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IRISS
Institute for Research and Innovation in Social Services

Delivering integrated care and support

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FOREWORD

This document is the second review of research evidence completed for ADSW by Professor Alison Petch from the Institute for Research and Innovation in Social Services on the factors that underpin best health and social care integrated practice.

The original document, *'An Evidence Base for the Delivery of Adult Services'*, published in 2011, presented the evidence for considering factors **beyond** those of structural change when planning to improve integrated outcomes for individuals. This latest report, *'Delivering Integrated Care and Support'*, further adds to the knowledge base by focusing on the key dimensions for effective implementation of change.

With the advent of the Public Bodies (Joint Working)(Scotland) Bill and the anticipated Act, social care and health professionals across Scotland are working hard to re-organise services and support within a context of limited resources and growing demand. The health and social care policy landscape — complex at the best of times — presents particular challenges for professionals at the moment, with parallel legislation anticipated in the field of self directed support. This legislation will place additional responsibilities on social care staff that are not matched with equal demands on health colleagues. Therefore, within that context, it is now more important than ever that negotiations across sectors and with individuals are informed by research evidence.

Best research knowledge will assist staff in navigating a more direct and productive way through this challenging landscape. We must apply this knowledge in planning and practice activities if we are to make informed changes in the most efficient manner. At the heart of our ambitions is to improve outcomes for individuals. This must remain the starting, finishing and reference point in all our professional activities.

I commend this work to you — a road map for the elements that should be afforded priority in your change activities — and hope that it is of great benefit in assisting in the delivery of best integrated services in your area.

Sandy Riddell

Sandy Riddell
President of ADSW

INTRODUCTION

Integration of health and social care has been a longstanding feature of the policy agenda in Scotland, as elsewhere in the UK. In the period since the Joint Future Report of 2000, the number and range of initiatives concerned to deliver more effective support across health and social care boundaries has accelerated. Key triggers have been the drive to reduce the number of people experiencing unnecessary admission to or delayed discharge from hospital and the desire to support individuals effectively in their own homes. The Reshaping Care for Older People programme, supported by the Joint Improvement Team, has provided a major focus for the integration agenda.

This report has been produced at a time when the Public Bodies (Joint Working) (Scotland) Bill[1] is going through the legislative process. The Bill itself follows a period of consultation on the draft proposals published in May 2012[2] and the response of Scottish Government to the issues raised during the consultation[3]. The aim of this document is not however to look at the detail of the specific proposals in the Bill; rather it seeks to distil from the research evidence key findings to assist health and social care partnerships in Scotland in their delivery of integrated care and support. Reference will be made as appropriate to the Bill and associated policy memorandum, but the focus is on highlighting the key dimensions for implementation and their associated actions irrespective of the detail of legislation or governance.

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1   http://www.scottish.parliament.uk/S4_Bills/Public%20Bodies%20(Joint%20Working)%20(Scotland)%20Bill/b32s4-introd.pdf
2   http://www.scotland.gov.uk/Resource/0039/00392579.pdf
3   http://www.scotland.gov.uk/Resource/0041/00414332.pdf

> '… the Scottish Government is clear that legislation alone will not achieve the scale of improvement that is required in order to address the challenges of demographic change and fiscal constraint'
> (para 14 Policy Memorandum for Public Bodies (Joint Working) (Scotland) Bill)

> 'Whatever the type, breadth or degree of integration aimed at, the challenge is often the implementation in practice. However, the process of integration in itself is also described as multifaceted in nature, requiring the integration of structures, processes, cultures and social relationships.'
> (Minkman, 2012)

Our previous review[4] of the evidence base for the delivery of integrated adult health and care services (Petch, 2011, undertaken for ADSW), confirmed that structural change by itself does not deliver the improved outcomes sought for service users and communities, unless equal or greater attention is paid to a range of other key factors. The King's Fund has published similar conclusions (Ham and Walsh, 2013; Ham et al, 2013). Summarising the lessons for England from the recent study on *Integrated care in Northern Ireland, Scotland and Wales*, Ham and colleagues concluded:

> An important lesson from this report is that structural integration within the NHS or between health and social care is only one factor among many in facilitating the development of integrated care… It is clear that structural integration in itself may bring few if any benefits unless it is accompanied by other changes. (p80)

It is clear from the Policy Memorandum published by the Scottish Government alongside the Public Bodies (Joint Working) (Scotland) Bill, that these arguments are widely accepted in Scotland:

> As the Scottish Government developed these proposals, considered the evidence regarding improving outcomes for people using health and social care services, and consulted partner organisations and stakeholders on priorities for integration, the conclusion was reached that reform based on centrally-directed structural change would be unlikely to deliver the shift in outcomes required. Available evidence suggests particularly that structural change per se is not a prerequisite for achieving better outcomes, though it can be helpful where local leadership for change is strong and consistent.
> (Policy Memorandum, paragraph 157)

The other factors necessary for effective integration can be grouped using the categories in the diagram below which summarises the conclusions from the earlier evidence review.

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4   The review findings are summarised in Integration of health and social care, IRISS Insights No 14 http://www.iriss.org.uk/sites/default/files/iriss-insight-14.pdf

This guide will report on the evidence relating to these key dimensions, seeking to assist local partnerships to build capacity for improving outcomes as they move forward on integration. It should be recognised that many of the dimensions are inter-related. Those seeking to deliver successful integration have to chart a path which both draws on successful examples from elsewhere and adapts to the specific local context.

