Figure 3: Characteristics of included studies

Title	First Author	Year	Setting	Aim	Results
Joint approaches for a better old age: developing services through joint commissioning	Poxton, R.	1996	Primary care Secondary care Local authorities	Discuss strengths, weaknesses, barriers to joint commissioning of services from health and local authorities.	Difficult to define success / outcomes; significant change often takes longer than time of observation / assessment; high turnover of staff in social services.
Randomised controlled trial of follow up care in general practice of patients with myocardial infarction and angina: final results of the Southampton heart integrated care project (SHIP)	Jolly, K.	1999	Primary care Secondary care	Assess the effectiveness of a programme to coordinate and support follow up care in general practice after a hospital diagnosis of myocardial infarction or angina.	Simply coordinating and supporting existing NHS care seems insufficient.
Exploratory cluster randomised controlled trial of shared care development for long-term mental illness	Byng, R.	2004	Primary care	Determine the effects of Mental Health Link, a facilitation-based quality improvement programme designed to improve communication between the teams and systems of care within general practice.	Facilitated intervention tailored to context has the potential to improve care and interface working.
Contextualising the coordination of care in NHS trusts: An organisational perspective	Maxwell, S.	2007	Primary care	Understand why change oriented towards improving the coordination of care for long term users of healthcare (and related) services is so difficult to achieve. To identify possibilities for how these difficulties may be overcome.	Many factors in the local and wider context of the NHS operate to fragment thinking about how care should be organised. Local contextual factors such as the character of the local electorate and the style and expected longevity of the senior leadership can undermine success in achieving agreed goals for coordinating and managing care.
Integrating assessments of older people: examining evidence and impact from a randomised controlled trial	Clarkson, P.	2011	Care homes	Enable potentially treatable health conditions to be identified, which might obviate the need for care home admission given the proper intervention.	Integrating health and social care assessments offers benefits, principally a reduction in physical deterioration for the very frail (those at risk of entering care homes).
Integration and the NHS reforms	Wistow, G.	2011	Local government Primary care Secondary care	Analysing the implications of the Health and Social Care Bill and subsequent Act (2012) from a local government perspective.	Integration will be determined by whether the NHS is enabled to become a fuller part of the local family of public services and how far it remains a single-purpose, non-elected and nationally controlled service. The future of the NHS may depend as much on the future of integration between it, local government and other community services as future outcomes

					from integration depend on the future of the NHS.
Redesigning the general practice consultation to improve care for patients with multimorbidity	Kadam, U.	2012	Primary care	Discuss changes to the standard primary care consultation for patients with multiple conditions.	Guided care model - Nurse led coordination of interaction between the patient, primary care doctors, and healthcare teams. A trial of this approach found limited effectiveness in reducing healthcare use.
Managing patients with mental and physical multimorbidity	Mercer, F.W.	2012	Primary care	Consider changes that are needed in managing the physical and mental health need of people with multimorbidity.	Application of the principles of chronic disease management to depression provides a potentially useful model for delivery of integrated care.
Does Comprehensive Geriatric Assessment (CGA) have a role in UK care homes?	Gordon, A.	2012	Care homes	Assess whether comprehensive geriatric assessment has a role in UK care homes.	Discontinuity of care between care home and GP; lack of anticipation; communication failure between GP and care home; inadequate training in care of older patients; arbitrary boundaries between care homes and NHS which interfere with care.
National Evaluation of the Department of Health's Integrated Care Pilots	RAND Europe, Ernst & Young LLP	2012	Primary care	Evaluation of the Integrated Care Pilot programmes .	ICPs developed and implemented a loose collection of 'integrating activities' based on local circumstances. Despite the variations across the pilots, a number of aims were shared: bringing care closer to the service user; providing service users with a greater sense of continuity of care; identifying and supporting those with greatest needs; providing more preventive care; and reducing the amount of care provided unnecessarily in hospital settings. Most pilots concentrated on horizontal integration – e.g., integration between community-based services such as general practices, community nursing services and social services – rather than vertical integration – e.g., between primary care and secondary care

