Future Care Capital

Digital Transformation in the NHS: Evaluating Integrated Neighbourhood Team Development

An Evaluation Report by Future Care Capital

About Future Care Capital

Future Care Capital (FCC) is the UK charity dedicated to breaking barriers and driving sustainable, measurable impact in health, care, and charitable sectors.

We recognise the systemic silos, short-term thinking, and resource constraints that prevent progress in health and care.

These challenges make it difficult to innovate, collaborate across boundaries, and deliver meaningful change.

FCC bridges these gaps by thinking and working differently, convening experts and diverse stakeholders, and driving solutions that address long-term challenges.

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2. **Impact Evaluation** - Measuring and demonstrating the real-world effectiveness of innovations to enable confidence, scalability, and systemic adoption.
3. **Impact Investment** - With investment expertise and learned experience of being a charitable investor, we can support other current, and potential, health and care charity investors to make strategic investments that align with their missions, reduce risk, and deliver sustainable impact.
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By thinking differently, working differently, and breaking barriers, we bring together innovators, providers, and investors to drive solutions that improve care, deliver better outcomes, and achieve systemic transformation.

1.0 Executive Summary

This report provides an evaluation of the Integrated Neighbourhood Team (INT) initiative within the Arbennek Primary Care Network (PCN) in Cornwall, England. It examines the development, sustainability, and potential transferability of the INT model and provides recommendations for further strengthening its integration into wider NHS structures. The INT was established to enhance collaboration between health and social care professionals, aiming to provide coordinated support to patients identified as being at high risk. The initiative arose organically from local context and personal relationships, creating a highly responsive, bottom-up approach.

This evaluation utilised qualitative methods including semi-structured interviews. Stakeholders including clinicians, people who work in social care, the voluntary/third sector, and administrative support staff were interviewed. The work explored themes around sustainability, translatability, communication, and leadership dynamics, and a focus was placed on Tuckman's stages of group development (Forming, Storming, Norming, Performing, and Adjourning). Observations and interview transcripts were analysed to identify core strengths, challenges, and actionable recommendations to support future development.

Findings:

The INT has successfully navigated its initial formation phase, benefiting significantly from strong, relationally grounded leadership. Leaders within the INT are highly regarded and demonstrate effective engagement with both frontline staff and higher organisational management. The INT's success is closely linked to its adaptability and responsiveness to local challenges, with leadership emerging organically rather than through imposed structures.

However, the transition from 'Forming' through the 'Storming' phase towards 'Norming' remains sensitive. This progression is inherently fragile and requires deliberate intervention to consolidate gains and mitigate potential disruptions. There is a need to strengthen the support structures for leaders, ensuring they have dedicated time and resources, such as leadership away days and professional coaching opportunities. Developing the capabilities of meso-level clinicians through targeted coaching and training is crucial for the sustainability and ongoing effectiveness of the INT.

It is recognised that the unique characteristics of the Arbennek INT—driven by personal relationships and tailored responses to local needs—cannot be directly replicated elsewhere. Indeed, attempts to standardise the INT approach risk undermining the very qualities that underpin its success. Instead, the key learning points and principles of successful integration need to be captured and thoughtfully adapted to different local contexts. INTs elsewhere should similarly be established with sensitivity to local characteristics, challenges, and professional landscapes, thus ensuring that the strengths of bottom-up leadership and adaptability are maintained.

Communication emerged as an area requiring specific attention. Participants highlighted the necessity for clearer strategic communication that explicitly defines how INTs integrate with existing NHS structures and organisations. Improved clarity around roles, responsibilities, and

organisational relationships would enhance the effectiveness and purposefulness of INT meetings, ensuring that only those whose participation is necessary or valuable are involved. However, communication improvements should respect and reinforce the organic, bottom-up nature of the INT, avoiding top-down management interventions that could potentially damage team morale, engagement, and local responsiveness.

Recommendations:

Based on the evaluation findings, we recommend:

- *Strengthen leadership support by offering structured opportunities* such as dedicated away days and professional coaching, especially targeted at meso-level clinicians.
- *Ensure the protocol used to form INTs contains explicit recognition of the local context.* There is a need to recognise the uniqueness of the Arbennek INT model and avoid direct replication. Instead, focus on capturing essential principles and learning points that can be sensitively adapted to other local contexts.
- *Develop a clear, strategic communication framework* clarifying INT integration with NHS structures, organisational roles, and relationships, without compromising the successful bottom-up approach.

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This is a report by Future Care Capital, who are independent evaluators and were not employed by the NHS for this project. This report was drafted by the Evaluator, Dr Melanie Fraser, with support by Professor Andy Jones, who also contributed to conceptualisation and study design.

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2.0 Introduction

This evaluation of an innovative National Health Service (NHS) team highlights the positive potential for primary care, community health, and community organisations to implement Artificial Intelligence (AI) in a way that improves people's health and reduces hospital admissions. This case study also demonstrates how the teams can be effectively created, operated, and led, and captures the energy and hope that they generate.

2.1 Background

Primary care and community health look after people in their own homes and are a key part of NHS infrastructure. These forms of healthcare are also critical for avoiding hospital admissions and reducing pressures on the NHS. Indeed, targeting community health resources and voluntary sector care towards patients who are most in need both reduces the burden on health services and enables people to stay healthy and in their own homes.

There is a much diverse infrastructure to support patients with managing their healthcare in the community. As well as general practitioners (GPs), there are both clinical and non-clinical staff who work in the community for the NHS, such as social prescribers. Beyond the NHS, a range of other services such as social support, charities, and third sector organisations provide a network which helps support both physical and mental patient wellbeing. However, efforts are often uncoordinated and there lacks integration with health records, which can lead to a lack of focus on the patients who are most at risk.

Identifying the most at need patients and ensuring that they get a range of support from different sectors of the community is potentially of significant benefit. Patients who are supported are more likely to stay healthy and in their own homes and less likely to need hospital care. Targeting resources at patients who are at risk and providing them with extra support before they experience an escalation of need is therefore a beneficial strategy.

How Technology can Help:

Providing proactive care by identifying the most vulnerable patients using algorithmic analysis of patient records is a well-established strategy. GP records are already routinely scanned to target healthcare based on a variety of criteria; for example, to target vaccine invitations based on patient age[1]. Traditional risk-stratification approaches are, however, being augmented throughout the NHS by the application of AI to scan routinely held records and identify patient needs[2]. An example of one such technology is "Brave AI" which uses primary care records to generate a score for each patient scanned which indicates their risk of an unplanned emergency hospital admission[3]. Patients who are identified using Brave AI as having a high 'Brave Score' can be given extra support to enable them to stay healthy and in their own home.

Whilst pointers that are provided by AI, they do not in themselves support patient care if no process is available to act on them. For example, a high Brave Score might identify a patient at risk of falling, but their risk will not be reduced unless some form of intervention can be implemented based on their score. This requires the development and application of a care framework for patients, as it is this framework that changes their risk of an undesirable health

[1] A systematic review of risk stratification tools internationally used in primary care settings - PMC
[2] Artificial Intelligence - NHS Transformation Directorate
[3] Brave AI | Bering

event. A team of healthcare and community workers is therefore needed to support the patient and reduce the risk, and an Integrated Neighbourhood Team provides that.

2.2 The Case Study Context

Cornwall:

Central Cornwall comprises several villages between the main urban areas of St Austell and Truro. Access to primary transport links is good with the A30 and the A390 within easy reach. The area is also well served with community hospitals, a dermatology service, minor surgery centre and an Acute Trust in Truro.

The Central Cornwall Integrated Care Area (ICA) covers a population of approximately 237,000 people. There are 6 Primary Care Networks (PCNs) in the ICA. These are groups of GP practices that work together to provide health and social care. The PCNs in Central Cornwall are: Coastal PCN – 29,000 people and 4 practices, Falmouth and Penryn PCN – 50,000 people and 4 practices, St Austell Healthcare – 37,000 people and 2 practices, Truro – 37,000 people and 2 practices, Watergate – 50,000 people and 3 practices, and Arbennek – 33,000 people and 4 GP practices.

Arbennek PCN:

This report presents an analysis of the working of an Integrated Neighbourhood Team in Arbennek PCN which is located in Cornwall. The 4 GP practices that comprise Arbennek PCN are Brannel surgery, The Clays Practice, Probus surgery and Roseland surgeries. Detailed information about these surgeries is included at Appendix A. Roseland in particular has a significantly higher elderly population, likely due to the scenic views and good lifestyle that this part of the coast offers, thus attracting wealthy retired people moving in from other parts of the country. By contrast, the more deprived areas of the PCN footprint – around the Clays villages – have a younger population. The elderly people in this area are likely to have lived in the area all their lives and are likely to have worked for low wages in the clay mining industry.

2.2.2 The Integrated Neighbourhood Team

Arbennek PCN have created an Integrated Neighbourhood Team (INT) to support patients using AI generated risk profiles to identify patients who would benefit. Specifically, Brave AI was piloted within the PCN to identify the patients who are at risk of an unplanned hospital admission. To support this, monthly meetings were held to consider how to support patients with high Brave scores. Each meeting decided action points, and these were revisited the following month. For example, having talked about a patient's needs, the meeting might decide on a home visit from a GP and a Care Navigator, together, to review the patient's needs. That review might unmask further needs and this could then lead to more follow-up, such as arranging a volunteer visitor to reduce loneliness.

The INT includes a GP, as well as other staff who work out of the GP surgery such as social prescribers. They have similarities with Multi-Disciplinary Teams (MDTs) but included a wide range of Voluntary, Community and Social Enterprise (VCSE) stakeholders drawn from across the Integrated Care Area (ICA).

There is some evidence that there was success for patients. Brave scores declined as a result of

the actions from the INT meetings, and hospital admissions were avoided for almost all patients.

2.3 The Purpose of this Evaluation

This evaluation is not focused on the effectiveness of Brave AI as a tool[4]*. Instead. this evaluation focuses on the process of creating, operating, and leading the INT process in a single INT, Arbennek, who have used Brave AI,* acknowledging that there are other INTs in Cornwall which have followed a different path and are beginning to roll out Brave AI. This case study provides an opportunity for learning points, drawn out of *the* experience of Arbennek trialling the new technology implementation mechanism.

The Arbennek INT is at an early stage of establishment, intended to contribute to an ongoing cycle of plan/do/study/act[5], and looking at the process of INT formation through Tuckman's team development stages[6] [7] By undertaking an evaluation at this point, and using a theoretical framework that explains team stages, learning points can be developed and applied to support care provision more widely.

