Integration of health and social care

A snapshot of current practice in Scotland

Report prepared for RCN Scotland
by Alex Mathieson
May 2011
Contents

1. Introduction ................................................................................................................. 3
2. Description of teams ................................................................................................. 4
   Team A .......................................................................................................................... 4
   Team B .......................................................................................................................... 4
   Team C .......................................................................................................................... 4
   Team D .......................................................................................................................... 4
   Team E .......................................................................................................................... 5
   Team F .......................................................................................................................... 5
3. Team working and professional roles ....................................................................... 6
   Team working ............................................................................................................... 6
   Professional roles ........................................................................................................ 7
   Professional tensions .................................................................................................... 9
4. Culture ......................................................................................................................... 12
   Addressing cultural barriers ....................................................................................... 12
   Language ..................................................................................................................... 13
   Response times .......................................................................................................... 14
5. Strategic issues ......................................................................................................... 15
   Funding ....................................................................................................................... 15
   Management structures and accountability ............................................................... 15
   Employment status ..................................................................................................... 16
   Communication systems ............................................................................................. 17
6. Operational issues .................................................................................................... 19
   Raising awareness about the integrated service ....................................................... 19
   Co-location of team members ................................................................................... 19
   Referral and assessment ............................................................................................. 20
   Joint training ............................................................................................................... 21
7. Conclusion ................................................................................................................ 22
   Summary of key learning across the main issues ..................................................... 23
   Team working ............................................................................................................. 23
   Professional roles ........................................................................................................ 23
   Professional tensions .................................................................................................. 23
   Cultures ....................................................................................................................... 23
   Strategic issues .......................................................................................................... 24
   Operational issues ...................................................................................................... 24
1. Introduction
Developing closer links between health and social care services, leading ultimately to integration, has been a strong policy driver in Scotland for some time. Major parties across the political spectrum have signalled their intent to pursue integration and professional organisations, including the Royal College of Nursing and the British Medical Association, have voiced guarded support.

As a means of increasing its understanding of health and social care integration, RCN Scotland commissioned a short project to review the literature on integration in a number of countries and consider the facilitating factors and barriers. A report that sets out the findings of the review and considers the implications for Scotland was subsequently published in January 2011.¹

This second report was commissioned to provide evidence of nurses’ practical experiences of working in integrated teams. It involved a series of telephone and teleconference interviews with groups of team members that focused on central issues identified as being important by the earlier literature review. These included:

- team working and professional roles and boundaries
- cultures
- strategic (funding, management and communication systems) and operational (co-location, joint training) issues.

The interviewees were identified by RCN Scotland and interviews were carried out during March and April 2011. Interviewees were assured that neither they nor their host organisation(s) would be identified in the report.

It should be emphasised that the views expressed in the report are those of the interviewees and may not represent views held more widely in the nursing community in Scotland. It must also be emphasised that the interviewees’ points of view cited in the report were made in a spirit of free and unhindered expression of opinion and belong to the interviewees. The ideas and views expressed by interviewees and summarised in the report do not necessarily reflect the views of RCN Scotland.

It is not possible to present in the report all the diverse views and ideas expressed by the interviewees, and an element of selection and analysis has been adopted in its preparation. Some minor editorial changes have been made to some quotations, but the sense of the original statements has not been altered.

2. Description of teams

An unequivocal message identified in the literature review is that there is no single, agreed definition of integrated care. Integration can take place at a number of levels, the review states: team, service or organisation. It can apply to a small number of specialist services or to the full range of health and social care services. Diversity in integration is reflected in the characteristics of the services represented in the teams who took part in the interviews, and which are briefly described below.

Team A
This discharge and rehabilitation service was established in 2003. Its primary function is to reduce length of stay in acute hospitals by proactively discharging patients early using an integrated approach that involves health and social work services. The service, which manages all age groups, covers orthopaedics, elderly care and medicine and tends to target patients with longer lengths of stay. It is hospital-based but team members travel to the community to see patients 24–48 hours post-discharge. Referrals come from all members of the hospital multidisciplinary team, following which team members will assess patients on the wards. Part of a wider health board area service, Team A consists of nurses, a physiotherapist, occupational therapist, dietetic and pharmacy staff, rehabilitation assistants, a social worker and administration staff.

Team B
Team B is an integrated addictions services team set up in April 2007. It comprises health and social work staff, occupational therapists and medical staff and is based in six sites across an area. There is one overall service manager with team managers (nurses and social workers) in place in each of the six sites. It was specifically designed as an integrated service through an agreement involving health and social work. Each site is staffed by nurses (mostly mental health nurses with addictions experience), a social worker, addiction workers and addiction support workers at different grades. The service has developed a care management process for both nurses and social work staff and receives referrals from GPs (the majority), social work services, accident and emergency departments, criminal justice and children and family services. It also takes self referrals.

Team C
A community health partnership that offers a wide range of nursing services, including night nursing, continence and tissue viability care. The service works very closely with the local authority, with some posts funded by the local authority but managed by health.