This review seeks to provide some signposts along that path which should be equally applicable whether the approach adopted be the 'body corporate' or lead agency model, as set out in the Bill and associated Policy Memorandum[5].

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5 'The Bill provides for two options for integrating budgets and functions. First, delegation to an integration joint board established as a body corporate - in this case the Health Board and the local authority agree the amount of resources to be committed by each partner for the delivery of services to support the functions delegated. Second, delegation between partners. In this case the Health Board and/or local authority delegates functions and the corresponding amount of resource, to the other partner'. Policy Memorandum, paragraph 53

OUTCOMES

'Integration is not an end in itself — it will only improve the experience of people using services when partner organisations work together to ensure that services are being integrated as an effective means for achieving better outcomes.

Nationally agreed outcomes for health and social care will employ measures that enable local and national partners to understand success at local level in terms of shifting the balance of care towards support provided within the community for people with complex support needs.

The underlying principle, of key importance in the Bill, is that Health Boards and local authorities must take joint and equal responsibility for the delivery of nationally agreed outcomes for health and wellbeing.
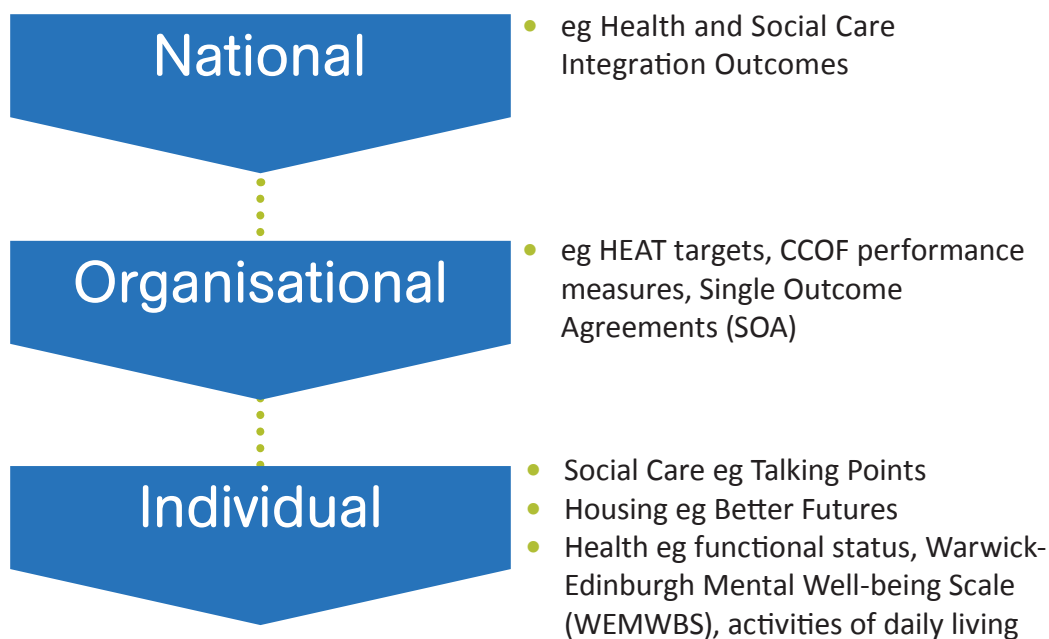
The Scottish Government is committed to an outcomes based approach to planning and delivery of public services.'
(Scottish Government: Policy Memorandum, paragraphs 5, 19, 54 and 68)

'The Scottish Ministers may by regulations prescribe outcomes in relation to health and wellbeing. Such outcomes are to be known as 'the national health and wellbeing outcomes.'
(Public Bodies (Joint Working)(Scotland) Bill, sections 5(1) and (2))

Discussion of outcomes and of outcomes-focused approaches has come to the fore over the last decade. As with the term 'integration' in the past, however, there is the tendency to compound different meanings and the potential therefore for people to be talking at cross purposes. Most particularly there is the need to distinguish individual (personal) outcomes from service or agency outcomes, and local from national outcomes. The following diagram is taken from the IRISS guide on Leading for Outcomes: Integrated working and seeks to clarify this distinction (IRISS, 2013).

National
- eg Health and Social Care Integration Outcomes

Organisational
- eg HEAT targets, CCOF performance measures, Single Outcome Agreements (SOA)

Individual
- Social Care eg Talking Points
- Housing eg Better Futures
- Health eg functional status, Warwick-Edinburgh Mental Well-being Scale (WEMWBS), activities of daily living

The suite of outcome measures proposed for Health and Social Care Integration (detailed below) shows a significant shift from the past tendency to see outputs and performance measures masquerading as outcomes. Put crudely the focus is not on delayed discharge or bed occupancy figures per se but on delivering positive experiences for the individual and ensuring quality of life.

- **Healthier living:** Individuals and communities are able and motivated to look after and improve their health and wellbeing, resulting in more people living in good health for longer, with reduced health inequalities
- **Independent living:** People with disabilities, long term conditions or who become frail are able to live as safely and independently as possible in the community, and have control over their care and support
- **Positive experiences and outcomes:** People have positive experiences of health, social care and support services, which help to maintain or improve their quality of life
- **Carers are supported:** People who provide unpaid care to others are supported and able to maintain their own health and wellbeing
- **People are safe:** People using health, social care and support services are safe-guarded from harm and have their dignity and human rights respected
- **Engaged workforce:** People who work in health and social care services are positive about their role and supported to improve the care and treatment they provide
- **Effective resource use:** The most effective use is made of resources across health and social care services, avoiding waste and unnecessary variation[6]

The Scottish Government's consultation paper stressed (3.2) that 'The underlying principle of these proposals is to provide national leadership in relation to *what* is required — the outcomes that must be delivered — and to leave to local determination *how* best to achieve those outcomes — the delivery mechanisms that will best suit different local needs'. From the perspective of the evidence this is to be welcomed; the challenge for partnerships is to maintain this focus rather than be dragged into preoccupation with the detail of governance and structures.

