

Factors that promote and hinder joint and integrated working between health and social care services

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Key messages

- This is an update of a previous systematic review on the factors that promote and hinder joint working between health and social care services. It demonstrates some positive outcomes of such an approach for people who use services, carers and organisations delivering services.
- Three broad themes are used to organise the factors that support or hinder joint or integrated working: organisational issues; cultural and professional issues; and contextual issues.
- There is significant overlap between positive and negative factors, with many of the organisational factors identified in research as promoting joint working also being identified as hindering collaboration when insufficient attention is paid to their importance.
- Securing the understanding and commitment of staff to the aims and desired outcomes of new partnerships is crucial to the success of joint working, particularly among health professionals.
- Defining outcomes that matter to service users and carers is important. Outcomes defined by service users may differ from policy and practice imperatives but are a crucial aspect of understanding the effectiveness of joint or integrated services.
- Although most service users and carers report high levels of satisfaction, more can be done to involve them in care planning and influencing future care options. Joint and integrated services work best when they promote increased user involvement, choice and control.
- The evidence base underpinning joint and integrated working remains less than compelling. It largely consists of small-scale evaluations of local initiatives which are often of poor quality and poorly reported. No evaluation studied for the purpose of this briefing included an analysis of cost-effectiveness.
- There is an urgent need to develop high-quality, large-scale research studies that can test the underpinning assumptions of joint and integrated working in a more robust manner and assess the process from the perspective of service users and carers as well as from an economic perspective.

Introduction

The aim of this research briefing is to give people who provide and use social care services an overview of the research evidence for joint and integrated working by identifying and systematically describing:

- different models of working between health and social care services at the strategic, commissioning and operational levels
- evidence of effectiveness and cost-effectiveness
- factors promoting and obstacles hindering the success of these models
- the perspectives of people who use services and their carers.

This briefing updates a previous systematic review by Cameron and Lart¹ that reported on the factors that promote and hinder joint working between health and social care services. Given their prominence in terms of policy debates about joint and integrated working, the briefing focuses on jointly-organised services for older people and people with mental health problems in the UK only. In line with the original review, papers have only been included in this briefing if:

- they refer to an actual, rather than proposed, model of joint working
- they include primary data
- an evaluation of the model has been carried out.

Papers reported evaluations published before 2000 have been excluded from this briefing but papers published before are reported in Cameron and Lart. Taken together, the findings provide a 30-year overview of UK-based evaluations of joint working in health and social care. Please note that 'joint working' is used as an umbrella term to describe all models of working together, with 'integrated services' used only to refer to health and social care services that have been merged.

What is the issue?

A consistent theme of policy over the past 40 years has been a concern that welfare services

could be improved if statutory agencies worked together more efficiently. In the field of adult health and social care a variety of strategies have been introduced to encourage or direct agencies to work together. In England, Wales and Scotland, the 1970s saw policy-makers focus on developing mechanisms by which health and local authorities jointly planned services. In the 1990s attention focused on efforts to overcome the fragmentation of responsibilities for adult social care² as well as on the introduction of initiatives (e.g. intermediate care services) conceived to improve the coordination of services in order to better support people making the transition between acute, primary and social care.³ In Northern Ireland, the structure is markedly different from the other countries having structurally integrated health and social care services in the 1970s. Since 2009, the health and social care board is responsible for planning and commissioning, with services for Northern Ireland's population of 1.7 million people delivered via five health and social care trusts.

Under the previous Labour administration, there was a drive to improve joint working.⁴ Initially, attention focused on the introduction of mechanisms to assist partnership working between health and social care services. The Health Act 1999 attempted to remove some of the obstacles that were perceived to hinder joint working – for example, allowing statutory agencies to pool budgets and jointly commission services – as well as to provide the legal underpinning for further integration.⁵ The government in England then set out an agenda calling for greater structural integration of local authorities and primary care services, which included the establishment of care trusts. Most of these new trusts were specialist mental health, physical or learning disability partnerships and involved the organisational integration of health and social care services.⁷ The previous Labour government also introduced specific mechanisms such as the single assessment process (SAP) to improve joint working at the frontline.⁸

The present Coalition Government has continued this policy. The 2010 White Paper *Equity and*

excellence: liberating the NHS set out the Government's aim to 'simplify and extend the use of powers that enable joint working between the NHS and local authorities' in order to make it 'easier for commissioners and providers to adopt partnership arrangements, and adapt them to local circumstances'. The White Paper makes clear the government's intention to 'unlock efficiencies' that are perceived to exist within the existing system.⁶ *A vision for adult social care*⁹ further emphasises the Government's intention to identify and remove barriers preventing the pooling of budgets between health and social care, while also encouraging the involvement of small social enterprises and user-led organisations in the provision of social care.

Why is it important?

While the specific focus of policy-makers' interest in joint working has changed over time, the reasons for this interest have remained consistent. Rising demand for services, coupled with the need to reduce public expenditure provide compelling arguments for greater collaboration in the UK.¹⁰ Additionally, the integration of health and social care services potentially offers further means of supporting people with complex needs to live independently in the community.¹¹ However, the question remains whether or not reforms over the past decade have been successful in meeting the objectives set out by policy-makers.

About this research briefing

Our previous review of the research literature concluded that while it had a lot to say about the process of joint working, very little attention had been paid to exploring the effectiveness of this approach, either for service users and carers or for the organisations providing services.¹ This research briefing provides an update. The methods used to identify and organise material in this briefing were developed by the Social Care Institute for Excellence (SCIE), and included undertaking systematic and reproducible

searches of the literature. The briefing aims to provide a signpost for further reading, rather than a definitive account of 'what works'. As noted above, we sought out UK-based evaluations of jointly-organised services for older people and people with mental health problems only. It is based on papers published in peer-review journals only. Forty-six papers were identified, reporting 30 separate studies. The majority of studies (22) evaluated services for older people while six looked at mental health services and two examined services for both older people and people with mental health problems.

Interestingly, categorisation of the papers by date showed that almost all the studies pre-dated 2009, and the majority of them (37) were published before 2007. Additional steps taken by the review team to ensure that no evaluation studies published after 2008 had been missed resulted in just one further paper from 2010 being included.¹² The final list of papers for inclusion was independently reviewed.