Team D
An integrated day services team that supports older adults with complex support needs. It consists of two units plus a community resource. All are integrated, with NHS and social work staff working together as single teams. The service is jointly funded by the local authority and NHS board, with some
posts being jointly funded and others being funded independently by the NHS board or housing and social work department. Staff include managers, nurses, senior care workers, care workers, a clinical support worker, a locality link officer, locality support workers and administration staff. The senior manager has worked in both nursing and housing and social work environments. The service has been running for four years, following a pilot, and was designed in an integrated way. Referrals come from mental health consultants/community mental health teams (who have access to ring-fenced places), GPs and social workers. It aims to provide a “one-stop shop” in which the client contacts just one person (a care manager) who will then develop the service around his or her needs.

Team E
This is an integrated day care service for people with functional and organic mental health problems. It is run by the social work department with community psychiatric nurse (CPN) input on a sessional basis two days per week, focusing on the provision of one-to-one and group work for people with early-onset symptoms. The social work department funds the CPN to be deployed from the NHS. The impetus for the service, which has been running for five years, was that while day centre staff may have been competent in working with people with established dementia, they were not so effective when working with people who had functional mental health problems or personality issues or who were at the early stage of their illness and exhibited a degree of fluctuation. Responses from day centre staff to clients’ behaviour fluctuations were not deemed effective, so the CPN input was requested to deepen their understanding of the underlying issues and enable them to develop more appropriate responses. The CPN reports to a manager in the NHS and remains a member of an NHS team.

Team F
Team F is a community-based learning disabilities team created by bridging finance after the closure of a large hospital. Following a process of joint planning involving the NHS and local authority that began in 2000, full integration was achieved in December 2004. The local authority takes the lead, with community learning disability nurses (CLDNs) and allied health professionals (AHPs) formally attached to the service, which is split into two teams to cover two major towns in the area. The management structure comprises a single service manager, operational managers for each team and a senior nurse as the professional lead for CLDNs across the two teams.
3. Team working and professional roles
The literature review described how removing organisational barriers is a key factor in integration, but also that integrated working cannot be achieved in the absence of meaningful professional collaboration between and within disciplines. It went on to describe the challenge staff face in adapting to a plethora of new roles as they begin to deliver an integrated service, raising uncertainty about their own role in an integrated team. Low awareness of what other roles involve is recognised in the literature as a barrier to effective team working, as is the potential for “role blurring”.

Team working
Team B reported a high degree of mutual respect within the team based on understanding of what each other offers. That was not the case initially, however, and it took time for team members to really understand what each other could bring.

“Early on, there were people who were not keen on the idea of integration and who actually tried to mount barriers against it,” a team member recounted. “It took time for those challenges to be overcome. We’re in a far better place now than we were four years ago when we integrated. I think there was a lot of fear at that time.

“People were worried that their roles were going to be changed or even lost, if they were going to be asked to do things they weren’t familiar about or use systems they had never used before,” she continued. “Sometimes it’s the fear that can be the barrier, rather than the reality. And the fear can only be dissipated as people accrue experience of working in the new service. New staff coming on board who know nothing but integration can help bring the others along.” This raises the important issue of how the idea of integration is “sold” to staff, and how their concerns are recognised and addressed.

Understanding was promoted in this team not only through working together day to day, but also within formal development sessions from which an action plan to resolve professional issues was developed. Crucially, members from health and social work services had enjoyed a close working relationship before integration, a relationship that integration has developed even further. The team believed that having a good working relationship prior to integration was helpful, and certainly preferable to trying to integrate teams that have no prior knowledge of what each other does.

Team C reported very strong team working, but that it had taken some time to build and develop. “We’ve come through the pain of getting over personality and professional issues and people now see we can deliver more together for the patient than we can apart,” a team member said. “But it has taken time – years.”
The team-working ethos in Team D has also evolved over time. Conscious effort was made in the early days to organise team development events and ensure staff were empowered to influence the structure, criteria and aims and objectives of the service. The model for the service and its aims would be presented at the events, with staff invited to suggest how they could be achieved. A monthly team meeting (involving both units) continues, with local team meetings being held each morning.

“When I was in the health service, I heard a lot of scepticism about working with social workers, but that’s not the reality,” a team member said. “The reality is, we work really well together. We’re paid from a different pot, but we’re all part of the same team.”

Team E pursued a collaborative process to promote a team ethos, including regular meetings between the day care manager (a social worker), NHS manager and sessional CPN to ensure “everyone is going in the same direction”. The CPN believed it was very helpful for her to be present when one of the day care centres opened for the first time – this supported the notion that everyone was part of the same team and promoted an understanding of what each other offered.

“One of the day care staff thought I was basically another pair of hands, so being there at the beginning helped us to put that right,” she said. “It enabled me to emphasise that we had different roles. But the results spoke for themselves – the staff could see the things they had been doing that were making things worse and began to understand how to behave differently – the confidence of knowing how to deal with certain situations took the stress out of it for them.” On the basis of the positive results achieved in this centre, the decision was taken to extend the CPN input to the second centre.

The result has been the development of a strong team-working ethos, with the CPN now being made to feel a very welcome member of the team. Maintaining positive relationships nevertheless requires ongoing effort. “You get different personalities and people with preconceived ideas about how their experience will be in the service,” the CPN reported. “They’ve maybe worked in other services and bring that baggage with them. We’ve had to say ‘come out with us and see what we’re all about’, and slowly but surely we’ve chipped away at these preconceived ideas. They can see that we’re not trying to pull a fast one, we do totally respect other disciplines and we want to work in a collaborative manner.”

