

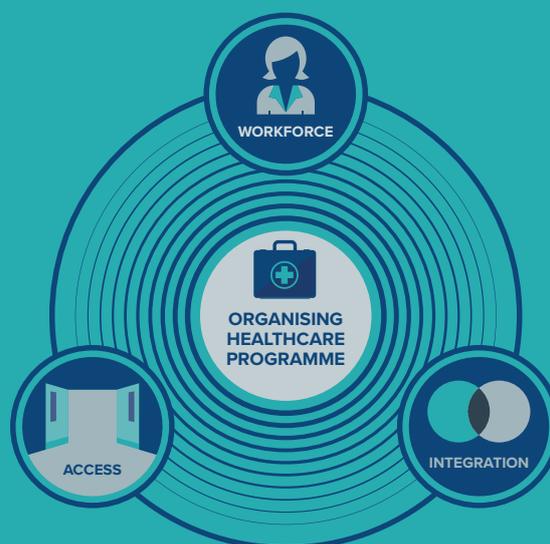


**Understanding and supporting
the integration of health and
social care at a neighbourhood
level in the City of Manchester**

This work was conducted by the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care Greater Manchester (NIHR CLAHRC GM), which is one of thirteen CLAHRCs in England. NIHR CLAHRC GM is a collaborative partnership between NHS organisations, the third sector and the University of Manchester focused on improving the health of people in Greater Manchester and beyond through the conduct and application of high quality applied health research.

This work is part of NIHR CLAHRC Greater Manchester's Organising Healthcare Programme. There is currently a drive to 'transform' the NHS to address the growing, and increasingly unsustainable, pressures faced by the system. This drive includes initiatives to transform the health and care workforce, to integrate health and care to better meet the needs of the population and to expand and improve patient access to healthcare. The Organising Healthcare Programme aims to inform and support this by:

- Conducting rigorous and research-informed evaluations which shed light on the implementation and impact of change initiatives across health and social care;
- Supporting partner organisations to generate and evaluate innovative projects seeking to better integrate primary care with other parts of the health and social care system;
- Providing commissioners and providers with evidence to support decision making to deliver effective and sustainable future service design and configuration.



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We would like to express our thanks to all the participants who took part in this study.

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EXECUTIVE SUMMARY

This report presents an evaluation of the development of twelve integrated neighbourhood teams across the three localities (North, Central and South) in the City of Manchester. This research was carried out in 2018 and the report produced in May 2019 by the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care Greater Manchester (NIHR CLAHRC GM) on behalf of Manchester Health and Care Commissioning (MHCC).

BACKGROUND

- Nationally there has been a drive to deliver integrated health and social care to offer person-centred care delivered locally to the individual in their communities. Offering seamless care for health and social need is thought to reduce hospital admissions and length of hospital stay making delivery of these services financially sustainable.
- Regionally, devolution has been a driver to transform delivery of health and social care in Greater Manchester and as one of the boroughs, the City of Manchester has taken the opportunity to embrace the integration of community health and social care services through the development of twelve integrated neighbourhood teams in the three localities it serves; North Manchester, South Manchester and Central Manchester.
- This report analyses the barriers and enablers as well as the context to the establishment of integrated health and social care teams across the three localities in the City of Manchester.

METHODS

- This study took the form of a qualitative process evaluation to understand the context of the development of the neighbourhood teams, and relevant enablers and obstacles to the integration of neighbourhood teams.
- Methods comprised: a rapid scoping review of the literature around integration of health and social care (in Report Part A – see separate report) and a thematic analysis of semi-structured interviews (Report Part B).
- Interviews were conducted with 24 individuals (comprising 6 strategic leads; 18 operational staff of all grades and experience, ensuring equal numbers of health and social care) to identify what is hindering and supporting the integration of neighbourhood teams.
- The study was not an outcome or impact evaluation, and so does not assess the impact of integrated neighbourhood teams on health outcomes, patient experience or financial implications.

FINDINGS

- Integration involved merging community health (from the NHS) and social care (from local authority) into one local care organisation. This local care organisation developed the blueprint of twelve integrated neighbourhood teams comprising of nursing and social care staff; four teams were established in each of the three localities.
- The main aim of the integrated neighbourhood teams was to consider the health and care needs of the local population, to deliver seamless care for individuals across health and social care services, reduce the number of different professionals one individual may see and reduce referrals through the system. The two key performance indicators were reduced hospital admissions and reduced length of hospital stay.
- The key enablers considered to support integration were:
 - A consistency of definition and vision of integration.
 - A positive description of the perceived benefits to individuals receiving care from integrated teams irrespective of professional background.
 - Having an understanding of the legal, financial, governance and role responsibilities of other professionals and the constraints of these.
 - Co-location in conjunction with streamlined terms and conditions for staff to facilitate improved working relationships.
 - Staff understood the benefit of an asset-based approach making links with local services and voluntary groups and wanted support throughout the organisation to embed this.
 - Fostering local decision making.
 - Ensuring sustainable involvement of GPs and defining the purpose of team meetings.
- The main challenges for integration were:
 - A need to employ multiple channels for communication between the leadership of the integrated organisation and the operational staff.
 - Lack of clarity regarding the detailed planning for the operational delivery of integrated services.
 - A disconnect between the vision of distributed leadership and the more limited devolution of authority to those making decisions at a local level.
 - A lack of joined up information systems affecting data sharing.
 - The challenge of establishing new ways of working without risking disruption of safe transfer of care.
 - Concerns that current measures of integration do not reflect what the integrated teams are trying to achieve.

DISCUSSION

- This report identifies likely enablers and barriers to integration arising at an early stage of the integration process as the teams were moving into co-located premises. This early opportunity to interview staff has identified some key areas of innovation, change and development that could support the ongoing process of integration.

- All staff interviewed shared a clear and coherent understanding of the vision, purpose and importance of integration. This is a key enabler of supporting integration. It is vital that this common understanding remains embedded as staff progress towards full integration. Communication could be disseminated through channels other than email.
- There were concerns that the plans shared for integrated service delivery lacked detail, or that detail was not being shared. Relatedly, some interviewees perceived a disconnect between a commitment to distributed leadership and an unwillingness to delegate, perhaps reflecting a lack of confidence in local decision making and the value of local assets. Many felt that local service delivery needs to develop a coherent approach to local decision making, particularly when finances are restricted, if the organisation is to embed asset-based work, making connections with and signposting people to local services in the community including voluntary organisations.
- There was a recurrent theme related to concerns from health and social care professionals around boundaries between professions and between different part of the health and care system. Investment in inter-professional and intra-professional learning could improve working relations as people develop an understanding of each other's responsibilities and governance. Improving integration should also focus on supporting learning between and within teams, to establish a common recognition of how different organisations can work together to support each other and facilitate streamlined care for individuals.
- Joint working is hindered by barriers between information systems and geographical separation of teams. The implementation of integrated information systems and effective and data sharing would have a major impact on time, safety, and workload. Similarly, it was felt that co-location would also lead to improved working relationships and greater confidence in sharing data. Human resource and organisational development interventions, including the streamlining of terms and conditions, may also support positive work relationships between professional groups and functions.
- The relevance of multi-disciplinary team meetings needs to be refined, including deciding which individuals need to attend and clarifying the purpose and timing of meetings. Involvement of GPs is considered key to the integrated teams and their input needs to be sustainable and resourced.
- There is agreement that the key performance indicators of reduced hospital admissions and length of hospital stay may not be the most appropriate measures of success or reflect what the integrated team is trying to achieve. Preventative work, self-care and improved quality of service delivery must be considered when developing impact evaluation of integrated neighbourhood teams.
- Safe transfer of care is a key priority but needs to be balanced with the need for innovative ways of working.
- In the day-to-day delivery of services, there is a need to consider how best to share and embed the pockets of innovation where an asset-based approach is working well and being driven forward.

RECOMMENDATIONS

System recommendations

- To continue to promote and embed the positive vision of integration at all organisation wide training events to ensure the engagement of current and (but particularly) new staff in the process.
- To consider or offer a variety of communication modes about the integration process with less reliance on email.
- To promote understanding and learning to facilitate closer working between community and acute hospital care staff – for example, integrated teams could potentially carry out training with hospital staff to inform, engage and establish connections to facilitate transfer of care.
- Integrated neighbourhood teams have identified a need for greater delegated authority from leadership level in making local care pathway decisions, and indeed local leaders have communicated a keenness to support this approach. Joint working groups where local leaders work with the integrated neighbourhood teams to support local decision making could foster the ethos of distributed leadership.
- Leadership to work with GP leaders to develop sustainable GP involvement in the integrated teams.
- Consistent human resource management practices necessary to avoid differences in terms and conditions.
- There is a need to develop meaningful measures of integration impact that reflect the intended benefit from integrated working involving co-production with individuals using health and social care services and professionals involved in delivery and leadership support.

Services recommendations

- Work from leadership to operational level is needed to address data sharing needs/data sharing agreements and common understanding between all services and teams.
- There need to be opportunities for shared learning across the integrated teams in all localities to promote the many areas of existing good practice and innovative ways of working with leadership support to champion cultural change across the whole organisation.
- Integrated teams need to develop, with management support, to foster distributed leadership; to facilitate the development of their own detailed, locally relevant care-pathways, ensuring the trusted assessor role is clear and the involvement of other professionals will be streamlined without further referrals and waiting lists.
- Regular cross-disciplinary learning sessions within the integrated teams should be introduced for shared learning about roles and responsibilities, complex case discussion, asset-based approaches, prevention work, self-care and sharing good practice.