Both Beresford and Branfield (2006) and National Voices (2011) argue the case for integrated working to deliver the outcomes that are important to individuals. This recognises that much of earlier discussion of partnership working has focused on the process of working together rather than on the impact on individuals accessing support (Dowling et al, 2004). In Scotland the development of Talking Points has generated considerable discussion and exploration of outcomes at the individual level (Miller, 2011; Cook and Miller, 2012; IRISS, 2012a; Miller and Daly, 2013). To date this discussion tends to have been led by social care; the challenge of leading a personal outcomes approach in integrated working is explored in *Leading for Outcomes* (IRISS, 2013). The cycle needs to move from outcomes-focused assessment, planning and review with the individual, to aggregation of outcomes across individuals, to outcomes-based commissioning.

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6 Scottish Government (2012) Integration of Adult Health and Social Care in Scotland: Consultation on Proposals, p41

There is particularly close interaction between the dimensions of vision, outcomes and leadership. Outcomes should form a major component of the vision; likewise strong leadership is required to transform the focus from one on inputs and outputs to the more challenging outcomes. The evidence suggests that there is a direct correlation between leadership and positive outcomes (Bogg, 2011).

Delivery on the dimension of outcomes requires:

- Commitment to the achievement of personal outcomes
- Understanding of the different layers of outcomes
- Adoption of a holistic perspective embracing health, social care, and housing outcomes
- Ability to identify outcomes of different types and to distinguish them from outputs
- Willingness to negotiate across different professional priorities in respect of outcomes
- Demonstration of the differences that have been made in terms of outcomes

VISION

'In order to be effective a vision has to be backed by a strong and committed senior leadership team who are willing to be 'open, honest and flexible' in their dealings with staff, partners and the local community. Evidence of the support of elected members is also useful.'
(Miller, Dickinson and Glasby, 2011)

Those who embark on the delivery of integrated care and support need to be led by a vision; there needs to be a sense of purpose and a logic for required action and change. Integration cannot be an end in itself; it must be for a purpose. As demonstrated through the evidence review (Petch, 2011; IRISS, 2012b), successful delivery of integrated care and support requires a commitment to and a belief in a goal to be achieved. Those working to a vision need to be proactive rather than reactive and, as detailed below, leadership is required to achieve the vision. The vision needs to be communicated, shared, reinforced and embedded.

The experience of Torbay as an early adopter of integrated working has been widely reported (Thistlethwaite, 2011); their driver of 'getting it right for Mrs Smith' provided the enduring vision placed at the heart of the transformation.

Mrs Smith is a fictitious woman in her eighties with a range of long-term health and social care problems for which she needs care and support. She encounters daily difficulties in navigating the health and social care system. Her problems include her many separate assessments, having to repeat her story to many people, delays in care due to the poor transmission of information, and bewilderment at the sheer complexity of the system.

The familiarity with the mantra of 'getting it right for Mrs Smith' indicates the success with which it became the vision to unite the activities of the different professional groups.

In their study of the development of integrated care in Trafford, Shaw and Levenson (2011) describe how the identification of founding principles underpinning the agreed vision helped to ensure that the focus was maintained, providing an 'acid test' for any revisions. The principles adopted in Trafford were very much from a health perspective:

- 'Nothing about me, without me' — the patient voice must be at the heart of all provision
- General practice should be the 'locus of integrated services'
- Specialist expertise is an essential component of effective integrated services
- The delivery of integrated services will rest primarily on extended roles for nurses and AHPs
- Integrated services must incorporate social care
- Future integrated services should bring together the full range of primary care services

Some of this language would not suit the development of integration in Scotland, where partnerships will wish to agree joint principles within a vision of integration that is based on health and social care as equal partners.

Maintaining fidelity to the vision is essential to avoid drift. Generally, a vision works best when it is developed in partnership with the range of stakeholders in the local community and can be articulated both at strategic level and to frontline staff.

Delivery on the dimension of vision requires:

- A vision that can be operationalised in a set of aspirational but achievable goals
- A vision that has at its core the delivery of outcomes for the individual
- Consistent communication of the vision to a wide range of stakeholders
- Demonstration of 'quick wins' to maintain buy-in

LEADERSHIP

'Leadership is key locally and nationally, to achieve the changes in working practices, culture and behaviour that are required.' (para 14 Policy Memorandum for Public Bodies (Joint Working) (Scotland) Bill)

'Transformational leadership styles, which encourage engagement by followers, and ownership of the process have the potential to create more positive outcomes and higher satisfaction levels than other approaches.' (Bogg, 2011:41)

It has become commonplace to emphasise the importance of leadership for the delivery of integrated care and support: 'in times of organisational transition... transformational leadership takes a central role in setting the vision and the outline of the organization for the future' (Dickinson et al, 2007). Leadership is more than management; it suggests a capacity to inspire, motivate and engage, to challenge embedded preconceptions and power dynamics and to negotiate competing understandings and agendas. The value of good relationships between key leaders should not be underestimated. In the case of Knowsley, where service integration has been achieved without structural change, the Council leader and PCT chair have been described as 'joined at the hip' (Ham and Oldham, 2009:6); moreover the PCT Chief Executive, originally from a local government background, was appointed also as a Council executive director.