The crux, she believes, is respect. “If you have mutual respect, it makes a huge difference,” she said. “I really admire what social workers do. We don’t always agree, but because we have the foundations of a strong relationship, we can weather the storm.”

**Professional roles**
Concerns about professional roles, boundaries and erosion were reflected in the literature review as barriers to integration, and interviewees were conscious of the issues they raised within their teams.
Team B believed an element of role adjustment was almost inevitable within an integrated service, but that role adjustment was already a reality for almost all nurses throughout the NHS. The manager said: “The adoption of different roles and services was happening to practically every kind of nursing service at the time our service was launched. Roles were changing because of Scottish Government and health board policies, but within our service, some nurses blamed it on the integration, which didn’t help.

“I have worked under the unintegrated and integrated systems,” she continued. “The truth is that you deal with the client in front of you, regardless of the nature of the service you’re in. If nurses aren’t doing that, and are allowing themselves to be restricted because of concerns about the nature of the service they work for, then we have a problem. But I honestly believe that isn’t happening.”

Team C felt there was a need to move forward from an attitude of “protectionism” around role definition, with health staff worrying about role seepage to local authorities and vice versa. “Let’s cut to the chase and put the patient or client centre stage and see what works best,” a team member said. “We need to be patient/client focused and forget the territorialism – there is plenty for us all to do.”

This was a view with which the health service manager of Team E agreed. She believes part of the reason for her strong working relationship with her social work counterpart was that fact that neither of them was “precious” about their roles. “We were very clear about what we could offer and what we were trying to achieve,” she explained. “Regardless of your background, the aim was the same – to improve the clients’ health and well-being – and we recognised the parts each other could play.”

Language may be an important factor in supporting team members to understand each others’ roles. Team A refers to itself as an “interdisciplinary” team, with the strong implication that members are happy to take on elements of each others’ roles. Certain functions are nevertheless reserved to specific professions – for example, removing a patient’s wound clips would always be performed by a nurse, and not by a physiotherapist or social worker. Similarly, in Team B, nurses would be involved if there was a need for substitute prescribing or a detox regimen with medication, while any statutory issues would be referred to social workers. Significant core elements of professional practice are therefore retained by individual team members.

Team A believes this is about supporting, rather than usurping, each others’ roles and team members are encouraged to adopt this stance through targeted education activity that aims to develop awareness of roles. “The essence of individual roles is retained and respected because the education programme raises awareness of what each member does,” a team member

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2 It was emphasised that all staff in Team B, regardless of professional background, were aware of their individual responsibility for protecting children and had been trained in Getting it Right for Every Child (GIRFEC) approaches.
explained. “Roles are appreciated more through some small elements being shared. It also enables patients’ needs and priorities to be identified more efficiently, because the assessor knows what expertise the different professionals can bring. Team members know their limits.”

Staff in Team D had a say in what their role and remit was, which was found to have been very helpful in promoting mutual understanding. “We offered opportunities for work shadowing, with staff picking who they would shadow, to the point that people quickly appreciated what other professionals were doing,” a team member explained. “It also helped them to see the huge overlap and similarities between what they did, building on the common issues rather than accentuating differences.”

Team E cited a very specific example of how a health care staff member had been able to support local authority staff to understand their roles and improve their performance. Local authority day care workers had, according to the CPN in the team, very limited knowledge of mental health issues. By working with them, she has been able to develop their understanding of the mental health problems clients present, meaning they have been able to recognise and rectify inappropriate responses.

“There was little recognition among the day care staff of the fact that people’s conditions and abilities can change on a day-by-day basis, so we were trying to help them understand that this was characteristic of the pattern of their illnesses,” the CPN explained. “Because the staff have now had the education input on issues such as how to recognise when clients are developing problems – maybe memory loss or their mood going down – they can spot these things early and refer appropriately to me.” The CPN believes that her becoming a “well-know face” within the service facilitated the education sessions and also gave the day care workers confidence to have informal chats with her to support what they were doing.

**Professional tensions**

Of all the teams, Team F appeared the one for whom this issue had raised most concerns.

The professional lead for nursing in the team explained that operationally, staff had knowledge of each others’ roles and worked well, but relationships between middle and senior managers from different professions, who were trying to drive forward the integration and other joint initiatives, were not so strong. “Difficulties arose when it transpired that we didn’t understand each others’ perspectives,” she explained.

One of the big issues for this team, unlike Team B, was the role of health staff within the care management\(^3\) agenda. Team members described how the

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\(^3\) The Scottish Government describes care management as: “a process in which an individual’s needs are assessed and evaluated, eligibility for service determined, a care plan prepared and implemented, services tailored to individuals’ needs provided, and needs are monitored and re-assessed; focused on people with complex, or frequently or rapidly changing needs; and undertaken by a range of professionally qualified staff in social work
local authority partner had an expectation that nurses and perhaps some AHPs would take on care management roles, but that this was not the professional lead for nursing’s expectation.

“The local authority argued that AHPs like speech and language therapists were too small a professional group to assume care management roles, but why would CLDNs be seen any differently?” she asked. “The local authority had a waiting list for care management and saw an easy opportunity to draft nurses in to fill the gap. We have done it from time to time, but it’s not in our interests – if we’re doing care management, we’re not doing nursing. On the occasions when we have stepped in, we’ve suffered as a consequence – the assumption became ‘well, you’ve done it once, why not carry on doing it?’”

