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New conversations between old players?

The relationship between general practice and social care in an era of clinical commissioning

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Scoping Review

HSMC

Improving the evidence base for adult social care practice

The School for Social Care Research

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ABSTRACT

General practitioners are the gatekeepers and care coordinators for the NHS as a whole, and also provide much of the direct clinical care within primary care. Their relationship with adult social care is central to the delivery of integrated care to individual patients/service users and their families. Following the Health and Social Care Act 2012, English GPs have the lead role in commissioning local NHS services. This relationship will also therefore be a key feature of the strategic planning and market shaping of health and social care services for populations. Despite the importance of GPs to achieving integration there is relatively little known about how GPs and social care currently work in practice, with most of the key studies being undertaken at the end of the last century.

This review seeks to examine the more recent evidence that is available about joint work between general practice and adult social care in relation to older people. This incorporates both 'integrated working' (at a practice or operational team level in relation to individuals and their families) and 'partnership working' (at an organisational or strategic level in relation to the needs of populations or sub-groups of populations). It provides an initial summary of the key knowledge regarding joint working available in 2000 (the date of a previous key review), and then a summary of empirical findings from UK based literature that has been published subsequently. To set these findings in this in the context of the emerging commissioning structures, interviews were held in late 2012 with ten key stakeholders drawn from health and social care bodies and academics with a particular interest in inter-agency working. The resources available for the review meant that it was not possible to consider the experiences of all user groups supported by adult social care. Older people were chosen as they comprise the majority of people actively supported by social care and general practice, and because they are so central to current debates regarding how best to respond to changing demographics and rising need. Many of the issues that have arisen in relation to older people will potentially be transferable to other user groups; however, it is recognised that other adult user groups will have differences as well as similarities to that of older peoples' services.

In total the literature review identified nine empirical studies. These studies were very mixed in both their focus and methodology, and encompassed small-scale pilots as well as large, externally-commissioned studies. Mirroring the broader literature regarding joint working, key issues included the practical difficulties of engaging GPs in inter-agency collaborations; a lack of mutual understanding; different priorities and geographical boundaries; and a turbulent policy context. Factors that may aid more effective joint working included the importance of time and space to build good relationships; trust and awareness of each other's roles; clear commitment at practice and senior level; shared priorities and outcomes; and appropriate practical and organisational development support. The studies contain very little information about costs or savings – and there remains insufficient evidence to know what impact joint working might have on future spending.

The interviews identified that recent changes have created opportunities for new relationships, but that progress may be difficult in a very complex policy environment. General practice and social care have had very little strategic contact, with previous relationships focusing on the local authority and Primary Care Trusts. Initial training does little to prepare either agency/profession to collaborate, and there are a series of practical barriers to overcome.

This review suggests that more opportunities need to be given for GPs and social workers to understand their respective roles and professional perspectives in order to develop a reciprocal acceptance of their differing practice, financial and performance contexts. This needs to be supported by a willingness to seek joint solutions to situations in which eligibility rules and organisational procedures issues prevent integrated care being delivered. A more rigorous approach to the setting and monitoring of outcomes will enable good ideas to be tested out in practice and strategic partnerships to gather and apply learning from new initiatives. Sufficient time must be being given to enable new structures to settle in and for trusting relationships to be developed between key strategic leads. There is a need for research to track how the new strategic arrangements are implemented in practice, and for evaluations to consider both the mechanisms and outcomes of local initiatives.

KEYWORDS

primary care, adult social care, integration

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BACKGROUND AND INTRODUCTION

> From the late 1940s closer collaboration between social work and general medical practice has been advocated as a means of improving primary health care. Despite the persuasive rhetoric of its advocates and the successful completion of several demonstration projects of attachment of social workers to group medical practices, the majority of general practitioners and social workers in the field remain unconvinced, not so much of the potential but of the possibility of inter-occupational collaboration (Huntingdon 1981, p.1).

The Health and Social Care Act 2012 has prescribed significant changes to the health and social care system in England, including the creation of a series of new organisations and lines of accountability. The major infrastructure changes include the transfer of 60-80% of the NHS commissioning budget to local Clinical Commissioning Groups (CCGs) led by GPs; the passing of local public health responsibilities to local authorities; and the creation of a national NHS Commissioning Board (now termed NHS England) to set outcomes for the NHS as a whole and commission primary care and specialist services (see DH 2013 for an overview of the new structures and responsibilities). CCGs are required to have specific stakeholder groups represented on their Boards: a lay member to champion patient and public involvement, a clinician working in secondary care and a registered nurse (NHS Commissioning Board 2012). There is no requirement to include a representative from the local authority on their Board, although they have freedom to develop membership above the minimum requirements. Commissioning support to the CCGs, and potentially local authorities in relation to their public health responsibilities, will initially be provided largely by new NHS Commissioning Support Units (CSUs). These have been created from the 'spinning-out' of commissioning support functions that were delivered by Primary Care Trusts, with the intention that over time a marketplace will be developed which will also include third and private sector providers (NHS England 2013).

Of all these changes, it is the advent of 'GP-led' or 'clinical' commissioning that has attracted the most attention and seems one of the most significant changes. With new CCGs taking up their role in difficult policy and financial circumstances, the relationship between local authorities and GPs was certain to be of paramount importance. Furthermore, following the work of the NHS Future Forum (2011) the necessity for horizontal integration between health and social care, and vertical integration between acute and community health services, is being emphasised. Local authority-led Health and Wellbeing Boards are being tasked with driving integration at the local level, with all the major players being given a duty to promote integrated working. A 'National Collaboration for Integrated Care and Support' has been launched, with new support for and expectations on local areas in relation to ensuring that people who access health and social care services experience integrated care (NCICS 2013).

Interestingly, however, we know relatively little about the relationship between GPs and local authorities at either operational or strategic levels. Although there was significant

emphasis on primary care/social care joint working and in concepts such as GP-attached social work in the late 1990s (see, for example, Lymberry 1998; Department of Health 1999; Department of Health/Social Services Inspectorate 1999; Rummery and Glendinning 2000; Le Mesurier and Cumella 2001), the focus since then has often been on local authority/Primary Care Trust (PCT) relationships – and GPs have not always been seen as key players in these discussions. For this reason, our chosen title tries to reflect the urgent need for 'new conversations between old players'.

Against this background, this review seeks to examine the evidence around joint working between general practice and adult social care that is relevant to the forthcoming era of clinical commissioning. Based on a review of the literature and on interviews with key national stakeholders, this review explores:

- what impact joint work between general practice and social care can have (at operational and/or strategic levels);
- what helps and hinders such joint working;
- what implications this has for current and future social care practice; and
- what the priorities should be for future research in these areas.

