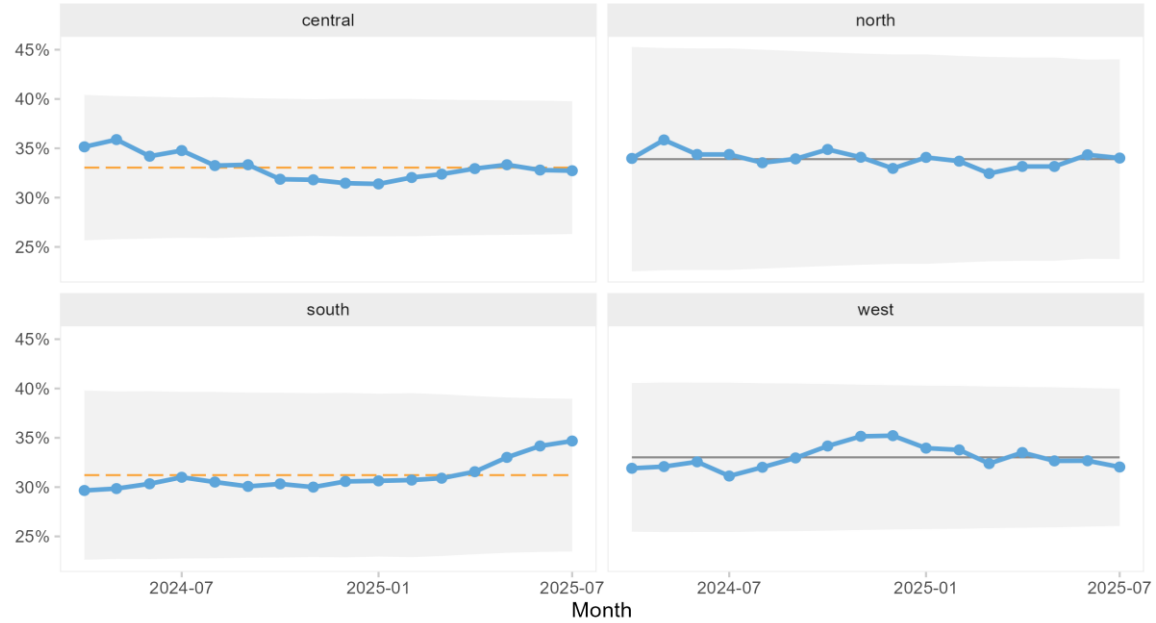



Small package of care

Proportion of residents receiving a small package of care (P chart) - East Neighbourhood



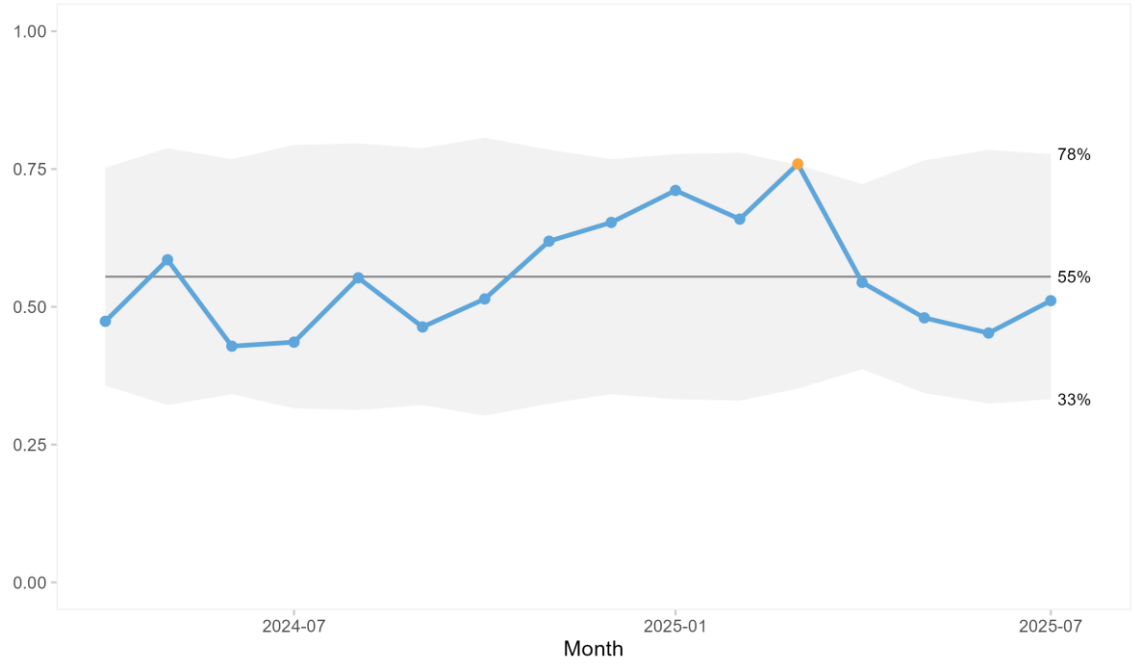

Proportion of residents receiving a small package of care (P chart) - Other Neighbourhoods



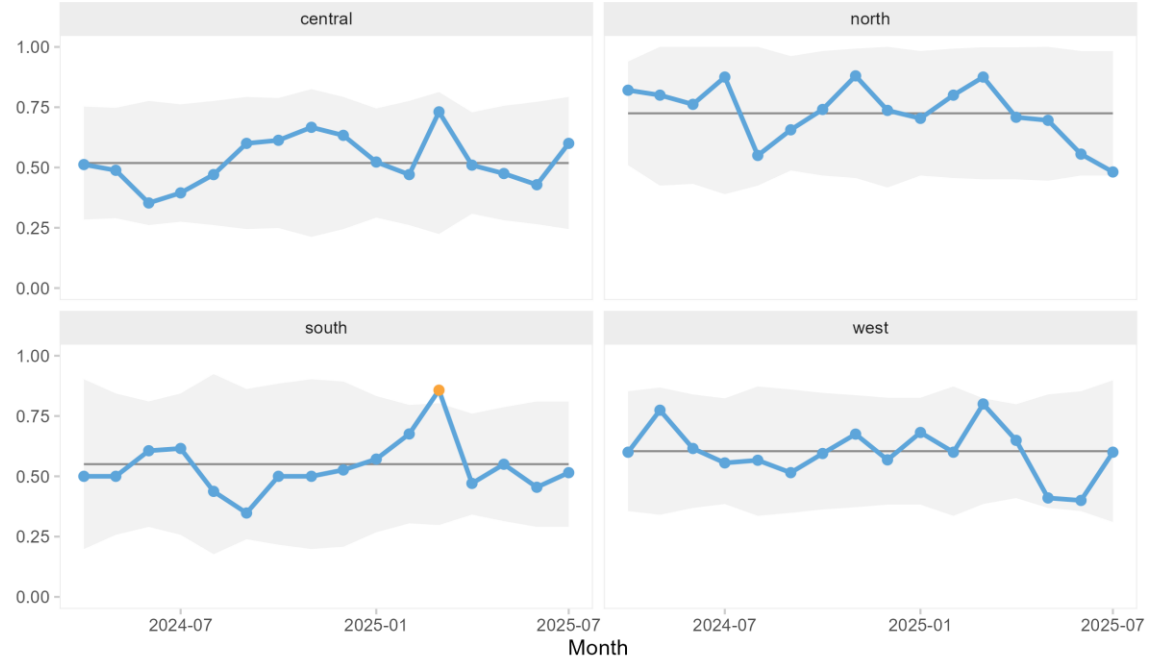
Reablement

Outturns

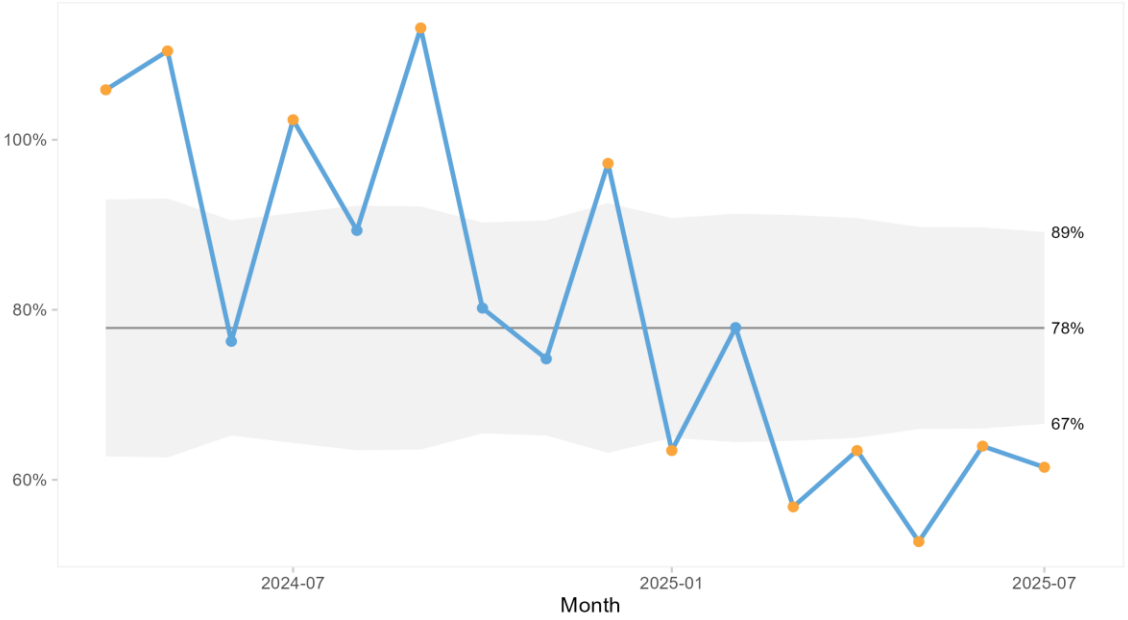
Proportion of reablements which were successful (P chart) - East Neighbourhood