The professional lead believes that at local authority level, there was a genuine misunderstanding about, or unwillingness to understand, what CLDNs did. “How many times are CLDNs going to have to explain what they do?” she asked. “I’ve had a 30-year career and I still have to explain what I do – so there was an element of frustration from the health side.” This led to rising tensions at management levels as claims and counterclaims about what CLDNs should and should not do were pursued. Ultimately, it was agreed that CLDNs and AHPs would continue with their usual roles and responsibilities in providing health care, but the process was fraught with difficulty.

A team member claimed that CLDNs are still facing pressure to take on care management roles and conceded that it was difficult to decline when they could see social work colleagues under intense pressure. “It’s difficult when people ask for help and you insist on sticking to the nursing role, but we do it because we value what nurses do,” she said. “We are specialist nurses, focused on health care. We take a holistic approach, but care managers think that means we can take on housing and benefits issues. We can’t do everything, or the client gets a disservice. It’s still a challenge, and it’s still very much on our agenda.”

The team has been reviewing the nursing role recently to make sure they were still contributing to the integrated team, and agreed that in an integrated team it is important to respect each others’ roles. “I would never tell anyone that they could do my job,” a team member commented. “The case managers were undervaluing and devaluing their own roles by running around asking people to do their job for them. It wasn’t an issue of professional rivalry. Instead, much of it arose as a result of the pressures case managers were under – huge case loads, chronically understaffed – they were hard-working and diligent, but they just couldn’t do it all.”

Team members believe that professional leadership of nurses is hugely important when tensions such as these arise within integrated teams. “There were occasional comments about nurses ‘not pulling their weight’, but

and health, with appropriate training, skills and experience.” (source: http://www.scotland.gov.uk/Topics/Health/care/JointFuture/plodcaremanagement).
interestingly, we never got pressure from those who had originally been learning disability nurses,” one commented. “They had a very clear idea of the health role. It was the people who had never worked in health who had a complete lack of understanding. It went on for a while, and it was exceedingly difficult at times – at those times, the professional leader was very supportive.

“I’m quite concerned by the numbers of nurses in Scotland who are doing case management, and it’s probably because there isn’t strong professional leadership and management lines are local authority led,” she continued. “It creates tensions – indeed, there are teams who were integrated once who are now no longer integrated. I believe the way forward is definitely integration – clients will get better outcomes from an integrated team rather than us working in our own silos – but lines have to be drawn somewhere.”
4. Culture
Common goals and a shared vision seem to be crucial to the success of integrated care, the literature review states, with differences in organisational culture between health and social services being well documented. Professional cultures can create barriers to integration as a result of differences in training, values and ideas of good practice. The literature review also found that social workers based in primary care lack credibility with colleagues working from traditional settings, and that the perceived lower status of social care staff compared to healthcare staff creates significant difficulties in developing integrated systems.

Addressing cultural barriers
Some of the teams described the difficulties of trying to integrate health and social care cultures.

Team E found the process particularly arduous at the beginning of their integration, when they were trying to change attitudes and cultures to help day care staff appreciate the variety of mental health issues clients present. “We didn’t go in with all guns blazing and telling them they were doing things wrong – we recognised there were lots of things they were getting right and lots of enthusiasm,” the CPN explained. “But changing attitudes was tough at the beginning, and there were a few who objected to receiving CPN input.”

She has nevertheless seen benefits in persevering with the programme and the educative approach. “On the whole, people have been grateful for the input and are almost seeing it as giving them another string to their bow – they understand their clients better,” she said. “They’ve recognised that the education can help them provide a better service.”

Team E also experienced some cultural challenges on the operational side of the CPN service. They found that pressures within the social work culture to ensure every place in the day centres was filled was superseding the imperative of having the clients who would benefit most from the CPN’s input in attendance on the days she was present. It meant that there were often “inappropriate” people there on the day the CPN visited, which in turn meant she had to constantly amend her approach day by day to meet their needs. It took much effort from the health service side to ensure that clients were assigned days that enabled them to access the CPN’s expertise.

“It’s understandable that it happened, as the day centres have to make maximum use of the resources at their disposal,” the health service manager of Team E said. “But the CPN has a good relationship with the manager at the centre and she will now approach us to discuss possible placements. The relationship is central to that – if we hadn’t established that rapport, it would have made the situation much more difficult.”

Team F found the bureaucratic nature of social work services frustrating. “Social work tends to be organised in a fairly rigid hierarchical structure,” the
professional lead explained. “This means an individual has to speak to her manager, who in turn has to speak to her manager, before a decision can be made, which slows the process down. By comparison, nurses are fairly autonomous. Also, nurses don’t tend to have to deal with budgets, which means they can get on and do what they need to do.” This latter point was supported by a team member from Team C, who said: “We [nurses] are very much patient focused, whereas the culture in local authorities could be money first, patients second.”

**Language**

“Sometimes it’s like we speak a different language,” a member of Team C commented when asked about communication between nursing and social work staff. There seemed to be a particular language problem at meetings, especially around classification of needs, where health and social care terms seemed to vary considerably. The team member felt this was imposing a significant impediment to ongoing progress. “We need to tackle this,” she said. “It is a barrier, especially around palliative care, but we are making progress and breaking down the barriers. It varies across the patch, but in my area, I’ve got to know the social worker, and that face-to-face contact is very useful.”

