Title: **"It's not a quick fix" Structural and contextual issues that affect implementation of integrated health and wellbeing services: a qualitative study from North East England**

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ABSTRACT

Objective: The objective of this paper is to examine factors affecting the design, commissioning and delivery of integrated health and wellbeing services (IHWSs), which seek to address multiple health related behaviours, improve wellbeing and tackle health inequalities using holistic approaches.

Study design: Qualitative studies embedded within iterative process evaluations.

Methods: Semi-structured interviews conducted with 16 key informants as part of two separate evaluations of IHWSs in North East England, supplemented by informal observations of service delivery. Transcripts and fieldnotes were analysed thematically.

Results: The study findings identify a challenging organisational context in which to implement innovative service redesign, as a result of budget cuts and changes in NHS and local authority capacity. Pressures to demonstrate outcomes affected the ability to negotiate the practicalities of joint working. Progress is at risk of being undermined by pressures to disinvest before the long-term benefits to population health and wellbeing are realised. The findings raise important questions about contract management and relationships between commissioners and providers involved in implementing these new ways of working.

Conclusions: These findings provide useful learning in terms of the delivery and commissioning of similar IHWSs, contributing to understanding of the benefits and challenges of this model of working.

Key words: integrated services; wellbeing; health inequalities; qualitative research

Highlights:

- Single-issue lifestyle services have made little impact on health inequalities
- Evidence is limited on the practicalities of developing, commissioning and implementing integrated services which address multiple health and wellbeing issues simultaneously
- Adverse structural and contextual factors risk destabilising these fledgling services
- Progress has been undermined by ongoing austerity and cuts to public health budgets
- Commissioners require robust, timely evidence of impact that takes into account the particular needs of the target communities

INTRODUCTION

While there have been some improvements over recent decades, far more people in North East England continue to suffer illness and premature death than the national averages.[1] Poverty and unemployment play a major part in contributing to inequalities in health outcomes across the life course.[2, 3] The previous 'silo' approach to the commissioning and provision of single-issue lifestyle services in the NHS was unable to address the wider determinants of health, and therefore made little impact on inequalities. The transfer of public health responsibilities to local government in 2013 created an opportunity to integrate preventive services with agencies that act on wider issues that contribute to poorer health outcomes, such as welfare, education and housing.[4] In response to these opportunities and challenges, a number of local authorities across England have developed integrated health and wellbeing services (IHWSs). Delivery models vary but most incorporate: one-to-one and group-based health improvement interventions such as smoking cessation, physical activity, healthy eating and mental health promotion; and community-based services which aim to address wider determinants such as employment and financial issues, often delivered in partnership with third sector organisations. (See for example[5] and[6]).

The existing service models in the North East are mixed but all incorporate some degree of community capacity building, volunteer and/or peer roles, and asset-based approaches. (See for example[7]). Each IHWS adopted Marmot's principle of proportionate universalism, targeting the most deprived communities while making a universal offer.[3] By doing so, it was anticipated that they would reduce health inequalities by working more intensively with the populations at greatest risk of poor health. Providing support and co-ordinating peer review of these services is important, given the significant investment in this new way of working at a time of ongoing austerity and cuts to local authority public health budgets.[8, 9] There is also a growing need to build the evidence base around complex, community-based interventions that aim to address multiple unhealthy behaviours as well as the wider determinants of health and inequality.[10, 11]

Separate bodies of literature exist in relation to the various components of IHWSs, including asset-based approaches,[12-15] community engagement and capacity building,[16, 17] and health trainers and similar lay health workers.[18-23] However, research is limited on the realities of bringing these elements together. A review of evidence and good practice examples in relation to 'wellness services' was published by Liverpool Public Health Observatory, detailing benefits to service users and potential cost savings, but significant changes in UK policy and practice have taken place since its publication in 2010.[24] In addition, wider changes in health and social care have influenced local public health priorities. The need to address multiple lifestyle behaviours and tackle health inequalities using holistic approaches is well-established, but it is not always clear how to translate this into practice.[3, 25-27] Research is needed to examine what happens when efforts are made to bring different approaches together.