After a brief discussion of key terms and trends in the previous literature, the review sets out our approach, presents our main findings and draws out implications for future research, policy and practice.

KEY TERMS

Primary care

Primary care, and in particular general practice, is a key component of and entry point to the broader NHS. Its importance is underlined by the following famous quotation from the World Health Organization (1978):

> It forms an integral part of both the country's health system of which it is the central function and the main focus of the overall social and economic development of the country. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process (p.1).

From the outset of the NHS, GPs have operated as independent business people, contracting their services to the NHS. Traditionally the majority of GPs owned a financial stake in their practice, either as sole practitioners or in partnership arrangements. In recent times, increasing numbers of GPs are salaried by their practice and effectively employed by the senior GPs (see Peckham and Exworthy 2003; Smith and Goodwin 2006 for further discussion of the nature and evolution of primary care). GP practices act as a community focus for a broader primary health care team (including practice nurses, district nurses, health visitors, practice managers and administrative staff – but also potentially community midwives, physiotherapists, psychiatric nurses, counsellors and so on). GPs, however, remain at the centre of both strategic decision-making and patient care at practice level and have the lead responsibility for the new CCGs. Within this review we will therefore be primarily focusing on GPs rather than on the broader primary care services and disciplines.

Adult social care

Adult social care is a diverse market in relation to both the supply and purchasing of care, with the majority of services being delivered by private and third sector providers, and almost 45% of residential care placements being paid for by older people and/or their families (Institute of Public Care 2010). Local authorities continue to have the lead role in relation to the assessment, funding and purchasing of public sector funded social care, and in overseeing the local market of providers for self-funders and those with direct payments. In the context of this review it is local authorities' roles as strategic commissioners and care managers that will be focus of our discussions.

Integration and partnership

The lack of clarity and consequent difficulties in understanding that result from the plethora of conceptual definitions and theoretical models used to describe and analyse joint working between health and social care is well established. In this review we will use the following terms to denote the type of joint working being considered:

- Integrated working – this will be used to describe joint working at a practice or operational team level between health and social care practitioners in relation to the needs of individual patients/service users and their families;
- Partnership working – this will be used to describe joint working on an organisational or strategic level between senior health and social care commissioners in relation to the needs of populations or sub-groups of populations.

When we directly quote the findings of a research study, the authors may have used alternative terms and these definitions may not apply.

PREVIOUS RESEARCH – WHAT DO WE KNOW ALREADY?

This review focuses on the relationship between adult social care and general practice. Although there has been relatively little research on this topic in recent years, the broader issues at stake date back over time, and this section of the review seeks to highlight key themes from this prior literature.

One of the main summaries of the research evidence is provided in Rummery and Glendinning's book *Primary Care and Social Services* (2000). Although this was published in a different policy context, in the early years of New Labour, Rummery and Glendinning review the relationship between primary care and social care with regards to older people's services (at both integrated and partnership levels). While clear-cut evidence about the outcomes of joint working at both levels was limited, the suggestion was that access to services might improve and that either the same or possibly slightly better care could be delivered at the same costs. However, the benefits of some models seemed to be fewer and the upheaval greater for social care, and there was a risk that social care staff working in primary care could feel isolated from their colleagues. Above all, there was a need for realistic expectations, since social care staff working in primary care still also had to work within current social care structures, processes and budgets (and therefore faster initial access to a worker might not necessarily mean faster access to subsequent services or indeed better services, if these simply were not available).

Similar findings also emerge from other studies around this time (see, for example, Dickie and Iliffe 1996; Ross and Tissier 1997; Callaghan *et al.* 2000). As an example, Poxton's (1999) edited account of 'experiences of primary health and social care partnerships in practice' identifies the personal motives that encouraged many workers to 'go the extra mile' in terms of integrated working and the importance of attempts to build mutual understanding and a shared vision. However, these stories also highlighted less positive issues such as potential power imbalances, the impact of reorganisation on previous relationships, frustration about the slow pace of change and the impact of resource pressures. As New Labour's primary care reforms seemed to be opening up new opportunities for joint working, Poxton stressed the challenges that remained, but also the positive desire of practitioners and managers at ground level to overcome such barriers, concluding that:

> The stories here suggest that real success will depend as much on the determination and creativity of practitioners and managers as it will on Government edict and structural change (p.3).

This seems slightly different to the summary provided by Glendinning *et al.* (2002a) when reflecting on past attempts at engaging GPs in health and social care partnerships:

> British GPs have ... historically been independent contractors, and until very recently remained largely outside mainstream NHS organisations and management structures ... The history of GPs' collaborative activities, either with

> one another or with social services, is not promising ... GPs were not involved in the joint health and social services planning and commissioning that took place from the 1970s, and when they did become involved, during the quasi-market of the 1990s, it was as GP fund-holders, who used their enhanced financial flexibility and purchasing leverage to buy additional social work services for their practices and their patients ... Even among leading-edge GP fund-holders, engagement with wider strategic planning and inter-agency activities was minimal ... Moreover, inter-professional relationships between doctors and social workers have been regarded by both academics and professionals themselves as poor, being characterised by a lack of mutual understanding and blame and therefore providing an unhelpful basis for collaboration (p.190).

At a national level, the mapping exercise carried out by Hudson and colleagues (1998) of local authority perspectives on joint working with primary care found that there was widespread recognition of the need to work with general practice and other primary care clinicians, with most social services authorities rating their relationships as 'good' or 'adequate', and with relationships improving over the past year. Despite a range of joint commissioning activities, the study concluded that 'structured links between operational staff across social care and primary health care are still patchy' and that 'there are continuing difficulties in developing a joint approach which includes general practitioners', with some participants feeling that some GPs displayed 'a general disposition towards independence and income maximisation which is inimical to joint working' (p.29). This was described by the authors in terms of perceived 'intransigence', and a supporting quotation suggested it was 'impossible to get them to meetings without payment, even with a free lunch' (p.29).

Through a series of more local case studies, the same team also explored working relationships across the primary care and social care interface, identifying a number of alternative options for developing more effective integrated and partnership working (Hudson *et al.* 1997; see also Hudson 2000 for a broader overview). Overall, the research concluded that:

> The interface between primary health care and social care remains relatively underdeveloped, but it is increasing in importance ... our findings would suggest that effective interprofessional collaboration is a product of local networks based upon co-operation, trust and mutual respect, and that these characteristics cannot be conjured up by administrative fiat. What the centre can do is to create a legal and financial framework which facilitates such networking ... At a macro level, the Government has committed itself to removing the legal obstacles that currently stand in the way of full integration of health and social services budgets, and legislation to permit the pooling of budgets is now expected. Our research suggests that this will be welcomed at local level, but that in itself it will be no panacea. The real issue – whether at professional or organizational level – is whether or not there is a willingness to align decisions. And this is as much a question of politics, personalities and culture, as legislation and finance (p.30).

