

# Integrated Adult Health and Social Care Teams in Leeds

A baseline study to inform future evaluation



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# EXECUTIVE SUMMARY

## Introduction

Partnerships have become a core way of working and a statutory duty since 1997. Leeds is in the process of creating a series of integrated health and social care teams across the city – beginning with three initial demonstrator teams in Pudsey, Meanwood and Kippax/Garforth. Health Services Management Centre (HSMC) at the University of Birmingham and the Social Care Institute for Excellence (SCIE) conducted a baseline study to support future evaluation. The Partnerships Outcomes Evaluation Toolkit (POETQ) a web-based tool was used to explore staff perceptions. Service user and carer perspectives were explored using a specially designed pack which community groups could complete. All the data was collected between June and August 2012.

## Key Findings: POETQ Staff Survey

### Themes

Overall, initial results in the three demonstrator teams and from broader partners seem very positive. Despite tight timescales over the summer, 72 people took part. This level of engagement seems a helpful starting point for the creation and roll out of the new teams.

In terms of barriers and success factors, there is agreement that integration can be hindered by a mix of practical (especially IT) and cultural issues, and strong support for co-location and the opportunity to interact more informally. However, there were divided views on having line managers from different professional backgrounds – with some seeing this as a key barrier and others viewing it as success factor.

In terms of staff aspirations for integration, there is a widespread and strong belief that integrated teams can make a practical difference to people's lives and that responses to complex problems need to be joined-up. However, this is currently very non-specific and further work may be required to unpick exactly what this means in practice (for example, exactly what impact do people think integration will have and why?) It is also very similar to messages emerging from national research into joint commissioning, where participants were positive about integration but couldn't necessarily link this to better outcomes.

The data suggests a very high degree of consensus with an optimistic view of integration as a solution to a complex problem. This viewpoint co-exists with slightly different perspectives, which still see integration as primarily positive but are more nuanced in terms of the extent to which:

- Integration might lead to better professional processes rather than to changes in ultimate outcomes for people using services.
- Doubts whether integration really free up professionals to spend more time with users.
- Doubts whether upfront investment of time and resources will later lead to a reduction in duplication.

## **Service Users and Carers Participatory Evaluation Process**

This part of the study explored people's views about integrated services whilst being mindful that, for most citizens, the mechanisms of how services are organised are not of particular interest.

156 people responded.

### **Key Findings: Service Users and Carers**

Service users and carers were asked two key questions:

1. How would you rate how well the services and support you get work together?

41% of people scored 8 or more to this question (1 being poor and 10 being excellent), while 38.5% scored 3 or less.

2. How would you rate how well the services you use help you to live independently and get on with your life?

41% of people scored 8 or more to question two while 34% scored 3 or less.

Participants expressed a range of concerns about current services. These fell broadly fall into seven themes:

#### **Theme one: Is anything really going to change?**

Some participants were unconvinced that the planned changes would actually tackle what they saw as the „real' problems.

#### **Theme two: Dignity and humanity**

This theme is about people feeling that the support that they get (particularly support for personal care) can sometimes be lacking in dignity and respect.

*„It would be nice to know when carers are coming – I have to stay in and wait.'*

#### **Theme three: Support that is about me and my life**

This is about the kinds of support that people say they need versus what is on offer and also about how support is organized.

*„There are so many stupid rules about what they can and cannot do and you don't know from person to person what they are going to say. Some can do washing up, some can't, some can clear and some can't.'*

#### **Theme four: Care and support is not joined up**

Some people had stories about services and support not being joined up although there was a range of experience here.

*„Someone needs to be in overall charge of my care – no one seems interested in my health and how I am managing at home."*

*„Appointments made for me so I don't have to remember to call to make one.'*

#### **Theme five: Process and protocol**

This is about the ways that services operate, or „how things are done'. In particular, people described *„being passed from pillar to post'*.

*„If you don't fit into one of their boxes then you won't get anything.'*

### **Theme six: lack of focus on prevention**

Lots of people talked about having to wait until things got really bad before help and support was available.

*„If you can stay well and in control of your life then you can articulate what you want. If things get really bad then it is harder and you are more likely to give up.’*

### **Theme seven: Not knowing what’s available**

This is about people’s lack of awareness of what is on offer, but also the lack of awareness of some health and social care professionals about community support. It links back to several of the previous themes.

## **Conclusion and recommendations**

Perhaps unsurprisingly, the multi-faceted approach adopted in this report has produced different findings from different stakeholders. While this is not unexpected, it does point to the difficulty of introducing significant changes that affect both staff and service users/carers at the same time. Integration is a broad concept and can often mean different things to different people. The findings here suggest that different participants have a range of positive and negative views on current services and on the proposed way forward. Working with such diverse experiences and trying to build consensus about the nature of the problem to be solved and the best way forward is therefore a key challenge.

For staff, there was a generally positive response to the research, good understanding of the integrated teams being created and an optimistic view about what integration can achieve. At this early stage, there was less clarity about issues such as future line management arrangements and less understanding of the new teams from broader partners – and these may be key areas to focus in the next phase. Many staff believe that integration can make a real difference to people’s lives – although this seems more of a general sense rather than a detailed analysis of exactly what outcomes integrated teams should be able to achieve and how. Again, exploring this in more detail may well be a crucial next step. By adopting a more nuanced approach to evaluation than is often the case in inter-agency settings, the POETQ tool has surfaced a number of underlying themes, including the extent to which:

- Integration might lead to better professional processes rather than to changes in ultimate outcomes for people using services.
- Integration will really free up professionals to spend more time with users.
- Upfront investment of time and resources will later lead to a reduction in duplication.

For users and carers, there is a much more mixed view of current services and future developments. While many people taking part in the research had a positive view of services, many also had negative experiences to report. When thinking about the future and about the advent of integrated teams, there was a degree of cynicism that anything will really change. In our experience, this is common in situations where services are integrating. Users and carers often say they have been promised dramatic benefits from previous reforms that they do not feel have materialised in practice. They therefore tend to wonder if integration will be the same. Significant work is needed by the system as a

whole to build trust and to demonstrate that such changes really can deliver positive outcomes.

Also unsurprising is that the bulk of comments by users and carers related not to integration per se, but to broader themes – such as dignity and respect, choice and control, greater information and advice, and flexibility. These seem important issues in their own right irrespective of whether or not teams are integrated, and it may be that users and carers value slightly different things about their care and support to professional staff and local health and social services. This being said, users and carers also talked about services in the past not feeling joined up, about being passed „from pillar to post’ staff not having enough time and about a lack of more proactive, preventative approaches – all of which link well to current proposals for integrated teams. With this in mind, one of the key challenges may be trying to produce a more joined-up response to need which enable staff to spend more time with people but also to use integration as a tool to support greater choice, control, respect and flexibility.

National Evaluation of the Department of Health’s Integrated Care Pilots showed that staff were positive about integration and thought it was producing better outcomes for users. However, users did not appear to share the sense of improvement. Whilst there may be a range of explanations for this divergence of views and they may change over time it is a clear finding which echoes the local work in Leeds.