This suggests that the evidence base is lagging behind current policy and practice. Reviewers speculate that this deficiency reflects policy priorities in England linked to the introduction of the Health Act 1999, and other initiatives such as the establishment of community mental health teams (CMHTs), and the introduction of intermediate care priorities that may have moved onto the implementation of personalisation following *Putting people first*.¹³ Papers in peer-reviewed journals from the Partnerships for Older People Projects (POPPs) evaluation are yet to report.¹⁴

This means that this briefing cannot comment on the impact of personalisation on joint working or changes introduced by the Health and Social Care Act 2012. However, it is based on a systematic assessment of the existing evidence base and its messages are crucial to the development of new joint working initiatives such as clinical commissioning groups and health and wellbeing boards, providing a solid base from which to consider the factors that promote and hinder joint work.

What does the research show?

Models of joint working

Our emphasis was on UK-based evaluations of jointly-organised services for older people and people with mental health problems. Within this area research is overwhelmingly focused on frontline services and service delivery. Studies fall into the following categories:

- multi-agency teams
- placements of individual staff across agency boundaries
- co-locations of staff that were not formal teams
- SAP
- the provision of intermediate care
- structurally integrated services
- use of pooled budgets.

Allowing for policy developments such as the introduction of SAP, intermediate care and pooled budgets, this is similar to the pattern we found in our earlier review.¹ Almost no studies focused solely on strategic-level joint working, with the exception of one that explored the use of pooled budgets.²

'Teams'

The largest category of models was 'teams'. However, this term covered a range of services and organisational models. Within mental health the teams were almost always CMHTs, characterised by the inclusion of staff from both health and social services.¹⁵⁻²⁵ However, two studies looked at specialist teams: crisis intervention and assertive outreach,¹⁵ and a 'memory service'.²⁶ In services for older people, teams had a range of functions, from rapid response, assessment and care planning, to direct provision of services, including time-limited intermediate care, both at home and in specialist residential facilities.²⁶⁻²⁹ One study compared two teams, one from mental health and one from older people's services.³⁰

Teams varied in the extent to which they could be described as 'integrated'. Key elements of integration included having shared processes

such as assessment and allocation, shared information and records, common management and at least some common activities or skills. At the other end of the spectrum were teams which had some or all of the following:

- distinct lines of management
- separate allocation and assessment
- separate information systems, kept confidential from each other
- clearly defined and maintained professional boundaries.

Not all studies provided enough information about working practices and arrangements to determine where the teams fitted on the spectrum.

Few team studies were comparative, describing only a single team. Those featuring comparisons compared integrated teams with more traditional ways of working. The set of five papers by Schneider et al.²⁰⁻²² and Carpenter et al.²³⁻²⁴ report on a complex study of CMHTs, comparing four districts that had fully implemented the care programme but organised their services differently. The teams differed in terms of whether they were 'integrated' or 'discrete' in terms of joint working: two mental health trusts worked closely with the local social services department ('integrated') and two worked independently ('discrete'). A further difference was whether they saw a broad range of clients ('inclusive') or focused on people with severe mental health problems ('targeted'), giving a comparison of four possible permutations of these variables: discrete and targeted; discrete and inclusive; integrated and targeted; integrated and inclusive.

Rothera et al.¹⁸ reported on a multi-agency home care service working with older people with dementia, and compared this to a standard service. Brown et al.²⁷ compared an integrated health and social services team, responsible for the delivery and management of community care to older people, with traditionally organised services. The study by Huby and Rees³⁰ looked at two sets of teams at either end of the spectrum of integration, working with completely different

client groups: CMHTs and rapid response teams for older people.

Taking the studies as a whole, few provide much detail about the organisational models being used for team working, and few have strong evidence about the impact on service users and their carers of joint working. Probably the strongest evidence is that of Schneider et al. who consider the different impacts of 'integrated' as opposed to 'discrete' organisational models in mental health.

Placement schemes and co-location

The next biggest category of models reported was placement schemes: arrangements whereby staff from one agency are placed in a setting run by another,³¹⁻³³ or where staff from across agencies are co-located but do not constitute a formal team.³⁴ These were usually social work staff placed in health settings, but one case of health staff working in a social services day centre for older people was also reported.³⁵ Several of the arrangements were early forms of multi-disciplinary team, and most of the studies dated from the early part of the study period. Perhaps unsurprisingly, many of the same issues described above relating to degrees of real integration in multi-disciplinary teams applied to these arrangements.

Single assessment

Four studies looked at processes for the integrated health and social care assessment of older people. In three of these, the model included the addition of assessment by a clinician to that by a care manager,³⁶⁻³⁸ while in the model investigated by Christiansen and Roberts,³⁹ district nurses based in general practitioner (GP) surgeries were enabled to carry out social care assessments and go on to become care managers.

Structural integration

Three studies looked at examples of the structural integration of health and social care services. One was a comparison of the degree of integration found in assessment and care management processes in Northern Ireland and England,⁴⁰ while in the two others the

settings were integrated health and social care trusts in England.⁴¹⁻⁴⁶

'Intermediate care' for older people

A further group of studies reported on arrangements for intermediate care for older people: services designed to provide either an alternative to hospital care or a bridge between acute hospital care and normal community health and social care. In some cases these overlapped with the category of 'teams'.⁴⁷⁻⁴⁹ Trappes-Lomax et al.⁵⁰ compared the use of a residential intermediate care unit with traditional community health and social services. A set of three papers reporting the national evaluation of intermediate care⁵¹⁻⁵³ describe case studies of this type of care from several different methodological perspectives. However, the central issues of joint working seem to be about the relationship between acute and community services, rather than that between health and social care.

Pooled budgets

One study looked at the experience of using pooled budgets as a result of the flexibilities introduced by the Health Act 1999, to enable collaboration between health and social care in England.² In this case the comparison was with arrangements in Sweden. The study looked at a range of case studies covering different services, budget sizes and organisational models. The published paper does not give details of the case studies included, but draws out general themes arising from the use of the flexibilities allowed by the Act.

Effectiveness of joint working

Assessing effectiveness is based on the evaluation of how a policy or other intervention is implemented, the effects it had, for whom, how and why.⁵⁴ However, not all the evaluations included in this briefing reported data in this way. Some studies are highly descriptive, providing no clear data on effectiveness,^{29,37} and others do not define specific outcome measures, with the result that reviewers have had to distil them from papers^{16,17,29,32,35,39,40,46,47} or report outcomes that are unrelated to the evaluation.⁴⁹ Few are comparative in design or

offer a before-and-after analysis following the introduction of a new service. This makes it difficult to assess whether or not an intervention has been a success. In other words, did it make a difference to the health and wellbeing of people using the service? Was the service accessible and acceptable? What outcomes mattered to service users?

This difficulty is compounded by differences in the models of joint working, the range of working practices and arrangements identified, the variety of standardised measures used, differences in study design and the complexities of comparing services in two large and heterogeneous service user groups (older people and people with mental health problems). However, trends in the data are evident and in this briefing have been grouped around clinical outcomes, service provision and impact on staff satisfaction and stress. Service user and carer perspectives are reported separately.