Members of Team F were conscious of how the use of different terms may reflect differing interpretations of the main issues clients faced and their relative importance. “What we [nurses] might judge as ‘complex’, they [social workers] didn’t judge as ‘complex’,” a team member explained. “‘Priorities’ was another one – health priorities on a Friday afternoon were quite different from social work priorities. These are things that you can’t change – social work will always prioritise social care, while health will always prioritise health – but you can call a truce over some issues. Terminology was definitely a difficult thing for a while. But co-location has helped.” Co-locating staff in the same office or building, where they have opportunities to interact both formally and informally, was also seen as a positive factor in overcoming language barriers by Team B.

Team D appeared to have taken positive steps to develop a common language within the team by addressing the use of very simple day-to-day terms. “We don’t talk about ‘differences’ between the professions, we speak about ‘specialisms’,” a team member explained. “They’re not NHS ‘patients’ or social work ‘clients’, they’re our ‘service users’”. Team A, on the other hand, had found that because it was invariably a health issue for hospitalised patients that prompted their interventions, the social worker on the team had tended to adopt health terms, and referred to service users as “patients”.

This position of trying to identify common ground on language and to adjust to the different use of language between health and social care settings was also being pursued by Team E. In particular, they seemed to appreciate that working in an integrated team would mean that adjustments in use of language would have to be made.
“You have to adjust, especially from the educational point of view,” the CPN said. “They [day care staff] don’t come from a health background and are not au fait with the jargon, so you have to put it into a more understandable format for them. But it hasn’t been difficult – it’s something we’re quite good at. To be honest, we can have a laugh about it at meetings – what do we call them, service users, patients, clients? We all say, ‘can we just call them people?’

Team E believed that even though the partners in the team used different terms and jargon, meanings could still be easily identified. “We all know what the other person is speaking about,” the CPN said. “It’s not a foreign language, it’s just a different way of describing things. I think when people highlight language as creating a big problem in integrated services, it might be a smokescreen to mask deeper problems about joint ethos, teamwork and professional respect.”

**Response times**

Two of the teams had found the different time frames within which health had social care staff work to be a problem. The issues revolved around health staff perceiving patient needs that required a quick response from social care, but finding their ambitions frustrated by what they believed were overly cautious, bureaucratic responses.

“The only problem regarding cultures within the integrated team is response times,” a member of Team A reported. “There’s a difference between health time and social work time in terms of responses. Our team needs to respond quickly and, because the social work officer works within the team, that’s what she does. But that’s not the case with the local authority – it can take a long time to get a patient’s house cleaned prior to discharge, for instance.

“The social work officer can sometimes feel caught in the middle between two response times,” the team member continued. “It could be that the local authority doesn’t really understand what we do and the need for quick response times. There is obviously a difference in how health and local authority define what is a safe time period, and we have had to come to quite difficult agreements at times around how quickly the local authority element of a discharge can be actioned. In fact, discharges have been delayed because the local authority has been unable to put the necessary infrastructure in place at the home.”

Team C experienced similar issues from a community-based perspective. “Our timescales are very different,” a team member explained. “We respond quickly in health, but local authority responsiveness is on a different timeline. Things often slow down when the local authority becomes involved – if, for instance, we have a palliative care patient coming home from hospital, we [nurses] pull out the stops to get all the people in place to support them and their family. But when we have go to the local authority for support, they can delay things and want to perform their own assessments before acting. Sometimes the small window of opportunity we have for these people is then missed.”
5. Strategic issues
The literature review highlighted barriers to integration around funding arrangements, employment issues and a lack of clear, realistic and achievable aims and objectives that are understood and accepted by all partners. Differences in organisational processes, priorities or planning cycles were also identified in the review as factors that could create a climate for conflict rather than co-operation.

Funding
A single source of funding used to deliver integrated care according to a care programme approach was seen as being a significant factor in successful integration in the literature review. It found that separate funding earmarked for either health or social care could not easily be redirected from one service to the other, as managers could not commit resources from budgets they did not control. Even where management structures were integrated, problems arose if budgets remained separate, the review stated.

All of the teams surveyed were supported by funds provided by both health and social care, which presented various benefits and challenges.

Funding has never been considered a source of contention by Team A. The service is jointly funded, with the local authority providing the budget to support the social work element of the team. Team B receives separate budgets from health and social work, but the resources are pooled and are managed centrally by the service.

Capital spend to build the new service provided by team D was provided by the NHS, with the local authority housing and social work department providing the ongoing day-to-day budget for maintenance. The NHS funds the nursing staff in the team and half of the senior manager and administration posts, with housing and social work providing the other halves and supporting social work staff. Operationally, the senior manager holds a single budget.

An example of the complexity separate funding can present was provided by team C. “The process goes like this,” a team member explained. “A patient coming home from hospital on a ventilator undergoes a lengthy assessment, which is taken to a health and local authority screening panel. The patient’s case is presented and options for funding are considered. If agreed, the patient goes forward to a health and local authority resource panel for funding approval – if approved, funding comes for one year and is then reviewed. It’s important the process is robust, but resources are getting tighter, and it’s becoming more of a tussle.”