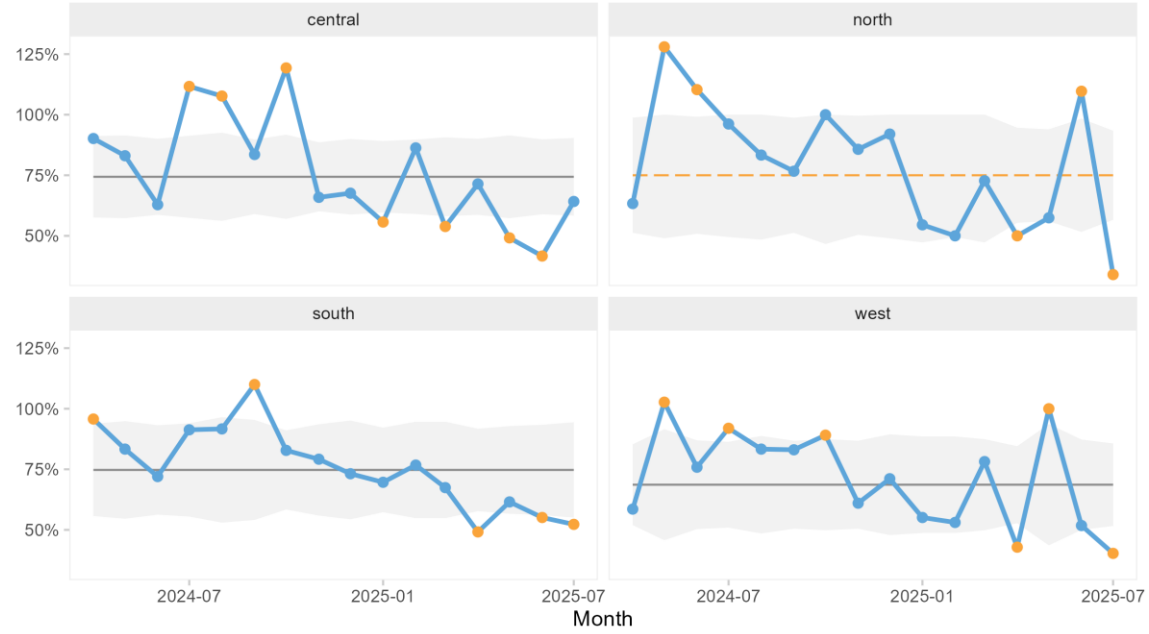

Proportion of reablements which were successful (P chart) - Other Neighbourhoods




Proportion of outturns received which were completed (P chart) - East Neighbourhood



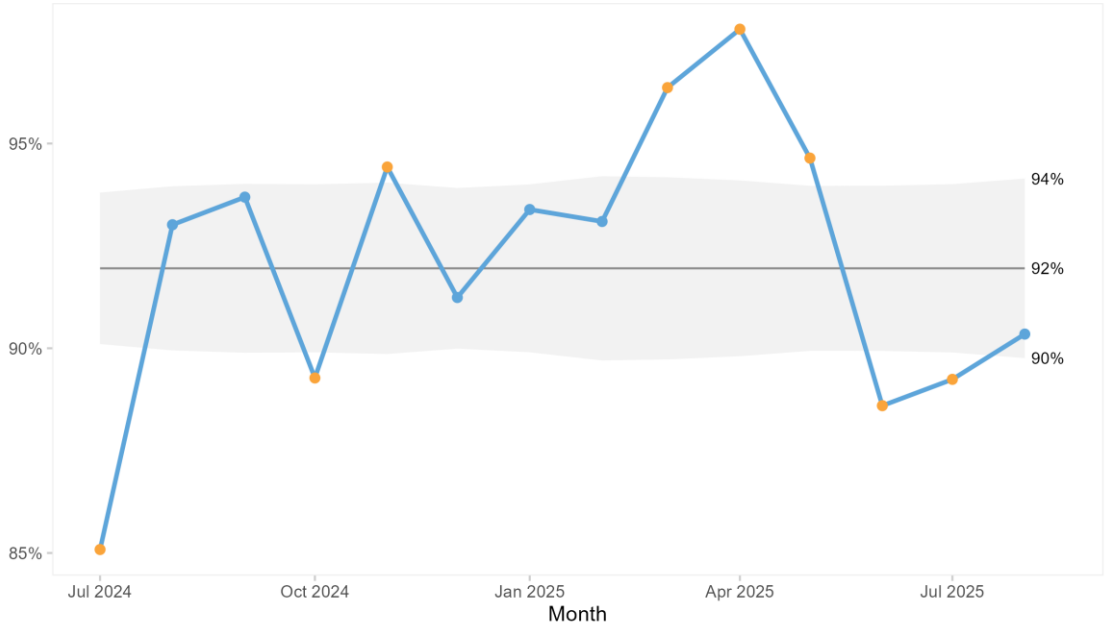

Proportion of outturns received which were completed (P chart) - Other Neighbourhoods



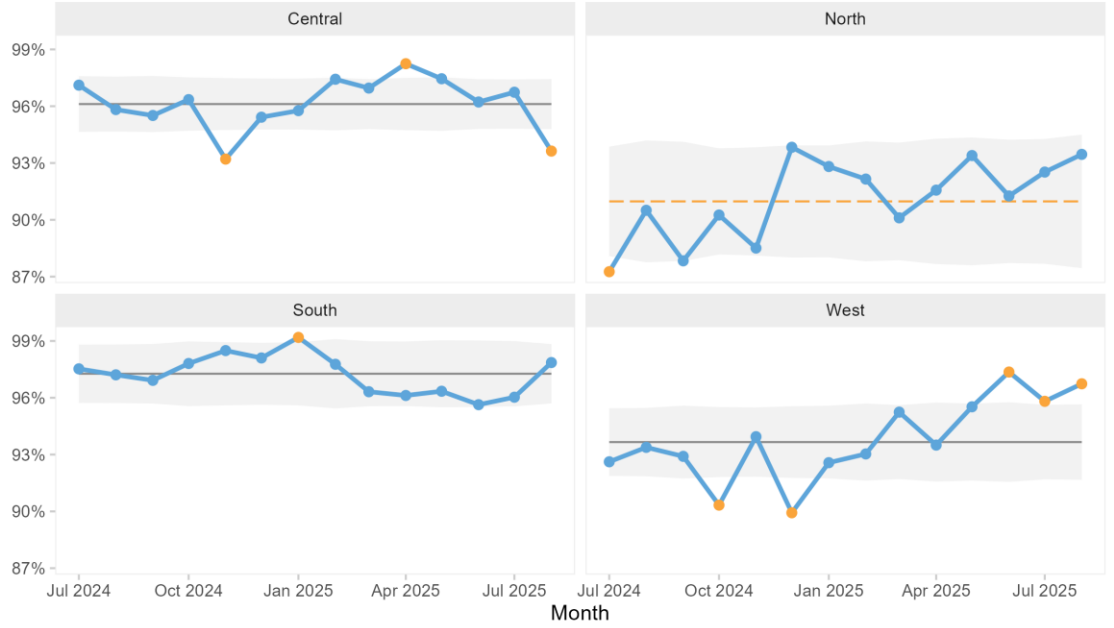
Successful Contacts

Discharges (negative)