New conversations between old players?

At a local level, Jones' (2004) account of ten years of joint working in Wiltshire provides an example of some of the more bottom-up approaches developed at the level of frontline practice and subsequent attempts to build more strategic relationships over time (see also Holtom 2001; Lindsay 2001; Lymberry and Millward 2002 for other local examples). Interestingly, an external evaluation of the Wiltshire scheme found an impact on the process of service delivery but not yet on clinical outcomes (Brown *et al.* 2003 – see below for further discussion) and this locality subsequently seemed to experience growing tensions in its inter-agency relationships (see, for example, Butler 2006).

Of course, as the quotation at the start of this review suggests, all these contributions build on and echo themes from a number of earlier accounts from the 1970s onwards which have identified the potential for closer integrated and partnership working but also a series of barriers to be overcome if this is to be achieved in practice (see, for example, Goldberg and Neill 1972; Ratoff *et al.* 1974; Huntingdon 1981; Corney and Clare 1982; Sheppard 1986). Commenting on the literature to date, Kharicha *et al.* (2004) conclude that:

> While collaborative (or joint) working between social services and primary healthcare continues to rise up the policy agenda, current policy is not based on sound evidence of benefit to either patients or the wider community. Both sets of practitioners report benefits for their own work from adopting new arrangements for collaboration. The underlying assumption behind much of this activity is that a greater degree of integration provides benefits to both users and their carers, a perspective that at times obscures the issue of resource availability, especially in the form of practical community services such as district nursing and home help. At the present time there is insufficient evidence to demonstrate that formal arrangements for collaborative working (CW) are better than those forged informally between committed individuals or teams. Furthermore, arrangements for CW have not hitherto been widely evaluated in systematic studies with a comparative design and focus on outcomes for users and carers rather than on processes (p.134).

OUR APPROACH

In order to explore the impact of the relationship between general practice and social care, and the potential enablers and barriers regarding achieving the potential benefits, we:

1. Reviewed the literature on relationships between general practice and adult social care, focusing on services for older people and on material published since 2000 (the year in which Rummery and Glendinning's summary appeared). This was also the time when New Labour published its ten-year blueprint, *The NHS Plan* (2000), and when Primary Care Groups (PCGs) were in the process of becoming Primary Care Trusts. Resources for this review were not sufficient meaningfully to consider all of the adult service user groups. However, older people were chosen as (i) they comprise the majority of people actively supported by social care and general practice, and (ii) because they are so central to current debates regarding how best to respond to changing demographics and rising need. Many of the issues that have arisen in relation to older people will potentially be transferable to other user groups; however, we do recognise that other adult user groups will have differences as well as similarities to that of older peoples' services;
2. Conducted interviews with ten key stakeholders about the current and future implications of clinical commissioning for integrated and partnership working. These were identified in consultation with the School for Social Care Research and from the Health Service Management Centre's (HSMC) national research, teaching and consultancy work with regards to health and social care partnerships.* Interviewees took part on an anonymous basis, but included representatives from a series of national health and social care bodies, researchers specialising in inter-agency working and local health and social care leaders. Interviews were held in late 2012 shortly before the health reforms came into full force in April 2013.

Rather than focus on a specific form of joint working, this review instead acknowledges that this can include a spectrum of approaches that range from informal relationships that been developed between individual practitioners, though integrated working, to more formal and structural forms of partnership working bound by legal agreement (see Glasby and Dickinson 2008 for further discussion). The literature search was undertaken by Rachel Posaner in HSMC's specialist health management and policy library, with documents identified via the following databases: ASSIA, Cinahl, EMBASE, HMIC, and Google Scholar, Medline, Proquest (including Proquest dissertations and theses), Social Care Online, Social Services Abstracts and Social Science Citation Index.. Additional searches were also conducted of the reference lists from each document included in the review. Search terms varied by database, but focused on:

* See http://www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/work/partnerships-collaboration-integration.aspx.

- social care, social work, social services;
- primary care, general practice;
- joint working, collaboration, partnership, integration;
- outcomes, outcome*, outcomes and process assessment, outcome assessment, outcome measurement;
- older people (various terms).

Studies were included if they presented original empirical data on the outcomes of joint working between general practice and adult social care in the UK and/or if they provided a formal/structured review of such evidence. As with the original Rummery and Glendinning review, the focus was on older people's services and includes developments at two different levels: *strategic relationships* between adult social care and locally-based primary care organisations (PCGs, PCTs, Practice-Based Commissioning (PBC) consortia and, more recently, emerging CCGs) – that is, examples of partnerships; and on more *operational relationships* between social care and general practice – that is, examples of integrated working. (Integrated working and partnership working are defined earlier.)

Specifically excluded were:

- material published and/or based on data collected prior to 2000;
- material from outside the UK;
- material where there was not a clear focus on older people;
- articles reporting findings from studies already included in the review;
- material describing schemes and potential benefits rather than presenting empirical evidence of benefits;
- broader material on joint working and partnerships more generally.

Even if sources met the above criteria, they were only included in the final review if they focused on the *strategic relationship* between social care or local government and general practice (i.e. partnership working) *or* if they focused on more operational, *practice-level* developments with a specific GP focus/element included (i.e. integrated working). This was intended to build on Rummery and Glendinning's (2000) review which distinguished between strategic and operational relationships.

Each abstract was reviewed against the inclusion and exclusion criteria outlined above on an independent basis by both main members of the research team (JG and RM) and discussed in research team meetings before inclusion. Data were then extracted using the pro forma in Appendix A, which was developed from the work of Mays *et al.* (2001) who discuss synthesising material from diverse study designs. While quality was not formally appraised, we have tried to convey something of the nature and style of the literature by noting below whether or not studies have been formally peer-reviewed, whether the research was conducted in-house or externally, whether a formal outcome measure was

used and whether the focus was on a specific case study or a wider practice.

Interviews took place by telephone with detailed case notes made during and immediately after the interview. Participants were reassured that any views expressed would be used in a non-attributable manner, and were asked about what impact joint work between general practice and social care can have (in relation to integrated and/or partnership working), what helps and hinders such joint working, and what implications this has for current and future social care practice.

KEY THEMES FROM THE LITERATURE

The nature of the literature

Our review identified nine studies (summarised in Table 1), which cover a range of integrated and partnership projects and relationships (from small-scale GP-attached social worker pilots to integrated teams, and from social services representatives on PCG/PCT Boards to fully merged organisations). Initially we had hoped to break down our findings into those relating to strategic partnership relationships and those focused on integrated delivery at practice level. However, this soon proved a false dichotomy, as some of the projects which involved the creation of integrated teams at local level arose from broader strategic debates about the future nature of service provision.