In terms of next steps, we would recommend that Leeds develops a clear outcomes framework to help articulate what success would look like locally and to help describe progress made to staff (who want to see integration work) and service users and carers (who have more mixed views, but also want support to be more joined-up). These needs more detailed work locally, but could include:

1. The impact integration has on professional processes (for example, the time taken to respond to referrals, the number of different professionals who need to work on a particular case, the extent to which information is shared, and so on).
2. How much time practitioners can spend with users/patients and the extent to which a more integrated approach frees them up for more direct user contact.
3. The amount of time/resource required to achieve integrated teams vs subsequent reductions in duplication (and the point at which a tipping point is reached).
4. The extent to which integration improves outcomes for service users and carers. At present this a very general aspiration, and further work may be required with staff and with users and carers to specify exactly what this might look like in practice.
5. The extent to which users and carers feel they receive a more joined-up, preventative service which is well linked to community facilities and services.
6. The extent to which people feel they are treated with respect, have choice and control, know where to go for advice and support, and perceive services as flexible and responsive.

# Integrated Adult Health and Social Care Teams in Leeds

## 1 Introduction

Partnerships have become a core way of working (and indeed, a statutory duty) since 1997, and have remained a key feature of Coalition policy. Successive governments have also been firmly wedded to the notion of evidence-based policy – „what counts is what works’. Yet, beyond the notion that partnership working is a „good thing’, there is little empirical evidence to support this belief. Thus far, many partnerships have not effectively demonstrated that they improve outcomes for those who use services.

Evaluations of partnerships have tended to be based more on how partners work together, than on whether this makes any difference in the long term for service users. This is partly because the notion of partnerships as a „good thing’ is so firmly embedded in the minds of policy makers, practitioners and evaluators that studies have tended to simply look at the processes of partnership working and, where successful, have inferred that this means a positive effect should be produced. However, it may also be because it is easier to evaluate process issues than to conduct an outcomes evaluation – particularly when many partnerships are unclear about what outcomes they are trying to achieve.

SCIE Research Briefing 41 (Cameron *et al.*, 2012) updated a previous systematic review on the factors that promote and hinder joint working between health and social care services. The Briefing noted that “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.” The authors also commented that in the literature the voice of service users and carers is largely absent and that their views are not routinely collected in evaluations of integration.

### 1.1 The Local Context

Leeds is in the process of creating a series of integrated health and social care teams across the city – beginning with three initial demonstrator teams in Pudsey, Meanwood and Kippax/Garforth. This is designed to (Leeds City Council/NHS, 2012):

- Minimise delays, and reduce duplication or fragmentation of services
- Reduce the number of different professionals who need to be involved. This will mean that people don’t have to keep repeating the same information to different staff
- Ensure information is shared more effectively
- Get a broader, more holistic understanding of the people being supported. This will make it easier to link them in with appropriate local services, and ensure they have access to activities and support that match their interests and needs.

Overall, the aim is to ensure:

- *A better experience for people who use services, their families and carers* (identifying need earlier, reducing the number of different professionals involved, giving greater choice and supporting people to stay at home for longer)
- *A better experience for communities* (with local teams to tailor support to the specific needs of the local population and more accessible services)
- *A better experience for staff* (with closer working relations, better understanding of each other's roles, a reduction of duplication, improved communication and higher job satisfaction)
- *Better value for money* (with fewer people going to hospital unnecessarily or into long-term care, shorter hospital stays and coordinated discharges, and care closer to home)

These are positive but complex aspirations, and Leeds has been clear from the beginning that it wished to commission external academic support to understand the impact of these changes and learn by doing and reflecting on the teams as they develop.

## **2 The Evaluative Method**

To help create a baseline for the project and to support future evaluation, the Health Services Management Centre (HSMC) and the Social Care Institute for Excellence (SCIE) have been asked to explore staff perceptions and service user/carer experiences in three initial demonstrator sites across the city. This will be accompanied by additional quantitative work within Leeds health and social services to understand the impact of integration in terms of activity and value for money.

Although this report focuses on the creation of integrated teams, this is only one of three current changes – and it is difficult to untangle the impact of this specific aspect of local policy from additional work taking place around risk stratification and the promotion of self-management and therefore the future evaluation will include the combined impact of these three elements.

### **2.1 The Partnerships Outcomes Evaluation Toolkit (POETQ)**

POETQ is an online resource developed by the HSMC at the University of Birmingham in order to assist health and social care partnerships to evaluate their work. This web-based tool recognises the importance of both process (i.e. how well do partners work together?) and outcome (i.e. does the partnership make any difference to those who use services?)

Overall, our work involved:

- Tailoring the POETQ online survey for the Leeds context and holding workshops in each of the three areas covered by the demonstrator teams to launch the research and answer any questions from staff. To help produce a more rounded picture, staff from the integrated teams were invited to take part – but so were partners in primary care, mental health, secondary care and the voluntary sector. A small number of service users and carers were also invited to participate. The survey was available to complete online for a three week period in June and July 2012, and a second workshop held with staff and key partners to feed back/check out initial findings and agree key themes to highlight.
- The design of a pack for use with service users and carers to enable local people to share their experiences of services and support. The pack was designed with members of the virtual reference group (an existing virtual steering group set up for the integration project in Leeds, with people who use services and family carers signed up to offering advice about specific issues) in a format that meant it could be used by groups and organisations during existing meetings or events and without the need of an external facilitator (although the offer of a facilitated session was available to any group that felt it would be useful). Information was collected during a four week period during July and August and the virtual reference group then had a further opportunity to comment on the draft of the issues raised.

From the beginning, Leeds was keen to create a baseline to help evaluate future changes and to ensure it included multiple perspectives and stakeholders in understanding the impact of integrated teams. With this in mind, HSMC and SCIE conducted both strands of the research simultaneously, with regular team meetings to help compare and contrast the different viewpoints emerging. A final meeting was also scheduled in Leeds for October 2012 to help finalise the discussion and to draw out the issues that felt most pertinent to the research commissioners.

The baseline evaluation was conducted in the three initial demonstrator teams in Pudsey, Meanwood and Kippax/Garforth during June to August 2012.

The teams working on each component whilst discrete were careful to maintain good communication. Where possible the methodologies and emerging findings informed one another. For example POETQ was adjusted to allow users and carers to also complete the online survey.

It was seen as important that these very different approaches were integrated into a one report with a single set of conclusions and recommendations. Findings which are appearing in both approaches can arguably be given particular weight.

## **2.2 The POETQ Process**

At the start of a new project such as the creation of integrated teams in Leeds, POETQ invites all staff members and relevant partners to complete an online survey which analyses how the partnership ‚feels‘ to them and also surfaces their underpinning assumptions about what the partnership is aiming to achieve in terms of outcomes for service users. This gives a clear sense of what success would look like for different stakeholders and what they are hoping to achieve. In the process, it also asks staff how well they feel that they and their teams understand the current integration process, and what factors seem to help and hinder integration.

In this way, POETQ is both:

- Formative - it seeks to evaluate how well partners are working together, helps people to understand and make sense of their current context, and highlights both areas for celebration within the partnership as well as areas where development work is needed.
- Summative - it is evaluative in that it requires partnerships to be explicit about desired outcomes, with subsequent scope to analyse the degree to which the partnership is successful in achieving these aims.

