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77

Community first: a systems approach to implementing integrated care

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Abstract

Purpose – Integrating health and social care services is a longstanding aspiration in England, but the question remains as to how to achieve it. This article compares the implementation approaches and its enablers and barriers of a strengths-based intervention (community-led support, CLS) in two sites, one led by a health organisation, i.e. National Health Service (NHS) and the other by a social care organisation, i.e. local authority.
Design/methodology/approach – This study was part of a wider research project that examined the implementation of CLS within five areas in England. A qualitative research design was adopted, drawing on seventeen semi-structured interviews with managers and frontline staff leading the implementation of CLS across health, social care and voluntary sector organisations. Data was analysed inductively for each site before comparing emerging codes between the sites.
Findings – Supportive leadership structures at various levels, a shared vision, pre-existing relationships with other sectors and introducing champions were helpful factors to adopt CLS. However, staff anxieties towards creative ways of working, the lack of involvement of individuals with lived experience and the insufficient integration of processes and systems hindered embedding CLS across the whole system.

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Originality/value – Emphasis on a community oriented approach encourages local innovation based on the needs of a community. This study provides helpful insights into aspects supportive of implementation while highlighting unique challenges arising from integration.

Keywords Whole systems, Integrated care, Community-oriented approach, Strengths-based practice

Paper type Research article

Introduction

Over the past 2 decades, understanding of integrated care has progressed to include embedding it across wider health, social care and welfare systems, placing individuals and communities at the centre of the design and, recognising its contribution to addressing health and social inequalities (Ehrenberg *et al*., 2024; Farmanova *et al*., 2019; WHO, 2019). In England, the rationale for better integration reflects this direction of travel with the question for successive governments not being *should* care be integrated, but rather *how* should integrated care be implemented (Miller *et al*., 2021). The most recent 10-year plan for the National Health Service (NHS) reemphasised the importance of integration and continuing care, bridging the gap between hospital and, care in the community (DHSC, 2025). England has introduced a plethora of national and local implementation strategies across all levels of the health and social care system, including pilot programmes, funding incentives, legal duties, governance structures, and best practice models. These have had some traction but tend to be patchy across the country with considerable difficulty in scaling up and embedding new practices beyond initial innovation sites (Lewis *et al*., 2021). However, innovation continues to persist, as evidenced by the NHS 10-year plan to develop a "single, coordinated, patient-orientated service" that provides "continuous, accessible and integrated care" through the development of neighbourhood health services (DHSC, 2025).

Alongside achieving better care coordination and improving pathways between health and care professionals and services, it is hoped that integrated care can improve outcomes in population health, tackle inequalities in outcomes, and support broader social and economic development (NHSE, 2021b). As well as the ethical basis for tackling underpinning inequalities, it is also hoped that integrated approaches will result in lower demands on health and care services through populations being able to avoid or delay long-term conditions by maintaining better health and well-being (NHS Confederation, 2024). This builds on previous developments relating to prevention, which in social care has been articulated through the concept of "strengths-based practice" (SBP) in which individuals are encouraged to draw upon their personal resources and informal networks before accessing formal care services (Caiels *et al*., 2021). SBP emphasises that the starting point should be what matters to the individual rather than the professional, and that there needs to be good collaboration with, and development of the voluntary and community sector (VCS). Whilst it is labelled somewhat differently (e.g. asset based or recovery orientated), similar practices have been introduced within health care, for example through the national funding of social prescribing posts within Primary Care Networks (NHSE, 2020). Despite different labels, these concepts share both the underlying principles with integrated care and challenge of implementing complex interventions.