Still a fine mess? Local government and the NHS 1962 to 2012	Wistow, G.	2012	Primary care Secondary care Social services	Take 'a long view' of initiatives promoting integration between local government and the NHS with the objective of seeking to understand why they have achieved consistently disappointing results.	Barriers lie in the foundational principles of basing (a) responsibilities on the skills of providers rather than the needs of service users and (b) organisational forms on separation rather than interdependence with national uniformity driving the NHS and local diversity local authorities. In addition, frameworks for integration have been established on a paradigm of seeking to build bridges at the margins of organisations rather than seeking to interweave their mainstream systems and processes.
Assistive technologies in caring for the oldest old: a review of current practice and future directions	Robinson, L.	2013	Secondary care	How can assistive technology support the future care of the oldest old?	Assistive technology has potential to help older people to 'age in place', but the ways in which assistive technologies are advertised and marketed to this group needs to be urgently addressed and given the same attention as marketing policies to younger generations
Delivering better services for people with long-term conditions: Building the house of care	Coulter, A.	2013	Primary care Social care	Improve personalised services for individuals with long-term conditions.	Leadership from professional bodies is needed to drive a culture change of personalised care planning integrated across services, e.g. from RCGP.
Co-ordinated care for people with complex chronic conditions: Key lessons and markers for success	Goodwin, N.	2013	Primary care Secondary care	Identify strengths and weaknesses in 5 vanguard care co-ordination programmes.	Programmes of care co-ordination take years to grow from development projects into mature models of care. The process of programme development does not reach an 'end point'; and new approaches that lie at the margins of what might be regarded as 'core business' appear to remain somewhat 'at risk', since their future is not guaranteed. Consequently, success in care co-ordination is a long-term process, facilitated by key local leaders, during which the capability and legitimacy of new ways of working is built up over time (at least six to seven years in the context of this study).

New conversations between old players? The relationship between general practice and social care in an era of clinical commissioning	Glasby, J.	2013	Primary care Adult social care	Examine evidence about joint work between general practice and adult social care in relation to older people.	More opportunities needed for GPs and social workers to understand their respective roles and professional perspectives. This needs to be supported by a willingness to seek joint solutions to situations in which eligibility rules and organisational procedures issues prevent integrated care being delivered. A more rigorous approach to the setting and monitoring of outcomes will enable good ideas to be tested out in practice and strategic partnerships to gather and apply learning from new initiatives. Sufficient time must be being given to enable new structures to settle in and for trusting relationships to be developed between key strategic leads.
Networks that work: Partnerships for integrated care and services.	Langford, K.	2013	Primary care Social care Secondary care Voluntary sector	Show how third sector organisations can develop and provide services to encourage self-management.	Improving the capacity of NHS patients to self-manage needs the development of clear services to provide extra capacity. Many people can be helped to do this on their own, but networks will provide fellowship and assistance to people who feel they may not be able to get on top of their disease on their own.
Evidence review - integrated health and social care	Institute of Public Care, Oxford Brookes University	2013	Residential/care home sector Secondary care Re-ablement services Primary care	Understand the characteristics of effective workforce practice in integrated health and social care services. Focus is on avoiding hospital admissions, improving reablement services, and speeding up and improving hospital discharge services and transfers between residential and nursing homes.	Much of the work identified was not primarily concerned with workforce issues and connections between workforce approaches and the impact and outcomes for service users were not always addressed. The creation of new roles working across professional boundaries supports integrated delivery.
Rethinking the integration agenda	Stirling, S.	2013	Focused on integrated care	Understand what the obstacles to integration are and offers practical ideas on next steps.	Reasons why care services have not developed further and faster include :Organisational Obstacles, Systemic Obstacles, Public Engagement and Politics and Policy
A Question of Behaviours: Why delivering care integration and managing acute demand depends as much on changing behaviour as new systems and structures	Khaldi, A.	2013	Primary care Secondary care Community services	This report addresses two connected challenges:• The increasing dependency on acute settings and urgent care, particularly for the elderly• The positive agenda to integrate care in home and community settings	Structural ‘big system’ change alone will not work. Behavioural norms for professionals and the public are stronger than any new system can create. Trust, relationships, behaviour and experience are the real drivers of positive outcomes.

Health and Care Integration Making the case from a public health perspective	Public Health England	2013	Public health	To help local areas, in particular health and wellbeing boards, make the case for integration focused on individuals' health and wellbeing as well as their quality of life if they become sick.	The launch of the 14 integration pioneer sites on 1 November 2013, combined with the introduction of the Better Care Fund, creates a real prospect for local areas to work together and do things differently. The pioneers will implement innovative approaches and share their experiences throughout, so we can learn in real-time, not only about what works, but also the processes required and the difficulties that need to be addressed to enable rapid adoption across the country.
Making our health and care systems fit for an ageing population	Patterson, L.	2014	Varied contexts	To provide a high-level resource and reference guide for local service leaders who want to improve care for older people.	Transforming services for older people requires a fundamental shift towards care that is co-ordinated around the full range of an individual's needs (rather than care based around single diseases), and care that truly prioritises prevention and support for maintaining independent living for as long as possible.
Delivering Integrated Care and Support	Petch, A.	2014	Primary care Secondary care Community care	Review of research evidence on the factors that underpin best health and social care integrated practice.	Focus on the key dimensions for effective implementation of change.
Integrated health and social care in England: the story so far	Royal College of Nursing	2014	Varied contexts	Overview of the current call for integrated health and social care services in England, the rationale behind the push for integration, the facilitators and barriers to this way of working, and the related workforce and funding issues.	Integrated care might be seen politically as a quick fix panacea for the many problems that face a health and social care system created for very different times and circumstances. Achieving real and long-lasting change will take time, as well as prolonged effort to establish and maintain successful integrated working practices.
Enablers and barriers in implementing integrated care	Maruthappu, M.	2015	No specific context	Address the fragmentation in patient services observed in many health care systems. Increasing rates of chronic disease and multimorbidity have drawn attention to the often significant reforms necessary to address these problems. This article discusses how integration may be achieved.	Implementing integrated care holds the potential for improving health care outcomes, access, and significant financial savings.