Extant evidence from the management literature suggests that partnership working is challenging, even when all partners agree with the overall aims of the joint project.[28] The reasons for this are many: different systems, timescales, processes, and governance structures; and different terminology and conceptual understandings of 'what counts' as evidence and is seen as valid over professional and sector boundaries (epistemic boundaries), hidden agendas, old rivalries and inherent competition for resources.[28-30] Requiring different partners to work together may result in

better (more acceptable and feasible) solutions, but equally may exacerbate old differences.[31, 32] Working across boundaries to achieve services delivery is likely to require significant relationship building, the development of shared understandings in non-politically neutral contexts.[33, 34]

Drawing on findings from two separate evaluations of IHWSs[35, 36], the aim of this paper is to explore structural and contextual issues affecting the design, commissioning and implementation of these services. Specific objectives were to: examine factors that influenced the commissioning process; establish whether the services had been implemented as planned; and, if not, identify any challenges and opportunities that arose. The intention was that the learning from these evaluations could be used to inform the planning and commissioning of IHWSs elsewhere.

METHODS

Design and setting

A nested qualitative design was employed, in the context of broader mixed methods evaluations. Both IHWSs sought to improve health and wellbeing and reduce inequalities through enhanced service integration, promotion of healthy behaviours, and action to address the social determinants of health. Live Well Gateshead (LWG) provided one-to-one, group-based and capacity-building support for individuals, families and communities, targeting the 35% most deprived areas in Gateshead as well as communities of interest. Wellbeing for Life (WFL) provided a similar mix of activities, targeting the 30% most deprived areas in County Durham in addition to selected non-geographical communities. See figures 1 and 2 for an overview. Both services were delivered by consortia of NHS and local authority partners, plus third sector providers in WFL.

In-depth qualitative studies were embedded within iterative service evaluations informed by the principles of co-production.[37, 38] This involves active collaboration between academic, policy and practice partners. In both sites research users, including commissioners, helped to design the evaluation and prioritise the research questions. Interim findings were fed back throughout and their implications discussed with relevant stakeholders.

Procedure

Semi-structured interviews were conducted by trained, experienced academic researchers (MC and SV) with 16 key informants from LWG and WFL between July 2015 and May 2016. See table 1 for details. A combination of convenience and purposive sampling was used to identify those involved in commissioning or implementing these services. Potential interviewees were approached by email, accompanied by an information sheet explaining the purpose of the evaluation and what participation would involve. All of those who were approached agreed to take part. Interview schedules were used to guide early discussions and were adapted to include emerging themes as fieldwork progressed. Topics discussed included influences on development of the service model, views on the commissioning process, experiences of implementation and service delivery, and areas for improvement. Recruitment continued until all relevant stakeholder groups were represented in the sample and no new themes emerged.

Most interviews were conducted at the participants' workplace; one took place at a café and another was conducted by phone. They lasted between 30 and 120 minutes. Formal interviews were

supplemented by a combination of: attendance at steering group, management and operational meetings; observations of training, service delivery and community events; and informal conversations with other stakeholders. These conversations and observations were conducted by the researchers (MC and SV) and recorded in unstructured fieldnotes. In line with the co-production approach, this way of working helped to ensure that partners were informed and engaged with the research, as well as providing further information to interpret and contextualise the findings.

Analysis

The interviews were audio-recorded, with participants' informed consent, and transcribed verbatim, before being coded manually. Transcripts and fieldnotes were analysed (by MC and SV) using thematic analysis, informed by a realistic evaluation perspective in terms of looking for evidence of what works, for whom, and under what circumstances.[39] The researchers separately identified and subsequently agreed emerging themes. Preliminary findings were discussed with Research Advisory Group members and shared separately with the local authority commissioners (BK and GG) for interpretation and validation, to check that themes accurately represented their perspectives, before being reported. The analysis did not seek to confirm or deny preconceived ideas or test specific hypotheses.

