Evidence review - integrated health and social care

A Skills for Care discussion paper

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Executive Summary

Introduction

This review was commissioned by Skills for Care's Workforce Innovation Programme which explores how people's care and support needs change and how the workforce has to adapt to meet the challenges that change can present.

It has sought to understand the characteristics of effective workforce practice in integrated health and social care services with a particular focus on avoiding hospital admissions, improving reablement services, and speeding up and improving hospital discharge services and transfers between residential and nursing homes.

The key questions that the evidence review aimed to address with reference to integration between health and social care, and the social care workforce were:

- What are current reported practices to support workforce intelligence, planning and development?
- What works, and what does not work, in current practice to support workforce intelligence, planning and development?
- What are the key characteristics of effective practice in workforce intelligence, planning and development?
- Is there any relevant international evidence?
- What are the gaps in the evidence base?

A flexible approach has been taken to the definition of integration for the purposes of this review to ensure all learning is captured; as noted in the National Evaluation of the Department of Health's Integrated Care Pilots (2012):

"*Integration is not a matter of following pre-given steps of a particular model of delivery, but often involves finding multiple creative ways of reorganising work in new organisational settings to reduce waste and duplication, deliver more preventative care, target resources more effectively or improve the quality of care*."[1]

Methodology

The review followed the Civil Service rapid evidence assessment methodology[2]. Having formulated the questions to be addressed by the review and developed a conceptual framework, inclusions and exclusion criteria were agreed. Articles published in 2002 or later, relevant to the review questions were included. Studies were excluded if they were not relevant, for example: integration within health; concerned with children and young people rather than adults; integration with other services such as housing, unless there was also a health factor.

[1] Rand Europe, Ernst & Young (2012). National Evaluation of the Department of Health's Integrated Care Pilots.
[2] http://www.civilservice.gov.uk/networks/gsr/resources-and-guidance/rapid-evidence-assessment/what-is

A wide range of databases, web-sites and grey literature were searched and screened, using search terms related to integration, social care and health, and workforce, staff and training. Experts in the field were also asked to identify relevant studies. After screening of abstracts and assessment of full texts, 61 full texts were included in the synthesis for the review.

Results

The evidence relating to integrated health and social care more generally, and workforce issues more specifically, has often been described as problematic, and this review found it to be weak. Much of the work identified was not primarily concerned with workforce issues, and connections between workforce approaches and the impact and outcomes for service users were not always addressed. The majority of studies were based on interviews and questionnaires for staff working within or managing integrated teams; there were also a significant number of case studies and articles drawing out learning from pilots. Most of the evidence was from England, with a small number from other UK countries, and Europe.

Five broad themes were identified:

Organisational structures and behaviours

Whilst evidence suggested that the form of integration does not necessarily affect the effectiveness of the service, there seemed to be clearer evidence of the importance of the quality and style of organisational leadership, both in terms of delivering change and maintaining an integrated approach to service delivery.

There was good evidence to support:

- Good leadership is key to successful integration, and should be distinguished from clinical or professional leadership.
- The effective management of integrated teams is also key.

There was some evidence to support:

- Importance of organisational approach to change management impacting on effectiveness of integrated approaches.
- Team management is different to, and should be separated from, clinical or professional management.
- Separate management structures do not support integrated approaches to delivery.

There was insufficient evidence to support or reject:

- Particular organisational structures support integrated approaches.
- Managing integrated teams requires a different type of expertise and skill than managing single teams.

Staff roles, staff recruitment and retention

The evidence review considered a range of different staffing models and types of joint working, and produced a similar range of recommendations around what works; the development of new cross-boundary roles does seem to support integrated working.

There was good evidence to support:

- The creation of new roles working across professional boundaries supports integrated delivery.

There was some evidence to support:

- There is some variation in success factors depending on the staffing model of joint working.
- A focus on the service user/patient helps in overcoming professional boundaries.
- An understanding of different roles and responsibilities is important to successful integration within a team.

There was insufficient evidence to support or reject:

- Particular staffing models are more effective in an integrated setting than others.
- Integrated working has a negative impact on staff retention.

Human resource management and regulation

The evidence relating to how human resource management practices can support effective integration is weak.

There was some evidence to support:

- Different terms and conditions can be challenging, but are a barrier which can be overcome.

There was insufficient evidence to support or reject:

- Joint workforce planning increases the ability to provide effective integrated services.
- Regulation of integrated services may fail where there is confusion about areas of responsibility for different regulators.

Communication/ICT

Communication is commonly raised as a difficulty across the range of partnership and multi-agency approaches taken within health and social care.

There was some evidence to support:

- Information sharing can be improved by effective integration.
- Difficulties in information sharing is commonly challenging for integrated approaches.

Training and education

The need for training to meet specific requirements, such as staff taking on new responsibilities, seems to be clear; however the most effective form of training requires further research. In particular, a better understanding of the link between inter-professional training and effective integration would be helpful.

There was some evidence to support:

- Training is a key success factor for integrated working, particularly to reflect changing roles and responsibilities.
- Inter-professional training can support inter-professional working and hence enhance integrated services.
- Co-location can support team working.