A number of key issues are immediately apparent:

1. Given the current and previous importance of this topic, there were very few studies that met our criteria. While this was not necessarily unexpected from our prior knowledge of the literature, this still feels a major gap in view of the importance of the issues at stake;
2. Even studies included sometimes seemed to be the product of late 1990s interest in this topic, with several starting before our cut-off point in 2000 but also including post-2000 data. It was therefore a matter of judgement whether or not to include them. Thus, the national 'Tracker' survey and subsequent interviews took place between 1999 and 2002, research by Davey and colleagues reported initially in 2002, Brown and colleagues study took place in 1999–2000 and Wistow and Waddington's local case study derives from 2001–2003. As Table 1 below suggests, there have been very few studies more recently – and this does seem a key area where the SSCR and other key funders may be able to target future research;
3. Although we initially found a number of papers, some were based on the same underlying material (that is a small number of research teams carrying out a study and then publishing a number of papers from this data). Examples are work arising from the national 'Tracker' survey of PCGs/PCTs (Coleman and Rummery 2003; Rummery 2003; Rummery and Coleman 2003; Glendinning *et al.* 2001a, 2001b) and research in London by Davey and colleagues (2005) (see also Kharicha *et al.* 2005). While these papers often take the material in different directions in different outputs, the fact remains that the articles addressing these issues tend to come from a very small number of original studies;
4. Several of the studies included reported some original research, but often with little detail about the approaches adopted to collecting and analysing data (see Table 2 and below for further discussion). Linked to this, several tended to appear in a small number of more practice-focused journals and could sometimes adopt either a descriptive approach or a broader policy commentary. While this material often gave

crucial insights into the issues at stake, some of the sources available felt much more on the boundary between formal, independent research and more 'quick and dirty' local evaluation than might be the case in other areas of policy and practice.

Table 1: Brief summary of included studies

Author, date and source	Brief description
Banyard *et al.* 2002 Health Service Journal	Local evaluation of four GP-attached social services assessors covering 16 GP practices in Hull
Brown *et al.* 2003 Health and Social Care in the Community	Evaluation of primary care-based health and social care teams in rural county in the south-west (identified as Wiltshire by Jones 2004)
Coleman and Rummery 2003 Journal of Interprofessional Care (see also Rummery 2003 and Rummery and Coleman 2003)	National survey of PCGs/PCTs and in-depth qualitative research in four PCGs/Ts at strategic, management and operational levels
Davey *et al.* 2005 and Kharicha *et al.* 2005 Journal of Interprofessional Care and Family Practice	Comparison of co-located social work/primary care teams and standard community, non co-located teams in two London Boroughs (and background interviews with social care staff and GPs)
Dodd *et al.* 2011 Primary Health Care Research and Development	Pilot complex care team (case management service). Co-located with surgery-based social workers, but focuses more on case management/admission avoidance. Began as more generic orthopaedic pilot, then focused more on complex care (mean age 83)
Syson and Bond 2010 Journal of Integrated Care	Local evaluation of a pilot health and social care team in Salford and discussion of a subsequent development programme to support joint working
Taylor 2001 Local Governance	Local, primarily descriptive evaluation of a pilot in three GP practices to create a generic health and social care worker
Thistlethwaite 2011 King's Fund policy paper	Policy paper written by local evaluator of Torbay Care Trust, based on a description of local joint working and on local action research in a pilot integrated team, data on staff perceptions and local performance data
Wistow and Waddington 2006 Journal of Integrated Care	Description of options for joint working and local case study of integrated working arrangements in Barking and Dagenham (2001–03), including a joint Chief Executive/Director of Social Services

Table 2: The type of literature included

Peer review?	In-house or external evaluation?	Single local case study or wider evidence base?	Outcome measures used?
Banyard *et al.* 2002			
No	Article has two authors from the local university and two from local health and social care – but the evaluation itself seems to be from the university	Four assessors across 16 practices in one city	No – evaluation seems more process-based
Brown *et al.* 2003			
Yes	External	Comparison of two integrated teams and one non-integrated team	Yes – main measure was the proportion of people living independently 18 months from referral
Coleman and Rummery 2003. See also Rummery 2003 and Rummery and Coleman 2003			
Yes	External	National study	Not applicable – annual surveys and interviews to explore the extent of collaboration/ scope for future development
Davey *et al.* 2005/Kharicha *et al.* 2005			
Yes	External	Comparison of co-located and traditional structures in two London boroughs	Yes – primary measure was whether older people were at home, in long-term care or had died six months after initial interviews
Dodd *et al.* 2011			
Yes	Mix of local university/local practitioners	Individual GP surgery	Quantitative analysis of impact on hospital bed usage

Table 2 (continued): The type of literature included

Peer review?	In-house or external evaluation?	Single local case study or wider evidence base?	Outcome measures used?
Syson and Bond 2010			
Journal is primarily peer-reviewed, but also encourages new writers and/or directly commissions individual pieces	One council and one university author – but there is reference to a university evaluation	Eight integrated teams across the city	No – qualitative interviews led to a series of subsequent organisational development interventions
Taylor 2001			
Not known – we understand that the journal has since ceased to operate in this form	Presumably – sole author is based at a university and commissioned to evaluate the pilot	Local pilot project	No – formative, qualitative evaluation
Thistlethwaite 2011			
No	Author is external but acted as a 'critical friend' throughout the development of the Care Trust	Development of a Care Trust in a small, co-terminous health and social care community	Some financial/ performance data cited – but focus is on approach adopted and lessons learned
Wistow and Waddington 2006			
Journal is primarily peer-reviewed, but also encourages new writers and/or directly commissions individual pieces	External	Integrated approach in single London borough	No – focus is on local perceptions of the nature of relationships and lessons learned. A process-based instrument – the Partnership Assessment Tool – is used

Factors that help or hinder integrated and partnership working

In trying to achieve better outcomes for local older people, the pilots and approaches summarised in our studies highlight a number of potential success factors and barriers (see Tables 3 and 4 for a summary) – albeit some of the more practical advice and recommendations tend to come from descriptive, practice-based studies (see below for further discussion). In particular, barriers seem to be caused by a lack of understanding of each other's roles and priorities, by differing priorities and professional approaches, by difficulties working with some GPs (who are independent contractors and may traditionally