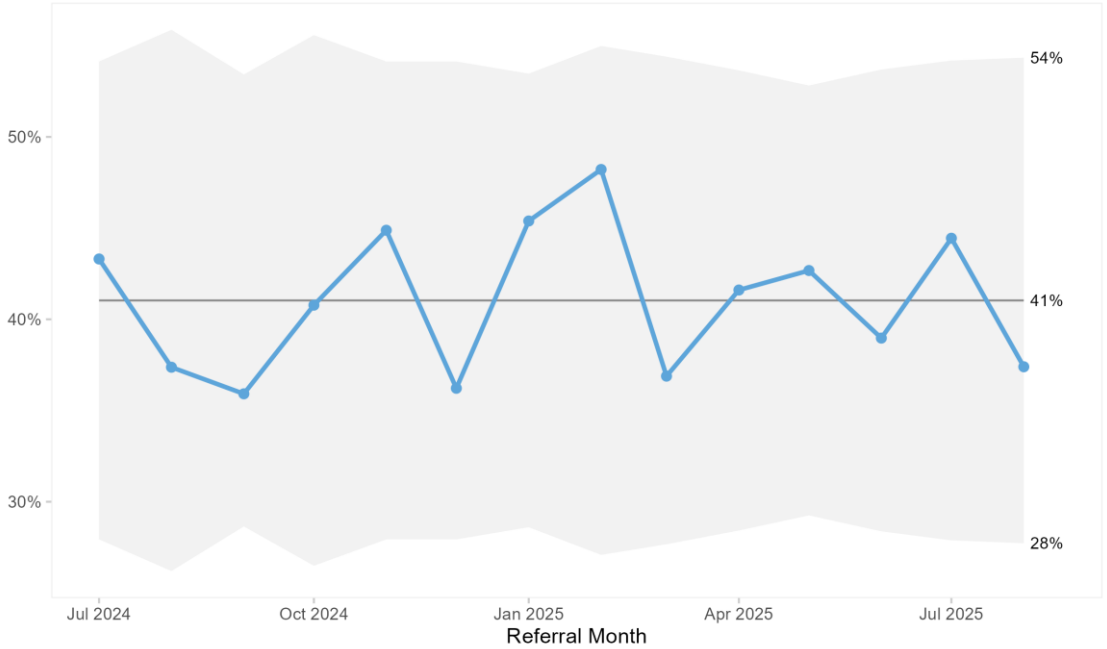
Proportion of attempted contacts where the resident was seen (P chart) - East Neighbourhood



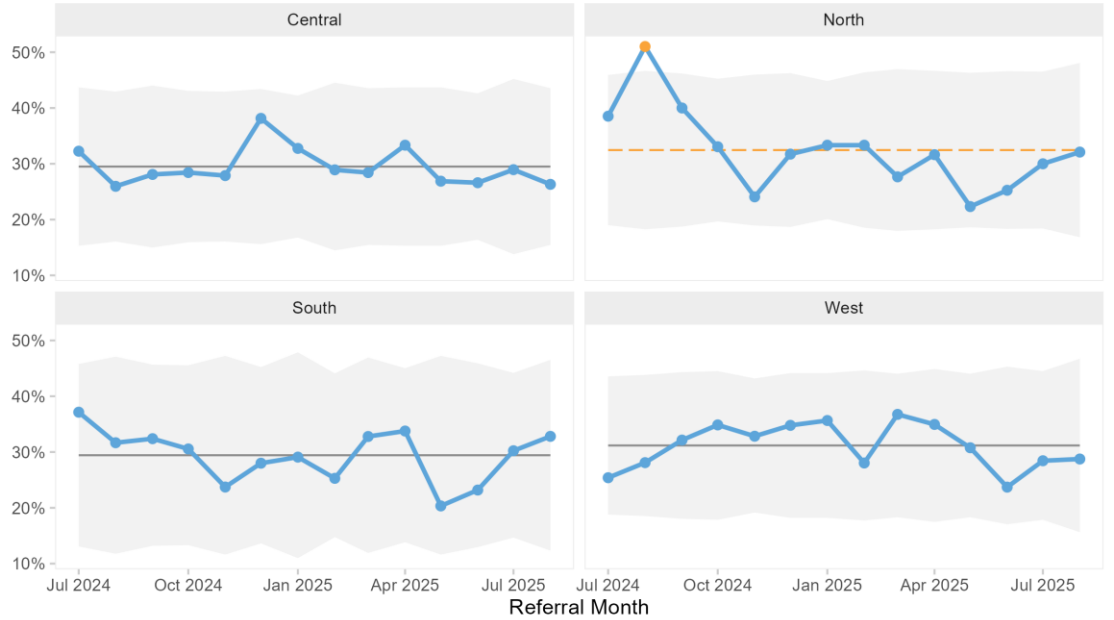

Proportion of attempted contacts where the resident was seen (P chart) - Other Neighbourhoods




Proportion of discharges due to negative reasons (P chart) - East Neighbourhood

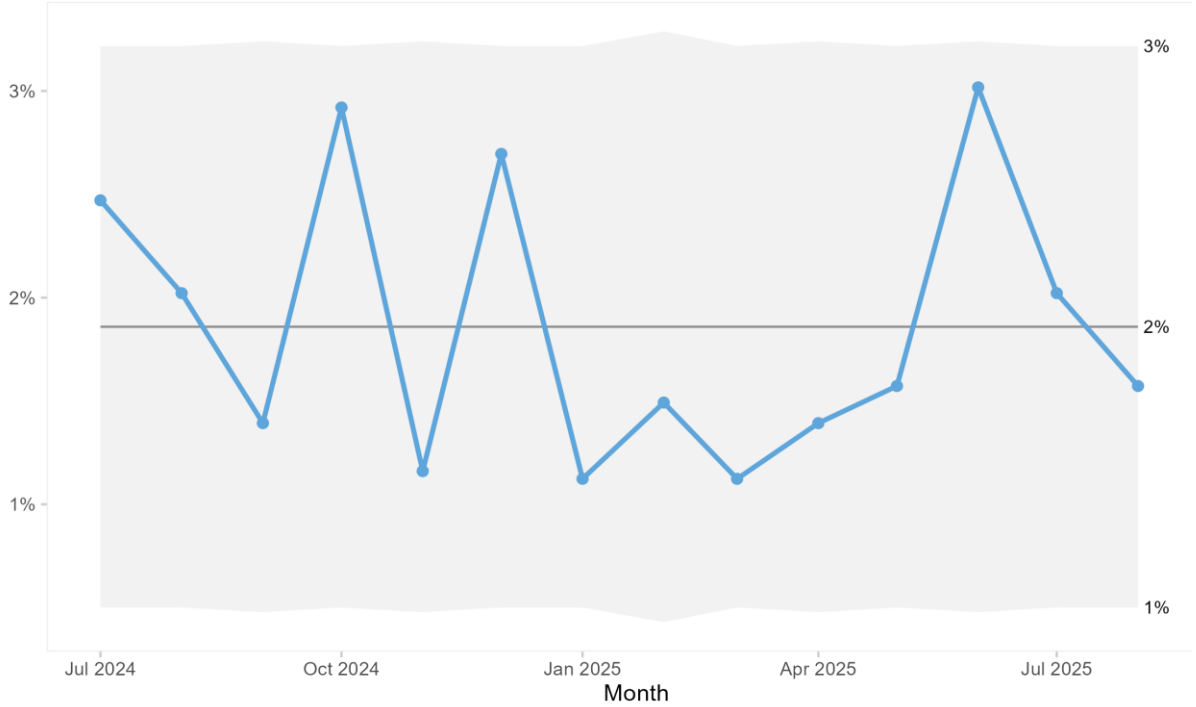



Proportion of discharges due to negative reasons (P chart) - Other Neighbourhoods