Clinical outcomes

Improvements in quality of life, health, wellbeing and coping with everyday living are reported across a number of studies.^{26,36,47,52} However, where evaluations are based on a comparative design which assesses different types of joint working, including integrated and non-integrated care, no significant differences or only marginal differences were reported.^{19,24,27,34,50} The complex study of CMHTs by Schneider et al.²¹ found few differences in quality of life between 'integrated' and 'discrete' districts. Where differences were identified, service users in integrated districts socialised more and had less difficulty accessing police and legal services. In their study of the effectiveness of a joint NHS/social services rehabilitation unit for older people on discharge from community hospital, compared with 'usual' community services, Trappes-Lomax et al. comment that 'results for the two groups are strikingly similar'.⁵⁰ These findings are not explained however. Other authors suggest that this may reflect a mix of reality at the frontline,²¹ service user characteristics³⁴ and the fact that the integrated services being assessed had not been fully

implemented.^{19,27} Equally, it may simply be the result of the study design itself: the instruments used may have been insufficiently sensitive to change over time, or the time period may have been too short to capture change.²¹

Avoiding inappropriate admission to acute or residential care

The reduction of inappropriate admissions to acute or residential care has been identified as part of the role of intermediate care.^{48,49,52} Small-scale studies of rapid response teams suggest that their provision of health and social care services in the community has an important role in supporting people to remain in their own homes. In Brooks' study⁴⁹ of a new intermediate care rapid assessment support service, just four (5 per cent) of all the older people using the service were admitted to an acute hospital. Making a similar point, Beech⁴⁸ uses staff estimates to suggest that 92 per cent of referrals would have remained in the acute setting without the intervention of intermediate care.

Remaining independent at home

The organisation of a service does not appear to improve the likelihood of service users being able to live in the community; rather, need and access to support at home are key factors. Clarkson et al.³⁶ found that although an integrated assessment completed by specialist clinicians and social services care managers reduced the overall risk of care home admission, 'the intervention increased the risk of care home [i.e likelihood] entry for the frailest individuals, a positive effect of targeting'. Two separate studies that compared outcomes for older people using a new integrated health and social care team with those served by a more traditional model of service found no statistical significance between the two.^{27,34} Davey et al.³⁴ found that an older person's score on the Mini-Mental State Examination (MMSE) was the most influential predictor of whether they were able to remain at home, followed by home care hours and living with others. Co-location between health and social care services was not significant as a predictor of whether a person remained at home.

Service provision

Surveys and interviews with staff identified a range of service developments that were believed to have improved provision. These included:

- rapid referral and assessments^{16,39}
- increased flexibility, responsiveness and adopting a proactive approach to individual circumstances and requirements^{16,18,32,53}
- the benefits of a single point of access^{39,53}
- a single key worker²⁴
- improved communication and coordination between agencies^{16,46}
- access to pooled knowledge and resources^{16,24}
- the opportunity to be more service user-centred.^{16,53}

In Sutcliffe's before-and-after study³⁸ of the introduction of SAP in three areas, significantly more multi-disciplinary assessments were found to be undertaken after the introduction of SAP than before. Where multi-disciplinary teams worked well, opportunities to discuss concerns with colleagues from different disciplines, seek back-up and agree a plan of action were welcomed and afforded 'more considered but potentially less conservative decisions'.¹⁷

Service organisation, staff satisfaction and stress

The effects of service organisation on staff satisfaction and stress were explored by Carpenter et al.²³ who found that there were systematic differences in team functioning, favouring teams in districts where mental health and social care services were integrated. However, service organisation had no evident impact on professional or team identification or on outcomes for staff in terms of stress or job satisfaction. This appeared related to role conflict, with social workers reporting poorer perceptions of team functioning and experiencing higher levels of such conflict.

Controlling for other factors, role conflict was a significant predictor of stress and job dissatisfaction, while role clarity promoted job satisfaction. The importance of support and

supervision aimed at ensuring a social work contribution to multi-disciplinary working was also noted. In Gulliver et al.'s final evaluation of the first fully integrated health and social services mental health trust in England⁴⁴ it was found that while role clarity and morale got worse for 18 months following integration, these reductions were levelling off and in some cases reversing after two years. This reflects improvements in the team environment, with proximity improving communication and staff welcoming the opportunity to learn new skills. However, boundaries between professionals continued to exist within community teams and other services, particularly the acute sector.

Costs and cost-effectiveness

Assessing the costs and cost-effectiveness of joint working is hampered by a lack of economic evaluation evidence, evidence that is dated^{19,22,31,32,47,55,56} and the diversity of approaches to integrating services. No evaluation included an analysis of cost-effectiveness, and this lack of evidence meant that Ellis et al.⁵⁶ were unable to carry out their proposed investigation and provided a resource utilisation analysis instead. They compared a joint NHS/social services rehabilitation unit for older people on discharge from a community hospital with 'usual' community services. Overall, they found that the costs were almost identical between the two groups. This finding is echoed in almost all other studies that compared integrated service provision with standard care.^{19,31,34,36}

There is some evidence that intermediate care can be cost-saving.^{47,52} Kaambwa et al.⁵² studied the cost of five intermediate care schemes in relation to health outcomes for older people and found that, compared with those admitted as part of a supported discharge scheme, those who were admitted as part of hospital avoidance schemes experienced greater gains on both the EQ-ED and Bathel indices. Importantly, hospital avoidance services were also associated with lower cost, with a mean episode (29.5 days) costing on average £1,200 compared with £1,500 for supported discharge cases.

However, while intermediate care patients who had been admitted to avoid hospital incurred higher costs – patients in residential settings cost more than three times as much as those in non-residential settings (£2,784 versus £879 per patient) – the authors point out that these patients would otherwise be occupying a hospital bed and so hospital costs are avoided. It should be noted that many of those receiving intermediate care would have simply stayed at home or gone home from hospital without such care. In other words, the new service could be described as an ‘add on’ – good for people who got it but sometimes providing additional rather than alternative services.

Service organisation, use and costs

Sophisticated analysis of costs across four districts providing community mental health services illuminates the impact of service need – rather than service organisation – on costs.²² As noted above, the study by Schneider et al. compared four districts that had fully implemented the care programme but organised their services differently. Two mental health trusts worked closely with the local social services department (‘integrated’) and two worked independently (‘discrete’). Two saw a broad range of clients (‘inclusive’) and two focused on people with severe mental health problems (‘targeted’). While people who were most likely to use social care lived in a district that was both integrated and inclusive, when the amount of services used (costs) were measured, there was a greater degree of service consumption in targeted districts. This is true for community mental health services and for social services, and consequently for costs in targeted districts. In other words, differences in costs reflect case mix, with services targeted at people with severe mental health problems increasing costs by 50 per cent.²²

Integrated districts were found to be no more costly than discrete districts. Indeed, there were indications that when taking health and social care costs together, integrated districts may be less costly. However, the authors conclude that since both targeting and integration are increasingly common mental health policies, it is important to recognise that they may have opposing effects on costs.