## **3 Key Findings: POETQ Staff Survey**

### **3.1 Participants**

Altogether, 72 people took part, taking an average of 31 minutes to complete the survey. While most respondents were from a social care or community health background, there were also significant numbers of participants from other agencies/settings – including the PCT cluster, primary care, mental health, acute care and the voluntary sector. Three service users also took part (see Table 1). There was also a good mix of participants from each of the three demonstrator teams, as well as from people from broader backgrounds who did not necessarily identify with a specific team (see Table 2).

**Table 1. Participants by background**

<b>Service</b>	<b>Numbers taking part (total = 72)</b>
Social care	25
Community health	24
PCT cluster	7
Primary care	6
Voluntary sector	4
Service user	3
Secondary care	2
Mental health	1

**Table 2. Participants by team**

<b>Team</b>	<b>Numbers taking part</b>
Meanwood	19
Kippax	15
Pudsey	11
Other	27

In terms of prior experience, participants seemed to be fairly new in post (under two years) or very experienced (six to nine years +) – with a smaller number of people in between (see Table 3).

**Table 3. Respondents by prior experience**

<b>Level of experience (years)</b>	<b>Number taking part</b>
Under 2	11
2-3	7
4-5	7
6-8	14
9+	33

### **3.2 Understanding of Integration**

In addition to initial biographical information, participants were asked the extent to which they felt they fully understood local plans for integration. This was captured on a sliding scale from 0 (no understanding) to 1 (full understanding). Participants were also asked to rate their own understanding as well as that of their wider team. Overall, participants rated their own understanding at 0.73 (out of a total of 1) but that of their wide team at 0.59 (with the exception of people in post for under two years who tended to rate others' understanding as better than their own). Whether respondents are more senior/experienced than other colleagues and genuinely understand the current agenda more fully – or whether people in general tend to rate their own understanding higher than other people's – is open to interpretation. It is also possible that many people rate their understanding of integration as high as the new teams are developing – but that more work might be needed in future to maintain this as the teams become mainstreamed.

Crucially, these scores can be compared to similar data from a national study of joint commissioning looking at staff perceptions in five case study sites well known for their joint working (Dickinson *et al.*, 2012). Here, people rated their own understanding at 0.79 and others' at 0.66. While this is slightly higher than in Leeds, these were nationally well known and long established partnerships – and so Leeds scores seem positive at this stage of the development of integrated teams.

Other than colleagues with less than two years' experience, there were also low scores from the small number of people taking part from the voluntary sector or from mental health (albeit that there were low numbers of people from these backgrounds) – so this may be an area to focus on as the new teams roll out.

### **3.3 Barriers and Success Factors**

Moving on from people's understanding of integration, participants were asked which factors helped and hindered joint working (see Tables 5 and 6 for the top five factors

cited). For those with experience of integrating teams and services, this might not come as a surprise, with practical issues such as IT and cultural issues such as different models of care and different language cited as potential barriers by many people. However, at least four key issues seem of note:

- I. The broader partnership literature (see, for example, Peck and Dickinson, 2008) suggests that integration requires both transactional leadership as well as more transformational approaches – so paying attention to both the practical barriers and the longer-term cultural aspects of joint working seems crucial in Leeds.
- II. Significant numbers of people highlight organisational complexity as a key barrier – and there is a risk that this could get worse as the current reforms take shape. At a local level, there may be scope to try to create stable, enduring integrated teams which can withstand some of the broader organisational changes taking place and give staff a sense of confidence in current/future structures.
- III. While some people saw having a line manager from a different professional background as a potential success factor, a slightly greater number saw this as a barrier. Working through these tensions at local level seems crucial as the demonstrator teams go live and roll out.
- IV. Many participants stressed the positive role of co-location and informal interaction. However, this will have implications for future estates strategies – and the broader emphasis on flexible/home working in some sectors could undermine the face-to-face contact that respondents seemed to value. As Table 4 shows, when we analyse this by the different teams it seems that co-location is popular across the demonstrator sites – although possibly more so with people who don't identify with a specific team and who might therefore be talking more hypothetically about co-location. Despite this, key comments included:

*“People build relationships, share information, get a sense of ‚us‘ and have emotional ‚buy in‘ to the process which is the key thing to ensure a drive towards innovation and real long-term improvement.”*

*“It enables the opportunities for interaction and impromptu debate and discussion to happen.”*

*“Leads to more working together and interaction. [It] can be frustrating when you don't know where services are based or how to contact them, so being in one place will help.”*

*“Great help being able to discuss referrals face-to-face, know who is taking [the] case, be able to do joint assessment visit and discuss progress.”*

**Table 4. Those citing co-location as a lever**

Team	Co-location cited as a success factor
Other	19 (70%)
Pudsey	5 (45%)
Meanwood	12 (63%)
Kippax	6(40%)

**Table 5. Common barriers**

Barrier	Frequency
IT systems	47
Different professional cultures	40
Organisational complexity	32
Different models of care	30
Different language	23

**Table 6 Success factors**

Success factor	Frequency
Opportunity for interaction	47
Co-location	40
Leadership	23
Availability of resources	13
Line manager from different professional background	10 (14 saw as a barrier)

### 3.4 Different Viewpoints

A key part of POETQ is its ability to portray a series of „viewpoints’ or perspectives amongst staff. This is done by presenting participants with a series of 40 statements around the possible outcomes of integration. These reflect outcomes for service users, for professionals, for local partnerships and in terms of productivity, and are designed to be as fully comprehensive as possible. Participants are then asked to sort these statements in different ways so we can explore what they really agree and disagree with and which issues they prioritise over others. Although every response is unique, a factor analysis can reveal any shared viewpoints or ways of thinking and talking about integration and its potential benefits. In the case of Leeds, this reveals one very strong, consensual viewpoint (Viewpoint 1) as well as three related but distinctive perspectives. However, it is important to note that this approach does not quantify the different viewpoints – they are „ideal types’ or broad ways of thinking/talking about integration rather than a category that people either fall into or not. In practice, though, the data here suggests a very high degree of consensus with viewpoint 1 (with nearly all staff agreeing to some extent with this perspective) – albeit with three additional viewpoints that add extra nuance:

***Viewpoint 1 - optimistic about the potential of a joined up solution to a complex problem:*** this viewpoint is positive about the scope for integrating care – it has the potential to improve real people's lives. Working together can help to share ideas, find creative solutions and increase understanding of one another's role. If properly done, integration can make a lasting and real change to how services are commissioned and delivered, and has the potential to deliver a seamless service. This perspective sees the task in hand as complex and requiring integration. Participants who tend towards this viewpoint suggest that:

*“People are complex, and therefore so are their problems. With truly integrated working, holistic assessment and care planning is facilitated, allowing for the whole person/situation, not just the 'health' or 'social care' need to be dealt with.”*

*“The process of learning how to work together empowers staff to work much smarter, be creative and become more patient focussed.”*

*“Because if it doesn't make real improvements to people's lives then there isn't any point!”*

*“Because it can change organisations from thinking about services to people's needs.”*

*“Because its aim is to improve users' lives - therefore it will have failed if it has minimal impact.”*

*“Dedicated professionals wanting to provide quality care are often frustrated by organisational barriers. Together we can make a bigger difference.”*

*“My experience is that people in receipt of care from various groups are confused and services provide duplication and gaps. Integration appears to be the solution.”*

*“Integration of care will transform services and change the way services are delivered. As a result, organisations will change but more importantly, people will get a safer and better service.”*

*“As a professional, care of people is my core function. Collaboration is sensible; sharing the roles across health and social care is just common sense and reduces duplication. Government provides the organisational churn with constant reorganising but the ‘front line’ care is provided by motivated and dedicated professionals who can work together despite the churn.”*

This was by far the most common view of integration, and this view was shared by people from a range of professional backgrounds/agencies and with different levels of experiences. As Leeds embarks on the process of integration, this seems a very positive initial finding – and the challenge now may be to find ways of harnessing and delivering on this optimism and good will.