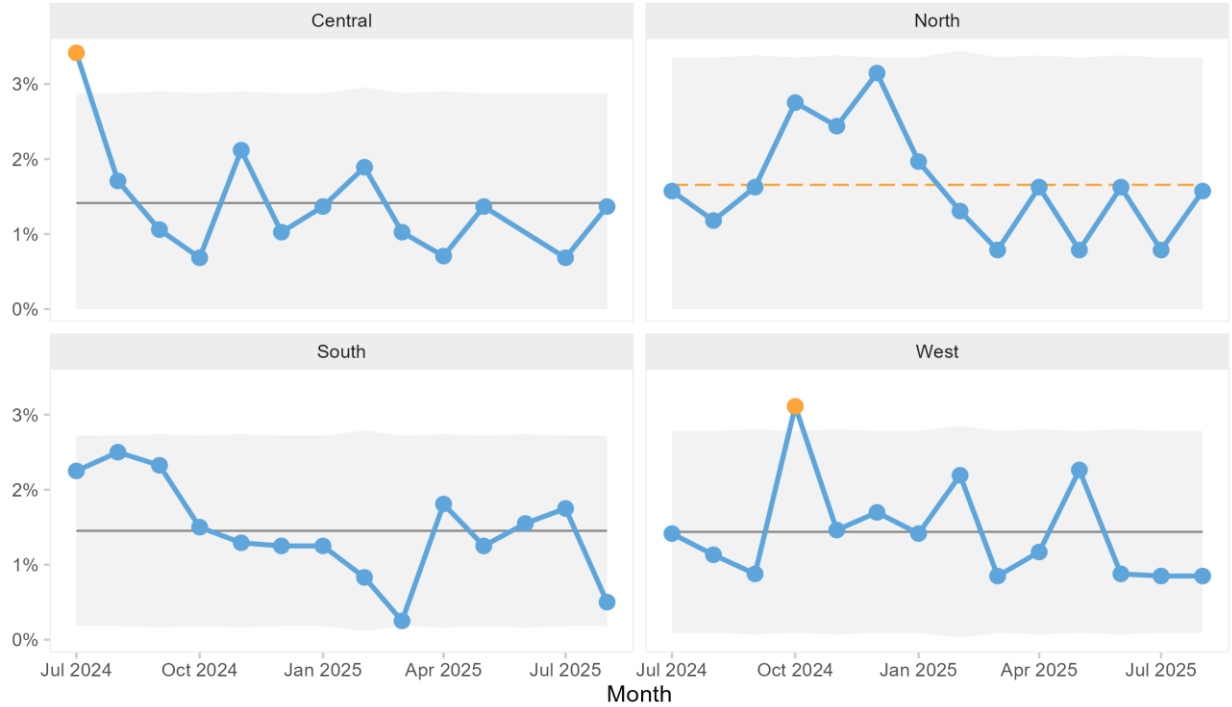


# Staff Sickness Rate

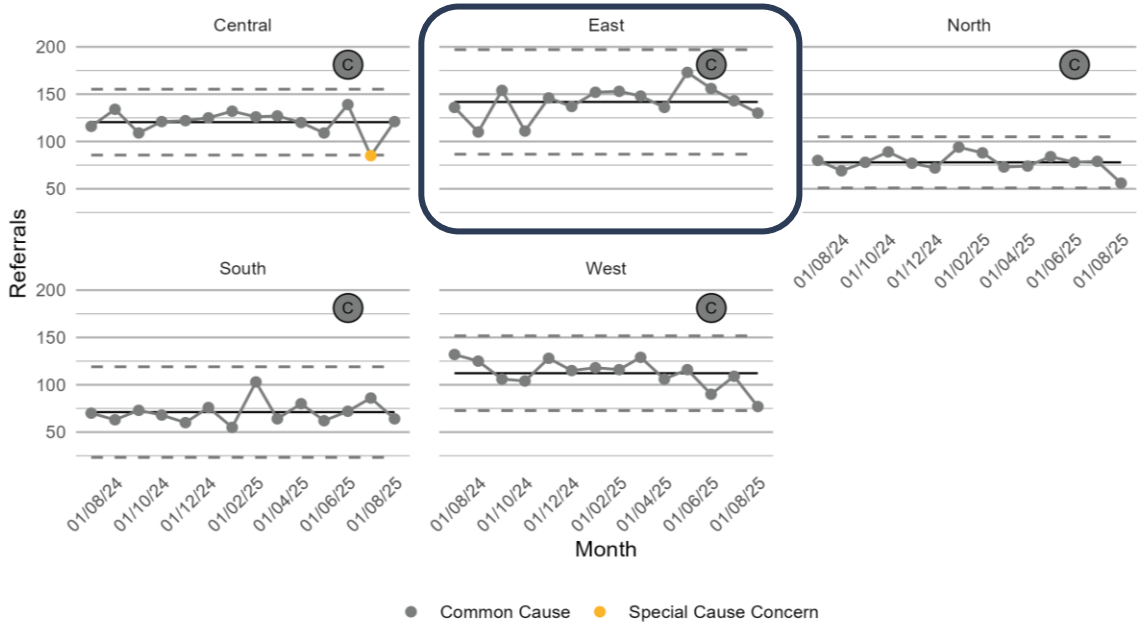
Proportion of contracted days lost to sickness (P chart) - East Neighbourhood



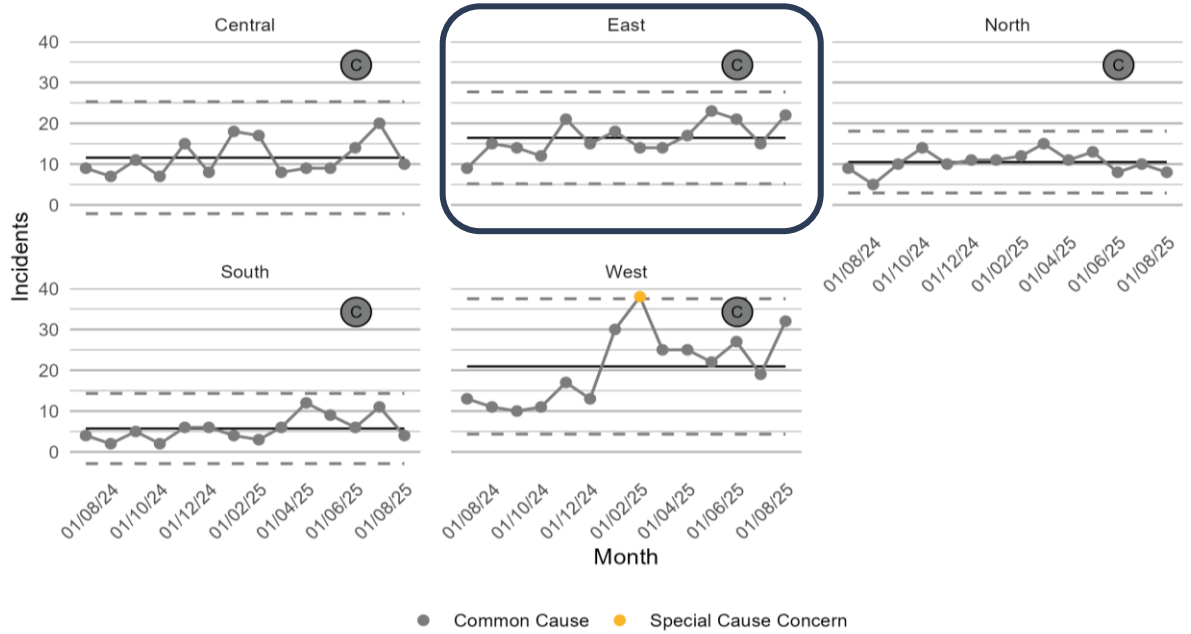

Proportion of contracted days lost to sickness (P chart) - Other Neighbourhoods



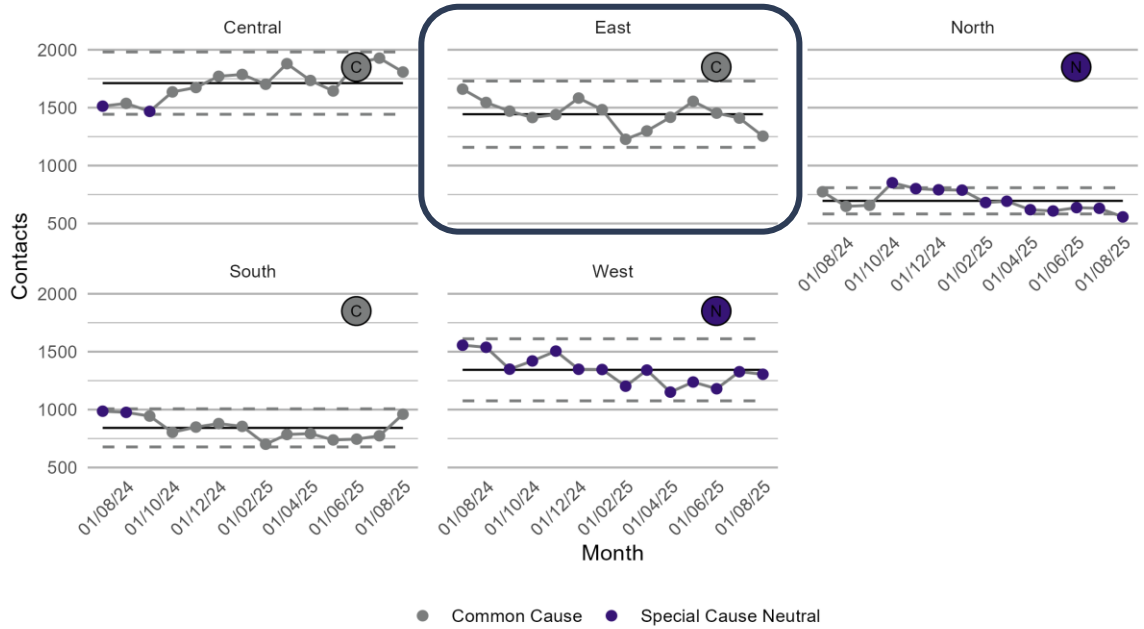
## Number of referrals to District Nursing Service (SPC-Chart)