Table 3: Factors that help or hinder integrated working

Factors that help/key lessons	Factors that hinder/key lessons
Banyard *et al.* 2002	
Good relationship with practice manager Social care staff working hard to be 'visible' Flexibility (sometimes accepting referrals outside geographic social services boundaries)	Primary care does not always understand social care roles Practicalities around office space/phones/admin support Difficulties engaging some practices, especially single-handed GPs
Brown *et al.* 2003	
Integrated teams might increase doctors' awareness of services and having a team upstairs might encourage them to recommend that patients request help	Having more of a 'one-stop' shop might not be enough to affect clinical outcomes Insufficient evidence of improved outcomes (makes it hard to win hearts and minds of staff, managers and politicians)
Davey *et al.* 2005/Kharicha *et al.* 2005	
Co-location can help to increase face-to-face contacts to an extent This can help to improve joint working – although social workers would also like more formal contact through multidisciplinary meetings Community nurses often acted as mediators between social workers and GPs	Lack of understanding of roles and priorities GPs and social workers have different understandings of joint working and want the other to change their culture Social workers can feel isolated/threatened by co-location (with concerns about differences in power and hierarchical authority) Different approaches to risk and concerns about GPs 'prescribing' residential care before a full assessment is complete

Table 3 (continued): Factors that help or hinder integrated working

Factors that help/key lessons	Factors that hinder/key lessons
Dodd *et al.* 2011	
Physical co-location aids good relationships and improves access to other staff in the same building Senior staff (described as a 'top-heavy' structure, p. 108) with good interpersonal skills Support from project champions and practical IT/admin support	Small team that cannot respond quickly if covering absences, or provide 24-hour service Lack of access to intermediate care (hinders admission avoidance) Some practice staff did not feel fully informed/involved
Syson and Bond 2010	
Co-location helped informal learning/networking Common vision and staff commitment to make it work Organisational development support/training (see Box 1) Flexible approach from staff and willingness to work through previous barriers	Some initial friction between professions Legacy issues relating to culture, different terms and conditions and professional specialisation Practical issues such as IT and accommodation Problems with initial training offered (which led to new organisational development programme) Staff felt they were sometimes left to work through the practicalities or resolve contentious issues at ground level
Taylor 2001	
Importance of training and informal contact between staff Building on positive existing relationships and communication	Different eligibility criteria and service boundaries Pressures on the home care system meant staff could not be attached to individual surgeries Some nurses worried about professional accountability for the generic worker

Table 4: Factors that help or hinder partnership working

Factors that help/key lessons	Factors that hinder/key lessons
Coleman and Rummery 2003. See also Rummery 2003 and Rummery and Coleman 2003	
Social services representation on Boards can have a positive impact but progress was slow Relationships and shared trust/values/priorities more important than structural integration Joint working needs management support/wider organisational support and needs to be seen as a joint activity not as a 'take over' Importance of time and organisational stability Have to acknowledge interprofessional differences in order to be able to develop trust, commitment and ownership of partnership working Importance of key individuals working flexibly beyond their own agency boundaries/priorities	GPs are independent contractors and may need reimbursing for their contribution GPs may have little experience of working with social care or of commissioning for whole populations New PCG/PCTs may focus more on own internal development Lack of understanding of each other's priorities Use of penalties (rather than incentives) can undermine trust Lack of coterminous boundaries and extra complexities in two-tier authorities
Thistlethwaite 2011 (see also Box 2 for a more detailed quotation)	
Urgent need to improve social care led to local commitment Organisational stability and continuity of leadership Project management, organisational development support and evaluation of process and outcomes Staff engagement/clear narrative focused on patient benefits	Integration is not a panacea – concerns remain in children's and learning disability services GPs initially had mixed knowledge of and contact with social services – although their views improved Further organisational changes are underway which might influence current approaches
Wistow and Waddington 2006 (see below for a more detailed quotation)	
Balance of ambition with what can realistically be achieved Focus on outcomes for local people Identify and resolve organisational incompatibilities Importance of equality of ownership to avoid debates about 'take over' and 'control' Importance of organisational maturity and strong leadership Willingness to work together and trust	Local innovation lacking the political and development support of formal, national policies such as Care Trusts Too much focus on structure at the expense of culture Complex change agenda (especially with new PCT) – concerns about going 'too far too fast' (p. 13) Lack of clarity of purpose and equality of ownership Basic incompatibilities arising from mismatch in culture, behaviour, understandings and external expectations Tension between national and local priorities

Box 1: A development programme to support joint working (Syson and Bond 2010)

The progamme had three main strands:

1. to develop a cohort of first-tier managers to lead change (with workshops focused on Myers-Briggs Type Indicators to help participants understand themselves and others; understanding and creating organisational vision; managing change; and concepts of leadership);
2. action learning sets to prepare teams for integration and support them during and afterwards;
3. four half-day development sessions rolled out across the city on a team-by-team basis, delivered for teams four to six weeks before teams became formally integrated.

have little direct experience of working with social care or of commissioning for whole populations), a lack of coterminous boundaries and the existence of significant organisational turbulence over time. In contrast, key success factors appear to include focusing on building trust and awareness of each other's roles (rather than on structural integration), working to develop shared priorities and values, practical and organisational development support, commitment and flexible approaches from key leaders and frontline practitioners, and a clear narrative and a sense of desired service user outcomes. Some schemes also seem to have built on previous pilot projects, positive relationships and continuity of leadership, which may offer less learning to areas which do not share these characteristics.

Overall, many of these messages seem broadly consistent with the more generic partnership literature (see, for example, Barrett *et al.* 2005; Glasby and Dickinson 2008; Glendinning *et al.* 2002b), which tends to suggest few easy answers – but instead focuses on the need for more locally-based, long-term relationship building, with committed leadership at all levels and a focus on outcomes for service users rather than on the process or structures of joint working. Some of the key factors seem to be those that are capable of being influenced by local actors, while others may be more to do with national structures and policy environments. In practice, many of the factors summarised in Table 3 seem inextricably interlinked, with local stakeholders capable of influencing some of what happens, but with their work shaped by the opportunities and tensions that emerge from national policies and priorities.

Although some of the sources included come from non-peer-reviewed or more practice-focused journals (see Table 2 above), the local insights they provide offer important lessons for other areas. A good example comes from Syson and Bond's (2010) account of a pilot integrated health and social care team in Salford. Although the evaluation of the pilot contains relatively few details about the methodology adopted, the article devotes significant space to the perceived limitations of an initial training course offered to members of the new team and the subsequent creation of a more detailed and tailored development programme (see Box 1 for further details). This seems an often neglected

but important contribution to the literature, which tends to focus on the barriers to integrated working and on the impact of new approaches. In contrast, this short, practice-focused paper concentrates much more on the training, cultural and developmental aspects of integrated working – crucial at a time when relationships between social care and general practice are changing rapidly. A similar contribution is made by Taylor (2001), where the training programme established to support generic health and social care workers was felt to be 'one of the most significant aspects of this project' (p.242). Indeed, Taylor concludes with a reflection on the importance of informal communication and positive local relationships:

> The long-term success of the project will be dependent on the wider systems of health and social care being supportive and willing to work in more flexible and innovatory ways ... the implementation of the project was dependent largely on the goodwill and enthusiasm of a small number of community based professionals being prepared to give time and co-operate together (p.245).