There are number of models that fall under the umbrella of SBP with community-led support (CLS) being one such approach. Unlike the other approaches, CLS has a different starting point as it adopts a systems-level implementation approach to transform health and social care service. Developed by an independent charity the National Development Team for Improvement (NDTi), CLS is described as a "journey" (Bown *et al*., 2020) that aims to redesign working of services rather than embedding a defined practice model. Although there are a set of core principles and elements that underpin and guide the implementation of the approach. Principles include developing a shared vision among all service partners (generally cutting across health, social care and voluntary services), building trust among partners, transparent sharing of relevant and timely information, minimal bureaucracy, ongoing

engagement and involvement of community participation and, delivering outcomes relevant to the community (Bown *et al*., 2017). Elements to support embedding these principles include setting up of community hubs (spaces within the community where service partners can offer services) where different conversations are had (strengths-focused conversations); devolved decision-making; local, community-based solutions; streamlined processes and development of leaders who can let go of power (Bown *et al*., 2020). To embed these, CLS involves working with communities and practitioners to understand their local system and identify the main opportunities to improve. The approach has always recognised the importance of collaborating with health professionals and agencies as part of reforming the system and integrated care has become more formally embedded within its guidance over time. CLS therefore provides an opportunity to study the implementation of integration across health and social care through a systems and community-oriented approach. Furthermore, as the approach can be led either by the NHS or a local authority, it is possible to compare how health and social care organisations undertake such implementation within these principles. In this article, we compare the implementation of CLS in two sites in the context of integration, one led by a health care organisation (NHS) and the other by a social care organisation, i.e. local authority. The article also examines the enablers and barriers that were encountered within their implementation approaches.

Methodology

Research aims and context

This study was part of a larger research project that examined the implementation of CLS within five local authority regions in England (Miller *et al*., 2024, 2025; Miller *et al*., 2024a, b). This article compares the implementation approach as well as the enablers and barriers for implementation in two sites who were trying to embed CLS in similar contexts in relation to their population demographics and socioeconomic environment (see Table 1). A key difference between these two sites was in relation to who was leading the implementation; site one was led by a health care organisation and site two, by a local authority.

Study design and data collection

The study employed a qualitative research design, drawing on semi-structured interviews with a number of practice partners. The overall research was guided by two stakeholder groups – a practice group comprising social care practitioners and a group of individuals with lived experience of health and/or social care. The practice group met once every year to provide feedback in relation to findings. The lived experience group met every two months and made a substantial contribution towards co-developing topic guides and interpreting findings.

The article draws on 17 semi-structured interviews with stakeholders from our two sites as well as with staff from NDTi (the national charity that developed CLS), who played an important role in supporting implementation. Interviews were conducted with the aim to capture personal experiences of those supporting or delivering CLS (Raworth *et al*., 2015) and included frontline staff, managers and implementation leads from health, social care and voluntary sector organisations (see Table 2 below). Participants were recruited via the implementation lead on the basis of inviting those who were directly involved in the CLS programme. These could include staff who offer leadership, services in community hubs or run voluntary organisations that supported CLS. Once identified, the research team confirmed that they met the inclusion criteria (as above) and were contacted via email to set up an interview. NDTi staff who were involved in supporting implementation in our two sites were also interviewed.

An interview schedule was prepared to ensure consistently and accuracy of the data collected (Bearman, 2019). Questions pertained to understanding change brought about by CLS in relation to culture, leadership and coproduction and processes associated with implementation. Interviews were held virtually and lasted for an average of one hour. They

Table 1. Implementation contexts of sites

Characteristics	Site 1 (health led)	Site 2 (social care led)
Local environment and population	Site 1 is classed as predominantly urban with a population close to 270,000. The majority of the population identify at White with the remaining 17.3% identifying with other ethnic groups	Site 2 is classed as predominantly urban with a population of nearly 260,000. Comparable to site 1, 84% of the population identify as White and the remaining as belonging to other ethnic communities
Implementation context	• CLS was first introduced in 2019 as part of the site's wellbeing strategy with the aim to make health services more strengths-based • Phased implementation approach with the initial focus on creating awareness, establishing a team to oversee implementation and setting up one innovation site	• CLS was first introduced as part of a wider transformation towards strengths-based practice in social care in 2020 • Phased implementation approach with an initial focus on creating awareness, establishing an innovation team to oversee implementation and setting up one innovation site
Community hubs (as of 2024) (key activity supportive of facilitating integrated care)	Four	Eighteen
Overall governance	Steering group comprising of senior leaders from health, social care and the voluntary sector	• Steering group comprising senior leaders from health, social care and the voluntary sector • Innovation team comprising of middle managers and frontline staff involved in day-to-day activities and administration of community hubs
Programme leadership	NHS leaders	Local authority leaders
Current and/or pre-existing links to integrated working	• Community nursing • Neighbourhood teams • Adult safeguarding boards • Integrated working within learning disability teams • Intermediate care provisions by social work team teams based in the local authority	• Community nursing • Neighbourhood teams • Adult safeguarding boards • Links with primary care networks: GPs, health clinics in community centres

were digitally recorded using a Dictaphone and a secondary backup device. They were transcribed verbatim by a professional transcriber, ensuring the removal of any identifiable information.