Interestingly, this viewpoint is very similar to one identified nationally in our evaluation of joint commissioning (Dickinson *et al.*, 2012). Here, many people had a very optimistic view of the potential of joint commissioning, yet sometimes struggled to identify tangible outcomes it had enabled them to achieve. Key questions for Leeds going forward may therefore be whether staff *hope* integration will achieve these things or genuinely *believe it will* – and whether it really does deliver in practice.

***Viewpoint 2 - Information and speed, but not more choice: systems over people:*** like viewpoint 1, people here strongly believe in the potential for integrated care - particularly in the potential to allow for discussion across professional boundaries and the ability to share ideas. Distinctively, viewpoint 2 sees potential in speeding up referral processes and ability to share information. This viewpoint places considerably less emphasis on the core focus being on improving lives in favour of outcomes for professional practice. This viewpoint distinctly disagrees with the statement that this somehow improves choice or the influence of partner agencies. Linked quotes include:

*“More effective referrals and working relationships are developed through trust and mutual respect between professionals. Integrated working practices are helping to build that trust.”*

*“I think the one thing that will improve care overall is better communication - this is usually what has broken down when problems occur. Co-location serves to improve communication and understanding between professionals.”*

*“I think integration is helping us to understand more about the different approaches taken by health and social care and also to learn and select the 'good bits' from each model.”*

While this approach also sees integration as potentially positive, it tends to stress improvements in processes, communication and trust between professionals – rather than necessarily focusing on improvements in people’s lives.

**Viewpoint 3 - Integrating the user experience:** this viewpoint sees the potential benefit of integration for sharing ideas and inter-professional discussion - but the main aspiration is to deliver a seamless path for service users, reducing duplication and improving scope for primary prevention more broadly. From their experiences so far, respondents holding this viewpoint are pessimistic that integration will reduce red tape or activities that take them away from working with users. Where they differ from viewpoint 1 is the issue of synergy, and they are relatively indifferent about viewpoint 1's focus on integration’s broad ambitions as first and foremost about improving lives. For example:

*“Clients find it difficult to contact the different services. Clients do not always know who to ask and what to ask for. Clients get fed up repeating themselves and then being told that the service they have rung is not for them and being passed on to yet another service.”*

*“As at present social and health services use completely different computer systems and call logging. So rather than timely ringing each other and leaving messages to contact each other..., it would be easier to just speak to each other in same office.”*

*“So far with all the meetings I am expected to attend with amount of personnel asked to attend it is reducing time doing my actual work with clients.”*

*“No sign of any speeding up from the area I work in.”*

*“Paperwork, computer and administration tasks continue to increase.”*

*“The referral process is quicker, however due to the number of referrals already awaiting allocation the timescales for allocation remain the same.”*

*“We are still required to complete mountains of paperwork.”*

*“Too many managers will make things more complicated.”*

Again, this feels a positive view of integration – but one focused more on creating a seamless pathway rather than improving lives per se. There is also more cynicism that integration will deliver less bureaucracy in practice or free up professionals’ time.

**Viewpoint 4 - Upfront investment to reduce duplication:** like the other viewpoints, this view acknowledges the potential to share ideas but it emphasises the possibility of reducing duplication and enabling better risk management, reducing inappropriate referrals and reducing red tape. It acknowledges the upfront costs of integration as likely to save money in the future. People here think integration is something users will notice - they will come to learn that one referral will get them all the services they require.

## 4 Overall Themes

Overall, initial results in the three demonstrator teams and from broader partners seem very positive. Despite tight timescales over the summer, there has been a strong response from people from different backgrounds – and this level of engagement seems a helpful starting point for the creation and roll out of the new teams. There also seems to be good understanding of the integrated teams – albeit with possible scope to improve awareness in the voluntary sector and in mental health. There is also a question as to whether staff understand integration as well as they say they do given that they rate their own understanding consistently higher than other people’s.

In terms of barriers and success factors, there is agreement that integration can be hindered by a mix of practical (especially IT) and cultural issues, and strong support for co-location and the opportunity to interact more informally. However, views on having line managers from different professional backgrounds are divided – with some seeing this as a key barrier and others viewing it as success factor.

In terms of staff aspirations for integration, there is a widespread and strong belief that integrated teams can make a practical difference to people’s lives and that responses to complex problems need to be joined-up. However, this is currently very non-specific and further work may be required to unpick exactly what this means in practice (for example, exactly what impact do people think integration will have and why?) It is also very similar to messages emerging from national research into joint commissioning, where

participants were positive about integration but couldn't necessarily link this to better outcomes.

In addition, viewpoint 1 co-exists with slightly different perspectives, which still see integration as primarily positive but which are slightly more nuanced in terms of the extent to which:

- Integration might lead to better professional processes rather than to changes in ultimate outcomes for people using services.
- Integration will really free up professionals to spend more time with users. This was also highlighted in initial feedback to staff, where colleagues commented that social care teams had been given slightly reduced case loads in the first instance. While this might provide extra time to attend meetings and establish new ways of working, it could also make positive staff outlooks harder to sustain once case loads increase again.
- Upfront investment of time and resources will later lead to a reduction in duplication.

As the integrated teams roll out, it will be important for Leeds to develop a clear outcome framework to evaluate the impact of this new approach. While this needs further work, there may be scope to build on these staff viewpoints to consider:

- The impact integration has on professional processes (for example, the time taken to respond to referrals, the number of different professionals who need to work on a particular case, the extent to which information is shared, and so on).
- How much time practitioners can spend with users/patients and the extent to which a more integrated approach frees them up for more direct user contact.
- The amount of time/resource required to achieve integrated teams vs subsequent reductions in duplication (and the point at which a tipping point is reached).
- The extent to which integration improves outcomes for service users and carers; at present this a very general aspiration, and further work may be required with staff and with users and carers to specify exactly what this might look like in practice (see next section).

Overall, it may ultimately be a matter for local discussion and debate as to how best to interpret these initial findings:

- On the one hand, Leeds seems to have a strong basis for future joint working with staff across key agencies and locations positive about the potential for integrated teams. Viewed from this angle, the challenge now might be to find ways of engaging with and delivering on this good will – with a risk that staff could become frustrated if their aspirations of better outcomes for people’s lives are not met in practice. Many integrated systems also find that large-scale changes in working practices can affect the identity and roles of front-line professionals, and that this can make things feel worse before they get better. If Leeds is able to achieve a situation where the whole is genuinely greater than the sum of its parts, some of this positive feedback from staff could become more mixed in the short-term as fundamental changes take place. A good example here might be the potential for single line management – which (as suggested above) would be welcomed by some and seen as a barrier by others. While this has not yet been addressed as the teams take initial shape, future judgements about such decisions could make some staff slightly less positive in the short-term (even if there are longer-term benefits/improvements).
- Equally, it’s possible that staff about to embark on a process of integration and already working in or linked to demonstrator teams might be more likely than other staff to be positive about integration. If this proves to be the case, the OD challenge going forward might be to build on the aspirations of the demonstrator sites in such a way as to share learning with and bring along other sites/teams. It is also possible that staff in the first demonstrator sites could benefit from more initial support than colleagues who are integrating in future waves, and maintaining an appropriate level of support for front-line staff as changes take place will be crucial.