It is important however to get beyond these headlines and examine more closely what effective leadership for integration might look like, and how the exhortations for leadership can be achieved in practice. A significant omission from the initial integration proposals in Scotland was discussion of how to achieve the leadership (at all levels) for integrated care and support that evidence suggests is key — as for example in the Knowsley experience where the two leaders worked closely together in developing integrated governance structures and the Joint Chief Executive facilitated the development of fully integrated arrangements at all levels.

The Public Bodies (Joint Working) (Scotland) Bill requires partnerships that adopt a 'body corporate' model of integration to appoint a chief officer (previously referred to as the 'Jointly Accountable Office' in the Scottish Government's consultation paper). The chief officer:

... will be jointly accountable, through the board, to the constituent Health Board and local authorities, and responsible for the management of the integrated budget and the delivery of services for the area of the integration plan. The chief officer will also lead the development and delivery of the strategic plan for the joint board. (Policy Memorandum, para 53)

This suggests there will need to be an element of distributed leadership at the top across the major players, together with the collaboration essential to achieve a common agenda.

Traditional notions of 'heroic leadership' as dynamic, decisive, authoritarian and competitive are not well suited to the environment of integrated care and support. Increasingly it has been recognised that the complex world of integrated working requires a different approach. This requires sophisticated skills of negotiation and consultation to enable collaborative agreement on the direction to be taken and to foster collective decision-making. Leaders need to be supportive of innovation, have an awareness and understanding of the complexity of integrated working, and need to be alert to the perspectives of all the different stakeholders involved. These new models of leadership have moved away from a focus on the 'heroic individual' to a more inclusive and organic approach. This has led to models of leadership based not only on the individual qualities of the leader but on how they enable the whole system to support innovation and work together as a team.

Transformational or dispersed leadership is characterised by a desire to create a sense of collective identity and ownership. Through acting as a role model, leaders seek to enhance people's motivation, morale and performance. Such an approach to leadership is designed to steer the development and delivery of a vision, to empower users and staff, to foster a strengths-based approach, to support positive risk taking, to encourage staff to reflect and challenge, and to encourage creativity. It requires a clear accountability framework, transparent governance, robust supervision, acknowledgement of the range of skills and experience in the workforce, and targeted professional development (Bogg, 2011).

Effective leaders are usually characterised by their sustained long-term commitment, enthusiasm and involvement in integrated care locally, and trust and respect given by their peers that has built up over time. Leaders for integrated care and support need to embrace change and take the initiative rather than adopting a fortress mentality focusing on their own organisations. Leaders need the skills and strategies necessary to understand, influence and lead the local agenda in the design, commissioning and delivery of integrated care and support. The range of roles that needs to be embraced includes:

- Identifying and demonstrating the core values and purpose that underpin approaches to integration
- Building common vision and goals between care partners
- Engaging professionals, developing good relationships, and building commitment, understanding and a shared culture
- Maintaining a clear vision communicating this clearly to staff and users
- Driving quality improvements, for example through benchmarking performance and peer-review

Shaw and Levenson's (2011) case study of Trafford shows that visionary leaders able to paint the broader picture were required from the beginning of the integration journey. Later, as implementation progressed, leadership focused on the detailed management of this implementation became more critical. 'Such leaders have been vital in persuading colleagues to change their practice, creating a more favourable climate for change, and adapting plans in the light of new developments' (p21). A locally tailored leadership programme was developed, facilitating different skills for different stages of delivery.

Likewise, a recent study by Williams (2012) based on a case study in South Wales highlights four components of leadership considered key to facilitating integrated delivery: promoting common purpose; developing a collaborative culture; facilitating multidisciplinary teamwork; and developing learning and knowledge management strategies. It is the realisation of these components that will advance integrated working and, as for other of the dimensions in the figure on page 3 above, it is the ability to achieve these locally in response to the particularities of the locality that will determine the extent to which the ambitions of integrated care and support are delivered.

A study by the Work Foundation for the National Skills Academy (2011) identified a style of leadership common to the highest performing leaders in the private sector, one that engaged and enabled people to achieve beyond what they thought possible.

Interviews with social care leaders identified much in common with private sector leaders; in addition there were a number of distinctive features: a vision which extends beyond their own organisation; a passion for making a difference; and a strong desire to inspire others with this passion. Leaders in social care were judged to be more externally focused, with a greater recognition of the need to collaborate and a greater appreciation of the need for transformational change.

An important role in the context of integrated working is what has been termed the 'boundary spanner' (Williams, 2002; 2011), key individuals who have a pivotal role across organisational boundaries. A range of different elements of this role can be distinguished:

- The leader, using skills such as brokerage, facilitation, negotiation, co-ordinated project management and cross-fertilisation
- The entrepreneur and innovator, making things happen through creative thinking
- The interpreter/communicator, able to understand the perspectives of multiple partners and developing trust between them
- The 'reticulist' making connections, skilled in bringing people together across boundaries and using interpersonal skills and effective networking in negotiation

It is generally acknowledged that certain personality types and personal attributes are prerequisite for the role — 'personable, respectful, reliable, tolerant, diplomatic, caring and committed'. Moreover the challenges inherent in the role are acknowledged, with the need to manage ambiguity and tension.