Data analysis

Using Braun and Clarke's thematic analysis approach (2006), all data were analysed using a coding framework as agreed upon by the research team. As part of the wider research project, a theory of change model was developed. This provided a helpful starting point to examine the data from both sites. The development of the coding framework was an interactive process, involving an inductive analysis of the data from both sites individually before comparing their individual codes. To arrive at the agreed coding framework, several workshops with the research team were held to particularly examine approaches, implementation processes and

Table 2. Participants profile for each site

Organisation	Job titles	Site 1 (health-led site)	Site 2 (social care-led site)	NDTi (organisation developing CLS)
Health care	Managers	2	2	
	Frontline staff	1	1	
Social care	Managers	2	1	
	Frontline staff		2	
Voluntary sector	Managers		2	
Total		5	8	4

challenges emerging from our sites. Comparisons were made to locate similarities as well as unique features in each site.

Ethics

Ethical approval for this research was granted by King's College London, approval number LRS/DP-21/22-28401. Informed written consent was obtained from all participants prior to undertaking interviews.

Results

This section outlines key themes that emerged from the interviews. The implementation approaches as well as the enablers and barriers to implementation are organised under three themes – implementation activities, community engagement during implementation, collaborative structures and dynamics.

Participants profile

Implementation activities

The health-led site and social care-led site perceived the implementation of CLS as an opportunity to bridge the gap between services by being a catalyst for culture change to more collaborative and community-based working. There was recognition, though, that culture was an ongoing process that CLS alone cannot be able to achieve but help steer organisations in that direction. To support this culture change and embed CLS, both sites initiated a common set of activities such as training for staff, restructuring the service offer and directing existing and new resources to support implementation.

The legal basis for adopting CLS in the social care led site provided a helpful platform to embed CLS. The underpinning social care legislation in England, the Care Act 2014's emphasis on strengths-based working meant that the local authority was strategically and operationally aligned to undertake the implementation of CLS through leadership support, somewhat supportive processes and systems and drive it through existing connections with service partners. It created a shared vision for CLS, with partners perceiving it as an opportunity to strengthen pre-existing relationships and further their work of leveraging community assets as service solutions. In contrast, the overall system context for the health-led site appeared more medically orientated, taking a more prescriptive approach, which did not always align with CLS. In essence, health professionals were more likely to focus on the physical or mental health difficulty without always considering other aspects of an individual's life. This meant CLS challenged their existing practice, requiring unlearning and re-learning their practice.

The overall implementation approach was similar in both sites. It involved taking an incremental approach to introducing CLS features, particularly through setting up one innovation site (community hubs) before rolling out into other areas. Whilst the incremental approach was designed to facilitate learning and adapting, it appeared to be a pragmatic decision in both sites based on how to manage resources rather than with the intention to pilot and learn from them. However, in the social care site, although there were no formal evaluations, there were informal reflections in relation to the functioning of the innovation site and adapting these learnings within other community hubs. A key example was in relation to the increased participation and involvement of voluntary organisation in subsequent hubs. In this site, CLS was introduced alongside other strengths-based approaches that focused on having strengths-based conversations and improving their community connections. Previous community links developed as part of other initiatives were a helpful starting point to build CLS on. On the other hand, CLS was introduced as a standalone strengths-based initiative in the health-led site with some steer from already existing community connectors who had built connections in the community.

