Supporting Reconfiguration of Social Care Roles
in Integrated Settings in the UK:
A comparative study across three health and social care economies. Grant no 035/0087
Revised final overview report, July 2010

University of Edinburgh Team:

Dr. Guro Huby    School of Health in Social Science, University of Edinburgh (PI)
Dr. Pamela Warner   Centre for Population Health Sciences, University of Edinburgh
Dr. John Harries  School of Health in Social Science, University of Edinburgh
Dr. Eddie Donaghy   School of Health in Social Science, University of Edinburgh
Mr. Robert Lee   Centre for Population Health Sciences, University of Edinburgh
Dr Linda Williams       Centre for Population Health Sciences, University of Edinburgh

University of Wales,
Swansea team:

Professor Peter Huxley
Dr. Sherrill Evans, All Centre for Social Work and Social Care research
Dr. Chris Baker
Ms Jo White
Ms Sally Philpin

The above project comprised three parts: (i) a scoping and survey of integrated teams for care of older people and people with mental health problems in England, Scotland and Wales; (ii) qualitative case studies of older people and mental health teams in England and Scotland; and (iii) a questionnaire feedback exercise with policy-makers, team staff and user representatives, culminating with a workshop. This overview report summarises, integrates and discusses findings for the entire project.

In addition, to facilitate dissemination of our study findings, we have prepared a briefer and more accessible executive summary for the entire project.

Finally, in case some readers of the overview report might want more detail of our research, we have also compiled separate sub-reports for the survey and case studies, each detailing design, methods and findings.
Acknowledgements

This project was funded as part of the Department of Health England Policy Research Programme ‘Social Care Workforce Research Initiative’. We thank the Department of Health Programme Team for their support and help, and in particular Hazel Qureshi for her invaluable advice and guidance.

Many thanks also to the Project’s Advisory Group:

Dr. Alison Petch, Director, Research in Practice for Adults
Professor Jill Manthorpe, Director, SCWRU King’s College
Dr. Susan Nancarrow, Senior Lecturer, Centre for Health and Social Care Research, Sheffield Hallam University
Mr. Mike Martin, Joint Improvement Team, Scottish Government
Ms. Mary Howden, Head of Education & Workforce Development, Scottish Social Services Council
Ms. Marilyn Barrett, Senior Policy Manager, Workforce Directorate, Scottish Government
Dr. Deborah Rutter, Senior Research Analyst SCIE
Ms. Toni Legget, Workforce Development Advisor Care Council Wales,
Ms. Natalie Cooper, Assistant Chief Inspector, Care and Social Services Inspectorate Wales

A large number of staff and managers in integrated social care services for older people and people with mental health problems in England, Scotland and Wales provided generously of their time and knowledge.

The views expressed in the report are of the authors only and not necessarily those of the Department of Health.
Headline findings

The study
In the UK, as in other parts of the “developed” world, increases in the proportion of older people and people with chronic and long-term illness are causing rising pressure on health and social services. “Social care” which helps people with long term needs manage the tasks of everyday life at home is therefore a key policy. “Integration”, or a closer alignment of health and social care organisation and delivery is a key element of health and social care policy in the UK.

Integration has an impact on those working in care services. As the boundaries between health and social care are redefined, staff have had to move beyond traditional roles aligned to professional and occupational identities and adapt to new ways of working. Staff in these services need training and support to adapt to new ways of providing care.

We carried out a study of teams for the care of older people and people with mental health problems in three UK countries: England, Scotland and Wales. All teams comprised both health and social care staff in order to provide a range of services to people with complex needs requiring help to live at home. The aim of the study was to explore the way different policy contexts with regard to “integration” shape the way “social care” is delivered, so that implications for English policy can be identified. The study comprised a survey, case studies and a feedback exercise.

Key findings:
“Integration”
Our findings confirm literature, which suggests, that policy initiatives and structural change can influence the way health and social care align at an organisational level, but the way these high level changes shape the delivery of care depends on a range of contextual factors. “Integration” of care happens in practice, as staff and their clients go about their day-to-day work. “Integration” means different things to different people and there are several ways to work in an “integrated” way. Our findings also suggest that

- An important factor that shapes practice “on the ground” is “governance” or demand for documentation in relation to performance management, the way electronic care assessment forms structures practice, and the pressure to demonstrate that targets are met. These factors impacted differently in the two care areas we studied; care for older
people and care for people with mental health problems because the circumstances of care for these two client groups were different. This was the main reason why the case studies found a greater difference between care area than between national context in the way roles were configured in teams.

- When we carried out the survey we found that the definitions of “integration” among staff we contacted were too narrow to recognise the wide variety of “integrated” forms that existed. This might suggest poor organisational capacity to support teams.

Roles in teams; the importance of relationships

The care way tasks are distributed across “roles” are sometimes depicted as fixed things which people hold on to in the face of change in ways of working, and are often seen as aligned with occupational distinctions, so the tendency for staff to “cling to” professional and occupational identities becomes a barrier to moves towards service integration. The case study findings however suggest that

- “Professional and occupational identity” was a malleable concept and on the whole respondents did not distinguish between “health care work” and “social care work”. Mutual recognition and understanding of capabilities people brought to the everyday work of providing care was the most important factor, which determined how people experienced their work in a team. Those who felt their skills and contribution to care were poorly understood or marginalised by others tended to emphasise their professional or occupational identity.
- The quality of relationships in teams was more important than content and labels of roles for the way people worked together – or not.
- “Social care” is provided from several roles, including health care roles, but the way this happens varies across settings.

Work satisfaction and quality of care: management, support and training

Retention and development of the social care workforce is an important aspect of policy. The survey provided an opportunity to explore factors that were related to work satisfaction in a large number of teams across the three UK countries.

- Work satisfaction was related to the quality of teamwork and the way the team was managed. These factors were also seen as related to the quality of care provided. Career progression and training opportunities were also related to work satisfaction.
• Team leaders may have a different and more positive perspective than their staff, on work in integrated services. They feel more secure in their role and feel more confident about their own and their team’s future than their staff.

The case studies complemented these findings:
• The creation of new roles was inseparable from the learning of skills needed to fill those roles. Moreover, much of the “training” required by more integrated ways of working was undertaken informally on the job, learning and “picking up skills” from others. The quality of relationships within teams was a crucial factor in both role re-configuration and learning.
• Many study participants were involved in a process of “life-long learning”, although it was often not formally recognised or accredited as such.
• The contours of a new role, namely “the skilled care professional” was apparent. This role was based on individuals’ personal portfolio of experience and training. This portfolio often included professional or vocational training as an important element, however the role was not defined by such training.
• “Managers”, in particular team leaders who had a personal relationship with team members were thought to be important in facilitating good team relationships. Good managers “translated” and accommodated the requirements of governance to practice within the teams. However, a striking and unexpected finding was that “management” and the wider organisation was generally opaque and inaccessible to staff in teams, and seen to work against collaborative working on the ground.

**Recommendations:**

Our findings suggest the importance of locally steered service development and change, flexible learning and personal relationships within teams and between teams and the wider organisations of which they are a part. Our recommendations reflect these main concerns.

**Recommendations for practice**
• Training is provided in building and managing relationships within teams to facilitate the iterative process of role reconfiguration, learning of skills and effective provision of care that is adapted to local conditions.
• Professional and vocational training emphasises skills required for ongoing learning and adaptation to a range of collaborative working models through practice.
• Flexible avenues of learning and career building are provided.
• Mechanisms are put in place to recognise and document changing skill sets.
• In order to strengthen relationships between teams and their organisations, upper and middle level management take time to listen to staff, formally and informally.

• Managers’ key role in translating and accommodating governance requirements to practice is recognised and supported so that relationships among staff and between staff and the people they help are protected.

• Team leaders’ role is recognised and supported as crucial in facilitating relationships within teams.

• Support for, and management of multidisciplinary teams are embedded in ongoing organisational learning and development.

**Recommendations for research**

• The meanings and variety of the term “integration” is revisited in different contexts.

• Factors that work across health and social care organisations to impact on integrated working, for example governance mechanisms, are further investigated.

• Definitions and empirical examples of good teamwork are further explored.

• Research, which explores users of services as partners in service delivery and planning is supported.

• The forms of training and learning that underpins teamwork and integrated working is further explored.

• The management styles that lead to better teamwork is studied.

• Relationships between features of teamwork and service user outcomes are investigated. Quasi experiments may be needed to study this question.
## Contents

1. Introduction: background, aims and design of study
   1.1 The study and its brief
   1.2 Policy context
   1.3 Policy contextualised: “Integration”, governance and professional boundaries as drivers of change
   1.4 Opportunities for Comparisons

2. Aims of project

3. The study and the report explained

4. Key findings from scoping, case studies and survey
   4.1 Scoping: The teams and some of their characteristics
     *Table 1 Teams Scoped*
   4.2 Case studies: capturing “insider” views
     4.2.1 Approach
     4.2.2 Methods
     *Table 2 Case Study Teams*
     *Table 3 Respondent in Teams*
     4.2.3 Key findings
     *Figure 1 Mapping Roles*
     *Figure 2 Mapping Relationships*
   4.3 Survey
     4.3.1 Methods of study
     *Table 4 Factors & their descriptions*
     4.3.2 Key findings
     *Table 5 Survey responses by care area & country*
     *Figure 3 Factor scores*
## Contents

<table>
<thead>
<tr>
<th>Table 6</th>
<th>Strongest correlations of ‘satisfaction with current job’ with other WDQ factors</th>
<th>Page 34</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 7</td>
<td>Strong correlation of ‘quality of care’ with other WDQ factors</td>
<td>Page 34</td>
</tr>
</tbody>
</table>

5. Feedback and consultation exercise  
   1.1 Questionnaire  
      5.1.1 A summary of the responses  
      Table 8 Respondents and designations  
   5.2 Workshop  

6. Discussion, conclusions and recommendations  
   6.1 Discussions and Conclusions  
      6.1.1 Assessment of the findings  
      6.1.2 Conclusions and discussion  
   6.2 Recommendations  
      6.2.1 Recommendations for practice  
      6.2.2 Recommendations for research  

7. References  

Page 35  
Page 36  
Page 37  
Page 38  
Page 39  
Page 42  
Page 43  
Page 44
1 Introduction: background, aims and design of study

1.1 The study and its brief

In the UK, as in other parts of the “developed” world, increases in the proportion of older people and people with chronic and long-term illness are causing rising pressure on health and social services. At the heart of the policy response to these challenges is modernisation of services to shift care out of acute, specialised and costly medical services into community settings closer to people’s homes, and the design of care systems that ensure flexible cost-effective services adapted to specific and different levels of need.