There was insufficient evidence to support or reject:

- The quality of communication between professionals has a bigger impact on outcomes for service users than the co-location of professionals.
- Existing training and education offers need to change to better promote integrated working.

Conclusions

The review has found the evidence relating to workforce and integration is often weak, and based on the views of staff, rather than relating to outcomes for service users. The range of definitions and service models means that approaches are often and probably most effectively developed on a local basis, although this makes comparative studies more difficult.

There is clearly a need for further research to understand better what works in these areas, and particularly how workforce management and development needs to be different in integrated settings.

1 Introduction

This paper presents the results of the evidence review of studies of workforce and integrated health and social care, and forms one of four evidence reviews commissioned by Skills for Care. These reviews are intended to facilitate the Skills for Care Workforce Innovation Unit in taking its work forward, based on a sound knowledge base with a clear understanding of what workers need to know and what the key issues are for the workforce. Each evidence review is followed by a resource mapping and assessment exercise which enables Skills for Care to identify where there are gaps in materials and resources, and where there are good quality relevant materials already in existence.

The review is focused on integration between health and social care: particularly in relation to reducing avoidable hospital admissions, improving re-ablement services, and speeding up and improving hospital discharge services and transfers between residential and nursing homes. However, it acknowledges the value of lessons learnt in other areas where workforce and integration have been studied and so refers to them as appropriate, and particularly where these highlight gaps in understanding in the focus area.

The key questions the review seeks to answer are:

- What are current reported practices to support workforce planning and development?
- What works, and what does not work, in current practice to support workforce planning and development?
- What are the key characteristics of effective practice in workforce planning and development?

The paper is presented in three sections:

Section A: Methodology (including search strategy).
Section B: Synthesis of evidence review
Section C: References.

2 Definition of integration

There is some ambiguity around the definition of integration: some studies look at multi-agency or inter-agency working, and partnership is a common theme. A flexible approach has been taken to the definition for the purposes of this review to ensure all learning is captured; as noted in the National Evaluation of the Department of Health's Integrated Care Pilots (2012):

"*Integration is not a matter of following pre-given steps of a particular model of delivery, but often involves finding multiple creative ways of reorganising work in new organisational settings to reduce waste and duplication, deliver more preventative care, target resources more effectively or improve the quality of care*."[3]

The Integrated Care Network's Guide to Integrated Working (2004) suggests that *"integration can therefore be contemplated at the level of organisation, service or professional team, and can be initiated on grand or small scales."*

Ham & Curry (2011) draw a distinction between "*real integration, in which organisations merge their services, and virtual integration, in which providers work together through networks and alliances."*

The Integrated Care Network's Guide to Integrated Working (2004) provides an adaptation of the World Health Organisation's framework for integration which sets out some of the characteristics of integration:

	Autonomy	**Co-ordination**	**Integration**
Vision of system	Individual perspective	Shared commitment to improve system	Common values, all accountable
Nature of partnership	Own rules, occasional partnership	Time limited or similar co-operative projects	Formal mission statements, legislation
Use of resources	To meet self determined objectives	To meet complementary objectives, mutual reinforcement	Used according to common framework
Decision making	Independent	Consultative	Authority delegated, single process
Information	Used independently	Circulates among partners	Orients partners work towards agreed needs

[3] Rand Europe, Ernst & Young (2012). National Evaluation of the Department of Health's Integrated Care Pilots.

Thus integration can take many forms: Gleave, Wong, Porteus & Harding (2010) reporting on a survey of local authorities and primary care trusts in England identified a continuum of forms of integration, with the most popular being enhanced partnerships and joint appointments.

Form of integration	Example	Number of responses from survey of LA/PCTs in England
Structure	Eg PCT and local authority care services have formed a single integrated legal entity (Care Trust) or a combined service (joint PCT and social care department	3
Enhanced Partnership	Eg system-wide commitment, shared vision and integration across most strategic and commissioning functions, senior and middle tier joint appointments, formal high level backing, but separate legal entities remain	27
Joint appointment	Eg PCT and local authority have some key joint appointments and the teams collaborate but are not integrated/combined	37
Co-ordination	Eg reasonable level of formal commitment to joint working, coordination around some areas of strategy and/or commissioning depending on circumstances	12
Relative autonomy	Eg local authority and NHS meet statutory requirements for formal partnership working, but most coordination largely informal	3

Adapted from Gleave et al (2010)

3 Policy context

In Caring for our future: reforming care and support (HM Government, 2012) the government has made a commitment to investing an additional £100 million in 2013/14

and £200 million in 2014/15 in joint funding between the NHS and social care to support better integrated care and support. This follows on from the Vision for Adult Social Care (Department for Health, 2010) which presented working across boundaries in a systematic way as a key characteristic of modern social care. This is to include information sharing, working with other agencies, working with and supporting providers, and engaging more closely with service users and other stakeholders. Local authorities are expected to provide the strategic leadership in their area.

Integration and partnership between social care and health are stressed as an important element in meeting prevention outcomes: '*The flexible use of resources should be encouraged if it improves outcomes. Coherent and integrated services are essential, not optional*' (Department for Health, 2010). Through shared involvement in activities such as supporting re-ablement, discharge pathways, falls prevention, nutritional advice and using community resources to prevent isolation, adult social care services and the NHS will become more closely linked. The workforce will be employed in different types of organisations, some working across traditional health and social care boundaries to deliver more integrated services.