RESULTS

Four key themes were identified from the data: the influence of organisational contexts; translating theory and evidence into practice; experiences of collaborative service delivery; and evidencing outcomes and impact. These issues affected the implementation of the IHWSs in different ways and are discussed in turn below, illustrated using anonymised data extracts.

The influence of organisational contexts

The relocation of public health from the NHS to local government provided important context for the introduction of IHWSs. Participants in both sites felt there were new opportunities to work across local authority directorates to address the wider determinants of health and health inequalities. However, these changes occurred at a time of reductions to public health budgets, coupled with the effects of austerity, which complicated the process of introducing new services:

> *We also know that the Council is under huge budget pressure… I think the original ideas behind the model had to change because of those resource pressures, and I don't think that builds in sustainability to the model… Or at the community level where you need it.* (LWG 3)

Contentious questions about where and how to focus limited resources generated significant anxieties for commissioners, providers and frontline staff. In this context, commissioning decisions became highly politicised, affecting the process of establishing the fledgling IHWSs. Major organisational change and restructure created further uncertainty and delays:

The [NHS] Foundation Trust have been through a major reorganisation and we've been through a major reorganisation. So this has been quite challenging in terms of – because we couldn't really recruit to this structure until we had people to manage the staff coming into it. […] I guess that's given us some issues because we haven't maybe hit the ground running in the way that we would have done. (WFL 2)

These issues were exacerbated by bringing together partners from different sectors with different approaches. Within WFL, the third sector providers were seen as being more flexible, creative and open to risk-taking, whereas the larger statutory organisations were described as slow, bureaucratic and characterised by linear ways of working – "*like two huge tankers that are very slow to turn around*" (WFL 4). The NHS Foundation Trust being the lead provider (in both sites) was recognised as both a challenge and strength:

I think the Trust brings lots of benefits because… At the moment it feels like it's all of the negative things that seem to be there – "Oh gosh, how long do you take with recruitment?" – but actually there's some good stuff around some of the governance structures we have in place and other things. But at the moment it feels like it's frustrating bureaucracy. (WFL 5)

LWG delivery partners were situated in the statutory sector but in different geographical locations, creating a sense of distance due to lack of day-to-day contact between teams. The shorter implementation phase (2-3 months, as opposed to 6 months for WFL) was seen as counter-productive, in terms of relationship-building and effective planning:

Some of it felt rushed. And I think that's had a knock-on effect. We're now having to rectify things later down the line. Whereas if we had more lead-in time, I think some of those issues might not have cropped up. (LWG 7)

Translating theory and evidence into practice

Both services built on existing practice within each locality, including health trainer services, Stop Smoking Services and NHS Health Checks. Efforts were made to bring together and apply evidence and expertise from a range of local stakeholders and external 'experts' as part of a co-production approach:

We had a whole series of events really where we were trying to gather the evidence from local good practice and work out how we could transform public health practice moving forward to the local authority. […] It was consolidating the evidence base, consolidating the theory. Looking at how we could deliver transformational public health. (WFL 7)

Participants were actively exploring new ways of commissioning evidence-informed public health services that required more holistic, targeted and integrated ways of working to reduce health inequalities. They drew reference to a few key sources of evidence to support this new approach, including the King's Fund report on clustering of unhealthy behaviours and the evidence review from Liverpool Public Health Observatory. However, some concerns were expressed by LWG stakeholders about the strength of the available evidence and its apparent impact on delivery:

My concern is that this one paper (from Liverpool PHO) *seems to have changed the way that services are going to be delivered forever… That paper came along at the right time, when there were lots of budgets being cut, and it seemed like a silver bullet that would fix everything* (LWG 1).