Common patterns of morbidity and multi-morbidity and their impact on health-related quality of life: evidence from a national	Mujica-Mota, R.E.	2015	Primary care	Investigate differences in HRQoL (EQ-5D scores) associated with combinations of long-term conditions (multimorbidity) after adjusting for age, gender, ethnicity, socio-economic deprivation and the presence of a recent illness or injury.	Patients with multi-morbid diabetes, arthritis, neurological, or long-term mental health problems have significantly lower quality of life than other people.
Managing depression in people with multimorbidity: A qualitative evaluation of an integrated collaborative care model	Knowles, S.E.	2015	Primary care	To report the results of a nested qualitative study within the COINCIDE trial which aimed to examine: a) How the collaborative care model was implemented by usual care providers in a UK setting. b) How patients and providers understood and experienced the integration of mental and physical health care.	For complex patients with physical-mental multimorbidity, collaborative care is best understood as a way of organising services to meet distinct physical and mental health needs. The development of pragmatic and flexible models of collaborative care that meet the needs of patients with physical-mental multimorbidity is therefore needed to meet the policy objectives of "No Health Without Mental Health" in practice. Attempts to explicitly integrate physical and mental health treatment were resisted by patients when it encroached on their freedom to talk about other factors, outside of their physical health, that might be linked to their mental health.
Integrated services for older people – the key to unlock our health and care services and improve the quality of care?	Oliver, D.	2015	Varied contexts	How integration might help support people in need of health and social care and improve their experience and outcomes?	Many different approaches to integrating services and many definitions, it is not appropriate to dictate ''one size fits all'' solutions. They must be tailored to local circumstances.
The NHS five year forward view: lessons from the United States in developing new care models	Shortell, S.M.	2015	Varied contexts	Outline two of the models proposed by NHS England and discuss how experience from the United States may help inform how they are implemented.	The benefits of integrated care occur primarily through clinical integration rather than organisational integration, and this requires those responsible for providing care to be intimately involved in development of new models. The mixed experience of integrated systems and ACOs in the United States points to opportunities and challenges for general practitioners and specialists working to implement the NHS forward view.

Deploying telehealth with sheltered housing tenants living with COPD: a qualitative case study	Bailey, C.	2015	Housing	Report on a telehealth pilot in local authority sheltered housing in north east England. This explored the training and capacity building needed to develop a workforce/older person, telehealth partnership and service that is integrated within existing health, social care and housing services.	Service users and workforces need to work together to provide flexible telehealth monitoring, that in the longer term, may improve service user, quality of life.
Person centred coordinated care: where does the QOF point us?	McShane, M.	2015	Primary care	Examine the validity of the Quality and Outcomes Framework and suggest how it should change in the future.	To contribute to the goal of person-centred coordinated care, any financial incentives should be designed to align across primary, secondary, and tertiary care, as well as with the wider health and social care sectors.
Multi-Morbidity in Hospitalised Older Patients: Who Are the Complex Elderly?	Ruiz, M.	2015	Varied contexts	Empirically identify the complex elderly patient based on degree of multi-morbidity.	Identification of multi-morbidity patterns can help to predict the needs of the older patient and improve resource provision.
Multimorbidity - older adults need health care that can count past one	Banerjee, S.	2015	Varied contexts	Study the healthcare needs of older people with multimorbidity, and the extent to which these needs are met.	Develop a system that works for multimorbidity, and create policy, commissioning, services, research, and education to deliver good quality care to patients with more than one condition. A good test of success will be how well these services work for those with dementia.
Putting integrated care into practice: the North West London experience	Wistow, G.	2015	Primary care Secondary care	Summarise progress to date and offer feedback on pilot integrated care systems.	National barriers included difficulty obtaining data sharing agreements, information governance arrangements; separate payment structures; separate governance structures; balance between collective leadership and local autonomy difficult to strike; change in leadership of programme during development weakened strategic management capacity; led by NHS commissioners, as opposed to social care, and tends to reflect NHS interests
Early evaluation of the Integrated Care and Support Pioneers Programme: Final Report	Erens, B.	2015	Primary care Secondary care Local services	Evaluation of the Integrated Care and Support Pioneer programme.	Limited evidence found to support integration