Why this PCN?

Arbennek PCN were selected for this evaluation because they had received access to Brave AI early, as part of a pilot process, and at the time of the interviews other INTs had not yet had access to Brave AI. Arbennek PCN had also received extensive resourcing to support learning, and this evaluation intends to capture those learning points for dissemination and to maximise impact. Preliminary indications were also that there was a positive experience associated with Arbennek INT and views were express that it had an innovative way of work such that it would be especially useful as an atypical case study of an impactful approach.

[4] See information about how Brave AI is being used in Somerset here: Using Artificial Intelligence to monitor wellbeing: BRAVE AI - NHS Somerset ICB

[5] https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2015/08/learning-handbook-pdsa.pdf

[6] Tuckman_1965_Developmental_sequence_in_small_groups.pdf

[7] Forming Storming Norming Performing | Tuckman's stages of group development explained [with diagram] — BiteSize Learning

3.0 Methods

Project Team:

In order to support the swift progress of this evaluation, a small project management team was convened, consisting of the evaluator (Dr Melanie Fraser) and two INT managers. The team met regularly to agree on the study protocol, review ethics, and help work out the practicalities of the evaluation such as identifying and recruiting participants. The interviews and data analysis were performed solely by the evaluator, who drafted this report.

Overview of Methodology:

Rich qualitative data was gathered through 13 interviews with key stakeholders, and the transcripts of these interviews were read in detail to enable the points made to be grouped into themes, looking at the range of data in all the interviews. This process used inductive thematic analysis, to develop themes to develop naturally from the data[8]. The coding was undertaken using Nvivo v15 which is a well-established qualitative data analysis tool and included an AI assist function to help summarise the points made.

3.1 Participants

The aim was to develop diverse insights from stakeholders with involvement and/or engagement in the Arbennek PCN INT, including NHS managers (top-down) and front line (bottom up) participants[9], including PCN and VSCE contributors.

The original intention was to have two participant groups; interviewees and focus group participants. Interviewees were originally envisaged as key stakeholders identified through a stakeholder mapping exercise, chosen for strategic involvement and engagement. The (redacted) stakeholder mapping exercise is included as an appendix to this report. It was also intended to conduct focus groups, which would be open to anyone who had any involvement or engagement with the INT. However, several staff sent apologies to the focus groups. Therefore, they were asked if they would like to participate in an interview.

Six participants in the evaluation were originally identified through the stakeholder mapping exercise for interview due to their high levels of involvement and/or engagement with the Arbennek PCN INT. The remaining 7 participants originally received an invitation to participate in a focus group and were re-allocated to the interview stream.

An invitation to participate in this research has been extended to everyone involved in the INT. Everyone who indicated a willingness and availability to participate in the evaluation was interviewed.

Participant Profiles:

Of the 13 interviewees, 7 participants were male and 6 females. In terms of role, 2 were employed by the ICA and 1 employed by the NHS as a regional manager, 1 by the County Council,

[8] Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, 3(2), pp. 77–101. doi: 10.1191/1478088706qp063oa.

[9] Top-down and bottom-up management have been explored in other NHS contexts. See, for example: Fatai Ogunlayi, Philip Britton - Achieving a 'top-down' change agenda by driving and supporting a collaborative 'bottom-up' process: case study of a large-scale enhanced recovery programme: BMJ Open Quality 2017;6:e000008.

and 2 are VCSE (Voluntary, Community, and Social Enterprise) participants; 1 of these was a cascade voice (a voice chosen to represent) for 27 other VCSE organisations. The remaining 7 participants were employed within the PCN, and include 2 INT managers, 1 INT administrator/care co-ordinator, 1 INT Clinical Lead/GP Manager, 1 GP Practice Manager and 2 employed in non-clinical patient-facing roles.

The 13 participants are therefore highly diverse including 3 clinical and 10 non-clinical staff although 3 of these were patient-facing participants working for GP surgeries. Out of the 13 there are 6 different employers, and 10 participants have management responsibilities. Also, 10 participants directly attended the Arbennek PCN INT with the remaining 3 having a strategic oversight role. There is therefore a range of seniority, perspectives and different types of involvement in the INT.

3.2 Data Collection

All interviews were conducted by Microsoft Teams by the Evaluator. Transcription was conducted automatically, using either MS Teams automatic transcription capability or by recording the meeting and then using Nvivo automatic transcription capability. Some data cleaning was necessary in the quotations used in this report. Interviews were conducted in December 2024 and January 2025.

Interviews focussed on three topics: creation, operation, and leadership of the INTs, mapped to Tuckman's team development stages. The interview guide is included as an appendix in this report.

Ethics and good governance have been central to this evaluation. An ethics analysis addressing issues such as informed consent, data management, and anonymity was produced and approved by the INT leadership prior to data collection. Participants were provided with an Informed Consent Form for Participants prior to the interview, with verbal consent confirmed during the interview on camera. These documents are included in appendices to this report.

3.3 Analysis Process

Interview transcripts were uploaded to Nvivo v15 in their entirety. Coding involves the systematic identification and labelling of meaningful segments of data in transcripts. This process organises qualitative data into distinct categories or themes to reveal patterns and deeper insights. Nvivo enables the comments in the interviews to be grouped together in codes, so it is easier to make comparisons and see what different interviewees said about the same topic, or which topics were common across interviews. Similar comments are coded in the same code, and then codes grouped together to form themes. It is easier to see where people agree with similar sentiments, and where they disagree with different viewpoints when all the similar comments are grouped this way. It is also more straightforward to see what comments are said frequently, and what is less commonly said when looking at all comments in this manner.

To capture emotions and energy, reflective memos were made by the evaluator after the interviews. These contained reflections on what was said and what was not said, and how she felt about the experience of interviewing participants. A reflective analytic log was also kept with emerging ideas of the key points and what the evaluator was learning from the process. This

enabled contemplative thoughts about the situation and revealed concepts and emotions that weren't explicit in the interviews to become apparent.

Multiple rounds of coding were conducted, using an inductive method. This allowed themes to emerge organically from the data rather than being predetermined. Comments were grouped into a named code describing what the comment was about, and the codes were grouped. This was checked for thoroughness by auto-coding the entire corpus of data, so all interview transcripts were coded to check all codes to all transcripts. This ensured all codes were captured in a consistent manner. This has been used to ensure that the evaluation is grounded in the data.

In all, 34,365 coded references were generated in the interview data. Codes were grouped to form sub-themes and subjected to a reflective analytic process using the log to identify the key aspects arising from the analysis. Visualisations such as word clouds and word trees, alongside sentiment analysis and cluster diagrams, alongside AI summaries, also contributed to the emergent analysis process and thoughts about what they showed were recorded in the log. This enabled the analysis to be rooted in the data.

4.0 Results

Discussions suggested how the creation of an INT to implement proactive patient care using Brave AI was an innovation with system disruption potential. It has been a positive, energising experience in the Arbennek PCN, and these organically emerging topics frame the discussion, whilst recognising that the process is still at a formative stage and depends upon the personal drive and vision of the INT leadership. In this section, the key topics are discussed with general descriptive comments preceding specific themes and quotes. Where there was some diversity in viewpoints amongst participants, a range of quotes have been included.

4.1 An exciting innovation

Arbennek PCN INT has implemented new technology, using the results of AI to produce improvements in people's health and reduce the burden on the NHS. Aspirations for INTs were coded 506 times in the data and innovation was coded 386 times. The innovation has got the attention of NHS management. One civil servant summed it up:

> *"The chief medical officer and other people in the ICB are very excited about what Arbennek could do. Because they've got numbers they can demonstrate. They had fifty people in their cohort. And out of that, I think one sadly died. Forty-nine were kept out of hospital. And for that one who did pass away, they were able to make sure that their wish of dying at home was delivered, which is a big positive, because you only get one chance of end-of-life. So, there's a lot of excitement about what Arbennek are doing."*

The word "excitement" was also used repeatedly by another NHS manager who has responsibilities across the ICB. They commented about the innovation that AI such as Brave implied, and the potentialities that were opening:

> *"This is happening right now... there's so much stuff going on in Cornwall round this, and a lot of excitement. Yeah, a lot of excitement. As a system they've really taken the INT seriously and its potential".*

Catching the Vision:

Potentially this is a system-changing moment. The Arbennek PCN INT has created expectation of a disruption to the current ways of working. Some participants wondered if INTs might become a new norm. However, innovation comes with challenges and is hard to manage. A VCSE sector leader described it:

> *"People have seen the value of it (the INT). And the people that appreciate the value of it have bought into it wholeheartedly. It's going to be rolled out as the expected norm. Then, you know, some people that are more reluctant are going to have to engage with it, and that's potentially where the challenge is."*

This sense of innovation is leading to uncertainty as people adapt to a new way of working. It's hard to innovate and to be a part of a new way of working. An INT participant explained

> *"It's just about changing your narrative a little bit, changing the way you work, or your approach, and getting people on board with that... it was the unknown."*

What are the Implications?

The existing infrastructure of NHS services in primary care are potentially impacted by this new innovative technology and there are potential knock-on effects that will ricochet around the management structures. A GP explained:

> *"What exactly is being asked by "forming an INT"? Strategically, organisationally, operationally?... There's always someone's time, someone's energy, and the bit I'd like to know: what other systems are going to take the hit?"*

Although the Arbennek PCN INT is an exciting innovation, the disruption that it has created is challenging. At the time of writing, there was even optimism amongst some participants that the Arbennek successes could be rolled out and change community care provision in a transformatory way; others were cautious and gave caveats, although all rated the Arbennek INT positively.

4.2 Convening the INT: Forming, Storming, Norming

The INT in Arbennek PCN is still forming, with considerable uncertainty among participants who are still working out how the new style of work functions in practice. However, the meetings have been effective in building collaboration, trust, and relationship. All participants talked about these issues, with collaboration being coded 225 times and Integration coded 268 times.

4.2.1 Brave AI was helpful in creating the sense of shared (although muddled) vision

A participant in the INTs reflected on her experience of attending meetings before and after the introduction of Brave AI and commented:

> *"We had a couple of meetings, but it was, really, I wasn't sure, I didn't really understand what the aim of it all was because Brave AI wasn't in existence at that point. We were talking about something that hadn't yet been shown, and we didn't know how it was, we knew the concept, but we didn't really know anything about it. We had these quite big meetings with lots of different professionals in the room, but it seemed a bit nebulous. We were like "What's all this about? Where is this going to go?" And then once Brave AI was issued, it became a lot more structured and focused and clear from my point of view."*

Although there remains confusion about what an INT is, the use of Brave AI scores to focus INT meetings and discuss patients helped participants understand INTs.