This new model of integrated care is aimed to meet the needs of the growing number of people with long-term conditions, such as dementia in the older population, and to reduce the pressure on more expensive acute healthcare services. The hope is that integrated care through service redesign and new skill mix will enable adult social care and the NHS to achieve gains in productivity. Improved relations and interaction between the two sectors [health and social care] '*could ultimately contribute to broader cooperation, more imaginative efficiencies, and more significant savings on both sides*' (HC 512, December 2010).

A: Methodology

4 Search strategy

Searches were undertaken of the Web of Knowledge, Cinahl, SCIE Social Care Online, ASSIA, Social Services Abstracts, Campbell Collaboration, Google Scholar, Department for Health, Skills for Care, Skills for Health, Centre for Workforce Intelligence, Joseph Rowntree Foundation, NDTI, RIPFA, IRISS, and King's College Workforce Unit websites.

A variety of search terms were used appropriate to the different databases. For example, for Web of Knowledge the following words were used:

Search words	Number of results
Adult integrat* social care workforce	24
Adult integrat* social care training	176
Adult integrat* social care staffing	133
Adult integrat* social care education	330
Adult integrat* social care partnership	39

In other databases, where fewer studies were located, the search was widened by using less restrictive terms in order to generate a good range of studies.

A number of experts in the area were contacted for their suggestions of relevant papers (both published and unpublished). We are very grateful to Steven Weeks, Peter Thistlethwaite and Carolyn Wallace for their suggestions of relevant articles and journals.

In addition, a hand search was carried out following up appropriate references in a number of papers.

5 Extent

The initial search of databases using the search words set out in the conceptual framework paper resulted in 462 documents. After screening to remove papers which looked at integration policy more generally, integration within health services, children and young people services, and international studies, as well as duplication, this number was reduced to 67 separate papers. The search of websites and discussions with experts produced a further 54 separate papers after initial screening.

The screening of the full texts reduced the number of documents for synthesis to 61.

In terms of the exclusions:

- There are a large number of papers which look at integration within health; there are also a significant number which look at children and young people often in the context of family services.
- Papers with a policy focus have been excluded unless they include workforce issues.
- Research which evaluates the different models of integration in terms of impact on service users unless they clearly include workforce issues.
- International studies except where they include comparison between the UK and other countries with a workforce focus.

- The integration of service users within mainstream services or communities.
- The integration of social care with housing has been excluded unless there is also a health factor.
- Transition has been excluded unless it is transition between integrated children and integrated adult services.

6 Quality assessment

For those abstracts meeting the basic screening requirements, we assessed the full text in terms of overall quality, key findings and key recommendations. This was recorded on a standard template.

For all research, we used a similar approach to grading material as recommended in Think Research[4] (which we advised on). This grades research evidence on a five point scale where: 1 = personal testimony or practice experience, 2 = client opinion study or single case design, 3 = quasi-experimental study or cross-sectional study or cohort study or literature review, 4 = randomised controlled trial, and 5 = systematic review or meta-analysis.

In terms of qualitative research, there has been considerable debate over what criteria should be used to assess quality[5] and concern to avoid a rigidly procedural and over-prescriptive approach. We therefore adopted the four key principles which Spencer et al [6] advise should underpin any framework:

- Contributory – advancing wider knowledge or understanding
- Defensible in design – an appropriate research strategy for the question posed
- Rigorous in conduct – systematic and transparent data collection and analysis
- Credible in claim – well-founded and plausible arguments about the significance of the evidence generated.

Thus we scored qualitative research in terms of these four principles with a maximum of four points where all four principles were satisfied.

[4] Cabinet Office Social Exclusion Task Force (2008) Think Research: Using research evidence to inform service development for vulnerable groups
[5] Long A & Godfrey M (2004) An evaluation tool to assess the quality of qualitative research studies, International Journal of Social Research Methodology, 2004, vol 7, 2, pp 181-196
[6] Spencer L, Ritchie J, Lewis J & Dillon L (2003) Quality in Qualitative Evaluation: a framework for assessing research evidence: a quality framework, Cabinet Office Strategy Unit.

7 Range

The areas covered within the reports and papers after initial screening included:

- Mental health services including dual diagnosis.
- Probation and mental health.
- End of life care including social care within a hospice setting.
- Intermediate care and virtual wards.
- Older people services including home care and residential care homes.
- Hospital discharge.
- Dementia services.
- Domestic violence.
- Homelessness and social exclusion.
- Social care within primary health care settings.

However, after screening of the full texts the range of documents narrowed, and can be categorised as set out in the table below.

Client group or service area	Number of full texts
Older People	14
Adults (including older people)	6
Mental Health	13
Generic	26
Other	2
Total	**61**

There does not appear to be anything looking at co-production and integrated workforce issues, although there are studies looking at the views of service users receiving integrated services. There is limited discussion of the personalisation agenda and integration, and of integrated or joint commissioning.