> So, when we were in [innovation site], we started off with 70% of our innovation team was statutory-led organisations and we were like, this is not how it was supposed to be, because its community led. We did a lot of work on how we can basically switch that. When we got to [other areas], we did a lot of preparation work prior to getting that message out to communities and getting them to understand. And in the end at, we had probably 70% of people were community and the rest were statutory, which was great (Site 2 implementation lead)

Training was a key element for embedding CLS. In the health-led site, these "new ways of working" often delineated from professionally orientated models of care, creating staff anxieties, especially for frontline staff who were expected to have strengths-focused conversations and be creative and autonomous in their service offer. CLS-specific training was made available to staff across services who were involved with implementation. Such focused training was reported as being particularly helpful in providing an overview of the approach, tools for embedding it in practice and for developing a common and shared understanding about the approach among partners. In addition to training, the health-led site initiated bespoke train-the-trainer workshops to help develop staff competencies and improve their confidence. This was combined with the development of CLS champions who were responsible for day-to-day activities and for providing advice and guidance to frontline staff. These posts were aligned with already existing community connectors, which proved particularly useful as champions were able to draw on their knowledge and networks in the community. In the social care-led site, we noted no additional training was made available to staff that was specific to CLS. The local authority relied on existing, wider strengths-based practice-related training offers that involved having different conversations and improving community connections. Whilst there may have been common ground between CLS-specific training and the broader strengths-based practice training, we noted these opportunities were not open to service partners like health staff, who appeared to struggle to align their work with CLS principles.

> We've got the community led support champions on each team. Them having some of those skills where they feel confidence to go and present and give advice to other people is very good. So, at our level, we've adopted that, and it works (Site 1 project quality officer)

To support CLS implementation, the health-led site initiated changes to their recording systems and paperwork to enable staff to have more strengths-based conversations. New forms that were introduced also encouraged staff to have different conversations and reduce the amount of time spent on administrative processes, thereby freeing up time for more contact time with people. In addition, this site also initiated minor reconfigurations within their service teams, including moving some teams into the community. Against the backdrop of implementing CLS alongside other strengths-based approaches, the social care site reported that existing systems and paperwork were largely supportive of delivering CLS. Similar to the

health-led site, there was considerable restructuring of teams, mainly relocating them into the community. This was done with the aim of offering quick and easy access to services as well as to encourage staff to better relate to the community.

Community hubs were an integral aspect of this restructuring and in embedding CLS. Both sites took a phased or incremental approach to setting up hubs and acknowledged that hubs needed to reflect local needs and preferences. In the health-led site, locating champions within each hub was reported as helpful peer support to deliver CLS and improve the confidence of staff who delivering services in these hubs. Hubs that were predominantly social care-based were more easily able to embed CLS, mainly due to their practice already being geared towards strengths-based working. However, other hubs, which were situated within integrated teams or community health teams, appeared less receptive to CLS. This was in part due to their set ways of working, often taking a more prescriptive approach. In the social care site, hubs were mainly situated within integrated teams and reported to offer a common set of services such as social work, occupational therapy, housing and other services that were situated under the primary care network, such as general practitioners, mental health services, etc. Service provision within the hubs evolved to reflect local needs but also had a strategic intention to integrate services.

> We thought about how that might be done. Well, where will they operate? Who will operate there? That wasn't something that was applied. We went into communities, I mean I remember our team was cycling around finding places. We spoke to communities, we asked them about their involvement, what they could do and what they wanted, what they didn't want (Site 1 implementation lead)

Community engagement during implementation

Both sites aspired to implement a whole-system approach that placed communities at the centre of CLS through better understanding, engagement and involvement of their communities in implementation. During the initial stages of implementation, the health-led site appeared to be better equipped to involve people with lived experience. A variety of initiatives, ranging from consultation events to co-designing parts of the service, were introduced as part of CLS. These included holding several meetings with local people to understand more about their area, needs and aspirations, gathering feedback on specific activities in relation to CLS, such as identifying appropriate locations to set up hubs, relevant services to be offered at the hubs and, then co-designing parts of the offer with individuals with lived experience (example reviewing direct payments policies or recognising, establishing and running bereavement groups). In engaging with various individuals, the health-led site was able to form an understanding of their community needs and mirror some of them by ensuring that these services were available in the hubs. In addition to being seen as a crucial activity, coproduction was also reported as the foundational principle for offering services within CLS with particular emphasis given to strengths-based interactions with individuals for recognising and developing their strengths and interests. However, these were not always sustained as it depended on an array of factors such as staff availability, resources in the community and individuals' motivation to coproduce.