But What Is the Vision?

Although a picture of what the INTs did was learned through the experience of attending meetings, there were still lots of confusion. An INT leader summed up the fluid, and somewhat messy, process as follows:

> *"You can't phone the INT. The INT is not a structure, it's not an organisation, it's a group of people. So, you could phone someone, within the INT, and they could link up with other members, but you couldn't have a hotline. That's not how it works. It's fairly nebulous, it's*

fairly loose. And as you work through looking at individuals, the INT itself will shift, because what one patient might need, another patient might need something different… it's kind of always moving, shifting, amoebic."

Brave was coded for 310 times, but it was described by interviewees as a tool for metrics. The insights that Brave generates are useful, but interviewees regarded collaboration and communication as key to proactive care, as described by a leader:

"The reason I wanted to use Brave was I felt there was a great opportunity to kickstart – to become a catalyst for collaboration and working. Brave is just a tool. It's a way of identifying patients."

So, the experience of INT was learned by doing, and the Brave scores provided a focus for the meetings.

4.2.2 The meetings are large and discussing patients is time consuming

There are a lot of voices at the table and there is a risk that a small number of patients are discussed extensively, meaning that there is too little time for other patient's needs to be included in the meetings. "Voices at the table" was coded 578 times. Participants in the meetings can be a cascade voice for other organisations, but even with this strategy, the meetings are still large, and given the close attention to each patient, there isn't the opportunity to discuss many patients.

Lots and lots of Staff at Meetings:

One participant who attends meetings regularly commented:

"It sort-of developed. We started having monthly meetings, and all our social prescribers are involved across the PCN, and then we started getting district nurses involved, and then we had adult social care, and Age UK, so voluntary sector too, and so it started as half a dozen, maybe, and then yesterday, there were probably about 35 people there."

Despite the already-large meetings, the INT leaders are concerned that non-attendance at meetings is still an issue. Especially with mental health and secondary care they want more presence from a wider group of professionals. One commented:

"We built up a network of interesting people, I can go "do you want to join in, and this person might be really good too". It's all about personal relationships and again, that element of trust."

One option would be to have the meetings focussed on specific GP surgeries, but the risk is that there would be a lesser range of services represented if that occurred, and participants found that listening to other patients was, at least in the early stages, useful for gaining knowledge. One person who works for a surgery commented:

"A lot of the patients aren't applicable to me because I'm with X surgery, so although I could maybe share a bit, they're not my patients. So, we have said, would it be better to have more

focused smaller meetings for the local surgeries? But facilitating that would be very difficult, because if you want, say, adult social care, and there are 4 surgeries, that's times their work by 4, rather than one big meeting."

There are other pressures with a big meeting. A VCSE sector manager commented:

"There's a big table, and there's more people (who attend) than can fit around it. So, I tend to find myself sitting on the outside now."

Spending a Long Time Talking:

These practical concerns are partially overcome through technology such as virtual attendance through Teams. Another concern with big meetings is that they are very time consuming, and don't manage to discuss many patients. A council employee working in public health explained:

"INTs are a great concept, but it's going to be time consuming. If you want something done, properly and intensively, with lots of people, potentially it's expensive. But of course, in the long run, as an investment return, it's probably going to be the best thing, because you're addressing that person's needs."

Spending time on patients, in a large meeting, means that INTs are resource intensive, and can't cope with a large volume of patients that require discussion. Brave therefore must be used carefully to focus the time on the highest needs.

4.2.3 Uncertainty over how the meetings fit into the bigger picture of NHS provision

Confusion about NHS provision above the level of GP surgeries, and therefore what manner of team the INT was, is a big factor. A side-by-side comparison of interview comments reveals dissimilarities around definitions and descriptions of NHS structures, including INTs. There was real confusion about how organisations above the level of GP practices work.

Layers of Leadership:

There were 314 coded references for how the INT relates to wider NHS organisations, 193 for the relationships between PCNs, MDTs, GPs, and INTs, and 136 for the relationship between primary and secondary care. PCN role wasn't clear, and nor was it clear how that relates to MDTs and INTs, with limited understanding of ICAs and ICBs. One senior member of staff said:

"You have a GP practice, and then a PCN, and then an INT, then a central ICA, and then an ICB... I don't know what an INT is replacing, or maybe it's what we thought a PCN would eventually turn into when we started PCNs."

This is also amplified by another well connected, senior participant, who commented:

"We need to clearly stipulate where INTs sit with PCNs. The leadership's clearly coming from a position on this, but the ambiguity is that we're being told a PCN isn't aligned with an INT, but without it the INT doesn't exist. So, there's a huge void unless a PCN is an INT. So, we need to get the vision right. And we need to clearly understand and demonstrate what the role is for an MDT."

Involving lots of stakeholders:

One aspect of an INT that was valued by VCSE was the opportunity to be part of the community of practice and contribute to the discussions, both within the meetings and by enabling conversations to get started about topics that were not immediately relevant to the meeting. One VCSE stakeholder commented:

> *"My understanding of the INT is starting to bring people from the community sector and other organisations.... we've had those conversations in the meeting itself, and then afterwards, I've caught NAME and say, okay, taking all that in the round, this is how it fits in with my work and some other initiatives."*

Involving VCSE as well as NHS staff has resulted in a large team meeting, with many voices at the table, and this may be part of the distinction between INTs and MDTs. But the distinction may also lie in strategic role, with MDTs being about patients and INTs more about ways in which organisations work together.

4.3 Operation of the INT: Performing, Adjourning

Roles are still being worked out in the INT, although it has been effective at overcoming some of the geographical and relationship hurdles which have previously hampered the PCN's efforts at integration. Access to data and medical records is still a problem. Some concerns arise around the lack of meso-level clinicians such as district nurses at meetings, which appear to be highly regarded and well attended by social care staff, but there is a risk that social prescribers, care co-ordinators and other non-clinical staff will need to guard their role.

4.3.1 Roles are inherently fluid within INTs

As people can comment on cases outside their workload and learn from professions that are adjacent to their own, there is considerable fluidity. However, this can lead to confusion around the clinical/non-clinical division. There were 325 references to this.

Social Prescribers are Caught in the Middle:

This can be a particular issue for social prescribers. Their role is non-clinical, yet the reason people need support is due to a high Brave score, indicating a clinical need. So non-clinicians may not be in the best position to provide the initial contact. This reluctance may be caused by a fear of proactively cold-calling patients who have otherwise not engaged in health services, as well professional boundaries. This stretch in role was described by a GP practice manager:

> *"Social prescribers and care coordinators have always been classed as non-clinical... are we putting ourselves in a vulnerable position by entrusting things to people who are classed as non-clinical? But by giving them the tools and the training and the empowerment these people start to feel comfortable that they can do it. And why shouldn't a care coordinator or social prescriber write that care plan?"*

Meso-Level Clinicians:

There may be a meso-level gap in attendance at meetings, with potential low clinical presence

from Community Health staff, secondary care, and mental health practitioners. Social prescribers worry about lack of clinical cover, as they may encounter role creep without it. A level of clinical supervision has been obtained by securing GP attendance in INT meetings, but under-attendance by clinical staff was a concern for this senior nurse:

> *"I haven't visibly seen much senior clinical leadership there. And the question is, do you need it? I think that's a question I don't know the answer to. Do you need it? Or not need it?... I think there were probably some gaps."*

The potential for non-clinical staff in wide-ranging roles to take on patient-facing tasks can be positive, but also understandably raises questions around boundaries and which profession is needed, as well as where clinical risk lies. One senior clinician commented:

> *"We haven't reached the black and white aspect of where our roles and responsibilities lie as a PCN, as clinicians."*

Wide Networks of non-NHS Participants:

The networking opportunities provided by INTs were highly prized by participants. Interestingly, this was most strongly expressed by participants who were in the social care or VCSE sectors, who were glad to have the opportunity to participate in NHS-led discussion. A green third sector rep explained:

> *"My inputs were kind of valued. We would talk about frailty and the carbon cost of end-of-life care, and they were shaped into the project... the angle is that the biggest GP [carbon] footprint is down to the drugs they prescribe, so anything that is aimed at reducing the number of drugs that a practice prescribes is going to have a telling impact on their carbon footprint, and LEADERS NAMES are keen on this"*

By getting close to patients care, he was able to advance his commissioned agenda in reducing carbon footprint, and this fluidity was something he valued. By listening to INT discussions about other patients and other surgeries, INT discussions generated ideas and identified possibilities in a flexible way. A participant whose role is to help develop INTs commented:

> *"My purpose is to help build relationships, so we think in a system wide way, and we're not looking at things in silos. We're not pointing the finger and saying, "that's not my job, that's your job." It's about how we can work together to provide seamless service to the people that need our help. I can see your eyebrows raising. I know, that's the challenge. We're not there yet, not by a long way."*

Networking and integrated working may well lead to fluid allocation of workload with implications for role boundaries.

4.3.2 Adjourning is barely relevant

Although all interviewees were asked about endings, it was only coded 80 times, and there were no calls for an end to the INT. Contemplating endings, some participants observed that inevitably some patients are end of life, and the INT can help with palliative care, and where

wanted, help patients die at home. This was rated as a positive outcome by participants.

Third Sector Pressures:
Endings are built into some sectors of work. A VCSE participant commented on the endings in commissioning and how building in planning for the end of the role has to be continually monitored in his sector.

> *"We get limited contracts. If they're a three-year contract, you get a mobilisation period of year one, and delivery year two and three. You run your exit strategy, and then you get to month 37, and then, they tell you that they've extended the contract for another year just after it's finished. So that's a challenge with endings. We need much more clarity on timelines of commissioned contracts."*

It is hoped that patients progress to independence, but in reality, many are likely to need continuing care. Reflecting on this, a local authority stakeholder commented:

> *"I don't think there can be an endpoint. They just keep an eye, they're monitoring, but using Brave they can see benefits… they're tracking these patients."*

So, although some members of an INT may face an ending of their commissioned role, in other ways the INT process does not end.