In summary, Reed (2004:159), echoed by Lunts (2012), suggests that leadership for integrated care and support needs to:

- Be person-centred
- Be broad rather than narrow in its scope (including the wider system of provision and setting long-term rather than short-term goals)
- Be inclusive to all members, partners and customers across the system of services
- Take place at all levels of the system, from service delivery to service management
- Negotiate shared visions and goals across the system
- Have impact across the system
- Be shared between key people across the system — 'leadership' is not just one person
- Motivate staff in organisations to be reflective and committed followers of new collaborative goals

Delivery on the dimension of leadership requires:

- Commitment and belief in a shared vision
- A focus on delivery on individual and organisational outcomes
- An ability to look outward and to transcend professional identities
- An ability to inspire and engage followers across the partnership
- Support for creativity and positive risk-taking
- Promotion of leadership at different levels across the partnership
- Identification and nurturing of boundary spanners

CULTURE

'Supporting partnerships to understand and build the conditions for change and improvement will be necessary for sustained success in delivering better outcomes for people and communities… This shared endeavour will be necessary to support the culture change that will be required to underpin greater multidisciplinary and multi-agency joint working and to reflect the move towards a greater community focus for service planning and delivery.' (Explanatory Notes to the Bill, paragraph 53)

'You know you've cracked it when there's only one kettle in the kitchen'. (Sullivan and Williams, 2012)

Much of the achievement of integrated care and support is dependent on successful culture change. Both professions and organisations are likely to have developed particular cultures which help to shape their identity and foster allegiance. Over time, as an individual settles into their role, they are likely to acquire tacit knowledge and implicit ways of working that both derive from and help to bolster this cultural identity. The strengths of such identity can become problematic when individuals and organisations are seeking to work more closely together. A new cultural identity needs to be fostered which transcends the traits of particular professions or individuals and provides the most effective basis for the delivery of integrated provision and the achievement of organisational and individual outcomes. Williams (2012) argues that the transfer of tacit knowledge between professional groups — which should be interpreted as all staff groups — is key to integration.

Reference to 'culture' is a common feature of discussion of integrated working. It reflects a sense of shared values, beliefs and assumptions, the essence of 'how we do things around here' (IRISS, 2012c). Some decades ago, Meyerson and Martin (1987) distinguished three different ways of understanding culture. The *integration model* suggests that culture is something an organisation *has*, a force that holds the organisation together. The *difference model* on the other hand identifies culture as more pluralistic, allowing different interest groups and cultures within an organisation. Finally, the *ambiguity model* defines culture as more local and personal, constantly changing over time and between groups. This idea of ongoing cultural creation connects with an interpretation of culture as something an organisation *is*, recognising the role of those who are part of the organisation in both shaping and changing that culture (Peck and Dickinson, 2009).

Schein suggested that there are three sources of culture. These are: the beliefs, values and assumptions of the founders of the organisation; the learning experiences of group members as the organisation evolves; and the fresh beliefs, values and assumptions brought in by new members (Dickinson et al, 2007). Moreover Schein identified culture as having three layers — cultural artefacts eg dress codes; espoused values eg mission statements; and basic assumptions eg ways to behave. All three of these dimensions are relevant to the cultural change necessary for effective health and social care integration, with a particular need not to overlook the detail of the everyday encounter in the workplace.

Sullivan and Williams (2012) add an interesting perspective through a discussion of the role of 'objects' as a feature of meditation and management at the boundaries of organisations, exemplified from health and social care organisations in Wales. Such objects can be either tangible and visible (the kettle mentioned in the opening quote above or an IT system) or intangible and invisible, for example concepts such as 'assessment' or language such as 'vulnerable'. In moving towards integration the challenge is to ensure that such objects begin to span the boundaries and their use becomes shared.

The development of integrated care and support requires an acknowledgement of the need for cultural change. Seeking to retain existing cultures inevitably leads to a fight for dominance and a concern that the culture of one or other of the partners in the collaboration will win out. The drive to deliver integrated care and support should lead to the emergence of a new cultural identity, one committed to the integrated working agenda. The notion of organisational 'sense making' is introduced by Dickinson et al (2007) in their discussion of the ways in which culture can be both an aspiration and a barrier for partnership working. This suggests that people create their understandings of organisations from their interpretations of what they see and experience rather than from structures or systems. Organisational goals and strategies, for example, are not 'things' out there but reflect people's ways of thinking; during transition and change this understanding needs to be challenged and a new narrative created.

From their case study of the establishment of a Care Trust, Dickinson and her colleagues suggest that in the attempt to keep the best of both existing cultures, to maintain familiarity and avoid 'rocking the boat', the opportunity for innovation may have been stifled. Consensus was seen as important and an element of 'collaborative inertia' ensued. The opportunity to engage with wider partners, for example the third sector, was also missed.

Peck et al (2001) explored in detail the role of culture in the development of the Health and Social Care Trust in Somerset and in particular the different interpretations attached to the term by different stakeholders. Their interviews revealed elements of all three models of the framework developed by Meyerson and Martin (1987), discussed earlier in this section, and suggested that the term 'culture' was being interpreted in diverse ways. Managers tended to assume an integration model of culture, professional groups focused on difference, while locality staff spoke of considerable re-negotiation of culture, consistent with the ambiguity model. Peck and his colleagues highlight a question critical to the discussion of culture change and the development of integrated care and support:

> Is the desired result one entirely new culture, albeit comprised of elements taken from all the current professional cultures — the melting pot approach to culture? Or is the desired result the enhancement of the current professional cultures by the addition of mutual understanding and respect — the orange juice with added vitamin 'c' approach to culture? (p325)

They also illustrate the extent to which culture is maintained and revealed through language, images and themes, through the pattern of interactions, and in the rituals of daily routines.