Where costs fall – health and social care agencies

Costs can fall differently on different partners. Investing in community services to reduce the cost of acute care is dependent on being able to release potential savings in practice. In the integrated districts, described above, social services bore a larger share of costs. In targeted areas, costs borne by health services were significantly higher. In the district that was both integrated and inclusive, there was a more equal share of the costs because the care manager also acted as a key worker. This ‘see-saw’ effect was noted in one other study: Ellis et al.’s investigation⁵⁶ of a joint NHS/social services rehabilitation unit. Here it was found that the cost of the unit option fell more heavily on social services (£5,011.56, compared to £3,530.72 to the NHS), whereas the community option fell more on the NHS (£5,146.74, compared to £3,363.94). The difference in NHS costs was largely due to the control group’s longer stay in hospital (costing £2,080.87 on average per person compared with £883.03 for the intervention group). The difference in social services was mainly due to the cost of the rehabilitation unit (a mean cost of £1,503.37).

Where costs fall – service users and carers

The costs of unpaid or informal care were almost never included in cost studies, and yet the unpaid care provided by friends and relatives and the time costs to service users themselves can have a major bearing on the potential cost-effectiveness of health and social care interventions. It is significant that Schneider et al.²² noted that productivity losses for service users and carers were not included, since their study was primarily interested in the cost to providers of different forms of service organisation.

Only one study offers us a rare insight into informal costs. Clarkson et al.³⁶ re-analysed data collected from a randomised controlled trial of an integrated assessment for older people completed by specialist clinicians and social services care managers. They included informal costs, in terms of ‘personal consumption’ (not explained) and housing costs incurred by carers and the older people themselves. For the frailest

individuals, the integrated assessment led to increased costs for the NHS and social services but a reduction in costs to older people and their carers. However, for those with severe cognitive impairment, the integrated assessment reduced NHS and social services costs while raising informal costs. The authors offer no explanation for these effects but they may reflect admission decisions by clinicians and social services managers. The views of service users and carers are not included.

Factors promoting joint working

It became clear that the three broad themes identified in the original systematic review were still valuable as categories under which to organise the factors that supported or hindered joint working. These themes were organisational issues, cultural and professional issues and contextual issues. Within these overarching themes, new areas of interest emerged.

Organisational issues

Aims and objectives

Ensuring that professionals and agencies involved in new initiatives understand the aims and objectives as well as the detail of the eligibility criteria and referral processes is important to the success of any new initiative. One way to develop a common understanding is to involve staff in the development of the policies, procedures and protocols underpinning the service.⁴⁷ Additionally, professionals who are not part of the core partnership (e.g. those working in referral services) need to understand the eligibility criteria if the initiative is to succeed.²⁶ Providing introductory as well as ongoing training was identified as a constructive way to ensure that a common goal is established among partners.²⁷

Roles and responsibilities

At an operational level it is important that all parties involved in a new joint initiative understand the roles and responsibilities of those involved, and such understanding is thought to lead to better outcomes.²⁷ Such responsibilities include the management of budgets, administrative support and the coordination of material resources.³² Once again the provision of training was identified as a

way to ensure that policies and procedures underpinning new initiatives are widely understood and that staff are competent to complete new procedures – for example, if new types of assessment are required.^{18,26}

However, it is equally important that there is a similar understanding of roles and responsibilities at the strategic level. For example, having a comprehensive service-level agreement drawn up to underpin the placement of social workers in GP practices enabled agencies to identify respective responsibilities for the initiative.³² Similarly, Drennan et al.²⁸ highlight the importance of having clearly specified reference terms and membership criteria for project steering groups and/or management groups as well as an explicit operational plan. Ensuring that there are clear frameworks, both legal and financial, underpinning the establishment of pooled budgets was identified as being supportive of partnerships.² Equally, strategic commitment at an executive level to devolve responsibility has been identified as important to the outcome of joint initiatives.³²

Flexibility in relation to work roles was reported to be beneficial in a number of studies.¹⁹ Regen et al.⁵³ note that flexible roles supported the aims of intermediate care services and that having a flexible approach to the organisation of work in specialist multi-agency teams was thought to improve the responsiveness of the service, ensuring that the needs and preferences of older service users were met.¹⁸

The development of new integrated roles was also identified as being supportive of joint working.^{27,29} Staff working in integrated teams reported less role conflict and fewer contradictory demands than those working in other types of team. They also considered integrated teams to be more innovative and supportive of new ideas.²³

Past history of joint working

A previous history of strong and supportive local partnerships was identified as an important factor in the success of joined-up services.^{16,37,47} For example, Taylor²⁹ notes how a previous

history of joint working between GPs, district nurses and home care managers enabled a new initiative to build on existing informal processes of communication and capitalise on the goodwill that the previous experience had fostered. Positive relationships at a strategic level, for example that in the past may have been between county council and health authority staff, were also seen to be supportive of integrated working.

Communication

Effective communication was reported to enhance joint working in a number of studies.^{16,18,27,46} For example, informal and open communication within a multi-disciplinary team was thought to be valuable in supporting a newly-established venture,¹⁶ and improved communication associated with integrating services was perceived to lead to improved outcomes for people using services.³⁶

Information sharing

Effective mechanisms to share information, including shared documentation and shared or compatible information technology systems were factors identified as improving joint working, leading to speedier and timelier assessments of need.^{19,27,49} Effective communication was also reported to lead to cases being prioritised more efficiently.³²

Adequate resources

Several studies noted the importance of having adequate funding to support an initiative. For example, ensuring that there were resources to provide holiday or sickness cover for placement schemes (e.g. where social workers practice from GP surgeries) was an important element of their success.³² Working in partnership can mean that agencies have access to additional resources to support a venture – for example, it might increase opportunities for joint training¹⁶ or improve access to a range of facilities.² The existence of a unified budget was identified as a factor that supported joint initiatives.²⁸

Co-location

Co-location was reported to be an important element in the success of joint working. For

example, it leads to greater levels of informal contact which in turn increases mutual understanding.¹⁹ It was also reported to lead to quicker and easier communication¹⁶ and to facilitate learning across professional boundaries.¹⁵