1.0

BACKGROUND AND CONTEXT

Table 1: Timeline of integration

2011- 2014

New approaches to deliver care through integrated services piloted across the city in North, Central and South Manchester and reports produced for the respective local Clinical Commissioning Groups (CCGs)

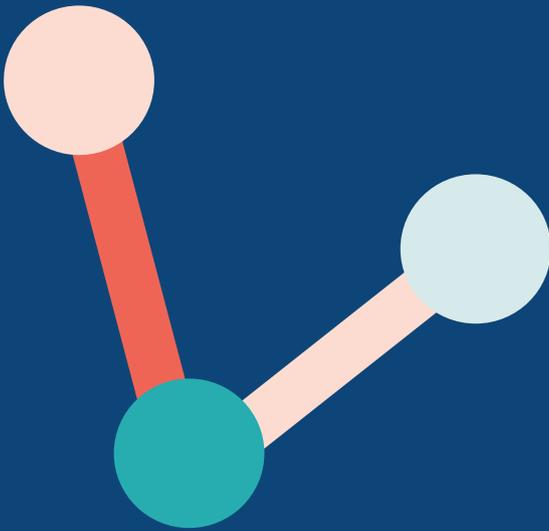
2015

NHS and local authorities signed the Greater Manchester (GM) devolution agreement. Establishment of the Greater Manchester Health and Social Care Partnership.¹

2016

1st April 2016 Greater Manchester Health and Social Care Partnership (HSCP) took charge of health and social care in the 10 boroughs in GM following devolution.

- The City of Manchester, as one of the 10 GM boroughs (covering North, Central and South localities within the city) in GM launches locality plan²; 'A Healthier Manchester'
- Locality plan commits to major transformation developing the 'three pillars' of organisational change: **a single hospital service, a local care organisation and a single commissioning function.**
- The City of Manchester Health and Wellbeing Board (HWB) is accountable for the delivery of the city's vision and transformation plan. Receiving an extra £450 million to help deliver health and social care transformation.



2018

1st April 2018: establishment of a Local Care Organisation for the City of Manchester (MLCO).

- New care models: main focus is to move care out of hospital in to a community setting, this started in 2017 but has progressed more slowly than anticipated.
- LCO developing 12 neighbourhood boards to develop around local community identities with four teams in each of the three localities in the City of Manchester.
- Integrated neighbourhood teams in development and in process of moving towards integration, some team members already in co-located venues. Integrated neighbourhood team lead role advertised in October 2018.

Research interviews for this process evaluation were carried out from April 2018 to November 2018. Aim of interviews: to understand and support the integration of health and social care in the City of Manchester.

2021

Expected benefits to the people of Greater Manchester

2017

1st April 2017: Manchester Health and Care Commissioning (MHCC) is established and assumes responsibility for commissioning health, adult social care and public health services across the City of Manchester, through the union of North Manchester, Central and South Manchester CCGs.

- MHCC will operate a single planning, delivery and assurance process from April 2018.
- December 2017: CQC report published on integrating health services in the City of Manchester. They found a sense of partnership but more work required.³



2019

Teams intended to be co-located and working towards being fully integrated. Integrated team leads to be in place by 1st April 2019.

1.1

INTEGRATION OF HEALTH AND SOCIAL CARE AND INSIGHTS FROM THE EXISTING LITERATURE

Historically, there have been various initiatives in the City of Manchester towards greater integration of health and social care and this is a key part of the devolution agenda for the Greater Manchester Health and Social Care Partnership (GMHSCP).^{4,5} Integration is often defined as the change in service delivery from separate organisations delivering care to the merging of these organisations to provide person-centred care. Integration is described by Rosen⁶ as “a set of methods, processes and tools to support the alignment and coordination of health and care services. The term describes both a set of activities and the ability to coordinate functions and activities across separate teams and operating units. Integrated care describes the end products of integration in terms of services, designed around patients’ needs to deliver high-quality, cost-effective care and high levels of patient satisfaction”. Due to the significant levels of health inequality in Greater Manchester, and the ambition to embed population health and well-being more broadly with an emphasis on preventative work⁷, integration was considered a financially sustainable way of delivering this and the timeline for this is shown in Table 1. Greater Manchester includes ten boroughs. The City of Manchester is one of these ten boroughs and continues to be organised around three localities; North, Central and South.

MHCC recognises that successful integration requires transformative change in working cultures and practice and is committed to evidence-based action in this regard. MHCC has therefore engaged the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care Greater Manchester (NIHR CLAHRC GM) to conduct an independent process evaluation of the early phases of development of the twelve integrated neighbourhood teams being developed across the three localities in the City of Manchester. The evaluation is designed to support an understanding of the enablers and obstacles to integration, recognising the context and complexity of this process. The findings from this evaluation will be shared with those involved in the process of integration in order to facilitate and support ongoing development of the integrated teams.

As part of this evaluation, NIHR CLAHRC GM has undertaken a detailed scoping review of the existing integration literature (Part A – separate document). This document (Part B) presents the findings from the process evaluation of the integration of health and social care in the City of Manchester informed by the evidence base summarised in Part A.

1.2

BACKGROUND TO THE INTEGRATION OF HEALTH AND SOCIAL CARE

Health and social care services have historically been completely separate systems since the divide created by the 1948 creation of the NHS.

They have had different budgets, administration and are accessed in different ways. Public health was historically an NHS responsibility

before it came under local authority control in 2013. Health services are funded via the NHS and social care services are funded by local government budgets. Health has been free at the point of need since the NHS was created while social care is means tested. These services, although they work together with people who have health and social care needs, are managed completely separately with different management, resources, governance structures and different service delivery boundaries.

The concept of integration is complex and its definition continues to be much debated⁸ (see report Part A for a more extended discussion). In simple terms, integration is where two separate bodies with their own management structures are brought together into one system or organisation so they become one single employer adopting the same systems throughout, but integration is particular to the local context and no one integration system fits all.^{9 10} This report focuses on the integration of specific services as part of the development of a

new partnership organisation Manchester Local Care Organisation (MLCO). The MLCO has taken on responsibility for the management of specific services; community health services, mental health, primary care and social care out of their existing NHS and local authority organisations.

The integration of health and social care has been high on government agendas since the 1970s, and in particular since the National Health Service Act (1977) which encouraged health authorities and local authorities to work together. Integration in various forms has remained on the national agenda ever since¹¹ with repeated efforts by successive governments to move this forward, including the Darzi review in 2008 and the NHS Five Year Forward View in 2014.^{12 13} More recently the NHS long term plan intends to move towards integrated care systems everywhere to be “more joined-up and coordinated in its care”^{14(1.4)}, with a plan to deliver the ‘triple integration’ of primary and specialist care, physical and mental health services and health with social care.¹⁴

1.3

WHY INTEGRATE HEALTH AND SOCIAL CARE SERVICES?

With an ageing population, and increasing life expectancy for those with multiple long-term conditions, there is an increasing number of people with both health and social care needs.¹⁵ There is evidence that fragmented health and social care systems have a detrimental impact on safety, outcomes and patient experience.⁶ A major focus of integrating existing health and social care provision is for services to be person-centred, an approach which involves providing care to individuals in the community. Ensuring health and social care offer a seamless

service and sharing information is thought to have an impact on reducing hospital admissions and delayed discharges.¹⁶

In addition to improvements in care, it is also hoped that integration will make delivery of health and social care more affordable, and it is proposed this will be financially sustainable by 2020. There is evidence that integration can improve efficiency of delivering care as well as improving the individuals’ experience and outcomes.^{17 18} There is also a view that wider social factors such as housing, employment

and social connections should be embedded to better address population health, as well as related social and health inequalities.¹⁹ Integration is considered by many to be the best way to meet these multiple challenges.

Measuring the impact of integration is proving challenging with much debate around what integration is trying to achieve and what is the best way to measure it.^{20 21} Many of the intended outcomes of integration are around broader prevention work, population health, self-care and using community assets, aspects of care which can be difficult to quantify. In fact the Baxter review²² found that the strongest evidence showing a benefit to integration are increased patient/service user satisfaction,

with a perceived better quality of care and improved access. Two key anticipated benefits of integration of health and social care are a reduction in hospital admissions and faster discharges from hospital. However, evidence for this in practice is mixed with one study finding an integrated care system associated with an increase in hospital admissions.²³ The potential for integration to produce significant savings is also disputed by some²⁴ and The National Audit Office's (NAO) 2017 report into health and social care integration found no compelling evidence that integration in England leads either to sustainable financial savings or reduced hospital activity.²⁵

1.4

WHAT ARE THE CHALLENGES TO INTEGRATION?

The integration of community health and social care services is complex on multiple levels. In terms of funding, a core tension arises from the fact that the majority of healthcare provision in the UK has always been free at the point of delivery while social care is typically 'means tested' i.e. conditional on assessment of eligibility and ability to pay. Relatedly, health and social care are historically commissioned in different ways, with different funding incentives in each sector producing different behaviours. Furthermore, the NHS and local government traditionally employ different professional groups and use different grading structures, information systems and inspection frameworks. Hence the challenge implicit in combining these separate systems, which entails pooling budgets, standardising pay structures and establishing joint commissioning mechanisms, should not

be underestimated. Integration can also involve the additional challenge of physically co-locating services with the intention of fostering inter-professional working, breaking down professional barriers to deliver person-centred care. Fundamentally, effective integration relies on professionals being able to share information about those receiving care, hence avoiding organisational barriers affecting data sharing and information technology systems.

In addition to these operational dimensions of integration, early research on new models of care points to the importance of generating shared understandings and trust to underpin collaborative working. The King's Fund also found time to be a key factor, suggesting that integration "will move at the speed of trust" and emphasising that integration "is really about relationships and trust between the partners".²⁶

Above all of these is the need to ensure safe ongoing operations and the reliable transfer of care for individuals using the services while

integration is underway; this dominates all other aspects of integration.²⁷

1.5

WHAT DOES THE RESEARCH TELL US WILL SUPPORT OR HINDER INTEGRATION?