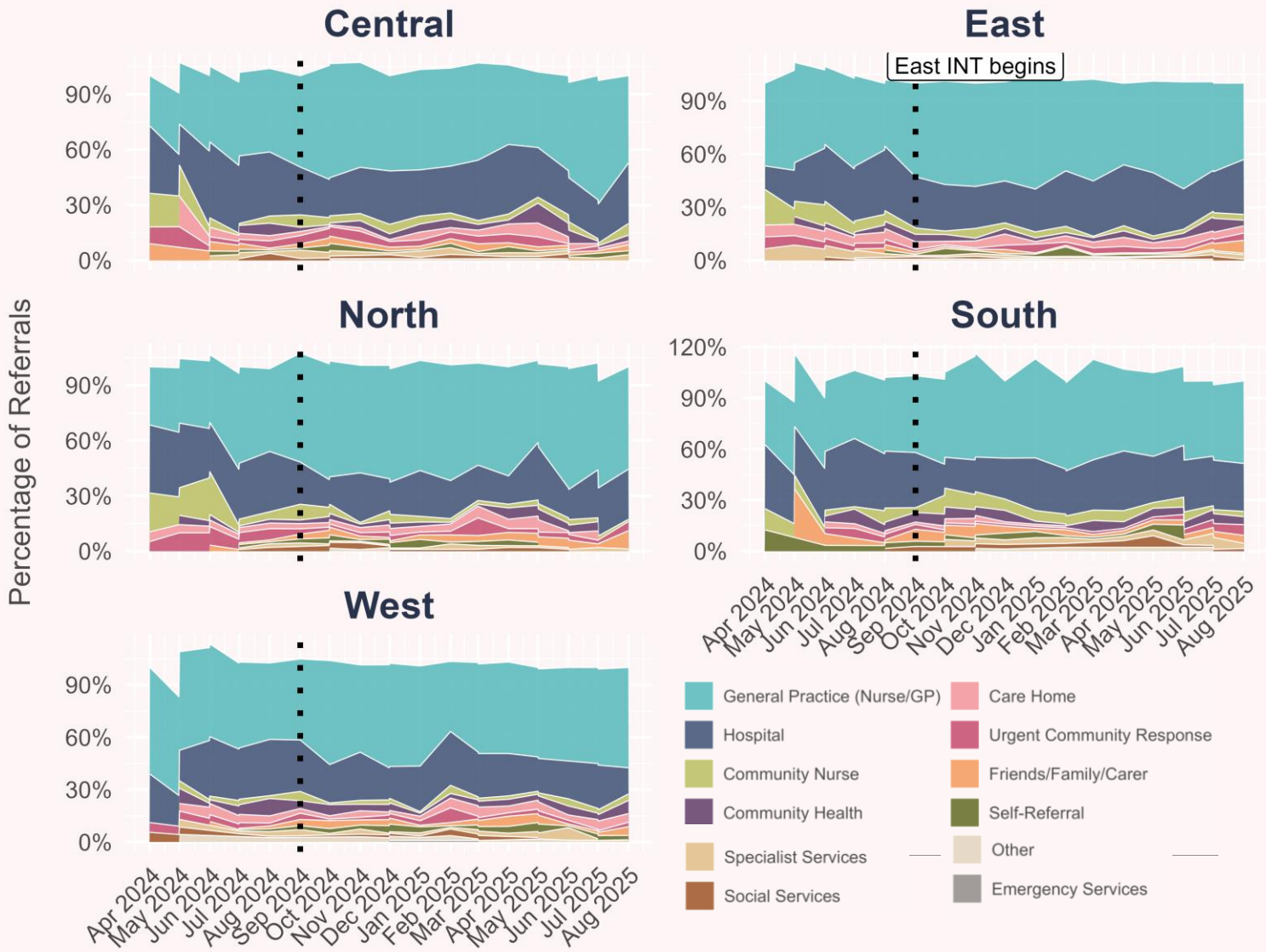

## Number of safeguarding incidents logged in Datix (SPC-Chart)




## Number of staff contacts with patients SPC-Chart



# Top 10 Referral Sources as % of Monthly Total by Neighbourhood






Camden

# Signals: Reflections

Early system change is usually visible first in the conditions that enable the system to work differently (i.e. staff relationships, behaviours, ways-of-working). The main challenge was identifying quantitative measures close enough to these shifts to be meaningful. Even indicators close to operational practice (e.g. appropriate referrals rate, caseload of staff), were probably too downstream from these condition changes that movement within the first year was unlikely.

Because these early conditions show up most clearly in how staff experience and navigate the system, staff experience (e.g. measured through a survey) is likely to be a more sensitive indicator than anything available in administrative data. A pre-post staff survey captured some of these shifts but could have been more integrated into the evaluation design.

Flat trends in signals are difficult to interpret in an emergent system where change unfolds gradually, unevenly and may not yet be detectable through administrative data. A wide range of (18) signals helped reduce the risk of missing detectable change. Further complexity is added by system changes altering trends in the past, where these were available, and in other areas undergoing different changes at the same time.

At this stage, the main value of quantitative indicators lies in updating and monitoring them regularly to spot system re-patterning, positive or negative. Their role is to guide qualitative inquiry and support understand, rather than to evidence whether the intervention is “working”, but this approach depends on having the time and capacity both to maintain the data flows and to interpret and investigate any emerging changes.

A primer on system-change evaluation could have supported stakeholders to understand the purpose of measurement at different stages and the role of causality. Early measurement is primarily about understanding how the system is beginning to work differently, with long-term outcomes only becoming appropriate to assess, using causal inference methods, much later. This would have avoided early effort spend on defining very downstream objectives which, while of high system priority, were unlikely to be impacted in short amount of time. This could have reinforced expectations around what the EINT could deliver.

# Appendix 4: Realist Evaluation

Report below by Cassie Moore (Public Health Specialty Registrar, London School of Hygiene & Tropical Medicine)

Camden

# A Realist-Informed Evaluation of Camden's East Integrated Neighbourhood Team Pilot

Cassie Moore
Public Health Specialty Registrar

# Summary

**About the project**

A realist-informed qualitative evaluation of Camden's East INT Pilot which explored how integration was experienced by staff, and how leadership, professional boundaries and culture shaped how integration plays out in the INT.

**Key findings**

- Integration was experienced more as a cultural shift than a system transformation
- Staff shared the ethos of person-centred care, but the INT remained a concept without clear operational goals
- Leadership was person-dependent, driven by goodwill rather than mandate or resource
- Estate and digital barriers limited co-location and collaboration
- Organisational boundaries, workloads and capacity pressures continued to constrain integration

**Implications**

- Develop the vision into actionable objectives that translate into everyday work
- Invest in embedded leadership with cross-organisational authority and infrastructure; digital, estate and shared resources
- Be realistic about scope and pace, and what kind of integration (structural/relational) is being developed; integration is a long-term cultural process

# Approach: Realist Evaluation

Realist evaluation, based on a critical realist perspective, assumes that programmes succeed or fail because certain mechanisms are triggered in particular contexts. It recognises that our understanding of these mechanisms is always partial, but by testing and refining theory, we can better explain what works, for whom, and under what conditions in complex health programmes.

Rather than asking "is this successful", realist evaluation asks, **what works for whom, in what circumstances and why?**

It does this by looking at the relationship between three things:

**Context:** The conditions/setting e.g. leadership, local culture, resources

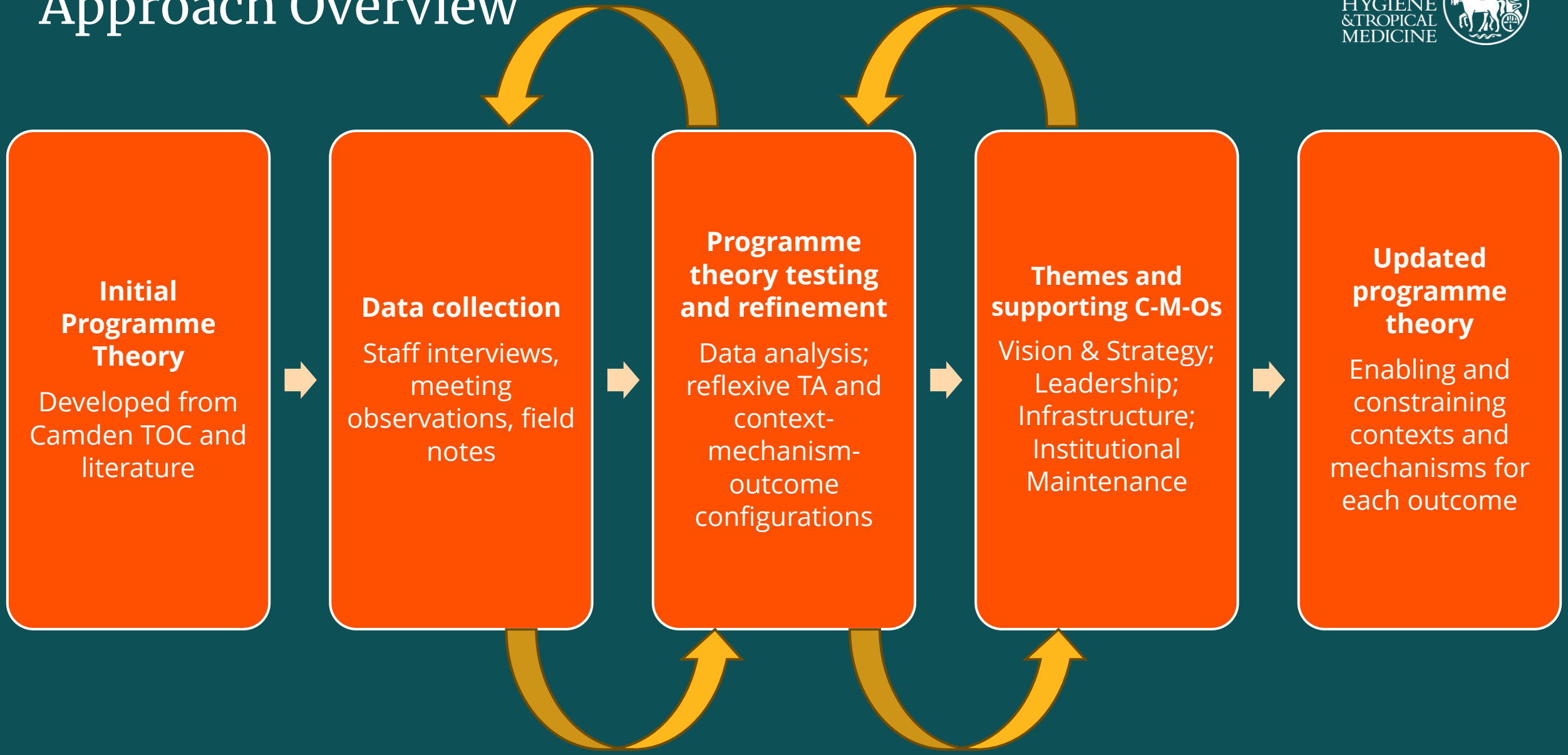
**Mechanism:** The underlying processes or responses that occur in particular contexts that generate (or not) an outcome, e.g. psychological safety, saving time, increased trust