Many of the studies covered a range of workforce issues and therefore provide evidence across the themes identified as enablers and barriers to integration, and of workforce issues more specifically.

8 Nature of evidence identified

The evidence relating to integrated health and social care more generally, and workforce issues more specifically, has often been described as problematic. In policy terms emphasis has been placed recently on attempting to ascribe improved service user

outcomes to integrated approaches, but, for example, the National Evaluation of the Department of Health's Integrated Care Pilots (2012) found that:

"Integrated care led to process improvements such as an increase in the use of care plans and the development of new roles for care staff. Staff believed that these process improvements were leading to improvements in care, even if some of the improvements were not yet apparent..... Patients did not, in general, share the sense of improvement."

Snooks et al (2006) found not only that there were issues around the quality of the evidence of the effectiveness of joint working initiatives, but that "*evidence relating to workforce issues in this literature is sparse*."

The evidence reviewed for this study can be broken down as follows:

Nature of evidence	**Number of documents**
Personal testimony or practice experience	7
Client opinion study of single case design	17
Quasi-experimental study or cross-sectional study or cohort study, or literature review	31
Randomised controlled trial	0
Systematic review or meta-analysis	5

The majority of the studies are based on interviews and questionnaires for staff working within or managing integrated teams; a small number draw on focus group discussions. .

There are a number of reports from seminars and other events that have explored integration and the barriers to its effectiveness.

There are a small number of literature reviews and systematic evidence reviews, although the majority have a wider focus than workforce.

There are a significant number of case studies and articles drawing out learning from pilots in various service areas.

Most of the evidence is from England, with a small number from Scotland, Wales, Northern Ireland or pan-UK; one study has a European-wide focus (including the UK).

9 Limitations of review

Much of the work identified in this review is not primarily concerned with workforce issues, and connections between workforce approaches and the impact and outcomes for service users are not always addressed. The reviewers have sought to identify what is relevant and addresses the key questions in the review, but may have overlooked some studies where the relevance was not immediately clear.

Given the different approaches to integration considered in studies, it is not always possible to compare like with like, however there are shared themes which appear relevant regardless of the integration model being considered.

The review was undertaken over a three month period. It is possible that further time would have allowed the identification of additional relevant evidence and more detailed examination and presentation of studies.

B: Synthesis of Evidence

10 Introduction

Studies have tended to identify very similar themes within the factors affecting the success of integration.

Stewart et al (2003) identified key operational factors affecting integrated working as falling within a number of themes: relations between partners, organisational culture, change management, enabling staff, professional behaviour, attitudes, and outcomes. The top four barriers were identified as lack of clarity of roles, poor communication, lack of clarity of procedures, and imbalances of power between individuals and agencies.

Robertson (2011) identified several factors which have been found to be important to successful integration including:

- Shared values
- Co-ordination of services
- Collaboration between disciplines
- Consistent rules and policies at organisational level.

Barriers identified in the same literature review include concerns about professional status. The medical model of care may dominate in integrated organisations and some medical staff may be reluctant to work in a multi-agency setting. Other barriers centre on

organisational boundaries, for example communication/IT systems, funding arrangements and employment issues such as training and career progression. The issues that are discussed within this paper fall within a number of themes:

a. Organisational structures and behaviours – in particular leadership, management and supervision.
b. Staff roles, staff recruitment and retention. This theme explores the development of new roles reflecting an integrated approach to service delivery, and the impact this has for staff.
c. Human resource management and regulation, including the development of integrated workforce strategies and how to protect vulnerable adults through effective regulation of an integrated approach.
d. Communication and information in an integrated setting.
e. Training and education. There are a number of papers looking at inter-professional learning and its effectiveness both within integrated and in multi-agency settings.

11 Organisational structures and behaviours

Good evidence to support

- Good leadership is key to successful integration, and should be distinguished from clinical or professional leadership.
- The effective management of integrated teams is also key.

Some evidence to support

- Importance of organisational approach to change management impacting on effectiveness of integrated approaches.
- Team management is different to, and should be separated from clinical or professional management.
- Separate management structures do not support integrated approaches to delivery.

Insufficient evidence to support or reject

- Particular organisational structures supporting integrated approaches.
- Managing integrated teams requires a different type of expertise and skill than managing single teams.

11.1 Organisational structures

As noted above, there are various organisational approaches to integration which fall on a continuum from a high degree of autonomy between two organisations, to a fully integrated organisation such as a Care Trust. It appears that structural changes in their own right are not sufficient to create an integrated approach to service delivery.

Thistlethwaite (2011) highlighted the importance of investing in a professional approach to organisational development/change management over an appropriate period of time when considering the success of Torbay Care Trust, and noted that "*cultural, political and organisational differences and financial and other risks do not have to be deal breakers – they can be overcome*."

Reilly et al (2003) in a comparison of integration in old age psychiatry services in England and Northern Ireland, found that while management arrangements were integrated, there was less evidence of integration in assessment, referral and medical screening. They noted that even where management structures were integrated, problems arose if budgets remained separate. The authors concluded that integrated structures are not enough in themselves to secure integrated service delivery.