Despite the growing calls for integrated care, evidence on the impact of integration as a model of care for all services is mixed²² and it may be that integration is most effective when it targets particular groups such as those with complex needs. Other research, however, suggests that targeting specific 'at risk' groups is fundamentally flawed²⁸ and the numbers available to treat are not large enough to achieve any sort of cost reduction or health benefit⁸ to justify whole system change.

There is a growing body of literature around learning from integrated care systems as they develop throughout the UK. Though varied in aim, scale and context, similarities in barriers and enablers of integration are evident within the literature and have been catalogued in existing reviews of this topic.^{22 29-31} Clear communication of the vision of integration, of what it is, why it is beneficial and how it will be implemented, is a significant enabler for integration, resulting in a more engaged workforce.³² The engagement of clinical and professional leaders is identified as key for this to occur.³³⁻³⁵ Management acknowledgement of workforce experiences of change and provision of support within their organisations to aid adaptation is a key factor of this.³⁶

Teamwork and good inter-professional and intra-professional relationships are key enablers to integration.^{32 37} Time for relationship building through shared education and learning and

explanations of the contributions and remit of each profession to break down prior conceptions and bias has been found to positively contribute to this.³⁸⁻⁴⁰ Lack of understanding of professional roles, remit, competencies and contributions, as well as statutory and legal obligations and perspective/values, can be a hindrance to integration.⁴¹⁻⁴³ This can result in unaddressed tension and conflict within teams, inappropriate work allocation and difficulty in agreeing responsibility across the skill mix of staff and poor utilisation of skills.⁴¹ ⁴² Professional hierarchy between and across professions is found to further exacerbate difficulties of interdisciplinary work.^{37 44}

Attempts to integrate health and social care were always constrained by the context in which they take place on multiple levels: organisational, professional, regional and national level. At an organisation and regional level, available finances and resources, existing workforce capabilities and the approach to integration taken were all key factors.^{21 27 29 45} More broadly, the relationship between health and social care in the UK at a national level, in particular ongoing separate funding, performance frameworks, governance systems and information systems is a barrier.⁴⁴ ^{46 47} The wider national political, economic and social context of the UK is also key, such as ongoing cuts, downsizing and a shortage of workforce in health and social care.^{21 45 48}

1.6

HEALTH AND SOCIAL CARE INTEGRATION IN THE CITY OF MANCHESTER

The process of devolution in Greater Manchester has been a driving force in the regional transformation of health and social care, supporting the strategic redesign of commissioning and service delivery⁴⁹ to develop “place-based” systems of care where providers of services improve health and care for the populations they serve.⁵⁰ This is particularly pertinent for the City of Manchester; over the previous ten years, Manchester was the fastest growing city in the UK, growth which is forecast to continue over the next ten years as the city becomes more ethnically diverse.⁵¹ Despite economic growth, there are still high levels of deprivation across the city and significant health inequalities when compared to the rest of England with lower life expectancy⁵¹. As population increases across all age ranges, an increase in the older age range is predicted with more people living with long-term conditions and disability when compared to the rest of England.⁵²

The establishment of the single community organisation MLCO in 2018, is one of the key pillars of organisational change as proposed in the GMHSCP strategic plan.⁵² This ambitious achievement has been a key part of the locality transformation plan and a lot of work to develop the integrated neighbourhood teams across the City of Manchester has been carried out in preparation. This development builds on early pilot work around possible approaches to integration carried out in 2011-

2014, prior to devolution. The findings from these different pilot studies of integrated pathways and evaluations carried out in North Manchester,⁵³ Central Manchester⁵⁴ and South Manchester⁵⁵ CCGs found several common themes supporting progress, and similar concerns around what might hinder integration. The key worker role, the one health or social care professional acting as the link person to the individual receiving care, was reported to be successful by those delivering services and receiving care. There was a perception by staff delivering care that the integrated teams led to better communication and more streamlined care. However, the evaluations suggested that more work was needed around risk stratification and the culture of professionals to enable self-care by individuals. It was felt that the vision of integration needed better buy-in from clinicians to ensure they saw integration as being of benefit to those receiving care not just a cost-saving measure. Further research carried out locally has led to the MLCO partnership embracing an asset-based approach, where community specific skills, knowledge and assets are valued as unique. This asset-based approach is intended to drive the devolvement of decision making to the neighbourhoods and has been considered a key driver in the opportunity to work differently through the process of integration.^{56 57}

1.7

THE NIHR CLAHRC GM EVALUATION OF INTEGRATION OF HEALTH AND SOCIAL CARE IN THE CITY OF MANCHESTER

1.7.1 Evaluation methods

NIHR CLAHRC GM conducted a qualitative process evaluation to understand the enablers and obstacles to the integration of adult health and social care, paying attention to the contextual factors affecting this process across the City of Manchester. When this evaluation was carried out, (April 2018 to November 2018), the integrated neighbourhood teams were on the cusp of integration, the team lead role was being developed and staff were about to be co-located but all teams were at different stages of integration. Interviews were carried out at a strategic director level and at an operational level in the three key localities (North, Central and South Manchester) involving those planning,

managing, leading or moving towards working in the 12 integrated neighbourhood teams (four in North, four in Central and four in South).

Purposive and 'snowball' sampling enabled semi-structured interview with key individuals to identify issues faced as the integrated teams were forming. Background planning documents from our partners (MHCC & MLCO) to guide the interviews and support analysis of the data were used. A brief interview schedule can be found in the appendix. Interviews were recorded, transcribed, anonymised and transferred into NVivo software. Analysis was carried out thematically, applying a combination of pre-determined and emergent codes.⁵⁸

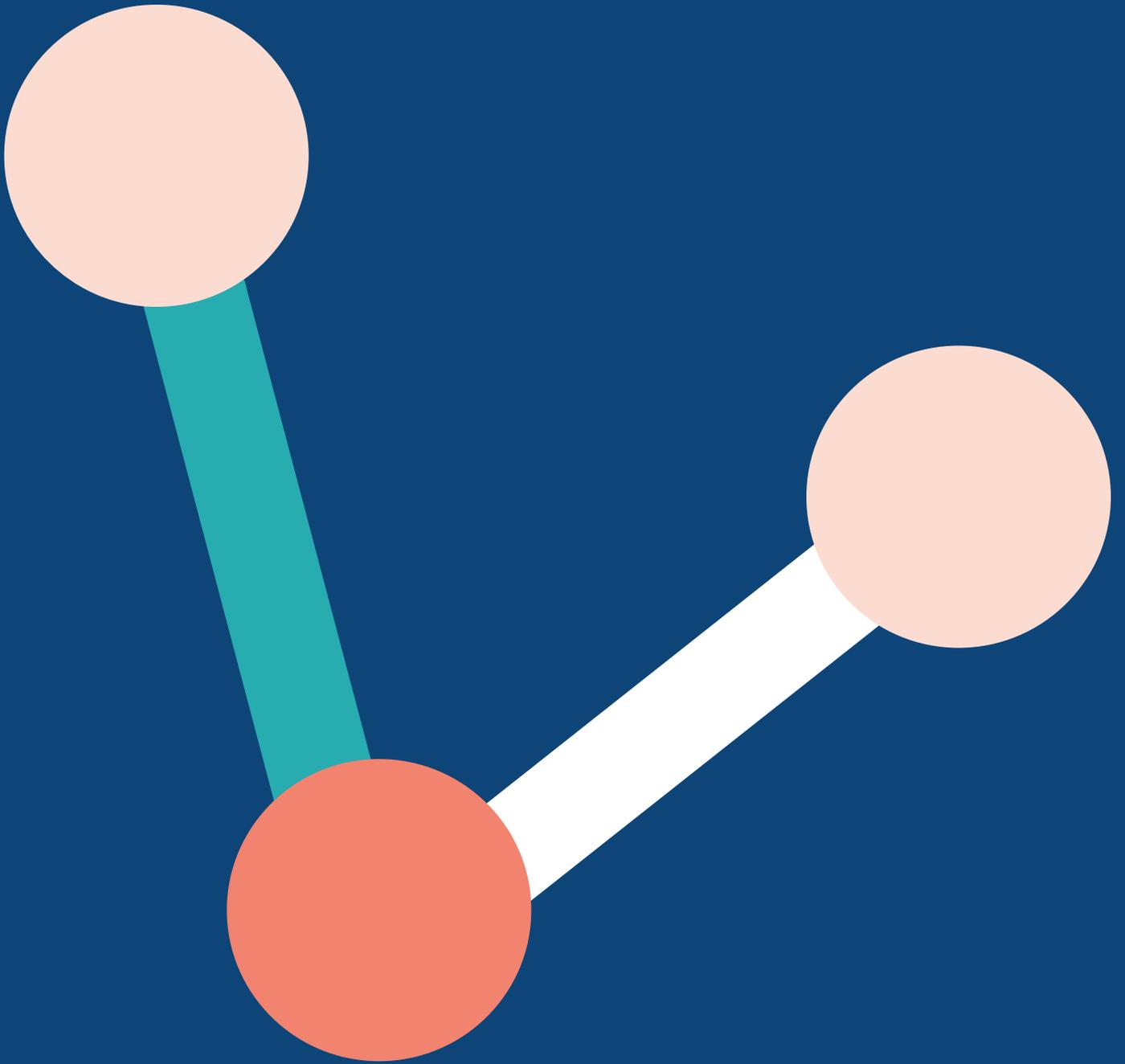
1.7.2 Participants

In total, 24 interviews were carried out (see Table 2). We interviewed 6 people at the strategic level of the LCO including 3 health and 3 social care integration directors, and 18 people in operational roles involved in integration from both health and

social care; team leader roles, managers, frontline health clinicians and social care staff involved in or moving into an integrated neighbourhood team. We interviewed equal numbers of those involved from a health and social care perspective.