4.3.3 Data and IT is good-but-imperfect

Medical records were coded 250 times. The INT leaders were praised for using IT creatively to encourage attendance at meetings, and Brave also received credit for providing an evidenced way to show INT success, but despite these credits, there are still issues.

> *"We don't have access to the records where information is held, about attendances at hospital, the only information we could look at was GP records, but that wasn't enough. We needed a wider view of the patient's history; we didn't have all the information."*

As the Brave AI protocol is that only registered healthcare professionals have access to patient data to contact individuals about potential care planning, many participants in INTs such as VCSE and social prescribers are not eligible for the information or to contact patients. So, there is a lot that can't be discussed in the meetings.

Metrics:
Finding metrics to measure success in INTs is difficult because of the priority that Arbennek PCN gives to relationships. A leader reflected:

> *"Where's the evaluation? Where's the methodology? Where's the logic model? How is this working? We think this is successful, by our measures, but I can't capture what you want to measure… What are our outcomes? What am I measuring? So, with our INT it's the number of people, with personalised care and support plans, and we're looking at Brave scores. If we didn't have Brave scores, I'd have probably found another measure that we'd use. So, I can say, well, this number of people, this number of plans, Brave scores before and after*

intervention. That's my evaluation."

The Arbennek PCN INT meetings are held with light touch paperwork: terms of reference circulated prior, an agenda, and records are kept of decisions. A local authority stakeholder described it like this:

> *"The terms of reference outlined the vision and the reasons they're doing this, obviously, ultimately, for patient health. But it's a way of collaboratively working. So that just framed it. And that was good enough."*

IT, including access to data, Brave, and using metrics is therefore a strong theme serving (and sometimes, frustrating) the INT, rather than replacing relationships.

4.4 Leadership of the INT

Arbennek PCN INT has two key leaders, a clinical director, and an administrator. All these have been interviewed in this evaluation. All interviewees were asked about how leaders within the INT are supported, and how top-down and bottom-up leadership had emerged within Arbennek PCN INT.

4.4.1 Leadership skills are important

Even in a non-hierarchical organisation such as an INT there was a need for effective leadership. Arbennek PCN INT was collaborative and there was shared responsibility, but it still requires a facilitator, as a VCSE sector leader explains:

> *"You need a cheerleader. Somebody who is motivated and passionate and can convey that. Almost evangelical. We can get ground down by doom and gloom, so we need someone who can keep everyone motivated about the difference we're making and seeing the improvements in the Brave scores helps that."*

Dispersed Leadership:

A big meeting with so many people might be a burden on the leaders. But an INT leader, reflecting on their role, suggested:

> *"If we have a leader or we have a manager, that's a single point of failure. The INT should be able to function without a leader. We do need someone in a meeting to chair and facilitate, but it might be per meeting. An INT should not be dependent on a leadership team."*

The concept of a network, a facilitator, and collaboration are all helpful, but all participants acknowledged the need for a chair and some framing to enable the meetings to produce useful outcomes. A senior NHS leader who is not involved in the INT day to day observed:

> *"I see strong leadership. As a team it's clear that they've had good conversations, but they are able to challenge each other and have those conversations that are open and not uncomfortable... they were getting the views of lots of people, and I think that's good leadership."*

The leadership of the INT has been critical to the success of Arbennek PCN's INT.

4.4.2 Supporting leaders to lead a cultural change

The new or reimagined ways of working includes top-down aspects (such as investment of money, redesigned working days, huddles, and structures). There are also organic, relationship-based aspects which work bottom-up. Creating strong relationships between team members, building trust, and establishing a common purpose through inclusive, empowering meetings has enabled leadership to grow.

Top-down Factors:

Top-down factors are a constant source of directives, with political and funding mandates in flux leading to directional shifts. A senior NHS leader commented:

> *"Every year there's different agendas and there's different initiatives, that can be challenging.... the challenge is that people are still quite traditional.... budgetary conflicts always, you know, there's so much money for each initiative and you have to compete for it."*

Bottom-up Factors:

As well as these mandates, with finance associated with them, the INT has the opportunity to respond to local, bottom-up pressures. A patient-facing participant explained:

> *"It's not as straightforward as putting an INT together and we'll work in a set way. It's going to be very localised, there needs to be some focus on the local requirements, the local resources. You can't just stamp it out across the nation."*

Arbennek PCN INT has evolved to meet the local context, and responded to the specifics of the health landscape, with strong bottom-up support for the leaders. The leadership empowers both clinical and non-clinical staff and is recognised as empowering collaboration and encouraging insights inclusively.

4.3.3 Relationships are the foundation

People were a major theme, with 456 coded references, and the key leaders 242 coded times. The Arbennek PCN INT was built on positive relationships particularly associated with the leaders of the INT. Yet success was not inevitable. An NHS manager observed:

> *"For them, geographically, and with regards to levels of deprivation, they've got challenges."*

Another senior manager observed

> *"I think people have struggled in the past to get relationships strong in that patch. And I think this has helped them."*

Yet despite these reservations, there were also positive features in the local healthcare environment. A PCN member commented on how professional networks support patients and regarded the INT as an extension of positive informal relationships:

"Any working together is beneficial. I feel there were some good relationships already, but this has enabled that to develop… There's INTs everywhere you know, functioning not just as formal groups with formal meetings, that's recognised as an INT, but everywhere people are working, linking in, professionals supporting each other… This is just like formalising them, I feel. And giving them opportunity to grow and develop and maybe have some resource."

Praise for Leaders:

The positive relationships of the INTs are largely associated with the personalities of the INT leaders. One participant commented on NAMES:

"Their links and their drive are what has really pushed this forward. Without them, we wouldn't have got anywhere. Without a doubt…. I'm really pleased, and really proud, with what they've done."

Having networks of positive support really helps to create the sense of hope, and this was largely built through the personalities and relationships of the Arbennek PCN INT leaders. One INT contributor put it this way:

"If you could roll it (INTs) out with NAME in every location, then you'd have success."

The personal relationships as well as the professional networking and connection building are intertwined but all contribute to the success of the Arbennek PCN INT.

4.5 Energy and Hope

Although morale was not an intended evaluation question, it was obvious to the interviewer how positively participants felt about the Arbennek PCN INT. The passion and zest that was communicated, even over Teams, was palpable, even if sometimes balanced with caution.

A sentiment analysis, performed by Nvivo, shows this numerically. 555 references are coded for positive sentiment, and 211 for negative. There are also 506 inductively coded references for aspirations for INTs, and 260 coded altruistic statements; there are 205 worries about INTs coded. These are spread evenly across themes. The positive energy which participants brought to the discussion was palpable in interviews. A GP Practice Manager commented:

"We want to support this kind of working, because I really believe… this integrated way of working is the only way forward that can save the NHS. For me, I firmly believe that. We've got to look at treating patients in a different way… This has been really exciting."

An NHS manager, who was not involved in day-to-day INT practice, observed:

"What I can see is that they have good relationships with internal and external partners. They have reached out and taken opportunities…. I don't know how they got there, whether they've always been like that, but what I saw is that they were, as a team, excited about the possibilities. "

Not Everyone is Convinced:

But some participants were unconverted. One who worked for a GP surgery described a situation that had occurred:

> *"There was one patient from my surgery. And the action point was – and I realise I'm sounding very negative here, I don't want to sound very negative – the action point was for a GP and a social prescriber to do a joint home visit. But the GP felt that everything was in place for the patient, so it wouldn't be a good use of time to go together. So, it didn't happen. Maybe the information that we had during the meeting was insufficient?"*

But others reported similar situations with more positive outcomes:

> *"When I was speaking to the district nurse, they said "I know that lady, so let's go and do a joint visit". And we sorted out half a dozen things in one visit that the patient would probably present the GP surgery with over a matter of weeks…. I think you get a lot more with your patients; it's not all medical, it's not all clinical, why patients present to GP reception half a dozen times."*

The sense of hope was a reoccurring theme in interviews. A VCSE stakeholder summed up their involvement in the INT:

> *"We started work with Arbennek PCN around Brave AI, because we can see huge potential for that, not only within the UK region, but also across the volunteering community sector as a whole."*

Overall, positive emotions such as energy, hope, and optimism associated with the INT process exceeded negative concerns by a ratio of 2:1 and were strongest among participants who were actively involved in the INT meetings.

5.0 Discussion

The work of the Arbennek PCN INT was highly rated by participants who described it with positive, hopeful emotions in the sentiment analysis. Attendance the meetings is high with the numbers of participants in the meetings is increasing rapidly. It has raised expectations, energy, and engagement. Brave AI was seen as helpful in formulating the vision and measuring the results of the INT work, but the leadership and the personal relationships of the key people was more important.

Pressures:

Managing large meetings and co-ordinating the INT, especially given the role of providing healthcare to the most vulnerable patients, is a huge responsibility. The size of the meetings and multi-faceted attendance requires focus and interpersonal skills.

Leveraging the opportunities presented to create INTs is partly about local context. The top-down NHS leadership has provided an array of supportive initiatives, such as the provision of Brave AI, conferences, commissioning and planning. Initiatives are already underway to support INT working and improve communications and understandings about AI use in the NHS. But study participants who work on the front line and attend INT meetings are confused about NHS provision above the level of GP practice. The definitions of wider NHS infrastructure, even the definitions of an INT, are unclear, as are MDTs and PCNs. Learning by doing, using Brave AI and attending INTs, was helpful but left gaps. The Arbennek PCN INT has largely operated on a bottom-up basis, by working with relationships and local networks to create connections and shared vision. The local context is therefore important to front line workers who participate in INTs.

5. 1 The key features of Tuckman's stages of group development are clearly apparent

In this review different aspects of the INT are at different stages of the theory, and yet all the stages (Forming, Storming, Norming, Performing, and some Adjourning) were present. The INT as a whole is still largely in the "Forming" stage. This is associated with excitement, anticipation, and anxiety. These emotions are clearly apparent in this early process review. There were also evidence of "Storming" and "Norming" in the form of conflicts, concern over roles, turbulence, fluidity, and developing relationships as challenges are successfully resolved. The Performing and Adjourning stages are still in embryonic form, with some evidence of the INT learning to leverage each other's strengths. This this is already well established within the leadership team, who display high-trust relationships with clear confidence in each other's abilities and real unity.