Strong management and professional support

Strong management and appropriate professional support at an operational level were reported to be important elements of successful joint working, whether in relation to integrated services,⁵³ multi-disciplinary teams working as part of an integrated service,^{16,47} specific initiatives such as the introduction of SAP^{37,39} or placement of social work staff in a GP practice.³² The presence of strong leadership was thought to contribute to staff feeling more confident in their new team or role.^{16,47} Additionally, having coordinated leadership between different professional groups within a multi-disciplinary team was reported to improve understanding of the aims of the initiative.⁴⁹

Similarly, Rutter et al.¹⁹ identified the importance of having an integrated management structure. Ensuring staff felt supported in their professional role was seen to be an important part of effective multi-disciplinary working.⁵³ Being able to access expertise from a range of professions within the team was thought to lead to better outcomes for people receiving services.^{36,49} Finally, the complexity of joint ventures often meant that key individuals played an important role in linking organisations and cultures, acting as a 'trusted allies'.²⁹

Cultural and professional issues

Regular team-building events were identified as a factor supporting the introduction of new multi-disciplinary health and social care teams.^{27,29} Team-building and subsequent weekly meetings were used to create a common sense of purpose, allocate and discuss cases and provide an opportunity to share information which supported the functioning of the team.²⁷ Regular team meetings were also seen as a means to foster understanding about different professional roles, overcome professional differences⁵⁷ and build trust and rapport between different groups.²⁹

Contextual issues

No contextual issues were consistently reported to be supportive of joint working. However, a number of interesting themes were identified in single studies. Asthana and Halliday⁴⁷ report that the specific context of a locality, in this case the demographic composition as well as the rurality of the area, provided a 'compelling' reason for agencies to collaborate and develop an intermediate care system. Drennan et al.²⁸ note the importance of ensuring that new services were linked into the 'whole system' – in their case, older people's services.

Establishing a new rapid response team was reported to be a welcome opportunity to make a fresh start.³⁰ Integration as such – for example, through the establishment of a combined health and social care mental health trust – was reported to improve joint working.⁴⁰ Finally, Hultberg et al.² suggest that one of the consequences of pooling budgets is that it makes transparent the process of resource allocation, thereby empowering organisations to challenge the conventional ways in which services have been delivered and enabling more creative solutions to be explored, while at the same time making the process more equitable.

Factors hindering joint working

Organisational issues

Aims and objectives

The importance of partner agencies understanding the aims and objectives of any joint working initiative is central to its success, but establishing a shared purpose can prove problematic.²⁸ Several of the studies exploring the introduction of intermediate care services and other examples of integrated services reported a lack of understanding of the central aim and underpinning philosophy of these initiatives among some health professionals.^{36,47,51} Without a shared understanding of aims and objectives, partnerships may struggle to develop a sense of purpose at the operational level, and this difficulty is compounded when there is little clarity about the lines of responsibility and authority for decision-making.²⁸ Without consensus about the aims

and objectives of an initiative it becomes almost impossible to evaluate progress.

Roles and responsibilities

A number of studies identified that a lack of understanding about new initiatives or services could lead to a lack of clarity about the roles and responsibilities of the agencies and professionals involved, as well about as the policies and procedures underpinning the new service or way of working.

For example, insufficient shared understanding about the aims of intermediate care resulted in a lack of appreciation of processes such as eligibility criteria and referral.⁵¹ The same study by Glasby et al. identified a lack of understanding of professional roles among hospital and intermediate care staff. A similar shortage of clarity was noted by McCormack et al.⁴⁶ who report that this resulted in inappropriate referrals and delays in treatment. At an individual level, insufficient appreciation of professional roles in relation to the introduction of SAP led to confusion and protectionism among those involved, as well as concerns about the blurring of professional identities.³⁷ Finally, Huby and Rees³⁰ note concern about maintaining role boundaries in multi-agency teams while Rutter et al.¹⁹ show that rigid and inflexible professional roles can undermine joint working.

Organisational difference

At a strategic level, competing 'organisational visions' about the joined-up agenda and a lack of agreement about which organisation should lead which ventures appeared to undermine the success of initiatives aimed at joining up services in a systems-wide approach, as did the absence of a pooled or shared budget.⁵³ Differences in resource and spending criteria between local authorities and NHS partners were thought to undermine the aims of joint working.¹⁹ Finally, Drennan et al.²⁸ note how difficult it is to turn divergent organisational agendas into an integrated operational reality.

At an operational level, differences in organisational policies hampered joint initiatives.

For example, different attitudes towards risk management that were evident between GPs and social workers led to inappropriate referrals to residential care,⁵⁷ while differences in health and safety policies presented challenges to frontline staff working in intermediate care services.⁵³ Additional difficulties were experienced by professionals straddling team and parent organisation boundaries.³⁰ For example, different funding streams frustrated attempts to develop joint assessment mechanisms.¹⁶

Communication

Communicating across professional or agency boundaries can often prove difficult. Professionals working in integrated services sometimes struggled to communicate effectively, particularly when they were not located on the same site. Occasionally these difficulties led to delays or gaps in care and treatment.⁴⁶ Brooks⁴⁹ notes that communication within a multi-disciplinary rapid assessment support service broke down once an older person was admitted to acute care. This resulted in information not being routinely shared with ward staff, thereby undermining the continuity of social work support that the service was set up to deliver.⁴⁹

Information sharing

Not surprisingly, difficulty sharing information, lack of access to information, as well as incompatible IT systems were reported as factors that undermined joint initiatives.^{2,19,25,39,53} Additionally, misunderstandings about the suitability of sharing information electronically between GPs and members of multi-disciplinary teams supporting older people caused delays in the setting up of services.²⁸ In a similar vein, professional concern about the logistics and appropriateness of sharing information via the creation of shared electronic databases was identified as a factor undermining joint initiatives,⁵⁷ and one study suggested that such concerns were most apparent among professionals with no previous experience of working together.³⁷ While such difficulties were generally reported in relation to specific services, occasionally they were apparent at the boundaries between different sectors and were likewise thought to impede integration for similar reasons.⁴⁶

Co-location

Fragmentation of services and a lack of uniformity in terms of their location meant that in some instances referral processes were complex and professionals struggled to respond consistently and coordinate individual programmes of care.⁴⁶ Interestingly, while most studies that reported the impact of co-location were supportive of the strategy, this view was not universal. In an evaluation of multi-agency working, Kharicha et al.⁵⁷ report that co-location sometimes led to greater informality, which could in turn undermine professional practice. The authors also note that social workers were concerned that co-location in a health centre undermined their ability to prioritise the work of their social service employer.