> I would say to people, right then let's get together and let's make things happen together. Let's create that plan. Let's co-produce together. Now, I don't have the means [to] offer that to everyone, I'll admit but we try (Site 1 social work team manager)

Unlike the health-led site, there appeared to be a lack of clarity on what coproduction entailed in the social care-led site. This was not only reflected in the synonymous use of the term coproduction to describe collaboration with partners, but also in their activities that were limited to ad-hoc informal involvement of individuals with lived experience during initial implementation. CLS was largely professionally led, with professionals making decisions

regarding CLS, then having to make adjustments to services offered as well as in the logistics to offer these services to reflect local needs. These adjustments included retracting some services within hubs that were not relevant or changing operational days of hubs to prevent conflict or duplication of services. However, as hubs developed, it appeared that the social care-led site engaged in more groundwork, i.e. getting to know their community before embedding CLS.

> So I think that sort of is a good example of, like where them sat in an office with a map going, That's the right place, doesn't work. And that's not community led. And that's not co-production (Site 2 voluntary sector organisation manager)

Irrespective of the level of engagement sites had with their community, both sites reported a substantial degree of dependence on their partners to undertake coproduction on their behalf. Whilst coproduction alongside other activities was said to be the joint responsibility of all partners involved with CLS, the decision to outsource it appeared to be largely influenced by their lack of confidence and capacity rather than seeking to delegate influence to voluntary sector partners. In the health-led site, social care services appeared to take on most of the coproduction work, primarily due to their already established networks with the community. Even in this case, it tended to be patchy with no clear direction for coproduction.

> I think maybe focus on coproduction, [make it] a bit more emphasised. I feel like, even in our local authority, coproduction is not probably one of our strong points and it's about staying on this journey, bringing service-users on board and you get new ideas and experiences. You can't let the approach disappear. It needs to be thought about and present all the time (Site 1 implementation lead)

In the social care-led site, community engagement was predominantly undertaken by a few voluntary sector organisations that the local authority had a good relationship with, a few describing this as being "tokenistic". Such an approach was adopted due to concerns relating to a lack of trust and poor relationships with their citizens, oftentimes leading to a reliance on their partners for coproduction and to rebuild the image of the local authority. However, as CLS became more embedded, the social care-led site appeared to be better equipped to understand coproduction. This involved listening and taking more feedback through meetings and other engagement activities, being more present in the community and, developing relationships with voluntary sector organisations and giving them a more substantial role within CLS leadership. Nevertheless, by not having a coproduction strategy or a systematic approach to coproduction, both sites acknowledge that more development and reflection were necessary to embed coproduction in the integrated care context.

> Sometimes [local authority] they will post things such as, have your say on whatever it might be, and you'll see the comments and people say, Well what's the point? You won't listen to us anyway (Site 2 voluntary sector organisation manager)

Collaborative structures and dynamics

Central to embedding CLS across health and social care services was identifying and involving appropriate service partners that understood and believed in the vision that CLS could be used as a vehicle to achieve integration. As a starting point, both sites utilised existing networks to promote CLS and bring partners onboard. There were two particular aspects within CLS elements that the NHS and local authority adopted to integrate their working. One, setting up system-level leadership structures in the form of a steering group to help make key decisions regarding CLS implementation. Steering groups typically consisted of senior leaders from health, social care and the voluntary sector who were tasked with the responsibility of allocating resources, deciding the appropriate direction for implementation and, in, offering practical guidance and advice. Two, community hubs were seen as an important opportunity to enable integration. Working alongside a number of services that cut across health and social

care meant not only easy access to services to the community but also opportunities to streamline processes and reduce bureaucracy.

A key tension for integration was in relation to creating shared capacity among partners. Processes and systems on the frontline remained siloed and those needing help were still expected to go through individual service channels. Although in the social care site, these hubs helped create a better relationship among partners, leading to a more informal referral system. Staff were able to signpost or refer individuals to specific services by having a simple conversation over the phone or through a common messaging platform. Whilst quick access was beneficial to individuals, the backend referral system still remained tedious and long. Within the health-led site, engagement between partners appeared poor, with some key professions, such as social workers, not even being involved with CLS. This meant that there was less opportunity to create a joint service and hence, systems remained siloed. For this site, an additional issue was in relation to greater stringency in their data-sharing policy due to internal protocols that further hindered systemic integration. Even the data collected as part of CLS was subject to these protocols, thereby impeding the development of a trusting and transparent data repository for their local area. A similar issue was experienced in the social care-led site, with partners often collecting similar data, leading to potential duplication.