**Outcome:** What actually happens as a result of the context + outcome, e.g. better relationships, more appropriate referrals

**Key steps** (following RAMESES II reporting standards for realist evaluations):

1. **Develop initial programme theory** from Camden's interim theory of change and other evaluations of INTs
2. **Test and refine:** Triangulation of data (interviews, observations, field notes, literature) to test and contest assumptions about how the programme works, and build a picture of what works (or doesn't), for whom, in real life
3. **Refine programme theory** about how an intervention actually works; construction of context-mechanism-outcome configurations (CMOCs)

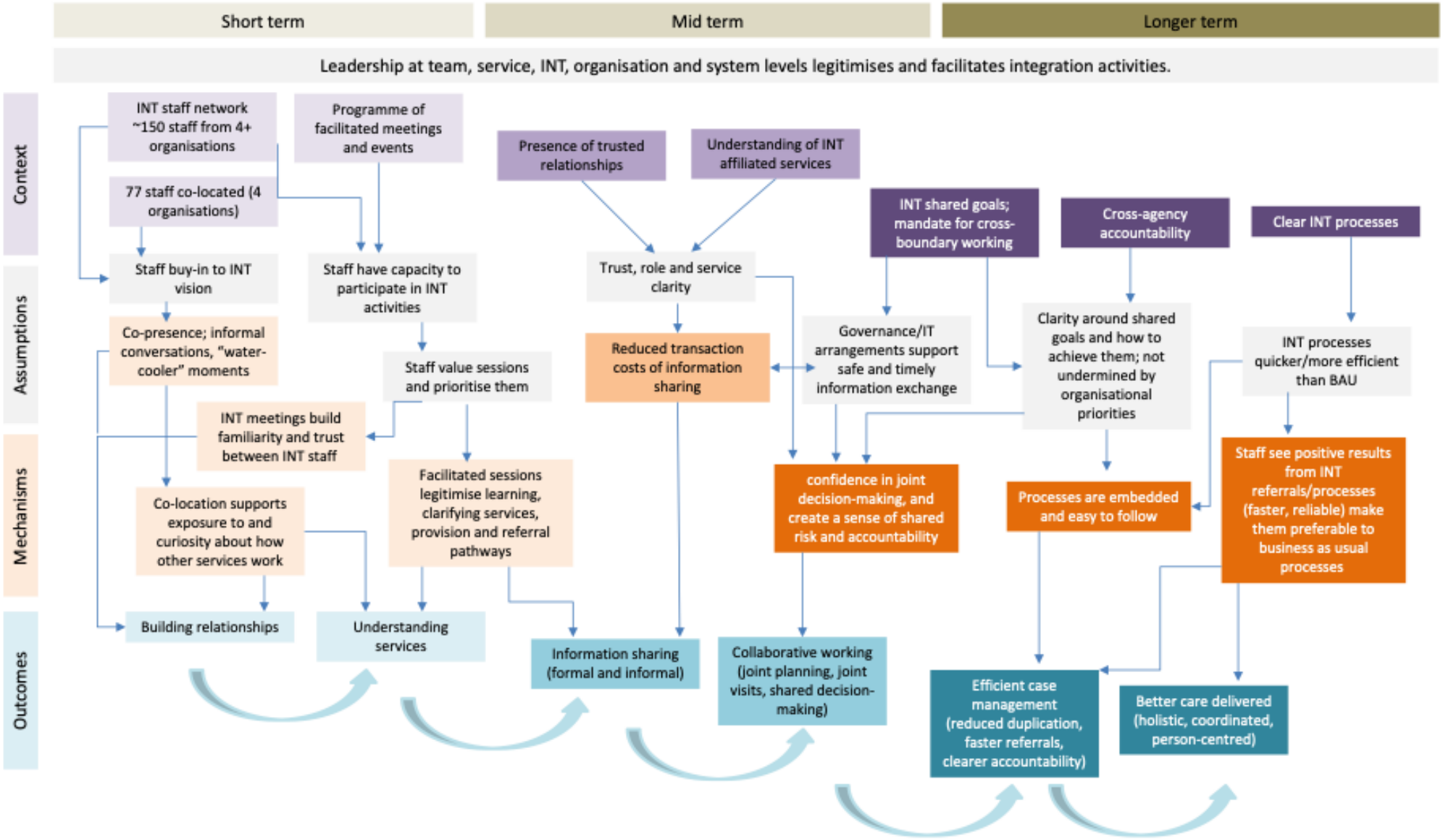
# Approach Overview



# Initial Programme Theory

- Camden's interim theory of change had a single short-term outcome: *"staff share information and collobarate more efficiently to manage cases and deliver better care"*
- Disaggregated into four outcomes: **information sharing**; **collaborative working**; **more efficient case management**; **delivering better care**
- Two additional "precursor" outcomes, identified from INT evaluation literature; **building relationships** and **understanding services**
- These six outcomes can be understood as a developmental process, each outcome building on the previous, from early relational work to delivering better care
- The programme theory should be understood as recursive; each stage both depends on and reshapes those preceding it; for example, collaborative working refracts back, reinforcing earlier gains in relationship building and understanding services
- Complex interventions are not adequately captured by linear programme theory – but it can be a useful heuristic to help us to understand what works, for whom, and under which circumstances

# Initial Programme Theory



# Data Collection

- Realist approach of multiple data sources; non-participant observation, semi-structured realist interviews and informal ethnographic fieldwork over a three-month period
- Approach supported an account of *what goes on*, as well as how staff describe and understand these processes
- Emerging context-mechanism-outcome theories were brought into interviews for discussion, testing and refinement

| Method | Description | Timeframe |
|---|---|---|
| **Non-participant observation** | INT meetings: Working Together, Team/Service Leads, Lunch & Learns, Hoarding Community of Practice, Service Team Meetings (13 meetings, 12.5 hours of observations) | 5th May - 13th August |
| **Semi-structured interviews** | 12 depth interviews (~1 – 2 hours) with staff across roles, levels of seniority, organisations and engagement | 19th June - 17th July 2025 |
| **Fieldnotes** | Embedded working in the INT: Notes from observations and informal interactions; spatial mapping; analytical reflections and thoughts | 5th May - 31st July |
| **Reflexive journal** | Personal reflections on field engagement, assumptions, and interpretations | Throughout |
| **Informal participation** | (When invited) attended INT lunches, INT relaunch | Throughout (ad-hoc) |

# Data Analysis

5 iterative stages of analysis, moving back and fourth between stages 1, 2 and 3, before moving onto stages 4 and 5

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Familiarisation with data; comparing and contrasting interviews, observations and fieldnotes. Recording reflections in analytic diary. | Coding data; codes generated from the data (e.g. *INT as concept*) and from ideas from previous evaluations of INTs (e.g. *Institutional Maintenance*) | Generated themes through an iterative process, moving back and forth between codes and potential themes | Applied a realist lens to each theme to interpret context, mechanisms and outcomes | Reviewed and updated the initial programme theory, developing mechanisms and contexts for the programme outcomes |

# Analytical Methods

## Reflexive Thematic Analysis

- Line by line coding of interview transcripts, observations and fieldnotes to explore how staff experienced and enacted integration
- Used Reflexive Thematic Analysis, developed by Braun and Clarke which recognises that themes are actively shaped and developed by the researcher, rather than “emerging” from the data
- Codes were first drawn directly from the data, then secondly codes were linked to relevant theory and developed further
- Codes grouped into themes via several rounds of review and reflection