Either way, this feels a nice dilemma to have as the demonstrator teams go live – and the challenge will be to live up to staff expectations in a difficult external policy environment.

## **5 Participatory evaluation process with people who use services and family carers**

The key aim was to gather the views of a range of people who use services and family carers in the demonstrator areas. The study aimed to explore people's views about integrated services whilst being mindful that, for most ordinary citizens, the mechanisms of how services are organised are not of particular interest. Their focus tends to be on the quality of the services and how well that support enables them to get on with their life.

The aim was (within the constraints of the tight timescale) to make this element of the evaluation user and carer led. The main ways in which the study design aimed to achieve this was:

- An independent disability specialist Tricia Nicoll who is a disabled woman with disabled children was recruited to lead the work.
- Local users and carers were involved in the design of the study tools
- Local users and carers validated the findings

The original plan was to run a series of focus groups across the demonstrator sites, but the experience of the consultant was that this excludes many people from taking part (in particular people who have complex medical problems that make travel difficult, or who have caring responsibilities). Therefore an alternative approach was developed. In collaboration with Leeds NHS a consultation pack, which community groups could complete on their own was developed. This has the advantage that groups can complete the pack during sessions that are already scheduled. To complement the pack a postcard with two questions was also produced. The postcard was specifically designed to capture the views of people who did not engage with groups and could be completed by individuals in their own home.

There is an existing virtual steering group for the integration project in Leeds, with people who use services and family carers signed up to offering advice about specific issues. So rather than creating a separate advisory group it was decided to use the virtual steering group as a source of advice to the study. This helped to ensure that the design of the study was informed by the views of local users and carers.

An initial meeting with members of the virtual Steering Group on 12<sup>th</sup> June confirmed the idea of a pack as a sensible approach and developed the „characters' around which the pack was based. The pack was drafted by the consultant and signed-off by the virtual steering group. The pack was sent out to a wide range of groups using the Community Healthcare NHS Trust database and the postcards were also given to primary care workers to give to their patients.

The pack contained:

- Information about the Leeds Integration project
- Three vignettes of fictitious characters and their experiences of services and support
- Questions for people to consider about the support that the characters were getting and how this related to their own experience of services
- Postcards for people to rate their experiences of services and support on a scale of 1 - 10
- A free-post envelope for people to return their completed packs

The postcard asked people to consider two questions and rate their answers on a scale of one to ten; one being poor and ten being excellent.

- Question one: how would you rate how well the services and support you get work together?
- Question two: how would you rate how well the services you use help you to live independently and get on with your life?

The postcard also had a free text question that asked people to suggest one thing that would make services and support better.

All groups were offered a facilitated session to work through the pack. Three groups requested this and these groups were facilitated by Tricia Nicoll (the consultant from SCIE).

156 people responded to the pack in some way; everyone completed a postcard and some people also took part in sessions run by local groups or in the sessions facilitated by Tricia.

People returned both packs and postcards by means of a freepost envelope.

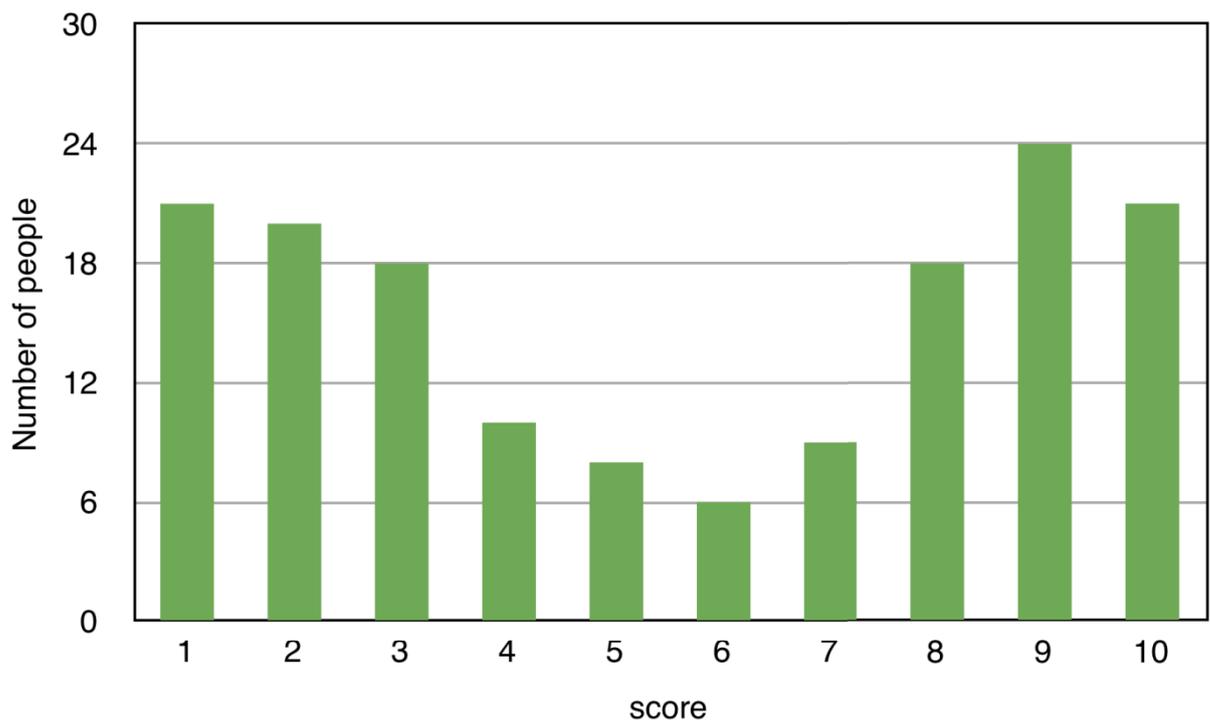
Tricia Nicoll completed a simple thematic analysis of the data liaising with Jon Glasby from the HSMC. The virtual steering group validated the findings by reviewing an emerging findings document.