Provision of “social care” is an important part of service modernisation. “Social care” is defined as the day-to-day support that people with long term and complex needs require to live independently in their own homes and participate as fully as possible in the life of their communities. Development of a workforce with the capacity and capability to meet these needs is a key area of development. This requires potentially far-reaching changes in established distinctions between the work that “health care” and “social work” staff carry out. As the boundaries between health and social care are redefined, staff have to move beyond established professional and occupational identities and adapt to new ways of working. This study focuses on the way “social care” tasks and responsibilities are distributed in “integrated” community service settings, where there is a closer alignment between health and social care. The purpose of the study is to understand the mechanisms of support and training that can be put in place to help staff provide efficient care.

1.2. Policy context

Social care workforce development: policy context

Policy for social care workforce development across the countries of the UK (Department of Health 2009, Scottish Executive 2006, Welsh Government 2003, 2005, 2007) focus on three main areas:

- Organisational change and transformation, centring on closer “integration” or alignment and collaboration among public, voluntary and private sector services, in particular health and social care. This includes
o Development of new roles and a changing skill mix to deliver care flexibly around user needs.
o The “personalisation agenda”, which involves placing the service users at the centre of service organisation and delivery. Increased user involvement has been a long-standing central point of policy. With Our health Our Care Our Say (Department of Health 2006a), the agenda is pursued further with the introduction of personal budgets, placing service users as the purchasers of care, thus aiming to make services responsive to individual needs.

- Improved governance, performance management and regulation to ensure quality and safety of practice.
- Workforce development, focussing on recruitment, education and ongoing training of the workers to deliver the reconfigured services.

A key part of workforce policy is the mapping of skills and competencies to roles, then identifying and developing the training opportunities workers need to develop the skills. For example, Skills for Care England (2009) provides a service that aims to

- Help employers understand what standards, learning opportunities and qualifications are applicable for the workplace.
- Help workers understand how specific standards, learning opportunities and qualifications can assist their competency and career development.
- Help training providers, awarding bodies and publishers understand what standards, learning opportunities and qualifications are required by the sector.

A successful social care workforce policy for integrated services needs to stay attuned to the dynamics of “integration”, the factors, which shape these dynamics and the impact, they have on the reconfiguration of roles.
1.3 Policy contextualised: “Integration”, governance and professional boundaries as drivers of change

“Integration” and partnership work

Social care has been predicated on a closer alignment between health and social care since the 1970’s, care in the community and the relocation of long-term mental health and psychiatric care from institutions into the community. Policy on partnerships between health and social care services describes relationships between health and social care organisations and professions as a main factor in the way “integration” of services develops or stalls (e.g. Glasby 2003).

Running through the literature about “integration”, is the question whether a large scale structural “top down” or incremental “bottom up” strategy works best to shape the relationships required to facilitate user-centered and cost effective services. (Glendinning et al 2004, Bell, Kinder and Huby 2008). Despite devolution and increasing divergence between health policy in the countries of the UK, the tension between wholesale structural reform and local incremental development is surprisingly similar across constituencies.

In England, the push from 1999 to establish Care Trusts as organisations that fully integrate NHS and local authority care provision in one organisation followed a period of emphasis on local incrementally built collaborations, which were seen to have failed to deliver the desired results in terms of reduction of pressure on acute hospital care (Hudson 2002). In Scotland, in response to pressures on acute care resulting from admissions of older people, the Joint Future policy introduced in 2000 put in place central national mechanisms for support and facilitation of pooling of funds, joint management structures and the option of central intervention in partnerships that were seen to be failing (Evans and Forbes 2009, Scottish Executive 2003). In Wales, the 2005 large-scale modernisation policy was introduced when a previous policy based on localism was seen to have failed to deliver reduction in hospital waiting lists (Welsh Assembly 2003, Drakeford 2006).

Large-scale structural reform has encountered a range of difficulties associated with differences between NHS and local authority legal frameworks. These include accountability, financial reporting arrangements, budget cycles and human resource arrangements with diverging pay scales and conditions and culturally based diverging expectations of care workers’ relationships with users of their services and each other (Glendinning et al 2004, Hudson 2002, Glasby 2003 ). In England, only 9 Care Trusts were formed which fully integrated health and social care in single organisations. In Scotland, the
Joint Future policy has produced a varied picture of local partnerships. Within the UK, Northern Ireland has gone furthest in pursuing a policy of structural integration in fully integrated Health and Social Services Boards but there is no conclusive evidence about the success of this approach in facilitating integrated working on the ground (Hudson 2004, Heenan 2006).

The success of structural reform moreover may be dependent on smaller, incremental collaborations developed locally in response to local service pressures and opportunities (Peck, Gulliver, Towell 2004, Glodinning et al 2004). Hudson (2002, 2004) argues for a “third way” solution privileging centrally supported local inter-agency networks (Rhodes 1997), over wholesale structural change. This is all the more important because with a wider range of private and public sector providers entering the care markets, the integration agenda has moved from one predominantly concerning health and social care, to one that includes a plurality of providers.

**Governance**

The emergence of governance mechanisms to steer and manage these complex and networked services is another shaper of “integration” between health and social care. In current contexts, “integration” is pursued through increased managerial control of public services in order to ensure transparency, public accountability and cost efficiency. Various termed “New Public Management” this implies a dis-aggregation of former unitary services into smaller units, often created by amalgamating elements (staff, funding, resources) from different sectors or organisations, performance managed against national and local targets and requirements (Hood 1991, Osborne and Gaebler 1992, Dunleavy and Hood 1994).

The “dis-aggregation” of public service organisations and the push towards flexible and cost effective services are in many ways a facilitator of locally based partnerships and networks forming across service and professional boundaries. The term “networks” carries a complex set of expectations in both policy and research literature (Perri6, Goodwin, Peck, Freeman 2006), but they are no panacea. The governance of networks, which cross several organisational and professional boundaries raise particular issues of mandate, responsibility and accountability (Perri6, Goodwin, Peck, Freeman 2006). The way networks link to national strategy, as well as providing frameworks of support and direction to services “on the ground” poses particular issues.
Professional boundaries

Freidson’s (1975) work on the profession of medicine suggests that configuration of work roles is less a matter of the content and nature of work, than negotiation and sometimes contest among professional and occupational groups regarding their privileged access to specific areas of work and the authority and remuneration that follows such access. This negotiation is shaped by political and organisational circumstances. Implicated in this process is the relationship between professions, occupational groups and the state. This is because the state has the authority to legislate for professions’ and groups’ privileged “ownership” of particular areas of work or “jurisdictional domains” (Abbott 1988) enshrined formally in public regulation and enforced by practice (Sanders and Harrison 2008). Part of the “New Public Management” project is to reduce the dominance of professions in the name of increased transparency, cost-effectiveness and democratic control (Broadbent and McLaughlin 2002). Social care in the community was an early project of the new managerialism, which, in conjunction with better and more efficient care provision, explicitly aimed to curb professional interests as drivers of service change and introduce stronger central control (Malin 2000).

With increased state control over public services, mediated by stronger managerial power, the conditions under which professions and occupational groups can negotiate work domains are changing (Nancarrow and Borthwick 2005). However, there is little sign that the negotiation and sometimes contest among professional and occupational groups for the “right” to certain areas of work are eliminated as a driver of workforce change.

“Integration” between health and social care is thus not only a matter of relationships between health and social care organisations and professions, but of a range of central and local drivers, which shape these relationships differently depending on the setting. Steering workforce change in “integrated” settings furthermore requires an understanding of the negotiations that take place between occupational and professional groups in specific contexts about the work they carry out and the way this work is labelled and interpreted.

The team

Multidisciplinary “teams”, are the most common service system that brings together practitioners from a range of different backgrounds and agencies to achieve results for service users that could not have been achieved by any one of the agencies acting alone (e.g Peck 1999 for Community Mental Health Teams, Dickinson and Glasby 2008). Our study is located at the level of teams in order to explore “integration” and its impact on work roles.
1.4 Opportunities for Comparisons

This study draws on a comparison of different types of “integrated” teams and their impact on social care workforce development. We wanted to use this comparison to explore the formation of (new) roles and understand how this process can be supported and steered. Two main variables were selected for the comparison; national policy context, and patient group or care area.

The UK has been termed a “natural laboratory” for the implementation of public services reform, and the countries of the UK are pursuing different approaches to change (British Medical Association 2007). A comparison of national policy context was a starting point for our strategy, and we assumed that if the policy context was important then the different policy contexts should produce different role patterns at local levels.

National policy contexts

In England after a history of policy changes regarding “local collaboration” or “central drivers” as a main mechanism for integration (Hudson 2002), England is now pursuing mechanisms of a “quasi market” as a key driver of change within a framework of public funding, central oversight and quality control driving provider behaviour. Primary health and social care public service organisations have become mainly commissioners of services, and the health and social care market has opened up to a wider range of providers from in addition to public services the voluntary and private sector. The 2005 reorganisation of NHS England reduced the number of Primary Care Trust purchasers and made their boundaries co-terminous with Local Authority partners. The reforms aim for devolution of decision-making around service priorities and commissioning strategies to local levels through increased involvement of GP practices (Practice-Based Commissioning), with local authorities encouraged to join Practice-Based Commissioning Consortia. (Department of Health 2005a). For people with mental health problems Mental Health partnership arrangements were created.

Competition among providers is intended to improve quality and cost-efficiency (Department of Health 2000, 2005a, 2006a) and a central performance monitoring mechanism has been introduced in the form of a shared outcome-based performance framework, aligned with joint planning and resource cycles between PCTs and local authorities (Department of Health 2006a). Competition is also thought to provide incentives for partnerships in the form of improved competitive edge of joint bids and more efficient and cost effective joint
commissioning. As Hudson (2007) points out however, the principle of competition is in fundamental respects incompatible with collaboration and partnerships.