## Context-Mechanism-Outcome Configurations

- Applied a realist lens to each theme, looking at how different situations (contexts) trigger certain responses (mechanisms) that lead (or not) to outcomes
- Used abductive reasoning (combining existing theory with new insights from the data) to explain how and why things happened in practice
- Reviewed and updated the initial programme theory, identifying enabling and constraining contexts using Greenhalgh’s (2009) approach

# Overview

- Camden's East INT pilot is a heterogeneous, evolving programme of work shaped by a design led-approach that emphasises agile testing and iterative learning. In practice, the INT functions as bricolage – a shifting assembly of partial co-location, initiatives and ad-hoc practices that evolved as initiatives emerged, changed direction, or faded.
- Some of the contexts assumed in the initial programme theory (IPT) were not present in practice
- Later outcomes in the initial programme theory (more efficient case management; delivering better care) were not evidenced in within the study period
- The results focus on how staff experienced and interpreted integration and the INT in everyday work, and are presented in two parts:
    - The four themes; **vision and strategy**, **leadership**, **infrastructure** and **institutional maintenance**, summarised by context-mechanism-outcome configurations
    - Updated programme theory using a realist approach, illustrating mechanisms and enabling and constraining contexts for each outcome in the programme theory

# Vision and Strategy: Engagement & Practice

Staff strongly supported the vision of joined-up, person-centred care, but saw integration as an aspiration rather than a lived reality

*"You know, but it is just a concept, in a way. Because in practical terms, nothing particularly has changed [...] just us going to different bits of the borough and sitting somewhere else"* (Participant 5)

Day to day work largely continued as before; separate caseloads, service boundaries and limited cross-agency working

Co-location and the Duty Desk helped to enable practical collaboration.

*"With the duty desk [... ] we're forced to work together for the day, for the seven hours that we're here. It works a lot of the time, and it's a nice opportunity to get to meet other people" (Participant 11)*

East INT meetings were actively facilitated by Head of INTs and Senior Design Researcher, whose personal commitment created safe and inclusive spaces, were institutional maintenance and professional hierarchies could be temporarily suspended

*"Yeah, really different [to an MDT]... a space to be heard, and to actually learn from people I wouldn't usually meet [...] And also, I don't know, a bit less political. It feels more like [we can] just say how we feel about something"* (Participant 8)

# Vision and Strategy: Progress & Learning

Staff and managers stressed the desire for tangible goals to work towards, and evidence that the INT was achieving something. In the absence of these, progress felt "fluffy", managers were keen for evidence of change to motivate staff

> *"But I would like to show some data, to be like, look, here are some concrete changes. Our waiting lists or patient readmissions have gone down, calls to LAS have decreased or, you know, something tangible"* (Participant 4)

The test and learn approach aimed to design the model from the bottom-up, by many staff struggled to see how learning was applied

> *"I'm not sure what anything we've done so far is built on to get to there. We're testing, but we're not learning"* (Participant 10)

Overall, integration was understood and valued in principal, but often experienced as abstract, with a lack of clarity around short-term aims and limited evidence on progress

# Vision and Strategy: CMOs

| Context | Mechanism | Outcome |
|---|---|---|
| **Staff share long term vision but can't articulate shorter term aims** | Ambiguity about what to work towards day to day | Integration experienced as intangible – a concept rather than a reality |
| **Uneven co-location: NHS staff full-time, council staff flexibly present; VCS, GPs, and mental health staff rarely visible** | Co-located staff more able to build familiarity and have ad-hoc conversations | Ad-hoc conversations, some quicker referral discussions, improved understanding of other services for co-located staff |
| **Relocation from "home" organisations** | Disruption of existing (multidisciplinary) networks | Staff experience reduced access to colleagues in other teams, undermining integration and staff buy-in to vision |
| **East INT meetings (Working Together, Lunch and Learns)** | Heavily facilitated structural spaces create a safe space for building trust and relationships across the East INT patch | Creation of trust and relationships between staff, but constrained to more engaged staff who attend and reliant on INT leads |
| **East INT and social events/lunches** | Seen as voluntary and peripheral by many staff; staff deprioritise attendance in favour of BAU tasks | Relationship-building confined to more engaged staff – less "coverage" than "work" based interventions |
| **Duty desk creates a structured work-based mechanism** | Structured cross-agency triage requires staff to interact, legitimising collaboration as part of work. Duty desk provides visibility, lowering the social cost of approaching colleagues | Tangible experience of integration; relationships and collaboration grow more comfortably in a "work" context |
| **Test-and-learn design approach** | Staff unclear what is being trialled, achieved and "learned" | Implementation gap widens; staff see the INT as abstract or a loss of momentum |
| **Lack of data/metrics on outcomes** | Without data, staff and managers struggle to demonstrate and understand the value of integration | INT perceived as "fluffy", symbolic and intangible |

# Leadership: Relationship-brokers

Leadership in the East INT was relational and person-dependent, rather than structural and embedded.

> *"I think a lot of this probably was driven by [Head of INTs] particularly, and [Design Researcher] [...] they've done a good job, tried to embrace the concept and get people on board."* (Participant 5)

Head of INTs and Senior Design Researcher acted as narrative constructors and relationship-brokers, fostering culture and continuity.

> *"You realise that so much depends on the person. I've seen consistent enthusiasm and positivity and that's at every opportunity from [Head of INTs]. That's what I mean about how a job description might be the same for someone else, but you might not be creating the same environment and feeling."* (Participant 6)

Progress was sustained through goodwill and personal effort, rather than by a mandate across organisations.

# Leadership: Capacity

Operational leads struggled to translate the broad INT vision into tangible, everyday practice

> *"It's still abstract and visionary [...] We have to clarify why [the INT] will benefit every staff group and how, and then measure it. It's a big task though, isn't it?"* (Participant 4)

Limited capacity and competing demands meant that "invisible" INT work was fitted around business as usual tasks, even for the few staff who had some protected time. Operational leads lacked capacity to drive integrative change.

No cross-organisational mandate or structural shared leadership to coordindate strategy, drive processes and maintain momentum

> *"One of the problems is that you need some direction, otherwise people just do whatever the hell they want. You've got [Head of INTs], but it's not [their] job to lead the whole team [...] So we're not really one team, we're just a few teams based together. You've got no leader. Everyone's just getting on with their job, you know, like they did, I think."* (Participant 5)

Overall, the INT's development relied on individual endeavor rather than embedded, resourced leadership

# Leadership: CMOs

| Context | Mechanism | Outcome |
|---|---|---|
| **Head of INTs and Senior Design Researcher provide visible facilitation, relationship building and creating a relational atmosphere** | Safe and respectful spaces cultivated where staff feel safe and valued | Meetings feel different from BAU; trust begins to build but is contingent on the ongoing presence of specific individuals |
| **No overall leader with mandate/authority/power to enact cross-agency integration** | Absence of an INT leader with cross-agency mandate leaves a gap - no one consistently driving and sustaining staff engagement | Challenging to progress integration past co-location, with limited cross-agency change;<br>Absence of shared identity and rituals prevents development of an overarching team culture |
| **Operational leads must translate abstract INT vision into practice** | 1. Leaders embed integration goals into BAU (e.g. appraisals)<br>2. Lack of data on outcomes impedes translation work of abstract to tangible | 1. Staff more likely to enact integration<br>2. Staff uncertain about the value of integration; enaction uneven and person-dependent |
| **Leaders manage large teams, INT work in additional to BAU work** | Lack of capacity forces leaders to prioritise BAU tasks; integration reframed as optional or secondary | Integration initiatives and momentum stall; embedding of integration unsustainable |
| **Gaps in system-level commitment (resources, mandate, delivery plan)** | Without shared accountability or aligned incentives, BAU feels safer than collaboration; staff perceive integration as discretionary rather than core work | Institutional maintenance reinforced, difficult to progress beyond rhetoric |

# Infrastructure

Infrastructure shaped how staff perceived and engaged with the INT. Experiences of the estate varied, depending on staffs' role and previous context; staff coming from less-resourced bases saw it as an improvement. In contrast, others viewed it as a downgrade; sometimes felt as a loss or resentment.

Some staff described a lack of investment in basic facilitates, that hindered their ability to carry out tasks.

> *"The things you need to do your job [are not here]. So having a printer, having a shredder. Having coffee. Having milk. There's not the tech. I'm basically storing paperwork in my locker until I can go to [central office] to get rid of it safely.* (Participant 2)

The shortage of clinical spaces limited participation in co-location, particularly for mental health staff. The lack of appropriate meeting and consultation spaces resulted in some staff felt that co-location was unrealistic, even if they bought into the INT vision.

> *"For me the biggest issue is clinical space. You know, if you're physically basing [staff] somewhere, you need to be able to have clinical space".* (Participant 7)

# Infrastructure: Digital

Digital infrastructure was universally raised as a barrier. Staff described how not having a shared electronic patient record (EPR) hindered collaborative working.