Similarly, a local case study of a London borough with a single Chief Executive of the PCT/Director of Social Services role (2001–2003) provides few details about the people who took part (although does state that clinicians are included) and how data were analysed (Wistow and Waddington 2006). However, this fascinating account of a short-lived experiment in partnership working nonetheless provides a series of practical lessons, as well as discussion of key issues when building for the future. Although a very innovative model, the borough faced a significant change agenda as it sought to create a new PCT and integrate with social care simultaneously. Perhaps inevitably, there was also a tendency to focus on structural approaches with less clarity around the outcomes that these were designed to achieve. Over time, difficulties arose from mismatches in the cultures, understandings and behaviours of partner organisations, and the very new nature of the PCT made some feel that this was a local authority 'take over' of a more junior partner. In particular, the authors stress four key themes:

- 'Pace and scope: balance ambition about aims with realism about what can be achieved in the light of all the other demands on management time and other capacity;
- Clarity of purpose: focus on outcomes for local residents while also establishing an appropriate balance between ends and means (function and form);
- Organisational compatibilities: openly identify areas where differences between organisations could work against partnership objectives and develop agreed strategies for managing them; recognise the legitimate existence of separate as well as joint objectives;
- Equality of ownership: equality of ownership is the essence of partnership but this does not necessarily imply equality of contribution; 'senior' and 'junior' roles may legitimately vary by theme/topic and at different stages in joint processes without necessarily undermining partnerships; the language of control and takeover is corrosive and should be surfaced immediately' (p.15).

New conversations between old players?

Although this joint role came to an end in 2003 following a zero-star rating for the PCT, participants were able to identify a number of positive foundations for future joint working, including:

- 'Growing organisational maturity and robustness in the PCT, leading to internal greater self-confidence and a growing sense of potential equivalence between it and the SSD;
- Recognition of strong leadership at the top of the PCT and SSD [Social Services Department], supported by mutual respect and good relationships between the two leaders;
- The willingness and commitment to commission this study jointly and as a basis for moving on rather than for self-justification or identifying blame;
- Largely new senior management teams in both agencies which lack the baggage of the past and, in several cases, were attracted to the locality by its integration agenda;
- Some effective partnerships at operational level and a belief that, even after their past experience, they were still ahead of the game at directorate level;
- Sufficient willingness and trust at senior officer level to contribute to the other's agenda, confident in the knowledge that a quid pro quo would be forthcoming but without needing advance specification;
- Recognition that national and local policy imperatives would increasingly push them together rather than pull them apart to the previous extent;
- Ability to begin to debate and develop a specific joint agenda aimed at securing improvements in the health and well-being of their local population' (pp.15–16).

In their concluding remarks, Wistow and Waddington (2006) stress that it is difficult to see how a different short-term outcome could have been achieved through another mechanism. With NHS priorities and performance management systems being non-negotiable and with little recognition of the importance of shared priorities in the targets of the two separate organisations, local partnerships will struggle to overcome the tension between 'centrally managed and locally governed services' (p.17). Above all, there is a need to strike an appropriate balance between culture and structure, recognising 'the critical role of local commitment, trust and leadership' (p.17).

Also at a local level, Thistlethwaite's account (2011) of Torbay Care Trust provides a detailed description of the approach adopted over time – but, in the process, also cites findings from a local evaluation and draws on local performance data. While there are few details about exactly how these data were collected, this source nevertheless offers a rich account of the origins and evolution of the Care Trust, with insights from local evaluation, staff surveys and performance data in key places (see Box 2 for key recommendations).

Box 2: Lessons from Torbay Care Trust (Thistlethwaite 2011)

Written by a key local evaluator and adviser to Torbay Care Trust, this policy paper highlights the following messages (pp. 23–4):

- 'Base any strategy on the benefits being sought for service users/patients. Specify the benefits in advance, communicate them constantly, invest in the things that will help achieve them, monitor progress, listen to staff experiences, share results and encourage further improvement;
- Use GP registration, not home address, to allocate work to integrated community support services – this is a key building block of sustainable team working that will simplify access to help and make co-ordination of effort easier;
- Establish joint governance early;
- Invest in a professional approach to organisational development/change management over an appropriate period of time;
- Make sure senior/middle managers and clinical leaders are engaged from the start;
- Prioritise continuity of care at home, with intermediate care provision and hospital discharge processes tied in to support it;
- Make sure everyone understands what is meant by the term "integration".'

The outcomes of joint working

As Table 2 above suggests, a number of studies in this review adopt qualitative, formative and/or process-based designs. Where outcomes data are included, there tends to be a relatively narrow focus on hospital bed days or admission to care homes (which are both multi-faceted issues that joint working alone might struggle to reduce). More generally, there seems to be a difference between more descriptive and practice-focused accounts (which can often make strong claims – see Box 3 for an example), and more in-depth, peer-reviewed and externally commissioned accounts (which suggest more cautious/mixed findings – see Table 5 for an overview). As examples of the latter, the evaluation by Brown and colleagues (2003) of integrated health and social care teams identifies some improvements in the process of integrated working (such as quicker assessments and some improvement in communication), but is unable to identify any impact on clinical outcomes. Indeed, older people receiving support from co-located teams were more likely to enter residential care – which could either reflect slightly higher needs or might be an unintended consequence of joint working (with more of a 'medical model' beginning to predominate). Similarly, in London, Davey *et al.* (2005) suggest that co-locating staff does not necessarily lead to closer interprofessional working, and that broader factors such as levels of cognitive impairment, the intensity of home care received and whether or not an

Box 3: Examples of claims made in some of the more local/descriptive studies (for illustrative purposes)

> Qualitative analysis of feedback indicated a 'seamless service' had been achieved in the admission-prevention role, aiding patients smoothly through their crisis ... Upton Surgery ... has significantly strengthened local collaborative, multi-agency working, creating a more sophisticated and effective service for its patients and colleagues ... The Complex Care Team has sensitively challenged cultural and traditional roles and responsibilities and enabled effective and cohesive teams (Dodd *et al.* 2011, pp.109–10).