In Scotland both health and social services are retained as unitary public service organisations with mainly provider functions. The market has been rejected in favour of partnerships as a mechanism for achieving integration (Woods 2001, Hudson 2007, Evans and Forbes 2009). Service change is based on collaboration and partnerships between NHS, social services and also the voluntary sector as an increasingly important part of provision. The role of the private sector is explicitly minimised (Scottish Executive 2003, 2005a) compared to England, where quality assurance is built into contracting and monitoring of contracts. The Scottish model emphasises a higher degree of central performance management, combined with support given to partnerships to attain targets. The Joint Performance and Information Assessment Framework (JPIAF), introduced in 2004 has evolved into the Community Care Outcomes Framework, which is integrated with other national performance management frameworks and indicators, for example HEAT and the Single Outcome Agreement. It provides partnerships with a tool to monitor themselves against their locally set targets and to compare themselves against other partnerships.

In Wales, integration was firmly placed on the agenda with the 2005 policy paper “Making the Connections” (Welsh Assembly Government 2005) following the Wanless (2003) Review of Health and Social Care in Wales. The relatively high levels of health expenditure combined with what was considered poor performance in reducing hospital waiting times was a key driver of the reforms. The Welsh policy focussed on the redress of health inequalities, with the issue of poorly addressed pressures on acute hospital care being less central than in the English and Scottish policies. A policy of “localism” and “collaboration” was promoted with funds channelled through 22 Health Boards charged with the creation of local commissioning partnerships with their co-terminous local authority and voluntary organisations (Drakeford 2006). The internal market and a commissioner-provider split was introduced in 2005, but the element of competition among an increased number of providers was toned down, and local collaboration in planning and commissioning services emphasised. Proposals are currently being implemented to end the internal market and purchaser/provider split (Welsh Assembly Government 2008). The emphasis on localism and collaboration is combined with separate governance arrangements for the NHS and social care.
These three UK health and social care economies thus provide three models of “integration” which differ in approach to partnership building and governance - two dimensions of most interest to our study. England is pursuing a market driven approach based on competition, emphasising central mechanisms for oversight and control of partnerships. Scotland is pursuing a policy of collaboration as a basis for partnership building, with central mechanisms for oversight guiding, rather than controlling, partnerships. Wales is pursuing a policy combining local collaboration and market mechanisms, with a fragmented system of oversight.

Care area: older people’s and mental health services
We wanted to further contextualise our comparisons by adding the variable of care area to national context. We chose older people and people with mental health problems because our previous research suggested that the different ways “need” is constructed for these two groups have implications for how care is organised, something which in turn impacts on the relationships among team members (Huby and Rees 2005).

2 Aims of project

1. To scope the composition of integrated teams caring for older people and people with mental health problems in English, Scottish and Welsh settings,

2. To understand how roles are defined, enacted and experienced in these integrated settings,

3. To understand the factors that shape team roles, with an emphasis on policy cultures in the three nations,

4. To develop recommendations concerning how people doing “social care” work in integrated health and social care settings can be trained and supported.
3 The study and the report explained

The study and the report explained

The history of the study commissioning process provides a background to the study design and its modifications, and the way we have chosen to present the report. The present study evolved from a peer-reviewed proposal, which was accepted in principle for funding at the first Programme call in 2005, for which the expected funding then became unavailable. When programme funding became available in 2007 the present study had to be cut back as the research costs had increased due to the introduction of Universities’ Full Economic Costing, with no corresponding increase in programme funding. The period available for a redesign of the project was interrupted while the situation regarding a Scottish run project in an English Department of Health funded programme was clarified. Changes were also necessary as, since the original application in 2005, other studies were underway or completed which overlapped with questions we wanted to explore.

For these reasons the project changed in two important ways. Firstly, in order to scale down the project the most complex and resource intensive element was omitted, which focussed on user experience and outcomes in relation to different forms of integrated service provision, and the factors that shaped the form of integration. This study would only make sense with a comparative framework of service integration and its shapers so it was chosen to work towards such a framework for this project.

Secondly, in order to draw on other relevant research, it included, for the survey element, collaboration with two other projects, which were separately funded. One study concerned integrated mental health teams in England and Wales (Huxley et al 2006), while the other concerned intermediate services for older people in England (Nancarrow et al 2005). All three projects, the present project and the two collaborator projects, used one and the same survey instrument, which was developed by Nancarrow et al (2005) for a study of team composition and staff experience of working in “intermediate” services for older people in England. The survey instrument used here was thus designed for a study with a similar but not identical focus to the present study. Three different research teams, with overlapping, but not identical project aims, carried out different parts of the survey of integrated teams in two care areas, namely older people and people with mental health problems in England, Scotland and Wales.
The design for this study was as follows:

1. **Broad patterns of team composition and size: scoping of integrated teams** providing services to older people in Wales and older people with mental health problems in Scotland. This was followed by meta-analysis of team size and composition across the two service areas in the three countries, by combining with secondary data sets of scoping for mental health teams in England and Wales (Huxley et al 2006) and older people intermediate care teams in England (Nancarrow et al 2005).

2. **Survey of samples of teams scoped: staff experience of multi-disciplinary work across settings using samples of teams scoped:** Survey of staff in samples of teams from the newly scoped settings, by means of Workforce Dynamics Questionnaire and by combining our survey data with WDQ data from the two other independently funded projects, meta-analysis of staff experience across all 6 settings, mental health and older people teams in England, Scotland and Wales.

3. **In depth qualitative case studies: Dynamics of team-work** in specific settings and the factors which shaped these dynamics: of eight team settings in England and Scotland.

4. **Feed-back and consultation on findings** consisting of
   a) **Structured feed-back exercise by postal questionnaires** presenting emerging findings and asking for comments from service managers, front-line staff, people/bodies involved in social care training and service users.
   b) b) **A workshop** with invited policy makers, service managers, front-line staff and service users in order to identify practical implications of findings.

There was less scope for integrative analysis of the survey and case studies than intended. This had two main reasons; timing and survey instrument. The scoping process took much longer than anticipated because of difficulties in defining and identifying “integrated” services in the NHS and Local Authority organisations that were investigated, and sampling for the case studies had to be done from scoping data rather than survey findings. The timescales also diverged further, even with generous extensions to this study, as the Huxley et al study (2006) was extended, making a full analysis of the survey before the case studies within the project time limits difficult. This meant that the survey findings could not inform the case studies as planned. The survey and case studies proceeded in parallel, with iterative analysis of the two data sets undertaken as far as possible. However, as the survey instrument was developed to ascertain the professional and vocational background of team
members, but not the tasks they carried out, there was limited possibilities to test emerging case study findings about the distribution of “social care” tasks among team members.

The survey element and the case studies therefore provide two independent but complementary perspectives on community health and social care services. We have chosen to present them in two freestanding reports, in order to be able to provide adequate detail of methods and findings. This overall project report focuses on key findings and their implications. Readers of this overview report can refer to the survey and case study reports for greater detail. The greater detail in the two freestanding reports will also be helpful for other researchers wishing to embark on work in this area.

Here, we report the study components in the order in which they were carried out. We begin with the scoping study in order to set the context for the case study and survey in terms of the types of teams we studied and their characteristics. We then present key findings from the case studies, which provide a picture of roles and relationships within 8 different teams, as defined by staff within those teams. We then use survey findings to explore overall experiences of work in “integrated teams” in the three UK settings. The feedback exercise and the workshop are reported to illustrate how our findings and their implications were checked and developed in light of wider consultation.

4 Key findings from scoping, case studies and survey

4.1 Scoping: The teams and some of their characteristics

We carried out the scoping because there is no register of “integrated teams” from which to sample for a survey. The scoping phase produced a register of teams as well as issues about the place of “integrated” teams in the organisations from which they are formed.

Issues around design of the scoping study

The three research teams went about the scoping in slightly different ways. To identify teams in Scotland and Wales they identified managers in all NHS and local authorities in charge of “integrated” mental health (MH) and older people (OP) services and obtained information about teams from them. In England the older people teams were identified by
“snowballing”, that is contacting people known to the research team and asking them to help identify teams they know of, and also provide information about others who may provide information about other teams. This study therefore did not approach all of the NHS and local authorities in England. For mental health teams in Wales and England comprehensive coverage of partnerships and Trusts was aimed for.

The sample comprises different types of teams scoped by the different research teams. England older people teams were “intermediate” teams providing support to older people in the transition from hospital to home. In Scotland and Wales we asked for information about teams with a wider range of functions. The England older people teams were scoped in 2005, that is two years earlier than the other older people teams in the sample for this study. In Wales, all the older people teams were local authority teams, as NHS contacts had not identified any “integrated” teams. This is one reason why Wales older people teams have a large number of social workers.

Table 1 shows teams scoped

<table>
<thead>
<tr>
<th>CARE AREA</th>
<th>Wales</th>
<th>England</th>
<th>Scotland</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older People</td>
<td>77</td>
<td>167</td>
<td>71</td>
<td>315</td>
</tr>
<tr>
<td>Mental Health</td>
<td>39</td>
<td>396</td>
<td>44</td>
<td>479</td>
</tr>
<tr>
<td>Both combined</td>
<td>116</td>
<td>563</td>
<td>115</td>
<td>794</td>
</tr>
</tbody>
</table>

Some findings

**Team size, and team staffing by population served**

There is considerable variation in team size within all six settings. There is also marked disparity in integrated OP and MH service provision across the six settings, in terms of ratio of total Whole Time Equivalent (WTE) of team staff, to regional populations being served,

**Team composition by setting**

We found a considerable variation in composition of teams (staff discipline/roles), and on the whole far greater variation within service/country setting, than the disparities apparent across settings.

Nevertheless, some patterns were apparent:
• Mental health teams had a higher proportion of nurses and doctors than older people teams.

• Older people teams had a higher proportion of support-workers than mental health teams.