Management structures and accountability
The teams had a variety of managerial structures and reporting lines in place, but each had either direct or indirect managerial input from both health and social care.

The management structure for team F, for instance, comprises a single service manager, operational managers for each of the two site teams and a
senior nurse as the professional lead for CLDNs across the two teams. Team E is run by the social work department with CPN input provided by the NHS: the CPN reports to a manager in the NHS and remains a member of an NHS team. Managerial accountability in Team D lies with the NHS, but there is strong partnership with housing and social work.

Team B has one overall service manager and team managers for each of the six sites in the service. It described two different management structures (one each for health service and social work), but working in collaboration. “We manage the service together and look on it as managing teams, not nurses or social workers,” the service manager explained. “Despite having two separate budgets, we’ve pooled our resources and have set up integrated planning and reporting mechanisms that feed into a stakeholder board. It’s complicated because so many agencies are involved, but the board structure enables us to plan strategically in a consensual way.”

**Employment status**
The literature review emphasised how issues such as employment terms and conditions could be very difficult to resolve and cited instances of difficulties arising over negotiations with central government to transfer staff between local government and NHS employment without losing pension entitlements. It described the advantage claimed for Northern Ireland’s integrated health and social care system in that all health and social care staff have the same employer, so reducing variation in management practice or terms and conditions. Scotland does not currently have an integrated health and social care system, so differing employment terms and conditions were found across all the teams surveyed.

Team B described two employers for its staff – the health board and the local authority. “This created problems initially with regard to different terms and conditions and cultures,” a manager said. “From a management point of view, it’s more difficult if you’re dealing with two systems. But we’ve worked on that, working with HR [human resources] to create a number of joint policies, so we’re moving in the right direction.”

Team D has two different pay structures for health and social care staff, but this has not caused any problems. “As a team, it seems that we have accepted that we have chosen the jobs we do and understand that everyone who does the same job gets the same pay,” a team member explained. “We’re paid differently, but our roles are different. Public holidays have been an issue, though – health service public holidays and local authority public holidays are quite different, so some integration around that would be helpful to the team.”

This team member concluded by saying: “I don’t tend to think about what other people get paid – I’m paid well as a nurse to do the job I do.”
Communication systems
Different IT systems emerged in the literature review as one of the biggest factors acting against integration, with the need to integrate IT systems between health and social care organisations being a recurring theme.

Health and social care staff in Team A work from the same location and use the same computers, but their background IT systems differ. While they have become accustomed to this situation and feel it does not cause many problems, they feel it would be much easier if the systems were integrated. “It’s a bit of a pain sometimes,” a team member said.

Two senior members of the team have read-only access to the local authority social work database. This enables them to check the background of patients from a social work perspective. Getting access to a comprehensive social work report can give a solid foundation for health team members to carry out what they have to do. “It was very frustrating in the years prior to having access, when we couldn’t get this information,” one said. “You need up-to-date information from a safety perspective above all. The care plan trigger system we use is helpful in highlighting where there may be a social work issue – it’s amazing how many times you follow up the trigger to find there is a child protection issue in process or circumstances that may even have put a team member at risk by attending the house. Being aware of these issues plays a significant part in the risk assessment.”

An information-sharing protocol introduced in the health board has been very helpful in determining what information should and should not be shared between health, social work and any other relevant agency.

IT was a big concern initially for Team B. “Everyone thought that moving from the health system we were familiar with to the new social work system we knew nothing about would be a nightmare,” one said. “But this was really about people being stuck in their ways and their initial inclination to block – as time goes on, people adjust. New staff coming into the service have been totally receptive to the system and feel much more positively about it.”

Despite this, Team B believes it still has a way to go with IT, and a project manager has been commissioned to look at developing an integrated system for the service that will also link in with other services.

Team C identified IT as a big problem that would require much resource to ameliorate. “Think of a child protection case,” one team member said. “Health, local authority, police, education, criminal justice – all are involved, so their systems need to be able to talk to each other. And there needs to be trust throughout the system that agencies can share information on a need-to-know basis. It’s important that assessments are not duplicated – there’s no point in health and social care professionals making the same assessment – but that’s what happens because the IT systems don’t articulate.” A joint health board–local authority information-sharing protocol has been developed to try and overcome some of the problems.
Team D uses both an NHS IT system and a housing and social work system, but there is also a central “store” where staff have consent to share each others’ reports. “It’s not all-singing, all-dancing,” a team member explained, “but a nurse can complete an assessment report for home care, put it on the NHS system and, if she ticks “consent to share”, colleagues in housing and social work can view it.”

This team member feels that as a compromise to investing in an entirely new integrated system, with all the expense, training requirements and complexity that would entail, organisations could look to adopt universal use of a single existing system. “We could look to use one system,” she said. “The housing and social work system is better. If we can’t invest in a single integrated system, I’d suggest we move to using the housing and social work system. It would make sense in the current economic climate.

Team E uses electronic nursing assessments that go into a multi-agency “store” (once written authorisation is achieved from the patient (or next of kin)) that social workers can access. Nurses can also access social work community care assessments. “There have been a few teething problems,” a team member explained. “The system we’re using wasn’t designed for this purpose, but we are getting a new system that will help in terms of the amount of information we can store and ease of access for the user. It’s only by using the system that we’ve been able to iron out some of the problems.” District nurses can also access the system.