PARTICIPANT ROLE AND BACKGROUND	INTERVIEWEES (SOCIAL CARE)	INTERVIEWEES (HEALTH)	TOTAL
Strategic level leads	3	3	6
Operational staff: Area 1	3	4	7
Operational staff: Area 2	3	3	6
Operational staff: Area 3	3	2	5
TOTAL	12	12	24

Table 2: Final study sample across all schemes



2.0

FINDINGS

From the thematic analysis we have separated the key themes into six sections:

1. The vision and definition of integration for those working in integration within the City of Manchester and how this has been communicated with the workforce.
2. Organisational levels of integration including leadership.
3. The impact of professional identities and boundaries on integration including financial differences between health and social care.
4. Human resource and information systems.
5. Day-to-day delivery of integrated services.
6. Measuring impact.

2.1

INTEGRATION: WHAT DOES THIS MEAN IN THE CITY OF MANCHESTER?

The literature reports that integration can be hard to define,^{21 29} and for transformation plans to be successful there needs to be a clarity of vision and purpose to overcome organisational and professional barriers.⁵⁹ Two of the three City of Manchester pilot studies reviewed found there needed to be more work done around the vision of integration, in particular to ensure clinicians were on board with the purpose of integration and intended impact.^{54 60} Other research suggests that communicating the message of integration will facilitate greater engagement with the workforce.³² Where the workforce does not buy into the concept of integration there was found to be greater resistance to change.³⁴

Across all three localities, in both health and social care, we found that without exception, all of those interviewed expressed a shared positive vision of integration described by all interviewees in a similar way, both at strategic and operational levels. This striking observation indicates that the vision of integration has been clearly communicated to all staff at all levels with evidence of buy-in across the board. The importance of integrating teams was described in terms of perceived likely impact on individuals receiving care, and again a consistently positive picture was presented by interviewees:

“ *Well the idea of integration is to make services more efficient, better, improve services. So, you would hope, absolutely, that it will make a massive difference. So, if this vision all slots into place beautifully, then it will make a massive difference to patients, won't it? GP access, lack of admission to hospital, their wellbeing will be better, they'll have access to services, their mental health will be better, because they'll have access to voluntary services, to social groups that meet their needs, absolutely. It's a ten year plan.*

Operational health, area 3, interviewee health a

“ So if you’ve got a patient who’s got lots of different long-term conditions and has complex needs and has social care needs, everything put together, and they’re getting support from an integrated team, it should feel as though they’re dealing with one service and one service is holistically supporting them rather than they’ve got a district nursing service and a community nursing and a social worker and perhaps a GP and somebody from a local community organisation, and they’re having to deal with them all in different ways... Even if you did need to see five different people, it should feel like the same service. And they should all know why they’re there and know about the other person and all have the same goal.

Strategic social care, interviewee 3

The vision and impact of health and social care professionals working together much more closely was described positively and seen by the majority of interviewees as one of the great benefits of integrated working. The anticipated challenges are also discussed later in the report but despite these interviewees described the potential benefits to joint working, closer collaboration and a deeper understanding of each other’s roles:

“ Beforehand I would’ve say come out to you and I would’ve said, look, I’m going to refer you into social services because I think you need a care package. And every single patient will say the same thing, well, what does that mean? Where will this package come from and will I have to pay for this package? And I would’ve actually said, I haven’t got a clue. I haven’t got a clue. I don’t deal with that. But now because I’ve worked with a...and I’ve been out and I’ve assessed a patient with a social worker I can say to them, you know, there’s different levels of care.....So I can discuss it.

Operational health area 2, interviewee health b

“ So I think it’s going to be more about understanding each other’s role in order to make integration work, if we professionals we take part in training education, that we know each other’s role, I think that would make things better, the only thing is making integration difficult or challenging is lack of understanding of each other’s role.

Operational social care, area 3, interviewee social care c

Communicating a vision of integration frequently relies on effective leadership and communication.^{32 34} In this study, interviewees raised some concerns about top-down communication, as well as a feeling that communication was too reliant on emails:

“ It’s all about communication. Communicate with us, come out, tell us face-to-face, tell us what it is you want of us, tell us why you’re doing it...Instead of sending us emails that we haven’t got time to read. And I know we should!

Operational Health, area 2, interviewee health c

Despite these concerns around communication there was often a perception reported that integration is inevitable, that people recognised this as a long-term policy focus at a national and regional level. However, even with this recognition interviewees typically saw this as a positive:

“ It feels like something that’s being imposed on us rather than something that we’ve thought is a good idea, but that doesn’t mean that it’s a bad thing. I think it is a good thing, but, yes, it definitely is a directive.

Operational social care, area 2, interviewee social care c

2.1.1 Key points

- There was a striking consistency of definition and vision throughout all our interviews; interviewees described integrated care with confidence using similar, positive language. This was the case irrespective of health or social care background, professional background or grade.
- Every interviewee described some aspect of integration in positive terms when explaining their understanding of what it is, what they hope it will look like, what the perceived impact might be on them, their colleagues and/or the people receiving care.
- Communication was reported to be challenging and the modes of communication did not meet everyone’s needs.

2.2

ORGANISATIONAL FACTORS

The evidence suggests that the key challenge to integration of teams, services or organisations lies at the organisational level.^{21 29} The challenges encompass issues such as finances, resources, workforce capacity and capability.²⁹ There is particular interest in the degree to which the process of devolution^{4 5 7} will help to overcome these barriers or whether the dominance of national policy-setting for health and care will hinder change (as found in other areas).^{21 45} The opportunity to develop a City of Manchester locality plan following devolution which has led to the single MLCO may have the potential to overcome national issues, but this process evaluation will be too soon to show the impact of the LCO.¹

2.2.1 The detail of integration

The issue raised most frequently related to a perceived lack of detail in integration planning, a concern felt particularly by those working on the frontline. While staff reported a clear broad vision for integration, the majority reported a concern at the lack of detailed planning or a lack of communication of this information as the reality of working in integrated teams became apparent:

“ That kind of reflects the situation really, that there are kind of big gaps and uncertainties, and also, probably, a lack of cascading messages down and a lack of kind of information that’s... You know, we know the headline that we’re leaving and things are happening, but I think a lot of the detail is lost and not fed down always.

Operational social care, area 2, social care b

There remain core differences between the health and social care services perhaps best highlighted by the ongoing confusion reported by several interviewees around terminology of those using services. Both health and social care staff at strategic and operational level indicated they were unsure whether to call individuals receiving care “patients” or “citizens” and that this seemingly basic problem calls attention to a perception that the detail of integration had yet to be decided:

“ Yes. And even the issue of patient/citizen, we’re no further on with that.

Operational social care, area 3, interviewee a

2.2.2 Social care vs. health service issues

Staff reported concerns where they felt a lack of knowledge about the detailed planning around service delivery and felt this was hindering integration. We found a perception particularly from social care staff that they were dominated by the much bigger NHS, which was also felt to be much better resourced.

“ ...it feels like it’s so hospital-centric, the whole system, you’re either in hospital or out of hospital services. People have short episodes of their lives hopefully in hospitals, then they live in their own homes, in neighbourhoods.

Strategic social care, interviewee 2

The geographical coverage of health and care was also seen to be a source of difficulties. Social care services and health services have traditionally used different boundaries, social care services are delivered according to local authority wards and health boundaries by strategic health authorities, now configured around CCGs. The four integrated neighbourhood teams in each of the three localities across the City have been configured around health boundaries, not around social care boundaries. It was suggested that the four teams will use the blueprint of a certain number of staff in each team which may not reflect levels of social care need in each area. The danger is that some social care staff in certain neighbourhood teams could be overburdened. Social care staff are concerned that the impact on caseloads, existing waiting lists and on-call duty rotas for social care and equity of this have not been considered in detail, with the decision around health boundaries taking precedent:

“ And there are differing amounts of GP practices within the localities, so really the hubs are different sizes, in terms of the workload, and I've been sort of staggered really about how little work has gone into analysing data around workloads. I think it's just a case... It seems like it's just been a case of dividing everything by four.

Operational social care, area 2, interviewee b

2.2.3 Community services vs. acute hospital care issues

While social care reported being dominated by health, both health and social care staff working in the community reported feeling dominated by acute care services. Acute care was considered by many to be seen as more important, to be better resourced, to have better access to information and to lack an understanding of what community care entails. Community staff reported their concerns about individuals being discharged without sufficient attention to the handover of care leading to significant issues for community staff to pick up the pieces in difficult circumstances:

“ Well, that's that thing where...they're not in my hospital. Happy days. Nothing to do with me now. And it's at the front door they basically say, it's not my responsibility. Over to you district nurse, over to you social worker.

Operational social care, area 1, interviewee c

2.2.4 Organisational leadership

Leadership was described as needing courage and a willingness to take risks as integrating health and social care represents, in many ways, a move into uncharted territory. Strategic level staff described the vision for distributed and devolved leadership and returned to the need for leaders to do things differently, particularly with budgets and devolving responsibility:

“ You need to have the right leadership, the right vision, with a real kind of... you have to be brave, senior leaders have to be brave.

Strategic social care, interviewee 2

There was a sense from the strategic level staff that a standard approach to devolving authority would need to be flexible due to the differences between the neighbourhood teams in terms of progress towards integration and variation in staffing experience as well as the inherent differences between localities and neighbourhoods across the city:

“ You would have distributed leadership. So you would have a high degree of autonomy at neighbourhood level, but you would have co-operation and collaboration, so that you didn't end up leaving people behind. You travel at the pace of the slowest.