Strong management and professional support

A lack of strong and appropriate managerial support was thought to undermine attempts to work across agencies and professional boundaries, leaving practitioners feeling unsupported.^{25,37} Drennan et al.²⁸ suggest that the absence of effective management might reflect a lack of experience in collaborative working among some professional groups. Additionally, the presence of separate management structures was regarded as an undermining influence.^{19,39}

Involvement

Whether or not professionals were involved in the development of new services and ways of working affected how such ventures were perceived and valued.³⁷ Glasby et al.⁵¹ report that within intermediate care services a lack of involvement in the initial planning of services by some professionals (specifically health staff) might have contributed to a perceived lack of understanding and appreciation of these services. They suggest that such a lack of understanding might lead to an unwillingness to refer patients into the service.

Cultural and professional issues

Negative assessments and professional stereotypes

Cultural differences between professional groups can undermine joint working at both the

strategic and operational levels.³⁹ Studies investigating intermediate care noted an imbalance of power between community and acute sectors, suggesting that new services might become dominated by the interests of acute services at the expense of their partners.⁵¹ Similarly, Drennan et al.²⁸ note that cultural differences could undermine partnerships and that, in the absence of clarity about lines of authority, strong and weak partners may emerge.

Different professional philosophies

By its very nature, joint working brings together professionals with different philosophies and values as well as divergent professional cultures. Not surprisingly, these differences can act as barriers to effective joint working.^{39,41,57} For example, Scragg²⁵ notes a perception that social work values, and in particular the social model, were not respected by health professionals and this led to a lack of appreciation of their contribution within multi-professional teams. Carpenter²³ reports that social workers based in such teams experienced higher role conflict and more stress compared to their colleagues. He suggests that this was due to a perception that their professional values and culture were under threat when working in a health-dominated environment. Differences in professional culture were also believed to undermine the introduction of integrated systems, with some professional groups appearing not to appreciate or value the aims of integration.³⁶

These professional differences could also affect specific elements of practice within a joint initiative. For example, a lack of understanding about the nature of supervision expected within a particular profession could result in either a lack of supervision or a duplication of arrangements within a multi-disciplinary team.²⁸ Several evaluations noted distinct professional attitudes towards the appropriateness of shared client records,¹⁶ particularly the electronic sharing of information,⁵⁷ and different attitudes to concepts such as 'risk' led to divergent practice related to the discharge of older people.³⁵ Gibb et al.¹⁶ note that health and social care staff differed in terms of the type and level of decisions they could make and that they had different lines of

accountability; such differences tended to dilute the effectiveness of joint working. Integration was also associated with an increase in bureaucratic activity, for example requiring primary care staff to apply eligibility criteria for home care services, a task they were not previously required to perform.²⁹

Trust, respect and control

Trust and respect between professionals is critical to the success of joint working. The introduction of initiatives such as SAP requires professionals to be confident with the assessments made by other groups. However, an evaluation of local implementation suggests that professionals sometimes lack confidence in, or are mistrustful of, the assessments made by others.³⁷ This was most pronounced when professionals had no prior experience of working together. Glasby et al.⁵¹ note that hospital staff were perceived to be reluctant to refer older people into intermediate care because they might 'lose control' of their patients. In another example, lack of trust in a team manager who came from a different professional background led social workers to bypass their leader and seek the support of their own professional lead.²⁵

Joint training and team-building

Joint training and team-building events provide opportunities to build relationships between different professions and agencies as well giving an opportunity to inform professionals about new services and the policies and procedures that underpin them. The absence or limited nature of such events was believed to undermine joint working.^{37,39} For example, in an evaluation of the implementation of an integrated health and social care assessment, professionals reported the need for more training. District nurses in particular wanted more training related to the practical skills required to complete the assessment, which included asking about personal finances – something they had never previously had to do.³⁹

Role boundaries

Several studies noted the negative impact joint working can have on professional identity, including role boundaries.³⁰ For example,

placement schemes appeared to raise concerns about role identity.³²

Contextual issues

Relationship between agencies

The relationship between agencies is always crucial to the success of joint working initiatives. Complex relationships between the different agencies involved in the delivery of intermediate care were identified by Glasby et al. as a factor that undermined the effectiveness of services.⁵¹ That study notes a perception that the intermediate care agenda was becoming dominated by the needs of acute health care at the expense of the aims of community services, health and social care.

Constant reorganisation and lack of coterminosity

The continual drive to reform welfare services, particularly in relation to health and social care, was another factor that undermined joint working. For example, reform within the sector tends to add to the complexity of any new development⁵¹ or divert attention away from operational issues.²⁹ A lack of coterminosity between home care services and GP practices undermined the ability of professionals to refer older people to a multi-agency team.²⁹

Financial uncertainty

Uncertainty about financing for joint initiatives was a challenge. For example, a lack of designated funding for intermediate care services allied to the short-term nature of funding was reported by Regen et al. to undermine the implementation of integrated services.⁵³ The same study also notes that the financial pressures facing all health and social care agencies meant that some joint initiatives were under-funded.

Burch and Borland³⁵ argue that the move towards greater collaboration in relation to services for older people requires adequate planning, particularly in relation to ensuring that facilities are fit for purpose, and this of course requires adequate funding. Finally, while Hultberg et al.² report many positive factors associated with pooled budgets they point out

that they could damage the viability of partner organisations if the pooling led to a fragmentation of service responsibilities.

Labour market

Difficulty in recruiting staff was another factor that appeared to undermine the progress of some new joint initiatives.¹⁹ For example, Regen et al.⁵³ note the difficulty of recruiting care workers and rehabilitation assistants to work in intermediate care services, particularly in rural areas.

Service user and carer views

Insights from service users and carers about their experiences and what outcomes matter to them are rarely included in evaluations of joint working. When they are included, often surprisingly limited details are reported. This in part reflects an evidence base characterised by small⁴⁹ or unspecified sample sizes,³³ and is also partly due to the fact that the views of service users and carers are rarely analysed in a way that promotes understanding of their differing and potentially competing needs.^{33,47–49} In some cases, it is simply down to the fact that the views of service users and carers were reported separately in research reports but not included in peer review papers for publication and hence excluded from this briefing.^{16,34,50}

Where evaluations took account of service users and carers, samples were largely drawn from the white population, meaning black and minority ethnic (BME) groups are under-represented. Only one evaluation of dementia services directly addressed the importance of improving referral rates from BME groups, although their views are not reported in any detail.²⁶ Diversity in terms of sexual orientation is never specified, meaning that any implications for lesbian, gay, bisexual and transgender (LGBT) people are missing from evaluations of different types of service delivery. These limitations make it difficult to assess the impact of integrated services on the experiences of all service users and carers. However, where accessible evidence exists, integration is associated with increased user involvement, choice and control.