Dickinson et al (2007) found that the shift to a care trust had not had a significant impact on day-to-day work of senior and middle managers, but this was in the context of partnership working in the locality.

However, Snooks et al (2006) in a similar review of the evidence concerning the effectiveness of services delivered jointly by health and social care providers, highlighted the importance of "*integrated and flexible management structures*", and a "*supportive environment including suitable institutional structures*".

11.2 Leadership

Leadership is highlighted across many studies as key to the successful implementation and delivery of an integrated approach. The complexity of leadership across health and social care is found to be challenging including in the language used in different contexts.

In the progress report on New Ways of Working, CSIP/NIMHE (2007) set out a useful description of the different terms used in this context:

Definitions	
Leadership	Delivery through complex systems by engaging partners in the pursuit of major, transformational change. Coping with change
Management	Transactional, operational processes, controls and problem solving. Ensuring that the performance of the team and the individuals within it matches objectives or requirements. Coping with complexity

Definitions	
Clinical leadership	No agreed definition. About strategic vision and driving service improvement and effective team working to provide excellence in patient/client care.
Professional leadership	No agreed definition. Includes the development of professional identity and standards in a professional group dispersed throughout many different types of team, representing the profession and developing its contribution to the overall objectives of the organisation.
Team leader	The person who: • draws attention to team process; • is responsible for resolving team conflicts; • is responsible for the team's interface with other teams; • is able to develop an appetite for change and development, and a tolerance of uncertainty, in the team as a whole; and • is able to marshal the efforts of the team in the pursuit of the agreed goals of the team and the organisation.

Mental Health: New Ways of Working for everyone: developing and sustaining a capable and flexible workforce. DH 2007

A number of studies emphasised the importance of leadership whether as a potential facilitator or barrier to integration. Glendinning et al (2002) noted the emphasis placed on the role of leadership in the success of emerging Section 31 Partnerships at the time "*A continuing, visible commitment from key individuals in positions of leadership and influence in the partner organisations was also widely regarded as essential*." Dickinson et al (2007) found evidence that an approach to leadership which aimed to keep the best of both organisations as they integrated was perceived as both supportive of change, but also potentially stifles innovation. IPC (2010) also highlighted strong leadership as important for successful integration.

CfWI (2011) in looking at virtual ward services described the importance of strong leadership that crosses professional boundaries and the challenges this presents particularly noting "*for GP led models, there is a requirement for more senior experience in order to manage multi-disciplinary teams and make decisions on higher acuity patients*."

Leadership is clearly not straightforward in the integration agenda. So, NHS Future Forum (2012) noted: "*whether at the level of commissioning or provision, the development of shared goals, culture, plans, governance, procedures and practices is a*

complex and difficult task, often requiring years of effort from leaders and staff." Whilst Rand (2012) found some pitfalls: "*enthusiastic local leadership produced expectations that were difficult to realise in practice."*

There can also be an issue about the form of leadership, with Rand (2012) noting that clinical leadership was often mentioned as critical "*primarily due to the ability of GPs and other clinicians to engage with their professional peer group regarding the credibility and feasibility of the intervention, and to motivate participation*."

11.3 Management and supervision

The relationship between management, professional supervision, and successful integration is discussed in a number of studies in terms of the style of management, the challenges of managing multi-disciplinary teams, the relationship with governance and organisational structures, and the protection of professional identity.

In a study of community mental health teams, Huxley et al (2011) described management style as a "*significant factor*" when looking at team integration, teamwork, quality of care and job satisfaction. Huby et al (2010) described how good managers "*translated and accommodated the requirements of governance to practice within the teams*." While Scragg (2006) highlighted the role of managers in reinforcing the vision of integrated working and suggests that management development, focusing on the demands of managing in multi-professional settings, would enable managers to extend their understanding of their role.

Several studies considered the distinction between team management, clinical management and professional supervision. Cameron (2010) distinguished line management responsibility and professional supervision for those working across organisational boundaries. Heenan et al (2006) found an integrated management approach key to success: "*it was seen as a reflection of the parity of esteem afforded to each profession*" but there was "*a strong view that it was essential that individual professional competences had to be maintained and enhanced and that all staff had a right to professional supervision*." This is further explored in the section on professional identity below.

Miller et al (2011) in their study of care trusts noted the response to separate management structures between health and social care "*whilst this provided social care with a clear 'place' in the organisation, it was also a barrier to staff perceiving that health and social care practitioners were now integrated. This led to the organisational equivalent of multi-disciplinary staff being 'co-located' but not working closer together*."

There is also some recognition of the challenge faced by managers working in a multi-disciplinary or partnership arena. Williams and Sullivan (2007) described how "*traditional styles and forms of leadership are not considered to be appropriate in collaborative settings*" while Maslin-Prothero & Bennion (2010) identified a need to focus on the management of multi-professional teams as "*this would help team managers understand their role and to enable them to reach out beyond the teams to leadership within the localities developing broader partnerships with organizations and community groups*."

12 Staff roles, staff recruitment and retention

Good evidence to support

- The creation of new roles working across professional boundaries supports integrated delivery.

Some evidence to support

- There is some variation in success factors depending on the staffing model of joint working.
- A focus on the service user/patient helps in overcoming professional boundaries.
- An understanding of different roles and responsibilities is important to successful integration within a team.