Application of Theory:

By understanding the INT in relation to these team development stages, it is hoped that this framework for team dynamics will help shed light on current challenges, anticipate future problems, and proactively plan for a flexible, adaptable way forward. It is possible that the Arbennek PCN INT will not follow the Tuckman's sequences; perhaps they will experience limited conflict, or the cultural differences in the specific situation will reduce these navigational challenges. Nevertheless, awareness of potential areas for team development, both positive and potentially negative, may help guide reflection and thereby assist management.

Disseminating the results of this evaluation in the context of Tuckman's stages is likely to assist

leaders. Indeed, a systematic approach to understanding the real-world Arbennek PCN INT initiative will help with positive team dynamics. It is hoped that the leadership of Arbennek PCN INT can use this report to help with creating presentations and writing thought-pieces to discuss their work with other INTs, and ICA and ICB leaders can use this evaluation to help them plan INT development across the UK. The example of a successful INT, evaluated within a well-established theoretical framework, will help with formulating and promulgating the learning points. This real-life, grounded and worked through example of how the team approach to health results in practical gains for real world populations.

5.2 Top-down approaches to Tuckman's team development stages are sparsely reflected in this data.

Examples of organisations that predominantly use top-down management are organisations such as General Electric (a former American multinational conglomerate) and Martha Stewart Living Omnimedia Inc. (an American diversified media and merchandising company). These have been studied by management theorists to see how top-down management effects team development stages in other real-life contexts. Top-down approaches to formation would typically be with leadership setting goals, roles, and expectations, but these features were light-touch in Arbennek PCN INT. In relation to Storming and Norming, top down is associated with leadership managing conflict and guiding through challenges using intervention and standards for behaviour, but the discussions undertaken to inform this report reflect a more flexible and nebulous approach towards these stages. Similarly, top-down leadership is focussed on Performing and Adjourning using interventions such as having a focus on performance and improvement targets; in this data, there was some discussion about the lack of this.

5.3 Bottom-up approaches to Tuckman's team development stages are abundantly apparent in this data.

In management literature, bottom-up approaches to team management have been previously linked with organisations such as Google (an American multinational corporation and technology company focusing on online content) and the Whole Foods Market (an American multinational supermarket chain). Bottom-up formation of teams is associated with collaboration and participation, which are strong themes in this evaluation. In relation to Storming and Norming, collective addressing of conflicts using open communication and consensus building are also well evidenced in this study. Performance and adjourning using bottom-up approaches such as autonomy, continuous feedback, reflection and valuing insights from a wide range of team members is also evident.

The local context, bottom-up organisation, and strong relationships that have generated the Arbennek INT are both a strength of this particular network and also mean that it is not replicable elsewhere in the same form.

5.4 Strengths and Limitations of this evaluation

This is a process evaluation of a new NHS team. It is a small-scale study of a specific situation, from which learning points can be drawn to support other INTs who may be involved in technology innovations such as using Brave AI. Whilst the use of a single case study means that not all the observations made will be applicable in other settings, there is a high likelihood that these findings will be generalisable. Indeed, by deliberately choosing a case study with atypically

positive attitudes towards AI and Brave in healthcare, the negative features identified in this evaluation are likely to be widespread in other contexts.

In terms of strengths, this study provides frequency counts to demonstrate the extent of inductive themes in the interviews. Nevertheless, qualitative data is not well suited to determining the prevalence of a phenomenon through thematic analysis, and a different interviewer, on a different day, with a different set of priorities might have generated different findings.

Inductive coding has been used with a single coder assessing all data, which has implications for subjectivity and interpretative role, but the use of auto-coding to apply the same principles across the whole data set has improved consistency and rigour; likewise, the use of AI summaries for codes, themes and interviews has improved the standardisation of the analysis.

This is an evidenced, data-driven study of a new and complex phenomena in a context where there are few worked examples and case studies available explore the potential. The insights, nuance, and foregrounding of participant voice enable an authentic, contextual and rich understanding which is especially useful when studying new situations - such as this response to the creative potential of Brave AI to inform and support primary healthcare, specifically looking at the initiation, operation, and leadership of INTs.

6.0 Recommendations

6.1 Actionable Steps

A range of actionable actions arise from this evaluation of Arbennek PCN INT:

6.1.2 Sustainability

The INT helps care for patients who have been identified as being at high risk. The large meetings have strong leadership based on personal relationships. Leaders are highly regarded and supported top down and bottom up. Nonetheless, reinforcing the support for leaders (e.g., by providing away days to focus on leadership) and providing additional strength for the team (especially through the development and coaching of meso-level clinicians) is needed. The INT is transferring from the Forming stage through Storming to Norming, and this may be a fragile transition.

6.1.2 Translatability

Clearly the Arbennek PCN INT cannot be duplicated. It was created in a local context, due to personalities and relationships. The bottom-up leadership has been a strength of the network Instead of trying to re-create this example with other INTs, the learning points need to be fully captured. INTs are rooted in an area and the professional landscape for health and social care of the locality impacts the nature of the team. INTs should be formed with sensitivity to local contexts. Bottom up, localised INTs will look different in different places and should not be standardised.

6.1.3 Communication

A stronger communications strategy should be developed, which clarifies how INTs integrate into existing NHS structures. Clearer understandings of the roles and relationships between organisations across the ICA will enable INT meetings to be better focussed on the purposes of the INT. This will also enable participants to identify better whether they need to attend INT meetings. However, communication needs to respect the strengths of the bottom-up evolution of the Arbennek PCN INT. It is a local network responding to local challenges. This has been an important success strategy for Arbennek PCN, and the energy and hope generated by this project could be crushed by a top-down management strategy.

7.0 Conclusion

7.1 Summary

Implementing new technology, in this case Brave AI, into primary health and community care, is challenging. Arbennek PCN have created a groundbreaking and innovative INT that uses the results of this technology to create practical improvements in people's lives. The hope and energy are inspiring, as is the bottom-up creative nature of the team.

Forming, Storming and Norming are all occurring with strong leadership emerging from within the team. Brave AI is helpful in creating shared vision, but there is still considerable confusion over what the nature of an INT is and how it fits into the bigger picture of NHS provision. This exciting, disruptive innovation has transformatory potential.

7.2 Final Thoughts

A bottom-up creative initiative that has generated such positive emotions requires nurturing and encouraging. This case study demonstrates huge potential for positive impact.

Marmerchant, 2023, Bottom-up leadership strategy (accessed 11/2/25) Bottom-up Leadership Strategy: A Comprehensive Overview

Marmerchant, 2023, The Top-Down Leadership Strategy (accessed 11/2/25) The Top-Down Leadership Strategy: A Comprehensive Overview

Simplilearn, 2024, Difference between top down and bottom up model explained (accessed 11/2/25) Difference Between Top-Down and Bottom-Up Model Explained

The Upwork Team, 2024, The 5 stages of Team Development (accessed 11/2/25) The 5 Stages of Team Development, With Examples - Upwork

Appendices

- **Appendix A**: Profile of the GP practices within the Primary Care Network
- **Appendix B:** Stakeholder Mapping Exercise (redacted)
- **Appendix C**: Interview Guide (redacted)
- **Appendix D**: Ethics and Governance (redacted)
- **Appendix E**: Informed Consent Form for Participants (redacted)
- **Appendix F:** Summaries of interviews (redacted)

APPENDIX A:

Profile of the GP practices within the Primary Care Network

Appendix A

Profiles: The GP practices in Arbennek PCN

All of the practices in Arbennek PCN are dispensing practices which increases a patients' access to community pharmacy services as well as bringing in extra income for the practices. Three of the four practices also have branch surgeries operating in villages where otherwise patients would have to travel to access primary care. As well as GPs and nursing staff, the PCN provides access to social prescribers, physiotherapists, mental health practitioners and, at Probus, specialist Veteran services.

Brannel Surgery

https://www.brannelsurgery.co.uk/

Brannel surgery is a dispensing practice, rated good by CQC. It has boundaries that cover the rural villages to the north of St Austell with good transport links. The staff consists of 3 GP partners, 1 Advanced Clinical Practitioner, 4 nurses, 3 HCAs, 4 dispensers, social prescriber, mental health practitioner, first contact physio and a paramedic shared across PCN.

The Clays Practice

https://www.theclayspractice.co.uk/index.aspx

The Clays is a dispensing practice rated "requires improvement" by CQC in the "safe", "effective" and "well led" domains. The boundaries cover the villages to the north of St Austell with a branch surgery in St Dennis. This area is called Clays country – reflecting the area of Cornwall known for clay mining up until the late 80's. Many of the older patients will have worked in that industry and lost their jobs when the industry began to close down. The staff consists of 8 GP partners, 1 advanced clinical practitioner, 5 nurses, 1 paramedic, plus share of a PCN employed paramedic, 5 HCAs, practice management team of 6 and 3 secretaries.

Probus Surgery

https://www.probussurgery.co.uk/

Probus surgery is a dispensing practice, CQC rated good, with a main site at Probus near Truro and with branches at Tregony (on Roseland Peninsula), Summercourt and Hewas Water. The practice boundary covers villages to the west and northwest of St Austell down to the Roseland Peninsula. It offers specialist day case surgery under local anaesthetic and is a training practice and have been involved in research, as well as a veteran accredited GP surgery. The staff consists of 8 GPs, 5 nurses, 4 HCAs, 2 social prescribers and a mental health practitioner, 3 pharmacists, 5 members of the on-call team, management team with a practice manager and a business and strategic partner, 4 medical secretaries, 8 receptionists, 4 administrators, IT and estates lead and a finance lead. It also has a secondary care team with a care co-ordinator, social prescriber, physiotherapist, 4 pharmacists and veterans' social prescriber.

Roseland Group Practice
https://www.roselandsurgeries.co.uk

The Roseland is a group practice consisting of three main sites in Portscatho, Tregony and St Mawes and covering the whole of the Roseland Heritage Coast/Roseland Peninsula which is to the southeast of Truro. It is a dispensing practice rated good by CQC, as well as a training practice and has been involved in research. The staff consists of 4 GP partners and 3 regular locums, 1 nurse, 1 HCA, dispensing team, 1 practice manager plus assistant and trainee, 1 secretary and 1 administrator, 9 receptionist staff and physiotherapist.

APPENDIX B:

Stakeholder Mapping Exercise (redacted)

Appendix B:

Stakeholder Mapping Exercise

Focus Groups:

Two sessions will be held open to all involved in the Integrated Neighbourhood Team.
Aim: Gather diverse insights and feedback.

Interview Selection:

Based on involvement and engagement.
Prioritise those with high scores for detailed insights.