Some of the challenges in communication the teams were experiencing seemed to be caused by having to negotiate two different IT systems. It would appear that progressing an integrated agenda would require serious consideration of integrated IT systems, although issues around confidentially and consent, data protection, Caldecott guardianship and electronic security/firewalls are formidable.
6. Operational issues

Raising awareness about the integrated service
Team A found that hospital wards initially required lots of information about what the service provided. There is now a rotation system that enables hospital therapy staff to work with the team for 6–9 month periods. “This provides a good grounding for staff to help them understand what we do,” a staff member said. The rotation system does not operate for nursing currently, but nurses can spend a day or half a day with the team as part of their personal development planning processes. Team members are also “very visible” on the wards. All of this has raised awareness of what the service can, and cannot, offer, as a team member explained: “When we started, 25% of all patients referred to the service were inappropriate – now it’s less than 1%.”

Team B has also worked hard to build awareness and good working relationships with other sectors, such as criminal justice, and have carried out awareness-raising sessions with other services.

Co-location of team members
The literature review found that sharing office space and client groups makes integrated working easier. The teams that did not have co-location (Team C and, partially, Team F) seemed to have found it more challenging to build a common team ethos and mindset. From the conversations conducted with team members, it can fairly be deduced that these teams were the most likely of those surveyed to still hold a “them and us” mentality. In addition, it appeared that respect across different professional groups had not grown as quickly in these teams. Some jealousies and resentments remained, particularly around issues like contributions to case management, and territorial and silo-driven attitudes were still evident.

Despite this, members of team F who had experienced co-location within the service spoke very positively about its impact. It was described as being helpful in overcoming some of the language barriers that were cited elsewhere in this report through giving people the opportunity to spend time with each other. “You get to know them as people and you overhear discussions they’re having, so you become familiar with the language they use,” a team member said. “Even though we knew everyone before we moved in, it was better once we were in the joint office. It meant we could discuss what we meant when we said such and such over a cup of coffee. It shouldn’t be a case of never the twain shall meet – there must always be a middle ground, even if it’s agreement to disagree.”

The team also felt co-location had helped to overcome notions held by some case managers that nurses weren’t “pulling their weight”. “There is now less of an idea that they’re running around and the nurses aren’t, because they can actually see us running around,” one said. “There’s also a bigger understanding of what we do and the complexities we face.”
The situation in this team is that while nursing and social care staff are co-located, AHP team members are situated elsewhere. This was creating some problems for integration in the team, it was felt. “Unless you’re all under the one roof, it’s difficult to see yourself as integrated,” one team member said. “It has meant that while camaraderie between social workers and nurses has developed, the AHPs are still a bit isolated. They can hotdesk in the office a couple of times a week and are always involved in away days and meetings, but there is still a difference when you’re sharing a room.”

Team B described co-location as “one of the biggest boosts” to team working and mutual understanding. “It has been great for building relationships and learning from each other,” a team member said. “I know people talk about the possibilities of ‘virtual’ integration, but physically being in the same building is a massive plus.”

Team C also felt that co-location of nursing and social work staff supported strong collaborative working and relationship building. “Where they are in separate locations, the relationships aren’t as strong and the access to each others’ services isn’t as good,” a team member said. “Barriers are minimised and informal networking is improved with co-location. You can hear it and you can see it.”

**Referral and assessment**

The teams described a variety of means of referral. Referrals to Team F come into a single point where a decision on onward referral to the appropriate locality team is taken. There is then discussion within the team about who would be the right person to see the client. “Most referrals are due to someone’s mental or physical health or behaviour deteriorating, and that means that 90% of the time, it’s nurses who go,” a team member said. “We need to remember too that some people will refuse to see social workers for whatever reason, and a nurse can be a bridge to that person.”

Any member of Team A can perform patient assessments. They have a competency-based framework that each profession in the team signs up to and which creates a common level of practice, backed up by training developed by the team.

Team B uses a single-shared assessment based on the existing social work system, but is currently working on a new IT system that will link with other services. Assessments undergo a screening and triage process to identify the level of priority and risk and are then allocated to the best-placed person for comprehensive assessment under a case management structure.

Team D claimed that assessments carried out by nurses are accepted by social workers, and vice versa, but Team C reported that health and social care assessment processes are different and use different language – “If we had the same assessment processes, it would really help,” a team member said.
Joint training
The literature review suggests that “soft’ issues such as culture, training and attitudes could be dealt with through joint training sessions. Training, however, was cited as a potential barrier, with instances of service planning and delivery being integrated but core professional training remaining separate. The literature review states that some consider this the key barrier to integration, because training reinforces issues of professional status and identity. It cites a review of integrated working in Scotland which found evidence that joint training was considered central to building a shared culture.

There were examples of joint training initiatives across all the teams. Team B considered joint training as having a big impact on encouraging respect and acknowledgement of different professions’ contributions. There are no uniprofessional training programmes in this team – all staff engage in joint, multi-agency training.

The manager of Team D can nominate NHS staff for any training that the housing and social work staff access, and vice versa. A nurse member of the team stated that she had had “more training since integration than I’d ever had before”.