Insufficient evidence to support or reject

- Particular staffing models are more effective in an integrated setting than others.
- Integrated working has a negative impact on staff retention.

12.1 Staffing models

Although there are many different staffing models and types of joint working and different factors come into play with different approaches, there is no evidence to suggest that one particular approach is best at delivering outcomes for service users, or creating successful teams.

In their systematic review exploring community and intermediate care services Nancarrow et al (2006) suggested there is insufficient evidence to draw conclusions about the best staffing models in terms of the delivery of outcomes for service users. They suggest it may be better to look at "*the input of whole team roles rather than the contribution of individual practitioners within the team*."

In their survey of community mental health teams, Huxley et al (2011) found inconclusive evidence of a relationship between team models and outcomes for service users, and noted that "*confidence in one's role and flexibility in roles emerged as important*

determinants of higher teamwork scores." Similarly, Huby et al (2010) in their comparative study of integration in the UK found that "*mutual recognition and understanding of capabilities people brought to the everyday work of providing care was the most important factor, which determined how people experienced their work in a team*."

Cameron and Lart (2003) in their systematic review of evidence promoting or hindering integration considered the factors affecting progress in three approaches:

- Placement schemes, where a post is established which crosses the organisational divide, tended to raise both organisational and cultural/professional problems.
- Multi-agency teams or projects and case/care management projects depended on similar factors, and also raised questions about the complexity of professional and service management and the need to ensure adequate professional support.
- Strategic joint working projects were more reliant on contextual issues such as financial or political uncertainty. However, organisational factors such as trust, continuity of personnel, commitment and effective communication strategies were also important elements of successful strategic joint working.

12.2 Professional identities

A number of studies consider the impact of professional identity on integration, and vice versa, and the importance of focusing on the service user to overcome any barriers this may create.

Rolls et al (2002) described the emergence of "professional tribalism" when individual professional groups protect particular roles and responsibilities in community mental health teams. Scragg (2006), in an evaluation of integrated team management in a health and social care trust talked about professional identity being "challenged and stretched", and hence the need to ensure access to professional supervision to ensure professional standards are maintained. Huby et al (2010) described the impact of people feeling their roles and contributions were undervalued who then overemphasised their professional and occupational identity.

A number of studies report on the importance of understanding each other's roles and responsibilities, including Holland (2004) and Cameron and Lart (2003). The latter highlighted difficulties in collaborations with GPs which were often thought to reflect lack of understanding in GPs of other roles, notably social work.

Robertson (2011) in a literature review looking at different models of integration found evidence that a focus on service users or patients is effective at overcoming professional boundaries.

12.3 New roles

The creation of new roles which work across professional boundaries is considered an effective facilitator of integrated working. Glendinning et al (2002) in a national evaluation of Health Act Flexibilities found that new appointments made to the partnership could help to change staff attitudes at other levels in the partner organisations: they were seen as "*buying into integration*". Hek et al (2004) described the creation of a new generic worker role as "*symbolic, in recognition of the joint working between health and social care and the use of joint funding."*

Other studies note the impact of generic roles as a way of overcoming professional resistance to integration: Gibb et al (2002) noted the impact of the new Community Support Worker role within a community mental health team acting as a shared resource for both social workers and community psychiatric nurses. Stanmore & Waterman (2007) in looking at generic rehabilitation assistants found that professionals were not overly threatened by these generic posts.

Reed et al (2005) in their literature review found evidence of roles being created which work across organisational boundaries and support the older person as they make the transition from one service to another (for example, discharge managers, care management co-ordinators). However, they found little evidence of the impact of these roles on outcomes.

12.4 Retention

The issue of staff retention is noted both in terms of the potential loss of champions of integration, and suitably qualified staff.

Thus, Cameron & Lart (2003) found evidence in earlier studies of the negative impact both of frequent staff turnover on joint working, as well as of the loss of managerial experience, particularly where that experience was of creating and managing multi-disciplinary teams.

Coxon (2005) in a European study of the experiences of staff working in integrated services found increased job satisfaction, but often at the expense of longer term career options: "*The relatively small size of integrated organisations contributes to improved*

multi-professional working but at the same time limits the careers of those who work in them."

13 Human resource management and regulation

Some evidence to support

- Different terms and conditions can be challenging, but are a barrier which can be overcome.

Insufficient evidence to support or reject

- Joint workforce planning increases the ability to provide effective integrated services.
- Regulation of integrated services may fail where there is confusion about areas of responsibility for different regulators.

13.1 Workforce planning

The importance of having appropriately skilled staff able to work in integrated services suggests the need for effective and potentially integrated workforce planning, but insufficient evidence has been found to suggest this approach is having an impact on the ability to provide effective integrated services.

Huxley et al (2011) in their study of integration within community mental health teams calls for more work to be done on workforce planning with an improved understanding of supply, demand and resource factors.