• The pattern was more complex for social workers, in that the proportion social workers comprised (of all professionals in the team) differed by both service area and nation. In Wales, older people teams had a very much higher proportion of social workers than all five other settings, whereas in the other two nations, mental health teams had a higher proportion than older people teams.

Team composition by in relation to team size

We wanted to know if “size of team” was related to the proportion of social workers and support workers in teams. We found overall correlations within care area, but also some settings that differed from the main trend:

• Support workers: In both care areas (MH & OP) we found that the larger the team the higher the proportion of support workers, but considering the six settings separately, this relationship was not evident in Scotland older people teams.

• Social workers: In mental health teams we found an overall correlation between the size of the team and the proportion that social workers comprised of all professional staff in the team; although within countries there is no such correlation in Scotland. In OP teams there was no correlation overall but within countries there was a correlation in England.

Knowledge and definitions of “integrated teams”

The scoping work for this project highlighted issues that are important to understanding the phenomenon of “integration”. Identifying teams for the survey was made difficult because of the many and complex ways in which NHS and local authority resources were joined to constitute specific services. The many forms which “integration” could take were overlaid by the many different ways in which the managers we approached for information employed the notion of “integration”. In spite applying one definition across all scoping, namely “teams that include both NHS and social work staff”, there were many examples where we were given different information by different managers about the number of services, because they defined “integration” differently. For example, the management structures for teams were often used as a basis for definition, and teams that were managed from only one organisation could be excluded.
The complexity of funding and management arrangements also made it very difficult for the managers we approached to give us the information requested. For example, establishing whether the location of the service was health or social work could be exceedingly difficult because management functions were often dispersed across several members of both organisations, and there were different arrangements for “pooling funding” from the two organisations. Establishing staffing levels was also very complicated because of the many part/whole-time equivalents and the informal referral arrangements that made up the service.

The scoping carried out for this study, and the SDO study about mental health teams in England and Wales, also showed that knowledge of “integrated” teams/services within organisations is patchy, and team structure and management arrangements are complex and fluid. This posed problems in terms of identifying and contacting teams (the English study on intermediate services for older people used a snowballing sampling technique and their experience of locating teams was different).

How and who define “integration”? The scoping produced a register of teams, which were different in important respects. Although broadly within two care areas they had a different function, rationale and history, and they related to their “parent” organisations in different ways. This is partly because the three research teams used different methods to identify teams and the focus of their research was different. This is however only a part of the reasons. The teams were also identified by managers who defined “integration” differently.

This raises a question as to how we can produce any general conclusions about role configuration and “integration” from such a diverse set of teams. It may be however, that this diversity is in fact a main feature of “integration”. A definition of “integration” is “a single system of service planning and/or provision put in place and managed together by parent bodies who nevertheless remain legally independent” (ICN 2004). Our experience from the scoping study suggests that this definition has room for a large variety of forms. Trying to organise a study around a particular definition of “integration” may therefore miss a major point about “integration”.

Another way to understand “integration” is to start from how “integration” is defined in day-to-day practice, who defines it and with what consequence in terms of roles and the division of tasks. We used this approach in the case study component of the project.
4.2 Case studies: capturing “insider” views

4.2.1 Approach

The aim of the case studies was to study a small number of teams in depth, in order to understand team roles in different settings, and the factors within teams and in the wider organisations, which shaped these roles. As in the scoping study, definitions became a problem early on in the case studies. We were looking for “social care roles” using the definition “the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships”. Early on however, it became clear that a “social care” role by this definition did not exist in any of the teams we studied. Tasks and responsibilities were distributed among team members in a way that defied fixed definitions of “health care”, “social care”, “professional care” and “care support”. One way of dealing with the problem of the plurality and complexity of organisational forms and roles was to “bracket” off the policy and academic language of “integration” and professional “roles” and pay attention to the language people use to describe the work they do as carried out in a service which connects and divides people in a variety of ways. In social scientific terms, our job as researchers is to “follow the links” (Latour 2005) created by those working within a service and in so doing, achieve an insider’s, understanding of roles and relationships, as they are constituted in everyday practice.

Boundary work in action

Our data was interview data and our analysis consisted of identifying main themes and concepts by which respondents ordered their working world. In other words, we captured the way people talked about their work and not how they carried it out. Respondents’ descriptions of their own work and the work of their colleagues arise from ideological positions and professional/political concerns as much as, perhaps more than, they reflect realities of practice. This is an important point, bearing in mind that a main body of literature about professions and occupational groups suggest that roles are formed by groups claiming privileged access to certain areas of work and negotiating and contesting access with other groups and occupations. We invited respondents to “do boundary work” and the material gives an insight into the way boundaries in social care are drawn and redrawn in contemporary community care settings.
4.2.2 Methods

Selection

The case studies are based on a comparison between eight teams across the two care areas in England and Scotland: two each of mental health and older people teams in Scottish and English settings respectively. As far as possible we ensured a spread across different types of location (urban, semi-urban) and in different types of partnerships. We also tried to ensure that the teams selected had similar combinations of these variables, so that comparisons would make sense. Teams selected had to be willing to accommodate a researcher’s presence for a length of time. The end sample, with pseudonyms reflecting the type of location for the teams looked like this:

Table 2; case study teams

<table>
<thead>
<tr>
<th>Scotland</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Big City Mental Health</td>
<td>Industrial City Mental Health</td>
</tr>
<tr>
<td>Fishing Town Mental health</td>
<td>Rural Town Mental health</td>
</tr>
<tr>
<td>Suburban Town Older People</td>
<td>Northern City Older People</td>
</tr>
<tr>
<td>Small City Older People</td>
<td>Seaside City Older People</td>
</tr>
</tbody>
</table>
“integration” meant to them and how it affected their work. For a full description of sampling methods and analysis see the separate case study report.

4.2.3 Key findings
In order to describe the way staff in teams understood roles and relationships we created conceptual maps based on the analysis of what people said to us. These maps display the “semantic space” (Fernandez 1974) within which roles and relationships are articulated. The reconfiguration of roles and the transformation of working relationships can be shown as movement within this space.

Mapping roles
Figure 1 shows how people mapped their “roles” and the reconfiguration of their roles on a “space” of service delivery.

This space was defined by two distinctions: 1) the distinction between “health care” and “social care” (where the former had roughly to do with the management of biomedical conditions and the later with the provision of various forms of support and assistance to ensure the service user enjoys a full life in the community). 2) The distinction between care management and care delivery (where the former had to do with assessing a clients needs and organising care according to those needs, and the later with the day-to-day work of providing that care).
Between these distinctions there lay a “grey area” of work, which did not easily “fit” into one domain or another. The notion of the grey area is complex and important to how people understood their roles. In one sense, they were produced by the organisation because grey areas were often those domains where the question of who did what was unclear or unresolved. But many we talked to also argued that grey areas were intrinsic to the complexity of the work they did, since clients’ situations did not, and should not be made to fit neatly into categories.

The notion of “grey areas” is different from that of “role blurring”, which is a term often used to describe situations where role distinctions between staff in multidisciplinary settings break down. Whereas “role blurring,” suggests that work is carried out with reference to pre-existing roles, “grey areas,” suggest that work was carried out without reference to existing distinctions and boundaries - people just took on tasks, which presented themselves as important.

The reconfiguration roles could be described as movement within this space. In general, our respondents experienced two kinds of movement:

One movement was away from roles defined by the distinction between “healthcare” and “social care” and towards more “grey area” working. Accordingly distinctions between professional domains became blurred in practice. Resistance to moves away from distinctions made on the basis of professional and occupational domains were articulated most strongly by “minority professions” such as OTs and psychologists. The boundary between health and social work was more malleable.

The other movement was out of the “grey area” and towards a distinction between “care management” and “care delivery” where professionals became increasingly involved with the work of organising care and the work of delivery care was devolved onto other organisations and/or support workers.
Mapping relationships

Figure 2 shows how people mapped their working “relationships” and the reconfiguration of their relationships within a “space” of service delivery.

This space was defined by two distinctions: 1) between working within the “grey area” and working in an area defined by distinct roles and remits; 2) between collaborative working and antagonistic working.

Almost without exception the people we talked to spoke positively about various kinds of “integration” (particularly collocation) as enabling better cooperation between individuals and agencies involved in managing and providing care. In particular it was argued that closer working relationships facilitated better communication and an appreciation of other professions’ skills and contribution to the care process. Within this consensus there were two distinct models of “cooperative working”:

According to model one, people work within the “grey area”, and role distinctions (between, say, social workers and nurses) begin to blur as people take on a wide spectrum of tasks associated. Other team-members are available to “go to” for advice and support.

According to model two people hold distinct roles and remits, and their contribution to the care process is defined by this role and remit. Clients are “passed” from one person to another as their care requires (e.g. a social worker putting in place supported housing, while a health visitor manages medication). Cooperation between different professions is invaluable to allow for seamless working.
Models one and two described circumstances where people were brought together in what was seen as positive ways of working. However, there was also much talk of situations when such collaboration fell away. New and more cooperative working was described as evolving from, but also potentially deteriorating into “antagonistic” working. There were two “anti-models” of antagonistic working: one where professional groups stayed within their own “silos”, not communicating with other professionals, protecting their work domain and entering into conflicts with other groups over role boundaries; and another where an individual worker would assume too much autonomy and authority in the management of a client’s care, and not “go to” or share this work with others in the team. A number of factors could lead to antagonistic working, which were not all primarily to do with inter-professional and occupational rivalries. For example, pressure from targets and the upheaval following reforms, were important factors.

Relationships and team types
The description of the two positive models mapped on to the two types of teams we studied; mental health teams and older people teams. Respondents working in mental health teams gave a description of their team, which corresponded with model one of collaborative working in “the grey area”. Respondents who worked in older people teams described their team in terms of model two i.e. working from clear and bounded roles and remits. Compared to mental health teams, the care management and care delivery distinction was emphasised more strongly in older people teams, where assessment and organisation of care packages to facilitate people’s early discharge from hospital was a key function. The work of organising care involved a considerable amount of “paperwork”, which was central to the work in these teams. In contrast, in mental health teams management of risk to clients and their surroundings was the main focus and ongoing relationships with clients were the main type of work carried out. The distinction between care management and delivery was not emphasised and the formalities of “paperwork”, although necessary, was not central to people’s everyday work the way it was in older people’s teams.