Both local authorities had a long-term strategic commitment to community development and asset-based approaches, which was seen as beneficial by public health commissioners. The IHWSs were perceived as drawing on "*strength and maturity in the system already*" (LWG 6) and "*building on something there was collective understanding about*" (LWG 9). Alongside an endorsement of the social model of health underpinning LWG and WFL, there was also broad acceptance of the principles of prevention and early intervention, which were recognised as being more cost-effective than treatment in the long-term:

Trying to nip in the bud some of the behaviours and problems that actually lead to the issues and problems later on. (LWG 8)

These quotations highlight the difficulties of translating evidence into commissioning decisions and designing feasible service configurations to ensure acceptable local delivery of IHWBS.

Experiences of collaborative service delivery

Participants recognised and articulated the potential added value of collaborative working between NHS and local authority partners, plus the third sector in WFL. Anticipated benefits included reducing duplication, extending the reach of existing services and programmes, sharing expertise and capacity, and maximising opportunities for innovation:

It provides an external kind of challenge, expertise, innovation, novelty – all of those sort of things, that you wouldn't get if it was just the local authority. (LWG 5).

The idea of offering "*a more streamlined accessible approach, which seeks to knit together a number of different functions"* (LWG 5) was broadly welcomed. However, it took time to acquire shared understandings of the principles underpinning the service models, develop systems and processes to drive implementation, recruit and train staff, and communicate service brands. Pressures to get both services 'off the ground' quickly, coupled with different organisational cultures, a history of competing for contracts, and mistrust arising from short-term contracts and reducing budgets, may have destabilised early efforts to build relationships among staff and with communities. There were also issues with communication and management across provider organisations:

> *The coordinators will have a hub meeting and say, "Right, this was agreed". And [staff employed by other organisations] will say, "Well, we don't know anything about that". So it's all of that to-ing and fro-ing. Or people perceive a message being slightly different or will have different perceptions and, "Well, that wasn't my understanding of what was agreed".* (WFL 5)

Devoting attention to the process of change management, and preparing staff for the transition to the delivery of integrated approaches, appeared crucial to successful implementation. Participants described the need to adapt to a changing world in which public services are delivered differently. This generated discussion about the role of commissioning in local government, and the importance of dialogue between commissioners and providers:

> *It can't be just contract management… There does need to be co-production… between commissioners and definitely between providers.* (LWG 5)

There was acknowledgment of the challenges involved in managing contractual relationships when trying to work collaboratively to co-design workable IHWSs.

> *It's just trying to find the balance of when it's co-producing and when it's then contract management, as in, "You're not hitting the numbers – what are you going to do about it?" And it's sort of when it flips from one to the other.* (WFL 3)

Evidencing outcomes and impact

The difficulties of defining and measuring 'success' in IHWSs raised questions about the purpose of performance monitoring systems. There was unanimous agreement amongst LWG stakeholders that the performance management framework (a 'scorecard' consisting of more than 180 key performance indicators (KPIs)) was overly complicated, divisive and time-consuming:

One of my big concerns is the massively onerous key performance indicator worksheets that we have to complete. I'm not sure they are holding the cohesion between the three services. (LWG 1)

The WFL scorecard was less onerous and yet tensions and delays were still reported. These had largely arisen from the need to develop shared systems between five provider organisations and the fact that only the NHS Trust had prior experience of using a scorecard approach:

It just seemed to take forever to get the [online system] and the paperwork configured. But I suppose everybody had different needs within that. […] In hindsight, probably could have done that in a slightly more streamlined way. It just seemed very cumbersome. And that might have just been because everyone else was learning about it. (WFL 5)

Although these frameworks facilitated more systematised data collection and reporting (and were used extensively in both service evaluations[35, 36]), there was recognition that gaps remained in the availability and interpretation of data to inform practice. In particular, there was a call to use aggregate data to identify whether the target populations facing greatest inequalities were being reached and having their needs met by these services. Clunky, over-engineered performance management systems did not help participants to make informed management decisions quickly to answer important questions regarding outcomes. This suggests a need to co-produce appropriate systems that make better use of 'soft intelligence':

From the customer's point of view, it's about what they really like as part of the service. A few more of the softer sides, rather than all of the processes being measured… We need to strip it back to basics in terms of the model – what are the most important things we need to do, to achieve? (LWG 6)