## 6 Key Findings: Service Users and Carers

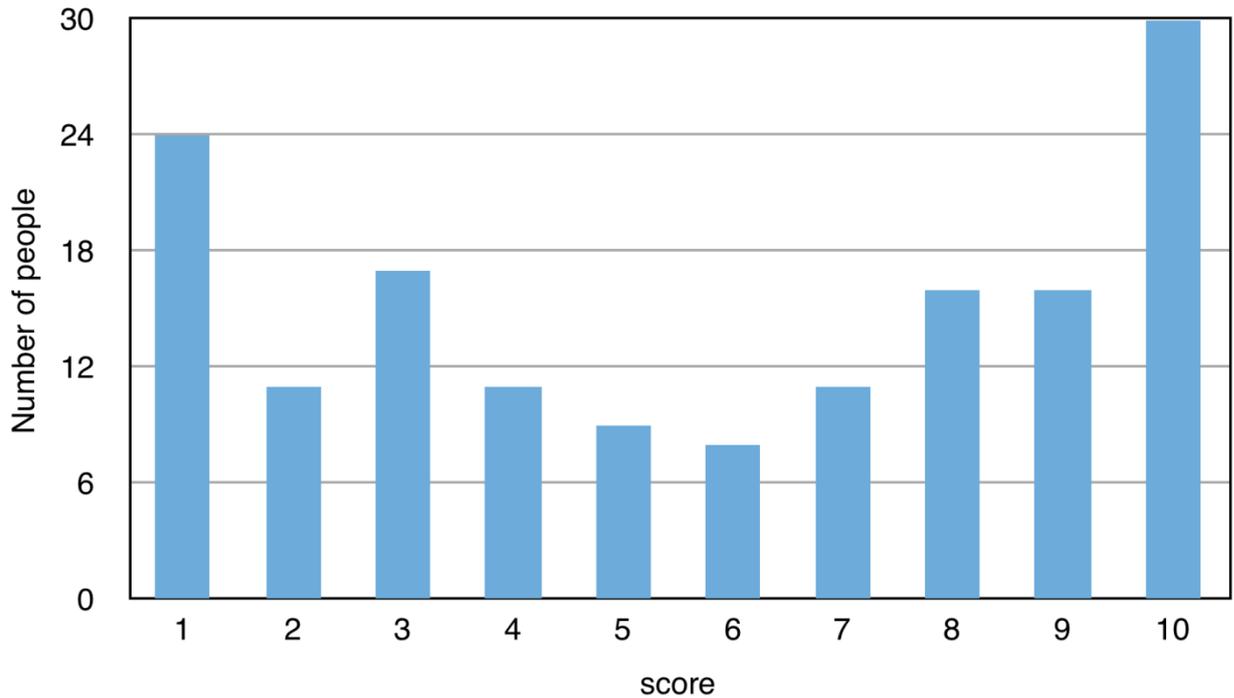
The data from the postcards is summarized below:

*Note: although 156 people completed a postcard, a few people only answered one of the two questions.*

Question one: how would you rate how well the services and support you get work together?											
Score	1	2	3	4	5	6	7	8	9	10	Total
Frequency	21	20	18	10	8	6	9	18	24	21	155



Question two: how would you rate how well the services you use help you to live independently and get on with your life?											
Score	1	2	3	4	5	6	7	8	9	10	Total
Frequency	24	11	17	11	9	8	11	16	16	30	153



It is clear that the full range of satisfaction/dissatisfaction with services was represented in the feedback from postcards that people completed - scores for both questions ranged from 1 to 10 and every number in between, although there is some concentration at each end of the scale for both questions.

41% of people scored 8 or more to question one about how well services and support work together while 38.5% scored 3 or less.

41% of people scored 8 or more to question two about how well services enable them to live independently and get on with life, while 34% scored 3 or less.

When people scored 8 or more to either question, this was usually accompanied by a comment about nothing needing to change, or a positive comment about a specific service:

*„Carry on as you are.’*

*„Nothing has upset me so I think it must be working well!’*

*„I get a really good service.’*

*„I wouldn't change anything.’*

*„My son had a stroke and he's had fantastic care and support, both from the clinic and at home.’*

*„The support I receive from the community matron in conjunction with the GP and chemist is first class. We could not do without the support we receive from matron.’*

*„The day centre at X is good.’*

*„Could not think of anything to improve. Service from admission to weeks after operation has been superb.’*

## **6.1 Themes One to Seven**

Participants expressed a range of issues and concerns about current services. These fell broadly fall into seven themes:

- 1) Is anything really going to change?
- 2) Dignity and humanity
- 3) Support that is about me and my life
- 4) Care and support is not joined up
- 5) Process and protocol
- 6) Lack of focus on prevention
- 7) Not knowing what's available

Each theme begins with an outline description. This is followed by illustrative verbatim quotes and commentary. Some themes close with some suggestions for how to address the issues identified.

### **Theme one: Is anything really going to change?**

There was cynicism from some people who took part. They found it hard to believe that anything would really change. They also were unconvinced that the planned changes around integration of health and social care services would actually tackle what they saw as the „real’ problems. These attitudes were expressed in each of the facilitated sessions and are well summed up by the following remark:

*„Do you think any of this is really going to make a difference then?’*

The context to such attitudes is that some of the problems and issues which were raised have been experienced by people over considerable periods of time. These issues were not perceived to have been resolved by policy initiatives and reforms over many years. It should be noted that this echoes the national picture and underlines the importance of finding ways to work more honestly and effectively in genuine partnership with people who use services and family carers.

### **Theme two: Dignity and humanity**

This is about people feeling that the support that they get (particularly support for personal care) can sometimes be lacking in dignity and respect. This was usually the first set of issues that people brought up when reflecting on the experiences of the characters in the pack and comparing them to their own experience.

Firstly, people often talked about not having any choice or control about when carers came to support them. This meant that people had their days governed by when they could get the support they needed (particularly to get up or go to bed) or by having to wait in for an appointment:

*„My aunt had to change the agency she used – they wanted to put her to bed at 6.00pm. The new agency puts her to bed at 11.00pm which is what she wants.’*

*„It would be nice to know when carers are coming – I have to stay in and wait.’*

Lots of people had issues with not knowing who would be coming to support them, with little chance to get to know people or build relationships:

*„She mostly knows who is coming, but only because she kicked up a fuss.’*

*„I have different carers coming every day.’*

*„They don’t like to send the same person every time as they say it means you get attached to them.’*

*„They send different people and they don’t always have your notes so they don’t know what you need.’*

The gender of staff came up several times. The following quote sums up what some people said:

*„Twice they have sent men to help me get a shower, it’s just not right. You need to keep your bit of independence and dignity.’*

People talked about how care felt rushed and how professionals did not seem to have the time to do everything that was needed:

*„I never knew who was coming or when. Some of them presumed I could do things I couldn’t - they just didn’t ask. One of them said, “I’ve got such a lot on – can you do that yourself?” Another couple just stood and watched me while I did things myself.’*

Perhaps most serious were the stories people shared of how they have been treated by carers and by other professionals, and about the attitudes of some carers and other professionals

*„My friend needed help to get up to go to the toilet in the night, but the agency suggested that they get some plastic bags and put them under the sheet to cover the mattress.’ (Several people had been offered pads at night rather than a home visit).*

*„They treat people like children and as if they don’t know what they want or need. If you make someone feel good then they can do really well. If you’re told, “shut up and sit down”, then you won’t ask again.’*

*„They came to assess me and asked me what I needed, but then they told me what they thought I needed. They sent two people who hadn't got a clue – they didn't even ask me to move from my chair but they seemed to think they knew what I needed.’*

*„They don't always trust you to know what's best.’*

*„I didn't ask them to come – I don't know who sent them (it was after I had an operation). I'd rather struggle than send for them myself.’*

There were some examples of how making a complaint can feel difficult:

*„It's not easy to say anything if you're not happy – who would you say it to and would it make a difference? It's about knowing the system.’*

*„If you complain it can be made out to be your fault. They say something clever like, „we're very sorry you weren't satisfied.’*

Suggestions for change under this theme were:

*„Listen to older people.’*

*„It's all about attitudes – that would make a lot of difference.’*

*„Listen to people. It's not what they are telling you, it's what they are NOT telling you.’*

*„Don't promise more than you can deliver. I'm not daft, I just want to know the truth.’*

*„Respect, inclusion, patient-led, Being on time for appointments.’*

*„The GP out of hours service should still be someone you know.’*

*„Time is measured in numbers – people aren't. Be more human.’*

*„I want to be kept informed. One thing that always annoys me is that when care agencies change your carer or your time slot they don't always call to let you know.’*

*„I needed further advice from the physio and OT and better follow-up from my original surgeon.’*

All of these issues are about the fundamentals; the right to be treated with respect and dignity in every aspect of the care and support I get, without exception. If people who use services and family carers feel these fundamentals are missing then they override all other strategic issues. Some these specific issues are about how services are organised, for example people not getting enough time for the support they need, but others are cultural and attitudinal.