Management
Management was often described as a critical factor in facilitating (or inhibiting) the successful reconfiguration of roles and working relationships and moves to more collaborative ways of working. A clear distinction was made between the face-to-face management in teams, and “management” overall.

Local managers, in particular team-leaders, who were closely and personally involved in the working of the team were, on the whole, highly regarded and their work was central to the
establishment of a successful dynamic team based on a respectful mutual recognition of individual roles and capabilities.

The organisation as a whole however, was generally not understood and with a surprising consistency described as divisive and as inhibiting collaborative and “grey area” working. This was observed not just by staff, but also by managers. There was consensus amongst staff that “management” above the level of team leader (“them up there” as many referred to it) did not fully understand or appreciate flexible, “grey area” ways of working. On the whole staff expressed a high degree of alienation from processes of policy making and implementation.

The proliferation of “paperwork” that involved recording practice for purposes other than communication about clients among staff was a matter of considerable concern. The kind of “paperwork” most often mentioned in this regard was assessment and CPA forms, which took people away from the ongoing relationships with clients and colleagues in day-to-day care delivery and emphasised the division between care management and care delivery. Delivery of care was seen as embedded in relationships among staff and between staff and users of services. Management of care was embedded in “paperwork”, which was dissociated from these relationships and therefore distorted care work.

**Training**

As people moved from one role to another they required new skills. This was particularly true for those who moved from domains clearly defined by the distinction between health and social care work and into “grey area” working. The people we talked to described themselves as being trained into a specific professional role (nurse, social worker, etc.) and, as they moved beyond this role, they found themselves taking on a plurality of tasks they had not been trained to do.

On the whole, people said that although they found the amount of learning required considerable, they were positive about learning new skills and to apply them creatively with colleagues to facilitate client care. The exception was some “minority” professions, who were concerned their professional skills were being “diluted” as they took on tasks that they had not been trained for.

Respondents said that by far the most important way of acquiring new skills relevant to the reconfiguration of roles was through informal, on-the-job, learning. People spoke of learning by “osmosis” and “just picking things up” as they worked collaboratively with different
professionals with different skill sets. “Going to” others in the team for advice was deemed to be essential to the successful acquisition of new skills.

The contours of a new role, “the skilled care professional” was apparent in the way respondents talked about the way they acquired their skills. This role was based on expertise and experiences that were personal to the worker, rather than defined by professional training.

In summary

• Our respondents did not consistently distinguish between health and social care as distinct and clearly demarcated domains of work.
• They were more concerned about “protecting” their role as a “skilled care practitioner” against moves to divide the work of care management and care delivery.
• There was not a great deal of difference between the ways staff in England and Scotland described the role patterns in their teams. The biggest difference was between those who worked in mental health and those in older peoples’ teams.
• The different role that tools and mechanisms of care management played in the everyday work of the teams was a main factor underlying these different patterns.

4.3 Survey

The case studies provided a view as expressed through staff’s language, of the way work was divided between staff in a small number of teams. We carried out the survey to provide a picture of the way staff experience their work in “integrated” teams in a larger sample of teams and across three UK policy contexts. The survey has produced overall findings about staff satisfaction and experience with their work and it is useful to reflect on the case study findings in conjunction with survey findings.

4.3.1 Methods of study

For all teams scoped in Scotland, and for a subset of scoped teams in Wales, team members were surveyed by means of Workforce Dynamics Questionnaire (WDQ). The WDQ asked for level of agreement with 68 statements concerning job satisfaction and aspects of team-working. The data sets for these three settings were combined with similar external data sets for Wales and England mental health teams and England older People teams to undertake a “meta-analysis” of workforce dynamics across the three countries and two service contexts.
Following Nancarrow et al (2005), 11 factor scores were calculated from the responses to 56 of the 68 statements. The “factor domains” covered aspects such as the nature of team working, degree of certainty about respondent’s and the team’s future, overall satisfaction and quality of care provided by team. Scores range from 0-100. The higher the score the more strongly the responder agreed with the statement.

Table 4. Factors and their description

<table>
<thead>
<tr>
<th>Factor (No. of items)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy (4)</td>
<td>Practitioner has control over his / her own work, or that of others.</td>
</tr>
<tr>
<td>Role perception (9)</td>
<td>Practitioner’s role is understood/valued by the public and colleagues.</td>
</tr>
<tr>
<td>Role flexibility (6)</td>
<td>Practitioner’s role allows/requires innovation and/or skills acquisition.</td>
</tr>
<tr>
<td>Same-profession support accessible (3)</td>
<td>Support is available to practitioner from a member of his / her own profession.</td>
</tr>
<tr>
<td>Team working (10)</td>
<td>The team is coherent/harmonious, has shared focus/goals, and practitioner’s suggestions are valued.</td>
</tr>
<tr>
<td>Management of team (5)</td>
<td>Line management is clear and the team management is accessible, receptive and satisfactory.</td>
</tr>
<tr>
<td>Access to technology and equipment (4)</td>
<td>Respondent has access to necessary equipment and administrative support.</td>
</tr>
<tr>
<td>Training and career progression (8)</td>
<td>Satisfaction with career development opportunities (and support for this) offered by current post.</td>
</tr>
<tr>
<td>Quality of care (2)</td>
<td>The team provides good quality of patient/client care.</td>
</tr>
<tr>
<td>Certainty (4)</td>
<td>Respondent is free of uncertainty about the team future and his/her role in team.</td>
</tr>
<tr>
<td>Satisfaction with job (1)</td>
<td>Overall satisfaction with current job.</td>
</tr>
</tbody>
</table>

The survey was the most difficult and complex part of this project. As we explained earlier it was carried out by three different research teams, working on projects that had similar but not identical aims. The sampling techniques and the way data was collected were not identical in all teams. Three research teams from three different projects with overlapping, but not identical aims, undertook the survey, using different approaches. In Scotland, where all teams scoped were surveyed by post, response rates were low. In Wales OP and England and Wales MH WDQ researchers in selected teams distributed questionnaires. Response rates were higher but the samples surveyed were not representative and the presence of researchers would have impacted on responses. In England OP recruitment to the survey was by snowball methods, i.e. the sample was recruited through personal contacts. The response rates were higher, but the samples were not representative. These factors should be borne in mind when interpreting the results.

The nature of the sampling and execution of the survey has led us to be cautious about the interpretations we make from this data set. For example, there is limited scope to reliably identify differences between nations and care areas in the way staff experience their work in integrated teams, something which would have been interesting in light of the case study
findings that the main difference in team work was found between care area and not by nation. More dependable are analyses of correlations between aspects of integrated teams working, and of these within profession, country and care area. A full description of methods is provided in the attached survey report.

4.3.2 Key Findings

There were 1187 completed questionnaires, divided between country and care area as follows;

Table 5 Survey responses by care area and country

<table>
<thead>
<tr>
<th>Service</th>
<th>Wales</th>
<th>Country</th>
<th>England</th>
<th>Scotland</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older People</td>
<td>294</td>
<td></td>
<td>292</td>
<td>173</td>
<td>759</td>
</tr>
<tr>
<td>Mental Health</td>
<td>151</td>
<td></td>
<td>158</td>
<td>119</td>
<td>428</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>445</strong></td>
<td><strong>450</strong></td>
<td><strong>292</strong></td>
<td><strong>1187</strong></td>
<td></td>
</tr>
</tbody>
</table>

Of the 1187 respondents to WDQ survey, the major groups responding were nurses, social workers, support workers and occupational therapists (n= 311, 237, 198 and 155 respectively).

Factor scores

Figure 3 shows mean WDQ factor scores by professional group. 100 is the most positive response
On the whole,

- Respondents agreed strongly that their teams delivered good “quality of care”, and that “management within the team” was good.

- Respondents agreed least with statements about “training and career progression” and “certainty” concerning the future of their team/role.

Social workers

- agreed less than all other groups that they were satisfied with their current team job, and that their role was understood (“role perception”). They agreed less than all the other professional groups, that in their team role they had “autonomy”.

Compared to other team members, team leaders agreed more strongly with all statements except “same-profession-support is accessible”. Differences were statistically significant for the following statements:

- “Certainty” regarding their own and their team’s future
- “Autonomy”
- “Not intending to leave employer”
- “Role flexibility”
- “Role perception”

Job satisfaction

Overall, job satisfaction was rated lower than other factors. A rationale for the study was to explore factors impacting on staff retention, so we investigated which factors correlated most strongly with job satisfaction:

- Job satisfaction correlated most strongly with “role perception” (that is how the respondent’s role is understood and valued by others).
- Also strongly correlated were team-working, training and career progression and the certainty concerning the future of the team and the respondent’s role in the team.
- Management structures within the team were also a factor that correlated fairly strongly with job satisfaction.
Table 6: Strongest correlations of “satisfaction with current job” with other WDQ factors

<table>
<thead>
<tr>
<th>WDQ factor</th>
<th>Rho</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role perception</td>
<td>0.55</td>
</tr>
<tr>
<td>Team working</td>
<td>0.45</td>
</tr>
<tr>
<td>Training and career progression opportunities</td>
<td>0.44</td>
</tr>
<tr>
<td>Certainty re team/role future</td>
<td>0.44</td>
</tr>
<tr>
<td>Management structures in team</td>
<td>0.38</td>
</tr>
<tr>
<td>Quality of care</td>
<td>0.37</td>
</tr>
<tr>
<td>Role flexibility</td>
<td>0.31</td>
</tr>
<tr>
<td>Same-profession support accessible</td>
<td>0.31</td>
</tr>
<tr>
<td>Access to technology and equipment</td>
<td>0.26</td>
</tr>
<tr>
<td>Autonomy</td>
<td>0.11</td>
</tr>
</tbody>
</table>

Quality of Care

There was a relatively strong correlation between “quality of care” and job satisfaction. There was a tendency for respondents to affirm that their team delivered “good quality of care”. We were therefore interested in what factors correlate with “quality of care”.