An evidence synthesis of the international knowledge base for new care models to inform and mobilise knowledge for multispecialty community providers (MCPs)	Turner, A.	2016	Multispecialty community providers	Provide decision makers in health and social care with a practical evidence base relating to the multispecialty community provider (MCP) model of care.	MCP seeks to overcome the limitations of current models of care, often based around single condition-focused pathways, in contrast to patient-focused delivery which offers greater continuity of care in recognition of complex needs and multimorbidity.
Behavioural health consultants in integrated primary care teams: A model for future care	Dale, H.	2016	Primary care	To present the view that integrated care models that incorporate behavioural health care are part of the healthcare solution	Fully integrated model of behavioural/psychological expertise within a reimagined primary care team shows great promise for addressing the on-going pressures faced in UK general practice and psychological services.
The Organisation of Care for People With Multimorbidity in General Practice: An Exploratory Case Study of Service Delivery	Lewis, R.A.	2016	Primary care	Explore the provision of services for people with multimorbidity in general practice. It considers three broad research questions: how services are organised; why they are configured in this way; and the impact this organisation has on service delivery.	To improve outcomes for people with multimorbidity, improving clinical care alone is not as effective as simultaneously improving the organisation or design of services across the whole system of provision.
New care models: emerging innovations in governance and organisational form	Collins, B.	2016	Primary care	Look at the different approaches being taken by MCP and PACS vanguards to contracting, governance and other organisational infrastructure. It focuses on developments at five sites: Dudley; Sandwell and West Birmingham (Modality Partnership); Salford; Northumberland; and South Somerset (Symphony Project).	Successful care models are based on trusting relationships and collaborative organisational cultures, often developed over time, which enable clinical teams as well as organisational leaders to work together effectively. The challenge now is how to build clinical collaboration and system leadership in a statutory context that was not designed for this purpose.
Harnessing social action to support older people	Georghiou, T.	2016	Primary care Social care	Evaluate seven social action projects funded by Cabinet Office, NHS England, Monitor, and Adult Social Services.	Volunteer services helped unmet needs, in particular around feelings of isolation; increased productivity and satisfaction of health and social care staff; families and carers benefited; the experience was rewarding for volunteers; community scheme associated with significantly higher levels of hospital use than matched controls; discharge scheme did not reduce time to discharge; A&E scheme did reduce admissions from A&E to hospital.

Real lives. Listening to the voices of people who use social care	Hall, P.	2016	Social care	A report based on interviews, capturing the experiences of people aged 65 and over with recent experience of the social care system to understand and exemplify the human cost of changes happening within the system.	For the social care system to continue to support people who need it now and in the future, a renewed national debate about how we pay for and provide care is needed. This is alongside an acknowledgement of the implications for individuals, families and wider society. Without change it seems inevitable that unpaid carers will be expected to do more. More individuals will be required to pay for their care, which will come as a surprise, and more people will go without the care and support they need.
Untapped Potential: Bringing the voluntary sector's strengths to health and care transformation	Bull, D.	2016	Primary care Secondary / tertiary Emergency (A&E, walk-in clinics and out-of-hours) services Voluntary and community sector Housing services	To show that the Voluntary and Community Sector (VCS) is not just doing the right thing by its beneficiaries, but also what works to deliver the improvements in health & wellbeing and in productivity and efficiency that the health and care system now so desperately needs to replicate at pace and scale	Our current model of health and care is unsustainable and this presents an unprecedented opportunity to redesign systems to focus on holistic, integrated, preventative and person-centred care. Charities can add value to the health and care system in a range of ways. By fully understanding each other's needs and priorities, and by making small compromises, partnership between charities and statutory organisations can build a health and social care system which is sustainable and fit for purpose.
Integrated primary and acute care systems (PACS): Describing the care model and the business model	NHS England	2016	Primary care Secondary care Community services	This framework document uses the learning from the nine PACS (Primary and Acute System) vanguards to support local health and care systems planning to implement a PACS model.	The evidence so far suggests five crucial elements for success of the PACS model: •A real commitment to partnership working between local providers so that GPs in particular genuinely feel they are full partners in the model; •A data-driven care model that organises care around population segments; •Integrated neighbourhood health and care teams, working at a population size of 30,000 to 50,000; •Flexible use of workforce and technology, that can disrupt existing ways of working and span organisational boundaries; •A contracting, funding and organisational model that is designed to deliver the population-based care model.