### **Theme three: Support that is about me and my life**

This is about the kinds of support that people say they need versus what is on offer and also about how support is organised. People shared examples of how support has changed - from being flexible and person centred to being more bound by rules and regulations:

*„When the warden was there it was great, she used to go and see everyone every morning and check they were OK – even do little things like helping my mum put her stockings on. Now they’re not called wardens anymore and they have to cover lots of places. There are also so many rules; they’re not allowed to „do’ anything. You just don’t get the same service. For lots of people, the warden was the one person they saw every day, so now they might not see anyone.’*

*„There are so many stupid rules about what they can and cannot do and you don’t know from person to person what they are going to say. Some can do washing up, some can’t, some can clear and some can’t. It’s crazy and there’s no common sense anymore.’*

*„There is little evidence of thoughtful constructive support.’*

Many people shared somewhat nostalgic views of „how things used to be’. They looked back to a less regulated and more informal service in which they felt people had more time for one another and there was a greater sense of community. This is echoed by the consultant’s experience elsewhere in the country. More integrated services offer a real opportunity for addressing these issues but it does mean tackling issues of different culture, policies and process.

People commented on how health and social care services seem disconnected from community and grassroots organisations which could offer people the everyday support they need and about the lack of easy access to really practical support - transport, help with the garden etc - that would often keep people from needing more complex support:

*„People need services and support that stops people spending so much time on their own. The groups are out there but people like GPs don’t always know about them.’*

This quote highlights that improving outcomes is not just about health and social care services but also about engaging the whole community

*„Sometimes it’s the really ordinary everyday things you need help with like the garden and house, but how do you get that? If you got some local scallies to go and sort out his garden I bet you would see something magic happening in their relationships. We forget how important intergenerational stuff is. Lots of issues are not about services they are about communities and you can’t buy that.’*

*„Sometimes when you’re on your own, you just need reassurance and someone to talk to.’*

*„[I need] a service that would help me move on [and get my own place].’*

*„I’m pleased with services but I need help with transport.’*

The main suggestions for change are summed up by the following two quotes:

*„Cut down on the Health and Safety and on political correctness! Use more common sense.’*

*„Make better use of the voluntary and community sector organisations that exist. Sometimes people just need someone to talk to.’*

#### **Theme four: Care and support is not joined up**

People had lots of stories to tell about services and support not being joined up, although (as with other factors) people have had different experiences within the demonstrator sites. For example, some people did not feel as if one person was responsible for coordinating their care, while others (particularly when they accessed a third sector organisation) did not feel this was a problem.

*„She [Lilly - one of the characters in the pack] needs a go-between, someone to deal with all the problems rather than her having to do it all separately – like we’ve got Caring Together. I know lots of people like Lilly.’*

*„I would like appointments made for me so I don’t have to remember to call to make one.’*

*„Someone needs to be in overall charge of my care – no one seems interested in my health and how I am managing at home. I have psoriasis, diabetes and heart failure. It seems that nowadays people are left to manage their own health without any support. I find it difficult to get out (I am 84) and it would be nice if someone could pop in now and again to see how I am doing and give advice.’*

There were several observations about how different it is for people who have some family to help them with organising support, but also how, if family is present that can be taken for granted:

*„Appreciate people’s family carers more and how much they save the state.’*

*„If you’ve got family then they think that’s it, you don’t need anything else. They end up doing everything and then they get ill.’*

People also talked about the issue of living with several different conditions and that the different services and supports for these conditions do not always talk to each other:

*„If you are living with more than one condition it just doesn’t get linked up.’*

Talking about Saul a character from the pack;

*„The people who do his leg (ulcer) will just come in to do that, they won't know about dementia, "it's not my department". A lot of the time it's just about people who care – the problem is they don't have time.'*

One person brought up a very specific health and social care issue in the different requirements of support when someone accesses a Direct Payment through social care and also has an identified health care need:

*„They don't work together in children's services – having a child who accesses Direct Payments who also has a „so-called' health need just means that no one has to provide care - just me!! I am fed up with being told that my son cannot have any overnight support as he has a gastrostomy – which apparently counts as a „health' need and therefore support workers are unable to „cope' with this and provide care. What a stupid system that categorises people into a „health' need and a „social' need. I doubt whether this questionnaire will change that!! You know – people first and all that!!'*

There was frustration about having to tell your „story' over and over again to different professionals and about the different record keeping systems used by different agencies and departments:

*„It's hard to know who does what and who is responsible (health or social services) so you don't know who to get in touch with. When you do find someone to talk to you have to start again from scratch.'*

There were some clear recommendations about how to do things differently:

*„You need to talk to each other and work together and share information.'*

*„People need to keep up to date with their clients and pass on information from one department to another.'*

*„Places to get more information or guide to services I don't know where to get help.'*

*„Communication between services and support could be improved thereby better information and help for me. Computer records need to be accessed by all involved including the patient (this could be read only.)'*

*„Recognise the many barriers that still exist within service provision. Join up services. Stop ending services due to regulatory practice, e.g. continence and physiotherapy.’*

*„You could use our NHS patient number for identity and personal records to avoid having to fill in some details at each new contact.’*

### **Theme five: Process and protocol**

This links with Theme four, but is about the ways that services operate, or „how things are done’. In particular, people described *„being passed from „pillar to post’* or feeling like they were given *„telephone numbers and leaflets’* or referrals to another service rather than a professional stopping to think about what the person really needs.

People talked about needing to have a certain diagnosis or condition before they could access some support:

*„If you don’t fit into one of their boxes then you won’t get anything.’*

*„The system often requires persistent prompting and seems designed to throw out patients.’*

This also links back to Theme three and the support that people need to live their life.