- Quality of care correlated most strongly with team working and the ability of the respondent to access same profession help when uncertain about client care.
- It also correlated highly with role perception and management structures in the team.

Table 7: Strong correlation of “quality of care” with other WDQ factors

<table>
<thead>
<tr>
<th>WDQ factor</th>
<th>Rho</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team working</td>
<td>0.59</td>
</tr>
<tr>
<td>Role perception</td>
<td>0.46</td>
</tr>
<tr>
<td>Team management</td>
<td>0.43</td>
</tr>
<tr>
<td>Role flexibility</td>
<td>0.43</td>
</tr>
<tr>
<td>Overall satisfaction with job</td>
<td>0.37</td>
</tr>
<tr>
<td>Same-profession support accessible</td>
<td>0.32</td>
</tr>
</tbody>
</table>

In summary

The WDQ responses suggest that relationships in teams are important for job satisfaction and for what team members consider quality of care. Even more important for job satisfaction is team members feeling that their role is understood by colleagues and the wider public, and equally that they feel their career is progressing, and that they feel certainty regarding their own and team’s future. The findings also suggest that team leaders have different characteristics from staff in teams and that they experience their work
differently. Compared to staff they may feel more positive about career opportunities, experience more autonomy, know where they and their team are going, and feel they will stay in the job.

5 Feedback and consultation exercise

In August 2008 we approached a wider group of stakeholders in social care to help us by commenting on some of the implications of our findings in a written feedback exercise. We also notified them of a workshop to discuss how to act on the implications. We wrote a summary of preliminary findings to give potential respondents some background.

5.1 Questionnaire

Based on preliminary findings from the scoping study and case studies, we constructed a questionnaire consisting of a series of statements about integrated care practice and management. These statements invited comments about our key findings at the time, concentrating on the care management care delivery divide, performance management, training and support (see Appendix A for questionnaire).

We distributed the questionnaire to user organisations, to practitioners and managers who had taken part in the survey and to organisations and staff involved in training and organisational development.

We sent the questionnaire to all the scoping contacts in Scotland, selected scoping contacts for mental health teams in England and Wales (based on information from the Swansea teams). They were also passed to relevant user organisations identified from national and local sources and individual user representatives we had met during meetings of the Social Care Workforce Research Initiative and to training and learning organisations and individuals whose contact details we obtained from SCIE. The exercise was also announced through the Intermediate Care Network in England, whose contact detail we had obtained from the Sheffield Team.

We undertook simple descriptive analyses of pre-coded responses for each item and summarised the free-text responses. Then from the descriptive analysis and summaries we produced an account of the feedback.
5.1.1. A summary of the responses

The findings from the feedback questionnaire have to be interpreted bearing in mind a low response rate. Nevertheless, the responses were informative and we have used them to develop our final conclusions.

Table 8 shows respondents and their designation

<table>
<thead>
<tr>
<th>Designation</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy maker</td>
<td>1</td>
</tr>
<tr>
<td>Manager</td>
<td>12</td>
</tr>
<tr>
<td>Staff in teams</td>
<td>29</td>
</tr>
<tr>
<td>Service user</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49</strong></td>
</tr>
</tbody>
</table>

**Patterns of reconfiguration: Care management and care delivery**

Our findings concerning the distinction between care management and care delivery being as important as distinctions based on professions were on the whole confirmed but the complex interplay between roles, professional background and experience of working in different settings was accentuated more strongly. There was some consensus that there should not be a clear division between care management and care delivery. However, professional roles were also important, and there was a stronger view that there were practical care tasks that “professionals” should not do, such as cooking and cleaning. Service area appeared as another factor, and the view that professionals should not be involved in care delivery was stronger in older peoples services than in mental health services, confirming the case study findings about different role patterns in older people and mental health teams.

**Skills and skills acquisition**

There was strong agreement that all staff in teams, both professional and support workers, should possess both health and social care skills. There was also strong agreement that experience is important for the acquisition of key skills. However, there was an even stronger agreement that professional education is important for the acquisition of key skills.
Factors underlying reconfiguration

Performance management, standardisation of care and its impact on care work

Our findings were on the whole supported, but with some qualifications. Importantly, views differed among staff and managers, with managers more positive about the value of performance management and standardisation of work than staff. There was a high level of agreement among staff that performance management cannot be applied to the work in an integrated setting, but less consistent views regarding the role of standardisation.

Support and management

Our finding that close, personal and informal relationships are an important source of support was confirmed. Informal support was valued more highly than formal supervision, and informal support from people who share the work in one service area is more important than support from people with the same professional background.

5.2 Workshop

In February 2008 we organised an end of project workshop where we presented our findings and some key messages from the written feedback exercise. We invited service users, staff and managers from integrated services, policy makers and strategic managers to identify implications and recommendations.

Following initial plenary presentations about the key project findings, participants divided into groups to discuss the study findings (in the light of their own experience) and to consider the main implications and identify areas of action. Some of the main issues identified were:

- The opaque and often confusing language used to describe roles, services and managerial structures.
- The pace of change and proliferation of service types.
- The processes of auditing and assessment that seem disconnected from what service users want and need.
- The importance of mechanisms which can facilitate better integration of services “on the ground”
Some action areas identified included:

- Promoting role flexibility whilst maintaining specialist skills (which are often, though not exclusively, acquired through professional training).
- Integrating “care management” and the doing of care, both at the level of individual practice and, in particular, at the team and service levels.
- Democratising the decision-making processes at all levels, in particular, effective mechanisms need to be established to ensure real service user involvement.
- Increasing training opportunities in the “soft” skills of team-working, inclusive practice and effective management so as to ensure effective and productive working relationships.

Please refer to appendix B for workshop programme, participants and report from workshop.

6. Discussion, conclusions and recommendations

6.1 Discussion and Conclusions

6.1.1 Assessment of findings
This was a complex multi-method project, which was designed around two studies using different methods and with complementary aims. The scoping and survey were carried out to identify patterns of role configuration in two care areas and at national levels in three UK policy environments. The case studies were carried out to gain an in-depth understanding of the process by which roles were formed and the factors, which impacted on this process. We tried to capture how tasks and responsibilities were negotiated among staff in multi-disciplinary teams during everyday practice of providing care. The intention was to select the teams for the case studies from survey findings and to build up a picture of role configuration at both national and team levels through iterative interrogation of the two data sets. In the event, the timing of the survey and the survey instrument prevented this.

The studies thus told somewhat different, if complementary, stories. The opportunities to complement case study findings with survey findings and vice versa were fewer than expected. In particular, the opportunities to interrogate the survey data to test the central
case study finding that the most marked difference in role configuration was between care area, not nation, were limited.

Nevertheless, we can draw broad conclusions from this study about “integration”, what it means for “social care” roles and the support, training and career development needs of people who provide this care. These conclusions are the basis for recommendations for practice and further research.

6.1.2 Conclusions and discussion

Integration
In general our findings reflect a discussion in the literature about “integration” as a process of central drivers towards structural integration interacting with local dynamics of co-operation and lack of it (Peck E, Gulliver P, Towell D 2004, Glendinning et al 2004).

Our findings suggest that “integration” happens to a large extent from the “bottom-up” by services and professionals finding ways to work together in ways that are adapted to specific circumstances (Bell Kinder and Huby 2008). “Integration” means different things to different people, there are several ways to work in an “integrated” way and “integration” of care happens in practice, as staff and their clients go about their day-to-day work.

On the other hand, our findings further suggest that the form that “integration” takes is also determined by wider organisational dynamics (e.g. Hudson 2002, 2004). Of particular interest are our findings that:

- There was a lack of clarity within organisations about what constitutes an “integrated” service and lack of knowledge about what “integrated” services exist. This might suggest poor organisational capacity to support teams.

- An important factor that shapes practice “on the ground” is “governance” notably the way care management tools, such as assessment forms and CPA paperwork structure practice, demands for documentation in relation to performance management and the pressure to demonstrate that targets are met. These tools create a division between the management and the provision of care, which impacted differently in the two care areas we studied; care for older people and care for people with mental health problems because the circumstances of care for these two client groups were different
Configuration of roles
The way tasks are ascribed to “roles” is sometimes depicted as fixed things, which people hold on to in the face of change in ways or working. Roles are sometimes described as aligned with professional and occupational distinctions, so the tendency for staff to “cling to” these identities becomes a barrier to moves towards service integration (Hudson 2002).

We found however that:

• “Professional and occupational identity” was a malleable concept and on the whole respondents did not distinguish between “health care work” and “social care work”. Mutual recognition and understanding of capabilities people brought to the everyday work of providing care was the most important factor, which determined how people experienced their work in a team. Those who felt their skills and contribution to care were poorly understood or marginalised by others tended to emphasise their professional or occupational identity. These were often minority professionals, such as occupational therapists and physiotherapists.

• The quality of relationships in teams was more important than content and labels of roles for the way people worked together – or not.

• “Social care” is provided from several roles, including health care roles, but the way this happens varies across settings.

• The contours of a new role, namely “the skilled care professional” was apparent. This role was based on individuals’ personal portfolio of experience and training. This portfolio often included professional or vocational training as an important element, however the role was not defined by such training.

Training
Our findings reflect debates about skills, knowledge and competencies and how and by whom these are defined. Much work is undertaken centrally to map skills and competencies onto roles and to ensure that training for these competencies are developed (e.g Skills for Care 2009). Some (e.g Sheppard 1995) argue that the informal and local aspect of training and support have been marginalised in the context of a drive towards stronger management of care. Our findings provide a commentary on this debate and suggest that:

• The organisational change towards role reconfiguration and the process of learning the skills required to fill new roles are intertwined and cannot be prized apart.

• Professional and vocational training can be a foundation for learning ways of “integrated” working, but much of this “training” has to be undertaken informally on the job, learning and “picking up skills” from others. This learning is “non formal” (Eraut 2000) and implicit.
• Facilitating a local process of implicit learning is important because this process is tied up with idiosyncratic organisational change and role reconfiguration towards social care provision.