Scoring Template:

- List of potential interviewees
- Score involvement (1-5) and engagement (1-5)
- Add scores for a total
- Rank by total score
- Select the top ten to invite for interview

Participants are prioritised (according to their strategic involvement and engagement) but also self-select.

Example Matrix:

Stakeholder Group	Role	Strategic Involvement (1-5)	Engagement (1-5)	Total Score (10)
Project Managers	Oversee the entire initiative	5	5	10
IT Managers	Implement and manage systems	5	5	10
Change Management Specialists	Manage transition and support staff	5	4	9
Doctors	Impacted by clinical workflow changes	4	4	8
Nurses	Affected by new digital systems	4	4	8
System Administrators	Maintain and support systems	3	3	6
Administrative Personnel	Experience changes in processes	2	3	5
Software Developers	Develop and customize tools	2	2	4

Redacted Matrix:

Scoring Criteria:

Involvement: 1 (Minimal) to 5 (High)
Engagement: 1 (Minimal) to 5 (High)

Included Stakeholders:

- **High:** Project Managers, IT Managers, Change Specialists
- **Moderate:** Doctors, Nurses, System Admins
- **Low but Important:** Admin Staff, Developers

Excluded Stakeholders:

- **Patients & Families:** Focus on internal processes
- **Non-Operational Staff:** Less impacted roles

Ensuring Equal Representation: We aim to include a diverse range of roles within the NHS to capture a comprehensive understanding of the digital transformation's impact. Efforts will be made to ensure a balanced representation of male and female staff, as well as participants from different ethnic backgrounds. Special attention will be given to include staff from underrepresented groups to ensure their voices are heard and their experiences are considered in the evaluation.

Addressing Bias: Researchers conducting interviews and focus groups have received training on unconscious bias and cultural competence to ensure that all participants are treated with respect and their contributions are valued equally. Data will be anonymised on publication to ensure the focus is on the content of the responses rather than the identities of the participants.

Ethical Considerations: All participants will be fully informed about the purpose of the study, their rights, and how their data will be used. Consent will be obtained in a manner that respects their autonomy and dignity. Measures will be in place to protect the confidentiality of all participants, ensuring that their identities are not disclosed without their explicit consent.

APPENDIX C:

Interview Guide (redacted)

Appendix C

Interview Guide: Arbennek PCN INT Evaluation

Welcome, identification, purpose of meeting, time frame (45 mins), recording and transcription, data analysis and dissemination plans.

Informed consent

Have you received the Informed Consent information, and do you agree?

Main interview

Context: What was your role in the INT? What did you understand the purpose of the INT was? How do you perceive it now?

Convening the team: Forming: How did you perceive the initial formation of the team? What were your expectations? What have you learned from this process? Storming: "What challenges and conflicts arose during the early stages? How were they addressed? What key lessons emerged?" Norming: "How did the team establish norms and roles? What strategies facilitated cohesion? What insights can be applied to future projects?"

Operation: Performing: "How would you assess the team's effectiveness? What contributed to high performance? What are the key takeaways?" Adjourning: Do you have any observations around the end of a mini project? If you are planning to move on, what learning points will you take with you from your involvement in this INT?

Leadership: Who emerged as leaders through the INT process? How were leaders supported during this process? What top-down directives helped your team with vision, mission or methodology? What top-down directives hindered your team and in what way? What is the bottom-up factors involved in getting to know local staff and being grounded in a region that were helpful to you as an INT? What difficulties were encountered as a result of your being removed from other leadership or management?

Triangulation

Are there any documents about this process that would be helpful for me to read and reference in my evaluation report?

Conclusion

Thank you and goodbye. Any further questions or observations, email me.

APPENDIX D:

Ethics and Governance (redacted)

Appendix D

Ethics and Governance Analysis

The primary objective of this evaluation is to analyse the process of creation and operation of Integrated Neighbourhood Team (INT) in the context of Arbennek PCN Primary Care Network. It is a case study from which learning points will be drawn to identify how to structure and deliver digital transformation initiatives in the NHS.

As a service evaluation, no formal ethical permission requirements have been identified. However, this protocol has been reviewed by NAME, POSITION and was formally adopted on 10.12.2024.

Participants

The evaluation will involve stakeholders, including:

- NHS staff with involvement in INTs (doctors, nurses, administrative personnel)
- Project leaders
- IT professionals involved in the digital transformation

Data Collection Methods

Data will be collected through:

- **Interviews** conducted via Microsoft Teams
- **Focus groups** conducted via Microsoft Teams
  Transcriptions of these sessions (by Microsoft Teams) for detailed analysis
- **Potential Risks**
  Potential risks to participants include:
  - Privacy and confidentiality breaches
  - Psychological stress or discomfort during interviews or focus groups.
  - Misuse of sensitive data
- **Risk Mitigation Strategies**
  To mitigate these risks, the following measures will be implemented:
  - Obtaining informed consent from all participants
  - Ensuring data anonymisation and secure storage
  - Providing participants with the option to withdraw at any time without penalty
  - Signposting to support services for participants experiencing stress or discomfort if requested

Confidentiality and Privacy

The confidentiality and privacy of participants will be safeguarded by:

- Using unique identifiers or pseudonyms instead of personal information
- Storing data in encrypted and secure databases
- Limiting access to data to authorised personnel only
- The use of ethical walls within the project team
- Teams' sessions are anticipated to be conducted in secure, private settings

Data Storage and IT Aspects

Data will be securely stored and managed using the following IT solutions:

- **Microsoft OneDrive**: All interview and focus group recordings, as well as transcriptions, will be stored in encrypted folders on OneDrive. Access will be restricted to authorised personnel only.
- **Microsoft Teams**: Interviews and focus groups will be conducted via Teams, ensuring secure and private communication channels. Recordings will be automatically saved to OneDrive.
- **Data Encryption**: All data stored on OneDrive will be encrypted both in transit and at rest to ensure maximum security.
- **Access Control**: Access control measures will be implemented, with permission for non-anonymised data access granted only to team members involved in the evaluation.
- **Data Backup**: Regular backups will be performed to prevent data loss, with backup copies stored in secure, encrypted locations.

Potential Challenges with IT Tools

While using IT tools like Microsoft Teams and OneDrive, the following challenges may arise:

- **Technical Issues**: Connectivity problems, software glitches, or hardware failures could disrupt interviews and focus groups.
- **Data Security**: Despite encryption, there is always a risk of data breaches or unauthorised access.
- **User Proficiency**: Participants may have varying levels of comfort and proficiency with IT tools, potentially affecting the quality of data collected.
- **Compliance with Policies:** Ensuring that all data handling practices comply with NHS and legal data protection policies can be complex.

  To address these challenges, the following strategies will be employed:

  - Consultations with FCC IT staff as needed
  - Implementing robust security protocols and regular audits
  - Offering alternative data collection methods if technical issues persist
  - Ensuring continuous compliance with data protection regulations

Data Integrity Measures

To ensure data integrity, the following measures will be implemented:

- **Data Validation**: Regular checks will be conducted to ensure data accuracy and completeness. This includes verifying transcriptions against original recordings.
- **Audit Trails**: Maintaining detailed logs of data access and modifications to track any changes and ensure accountability.
- **Consistent Data Entry**: Standardised procedures for data entry and coding will be established to minimise errors and inconsistencies.
- **Regular Reviews**: Periodic reviews of data collection and storage processes to identify and rectify any issues promptly.

- **Secure Data Transfer**: Using secure methods for data transfer to prevent unauthorised access or tampering during transmission.

Data Analysis Methods

The data analysis will be conducted using inductive qualitative analysis, with the following approach:

- **Primary Researcher**: The primary researcher will conduct the majority of the data analysis, ensuring a consistent and thorough examination of the data.
- **Project Management Team**: The project management team will contribute to the analysis, providing additional perspectives and insights.
- **Ethical Walls**: Ethical walls will be established to prevent feedback loops and ensure unbiased analysis. This involves separating the roles and responsibilities of team members to maintain objectivity and integrity in the analysis process.

Ethics of Dissemination

The dissemination of findings will be conducted ethically, with careful consideration of the following aspects:

- **Anonymised Quotes**: Anonymised quotes from participants will be used to illustrate key findings while protecting their identities. This involves removing any identifying information and using pseudonyms where necessary.
- **Transparency**: Participants will be informed about how their data will be used and how findings will be disseminated. This includes providing clear information during the consent process.
- **Respect for Participants**: The dissemination process will respect the dignity and contributions of participants, ensuring that their views are represented accurately and respectfully.
- **Purpose of Dissemination**: The primary aim of disseminating findings is to identify problems and learning points that can benefit the wider NHS. This includes sharing best practices, challenges, and recommendations for future digital transformation initiatives.

Sharing Findings with Participants

The findings of the evaluation will be shared with participants through:

- A summary report distributed via email
- Providing access to detailed reports upon request
- Ensuring that all shared information is anonymised to protect participant identities

Ethical Approval

This proposal will be submitted to Arbennek PCN INT for review and approval before the commencement of the evaluation.

Conclusion

This ethics proposal ensures that the evaluation will be conducted with high ethical standards, prioritising the well-being and rights of all participants.

APPENDIX E:

Informed Consent Form for Participants (redacted)

Appendix E

Informed Consent Form for Participants

You are invited to participate in a research study into the creation and operation of INTs within the context of Arbennek PCN PCN. This evaluation will be conducted for Future Care Capital and conducted by Dr Melanie Fraser, the primary researcher, with a project team that includes NHS staff.

The purpose of this study is to evaluate the implementation and operation of INTs as part of the NHS Digital transformation initiative, focusing on team development and capturing learning points for dissemination. The intention is to identify problems and learning points that can benefit the wider NHS. Your participation will help us understand the impact of the digital transformation on healthcare delivery and operational processes.

Procedures

If you agree to participate in this study, you will be asked to:

- Participate in an interview conducted via Microsoft Teams. OR.
- Join focus groups conducted via Microsoft Teams.
- Allow the sessions to be recorded and transcribed for detailed analysis.

Duration

The interview and focus group sessions will each last approximately 45 minutes.

Risks and Discomforts

There are minimal risks associated with participating in this study. However, you may experience some discomfort when discussing certain topics. You are free to skip any questions or withdraw from the study at any time without penalty.

Benefits

While there are no direct benefits to you for participating, your input will contribute to improving NHS services and the implementation of future digital transformation initiatives.