A survey of Directors of Adult Social Services in 2009 which maps the extent of integrated workforce planning in England (ADASS/Skills for Care 2011) found that " *the vast majority of local authorities surveyed have started to couple service commissioning to workforce commissioning in their local area."*

IDeA (2009) in a study of both adult and children integrated workforce issues found that many areas had focused on what is achievable, and very few had fully integrated comprehensive workforce strategies: "*work is often focused on 'what is possible' rather than necessarily on what will have the biggest impact on outcomes."*

13.2 Regulation

In an evidence review Cornes et al (2007) discussed the shift towards integration and non-professional roles and what it means for regulation, including the arbitrary nature of whether an individual is NHS or LA employed and what it means in terms of registration. They highlighted that "*regulators need to ensure connectivity between their approaches*

and to regularly review that there are no holes in the safety net" but noted there is weak evidence as to whether regulation itself impacts on quality of outcomes for service users.

13.3 Terms and conditions

A number of studies discuss differing terms and conditions for staff, and the impact this can have for the integration of services, however the evidence of the significance of this issue is unclear.

Thus Glendinning (2003) in an early evaluation of two integration initiatives suggested that "*terms and conditions of employment need to be harmonised; these include rights to employment security and access to occupational welfare benefits*." Miller et al (2011) cited the potential harmonisation of terms and conditions as a "*positive factor in promoting affiliation with the care trust."* Similarly Rand (2012) in their national evaluation of integrated care pilots cited changes to staff employment involving TUPE (Transfer of Undertakings Protection of Employment) as a major challenge; this issue was also picked up by Pickup (2004).

However, Ottley et al (2005) in a study of the role of support workers in intermediate care reported 23% responses from the intermediate care pilots considered pay to be a barrier. Mathieson (2011) in a study of Scottish integrated health and social care teams found that "*differing employment terms and conditions do not appear to present significant problems*."

14 Communication/ICT

Some evidence to support

- Information sharing can be improved by effective integration.
- Difficulties in information sharing is commonly challenging for integrated approaches.

Whilst a number of studies find that integrated approaches can improve communication between organisations and professional groups, difficulties with communication, particularly those associated with systems including ICT, were found to be an important barrier to developing integrated services.

Rand (2012) reported that information technology was commonly cited as a barrier amongst integrated care pilots. Similarly Frontier Economics (2012) found that "*Information sharing among organisations and to service users is a key barrier to successful integrated care. This also includes poorly-connected IT systems*."

However, Rand (2012) also found that a high percentage of staff in the integrated care pilots reported improved communication both within their own organisation and with other organisations. Good communication was also a benefit identified by Coxon (2005) from a study of European integrated approaches.

In an evaluation of a pilot project for integrated care assessment and management, Christiansen and Roberts (2005) found that a lack of shared systems meant staff were often unaware of what activity had been undertaken by others for particular service users.

15 Training and education

Some evidence to support

- Training is a key success factor for integrated working, particularly to reflect changing roles and responsibilities.
- Inter-professional training can support inter-professional working and hence enhance integrated services.
- Co-location can support team working.

Insufficient evidence to support or reject

- The quality of communication between professionals has a bigger impact on outcomes for service users than the co-location of professionals.
- Existing training and education offers need to change to better promote integrated working.

A number of studies identify the importance of training for staff involved in integrated services, whether as a response to changing roles and responsibilities, or the challenges of managing and being part multi-disciplinary teams.

Thus RAND (2012) found that "*if education and training specific to the changed service was provided, this increased the chance of success*."

Mitchell et al (2011) reported in a case study from Scotland which included workforce development that "*there are early positive indications that the investment has improved the leadership and service evaluation skills of team managers, is increasing the skill base of a wide range of professional staff and care assistants, and has started the process of organisational change."*

15.1 Preparation for new roles

Several studies describe the specific training needs of particular staff groups in integrated services.

For example, in a review of a number of integrated services, the Centre for Workforce Intelligence (2011) found that for virtual wards there are training needs for GPs in GP led models in managing multi-disciplinary teams, for all staff members in case management, and at a basic level for all staff to enable them to cover simple interventions for each other and maximise the benefit of individual patient visits.

Christiansen (2005) found that training is needed for district nurses to build their understanding of the social care sector, and their ability to carry out social care assessments.

In a study of assessments and eligibility in Community Mental Health Teams in England, Huxley et al (2008) found that different professional groups have a differential ability to make eligibility determinations, and recommended training in this area

15.2 Team development

There are several factors reported as important to the successful development of integrated team working.

Gibb et al (2002) provided evidence of the importance of shared goals for team members in terms of developing an integrated approach, which included negotiation around roles for the common goal of the care of service users.

Mathieson (2011) identified difficulties around language and suggested that co-location and work shadowing can help to address this. Similarly Syson and Bond (2010) find that co-location and proximity have helped generate "*transfer of knowledge and development of shared practice focused on delivering more appropriate interventions for service users."* However, Davey et al (2005) found weak evidence that co-location of social workers and primary health care impacts on outcomes for older people; it is the quality of the communication between professionals which may be a bigger factor and they suggest this needs further research. Holland (2004) highlighted the need to understand each other's professional roles and responsibilities.

15.3 Approaches to training and education

The importance of training and education, whether informal or formal, is highlighted across many of the studies as key to successful integration, although there is little evidence to link particular approaches to improved outcomes for individual service users, and so the evidence of the importance of training is not always clear.