Strategic health, interviewee 3

“ I think that working together at leadership levels in the locality and in their neighbourhood, will really drive small scale changes. And already, we do kind of that informally. And I think it will just really support that small-scale change of integrated working.

Strategic health, interviewee 2

However, some reported that devolved leadership was circumscribed as staff were not being given sufficient authority for local decision making or that staff were not aware of distributed leadership which was particularly apparent at operational level:

“ So, people need to understand that they are empowered to do that and that the solutions will come from the staff not from a small bit of the organisation, less than one per cent who would be seen as decision makers. This is decision-making from the ground up.

Operational health, area 1, interviewee a

2.2.5 Key points

- Insufficient attention to the detail of integration, or perhaps failure to communicate this detailed knowledge, was reported to present a challenge to integration at an operational level.
 - Anxiety arose in social care where staff often felt dominated by health.
 - Anxiety also arose around vertical integration, where community services
- staff often felt undermined or neglected by acute health care services.
- Although distributed leadership is discussed and widely seen as important, in places there is a disconnect with either a failure to devolve authority to operational staff or a failure to clarify when authority has been delegated for local decision making at neighbourhood team level.

2.3

PROFESSIONAL IDENTITY AND BOUNDARIES

Issues relating to professional identity and boundaries were frequently raised in the interviews. We know from the evidence that a lack of understanding between different professions can hinder integration.⁴¹⁻⁴³ This lack of understanding can lead to conflict within teams affecting shared decision making and communication between team members.⁴¹⁻⁴³

2.3.1 Professional identity and integration

What was clear from our interviews was that health professionals had exactly the same concerns and anxieties as social care professionals about each other. Both health and social care interviewees

reported the other professional group didn't fully understand their professional responsibilities, duties and governance. The majority of comments reflected tensions between health and social care, but issues also arose within health between different professional groups, and between community and acute services. Much of the concern related to anticipated problems emerging from unaddressed questions of professional trust and inter-professional relationships:

“ So we need to get the language right, but also, if health and social care, as professionally registered bodies, if somebody needs something doing, and you've delegated it, you are still accountable professionally.

Operational health, area 3, interviewee a

Social care staff felt there were fundamental differences with health staff related to their understanding and implementation of the mental capacity act. Social care have a role in safeguarding vulnerable people and are involved in decisions showing evidence that people do or don't lack capacity to make decisions about their care. There was a suggestion during the interviews that social care staff are more comfortable than health professionals in accepting people making 'unwise' decisions. This also related to a similar assertion from social care staff that they were more comfortable with higher levels of risk compared to health staff, usually as a result of 'unwise' or decisions by individuals with capacity that goes against professional advice. All these 'differences' were considered in the interviews as potential barriers to shared responsibility and trust:

“ From my experience the health staff don't seem particularly aware of the Mental Capacity Act in the work and our responsibilities around that and about people being able to make decisions for themselves. I think that they quite like to make decisions for people.

Operational social care, area 2, interviewee c

“ We do have very different kind of ideologies, and really my experience is that the health professionals do tend to be [more] risk-averse.

Operational social care, area 2, interviewee b

Health care staff had their own concerns around responsibility, largely relating to their professional accountability and duty of care to people receiving health and social care services, accountability it was felt that other professions may not be aware of. Health professionals reported a sense of great responsibility towards those who come under their care, due to the nature of offering 24 hour care or due to their professional standards. This generally made health staff feel as though both social care and acute health services might offload responsibility for certain tasks to them:

“ But because we are the nurses, throw it over to them [the nurses], last stop saloon. Because we can't say no, we've got a duty of care.

Operational health, area 2, interviewee c

“ So then, what usually happens, is the district nurses pick it up, because they think, well somebody's got to do it, and we have a duty of care, and nurses feel, as part of their professional registration, that they have a duty of care, whereas a social work approach is very much, if you have capacity, and you understand the consequence of not doing something, well that is your choice.

Operational health, area 3, interviewee a

Both health and social care staff explained the complexity of 'trusting others' in light of their professional responsibility, with the concern that the different ways in which other professionals work may leave them professionally accountable in the case of incidents. Social care staff reported a greater responsibility to, and knowledge of, the legal system; by the nature of their work, they argued they were more likely to be required to justify their actions in court and this distinction was identified as a source of tension between health and social care. Both health and social care staff were concerned about being managed by people from different professional backgrounds who may not be familiar with their professional codes of practice and current evidence base:

“ Well I think the first thing is that we have statutory responsibilities. So, I think it's a big learning curve for our health colleagues to understand the importance of that, that we are guided by legal requirements, we're not just doing it because somebody thought it was a good idea that somebody should have a care package.

Operational social care, area 2, interviewee a

It is clear that more work needs to be done around inter-professional trust, particularly in light of the 'trusted assessor' role.⁶¹ The 'trusted assessor' role is the concept that any health or social care professional who is competent and trained to do so, can carry out assessments on behalf of other partnership services to reduce the number of repeated assessments on individuals as described in the GMHSCP standards.⁶² It was not clear whether the role of the 'trusted assessor' had yet been implemented in all the teams or whether this was another aspect of the detail around integration that was still under discussion although there were some examples where this was working:

“ Therefore, then for me, that's where true integration is, it isn't oh that's yours, that's mine because when I was a social care practitioner, if a referral came through the wrong door, you bat it off. Whereas here, I say I don't want that but at the end of here, is a customer and true integration doesn't mean if you're health or social care, it's around who's the best person to go and assess that customer at that time.

Operational health, area 1, interviewee c

There were many reports of positive experiences of inter-professional working in some areas and it was anticipated by many of the interviewees that increasing inter-professional collaboration would have

benefits for both staff and individuals receiving care. There were also many suggestions around the need to share knowledge, to educate others about roles and to engage in joint learning and development alongside other professional groups. The ability to give further information about health or social care when from a different professional background was seen by some staff as a great benefit to the individual and their family, as well as the ability to know when another professional would have something to offer:

“ ...accepting each other’s assessments of an individual, for example, is a classic [case]. If we can’t get to a core level of understanding of someone’s needs because any old professional has entered the front door and understood the family needs, then we won’t have succeeded. At the moment that has to be done several times over by different professionals.

Strategic health, interviewee 1

“ But now because I’ve been out and I’ve assessed a patient with a social worker I can say to them, you know, there’s different levels of care. They come from different services. They will give you an assessment of your needs. They will also assess your means and what you’ve got in the bank and if you own your own house. And don’t be frightened, you won’t have to sell your house because that’s a myth, you know, don’t worry about that. So I can discuss it...

Operational health, area 2, interviewee b

The flip side of integrated working was a fear from particularly frontline staff that people would become generalists and lose specialist skills. This was a particular concern within health reflecting the multiple nursing specialisms:

“ Because we all have our identity... and within that how do we keep our own identity in our specialism of what we do?

Operational health, area 1, interviewee d

Other people felt that this blurring of boundaries would always have limitations and people would not be likely to completely lose their identities:

“ I don’t know, I suppose, kind of, true integration is other people doing bits of other people’s roles so that we’re all... like we can all do a little bit of the other thing, but I think we’ll still be very separate. I think we’ll still have very defined roles.

Operational social care, area 2, interviewee c

2.3.2 Financial differences impact on health vs social care professionals

The historic complexities of different modes of funding between health and social care continue to greatly hinder integration, according to the literature.²¹⁴⁵ The lack of investment in both social care and community services over many years is also thought to exacerbate the challenge to integrated working⁴⁶ across health and social care, particularly in the wider context of the growing older population.

Similar concerns were expressed by both health and social care staff about the impact funding has on their services as they integrate.

“ Social care have to balance the budget, and we’re successful if people don’t need us, and in health you get payment by activity and all the different perverse incentives.

Strategic social care, interviewee 2

“ I know that’s where all the big money is in terms of spending, but actually people live most of their lives in the community. They make risky decisions. They fall out with people. They have rows with their family. They live their life to the full. And actually hospital, and hospital admission, may be a very small part of their life but somehow that’s been turned over its head and what I think is the difficulty for the community workers is that that bit is only a small bit.

Operational social care, area 2, interviewee a

For health staff, a key aspect of this tension reflected a lack of investment in community health services compared to acute health services.

“ I think what’s played out is (...) community health services as less important than acute staff. They’re always a bit second-rate, really. And I think there’s a great lack of understanding in acute-centric circles and hospitals around actually what a difference an investment in community services could make.

Strategic health, interviewee 3

For social care staff, the tension related as much to the lack of investment in social care compared to health as to the prioritisation of acute services over community:

“ ...the social care element, is the small bit. The bit that’s really under-funded, the bit that has no money, and the bit that’s busting the system.

Strategic social care, interviewee 1

Despite this difference in perception, both health and social care staff saw the difference in funding between health and social care as a hindrance to integration. Social care staff felt health staff didn't always consider or understand means testing when talking to those needing social care which led to unrealistic expectations from individuals about what services they could expect to receive in the community:

“ I think funding is a massive thing because obviously when it's the health service it's free and then when we come along we're asking people to pay a contribution and I think, the health staff don't have to deal with people's money or even ask those questions.... Yes, people don't have to think about how much it costs for a district nurse to come and visit because they never see the bill.

Operational social care, area 2, interviewee c

The impact of financial implications and how it may affect delivery of services was also a concern. There are some elements of service delivery that sit on the boundary of both health and social care remits and could potentially lead to an increased number of visits unless a common-sense approach is agreed at a local level:

“ So medication under the Care Act is not social care, so prompting medication is not social care, it's health. But traditionally we've always done it in social care. So we haven't got a problem with continuing with that, but there is a sticking point in that, well, if they come under a service with us, they get charged. But NHS is free. But technically it should be [health], so what happens there?