Experiences

Many service users report high levels of satisfaction with integrated services.^{18,24,28,33,47-49}

Service users value:

- responsiveness to their needs through more timely initial assessment and subsequent interventions^{18,28,33,49}
- partnership working and the development of trusting relationships with named key workers^{18,24,29,49}
- improved communication between agencies^{15,49}
- help interpreting information and navigating unfamiliar and complex systems³³
- support to maintain their independence in the community.^{24,28,46,48,49}

As one older person who had been referred to five different health and social care services following assessment by a multi-disciplinary team targeting older people at risk said, 'I think it's [the team service] excellent; it's been a lifesaver for me. It's opened up so many vistas for me. They've helped enormously.'²⁸

Like service users, carers also welcomed the responsive nature of the service, highlighting timely assessments and interventions that were tailored to their individual needs as well as those of the service user.¹⁸ They valued the additional support and felt relieved of some of their responsibilities, which led to reduced stress and fewer crisis situations.³³ This was particularly welcome where carers were combining caring with other responsibilities, such as parenting, or crucially where carers were service users themselves.⁴⁹ As a carer and service user commented when describing a new intermediate care rapid assessment service, 'I don't want to go into hospital, you know. I look after my wife ... I think that the idea that the scheme prevents this is very good.'⁴⁹

Comparative studies suggest that such support is not necessarily available in standard, non-integrated services.¹⁸ Based on a study of 64 carers of people with severe mental health problems served by four different mental health

care services, Schneider et al. conclude that the carers in integrated districts were 'on the whole less adversely affected by their role'.²⁰

Links between service organisation and user satisfaction

Unravelling the impact of service organisation on service user and carer satisfaction can be difficult. Where studies attempted to identify a direct relationship between users' experience of a service and changes in organisational arrangements, people made little distinction between who organised or delivered the service and focused only on whether or not it was appropriate for them.^{25,27,29,41} In other words, service users did not articulate a concern with the integration of health and social care as such; rather they simply appreciated the fact that they had access to the support and services of their choice.

As part of the suite of papers concerned with how different models of community care impact on the experiences of 260 mental health service users, Carpenter et al. found 'a statistically significant advantage in terms of users' satisfaction with integration as an approach'.²⁴ Users in integrated districts felt more able to state their aims for care and treatment, felt less limited in their choice of care, felt better informed about medication and less negative about their family's involvement, and were more positive about being supported in independent living. The authors suggest that this is linked to the following features of integrated services:

- 'holistic' common assessment protocols that include social care as well as clinical mental health needs
- a single key worker/care manager based in the community (a system that both service users and carers welcomed as promoting more choice than hospital-based discharge planning)
- key workers having the authority to use resources from both agencies, without needing to refer users to an assessor in another agency.

The authors conclude that 'user involvement and choice is facilitated by policies and procedures in integrated service districts'.²⁴

Dissatisfaction and difficulties

Despite this, service users and carers also reported significant problems. Areas of dissatisfaction included continuing communication difficulties between agencies, particularly when a service user was to be admitted to respite care or hospital, and continuity of care was therefore broken. This was especially apparent in mental health services.⁴⁹ Service users also identified difficulties with their involvement in care planning and their ability to influence the choice of care options.^{33,41,46-48}

Even in the best services, there is always room for improvement. Carpenter et al.²⁴ highlight the fact that only half of mental health service users reported that they had a written care plan as part of the care programme approach. Feedback from professionals acknowledged that the discrepancy could not be accounted for by users having lost or forgotten their care plan. Given that users were generally positive about their care plans, the authors conclude that this is an area of serious concern and that practitioners must 'redouble their efforts to ensure users receive their entitlement to a care programme'. Peck et al.⁴¹ point out that while service users were largely satisfied with services throughout the reorganisation process in Somerset, 'the concerns of users about their relationship with staff – often expressed in terms of staff attitudes – appears to have played no part in the design and implementation of the changes'.

Outcomes that matter to service users and carers

The complexities of developing appropriate outcome measures, particularly for older people, are widely recognised.³⁴ However, although some studies attempted to capture user- and carer-defined outcomes, these outcomes were not always well described.²⁸

Only one study provided a detailed analysis of the outcomes that matter to the people using the services themselves. McLeod et al.³³ conducted a

small-scale qualitative evaluation of the significance of the social worker services received by older service users on admission to accident and emergency (A&E) departments. The development of social work in such departments was part of a joint health and social care policy drive to divert older people from 'unnecessary' admission to acute hospital care on social care grounds. However, the authors conclude that from the older people's standpoint the prime criterion for assessing social work needs in the A&E environment was not its powers of diversion but its contribution to optimum health and social care. McLeod et al. argue that it should not be assumed that social care can be a substitute for emergency admission; from an older people's perspective they often considered their admissions to be caused by a medical emergency that required hospital treatment at that time.

Gaps in the research evidence

Studies largely focus on small-scale evaluations of local initiatives that are often of poor quality and poorly reported. Details about working practices and arrangements are often limited and/or the authors fail to discuss the factors that promote and hinder joint working. Few studies are comparative in design, so differences between 'usual care' and integrated care are not assessed. Small-scale, 'boutique evaluations' of joint working make it difficult to draw firm conclusions about the effectiveness of UK-based integrated health and social care services.

As indicated, evidence on cost-effectiveness was not identified in our searches. This means that we have no means of assessing the costs and benefits to service users and carers of integrated care versus standard care or different types of integrated services.

The voice of service users and carers remains largely absent. Their views are not routinely collected in evaluations, which makes it almost impossible to comment on the outcomes that matter to the people who use services

themselves. Where they are included, service users and carers are treated as a homogeneous group. This makes it difficult to unravel the impact of integrated services on groups who may have different and sometimes competing needs.

The impact of personalisation on integrated services is missing from this briefing. Most of the studies pre-date 2007 and the signing of the *Putting people first* concordat in England, a joint agreement between the NHS and local authorities which was also signed by the Department of Work and Pensions.¹³ This means that we cannot comment on the development of personal budgets and any effect this has had on the way in which health and social care services are organised. Nor can we comment on the potential of integrating personal budgets, assessment and self-directed support planning in health and social care and what this may mean for the experiences and outcomes of service users and carers. For recent information on the effectiveness of joint working, the national evaluation of DH's integrated care pilots provides a detailed assessment of 16 projects that aimed to integrate care, largely between community-based services such as general practices, community nursing services and social care.⁵⁸

Implications from the research

Implications for organisations

A clear message emerging from the research is the need to ensure that new partnerships and integrated services are developed in such a way that the different professions and agencies involved understand their the aims and objectives, and appreciate the relevance of the initiative to the local context. The involvement of operational staff in initial discussions about such ventures is one way to overcome misconceptions about new services, while regular meetings provide an opportunity to develop policies and procedures as well as offering a setting to resolve problems and review practice.