Improvements in Salford were perceived as including faster/simpler access, more efficient working, better use of single assessment, better understanding of roles, improved trust, opportunities to consider skill mix, enhanced learning and skill sharing, a more holistic approach, improved patient experience, and improved information sharing, risk management and decision-making (Syson and Bond 2010). The lead author was working for Salford City Council.

older person lives alone are more likely than the extent of joint working to influence whether or not people remain living independently in the community. At a national level, Coleman and Rummery's review of social services representatives on the Boards of Primary Care Organisations suggests some initial positives in relation to partnership working, but concludes that 'progress is slow and often fragmented'.

Helpful summaries are provided in a number of the studies included in this review:

Integrated working

- Brown *et al.* (2003):

  > the co-located health and social care teams described in the present study have not had an impact upon the clinical outcomes for their service users: it might be that the degree of 'integration' seen within these teams is not sufficiently well-developed to make a difference (p.93).

- Davey *et al.* (2005):

  > Co-location does not necessarily lead to substantially closer interprofessional working ... factors affecting outcome were degree of cognitive impairment, intensity of home care received and whether the older person lived alone. Whatever the model of collaborative working, its effects on remaining in the community must be assessed in the wider context of the characteristics and services received by older people (p.22).

- Kharicha *et al.* (2005) add:

  > whilst GPs and social workers agree that joint working should have advantages for

Table 5: Outcomes of closer joint working between social care and general practice

Source	Brief summary of key outcomes observed
Banyard *et al.* 2002	Examples of quicker referrals, better response times and improved communication or reduction in stigma for some patients – but some practical difficulties and an initial lack of understanding of social care roles. Some practices could be difficult to engage – especially single-handed GPs.
Brown *et al.* 2003	Some improvements in the process of service delivery (patients served by integrated teams may self-refer more often and may be assessed more quickly, and there may be some improvements in communication, understanding and exchange between practitioners). However, the degree of integration may not be enough to change clinical outcomes. There may also be some unintended consequences (for example more rather than fewer people admitted to residential care). Finally, older people do not care who provides their services – the quality of relationship with providers is key.
Coleman and Rummery 2003; see also Rummery 2003/Rummery and Coleman 2003	Social services representatives on PCG/PCT Boards felt attitudes to them had improved over time – but their influence remained limited. Relationships between social care and general practice may have improved – but overall 'progress is slow and often fragmented' (p. 277). Partnership could come fairly low on PCG/PCT agendas, especially early on, and GPs often had little experience of working with social services or of commissioning for whole populations.
Davey *et al.* 2005/Kharicha *et al.* 2005	Co-location does not necessarily lead to greatly improved interprofessional working. Degree of cognitive impairment, intensity of home care and whether older people live alone may affect whether people can stay at home more than collaborative working.
Dodd *et al.* 2011	£148,000 savings through hospital admission avoidance; perceived improvements in collaborative working; reduced duplication; access to wider range of services – but this seemed to be more a study of case management than of joint working per se.
Syson and Bond 2010	Broad/general impacts described including faster/simpler access, more efficient working, better use of single assessment, better understanding of roles, improved trust, opportunities to consider skill mix, enhanced learning and skill sharing, a more holistic approach, improved patient experience, and improved information sharing, risk management and decision-making.
Taylor 2001	Generic health and social care worker pilot – helpful description of the approach adopted and key factors that shaped the pilot, but less on specific outcomes.
Thistlethwaite 2011	More general policy paper highlighting broader outcomes, including speed of response, more integrated working, improved access to intermediate care, improved confidence/PCT survival during national reorganisation, and positive performance data (for example on the use of hospital beds).
Wistow and Waddington 2006	Joint post of PCT Chief Executive and Director of Social Services, intended as first step to more structural integration. Later disaggregated following a zero star rating for the PCT.

their shared clients/patients, each profession wants the other to change its way of working (p.404).

- Taylor (2001):

  if this pilot project is to be incorporated into mainstream practice attention needs to be given to the positive nature of the informal communication that existed between [front-line staff] ... It was an important underpinning aspect of the work of this pilot and should not be assumed to automatically exist elsewhere. The time involved in these informal processes particularly needs recognition (p.245).

Partnership working

- Coleman and Rummery (2003):

  PCG/PCTs should probably be concentrating on fostering more effective partnership working ... [rather than seeking structural integration via Care Trusts] ... before the shared trust, values and priorities that would be necessary to make Care Trusts effective are in place (p.279).

- Rummery (2003) adds that:

  the lack of tangible benefits to date for users and carers is of concern... the purpose of partnership working should be to deliver improvements in access and services to users. Until they start delivering that, the partnerships between [Primary Care Organisations] and local authorities will simply be another form-filling exercise designed to please central government (p.41).

- Thistlethwaite (2011):

  Torbay's story underlines the time needed to make changes ... and the role of local leaders in this process ... It also demonstrates the importance of organisational stability and continuity of leadership. The power of keeping patients and service users ... at the centre of the vision for improvement is another key message, and one whose importance is difficult to overestimate (p.1).

- Wistow and Waddington (2006):

  the case study and other evidence... demonstrate that the route to improved outcomes depends on managing not only the tension between structure and culture but also that between national targets and local discretion. We are still some distance from designing an integrated governance system capable of reconciling either of these tensions and certainly not both of them (p.17).

Interestingly, there is little discussion in any of the studies included about the financial costs or benefits of collaboration. Given that assumptions about likely cost savings often underpin arguments for closer integrated and partnership working, this seems a key finding.

KEY THEMES FROM INTERVIEWS

Interviews took place in late 2012. This was a time of considerable flux and uncertainty, as CCGs were in the process of forming as organisations and building towards the 'authorisation' process, Health and Wellbeing Boards were operating in shadow form, and the details regarding the transfer of public health responsibilities, funding and workforce to local authorities were yet to be confirmed. Many of the participants were either directly involved in the corresponding local and national negotiations that these changes entailed and/or in senior positions within organisations who supported or represented those leading on these discussions. Other participants had studied previous reforms and could therefore draw from the contexts and processes that these entailed as they considered the current developments.

The findings from the interviews are themed against the research questions set out in the introductory sections.

Previous engagement between GPs and social care

According to the interviewees, social care and general practice have not historically enjoyed a close and trusting relationship. Despite their respective centralities to the health and social care system, operational contact between the two sectors in relation to integrated care has been limited (or in the phrase of one interviewee 'more incidental than by design'). This was seen to be due to:

- a lack of shared incentives within performance and/or payment mechanisms for GPs and social care to work collaboratively;
- practical difficulties around GPs' need for cover in order to attend meetings outside their practices and social care being used to standard working hours);
- working to different boundaries, with GPs focusing on their practice populations and local authorities on residents within their geographic localities.