• Skills in team work are important not only for the quality of care delivered but also for the process of organisational change and individual learning. Team work skills are an important part of relationship building, which in turn facilitates the non formal aspect of learning as staff and users work together to problem solve, find new ways to provide services and build the skills needed.

• Feedback from the workshop further suggested that users of services should be part of team work.

Support
Social care policy emphasises improved governance, performance management and regulation to ensure quality and safety of practice. Current policy recognises leadership and management of commissioning and delivery of care as a key ingredient in successful workforce reconfiguration (Department of Health 2009). Our findings echo the importance of management in providing support to integrated working and the reconfiguration of roles to provide “social care”. Of interest is our findings that:

• Staff in teams consistently perceived “management” as an opaque and distant part of the organisation where decisions were made and which impacted negatively on work conditions, but over which staff have no control. However, people had a positive experience of team leaders and other managers, to whom they had a personal relationship.

• Team leaders may experience their work environment differently and more positively than staff and that they may feel more secure in their role. Team leaders may thus be a considerable resource in the facilitation of good conditions for collaborative working.

• Team leaders and managers are key in creating and protecting the flexibility and freedom which staff need to develop new practices and the skills required. They are also in a key position to mediate between strategic thinking and on the ground service transformation. A key role of team leaders and managers appears to be to simplify and translate strategic exigencies of an opaque and distant “management” into supporting and structuring relationships among staff and users.
The emphasis on relationships as a mediator of support, learning and workforce change places managers in a difficult position, as so much of the managerial tasks they are required to undertake are dis-embedded from personal relationships (Power 1999, Strathearn 2000). Development of team work and personal relationship in teams is an important management task (Dickinson and Glasby 2008). This is partly a matter of individual skills and aptitude, but also of the way the organisation facilitates this task in (re) embedding managerial functions in relationships.

6.2 Recommendations

Our conclusions revolve around the importance for development of social care of local service development and change, flexible learning and personal relationships within teams and between teams and the wider organisations of which they are a part. Our recommendations reflect these main concerns.

6.2.1 Recommendations for practice

Training

- Training is provided in building and managing relationships within teams to facilitate the iterative process of role reconfiguration, learning of skills and effective provision of care that is adapted to local conditions.
- Professional and vocational training emphasises skills required for ongoing learning and adaptation to a range of collaborative working models through practice.
- Flexible avenues of learning and career building are provided.
- Mechanisms are put in place to recognise and document changing skill sets. Portfolio based career progression is a mechanism.

Management and support

- In order to strengthen relationships between teams and their organisations, upper and middle level management should take time to visit and listen to staff, not only in formal consultation exercises but also informally.
- Managers' key role in translating and accommodating governance requirements to practice is recognised and supported so that relationships among staff and between staff and the people they help is recognised and protected.
- Team leaders' role is recognised and supported as crucial in facilitating relationships within teams.
Support for, and management of multidisciplinary teams need to be embedded in ongoing organisational learning and development

6.2.2 Recommendations for research

Our findings also raise questions, which have to be answered by further research:

- The meanings and variety of the term “integration” needs to be revisited in different contexts.
- Factors that work across health and social care organisations to impact on integrated working, for example governance mechanisms, need to be further investigated.
- Definitions and empirical examples of good teamwork need further exploration.
- Research, which explores users of services as partners in service delivery and planning is needed.
- The forms of training and learning that underpins teamwork and integrated working needs to be further explored.
- The management styles that lead to better teamwork need further research.
- Relationships between features of teamwork and service user outcomes need to be investigated. Quasi experiments may be needed to study this question.
7 References


British Medical Association, Health Policy & Economic Research Unit 2007 *Devolution and health policy: a map of divergence within the NHS*


Department of Health 2000 *The NHS Plan: a Plan for Investment, a Plan for Reform* London; Department of Health

Department of Health 2005a *Independence, Well-being and Choice* London; Department of Health

Department of Health 2005b *Health Reform in England; next steps* London; Department of Health

Department of Health 2006a *Our Health our Care Our Say* London; Department of Health

Department of Health 2006b *Options for Excellence: Building the social care workforce of the future*

Department of Health 2009 ‘Putting People First, Adult Social Care Workforce Strategy’ London: Department of Health


Drakeford M 2006 Health policy in Wales: ‘Making a difference in conditions of difficulty’ *Critical Social Policy*, 26; 543-56

Dunleavy P, Hood C, 1994 “From old public administration to new public management” *Public Money and Management* 14(2) 9-6


Glasby 2003 ‘Bringing down the Berlin Wall: the Health and Social Care Divide British Journal of Social Work 33; 969-973


Griffiths 1998 Community Care; an Agenda for Action. London: HMSO

Heenan D. Birrell D, 2006 The Integration of Health and Social Care: The Lessons from Northern Ireland Social Policy and Administration 40; 47 - 66


Huxley P, et al 2006 ‘Integration of social care staff with community mental health teams’ Project funded under the SDO Workforce Programme SDO/114


Nancarrow S et al 2005 ‘The impact of workforce flexibility on the costs and outcomes of older peoples’ services’ Project funded under the SDO Workforce Programme SDO/95


Peck E 1999 ‘Introduction to special section on community mental health teams Journal of Mental Health 8;215-216


Sanders T, Harrison S 2008 Professional legitimacy claims in the multidisciplinary workplace: the case of heart failure care Sociology of Health and Illness 30; 289 – 308

Scottish Executive 2003 Partnership for Care; Scotland’s Health White Paper

Scottish Executive 2005a Delivering for Health Edinburgh; Scottish Executive


Welsh Assembly Government 2005 Making the Connections Welsh Assembly Government


Welsh Assembly Government 2008 Proposals to change the Structure of NHS in Wales; consultation paper.

Woods KJ, 2001 ‘the development of integrated health care models in Scotland.1 International Journal of Integrated Care 1;1-5
Appendix A: Structured Feedback Form

Reconfiguration of social care roles in integrated care settings in England, Scotland and Wales

STRUCTURED FEEDBACK FORM

Oxford Research Ethics Committee reference number: 07/H0605/95

Instructions:
Below are groups of statements that we have generated on the basis of our findings. Please indicate how much you agree or disagree with each statement by ticking one response option on each line.

The statements are grouped into three sections. At the end of each section there is space for you to make further comment and/or suggest other issues that have not been covered by the statements.

Key terminology for this feedback form:
As you are probably all too aware, there is fast-changing terminology to match the ongoing changes in health service organisation. Furthermore, understandings of specific terms can vary by setting, application, profession and individual. This presents a considerable challenge for systematic and accurate collection of views/feedback. We have sought to keep these statements simple; nonetheless there are a few key terms which may require some clarification for the purposes of this feedback exercise:

“Team(s)”: Team refers specifically to a multidisciplinary team, usually consisting of both social and health care staff, which manage and/or deliver care for people living in the community with long-term conditions and/or assist with the transition of clients with long-term conditions between the hospital and community setting.

“Service(s)”: Service refers to a complex organisation dedicated to providing care to a defined client group (older people, people with mental health problems etc.).

“Social care work”: Social care work refers specifically to that work which enables and assists those living with debilitating long-term conditions to be active, independent, maintain/improve their health and participate in and contribute to society. Much of this takes the form of assisting with routine tasks which the client finds difficult to perform themselves: cleaning, cooking, grooming, shopping, exercising, using public transport, filling in forms and paperwork etc.

Skills and Training

<table>
<thead>
<tr>
<th>Agree strongly</th>
<th>Agree</th>
<th>Disagree strongly</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please tick one option for each statement

1. Key skills required by staff in teams can only be acquired through the experience of doing the job.

Skills and Training continued
<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Disagree strongly</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Staff <strong>new to practice</strong> in <strong>teams</strong> are often not prepared for the work they are required to do.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Accredited <strong>professional and/or vocational training</strong> does <strong>not</strong> equip staff in <strong>teams</strong> with the necessary skills to do the job.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Skills acquired <strong>through experience</strong> in working in <strong>teams</strong> need to be <strong>formally accredited</strong> to be properly valued within the <strong>service</strong>.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Skills necessary for <strong>effective practice</strong> in <strong>teams</strong> <strong>cannot</strong> be formally taught.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Staff in <strong>teams</strong> require a skill-set which encompasses <strong>both health and social care</strong> skills.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td><strong>Professional education</strong> provides staff with the <strong>core skills</strong> which are the basis for their contribution to the <strong>team</strong>.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Regular in-service <strong>skills updates</strong> for staff in <strong>teams</strong> are necessary to maintain quality of service provision.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td><strong>Social care work</strong> requires <strong>specialised training</strong>.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>It takes a <strong>special kind of person</strong> to do <strong>social care work</strong>.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Please tick one option for each statement*
Have you any additional comments regarding skills and training?

Teamwork and Support

1. Staff working in teams benefit from the support of those with the same professional background.
   a. to provide better client care. ................................
   b. to feel happier in the job. ....................................
   c. to enable their professional development. ..

2. Staff working in teams benefit from the support of those working with the same client group.
   a. to provide better client care. ..............................
   b. to feel happier in the job. .................................
   c. to enable their professional development. ..

3. Staff working in teams benefit from supervision by those with the same professional background.
   a. to provide better client care. ..............................
b. to feel happier in the job. 

\[\text{\ldots\ldots\ldots\ldots}\]

c. to enable their professional development. 

\[\text{\ldots\ldots}\]

4. Staff working in teams benefit from supervision by those working with the same client group, 

a. to provide better client care. 

\[\text{\ldots\ldots}\]

b. to feel happier in the job. 

\[\text{\ldots\ldots}\]

c. to enable their professional development. 

\[\text{\ldots\ldots}\]

5. Time and resource for team-building are important to develop good practice in teams. 

\[\text{\ldots\ldots}\]

6. Team-building exercises are not cost-effective in terms of the quality of service provision. 

\[\text{\ldots\ldots}\]

7. Training in team-building skills for team-leaders would, 

a. improve the service provided by the team. 

\[\text{\ldots\ldots}\]

b. increase the retention of staff in the team. 

\[\text{\ldots\ldots}\]

c. enhance the job satisfaction of team-members 

\[\text{\ldots\ldots}\]

8. Training in team-building skills for all staff-members in a team would, 

a. improve the service provided by the team. 

\[\text{\ldots\ldots}\]

b. increase retention of staff in the team. 

\[\text{\ldots\ldots}\]

c. enhance the job satisfaction of staff. 

\[\text{\ldots\ldots}\]

d. improve recruitment of service staff. 

\[\text{\ldots\ldots}\]

9. Sharing a common base (offices, a building etc.) is important for the development of good 

\[\text{\ldots\ldots}\]
working relations in a team.