Developing a user reported measure of care co-ordination	Crump, H.	2017	Varied contexts	The study aim was to design and test a survey tool to capture the experiences of older people with chronic conditions regarding how well their health and (where applicable) social care was co-ordinated.	The growing focus on care co-ordination demonstrates the need for a tool that can capture the experiences of patients accessing care across organisational and professional boundaries, to inform the improvement of care co-ordination activities from a patient perspective. Early results suggest that our tool may have a contribution to make in these areas.
Multimorbidity and Integrated Care	Stokes, J.	2017	Varied contexts	What does 'integrated care' currently look like in practice in the NHS? What is the effectiveness of current models of 'integrated care'? To what extent are there differential effects of 'integrated care' for different types of multimorbidity?	Integrated care, in its current manifestation, is not a silver bullet that will enable health systems to simultaneously accomplish better health outcomes for those with long-term conditions and multimorbidity while increasing their satisfaction with services and reducing costs.
Creating and facilitating change for Person-Centred Coordinated Care (P3C): The development of the Organisational Change Tool (P3C - OCT)	Horrell, J.	2017	Varied contexts	Examination of current policy, key literature and NHS guidelines, together with stakeholder involvement to identify domains, subdomains and component activities (processes and behaviours) required to deliver patient-centred co-ordinated care.	Ongoing interrogation of the interaction between domains / subdomains (question items) and components (response codes) from implementation data will allow the development of a more comprehensive theory of what works for whom and in what situations to best accomplish patient-centre co-ordinated care. This tool is based in on the principles of promoting person-centred relationships with service users and between practitioners, and highlights how organisations can support its achievement.
Shaping innovations in long-term care for stroke survivors with multimorbidity through stakeholder engagement	Sadler, E.	2017	Varied contexts	Develop a process of engaging stakeholders in the use of clinical and research data to co-produce potential solutions to improve long-term care for stroke survivors with multimorbidity.	Stakeholder engagement to identify data-driven solutions is feasible but requires resources.
Better value primary care is needed now more than ever	Watson, J.	2017	Primary care	We explore how the value-based healthcare framework can help decisions about how to allocate resources, and the importance of good evidence not only for patient treatment but for the organisation of health services.	Effective primary care is essential to deliver high value care, but change needs to be driven by evidence based policy and investment.

Enhancing Health and Wellbeing in Dementia: A Person-Centred Integrated Care Approach	Rahman, S.	2017	No specific context	To challenge the idea that nothing can be done to improve dementia care and set out practical thinking around how we can move towards truly integrated, person-centred ways of working.	Key underpinnings of integrated care for wellbeing when living with dementia, including technology, staff performance, leadership, and intelligent regulation of services.
Integrated Working for Enhanced Health Care in English Nursing Homes	Cook, G.	2017	Nursing home	Explore views and experiences of practitioners, social care officers, and carers involved in the enhanced health care in care home programme, in order to develop understanding of the service delivery model and associated workforce needs for the provision of health care to older residents.	The programme provides a whole system approach to the delivery of proactive and responsive care for nursing home residents. The service model enables information exchange across organizational and professional boundaries that support effective decision making and problem solving.
Delivering person-centred holistic care for older people	Beech, R.	2017	Varied contexts	Conduct an evaluated case study of the Wellbeing Coordinator (WBC) service in Cheshire, UK. WBCs are non-clinical members of the GP surgery or hospital team who offer advice and support to help people with long-term conditions and unmet social needs remain independent at home.	The WBC complements medical approaches to supporting people with complex health and social care problems, with support for carers often a key service component. Users reported improvements in their wellbeing, access to social networks, and maintenance of social identity and valued activities. Health and social care professionals recognized the value of the service.
Enhanced health in care homes: Learning from experiences so far	Baylis, A.	2017	Principally Care Homes, includes primary care interface	Help care homes and NHS providers join up and co-ordinate services locally, and manager the complexities involved.	1) Enhanced health in care homes is achievable in England without extra funding; 2) better ways of measuring impact (including on care quality and QOL) are needed; 3) skilled leadership is required; 4) networks and communities of practice are essential to support leaders at all levels; 5) leaders need to focus on reinforcing equal partnerships and involve care homes in decision making; 6) areas with a history of cross-organisational working were better able to implement; 7) system-wide approaches tend to be more strategic with clearer paths for scaling up, compared to "bottom-up" approaches driven by highly motivated individuals; 8) importance of distinguishing doing things *"to"* care homes from doing things *"with"* care homes.