The difficulty of providing timely evidence of outcomes from community development activities was acknowledged. Many of the KPIs related to lifestyle changes (e.g. increased physical activity, stopping smoking, weight loss), which were seen as easier to measure than improvements in social cohesion or mental wellbeing. Commissioners were under pressure to show impact to justify the investment being made in IHWSs. As a result, tensions had arisen between meeting targets in the short-term and trying to ensure the models were sustainable by taking a longer-term view. However, there was a sense of optimism that the services would have a positive impact:

It won't in two years get the population of County Durham fit and healthy, but it will leave a legacy of a very strong infrastructure around wellbeing. And it will have switched on communities to the benefits and opportunities around health and wellbeing. (WFL 4)

DISCUSSION

The findings of this study indicate a challenging context in which to implement innovative service redesign, as a result of large-scale budget cuts and changes in NHS and local authority capacity. There were pressures on commissioners to deliver services differently, with limited experience, patchy evidence and developing infra-structure (including new IT systems). Although the principles of an IHWS approach were broadly welcomed, there were challenges in putting these into practice using a multi-provider model. This was despite a commitment to developing evidence-based services and a desire to build on existing strengths and experience amongst local providers. The findings raise important questions about contract management and relationships between commissioners and providers involved in implementing new ways of working.

While efforts are underway to develop appropriate wellbeing measures[40, 41], commissioners are struggling to identify timely evidence of impact at a local level. Genuine progress risks being undermined by ongoing austerity measures and reducing public health budgets, resulting in pressures to disinvest before the long-term benefits to population health and wellbeing are realised. This study suggests that the co-production of meaningful KPIs, alongside some flexibility on the part of commissioners, may help overcome the dangers of overly-engineered performance monitoring systems.[42] The findings have wider implications for commissioners, who may be under pressure to disinvest prematurely in upstream public health interventions that take a holistic approach and tackle the wider determinants of health and which have been shown to address health inequalities.[24]

Our findings highlight that delivering transformational change in public health through IHWSs was not straightforward, despite clear alignment with the strategic priorities of prevention and early intervention identified by participants. Pressures to deliver services quickly and demonstrate outcomes affected the ability to dedicate time to establishing values and principles, and negotiate the practicalities of collaborative working. Threats to funding and jobs heightened insecurities, increased tensions and affected efforts to work and learn together across disciplinary and organisational boundaries. There was some fragmentation in delivery, which appeared to have reinforced an initial lack of cohesion, trust and co-ordination. However, there remained a sense of optimism that these services could have a positive impact, which is increasingly supported by research evidence. For example, a recent study of a community-based healthy lifestyle programme in the West Midlands found significant improvements in mental wellbeing that were sustained at three-month follow-up.[43] A systematic review and meta-analysis of the effectiveness of interventions targeting multiple health risk behaviours identified 69 relevant studies and found modest improvements in most behaviours.[27] Lessons from a similar service in North West England highlight the benefits of a focus on the social determinants, but also stress the importance of communication between teams, robust recording of relevant measures and the need for flexibility in delivery.[44] This suggests that IHWSs have the potential to contribute to the 'radical upgrade in prevention and public health' identified in the NHS Five Year Forward View[45], but that these

approaches require positive cross-sector working relationships and take time to show evidence of positive outcomes.

Implications for policy and practice

This study suggests a number of implications for the future planning, commissioning and delivery of IHWSs (see box 1). The organisational challenges of implementing these services highlight a need to focus on the processes of complex change management, promote collaboration and ensure robust systems of staff support are in place. The findings also suggest a need for better systems and structures to understand what difference these services are making and for whom. Given that appropriate performance monitoring frameworks for IHWS approaches are in the early stages of development, investment in the co-production of shared KPIs is recommended. Bringing together key stakeholders to develop their local service model, clarify expectations, build relationships and resolve issues at the planning stage is likely to be time well spent.