The CARMEN project (Care and Management of Services for Older People in Europe Network) usefully identifies objectives for cultural change in integrated care to support older people (Defever, 2004:144):

- A fundamental shift in the paradigms about care for older people among the people and organisations involved in the integrated care process — including staff, older people and carers
- A perception among older people, their carers and staff in daily interactions of shifts towards person-centredness as a result of cultural change efforts
- A tangible reorientation in beliefs and attitudes towards the core values of integrated care
- A shared purpose and vision that puts older people at the centre
- Deeply rooted and sustainable change, internalised by the different partners, operational at every level and in all parts of the system
- Understanding, respect and sensitivity to cultural differences and mutual roles, for the work of each other between the different persons and agencies involved
- Sustainable change, with the aspiration of reaching a cumulative and non-reversible change in attitudes, values and beliefs

The account by Wistow and Waddington (2006) of the experience in Barking and Dagenham provides a cautionary tale of the consequences of failure to understand and allow for fundamental cultural differences between local government and health. Too much attention, it is suggested, was paid to the structure of the partnership and the performance management of the respective partners rather than to the cultural differences that needed to be addressed.

Culture change is the focus of IRISS Insight 17 (IRISS, 2012c) and the associated storyboard[7]. As part of a useful summary of culture change, this highlights a number of features that enable culture change:

- A clear vision
- Identifying stories
- Effectively communicating the vision
- Development of a strategy
- Identifying quick wins
- Measuring indicators of success
- Developing leadership

Elements to be avoided include short-term budgets, the risk averseness associated with hierarchical control, and a lack of operational leadership skills. This emphasises again the essential linkages across the different dimensions presented here.

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7 http://www.iriss.org.uk/resources/culture-change-what-it-all-about

Delivery on the dimension of culture requires:

- Acknowledgement of the differing cultures of different organisations, professions and individuals
- Awareness of the need to facilitate, promote and foster the development of a fresh emerging culture
- Effective communication of the emerging cultural identity
- Leadership which encourages positive risk-taking and rewards innovation and engagement with unfamiliar activities or approaches
- Addressing issues for front-line staff
- Navigating and overcoming barriers of communication and perception

INTEGRATED TEAMS AND OTHER WAYS OF WORKING

The delivery of integrated care and support at the local level is achieved through a variety of teams and other structures. This section will explore the features that are more likely to facilitate the delivery of integrated support. As with other dimensions there cannot be a single prescription and the model for delivery will need to be configured to local circumstances. A number of key elements can however be distilled.

There is a fairly well-developed evidence base on what makes for effective integrated team working (Maslin-Prothero and Bennion, 2010). The work of Ovretveit and colleagues (1993; 1997) has endured over many years. The continuum identified at organisational level, from relative autonomy through partnership to structural integration, has a parallel in terms of different degrees of integration at the team level. At one end there may be a network of associated professionals; at the other a fully managed multidisciplinary and multi-agency team. Ovretveit suggests interprofessional teams can be described in terms of four key dimensions: the degree of integration; team membership; team process issues (who does what during the user journey); and team management.

In terms of team process six models were identified by Ovretveit and can still commonly be found:

- Parallel-pathway team: the pattern of most network teams where each profession has their own care pathway for service users
- Allocation or 'post-box' team: referrals are allocated at a team meeting and then worked with by the single professional
- Reception-and-allocation team: there is a short-term response at the reception stage prior to the team meeting allocation
- Reception-assessment-allocation team: this includes two allocation stages, one for assessment and one for longer-term work
- Reception-assessment-allocation-review team: a review stage is built in at which the team member reports on progress to the team
- Hybrid-parallel-pathway team: a mix of different elements from the above

With respect to multidisciplinary team management there are five broad types of management structure for formal teams:

- Profession-managed: practitioners are managed by managers from their own profession, most common in network teams
- Single-manager: all team members, regardless of profession, managed by a single manager
- Joint management: a mix of team co-ordinator and professional superior who agree a division of roles
- Team manager-contracted: a model whereby a team manager with a budget contracts in team members who retain their profession managers
- Hybrid management: a mixed management structure with the team manager managing core staff, co-ordinating others under a joint management agreement and contracting-in others

There is no evidence to suggest one form of team management is inherently superior; however it is essential that there is a structure and process for team accountability. Excessive dependence on management by individual professions can lead to a lack of cohesion and an absence of team identity. Teams need to be more than the sum of the individual members. Successful teams require the development of a shared team ethos for working with people, professional respect for other members of the team, and opportunities for team learning. There also needs to be an understanding amongst individual members of each professional group as to what are their own unique professional skills and where there can be flexibility around common skills.

Based on interviews with members of an interprofessional team, Molyneux (2001) isolated three indicators of positive team working: the personal qualities and commitment of staff; communication within the team; and the development of creative working methods. A word of caution in terms of team work is offered by Xyrichis and Ream (2008). They suggest that team-work is often cited as the 'great panacea' but it is important to define what is being meant by the term. Their approach using 'concept analysis' defined three core attributes: exercising concerted effort; employing interdependent collaboration; and utilising shared decision-making.

The challenge of maintaining essential aspects of professional identity whilst at the same time relaxing into more inclusive identities is a key issue that has to be navigated in the delivery of integrated care and support. In arguing the need for a 'fundamental change in thinking', Hubbard and Themessl-Huber (2005) highlight the constraints that can be imposed by individuals' allegiances to traditional roles and boundaries — 'old habits die hard'. Access routes for services can also constrain integrated working. Ideally the delivery of integrated care and support needs to become the core focus of an individual's professional identity.