10. Experienced staff in a team require little advice or direction.

Have you any additional comments regarding teamwork and support?

Management and Bureaucracy

Please tick one option for each statement

1. **Performance targets** are necessary to ensure a cost-effective service.

2. **Performance targets** improve the quality of care in a service.
**Management and Bureaucracy continued**

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Agree strongly</th>
<th>Disagree</th>
<th>Disagree strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. <strong>Measures of performance</strong> do not relate to the real work of providing care within services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The performance of individual staff members should be assessed according to <strong>standardised performance targets</strong>.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. <strong>Decisions about the delivery of care</strong> are best made by practitioners <strong>directly involved</strong> in the provision of that care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. <strong>Only</strong> staff with <strong>professional qualifications</strong> should be making decisions concerning patient care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Staff with <strong>professional qualifications</strong> should <strong>not</strong> spend time doing <strong>simple social care tasks</strong> (helping with cooking, cleaning, shopping etc.).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. <strong>Standardised procedures</strong> ensure a high quality of care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. <strong>Standardised procedures cannot</strong> be applied to much of a team’s work, due to the nature of the client group and their situation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. <strong>Effective care</strong> depends on a good relationship between the <strong>individual</strong> carer and client.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Have you any additional comments regarding management and bureaucracy?**
Information about you

What is your discipline/profession or vocation? ______________________

Have you ever worked in multidisciplinary health/social care teams?

Yes  No  please circle one

If no, please skip to the end

If ‘Yes’, please answer the following question:

Are you currently working in a multidisciplinary health/social team?

Yes  No  please circle one

If no, please skip to the end

If ‘Yes’, please answer the following questions:

1. What client group does your team care for? People with Mental Health Problems/Older People/Other please specify:

2. What is your role in the team? (e.g. Support worker/ Nurse/CPN/Social Worker/Occupational Therapist/ Care-manager/ Clinician/ Psychologist/ Physiotherapist etc.):

3. What is the area covered by team? (eg. largely urban, largely rural, mixed etc.):

4. Years working in current team: ______ years

The End

Thank you for taking the time to complete this.

Please post in the freepost envelope provided to:
Appendix B: Workshop Summary

OUTCOMES from the WORKSHOP

To discuss the implications and develop recommendations from research concerning the reconfiguration of social care roles in integrated care settings in England, Scotland and Wales

BACKGROUND

Our study, “supporting the reconfiguration of social care roles in integrated care settings in the UK”, has been funded by the Department of Health with view to achieving a better understanding of:

1. How “social care roles” are a) defined and enacted in “integrated care settings” and b) shaped by the different policy cultures of England, Scotland and Wales;
2. Ways in which those doing social care work in integrated care settings can be better supported and trained to do this work.

The workshop, held on February the 26th in London, was the fifth and final phase of the research. It brought together community team staff members, managers, trainers, service-users and policy-makers from across the UK to discuss the implications of our findings to date and how these findings may be applied in real and meaningful ways to improve service provision in multidisciplinary health and social care settings.

PARTICIPANTS

Kevin Barker
Gemma Bathurst
Terry Beresford
Tony Beresford
Debra Chand
Faith Chowney
John Harries
Morag Halliday
Guro Huby
Peter Huxley
Glyn Jones
Eileen Laurie
Ann Lewis
Shelia Lockhart
Mike Marshall
Mary Nettle
Sarah Nunn
Gail McCracken
John Peardon
Alison Petch
Charles Sargent
Frances Thielen
Lorraine Vaughan
John Wallace
Pamela Warner
Adam Woolfenden

PROGRAMME

INTRODUCING THE STUDY and some key findings

GROUP WORK: implications of findings

PLENARY DISCUSSION of implications for action

GROUP WORK: how to implement action

* Please see accompanying documents for a copy of the presentation and a summary of the findings.

The WORKSHOP

The structure of day-long workshop aimed to facilitate an open and wide ranging discussion of the implications and applications of this research.

Three working groups were create, each comprising people with diverse “stakes” in the provision of integrated services.

The morning groups’ work, addressing the implications of our findings was followed by a plenary discussion. On the basis of this discussion we developed the foci for the afternoon discussions concerning how to implement action and improve services.
GROUP 1

Summary of main points

Care:
- Skilled practitioners work with a mixture of common sense, generic skills, with an element of specialism.
- They emphasise the continuity of care.
- This is difficult because organisation of care is becoming increasingly complex, with necessary skills spread thinly over several services.

Skills:
- There is a mix between generic and specialist skills in one team.
- Skill co-ordination is important because of the complexity of services.

Management:
- Shifts away from a health-driven management and policy.
- Emphasises integration not just between health and social care but also between other services.
- Works to simplify language around integration.

Please Note:
The discussions during the workshop were complex and wide-ranging. The authors of the summary have attempted to distil the main themes and points that emerged from these discussions. In so doing some of the complexity and nuance has inevitably been lost. The opinions and ideas expressed in the summary are not those of any single participant, nor should they be thought to reflect the opinions and ideas of any single participant.

GROUP 2

Summary of main points

Care:
- Concern with alienation care managers from the clients being cared for (too many forms, less time with clients).
- Emphasis on a flexible, person-centred, approach to care; less concern with boundary-marking.

Skills:
- Recognition of the importance of managerial skills.

Management:
- Need to improve integration at the managerial and structural level (budgets, provisioning of training etc.).
- Recognition that resources (or lack thereof) are one of the main drivers shaping services.
- Importance of peer support and a requirement to create effective peer support structures for staff and service users.

GROUP T3

Summary of main points

Care:
- Starting from a common assessment process and a common value base that transcends professional boundaries.
- Recognising that care is “processual”, that is a process in which the client is an active and engaged participant.
- Adopting a flexible and commonsensical approach to care.

Skills:
- Balancing the requirements for specialised skills and a flexible approach to working.

Management:
- Concern with a lack of integration at the managerial level.
- Need for the integration of service-users into the decision making process at all levels.
GROUP 1: the language of care roles and relationships

Problem
There has been a proliferation of terms describing roles, processes and organisational entities, much of which has been driven by national policies and associated auditing procedures. This language has the effect of confusing staff and clients and making the care process more rigid. There needs to be a simple language of roles and relationships that is shared equally by all those involved in the care.

Solutions
- Training in communication and clear use of language, both vocational and on the job.
- Users should be involved, in co-operation with staff, in the design of assessment forms.
- There is a general need to develop systems of computer technology and admin support to ease the work of audit driven form-filling, so that care practitioners can focus on the provision of a flexible, person-centred care.

GROUP 2: Training needs in changing services

Problem
The organisational reality of rapidly changing service structures and the increased blurring of traditional occupational distinctions raises questions about how best to train a workforce so that they have the skills required to in integrated teams caring for older people or people with mental health problems.

Solutions:
- Improved structures of peer support both for staff and service users, and training for peers so they can be effective in their role.
- Develop and communicate a common value base that is shared across professions.
- Recognise the importance of specialist skills (acquired through professional training or otherwise) and ensure that these skills are not “lost” in the move towards generic ways of working.

GROUP 3: The organisational implications of personalisation agendas

Problem
Organisational structures often seem to be a barrier to the development of processual ways of working that not only successfully integrate the efforts of the various groups involved in the care process, but ensure the full and active involvement of the individual service user in care management and delivery.

Solutions
- The creation of local management groups that are truly inclusive of staff and service-users and have a real, active and transparent role in shaping the implementation of national policy at a local level.
- Training in the ways in which committees work and how to effectively participate in the committee process.
- Mechanisms to ensure that those representing staff and user groups are truly representative, thereby moving beyond tokenism and towards an open and democratised managerial process.
BRINGING IT ALTOGETHER: SUMMING UP and MOVING FORWARD

A workshop is designed to facilitate discussion between stakeholders around a specific topic, in this case social care roles in integrated services, in a way that is both focussed and open-ended. Such a discussion inevitably goes in unanticipated directions and encompasses a multiplicity of issues that are of more general concern, albeit often framed in the much more specific concerns and experiences of the individual participants. This kind of discussion has the potential to propose new understandings and novel solutions/actions. This is particularly the case for complex topics, such as social care roles in integrated services.

However, a workshop such as this cannot yield concrete and specific recommendations in a form that can be taken-up and implemented within a given service. Nevertheless it did achieve a broad consensus concerning what the main issues shaping the work of integrated services are and how we should move forward in addressing them.

Amongst the KEY ISSUES identified were:

- The pace of change and with the proliferation of organisational forms.
- The opaque and often confusing language used to describe roles, services and managerial structures.
- The proliferation of processes of auditing and assessment that seem disconnected from the realities of service provision and what service-users want and need.
- The importance of structural integration and in particular the integration of funding streams and IT systems, which would facilitate the better integration of services “on the ground”.

The groups also proposed the following ACTIONS that they judged could enable progress in addressing these issues:

1. Promoting role flexibility whilst maintaining specialist skills (which are often, though not exclusively, acquired through professional training).
2. Integrating “care management” and the doing of care, both at the level of individual practice and, in particular, at the team and service levels.
3. Democratising the decision-making processes at all levels, in particular, effective mechanisms need to be established to ensure real service user involvement.
4. Increasing training opportunities in the “soft” skills of team-working, inclusive practice and effective management so as to ensure effective and productive working relationships.

Thanks to:
Alison Petch, RIPFA, who chaired the plenary discussions.

Report Prepared by:
John Harries¹
Guro Huby¹
Pamela Warner²
Lorraine Vaughan²

¹ School of Health in Social Science, The University of Edinburgh
² Centre for Population Health Sciences, The University of Edinburgh

To comment or ask for additional information please contact Guro Huby: guro.huby@ed.ac.uk