Limitations of the study

This is a relatively small-scale, qualitative study and the views of those who participated in the research may not represent the views of all stakeholders. Efforts were made to ensure a wide range of views and experiences were captured, but practical constraints placed limitations on the numbers of participants involved. However, active collaboration between academic, policy and practice partners and participants' endorsement and support adds weight to the validity of the findings; for example, by co-producing the suggested practice implications set out in box 1. The research process and findings reported were inevitably affected by the challenges of evaluating services in a rapidly evolving local context, which is highly politicised and characterised by high levels of organisational change and growing resource restrictions. Caution should be exercised in interpreting the data in light of these limitations.

CONCLUSION

In this paper we have outlined the structural and contextual issues affecting implementation of two integrated health and wellbeing services in North East England, where inequalities in health are widespread and cuts to public sector finances have been keenly felt. The findings replicate many of the issues faced when services are delivered across multiple organisations through partnership arrangements: time needed to build relationships and trust, differing systems, terminology, and expectations that divert early attention away from the immediate tasks at hand and the challenges raised by existing or historical tensions (including competition and job insecurity). In these particular cases to establish IHWSs, sustained efforts are required to ensure fully integrated services operate as coherent, coordinated systems, able to deliver effective, responsive, innovative, client-focused outcomes in partnership. Quality improvement and service re-configuration processes take time to bed-in, and require robust leadership, management, trust and strong collaborative relationships. The behavioural, cultural and systemic changes needed are especially challenging at a time of austerity, with cuts to public health budgets, future uncertainties and widening inequalities. This turbulent background may mean that the IHWS are not given sufficient time to work through the partnership issues, develop, embed and show health gains before financial pressures, and multiple competing demands, force de-commissioning. Whilst there has been recognition of the benefits of integrated

approaches to improve health and wellbeing and tackle inequalities, there are few published examples of integrated approaches in the UK which seek to address multiple health issues simultaneously. Empirical research is limited on the factors associated with the effective delivery of these new models of delivery. The findings in this paper, which relate to early experiences of commissioning, developing and implementing LWG and WFL, provide useful learning in terms of ongoing service delivery and commissioning of similar integrated services, contributing to understanding of the benefits and challenges of this complex, multi-provider model of working.

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TABLES, FIGURES AND BOXES

Table 1: Participant characteristics

Characteristics		Live Well Gateshead	Wellbeing for Life
Gender	Female	6	5
	Male	3	2
Role	Commissioner	2	1
	Provider	5	6
	Elected member	2	0
Employer	Local authority	7	2
	NHS Foundation Trust	2	2
	Third sector organisation	0	3
Total		9	7