Hudson, a long term commentator on partnership working in its various forms, has contrasted a 'pessimistic model' of inter-professional working (2002) — based on literature on inter-professional working that highlights differences of knowledge, status, power, accountability and culture as obstacles — with the articulation of an

'optimistic model', based on commonality of values, location, culture, cases, learning and accountability (2007a). His evaluation of five locality based, co-located front-line teams in Sedgefield, comprising social workers, district nurses and housing officers, found that:

- Promotion of professional values of service to users can form the basis of inter-professional partnership
- Socialisation to an immediate work group can over-ride professional or hierarchical differences among staff
- Effective inter-professional working can lead to more effective service delivery and user outcomes

Hudson concluded that

Given the right degree of inter-organisational commitment, preparation, planning and sustained fashioning, it is feasible to transcend traditional professional boundaries, at least across the 'semi-professions'. In [Sedgefield] there is good evidence that a well-prepared, co-located team can use commonality of cases to establish a culture within which team learning can flourish and accountability is to service users rather than to professional domains. (p14)

Hudson has also argued for the potential value of partnering through networks (2007b), notwithstanding that the concept is 'slippery'. He identifies a continuum of network arrangements of increasing complexity: integrated care pathways; managed clinical networks; and managed care networks. Network effectiveness requires clarity of purpose, facilitative management supported by a cadre of reticulists (see page 15 above), and resolution of issues of governance.

The Integrated Care Network (2008) concludes that multidisciplinary teams or managed networks should:

- Have a single manager (or co-ordinator)
- Include a mix of staff appropriate to the role of the team
- Have a single point of access, single assessment process, record system, administration
- Have access to a pooled, delegated budget
- Support individuals in commissioning individual care programmes
- Link easily and coherently to universal services such as GPs and schools and to secondary care such as hospitals

Co-location is an important factor in facilitating effective joint working (Freeman and Peck, 2006; Hudson, 2007a). Staff tend to have better working relationships, including greater mutual understanding and better communication. It should be noted however that co-location alone is not necessarily sufficient; commitment to work towards shared objectives can be key (Warne et al, 2007). This was underlined by the experience in several of the Care Trusts where social work, although co-located, remained a separate division, a barrier to the perception of integration.

Delivery on the dimension of integrated teams and other ways of working requires:

- Clarity of team or network structure
- Clear lines of management responsibility
- A manager with final accountability
- Work to develop a common identity and sense of purpose
- Mechanisms for resolving areas of uncertainty and/or conflict

LOCAL CONTEXT

'Reviews of [other] integrated care initiatives show that their effectiveness, and the factors that facilitate or impede success, depend substantially on the context in which integration takes place.'
(Ling et al, 2012)

As demonstrated by the 'early adopters' of integrated working in England, there is no single 'one size fits all' design. Development of integrated care and support needs to be sensitive and responsive to the particular geographic, financial, policy and professional features of the particular locality. At the same time, however, there needs to be a considered judgement that reaches an appropriate balance between excessive fragmentation at the local level and standardisation which is insufficiently responsive to local characteristics (Hubbard and Themessl-Huber, 2005).

The influence of local factors can be frustrating for those seeking to replicate what has been successful elsewhere. Direct import of a particular configuration is rarely possible; what is required is an understanding of the local context and adjustment to it. Increasingly, consideration is being given to understanding the strengths (assets) within a locality and to adopting a total place perspective. Such an understanding is closely linked to the development of the vision and to the presence of the leadership detailed above. Effective engagement of the third and community sectors can be key. Co-terminosity is likely to be a facilitating factor, although the Bill suggests that each local authority area is to be divided into two or more localities for locality planning purposes.

The influence of context is demonstrated from the Northern Ireland experience (Heenan and Birrell, 2009). In the development of the local integrated trust for each area, reference was made to the context of local frameworks and to the analysis of local demand. Flexibility was built in to enable each integrated care partnership to design local arrangements and optimise services for the local population.

Effective communication and exchange of information at the local level is an essential prerequisite for the delivery of integrated care and support. The interviews conducted by Hubbard and Themessl-Huber (2005) across six Health Board areas highlighted the need for better exchange of information between professionals, both on individual patients and on services. Mechanisms can include managed care networks, journal clubs, casework meetings, attached practitioners or a range of informal networks. Fundamental however is common access to the records for an individual, in many areas one of the 'wicked issues' that appears to defy an integrated IT solution. Current IT capability for shared electronic databases would suggest this barrier is professional rather than technical.

Hubbard and Themessl-Huber suggest that sharing existing knowledge is not sufficient:

> Joint working is not simply about health and social care professionals sharing and transferring knowledge about patients and services, it is also about creating new ways of thinking and models of care bespoke to joint working. This means that there is a need to focus attention on how knowledge is created rather than upon how knowledge is exchanged. (2005: 382)

This theme is echoed by Williams (2012) who argues that learning and knowledge exchange, understanding the differing worlds of the professionals involved, lie at the heart of integrated working — 'searching for common purpose through new models of service'. At the local level, the primary concern of staff involved in change is to understand their role in the new arrangements and to determine how this fits with their current professional identities and their own professional development.

'All Hands on Deck', a report produced by Frank Strang for the Joint Improvement Team[8], offers initial thoughts on the most effective involvement of the full range of stakeholders across localities. It is likely to inform the guidance that will accompany the Act. Particularly resonant is the assertion that localities are 'the engine room of integration' (para 2), and the observation at para 14 that 'to make localities work it is essential to be clear what they are for and why they matter … once this is clear, form will follow.'