Primary Care Home Evaluating a new model of primary care	Kumpunen, S.	2017	Primary care Secondary care	Understand how "primary care home" integrated models were built; advise on evaluation approaches; share learning across sites.	All models targeted local health needs and weaknesses in local services, particularly high-need, high-cost patients; and developing proactive services to avoid admissions / most PCHs incorporated objectives for evaluation in line with a four pillar model; enablers for development included provider-led leadership (fast, agile decisions) or CCG leadership (access whole-system data, allocate staff and resources, link PCH work to commissioning priorities); workforce training; co-location of new MDTs.
Hope over experience: still trying to bridge the divide in health and social care	Wistow, G.	2017	Healthcare Local government	Discuss the divide in health and social care, specifically local government and how this might be bridged.	Little progress has been made on integration. Local government is critical of the whole approach, seeing it as 'all about NHS bodies and financial control, with local authorities a sort of optional add on… when a whole system solution remains the answer'.
Improving Hospital at Home for frail older people: insights from a quality improvement project to achieve change across regional health and social care sectors	Pearson, M.	2017	Secondary care Social and community care	To change practice in order to deliver a Hospital at Home programme (admission avoidance and early supported discharge) for frail older people across a regional commissioning area.	Against a backdrop of intense financial pressures, significant community bed closures, and difficult relations between hospital and community services, outcomes remained stable (discharge destination, length of hospital stay, and number of referrals to the community team).
Long-term clinical and cost-effectiveness of collaborative care (versus usual care) for people with mental-physical multimorbidity: cluster-randomised trial	Camacho, E.M.	2018	Primary care	Explore the long-term (24-month) effectiveness and cost-effectiveness of collaborative care in people with mental-physical multimorbidity.	In the long term, collaborative care reduces depression and is potentially cost-effective at internationally accepted willingness to-pay thresholds.
Management of multimorbidity using a patient-centred care model: a pragmatic cluster-randomised trial of the 3D approach	Salisbury, C.	2018	Primary care	Examine if patient-centred, so-called 3D intervention (based on dimensions of health, depression, and drugs) for patients with multimorbidity would improve their health-related quality of life.	The 3D intervention did not improve patients' quality of life.
Elements of integrated care approaches for older people: A review of reviews	Briggs, A.M.	2018	No specific context	To identify and describe the key elements of integrated care models for elderly people reported in the literature.	Evidence of elements of integrated care for older people focuses particularly on micro clinical care integration processes, while there is a relative lack of information regarding the meso organisational and macro system-level care integration strategies.

Understanding care navigation by older adults with multimorbidity: Mixed-methods study using social network and framework analyses	Vos, J.	2018	Primary care Secondary care Social care	Design technology to assist people with LTCs in navigating health and social care systems.	Quality of care is dependent on the determination and ability of patients. Those with less determination and fewer organization skills experience worse care. Thus, technology must aim to fulfil these coordination functions to ensure care is equitable across those who need it.
Supporting shared decision making for older people with multiple health and social care needs: A realist synthesis	Bunn, F.	2018	Varied contexts	Provide a context-relevant understanding of how models of shared decision-making might work for older people with multiple health and care needs, and how they might be applied to integrated care models.	Models of Shared decision-making for older people with complex health and care needs should be conceptualised as a series of conversations that patients, and their family carers, may have with a variety of different health and care professionals.
'Trying to put a square peg into a round hole': a qualitative study of healthcare professionals' views of integrating complementary medicine into primary care for musculoskeletal and mental health comorbidity	Sharp, D.	2018	Primary care	Explore professionals' experiences and views of CAM (Integration of conventional with complementary approaches) for comorbid patients and the potential for integration into UK primary care.	CAM has the potential to help the NHS in treating the burden of musculoskeletal and mental health comorbidity. Selective incorporation using traditional referral from primary care to CAM may be the most feasible model.
Primary care redesign for person-centred care: delivering an international generalist revolution	Reeve, J.	2018	Primary care	To draw on the UK Society for Academic Primary Care's model of blue sky thinking to propose a 'Dangerous Idea': an idea that challenges the status quo but with a commitment to action.	To achieve person-centred healthcare, we need to redesign healthcare around the expertise of the generalist clinician in making whole-person, goal oriented clinical decisions.
Is telephone health coaching a useful population health strategy for supporting older people with multimorbidity?	Panagioti, M.	2018	Primary care	Examine health coaching, which is 'a regular series of phone calls between patient and health professional to provide support and encouragement to promote healthy behaviours'.	Health coaching in patients with multimorbidity did not lead to significant benefits on the primary measures of patient-reported outcome. The optimal role of this model of care within integrated care systems for patients with multiple long-term conditions remains unclear.
Enacting person-centredness in integrated care: A qualitative study of practice and perspectives within multidisciplinary groups in the care of older people	Riste, L.K.	2018	Varied contexts	Describe how person-centred care is enacted within multidisciplinary groups (MDGs) created as part of a new service, integrating health and social care for older people.	Three core themes were identified which impacted on enactment of person-centred care: the structural context of MDGs enabling person-centred care; interaction of staff and knowledge sharing during the MDG meetings; and direct staff involvement of the person outside the MDG discussion.