Confidentiality

Your privacy and confidentiality will be protected throughout the study. Data will be anonymised, and unique identifiers or pseudonyms will be used instead of personal information. All data will be stored securely on encrypted folders, and access to non-anonymised data will be restricted to authorised personnel only.

Data Usage

The data collected during this study will be used for the following purposes:

- **Analysis**: To understand the creation and operation of INTs and the impact of the NHS Digital Transformation Initiative.
- **Reporting**: To create summary reports, detailed findings, and recommendations for the wider NHS.

- **Dissemination**: Anonymised data, including quotes, may be used in publications, presentations, and reports to illustrate key findings and learning points.
- **Future Research**: Anonymised data may be retained for future research related to digital transformation in healthcare.

Data Sharing

The findings of this study will be shared with participants through summary reports, virtual meetings, and detailed reports upon request. Anonymised quotes may be used in the dissemination of findings to illustrate key points.

Voluntary Participation

Your participation in this study is entirely voluntary. You may withdraw at any time without any consequences. If you decide to withdraw, any data collected from you will be destroyed.

Contact Information

If you have any questions or concerns about this study, please contact:
Dr Melanie Fraser, Primary Researcher: melanie@futurecarecapital.org.uk
NAME, EMAIL

Consent

By participating in this study, you acknowledge that you have read and understood the information provided above, and you agree to participate.

APPENDIX F:

Summaries of interviews (redacted)

Appendix F

Interviews Summary

Redacted and Anonymised.

PARTICIPANT explains their role focusing on integrated care systems and addressing challenges related to relationship building across various integrated neighbourhood teams (INTs). He mentions existing initiatives on integrated neighbourhood teams (INTs) emphasizing the importance of building relationships among teams to work collaboratively rather than in silos. Two approaches to INTs are highlighted: most teams focus on relationship-building through workshops, while Arbennek PCN utilizes brave AI to identify at-risk patients and form supportive teams around them to prevent hospital admissions. PARTICIPANT stresses the need for both solid relationships and data-driven tools like brave AI to enhance patient care. He acknowledges that Arbennek PCN's distinct approach has provided valuable perspectives. He also reflects on the varying degrees of relationship building across teams, noting the strengths and weaknesses of each method, and expresses hope that, over the next year, both aspects of INT development will be achieved for improved patient outcomes. He describes the differing approaches between teams, with some prioritizing relationships and others focusing on using data from Brave AI to manage patient cohorts and prevent hospital admissions. PARTICIPANT highlights the significant support and enthusiasm generated around use of Brave AI but notes concern about narrower community engagement. He emphasizes the need for both relationship-building and data-led approaches to succeed. He discusses the importance of constructive top-down support and the necessity of restructuring workdays to enhance team collaboration. Finally, PARTICIPANT wishes for Arbennek PCN to maintain its forward momentum while being open to learning from other teams, aiming for a balanced approach in improving integrated care services.

(ICA Stakeholder)

PARTICIPANT discussed the use of the BRAVE AI system and its deployment strategy, outlining the development of INTs. Efforts are being made to improve the relationships between community nurses and GP practices, which had deteriorated due to geographical challenges and limited communication. Workshops were introduced to foster collaboration, particularly in a region where geography complicated the teamwork. An integrated neighborhood team structure is being developed, comprising representatives from primary care, social care, the voluntary sector, and community services. This aims to enhance cooperation and streamline services. A facilitator role will be established within each team to maintain momentum and support inter-professional relationships beyond workshops. The initiative has already resulted in daily and weekly collaborative meetings among healthcare professionals. Going forward, a blueprint highlighting key focus areas for the integrated neighbourhood teams has been created, including refining workflows and leadership dynamics. Importantly, the Integrated Care Board plans to invest into these teams indicating strong commitment to the initiative's success. They note significant progress made in various primary care networks (PCNs), including achieving a cohesive team approach and improving relationships among community nurses and GPs. They mentioned that additional funding would be allocated to INTs to continue supporting collaborative efforts, highlighting the importance of efficient operations.

They aim to facilitate interactions between different healthcare roles, encouraging an integrated approach rather than solely focusing on patient care. PARTICIPANT also remarked on the need for strong leadership within the INTs and expressed optimism about the confidence gained by teams over the past year.

(ICA Stakeholder)

PARTICIPANT provided insights into his role and understanding of INTs, describing them as collaborative teams focused on patient-centred care involving various stakeholders. They emphasize a collaborative approach through integrated network teams (INT), akin to a multidisciplinary team (MDT), involving all stakeholders to holistically address patient needs. The discussion centres on understanding barriers and facilitators to improve patient care, especially in cases like Brave AI. They discussed the structured approach to forming the INT, emphasizing good communication and equal participation among team members to ensure all voices are heard. Challenges identified included scheduling conflicts, and the intensive time commitment required from participants. PARTICIPANT noted the importance of documenting outcomes from these meetings for transparency and tracking patient progress. Overall, the conversation highlighted the positive aspects of INTs in breaking down silos within healthcare, though there were concerns about ensuring adequate resources and managing workload as more patients are monitored. They concluded that the collaborative approach could lead to better health outcomes for individuals in Cornwall. They discussed challenges such as scheduling conflicts and time-intensive commitments for participants, noting that despite these challenges, the INTs allow for thorough assessments of patients. PARTICIPANT highlighted the importance of horizontal leadership in INTs, where every participant's voice is valued, contrasting it with the hierarchical structure often found in hospitals. They reviewed the structured yet informal nature of INT meetings and the emphasis on open communication. PARTICIPANT reflected on the benefits of bringing together diverse professionals to address patient needs, underscoring that bottom-up insights can inform care without hindering progress. Both participants acknowledged the need for effective leadership and well-defined objectives for the success of INTs, as this ensures that all members understand their purpose in enhancing patient care. They concluded with a commitment to ongoing monitoring and evaluation of the INTs' effectiveness.

(Local Authority Stakeholder)

PARTICIPANT introduces their professional roles and discusses the challenges faced, such as the limited access to patient information and inadequate initial contacts with patients. They feel that social prescribers might not be the best suited for initiating contact due to their lack of comprehensive patient backgrounds. Discussions around optimizing meeting efficiency and team roles highlight the difficulty in managing patient lists and the need for clearer communication of responsibilities. PARTICIPANT describes a lack of evidence supporting positive impacts on patient services through their involvement, emphasizing the importance of proper information flow and team dynamics.

(PCN)

PARTICIPANT discusses the formation and operation of INTs, emphasizing the importance of collaboration among various healthcare professionals and the need for effective use of technology to improve patient care. PARTICIPANT highlights the challenges faced, such as geographical disparities and varying levels of deprivation among patient populations, as well as the need to recruit and retain competent staff. She notes that technology adoption has been slow due to mistrust, yet acknowledges the positive shifts initiated by the pandemic. The conversation touches on leadership dynamics within the team, the significance of engaging staff in decision-making processes, and the necessity for both top-down and bottom-up leadership approaches. Overall, PARTICIPANT provides insights on the team's effectiveness, culture, and the importance of ongoing evaluation and adaptation in healthcare practices.

(NHS Manager)

The conversation centres around an individual's experience and insights regarding healthcare initiatives and community support particularly emphasizing the role of AI in healthcare prevention and service delivery. They participated in a monthly meeting with case coordinators and representatives from various sectors to discuss clients at risk of emergency admissions. Covid facilitated partnerships among organizations, leading to informal entities that support communities. The Arbennek PCN model evolved organically, leveraging existing collaborations. Key challenges in the past, such as competitive tendering for contracts in health and social care, have been mitigated by a focus on outcomes rather than competition for funding. Meetings are described as respectful and productive, with a focus on individual cases and supporting one another, fostering a culture of inquiry and mutual assistance. The speaker discusses their work with a charity detailing collaborative projects aimed at aiding vulnerable populations, especially in the context of health and social care. Key points include the importance of a preventative approach to healthcare to reduce acute service demands, the establishment of effective collaborative frameworks among various organizations during and post-COVID, and the need for strong leadership to balance top-down and bottom-up strategies. The speaker highlights challenges such as resource allocation, maintaining effective communication, and managing diverse expectations across organizations. They also stress how crucial it is for leaders to stay connected with outcomes to ensure that initiatives remain focused on individual and community needs. The conversation concludes with reflections on the necessity of embracing AI technologies like Brave AI to foster preventative strategies and improve overall health outcomes, emphasizing the importance of community ownership of health.

(VCSE Stakeholder)

PARTICIPANT details how INTs differ from traditional Multidisciplinary Teams (MDTs), highlighting the inclusion of community sector professionals in INTs, noting that he had not participated in such discussions before. He finds the topic interesting and believes he now has a better understanding than some senior colleagues. The abstraction of the concept of INTs has clarified since he joined the field. He explains that while MDTs primarily consist of clinical professionals, INTs incorporate a wider range of community members and organizations, indicating a broader approach to healthcare collaboration. The discussion covers the creation and operation of these teams, where PARTICIPANT outlines the importance of open communication and collaboration in nurturing team cohesion and high performance. The speaker emphasizes the importance of collaboration with their bank and positive experiences

with leaders. He emphasizes how effective leadership and respect for all participants, regardless of their professional background, contribute to the success of the INTs. Challenges include resistance to change among some team members. PARTICIPANT also discusses the focus on proactive community care over traditional medication approaches, noting the team's success in reducing hospital admissions among vulnerable patients.

(VCSE Stakeholder)

PARTICIPANT discussed the nuances of different healthcare teams, specifically comparing Integrated Neighbourhood Teams (INTs), Multi-Disciplinary Teams (MDTs), and Primary Care Networks (PCNs). He characterized MDTs as clinically focused and patient-specific, while he viewed INTs as operating at a higher strategic level, working more broadly on service issues rather than individual patient details. He suggested that feedback from MDTs on unmet needs should inform INTs to address systemic issues. The conversation then shifted to the role of Primary Care Networks (PCNs), with PARTICIPANT expressing confusion over their necessity alongside INTs, suggesting potential redundancy. He raised concerns about excessive operational layers, culminating in a complex hierarchy that complicates decision-making across multiple agencies. PARTICIPANT emphasized the challenges of reaching consensus among diverse stakeholders, which can lead to inertia in implementing changes. He concluded by highlighting the need for clarity about the purpose and structure of these various teams and how they relate to one another, expressing a desire for operational details. He believes understanding these dynamics will enhance the effectiveness of healthcare services moving forward. PARTICIPANT emphasized that while MDTs focus on specific patient care and clinical issues, INTs operate at a strategic level addressing systemic issues. He expressed concerns about the complexity of healthcare structures, finding the multiple layers (PCNs, MDTs, INTs, ICAs, and ICBs) potentially cumbersome and confusing, which complicates decision-making processes. PARTICIPANT is accountable to the PCN, though his role has grown alongside emerging structures. He noted how teamwork with non-clinical staff is vital for operations and expressed a desire for clearer delineation of roles and responsibilities within new setups like the INT. He acknowledged the support from colleagues and shared insights on the creation and operation of their teams, suggesting a need for simplification in the healthcare system to reduce capacity issues and enhance operational efficiency. Finally, they discussed ongoing evaluation and the importance of clarity in healthcare structures.