Operational social care, area 1, interviewee c

2.3.3 Key points

- Understanding constraints of other professionals' roles, responsibilities, legal responsibilities and governance is key to supporting integration.
- Understanding different philosophical and theoretical backgrounds particularly around risk and capacity could improve trust and understanding.
- There were concerns from both health and social care staff around under-funding and the impact this will have on services going forward to integration.
- Need for action to improve knowledge of how funding for social care works is required so all those working in integrated teams can give relevant information to those receiving care.
- Local decision making is needed around service delivery where finances are limited.

2.4

IMPACT OF HUMAN RESOURCE AND INFORMATION SYSTEMS ON INTEGRATION

A lack of coherent, integrated technical information systems covering health and social care has been shown to hinder integration.⁴⁸ Sharing information and data at an individual level is also known to be affected by the historic division of health and social care,⁴⁶ which is affected in turn by trust and wider underpinning relationships. The long-standing separation of the health and social care systems and organisations hinders integration as separate human resource departments and arrangements exist, with inconsistent grading and responsibility structures.^{45 21 29}

2.4.1 Information systems

The problems due to inadequate Information systems were raised at all levels by every interviewee, perhaps unsurprisingly given what is known from the literature:

“ So IT doesn't support us [it] doesn't support that seamless workflow. So from us having a single record with EPR, we have definitely reduced duplication, because now someone can see. You get a referral and they go, well, they've actually tried this, this and this. What value am I going to add? Actually, does it need a social worker? Actually, what you need is X. And so having that kind of shared record, is a key thing. Strategic health, interviewee 2

There was widespread perception of a limited use of technology by staff, particularly in health, when compared to social care who reported having more advanced technology systems and support:

“ Yeah for accessing our systems. It is fair to say that social care are very...everything is computerised, everything, even your annual leave, and everything. We have to have access and do everything...Whereas in health they don't. ...they're still pen and paper people. Operational social care, area 3, interviewee b

2.4.2 Data sharing

All interviewees report the lack of joined up IT systems both within health and across other services as problematic, this went across community services reporting that GPs, mental health services and police had different information and had a big impact on data sharing:

“ But, with the new GDPR it's, kind of, now making things a bit more challenging....Because, when you're requesting information and consent has to be given, so we have to do it in a way were maybe at that moment in time I'm not in contact with the person, therefore I'll have to liaise with the doctors or the health professional that is working with that person... Operational social care, area 3, interviewee c

On an individual level, there seemed to be widespread concerns around what information can be shared and who it can be shared with. This related to a perceived lack of trust between services; from acute to community, and between health and social care. This lack of coherence about who could access what information was perceived to be a potential risk to individuals and a safeguarding issue. This could have an impact on staff safety as well as different services get different information, improving data sharing could ensure staff were fully informed when lone-working and carrying out home visits. This was also considered to have an impact on increasing referrals to other services unnecessarily when full information about individuals wasn't known:

“ Like I rung the hospital yesterday and asked for a copy of somebody's capacity assessment and the discharge facilitator said to me, she was like, oh, I don't know if I can send you that because of confidentiality. I was like I can't make the decisions that I need to make if I don't...

Operational social care, area 2, interviewee c

There certainly seemed to be a perception that improved relationships between services and professionals, could improve trust which would give more confidence around data sharing. This was seen to be a potential benefit of integration, where staff understood the limitations of information systems and accepted that seamlessly streamlined technical tools across all services and professions was an unlikely development in the near future.

“ It's about good working relationships because they know even though you've not seen them physically, but they know...oh this...social worker is involved and I've dealt with this social worker in a previous case so, I think, part of it is that our relationship.

Operational social care, area 3 interviewee c

2.4.3 Human resources

Inevitable differences in bringing together two services is reflected by concerns around different grading and responsibilities between health and social care:

“ So, what I would say is, we are trying to bring the services together, to integrate them, and that will take some teasing out, because they all have different budgets, different management structures, different professional bodies. They have different training and development needs, they all have different policies, different procedures. They probably have different, even practical things like different core hours, and different holiday entitlement. And even though you're trying to do all this great work, the most important thing to them will be, they get more holidays than me, that's not fair.

Operational health, area 3, interviewee a

Co-location was reported by the majority of people to be a necessary aspect of integration. Many felt physical co-location would be a way of facilitating integration and fostering trust, relationships and shared working. A possible benefit may also be around greater confidence in data sharing:

“...co-locating, sharing the same building together, and in order for me to have district nurses information, or in order for me to have information from the GP if I am in the same place as them, and they know that...yes, this is way forward, part of integration, I think, that would make it very easy.

Operational social care, area 3, interviewee c

Several, however, felt that co-location was not a sufficient approach on its own without investment and support in integration and shared locations did not automatically lead to integrated professional teams:

“So, bringing them all together is about wrapping all these services around what's happening in the community, but it's very much about, I see it as the practical steps to get people to work together. 'Cause putting a bunch of people in a room together, doesn't mean that they like each other, that they'll work together, or that they'll be any more efficient than they already are. In fact, because there might be so much in fighting, well I'm not doing it, that's their job, and they get more of this than me, you might find that you create more problems.

Operational health, area 3, interviewee a

2.4.4 Key points

- The lack of a comprehensive IT system was accepted as a wider issue but the problems this raised were widespread.
- Data sharing was found to have an impact on the individual receiving care, staff safety, staff time, staff workload and there seemed a lot of ambiguity around who was allowed to share what information with who, this spanned professionals, services and organisations.
- There were differences between professionals' terms and conditions which may continue to hinder integration.
- The importance of co-location, while not automatically leading to integrated services, the majority of interviewees suggest this will support the process by building relationships and trust.

2.5

IMPACT ON DAY-TO-DAY DELIVERY OF INTEGRATED SERVICES

We know from the evidence that the detail of integrated health and social care systems has to respond to local need and different approaches to integration are required.⁶³ A crucial issue that was raised by many of the interviewees was the importance of having GPs actively involved in the integrated teams. The NHS Long term plan outlines the importance of dissolving barriers and having seamless integration across the board and GP involvement as part of the integrated team is clearly an important factor.¹⁴ It seems that it is important that GP involvement does not lead to a more medicalised model affecting the person-centred aims of the integrated teams.^{41 42 44} The broader aims and objectives of integration to embed 'asset based' approaches to care while well documented^{56 57 64} and firmly embedded in the strategic vision, have limited evidence of evaluation.

2.5.1 GP involvement and meetings

The practicalities were discussed in some detail of how staff would work together to deliver this seamless delivery of care and what this would involve on a daily basis. This then related to the importance of having relevant multi-disciplinary team meetings, with the potential for GPs to be involved in order to encourage a belief in the mutual benefits of integration for GPs and the teams. Operational health staff in particular discussed the importance of GPs being involved in the integrated teams including involvement in meetings or huddles. Involvement of GPs was seen as another potential benefit to integration as previously, access to GPs was reported to be a problem. There was an understanding that meetings needed to be streamlined to ensure sustainable working resources for all staff:

“ ...when you're looking at your staffing and you're looking at your resources, you're wasting your resources by having these two meetings [huddle and MDT], your MDT [multi-disciplinary team] is where it should begin because that's where you get your GP's.

Operational health, area 1, interviewee b

Interestingly there were concerns that GP involvement needed to be carefully managed and sustainable as this was considered a crucial part of integration. Convincing GPs that involvement in the integrated teams and participation in team meetings would be beneficial, was seen as a potential barrier to delivering seamless integrated care. GP views from our interviews suggested the benefit to involvement with integration out-weighed the time taken. It was felt by other professions that GPs may view involvement in integration as leading to an increasing workload and taking time out of an already unmanageable workload:

“ ...for us working in the community the GP is at the heart of everything. And if a GP is not part of your integrated team, what do you call integrated? I think it needs to be looked at, where does the GP fit within this integrated working? What is their commitment to joining with integrated working instead of keeping separately on their own and we're forever banging on their door and saying will you join in with us?

Operational health, area 1, interviewee d

The relevance and planning of multi-disciplinary meetings or huddles, where integrated team staff would discuss the individuals on their caseloads, were frequently discussed particularly by operational level staff:

“ we used to have weekly huddle meetings, but there was no focus, there was no framework, what that was supposed to achieve and what we were discussing. There was none of that. It was just health bringing.... bringing their cases and we were just sitting there nodding and listening, because as soon as a problem hits on ours, we're on the phone or we're trying to knock on someone's door. We can't leave it lying and those guys can't either, but we can't wait for a week to go by to see...

Operational social care, area 3, interviewee a

2.5.2 Asset-based approach for health and social care services

A key part of the plan for integration of health and social care has been the concept of asset-based community development. This is the plan to embed existing and often undervalued community specific strengths and skills that are unique to the location and can support the broader aims of prevention and self-care within integrated care services. Although this is considered a key element of integration by strategic level staff, there is a sense from some operational staff that the resources to support this and wider support is felt to be lacking. It was suggested that for true asset-based working to be embedded throughout the partnership as detailed in the strategic health and social care plan, there needs to be support and sharing of best practice:

“ The way we are working we've all had training in asset based ways of working and changing the culture of how we work with people...[this includes] development of the neighbourhoods to see what needs to be put in place. I think one of the things then really is if you're going to be doing asset based ways of working how does everybody know what is out there already?.... Because unless we do change how we think and how we're working, then integration isn't going to change.