For some, it was impossible or very difficult to access their own EPR system from the health centre, meaning that co-location was perceived as unrealistic.

> *"I hope we can co locate and be part of one big team. But you know we need to our IT systems to marry [...] because there's no point being co-located somewhere when you can't access your EPR. Or you if you're using a different EPR [to your colleagues]."* (Participant 7)

Many staff identified the potential of an INT instant messaging platform as a mechanism to extend integration beyond co-location, especially given hybrid and varied working patterns. In the absence of digital infrastructure, integration relied almost entirely on personal relationships between staff.

> *"For [co-location] to work even better, we'd have some digital platform - sharing and rights. Because then you'd really have INT across many levels, at the moment you don't have INT working in the electronic record level, so you rely on the people. Yeah, it's just all on the people"* (Participant 4)

# Infrastructure: CMOs

| Context | Mechanism | Outcome |
|---|---|---|
| **Limited clinical space and general facilities (meeting rooms, IT equipment and systems, confidential spaces)** | Absence of clinical and confidential spaces signal to staff that their service is not fully supported to participate | Staff (especially Mental Health) unable to participate in co-location, undermining the INT model. Staff who can flexibly prefer to work out of other locations where possible. |
| **Staff on different electronic record systems – digital inoperability in the health centre** | Staff can't connect to the EPRs; inability to access or share records and information safely | Staff cannot work out of the health centre or join the Duty Desk (e.g. GPs, Mental Health) |
| **Staff relocated from varied settings into the INT health centre** | Staff from better-resourced offices compared the new environment negatively, leading to frustration and a sense of loss<br>Staff from less well-equipped or more peripheral contexts saw the health centre as an improvement, increasing willingness to engage | Perceptions of the estate diverged: some staff felt demoralised and disengaged, while others were content |

# Institutional Maintenance: Culture

Despite co-location and a formal hot-desking policy, the office was divided into organisational territories, space was clearly demarcated into teams, with desks implicitly "owned".

> *An OT told me I shouldn't sit at a particular desk. She laughed and said: "You can sit wherever you want, apart from there and there…and there" Despite being a hot-desking office, the office is segregated into organisations and teams* (Fieldnotes, July 2025)

Cultural differences between organisations and teams remained strong and maintained divides between professions and organisations.

Service boundaries remained strong; different eligibility criteria and service priorities limited collaboration.

> *"We have different criteria. Health always have a stricter criteria, and basically [social care] see everyone. It feels like we're always on the losing wickets."* (Participant 10)

The lack of a cross-agency mandate left staff uncertain about their license to collaborate, and to manage risk and service capacity. Collaboration often relied on informal, personality-driven favours and workarounds.

# Institutional Maintenance: System

Capacity pressures at all levels restricted staff from engaging with the INT and enacting integration. Integrative work was often seen as additional and optional to business as usual. This was reinforced by mixed messages from “home” organisations.

*“The messages we get from our senior managers is like, you know, be integrated but to a degree, because we still need to retain our staff and do the clinical work that we have to do.”* (Participant 7)

System-wide constraints hindered collaborative working, frustrated staff and fostered disillusionment with the INT vision.

*“But there's a waiting list [...] And then I'm telling you by the way, you need to wait three months for an assessment and then two years if you're eligible. So you can have those nice relationships [with INT staff] and like, go up to each other and have a chat in the office. But at the end of the day...I don't know that it's serving the resident”* (Participant 11)

Whilst institutional maintenance persisted, disruptions occurred through facilitated meetings and events, and the duty desk. These efforts were largely reliant on individual effort and were not embedded in system structures.

# Institutional Maintenance: CMOs

| Context | Mechanism | Outcome |
|---|---|---|
| **Hot desking policy in physically co-located office** | Staff cluster into organisational territories; new/VCSE staff feel unwelcome | Clustered seating visibly reinforces silos and integration rhetoric undermined |
| **Distinct organisational and professional cultures** | Stereotyping and slurs (e.g. "*task-focused*") reinforce professional identity boundaries | Misunderstandings persist; limited cross-disciplinary trust |
| **Different eligibility criteria and service thresholds** | Staff perceive colleagues as protecting their own workload/resources | Reinforces service divisions and identities |
| **No cross-organisational mandate; mixed senior messages** | Staff perceive integration as "helping out" or personal favour | Integration progress dependent on individuals' goodwill and personalities (fragile) |
| **Heavily facilitated meetings; duty desk; individual initiatives** | Temporary suspension of silos; visibility of other services | Small disruptions to maintenance, but fragile and reliant on specific people |

# Updated Programme Theory

- The table below presents the refined programme theory developed from the data collected, nine months after co-location commenced.
- It focusses on the six outcomes in the initial programme programme theory (building relationships; understanding services; information sharing; collaborative working; more efficient case management; delivering better care) and reflects the outcomes and mechanisms observed in practice.
- Later outcomes (more efficient case management; improved care) were not evidenced within the study period.
- Drawing on Greenhalgh's (2009) approach, contexts are presented as enabling or constraining.

# Updated Programme Theory

| IPT Outcome | Mechanism(s) | Outcome in practice | Enabling Contexts | Constraining Contexts |
|---|---|---|---|---|
| **Building Relationships** | Visibility of colleagues created opportunities for informal interaction<br><br>Facilitated meetings enabled respectful, curious dialogue across services<br><br>Practical interventions (Duty Desk) legitimised interactions | Some new cross-agency relationships<br><br>Trust and relationship building fragile and dependent on individuals | Co-location (for some staff)<br><br>Facilitated meetings and events<br><br>Relational culture set by Head of INT and Design Researcher<br><br>Operational, work-based (not just relational) interventions legitimised staff contact | Staff turnover<br><br>Inconsistent attendance at meetings due to staff capacity and buy-in<br><br>Gaps in cross-cutting leadership presence |
| **Sharing information** | Duty Desk provided visibility and immediacy, legitimising quick referral discussion<br><br>Occasional ad-hoc exchanges | Some timelier information sharing in co-located teams<br><br>More appropriate, timely referrals into some services | Relational and structural foundations (co-location, relationships, leadership)<br><br>Duty Desk | IT and data governance barriers<br><br>No shared INT messaging/comms platform |
| **Understanding services** | Lunch and Learns and other cross-agency fora provided structured learning opportunities<br><br>Duty Desk interactions clarified service provision and criteria<br><br>Informal exchanges revealed how other services "work" | Some timelier referral discussion and appropriate referrals<br><br>Improved understanding of services and pathways | Relational and structural foundations (co-location, relationships, leadership)<br><br>Structured learning and networking meetings and events<br><br>Duty Desk | Capacity pressures limiting attendance<br><br>Knowledge gains limited to meeting attendees<br><br>Numerous meeting and service forums creating competing demands |
| **Collaborative working** | Duty desk enabled informal cross-agency collaboration<br><br>Some staff went "above and beyond" remits<br><br>Facilitated meetings reduced psychosocial and knowledge barriers | Collaboration patchy, framed as favours<br><br>Dependent on personalities and capacity<br><br>Silos largely persisted | Emerging trust and relationships from earlier stages<br><br>Capacity and desire to "go above and beyond"<br><br>Facilitation to bring people together and encourage relational working | No shared mandate or accountability<br><br>Persisting cultural/professional boundaries<br><br>Reliance on goodwill<br><br>Reliance on Head of INT and Design Researcher facilitation |

# Reflections

## Reoccurring challenges

- Camden's experience closely aligns with findings from other integrated teams that also highlight leadership gaps, infrastructure barriers and persistent oragnisational boundaries
- These challenges are well-documented, suggesting a need to focus on embedding lessons, rather than continually re-learning them in pilots
- The findings points to an opportunity for stronger alignment between existing evidence and policy design

## Implementation Gap

- There is a gap between the external narrative of integration in the East INT and the day-to-day realities of implementation and staff experiences
- The INT attracted significant attention locally and nationally, with promotional videos and ministerial visits emphasising strong relationships and improved care. Yet in practice, fragile leadership, uneven co-location, and ongoing silos were more characteristic.
- This gap risks masking ongoing challenges and discourages sustained investment required for integration

# Recommendations

1) **Set a clear vision that translates into tangible objectives**: A shared ethos is not enough; staff need clarity about how being in the INT should change everyday practice. Without this the INT risks being experienced as a concept rather than a reality.
2) **Balance “soft” and “hard” approaches**: Relationship-building, trust and culture change are all vital, but must be matched by structures, processes and resources.
3) **Resource and embed leadership**: Visible, boundary-spanning leaders with cross-organisational mandates are needed to sustain momentum; reliance on “hero” leaders is fragile and unsustainable.
4) **Institutional commitment**: Policy, funding and workforce capacity must be aligned with INT goals; without earnest organisational buy-in staff engagement will remain fragile.
5) **Shared governance**: Create cross-agency accountability and shared risk frameworks are required to move beyond business as usual.
6) **Evaluate culture as well as outcomes**: Evaluation should capture cultural and relational outcomes alongside service indicators.

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