A year of integrated care systems: reviewing the journey so far	Charles, A.	2018	Primary care Secondary care Local Government Community providers Mental health	Assess features, changes in services, leadership, organisation, development, regulation of developing integrated care systems on local and national level; understand factors helping and hindering progress in developing integrated care systems.	Enablers of integrated care: collaborative relationships / shared vision and purpose / system leadership / clinical leadership and engagement / partnerships with local authorities / meaningful local identity / established models of integrated working / stability of local finances and performance / funding to support transformation / permissive and supportive national programme. Barriers to integrated care systems: legislative context not supportive of system working / legacy of competitive behaviours between organisational actors / regulation and oversight not aligned with ICS / frequently changing language and lack of clear narrative / leaders facing competing demands / funding pressures hindering, as well as helping, progress.
Managing the hospital and social care interface: Interventions targeting older adults	Holder, H.	2018	Secondary care Social care	Explore actions and strategies providers and commissioners employed to improve interface between secondary and social care; particularly focusing on hospitals.	Focuses on delayed transfer of care does not address wider issues facing health and social care, and focusing on this issue causes confrontation and negatively impacts local relationships; small- and large-scale organisational change are both required; workforce training for health and social care is needed; incorporate understanding of capacity of community services into understanding of secondary care / social services interface; involve social care in decisions (as opposed to making decisions about social care without social care).
Advancing Integrated Care in England: A Practical Path for Care Transformation	McClellan, M.	2018	Primary and Acute Care New Care Models (NCM) Multispecialty Community Provider NCMs Emergency and urgent care NCM Enhanced health in care home NCM	Assess effective and practical paths to accelerate the adoption of better integrated, higher-value care.	Limiting factors to progress integrated care included: tight budgets, strong pressure to meet performance targets in the short term (e.g., A&E wait times for acute hospitals), conflicting requirements across regulatory entities with overlapping oversight, and the perception of frequently shifting policy terms and objectives.

Priorities for the Plan. The long-term NHS plan and beyond: Views from leaders in charities and voice organisations	Redding, D.	2018	Primary care Secondary care	Discusses the need for new models of integrated care, especially the importance of person-centred care.	So long as separate performance requirements and perverse funding incentives remain in place, system-centred reform will always trump a person-centred approach.
Multimorbidity - Understanding the challenge	Aiden, H.	2018	Third and Community Sectors Think Tanks Primary care University sectors	Understand and respond to one of the largest and most complex challenges facing modern health and care systems.	The key voice missing in the discussions around multimorbidity is the voice of those living with multimorbidity. A better understanding of the experiences, wishes and goals of people with multiple conditions will help inform the design and delivery of health and social care services. It would also help to inform targeted work to address the wider structural factors that are blocking an effective response to the multimorbidity challenge.
Beyond barriers. How older people move between health and social care in England	Care Quality Commission	2018	Primary care Community health services Social care Third sector	Review local health and social care systems in 20 local authority areas.	People experience the best care when they and organisations work together to overcome the fragmentation of the health and social care system and coordinate personalised care around individuals.
A patient-centred intervention to improve the management of multimorbidity in general practice: the 3D RCT	Salisbury, C.	2019	Primary care	Assess a care model that incorporated all strategies recommended by current guidelines.	Both patients and staff welcomed having more time, continuity of care and the patient-centred approach. The economic analysis found no meaningful differences between the intervention and usual care in either quality-adjusted life-years or costs. The cost-effectiveness acceptability curve suggested that the intervention was unlikely to be either more or less cost-effective than usual care.
Interventions for involving older patients with multi-morbidity in decision-making during primary care consultations	Butterworth, J.E.	2019	Primary care	Review available evidence about the effects of interventions intended to involve older people with more than one long-term health problem in decision-making about their health care during primary care consultations.	No consistent evidence that interventions for involving older people with more than one long-term health problem in decision-making about their health care can improve their self-rated health or healthcare engagement, or make any difference in self-efficacy (one's belief in one's ability to succeed in specific situations) or in the overall number of general practice visits. The interventions make little or no difference in patients' quality of life.