Delivery on the dimension of local context requires:

- In-depth understanding of the strengths and needs of the locality
- Flexibility
- Co-production
- A 'can-do' approach
- Good communication
- Robust data sharing
- Effective leadership at all levels

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8 http://www.jitscotland.org.uk/news-and-events-files/All%20Hands%20on%20Deck.pdf

TIMESCALES

'The difficulty with integration is that the detail of trying to make it work is extremely difficult and it has to be done slowly. And at the moment, I think, those at the centre want it done quickly and it won't be done quickly because you just can't — you cannot alter people's mind sets in the way that they've been working for the last 30 years, within a matter of months. It's going to take time.' (Hubbard and Themessl-Huber, 2005:376)

The quotation above from one of the respondents in a study of joint working captures a key challenge for the delivery of integration. The political imperative is for visible change and a 'solution' to the delays and disjunctures that have driven legislative change. Embedding whole scale cultural change on the other hand is likely to take a minimum of three years and may take much longer (IRISS, 2012c).

Delivering for Mrs Smith in Torbay evolved over a ten year period, based initially in a handful of GP surgeries (Thistlethwaite, 2011). Hultberg et al (2005), in their study of interdisciplinary collaboration in rehabilitation services in Sweden, similarly stress the time that is required for any formal partnership agreement to be translated into changes in attitudes, culture and ways of working amongst front-line staff. From their work with the 16 Integrated Care pilots funded in England by the Department of Health for a two year period, Ling et al (2012) suggest that too much was expected of the pilots within such a timescale. They also conclude that two years of initial development and a year of live working is required for significant change. They also flag that the strategies required for early quick wins may require modification to achieve sustained change.

Delivery on the dimension of timescales requires:

- Realistic appraisal of timescales
- Communication of timescales to stakeholders including elected members and board members
- Recognition of the need for continual revision and modification of implementation strategies

CONCLUSION

The evidence base which has accumulated over the last decade and more offers a range of robust indications of the most effective ways of achieving integrated care and support (Stewart et al, 2003; Cameron et al, 2012; Glasby, 2012).

The advent of the Public Bodies (Joint Working) (Scotland) Bill and the anticipated Act offers an opportunity to draw on this evidence in the course of putting the legislation into practice. Much of the debate to date has tended to focus on the intricacies of structures and governance arrangements, despite protestations to the contrary. Yet, as reinforced by the evidence reiterated here, the factors likely to have greater impact on the delivery of acceptable outcomes for individuals are those which focus on leadership, on vision, and on context.

This guide seeks to offer to those seeking to implement the legislation a summary of what can be learnt from experience and evidence elsewhere and a route map for the elements which should be afforded priority.

ANNEX — TOOLS FOR EFFECTIVE IMPLEMENTATION

There have been a number of attempts to develop guidance and tools for those embarking on integrated working. A selection of these are outlined below on the basis that one or more may be of assistance at some stage in the process.

Based on their work with the Integrated Care Pilots in England, Ling et al (2012) have devised a route map to assist navigation during the establishment of integrated working. Several of the elements they highlight are common to any large-scale organisational change: leadership; organisation culture; information technology; physician involvement; availability of resources. Others they identify as particularly important for integrated care and support:

- Personal relationships between leaders in different organisations
- Scale of planned activities
- Governance and finance arrangements
- Support for staff in new roles
- Organisational and staff stability

The King's Fund and the Nuffield Trust[9] (Goodwin and Smith, 2011) provide their own analysis of critical elements:

- Have a regulatory framework that encourages integration and integrated care
- Have a financial framework that encourages integrated care
- Provide support to innovative approaches to commissioning integrated services
- Apply national outcome measures that encourage integrated service provision
- Invest in continuous quality improvement including publishing the use of outcome data for peer review and public scrutiny

They have also provided a more detailed formulation which offers the basis for a detailed checklist.

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9 http://www.nuffieldtrust.org.uk/sites/files/nuffield/evidence-base-for-integrated-care-251011.pdf

Tools for clinical or professional integration	Tools for service integration
• Case finding and use of risk-stratification • Standardised diagnostic and eligibility criteria • Comprehensive joint assessments • Joint care planning • Single or shared clinical records • Decision support tools such as care guidelines and protocols • Technologies that support continuous and remote monitoring • Peer review	• Care co-ordination • Case management • Disease management • Centralised information, referral and intake • Multidisciplinary teamwork • Inter-professional networks • Shared accountability for care • Co-location of services • Discharge/transfer agreements • Personal health budgets

The guide to integrated working produced for the Integrated Care Network (2008) suggests five areas for determining the impact that integrated working has had for the individual user in terms of:

- The easiest access to advice and help
- The simplest processes for assessment and decision-making
- The swiftest delivery of whatever help is needed
- The least risk of errors and unnecessary stages in the process (and no passing the buck)
- The maximum opportunity for controlling events themselves

A more structured resource for mapping progress is the Partnership Assessment Tool (Hardy et al, 2003[10]). This identifies six key principles:

- Recognise and accept the need for partnership
- Develop clarity and realism of purpose
- Ensure commitment and ownership
- Develop and maintain trust
- Create clear and robust partnership arrangements
- Monitor, measure and learn

For each of these principles partnerships are able to assess their position in respect of six statements, producing both a score for each principle and an aggregate for the partnership as a whole.

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10 http://webarchive.nationalarchives.gov.uk/20120919132719/http://www.communities.gov.uk/documents/localgovernment/pdf/135112.pdf

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This report was commissioned by ADSW

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