Team D staff have accessed joint training on issues such as adult protection and child protection, but there are also opportunities for role shadowing and joint visits that the team claims are educational – “when we’re out in the field with [social care staff], we’re updating them on what’s going on, and they do likewise,” a team member said.
7. Conclusion

“In the unintegrated service, I would often be frustrated because I felt my hands were tied – having to refer clients to services elsewhere or placing them on a waiting list that stretched forever and a day. Now, in the integrated service, I can access what I need very quickly. In fact, we’ve set a local target to ensure anyone referred into our service is assessed and receiving treatment within 21 days, which is a big advance on the national target. We’ve always been ahead of the game. Under the old system, people would wait on waiting lists forever – they would die on waiting lists – because we didn’t have the additional resource that integration has brought with support for social needs and links into the community for rehabilitation. These opportunities didn’t exist under the old system of separate health and social systems.” (Team member, Team B)

This quotation seems to summarise what many of the interviewees felt: despite the inevitable challenges and problems integration poses, those who work in integrated services prefer them to what existed before. There seems to be a strong appetite for integration across all the teams, noticeably in services with a solid tradition of collaborative working and linkages across agencies – mental health, addictions, elderly care and learning disability. Perceived benefits of integration and its definition as a desirable goal were also evident in the two teams in which integration has followed an inconsistent pattern.

Key learning from the interviews across the core areas explored are set out below. Some general messages from the interviews on elements that enable integration are:

- good communication, co-ordination and trust are essential
- the chances of integration are boosted when partners know each other prior to integration and understand each others’ roles
- services that are designed as integrated services from day one are more likely to encourage a strong team working ethos with all partners pulling in the same direction
- buy-in is necessary at all levels of the service, with operational staff having an opportunity to shape and influence the service’s strategic direction
- “visible, integrated and strong leadership is vital to making it happen” (team member, Team C).

Factors that appeared as barriers to integration varied across the teams. For those in which integration was working well, IT issues seemed to pose the biggest problems, although work is clearly under way to address the issues. Perceived differences in the “pace” at which health and social care members worked and the cultures from which they emerged also posed challenges that may prove difficult to overcome. In the two teams in which integration appeared not to be so deeply embedded (teams C and F), additional
challenges were posed around perception of professional roles and ways of working.

While there are indications from this short “snapshot” of practice that integration is working well, there are concerns across the teams that as money gets tighter, team members may become protective of their professional roles again, with consequent negative impacts. “It would be a huge pity if integrated working that has been going on for years suffers because of money,” a member of Team C said.

**Summary of key learning across the main issues**

**Team working**
- How the idea of integration is “sold” to staff, and how their concerns are recognised and addressed, should be considered.
- It is helpful if team members have a good working relationship prior to integration.
- Building a team ethos among previously unintegrated team members takes time, perhaps years.
- Structured team development events are helpful in supporting integration.
- Staff should be empowered to influence the structure, criteria and aims of objectives of the service.
- Maintaining positive relationships among team members requires ongoing effort and attention.

**Professional roles**
- An element of role adjustment is almost inevitable within an integrated service.
- Certain functions will nevertheless be reserved to specific professions.
- Roles are appreciated more through some small elements being shared.
- Targeted education activity develops awareness of roles within teams.
- Activities such as work “shadowing” are helpful in supporting staff to build on the common issues between professions, rather than accentuating differences.

**Professional tensions**
- In an integrated team, it is important to understand and respect each others’ roles. Difficulties arise when partners do not understand each others’ perspectives.
- Professional leadership of nurses is hugely important when tensions around roles and boundaries arise within integrated teams.
- Integration is seen as the way forward, but professional boundaries have to be respected.

**Cultures**
- Positive relationships between health and social care staff are central to identifying and breaking down cultural barriers.
• Health and social care staff may have different priorities and may have to negotiate different management and approval structures, which can lead to perceived delays in progress and resultant frustrations.
• Nurses tend to be more autonomous in decision-making than social workers and tend not to be so encumbered by budget issues.
• Co-locating staff in the same office or building, where they have opportunities to interact both formally and informally, is seen as a positive factor in overcoming language barriers between professional groups and in building a team ethos.
• Working in an integrated team means that adjustments in use of language have to be made to overcome issues of jargon and interpretation. Some teams are trying to develop a common language for their service.

Strategic issues
• In the absence of combined health and social care organisations, funding mechanisms and employment practices, partnership management approaches with pooled resources seem to be most productive.
• Differing employment terms and conditions do not appear to present significant problems.
• Information-sharing protocols have been very helpful in determining what information should and should not be shared between health, social work and any other relevant partnership agency.
• As a compromise to investing in an entirely new integrated IT system, with all the expense, training requirements and complexity that would entail, organisations could look to adopt universal use of a single existing system.
• It would appear that progressing an integrated agenda would require serious consideration of integrated IT systems, although issues around confidentiality and consent, data protection, Caldecott guardianship and electronic security/firewalls are formidable.

Operational issues
• Co-location is a strong supporter and enabler of integrated working.
• The teams that did not have co-location seemed to have found it more challenging to build a common team ethos and mindset.
• Having the same assessment processes across health and social care would be considered helpful.
• Joint training is having a big impact on encouraging respect and acknowledgement of different professions’ contributions.