Thus, in their study of the “care at home” workforce in Wales, Llewellyn et al (2010) infer that in order to promote effective working across service boundaries “*frameworks for training and skills development must change*” and they call for more innovative approaches to training that promote integrated working.

Howarth et al (2006) in their systematic review of the education needs of the workforce within primary care to promote integrated working with social care also call for education which “*embeds the essential attributes for integrated working*” but equally note the need to further research to understand what sort of education is most effective at this.

Ottley et al (2005) reporting on a survey of generic health and social care support workers after 12 months found staff highlighted the importance of the development of sustainable training options for staff working in integrated settings.

Training which brings health and social care staff together is seen to be a way of increasing understanding of each other’s sector, and roles although again evidence is unclear. Thus Scragg (2006) recommends “*joint activities that increase understanding of the unique contribution of each of the various disciplines and the potential for shared responsibilities.”*

Marshall & Gordon (2005) reported the key factors of inter-professional working and learning are “*concerned with placing the patient/service user at the centre of the care, with an aim of promoting collaboration across professions.*” Santy et al (2009), in evaluating on line case conferencing to facilitate inter-professional learning, noted that students said “*they had appreciated the opportunity to work with others from different professional groups”*; they also note the stated preference for on line discussions rather than face to face classroom sessions.

16 What are the gaps in the evidence base?

As noted earlier, the evidence base for integrated working across health and social care particularly as related to workforce issues is problematic.

The range of definitions of integration and service models, mean that approaches are often and probably most effectively developed on a local basis. This means that comparative studies can be difficult, and evidence is often weak when determining the impact of different approaches, particularly in terms of outcomes for service users over a period of time.

Gaps in evidence include:

- Studies which link workforce approaches to performance in the key focus areas for the review, such as improving hospital discharge services.
- The relationship between different staffing models and outcomes for service users.
- Longitudinal studies which look at the impact of different forms of staff training and education on outcomes for service users.
- The impact of different leadership and management styles on effective multi-disciplinary working, and the most effective way to support and develop leadership of integrated services.
- The relationship between features of team working and outcomes for service users.
- The relationship between co-production and integrated working.
- Effective approaches to staff retention and career progression within integrated settings.
- The relationship between joint workforce planning and the ability to provide effective integrated services.

17 Conclusion

This evidence review has sought to understand the characteristics of effective workforce practice in integrated health and social care services with a particular focus on avoiding hospital admissions, improving reablement services, and speeding up and improving hospital discharge services and transfers between residential and nursing homes.

It has found that the definition of integration is fluid, with approaches typically sitting on a continuum from relative autonomy to structural integration. There are many more studies looking at integration within health, and within children services, and a number of the evidence reviews found comment on the paucity and quality of the evidence in this area. This has been reflected in the results of this evidence review, particularly in terms of linking workforce issues to outcomes for service users.

Whilst there is evidence to suggest that the form of integration does not necessarily affect the effectiveness of the service, there seems to be clearer evidence that the quality and style of organisational leadership is key, both in terms of delivering change and maintaining an integrated approach to service delivery.
There is a distinction to be made between strategic leadership, the operational leadership of integrated services, and the professional supervision of individuals working in an integrated environment. However, there is less evidence about the characteristics of

effective performers in each of these areas, and in the forms of support and training that facilitate effective leadership and supervision in a multi-disciplinary environment. It does seem that it is important to recognise the challenges of managing in this environment, particularly where professionals are placed in leadership situations for which they have little or no training (such as described for GP led service models).

Although no evidence was found that staff turnover in integrated services was significantly different to that in traditional services, the evidence does suggest that staff often found that working in integrated services was very satisfying particularly because of the focus on the service user. However, this tended to reflect the experiences of front line staff, and there was no evidence found of turnover or levels of satisfaction in more senior staff working in integrated settings.

The issue of professional identity was often seen to be an important barrier to effective integration, however there do seem to be a variety of approaches which evidence suggests are effective at managing this issue: maintaining professional supervision and valuing individual contributions; promoting understanding of each other's roles and responsibilities; maintaining a focus for the service on the service user; recognizing training needs and ensuring training opportunities promote integrated approaches.

The creation of new roles, and particularly the generic support roles, was found to have a positive impact on the integration of services, whether this was because it provided a link between professions for the service user, was perceived as less of a threat by professionals, or was perceived as an additional and new resource.

Whilst joint workforce planning is appearing to have beneficial results in terms of better partnership working, no evidence was found of a longer term impact on the effectiveness of integrated services where joint workforce planning was in place. There is also unclear evidence of the importance of differing terms and conditions, and how difficult a barrier it is to overcome.

The need for training to meet specific requirements, such as staff taking on new responsibilities, seems to be clear, however the most effective form of training requires further research. In particular, a better understanding of the link between inter-professional training and effective integration would be helpful.
In conclusion, this review has found the evidence relating to workforce and integration is often weak, and based on the views of staff rather than relating to outcomes for service users. There is clearly the need for further research to understand better what works in

these areas, and particularly how workforce management and development needs to be different in integrated settings.

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