### **Theme six: lack of focus on prevention**

Lots of people talked about having to wait until things got really bad before help and support was available. This then had knock-on implications:

*„If you can stay well and in control of your life then you can articulate what you want. If things get really bad then it is harder and you are more likely to give up.’*

One group talked about needing more time from a specific intermediate care service:

*„I needed more than the 12 weeks support I got.’*

*„Could have done with more weeks.’*

*„I wanted help when I got home but they said I couldn’t have it.’*

People talked about having to get back in touch with services when things were getting worse, rather than knowing that someone would be checking how they are:

*„How you are doing is not always monitored closely. It’s easy to fall through the net.’*

*„Doctors should visit patients at home at least once a month, whether the person is ill or not.’*

People did share some really positive experiences of living with Chronic Obstructive Pulmonary Disease (COPD) and having emergency antibiotics and steroids so that they can manage their own condition:

*„I have my stand-by antibiotics and steroids and that works really well for me. I know when I need to take them and I’m in control.’*

There was also this example of really thoughtful preventative care:

*„I have a fantastic GP – she arranged for the cover GP to give me a call to check how I was when she was away for a week. I couldn’t believe it. It was just a 2 minute phone call but what a difference it made.’*

### **Theme seven: Not knowing what’s available**

This is about people’s lack of awareness of what is on offer, but also the lack of awareness of some health and social care professionals about community support. It links back to several of the previous themes:

*„If you don’t know what your options are then you just take what they offer.’*

*„This group (older people’s support group) has meant the difference between coping and not coping. I don’t know what I’d have done without everyone here, but not everyone has this sort of support, or knows that it exists. The GP certainly doesn’t.’*

*„Peer support is difficult to find, but I know lots of places that offer it.’*

*„There is some good information about services in the Directory of Care and about repairs etc, but you have to know where to find it.’*

People said that they want:

*„Someone to tell me what to do next. There's no one there to tell you unless you already know.'*

*„People need clear guidance on what you can expect, what you are expected to know or ask. They all say something different and blame each other. There is no communication.'*

## **6.2 Validation by the virtual steering group**

The seven themes were shared with the virtual steering group for the project. They were asked:

- a) Do these themes reflect what you would have expected to see?
- b) Are there any surprises or any omissions?
- c) Do they reflect your personal experience?

Members of the group who responded all felt that the themes were accurate and made the following observations:

*„All the themes are true and through LIP (Leeds Involvement Project) we have proof that they are issues that people are unhappy with and there is a reluctance to get down to it and focus on these issues and do something about and something that people can see and experience the change.'*

*„I am somewhat but not totally surprised by the views. There are none missing that I would have expected to see.'*

*„Being bounced from pillar to post is certainly a real experience. Getting a professional to commit themselves to a firm diagnosis and prognosis is hard and leads to much concern amongst the family..'*

*„If we returned and audited the outcomes of whatever patient focused changes had been made in say one year and two years after deployment, would we really see a measurable set of outcomes which meet the project's design criteria in that respect?'*

*Most things (that I would have expected to have seen) have been covered, especially themes 1, 2 and 3. This list is not really any different to those from the past, if you had said this was from 1965 or 1972 or 2000 it would not have shown much difference.*

*It is a bit unfair of me, because I know that there are a lot of caring people out there. But they are often 'fettered' by silly rules and are not allowed to use 'common sense' - they call it progress!!!! The book needs to be rewritten. Sorry don't mean to be negative, but have come across this type of thinking so often and it spoils it for those many dedicated and caring people working in this field.'*

In summary the feedback from people who use services and family carers is partly focused on things that might not seem to have anything to do with integration; the need for dignity and respect and for services that are flexible and person centered. Much of what people want is very much what the move to an integrated service aims to achieve – holistic, person-centered care and support for people that has a focus on prevention and that supports them to get on with life.

## 7 Conclusion and Recommendations

Perhaps unsurprisingly, the multi-faceted approach adopted in this report has produced different findings from different stakeholders. While this is not unexpected, it does point to the difficulty of introducing significant changes that affect both staff and service users/carers at the same time. Integration is a broad concept and can often mean different things to different people – and the findings here suggest that different participants have a multitude of positive and negative views on current services and on the proposed way forward. Working with such diverse experiences and trying to build consensus about the nature of the problem to be solved and the best way forward is therefore a key challenge.

For staff, there was a generally positive response to the research, good understanding of the integrated teams being created and an optimistic view about what integration can achieve. At this early stage, there was less clarity about issues such as future line management arrangements and less understanding of the new teams from broader partners – and these may be key areas to focus in the next phase. Many staff believe that integration can make a real difference to people's lives – although this seems more of a general sense rather than a detailed analysis of exactly what outcomes integrated teams should be able to achieve and how. Again, exploring this in more detail may well be a crucial next step. By adopting a more nuanced approach to evaluation than is often the case in inter-agency settings, the POETQ tool has surfaced a number of underlying themes, including the extent to which:

- Integration might lead to better professional processes rather than to changes in ultimate outcomes for people using services.
- Integration will really free up professionals to spend more time with users.
- Upfront investment of time and resources will later lead to a reduction in duplication.

For users and carers, there is a much more mixed view of current services and future developments. While many people taking part in the research had a positive view of services, many also had negative experiences to report – with a real spectrum of opinion. When thinking about the future and about the advent of integrated teams, there was a degree of cynicism that anything will really change. In our experience, this is common in situations where services are integrating – and users and carers often say they have been promised dramatic benefits from previous reforms that they do not feel have materialised in practice. They therefore tend to wonder if integration will be the same – and significant work is needed by the system as a whole to build trust and to demonstrate that such changes really can deliver positive outcomes.

Also unsurprising is that the bulk of comments by users and carers related not to integration per se, but to broader themes – such as dignity and respect, choice and control, greater information and advice, and flexibility. These seem important issues in their own right irrespective of whether or not teams are integrated, and it may be that

users and carers value slightly different things about their care and support to professional staff and local health and social services. This being said, users and carers also talked about services in the past not feeling joined up, about being passed „from pillar to post’ staff not having enough time and about a lack of more proactive, preventative approaches – all of which link well to current proposals for integrated teams. With this in mind, one of the key challenges may be trying to produce a more joined-up response to need which enables staff to spend more time with people but also to use integration as a tool to support greater choice, control, respect and flexibility (or at least as a way into this conversation with front-line staff).

National evaluation of the Department of Health’s Integrated Care Pilots (Ernst and Young/Rand Europe, 2012) showed that staff were positive about integration and thought it was producing better outcomes for users. However, users did not appear to share the sense of improvement. Whilst there may be a range of explanations for this divergence of views and they may change over time it is a clear finding which echoes the local work in Leeds.

In terms of next steps, we would recommend that Leeds develops a clear outcomes framework to help articulate what success would look like locally and to help describe progress made to staff (who want to see integration work) and service users and carers (who have more mixed views, but also want support to be more joined-up and to be convinced that these changes will work in a way that previous reforms may not have done). As suggested above, this needs more detailed work locally, but could usefully include:

- The impact integration has on professional processes (for example, the time taken to respond to referrals, the number of different professionals who need to work on a particular case, the extent to which information is shared, and so on).
- How much time practitioners can spend with users/patients and the extent to which a more integrated approach frees them up for more direct user contact.
- The amount of time/resource required to achieve integrated teams vs subsequent reductions in duplication (and the point at which a tipping point is reached).
- The extent to which integration improves outcomes for service users and carers. At present this a very general aspiration, and further work may be required with staff and with users and carers to specify exactly what this might look like in practice.
- The extent to which users and carers feel they receive a more joined-up, preventative service which is well linked to community facilities and services.
- The extent to which people feel they are treated with respect, have choice and control, know where to go for advice and support, and perceive services as flexible and responsive.

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