Operational health, area 1, interviewee d

2.5.3 Key points

- Clarifying the relevance and optimising the timing of meetings for neighbourhood teams were important considerations to maximise engagement.
- It seemed that GP involvement in integrated neighbourhood teams was considered essential by many, and all efforts need to be made to facilitate this involvement.
- Continued support to ensure the asset-based approach to care is embedded throughout the organisation and sharing best practice.

2.6

IMPACT OF INTEGRATION ON DELIVERY OF HEALTH AND SOCIAL CARE SERVICES

The evidence suggests that integrated care services do not necessarily improve health and social care outcomes, but there is evidence that integration can lead to improved experience for the individual receiving care and/or the carer.³⁴ In the Baxter systematic review,³⁵ the strongest evidence on the impact of integration shows that it leads to increased patient/service user satisfaction, increases perceived quality of care and improves access to services.

2.6.1 Transfer of care to new local care organisation

Our interviews with both operational and strategic staff suggest that safe transfer of care for all those using health and social care services with the creation of the MLCO has been of paramount importance. In some interviews, however, staff felt that excessive concern around this, particularly at a leadership level, was hindering the development of different ways of working and delivering care:

“...we have got to do things, we've got to be safe, we've got to keep people safe. So, that work has to be done. But there's also, if we just do that stuff, and we keep on doing that stuff, actually things are not going to get any better, people are still going to die, people are still going to have long term conditions, A&E will still be busting. So, there is something about, how do we change the way we do things?”

Strategic social care, interviewee 1

Although the majority of staff considered integration to have potential service delivery benefits likely to improve the experience of the individual and their carer/family receiving care, some queried whether it is necessary to integrate all health and social care services. Several interviewees suggested that many people could be served by either health or social care services and that only certain cases required integrated health and care pathways:

“So for our nursing and social worker teams, we'll have business as usual. We will all have things that we will continue to need to do and some of which, don't need the world and his wife to be integrated. If we go in to give somebody [an] injection every day, Social Care don't need to be bothering with that. Where somebody is complex, we need to be able to work together better.”

Strategic health, interviewee 2

One of the key proposed benefits to integration involve a streamlined service with clear integrated care pathways for those needing either or both health and social care which should result in two main benefits: a clear single point of entry and a seamless system to involve other health or social care professionals as appropriate without people getting lost in the system or being repeatedly handed on to alternative waiting

lists for other health and care services. Although the detail of how this will work in each neighbourhood team is still to be finalised, staff clearly recognised how this should improve the experience of those accessing services:

“ So that whole thing around, we’re supposed to be integrated, so the fact that, I’ve got a big bugbear about referrals, so that idea that somebody has to be referred here, and then they have to be referred there, and nothing is ever joined up. Actually there’s something about how we change that relationship, so people just are not ending up with 25 different referrals, and none of it ever gets followed up, and actually some of it is about, sometimes it feels it’s about the need of the practitioner, ‘cause either their role is finished, or there isn’t anything more that they can do.

Strategic social care, interviewee 1

2.6.2 Measuring impact of integration on health and social care delivery

This section considers the complexities of measuring outcomes at system and individual levels. The literature suggests defining what is being measured is difficult in itself, and establishing how best to measure this, including success/failure, is yet more difficult.^{29 34 38}

There was a broad recognition from all interviewees that the key agreed measures of success for integration were reductions in hospital admissions and length of hospital stay. Whether these were the most appropriate measures was a much more contentious issue. Many people interviewed felt that these measures were seen as important by senior leadership but personally felt them to be poor measures of success. Several observed that the focus of integration was on prevention (by enabling individuals to take responsibility for their health, by signposting other services or by reducing impact on other services) and were unconvinced success in this regard could be identified in the short to medium term:

“ ...aims are reducing A&E admissions and stays in hospital and stuff. But the bigger thing is, we will talk about improving health outcomes, enabling people to live longer... Well, in terms of the prevention work, and some of the stuff that we’re doing, there’ll be no deliverables...we’re actually trying to rebuild relationships, or start new relationships, to make some of this stuff happen.

Strategic social care, interviewee 1

“ For us it’s how we collect the data that demonstrates, yes we work with people that we can enable self-care, but the complex people who have many complexities for many different reasons, if we don’t keep that intervention going they will end up in hospital. So how do we collect data about that and how do we demonstrate how it’s keeping people out of hospital? Not just hospital but we’ve given them the skills to engage with the rest of the community again I think.

Operational health, area 1, interviewee d

At the broader level individuals spoke about the expectation to work differently and to transform current working while being judged on the existing metrics. Several suggested that integration could be successful without improvements registering through the anticipated measures; for instance, because integrated working leads to an increased workload as an unmet need is identified and addressed. There was a sense that the growing, ageing population and corresponding health and social care needs cannot be solved by integration as need will continue to rise. There were many comments therefore that integration should be judged against meaningful measures, some suggested it should be the view of the individual receiving the care but more described the impact on the services themselves:

“ One way that I would consider to measure it would be to see how effectively the teams are working, how efficiently the teams are working. So if the teams are struggling and have unallocated cases, huge backlogs, people off sick, people unable to go out and to kind of do the job because they've got to stay in the office for whatever reason. So if those are happening, that's certainly an indicator that things aren't working.

Operational social care, area 2, interviewee b

Relating to many of the concerns around the best way to measure integration, showing a cost-benefit to integration was considered a difficult issue that needed further consideration:

“ And also that other thing is, is that we're constantly having to prove that we're going to save money, so there's all this thing about, what's the cost benefit analysis? Not, actually, are we going to make a difference to people's lives, are we going to improve the outcomes for individuals, and actually, they have a better experience of their contact with health and social care, but actually for every pound invested, how much did we save?

Strategic social care, interviewee 1

2.6.3 Key points

- Integration was seen as an opportunity to work differently; it was recognised that safe transfer of patient care was essential but excessive preoccupation with safety at all costs could stifle innovation.
- Safe transfer of care also relates to ensuring robust integrated care pathways so individuals are not lost in the system and there is confidence that care pathways will promote a seamless service.
- Measures of success should be meaningful and reflect what the teams are trying to achieve; this includes difficult to measure actions such as promoting safe care and prevention work.



3.0

DISCUSSION

3.1

OVERVIEW

This evaluation does not seek to measure the impact of integration, which would not be appropriate at this early stage. Instead, it draws on the insights of staff across health and social care and constitutes a broad and balanced consideration of how integration is understood among those most directly involved, factors which support the integration of health and social care and those which may hinder the process. When this evaluation was carried out (April 2018 to November 2018), the integrated neighbourhood teams were at slightly different time points but on the cusp of integration, with the team lead roles in the process of being advertised and many staff soon to be co-located, while others were starting to work out the detail of how the teams would work together. The opportunity to interview staff at this key point in the process of integration in the City of Manchester has offered some useful context, insight and recommendations for this ongoing iterative process. Integration, while high on the national and regional agenda, has mixed evidence from the research.⁶⁵ Some of the core anticipated impacts such as cost-benefits, reduced hospital admissions and length of stay may not be the best measure of integration.²⁰

The multiple potential versions of integration reinforce the importance of clarity over the definition of integration here, the

expected impact and the measurement of outcomes. Our study found a remarkably consistent understanding of what integration should mean amongst those interviewed. Despite concerns about the integration process and the acknowledgement of widespread challenges, there was a general conviction that integration could benefit those using community health and social care services, and help the professionals involved in delivering those services. Staff were less convinced that attention had been paid to the detail of integration and the practicalities of implementing change in light of the complexities arising from the fundamental challenges of contrasting funding models and conflicting professional approaches, priorities and accountabilities.

Throughout the three localities there were instances where good practice could be shared and valuable suggestions for improved service delivery and inter-professional working. There are skills, knowledge and ideas from the process evaluation that show significant potential for inter- and intra-professional learning, inter-team learning and a resource of untapped knowledge across the city. Realising this potential will require close collaboration between those at a strategic level and operational staff, to facilitate more distributed leadership and local decision making.

3.1.1 Definition and vision of integration

Research evidence underlines the importance of having a coherent vision and purpose to help overcome organisational and professional boundaries.^{29 59} This evaluation indicates that the wider vision, definition and impact of integration has been effectively communicated within the MLCO to staff at all levels and there is a shared understanding of anticipated benefits to both those using services and those professionals delivering health and care. All staff interviewed described the potentially positive impact of streamlining services with better use of resources. Even where staff felt integration

was imposed on them, and despite concerns about the process, they could still identify an anticipated beneficial impact. This positive buy-in from staff should continue to be embedded across the MLCO, particularly where new staff come into the organisation. Communication with staff around the process of integration is an area that is more challenging and currently does not meet everyone's expectations. A greater variety of channels of communication could be offered, with less reliance on email to communicate ongoing information about progress.

3.1.2 Organisational factors

While a positive vision of integration was widely shared, many expressed concerns that the detail of how integration was going to work in practice had not yet been addressed. Some felt that leadership was not seen to be enabling local decision making or facilitating teams to work through the detail of integration at a local level. Leadership and strategic-level staff discussion of distributed leadership were at times at odds with the views of operational staff. Although many saw a need for distributed leadership to empower staff, the lack of shared

detail around delivery of services, streamlining care, reducing referrals, and workload distribution generates a sense that operational staff have not been given the authority to make decisions. Shared learning between those at the highest level of the organisational structure working to facilitate and empower local level decision making could address this disconnect. Issues hindering progress could be enhanced by activities focused on shared learning between health and social care, as well as community and acute health services.