Figure 1: Live Well Gateshead

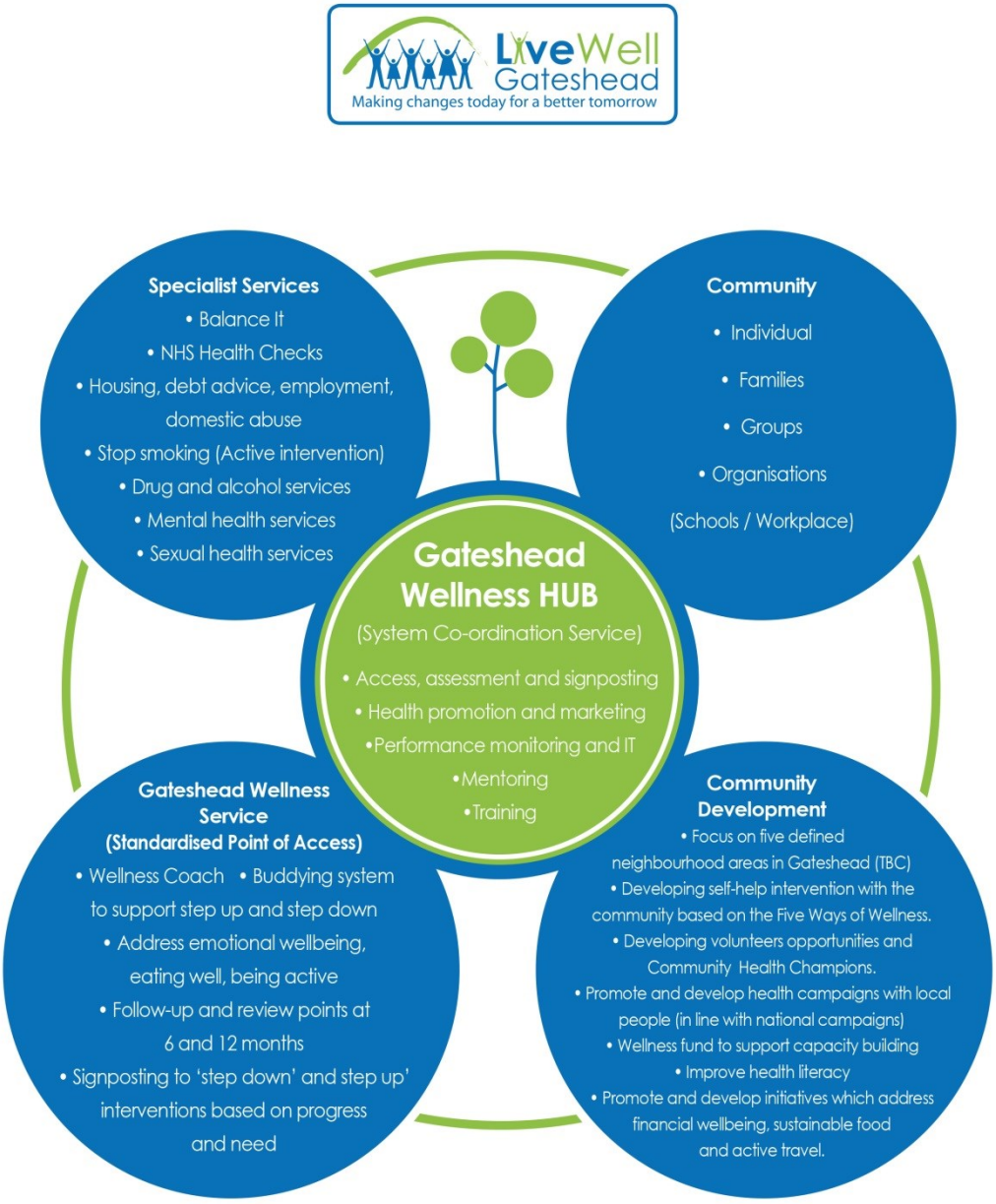

Figure 2: Overview of the WFL service model

Box 1: Implications for future policy and practice

The study findings suggest a need for:
• A clear strategic vision and leadership to ensure the success of the integrated model
• Recognition of the challenges of implementing transformational public health services and promoting collaboration in hostile economic conditions
• Clarity about the aims and intended outcomes of commissioning an integrated lifestyle service in the context of a need to tackle health inequalities
• Drawing on learning from existing research and practice with targeted groups
• Investing time and resources in supporting change management processes with new and existing staff, to build coherence, ensure buy-in, shared values, feasibility and complementarity between all elements, and enhance 'fit' with existing services
• A workforce that is sufficiently trained to implement an integrated service effectively and ensure the transition to new staffing roles and structures is managed appropriately
• Sufficient time built into the mobilisation and set-up time of the new service, especially across provider organisations, to ensure teams are working towards a shared vision
• Appreciation of the complexities of multiple providers delivering an integrated service, and commissioning and provider responsibilities being managed in the same organisation
• Use of meaningful, co-produced and robust performance management systems linked to a shared understanding of what the service is aiming to achieve and what success looks like
• Shared performance indicators across providers to ensure fully integrated working, and quality assurance measures to ensure the outcomes of the model can easily be reviewed as a whole
• Identification of effective tools to capture change over time and measure outcomes valued by communities themselves (e.g. gaining a sense of belonging, expanding social networks, building self-belief, etc)

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