> Probably not marrying that up or mapping that together, which I think is missing now particularly around population health and looking at primary care data, our community service data and the social care data as well. I think the bit that we're missing is the VCSC data (Site 2 health service manager)

Leadership structures within CLS were reported as important in shaping implementation and a key aspect for collaborative decision-making. In the health-led site, implementation was largely top-down, with senior leadership from health, social care and the voluntary sector responsible for taking key decisions regarding CLS. This, however, meant little involvement of staff at the middle levels and the frontline, who dealt with everyday challenges. Moreover, such an approach largely led to one-way communication, with little information being fed back to those making key decisions. In addition, it appeared that partners struggled to arrive at developing a common vision for CLS, partly due to their immediate priorities, which were not always related to CLS. In the social care-led site, leadership was distributed, with senior leaders deciding on overall direction and middle management and frontline staff leading operational aspects. This was achieved through the innovation teams that were established within each community hub. The makeup of this team varied across hubs, depending on the services that were offered and mainly consisted of middle-level managers and frontline staff who were responsible for delivering CLS. The innovation teams acted as an important bridge between senior leadership and frontline staff, enabling horizontal and vertical communication and feedback within and between services. The involvement of senior- and middle-level leaders was perceived as leaders extending their support for CLS. Moreover, partners agreeing on a vision and a suitable operational model was favourable to this site to establish a cohesive strategy for implementation.

> With this approach is that it feels like it's managed to bring together leaders from the different organisations, who have a common goal about joining things up and working in a much more kind of community development focused way (Site 2 implementation lead)

In both sites, community hubs certainly created a space for joined-up working, bringing together key services under a single roof. However, due to poor involvement and engagement with service partners, the health-led site was challenged in being able to consistently deliver a joined-up service offer. This was, in part, attributed to some services not being aware or not fully engaged with CLS due to their own anxieties about the approach or leaders not setting a clear vision or consistently showing their support. In some instances, frontline staff did not have the autonomy to explore opportunities for joined-up working with their partners. In the social care-led site, the phased approach to setting up hubs helped in cultivating new relationships and strengthening existing ones. An awareness about CLS was intentionally

created, which not only developed interest among other services but also strengthened the provision of existing services. However, as systems remained siloed, hubs were often seen as a co-location of services rather than an integrated service offer.

> Some of our challenges is with our health colleagues. And it's took a long time to kind of chip away with our health colleagues to get them on board and I would say that they're still not fully on board with it (Site 1 implementation lead)

Discussion

Integration of health and social care has been reinforced both internationally (WHO, 2015) as well as nationally (DHSC, 2022; DHSC, 2025) with the aspiration to improve the wellbeing of people. Integration is often seen as an effective solution to reduce fragmentation of services (Buch *et al*., 2018), provide more coordinated and continuous care (Maruthappu *et al*., 2015) and reduce the burden on health systems by preventing acute situations from developing into chronic problems (McKeown, 2023). These align with the aspirations of CLS, whose aim is to bring a systems-level transformation in health and social care services at the local level. Emphasis on a community-oriented approach encouraged local innovations that had the potential to offer flexible and effective help and support. However, in line with previous evidence (Baxter *et al*., 2018), our study highlights that achieving integration through community-based interventions is highly complex and is often subject to unique challenges arising from both integrating care and embedding strengths-based/asset-based approaches. Whilst there were differences in the sites' context and approaches to CLS, they encountered many similar barriers such as resource pressures, professional cultural tensions and a lack of trust between partners.