3.1.3 Professional identity and boundaries

A core and recurrent theme in the interviews related to professional identity and boundaries. Research shows that this is a critical aspect of integration that can hinder progress.⁴¹⁻⁴³ Interestingly both health and social care professionals had similar anxieties and issues around others being able to understand and appreciate their professional responsibilities,

governance, duty of care and professional identities. Concerns around this, as well as the worry that specialisms might become diluted, could present a specific action point for attention by the integrated team leads. Sharing knowledge around roles, understanding of means testing, joint working, joint problem solving and greater awareness of the

responsibilities and governance of the different professions could improve understanding. Early work with the integrated neighbourhood teams should allow time to learn from each other, work through problem solving and complex cases in a supportive environment.

This would enable access to integrated care pathways to be further developed according to local assets and roles in each locality. Greater knowledge of the different professional backgrounds could benefit the delivery of care may support integration.

3.1.4 Impact of IT systems and human resource

Some of the concerns around professional identity and boundaries could also be addressed when considering human resource management, in terms of co-location, managing staff and improving access to shared data. Co-location, while being recognised by many interviewees as not automatically leading to integration, was still considered an enabler for joint working and inter-professional working. A more streamlined approach to human resources as the MLCO develops will need to be mindful of the issues that concern staff around professional accountability, workload, terms and conditions. Interviewees were realistic about IT and understood that comprehensive technology

systems were a wider system challenge. While they experienced frustration, this was not something they were expecting to be an easy fix, although the evidence suggests this is a real hindrance to progress of integration.⁴⁸ As staff cannot access the same information system, there is a lack of confidence around what data is acceptable to be shared between staff, teams and services. Locally, particularly within the teams, more work could be done around data sharing to improve individual safety as well as ensuring staff are fully informed when lone-working and carrying out home visits, as well as reducing duplication of information and time spent trying to access information.

3.1.5 Impact on day-to-day delivery of integrated services

The day-to-day functioning of the teams, and how decisions would be taken in this regard, was a source of some concern. Staff involved in the provision of services did not always feel that they had the power to make these sorts of decisions. Team meetings were clearly key here, and were mentioned many times, staff suggesting these needed to be prioritised and their purpose made clear. There were multi-disciplinary team meetings and huddles, but staff felt attendance at these should be guided by relevance. Given the importance of GP involvement in integrated neighbourhood teams, it was seen to be vital to target meetings so as to maximise the

likelihood of GP participation. There was a general understanding of place-based care and pockets of real enthusiasm around asset-based community care, person-centred care and self-care, where individuals felt this was an opportunity to embed a different culture leading to improved health and social outcomes for individuals. Those interviewed had opinions on how the neighbourhood teams would work best but many felt that others would make these decisions, reflecting a need for greater support to facilitate local decision-making throughout the teams.

3.1.6 Impact of integration on delivery of health and social care services

Integration was certainly viewed by many as an opportunity to work in a different way although, clearly, the ongoing safety of those needing health and social care was paramount.^{18 27} There was a feeling that without careful planning and preparation staff could revert to old ways of working as concerns about safe transfer of care took over. Some interviewees suggested that integrated care pathways could be developed further to ensure a single point of access, streamlining care and using a more coherent referral system, leading to a much better experience and outcome for those using services. The challenge of effectively

evaluating integrated services raised many issues mirroring wider research in this area.^{22 66} Although the majority of staff understood a reduction in hospital admissions and reduced length of hospital stay were relevant indicators, many felt these did not accurately reflect the ambitions of integration. In particular, asset-based working, self-care and preventative work were considered difficult to quantify and although some suggested the experience of the individual receiving care should be taken into account, service delivery and the role of the professional were considered important.

3.2

SUMMARY

Integration at any level is widely acknowledged as a hugely challenging and complex undertaking.⁴⁰ Integration covers team (integrated neighbourhood teams), service (health and social care) and organisational aspects (development of the MLCO) of integration. This evaluation considers the staff view across these levels and the analysis underlines the wealth of knowledge across the localities.

The integrated neighbourhood teams are at different stages of integration, and across the teams there are some examples where innovative working has already been introduced and areas of good practice. There were concerns raised about what might hinder integration and suggested

solutions for this throughout our interviews as well as opportunities that might foster and promote integration. The recommendations are informed by the skills, knowledge and strengths already existing across all of the neighbourhood teams up to the strategic level of the MLCO. This reflects the transformation plan proposed by Greater Manchester Health and Social Care Partnership^{51 56 67} where local strengths, resources and untapped potential are a key factor in asset-based working, and this learning will support the ongoing development of the integrated neighbourhood teams in the City of Manchester.

3.3

RECOMMENDATIONS:

3.3.1 System recommendations

- To continue to promote and embed the positive vision of integration at all organisation wide training events to ensure the engagement of current and new staff.
- To consider or offer a variety of communication modes about the integration process with less reliance on email.
- To promote understanding and learning to facilitate closer working between community and acute hospital care staff - integrated teams could potentially carry out training with hospital staff to inform, engage and establish connections to facilitate transfer of care.
- Integrated neighbourhood teams need support from leadership level in making

local care pathway decisions, joint working groups to foster shared responsibility for this from the highest level could promote distributed leadership.

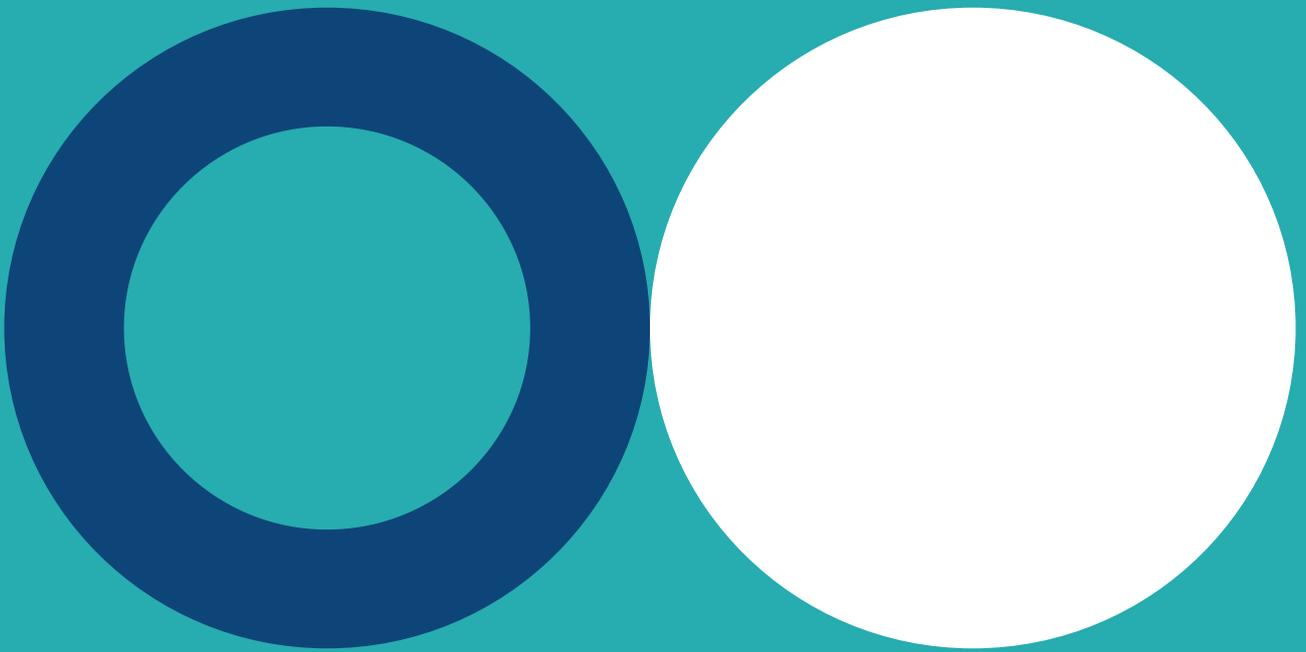
- Leadership to work with GP leaders to develop sustainable GP involvement in the integrated teams.
- Consistent human resource management practices necessary to avoid differences in terms and conditions.
- There is a need to develop meaningful measures of integration impact that reflect the intended benefit from integrated working involving co-production with individuals using health and social care services and professionals involved in delivery and leadership support.

3.3.2 Services recommendations

- Work from leadership to operational level is needed to address data sharing agreements and common understanding between all services and teams.
- There need to be opportunities for shared learning across the integrated teams in all localities to promote the many areas of existing good practice and innovative ways of working with leadership support to champion cultural change across the organisation.
- Integrated teams need to develop, with management support to foster distributed leadership; to facilitate the development

of their own detailed, locally relevant care-pathways, ensuring the trusted assessor role is clear and the involvement of other professionals will be streamlined without further referrals and waiting lists.

- Regular cross-disciplinary learning sessions within the integrated teams should be introduced for shared learning about roles and responsibilities, complex case discussion, asset-based approaches, prevention work, self-care and sharing good practice particularly where integration has made a difference.



APPENDIX: INTERVIEW SCHEDULE

Introduce project aims, purpose of interview, agree anonymity and sign consent

Questions about yourself and your role in your organisation and in relation to integration:

Confirm name, gender and job title/definition.

How long have you been in the post/ with current organisation?

Is that role health or social care?

How does the role connect to the integration of health and social care?

Integration definition

What does the partnership mean by integration?

What does it mean to you?

What difference do you think it will make?

How will you define whether a team is integrated or not?

How will integration affect the health and social care needs of local population?

What will this offer them?

How will it be different to before?

Is this a top down or bottom up approach?

What organisations are involved?

What professions?

Members of the MDT?

How will you measure success of integration?

Key objectives

Partnership objectives

Your personal measure or objective of success

When do you think changes will be shown?

When will the population feel the impact?

Are any particular group of people being targeted through integration?

How will their care be different?

How will they be in control of their health and social care?

Systems

Are systems in place?

Data sharing?

Systems fit for purpose?

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