Service user, carer and provider perspectives on integrated care for older people with frailty, and factors perceived to facilitate and hinder implementation: A narrative synthesis	Sadler, E.	2019	Varied contexts	Explore service user, carer and provider perspectives on integrated care for older people with frailty, and factors perceived to facilitate and hinder implementation, to draw out implications for policy, practice and research.	Similarities and differences in lay and professional stakeholder perspectives on integrated care for older people with frailty, and factors perceived to facilitate and hinder implementation were evident. Findings highlight the importance of addressing organisational and system level components of integrated care and factors influencing implementation Greater attention needs to be placed on collaboratively involving service users, carers and providers to improve the co-design and implementation
Does pooling health & social care budgets reduce hospital use and lower costs?	Stokes, J.	2019	Secondary care	The Better Care Fund is a large pooled funding initiative gradually taken up by local areas in England between 2014 and 2015.This study examined variation in timing of uptake to examine the short- (1 year) and intermediate-term (up to 2 years) effects of the Better Care Fund on seven measures of hospital use and costs from a cohort of 14.4 million patients.	In the short term, pooling health and social care budgets alone does not appear to reduce hospital use nor costs but does appear to additionally stimulate integration activity.
Does a social prescribing 'holistic' link-worker for older people with complex, multimorbidity improve well-being and frailty and reduce health and social care use and costs? A 12-month before-and-after evaluation.	Elston, J.	2019	Primary care Secondary care	Evaluate the impact of 'holistic' link-workers on service users' well-being, activation and frailty, and their use of health and social care services and the associated costs.	Holistic link-workers improved quality of life, patient activation and reduced frailty in a complex cohort with multiple long-term conditions. Just under half of referrals saw a decrease or no change in cost and activity after 12 months.
An Investigation into the Awareness, Demand and Use of Community Pharmacy Services for People with Long-term Conditions	Hindi, A.M.K.	2019	Primary care Community services	Explore and identify ways to improve low awareness, demand and use of community pharmacy services which may benefit patients with LTCs.	Community pharmacies have the potential to offer more support for patients with LTCs but further developments are needed to fully integrate community pharmacy services within patient primary care pathways.
Leading for integrated care: 'If you think competition is hard, you should try collaboration'	Timmins, N.	2019	Varied contexts	Reflect the views of 16 chairs and leads of both STPs and ICSs on the challenges involved.	Better integrated care requires the dilution or destruction of the long-standing barriers between hospitals, GP practices, community services and social care, with the health system also working far more effectively with local government in tackling the broader determinants of population health. Getting there requires system leadership:

					the creation of collective leadership across all of that, for the benefit of the whole.
Payments and contracting for integrated care: The false promise of the self-improving health system	Collins, B.	2019	Primary care Secondary care	Explore if new funding models incentivise effective delivery of integrated care?	Current funding for integrated health care systems relies on incentives for performance etc. However, as there are no standardised ways to measure success in delivering integrated care, these metrics may not drive desirable performance.
Age UK's Care Programme Personalised Integrated Evaluation of Impact on Hospital Activity	Georghiou, T.	2019	Healthcare Social care Voluntary services	Does PICP intervention (AGE UK) improve outcomes?	Personal integrated care programme (AGE UK) is associated with increased admission rates and increased healthcare costs.
Effects of participating in community assets on quality of life and costs of care: study of older people in England	Munford, L.A.	2020	Community	Generate evidence on whether expansion of social prescribing to charity, voluntary and community groups is associated with better quality of life or lower costs of care.	The results support the inclusion of community assets as part of an integrated care model for older patients.
Leadership for integrated care: a case study	Kozlowska, O.	2020	Primary care Specialist care	Explore the complexities of leadership in an integrated care project and aims to understand what leadership arrangements are needed to enable service transformation.	Integration was supported in the narratives of the system and organisational leaders but there were multiple challenges: insufficient support by the system level leadership for the local leadership, insufficient organisational support for (clinical) leadership within the transformation team and insufficient leadership within the transformation team because of disruptions caused by personnel changes, roles ambiguity, conflicting priorities and insufficient resources.
Integrated primary care for patients with mental and physical multimorbidity: cluster randomised controlled trial of collaborative care for patients with depression comorbid with diabetes or cardiovascular disease	Coventry, P.A.	2015	Primary care	Test the effectiveness of an integrated collaborative care model for people with depression and long-term physical conditions.	Collaborative care that incorporates brief low intensity psychological therapy delivered in partnership with practice nurses in primary care can reduce depression and improve self-management of chronic disease in people with mental and physical multimorbidity.

The Real-World Problem of Care Coordination: A Longitudinal Qualitative Study with Patients Living with Advanced Progressive Illness and Their Unpaid Caregivers	Daveson, B.A.	2014	Primary care Secondary care	Develop a model of care coordination for patients living with advanced progressive illness and their unpaid caregivers, and to understand their perspective regarding care coordination.	Within the midst of advanced progressive illness, coordination is a shared and complex intervention involving relational, structural and information components. Our study is one of the first to extensively examine patients' and caregivers' views about coordination, thus aiding conceptual fidelity. These findings can be used to help avoid oversimplifying a real-world problem, such as care coordination.
Integrated care. What is it? Does it work? What does it mean for the NHS?	Ham, C.	2011	Report	Describe the different forms of integrated care and to summarise evidence on their impact.	Organisational integration appears to be neither necessary nor sufficient to deliver the benefits of integrated care, notwithstanding the achievements of integrated systems such as the Veterans Health Administration.
Integrated care in Northern Ireland, Scotland and Wales: Lessons for England	Ham, C.	2013	Qualitative study	To describe the approach taken to integrated care in Northern Ireland, Scotland and Wales with a view to drawing out the lessons for England.	Structural integration either within the NHS or between health and social care is only one factor among many in facilitating the development of integrated care. Integrating health and social care within the same structures may have the unintended consequence of social care becoming subservient to health care.