Transparent and appropriate management arrangements are vital to the success of any joint working venture. Clearly articulated and effective managerial structures, that incorporate both professional as well as organisational managerial support, appear to be associated with staff feeling more secure and confident in their new roles and working contexts.

Implications for practitioners

Successful joint working requires practitioners to reconcile their professional values and roles with the aims and objectives of the joint initiative. One way to achieve this is to ensure that the outcomes for service users and carers are made explicit from the start, so that practitioners appreciate the benefits of the joint activity to those they support, and progress can be monitored routinely.

A willingness and ability to share information in a timely and appropriate fashion is also key to joint working. Attention has focused on establishing the means to share information (such as shared databases and compatible IT systems). However, there remain some professional barriers to sharing information and attention needs to be paid to ensuring that professionals understand the need to do this and have confidence in the processes in place for doing so.

Implications for service users and carers

Defining outcomes that matter to service users and carers is important. Outcomes defined by service users may differ from policy and practice imperatives and are a crucial aspect of understanding the effectiveness of integrated services from the perspectives of the people who use them.

Integrated services work best when they promote user involvement, choice and control. Although most service users and carers report high levels of satisfaction, more can be done to involve them in care planning and influencing future care options. Such involvement in the current policy context is the cornerstone of self-directed support.

Service users and carers value services that are appropriate to their needs; they are less concerned with how services are organised. Service users value timely assessment and services, partnership, and the development of trusting relationships with named care coordinators. Improved communication and coordination between agencies is also important to them. Carers value assessment in their own right and welcome additional support, particularly when they are service users themselves.

Implications for researchers

Given the importance of the issues raised in this briefing for policy-makers, there is clearly a need for researchers to sharpen the approaches brought to studies of joint working. The central issue for research is to develop ways of identifying and evaluating the outcomes of joint working for users and carers. Compared with the earlier review, there were more papers included that did this, but they tended to be clustered in the bigger, more complex studies.

There is also a need for studies to describe more clearly the organisational models being used. Words like 'team' cover a multitude of forms, and it was not always possible to discern from the published papers how different research sites operated in terms of some of the key issues such as communication, information sharing and management arrangements.

Implications for the policy community

The evidence base on joint working remains lacking. While there is some indication that integration in particular may have positive

benefits for organisations as well as for users and carers, there is a need for more high-quality, large-scale evaluations to test the underpinning assumptions in a more robust manner.

Studies exploring the establishment of integrated services/systems consistently report a lack of appreciation of the aims of integration among health professionals. Additionally, there appears to be concern that the contribution of community health and social care services might be marginalised by the interests of the acute sector. Such perceptions are not helpful and suggest that more attention needs to be paid to explaining the aims of this policy, and its contribution to health and wellbeing, if it is to be successful.

Conclusion

There are some tentative signs that progress has been made since our original review and that it is now possible to demonstrate some positive outcomes for users of services, carers and service organisations. However, the evidence base is patchy and more research is required to sharpen and broaden our understanding of these outcomes.

There is a need for more high-quality and complex studies to be undertaken in order to gather sufficient data, on a large enough scale, to demonstrate the effectiveness of joint working for users of services and the wider health and social care economy. Without this evidence base some professionals will remain sceptical about the importance of joint working and integration to adult health and social care.

Useful links

Shaping our lives

A national network of service users providing resources on the design, delivery and experiences of integrated care from the perspectives of people who use services themselves.
www.shapingourlives.org.uk/

DH Care Networks

The DH Care Networks existed to improve outcomes for service users and carers via integration between health and social care. The archive site provides a list of the networks, including personalisation, dementia, dignity in care and commissioning.
www.dhcarenetworks.org.uk/

The national evaluation of the DH integrated care pilots can be found at:
www.dh.gov.uk/en/Publicationsandstatistics/

Health and Social Care Partnerships, Collaboration and Integration Programme

Offered by the University of Birmingham's Health Services Management Centre (HSMC) for health and social care communities to investigate issues of collaboration through research, consultancy and the dissemination of good practice.
www.birmingham.ac.uk/schools/

NHS Future Forum

The NHS Future Forum was set up to report people's views on the Health and Social Care Bill, and integration has emerged as a key theme.
www.dh.gov.uk/en/Publicationsandstatistics/

Research in practice for adults (RIPfa)

A round-up of the evidence for integrated care aimed at staff in health and social care who are dealing with the integration agenda on a daily basis, provided in an accessible and up-to-date format.
www.ripfa.org.uk/publications/integratedcare/

The King's Fund

Integrated care is a key theme of The King's Fund, which provides multiple resources and forums for policy and practice debate.
www.kingsfund.org.uk/topics/

Related SCIE resources

At a glance 18: Personalisation briefing – *Implications for community mental health services*
www.scie.org.uk/publications/atagance/atagance18.asp

At a glance 30: Personalisation briefing – *Implications for NHS staff*
www.scie.org.uk/publications/atagance/atagance30.asp

At a glance 45: *Social care and clinical commissioning for people with long-term conditions*
www.scie.org.uk/publications/atagance/atagance45.asp

Research briefing 33: *The contribution of social work and social care to the reduction of health inequalities: four case studies*
www.scie.org.uk/publications/briefings/briefing33

SCIE Guide 30: *Think child, think parent, think family: a guide to parental mental health and child welfare*
www.scie.org.uk/publications/guides/guide30/

Inter-professional and interagency collaboration
www.scie.org.uk/publications/elearning/ipiac/index.asp

NICE/SCIE clinical guide 42: Dementia – *Supporting people with dementia and their carers in health and social care*
www.scie.org.uk/publications/misc/dementia/index.asp

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About the development of this product

Scoping and searching

Focused searching was carried out between September and October 2011. The scope included peer-reviewed papers reporting UK-based evaluations of different models of joint working across the health and social care interface. It updates a previous systematic review by Cameron and Lart (2003) that reported on the factors that promote and hinder joint working between health and social care. Papers published before 2000 were excluded; papers before 2000 are reported in Cameron and Lart (2003).

Peer review and testing

The authors have research and topic expertise. The briefing was peer reviewed internally for methodology. It was peer reviewed externally by a leading academic expert, Professor Jon Glasby, Director of the Health Services Management Centre (HSMC), Birmingham University. We are grateful for his comments.

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