(PCN GP Manager)

PARTICIPANT reflects on initial meetings about community vanguard projects with their Primary Care Network (PCN), which began nearly a year ago. Initially, attendance was modest, with about 12-15 people involved, including social prescribers, district nurses, and voluntary sector representatives like Age UK. Participation has grown significantly, with around 35 attendees at the latest meeting, signalling increased engagement. The speaker's role involves collaborating with various professionals and using tools like 'brave' to identify patients, particularly those who often go unnoticed, such as those with frailty and comorbidities. The approach has led to improved understanding of patients' needs beyond clinical symptoms, encouraging joint visits and addressing multiple concerns in one outreach. The speaker expresses a strong appreciation for this collaborative, holistic way of working with patients, which aims to enhance care and communication. PARTICIPANT mentions challenges faced in changing work narratives and ensuring everyone is on board with new approaches. However,

PARTICIPANT reports a positive climate of support from management and clinical leaders. She also emphasizes the effectiveness of collaboration among diverse professionals, including social prescribers and voluntary sector representatives, which contributes to better patient care. Additionally, PARTICIPANT shares successes, such as reducing patient visits for wound care by addressing underlying health issues, boosting overall quality of life. For future sustainability, she suggests having a coordinator within the INT to streamline communication and patient management, ensuring that the initiative effectively meets patient needs. Overall, the dialogue highlights positive developments and areas for continued growth in integrated healthcare delivery.

(PCN Admin)

PARTICIPANT discusses their role in a project aimed at establishing integrated neighbourhood teams, highlighting that their personal vision was not initially communicated as the overarching strategy. They emphasize the need for clarity regarding this vision to better align team efforts. The importance of understanding "why" the project exists—supporting patients—emerges as a crucial factor driving collaborative work and trust among participants. The speaker notes visible improvements in patient care and teamwork dynamics, indicating that trust is being built through shared goals and ongoing discussions about patient outcomes. Key takeaways include the necessity of a common purpose to foster collaboration, the value of measurable goals to gauge performance, and the distinct needs of various patient cohorts, which inform their approach. The speaker expresses a commitment to executing next steps, including the establishment of a steering group for evaluating the Integrated Model Team (IMT) initiative. They assert that their leadership and vision are essential for the progress being made, pointing out that this development is largely driven by their initiative rather than external directives. The conversation revolves around the integration of collaborative practices within the NHS, focusing on collaborative working opportunities and the challenges faced in establishing Integrated Neighbourhood Teams (INTs). The speaker's express concerns about the immense political pressure to address current healthcare demands and highlight the positive energy surrounding the opportunities for collaboration. PARTICIPANT discusses the importance of a unified collaborative approach to patient care, emphasizing the need for a common purpose and trust among team members to create effective INTs. Importantly, there's a focus on how the implementation of tools like "Brave" aids patient identification, though the necessity for alternative methods is acknowledged if this tool fails. The dialogue delves into overcoming challenges such as change management, disparate practices, and varying levels of team engagement, advocating for a trust-building process alongside demonstrating tangible benefits of collaborative work. The interview concludes with reflections on leadership, the bottom-up approach to operationalizing the INT, and the ongoing ambiguity surrounding the integration model in the healthcare system, stressing the need for clarity and effective communication regarding roles and responsibilities. Overall, the emphasis is placed on leveraging the potential for innovative and effective patient support through collaborative efforts in healthcare settings.

(PCN Manager)

In a discussion on integrated neighbourhood teams (INTs) PARTICIPANT shared her experience in early meetings, emphasizing the nebulous nature of initial discussions surrounding the INT and the implementation of the BRAVE AI system, which structured those conversations and clarified roles. The speaker has participated in several meetings related to the PCN but feels that their surgery has had fewer patients involved. Initially, they found it challenging to grasp the purpose of the meetings since "Brave AI" had not yet been introduced, leading to discussions that felt unclear. Once "Brave AI" was launched, the meetings became more structured and focused. The meetings aim to bring together various professionals from the PCN and other sectors, fostering collaboration and improving connections, which PARTICIPANT views positively, even if articulating the experience is difficult. The meetings, while inclusive of varied professionals, sometimes led to challenges when discussing patients not directly relevant to attendees. PARTICIPANT noted that more focused meetings for specific surgeries could be beneficial but difficult to coordinate. She highlighted the positive impact of shared knowledge in addressing complex patient needs and fostering connections among professionals. They also identified the need for ongoing development and localization of services to ensure effective collaboration amidst differing local resources. PARTICIPANT emphasized the role of relationships built through these meetings as essential for future improvements in patient care and expressed hope for refining BRAVE AI's implementation through feedback and evaluation of the INTs. Overall, the discussion underscored the importance of adaptability and collaboration in enhancing healthcare delivery.

(PCN)

PARTICIPANT discusses her role focusing on integrating health services within Integrated Neighbourhood Teams (INTs). She emphasizes the purpose of INTs as a collaboration across various healthcare sectors—primary, secondary, and community—reflecting a shift from siloed practices to cohesive care delivery. PARTICIPANT describes the INT as a flexible network, highlighting its focus on person-centred care that adapts to individual needs. She critiques the traditional Multidisciplinary Team (MDT) structure, expressing that INTs should not replicate existing models but serve a broader, more dynamic purpose. Communication and collaboration are essential, as is fostering trust between team members. PARTICIPANT envisions INTs as evolving entities that can function independently of hierarchical leadership, encouraging a collegiate environment. Evaluation of INT effectiveness should be built from clear, desired outcomes, learning iteratively from experiences, and ensuring personnel foster psychological safety for open communication. The process has been organic, supported by leadership without becoming overly formalized. PARTICIPANT identified the importance of building relationships between different roles within healthcare, which have traditionally operated in silos. Clarifying the disconnect between various digital innovation efforts and the NHS's overarching strategies, emphasizes that integration and streamlined cooperation among healthcare professionals are vital. Key points include the need for strong relationships among team members to ensure efficient operations and to focus not just on individual patient treatment but also on systemic efficiencies. The dialogue reflects on the initial challenges of setting up these teams, fostering trust, and navigating the shifting dynamics of collaborative work. Discussions revolve around how to identify and wrap care around specific patient cohorts while ensuring the integration of services both at a local and system-wide level. She emphasizes innovation, flexibility, and the consensus that an integrated approach is essential for the future of healthcare delivery, ultimately aiming for improved care pathways for

patients. However, some challenges include varying levels of engagement from professionals, difficulties in achieving consistent attendance due to time constraints, and the necessity of having adequate leadership and direction in the teams. PARTICIPANT explores how the INTs, originally formed as a response to the need for better patient care and collaboration among various healthcare professionals, are evolving, the purpose of these teams is vehicles for collaboration among diverse healthcare providers to deliver comprehensive care to patients. She highlights how INTs differ from traditional Multi-Disciplinary Teams (MDTs) in their approach, emphasizing a networked rather than hierarchical structure. Challenges include defining what an INT is, gaining buy-in from sceptical colleagues, and addressing the complexity of integrating various care services. They also discuss the importance of leadership, data sharing, trust among team members, and the need for clear goals to measure the success of INTs. PARTICIPANT notes that fostering connections between primary and secondary care remains a struggle and expresses an optimistic view towards improving end-of-life care outside of hospital settings.

(PCN Manager)

Discussion centred around the process of forming and operating integrated neighbourhood teams, emphasizing the challenges of initial meetings that lacked actionable outcomes. PARTICIPANT highlighted the need for a shift in mindset among clinical staff towards adopting new roles and responsibilities in integrated care, advocating for empowering non-clinical roles like care coordinators and social prescribers. The speaker expresses a strong commitment to proactive practices that support an integrated approach to healthcare, particularly within the NHS, which is facing significant challenges. They emphasize the need for innovative working methods to address the crisis in primary care and advocate for changing how patients are treated. The speaker highlights the importance of social prescribing and moving away from traditional biomedicine and polypharmacy, as many patients return without proper treatment of underlying issues. Collaboration with like-minded colleagues has motivated them to push for these changes, as they believe the current model is unsustainable. The speaker wants to contribute to solutions rather than waiting for external help, and they have embraced a leadership role in promoting integrated healthcare practices, which they view as essential for the future. He shared positive developments from collaboration with various healthcare providers, noting improved communication and quicker patient care through a more integrated approach. PARTICIPANT expressed optimism about the potential of integrated working to enhance patient outcomes and sustainability in the healthcare system, emphasizing the importance of adapting to changing needs and breaking down bureaucratic barriers for effective teamwork. PARTICIPANT discusses the staffing shortages at the surgery, ongoing sickness, and the importance of passion in their work even during long days. PARTICIPANT emphases a proactive and innovative approach to healthcare, believing that integrated working is essential for saving the NHS from crisis. They discuss initial frustrations within team meetings and the need for clear outcomes, which improve as necessary stakeholders become involved. PARTICIPANT appreciates the progress made in collaboration and breaking down bureaucratic barriers, allowing for faster communication benefiting patient care. He highlights the importance of empowering team members to make decisions and the evolving roles within the INTs. Despite challenges, he expresses optimism about the project's future and its potential impact on patient care and job satisfaction within the healthcare sector.

(GP Practice Manager)

Future Care Capital

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About Us
Future Care Capital is a charity which undertakes research to advance ideas that will help shape future health and social care policy and deliver better outcomes for individuals living in the UK.

Beginning life as the National Nursery Examination Board in 1945, the charity has evolved throughout its 70-year history. For further information about us, see: www.futurecarecapital.org.uk

Further Information
For further details about us, our mission and values, the Board of Trustees and the Executive Team please visit our website or follow us on Twitter.

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