Through the CLS programme, both sites mainly sought horizontal integration of services, laying specific focus on collaboration with services across sectors and enabling physical co-location (Maruthappu *et al*., 2015). Physical co-location and single access points to health, social care and voluntary services were largely achieved through the community hubs, but these initiatives did not always translate to the wider integration of processes or systems, nor did it result in the streamlined development of service offers (Looman *et al*., 2021). Although some degree of standardisation of processes is reported to be helpful (Looman *et al*., 2021), flexibility in setting up and operationalising the hubs formed the basis of the hubs and enabled in making the service offer more relevant and appropriate to the local context. Nonetheless, considering the number of partners involved along with their varied operational styles, achieving a balance between standardisation via establishing formal structures or through task divisions and maintaining flexibility may have helped in the realisation of effective integration.

Collaborative governance (Looman *et al*., 2021) and distributive leadership (Buch *et al*., 2018) are often identified as important factors for integration. Pre-existing relationships within the social care-led site clearly helped in bringing partners together and gaining initial support for CLS, which led to the development of a shared vision, an important aspect for integration. Even in this site, it was a challenge to develop capacity for joint action and influence the active involvement of all partners, particularly from those at the community level, mainly due to a lack of demonstration of shared leadership and ownership. Although it is helpful when the organisation leading the implementation offers ongoing support and help (Cooper *et al*., 2021), in both sites, there was a danger of over-reliance on the lead organisation that appeared to impact the extent of collaboration and openness towards service integration. Though challenging to achieve, distributive leadership is a necessary condition to create shared ownership and alleviate tensions arising from collaborations (Spillane *et al*., 2004). It can, however, be achieved by clearly articulating the roles and responsibilities of all partners through participatory means and, in the sense-making of

vertical and horizontal leadership strands (Eriksson *et al*., 2025). As with the health care-led site, a lack of supportive leadership structures both horizontally (across sectors) and vertically within organisations notably impacted the level of engagement and support generated for implementation. In contrast, by creating relevant opportunities and by recognising differentiated roles of strategic and practice leaders, the social care-led site was better positioned to provide leadership structures that were conducive to adopting a community-based intervention. This cannot be taken to suggest that social care is inherently more distributed, but does indicate that with a planned strategy for those in less senior organisational roles can be encouraged and supported to innovate.

In both sites, there appeared to be relatively little engagement with communities in the design of the programme despite this being a core principle. This potentially reflects the loss of community development expertise and capacity within many local organisations in England (Miller and Mahesh, 2025). Although in principle community-based integrated care can create a platform for meaningful integration, health and care organisations can struggle to meaningfully articulate and translate local needs of people Lowe, 2017) and develop a system that involves communities in the decision-making, delivery and evaluation of the service offer (NICE, 2017). By taking a pragmatic approach that generates a shared vision, plan and responsibility towards coproduction among partners, service user involvement may be well embedded and sustained within service integration (Miller *et al*., 2024a, b).

Limitations

A small number of individuals were interviewed who mainly held middle- to senior-level managerial positions due to the aims of the wider research study that explored overall implementation of CLS. Gaining insight from more senior leaders as well as frontline staff who were involved in the day-to-day activities of CLS would have further strengthened our findings.

A related issue was the reliance on implementation leads in our sites to gain access to research participants. Although the research was able to capture varied perspectives of service professionals, there may have been favourable bias that our sites introduced. Nevertheless, these were partly mitigated by other data collected as part of the wider research project, even though they do not form the basis of this article. To prevent such bias, the direct call for participation of all those involved could have been made by the research team.

Conclusion

Integrated care developments in many countries are seeking not only to improve care processes and pathways, but also to proactively respond to social determinants of health and wellbeing through collaborating at a population level. Engaging with communities to understand need and design programmes which respond to their local context will be crucial to use resources effectively and build on their existing networks and assets. This research highlights that there are considerable challenges to traditional bureaucracies in adopting a more community-oriented approach to integrated care and that this will require a deliberate and planned approach to distributing leadership and resources and providing concrete opportunities for communities to influence the design and implementation of programmes. It also suggests that more collaborative and creative approaches to integrated care are possible where senior leaders create an encouraging environment and invest in supportive activities such as innovation teams and professional development. In relation to CLS itself, the national programme team has responded to the insights of the research through refreshing their offer to local areas, strengthening the centrality of people with lived experience and communities within this, and committing to further research on how the community hub model can best be adapted to reflect local circumstances and opportunities.

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