Furthermore, the continued emphases on medical needs in GP training and broader societal issues within social care were seen as still leading to differences in outlooks and approaches, and many GPs were thought to be struggling to understand how the social care system actually worked in relation to assessment processes, eligibility criteria and personalisation.

On a strategic level, both GP and social care practitioners could and did survive without the need for close partnerships (integration). Discussions tended to be between the local authority and PCT, and GP clinical engagement within many PCTs was limited. That said the experience of developing Primary Care Groups (which were launched with the aspiration that GPs would have a greater level of involvement) was seen as being relevant to these new arrangements. One interviewee picked out the importance of having social care represented on the CCG Boards:

> A really important lesson from the development of PCGs was the involvement of a local authority rep on the board, and for these representatives to have both an operational and strategic understanding.

This mirrors the findings of Coleman and Rummery (2003), who found that it took time for benefits of social care representation to be realised.

The potential impact of joint working in the new policy environment

While the dangers of generalising were emphasised, on the whole GPs were seen as a collection of individuals who could bring a new dynamic to the strategic commissioning of health care and to partnership working between health and social care. This was partly on the basis of the unique knowledge of their patients and communities that they can build up over years, but also due to the decisive approach that many GPs bring to both their clinical and business responsibilities: 'You can pitch them something and, if they go for it, it happens. This makes then easier to do business with than a semi- but not openly political animal like a PCT'.

On an individual patient level, the potential for joining up health and social care funding in the form of integrated personal budgets was raised, although it was recognised that this would require GPs and CCGs more generally to have a better understanding of the process and for flexibility in financial controls on both sides. On this it was commented that:

> Money has to lose its identity so that people do not have to be separating out how they spend the local authority and health budgets. This will require a good relationship in which the different accountants are willing to give up their obsessions regarding how every penny of their budget is spent.

The potential benefits of GPs and social care sharing their intelligence on the needs of, and services accessed by, patients were highlighted. Commissioning Support Services (CSSs – set up to provide CCGs with commissioning support) were felt by some to be an opportunity to integrate the commissioning infrastructures of health and social care, which could provide both efficiencies and added value of sharing approaches and insights.

What may hinder joint working?

The financial pressures that all parts of the system were working under were seen as providing considerable pressure for primary and social care. While it was thought this could be a force for change and doing something different, there were also concerns that it would mean that the new arrangements did not have the time and freedom to develop new collaborative approaches. In particular, there were concerns that the financial context may prevent opportunities for more informal networking, which was seen as vital for the development of personal relationships between GP and social care representatives at the integrated and partnership levels. The membership nature of CCGs may mean that the lead contacts will change over time and social care representatives need to be able to respond appropriately to this flux. At the time of the interviews many social care

departments were also being reorganised, which again may mean that those leading negotiations would not be in the same post (or indeed authority) in six months' time.

It was also highlighted that taking on responsibility for identifying need, prioritising investment and procuring from a market will be a steep and time-consuming learning curve for most GPs. Learning about these strategic roles and gaining experience of their implementation would be the main priority for GPs, and this again may restrict their ability to network with social care. The potential for them to be over-stretched was noted by one interviewee: 'We're asking GPs to be medical experts, purchasers, providers, clinical leaders and good partners – and it's a lot to ask'.

This in turn may mean that opportunities for improving quality and efficiency are lost: 'The GPs are arriving at the table at an incredibly challenging time …. They are not only running to catch up, but the bus is moving away at pace …'.

A number of respondents emphasised the difficulties that CCGs may have in engaging individual practices in new joint working arrangements. To quote one interviewee: 'My impression is that your average jobbing GP will carry on as before'.

Local authorities were also seen as having work to do in order to be responsive partners, as in this comment from an interviewee: 'LAs need to be more organised from our end and to be sure that social care are "lean and mean", in the sense that we know what we are doing and why and that it is part of our core responsibilities'.

Outside CCGs and LAs, other changes in the system were seen as potentially disruptive. Subjecting CSSs to competition opens up the possibility that more entrepreneurial CSSs could end up expanding and covering a range of different geographical areas. One Director of Adult Social Services raised this as a particular concern, reflecting on the extent to which local authorities might want to develop joint commissioning arrangements with a local CSS that might in future be taken over by a CSS from another part of the country. Active private sector involvement was also seen by some as a potential threat if it led to a situation where companies with a vested interest in selling additional services were involved in commissioning support. At a national level, it was also felt that the relationship between local bodies and the NHS Commissioning Board was insufficiently clear at that time. Finally, the ever-changing nature of NHS structures was seen as a threat to long-term relationships and planning, an experience one interviewee reflected on: '[Previous good working arrangements have] come and gone – and some practitioners are left bewildered as to why it's gone at all'.

IMPLICATIONS FOR POLICY, PRACTICE AND RESEARCH

This review of the relationship between social care and general practice raises a series of key issues for future research, policy and practice. In terms of the formal literature, we know relatively little about partnership and integrated joint working between social care and general practice. This is due to the limited evidence base and the different policy era in which it was completed (much of it deriving from the late 1990s, from the advent of PCGs and/or from a number of GP-attached social work or integrated team pilots). The studies reviewed here are also very mixed in focus and methodology – focusing on a range of different operational and strategic approaches, appearing in very different types of journal, spanning the academia-practice divide in different ways and covering a number of small-scale pilots as well as large, externally-commissioned studies.

As with the broader literature regarding joint working, key issues include the practical difficulties of engaging GPs in inter-agency collaborations; a lack of mutual understanding; different priorities and geographical boundaries; and a turbulent policy context. Key factors that may aid more effective joint working include the importance of time and space to build good relationships; trust and awareness of each other's roles; clear commitment at practice and senior level; shared priorities and outcomes; and appropriate practical and organisational development support. Also like the broader literature, our review contains very little information about costs or savings – and there remains insufficient evidence to know what impact joint working might have on future spending.

From our interviews, recent changes have created opportunities for new relationships – but the consensus is that this will be challenging for new CCGs and that progress may be difficult in a very complex policy environment. General practice and social care have had very little strategic contact, with previous relationships focusing on the local authority and the PCT. Initial training does little to prepare either agency or profession to collaborate, and there is a series of practical barriers to overcome. There is also a need to clarify how key parts of the new system, such as CSSs and the NHS Commissioning Board, will work and link with local bodies. While the former may offer scope for more integrated approaches at local level, the uncertainty surrounding the role of CSSs may also undermine efforts at joint working.

Implications for integrated working from this review

- GPs and social workers often do not understand the other profession's unique role, responsibilities and perspectives. Addressing this requires both formal (for example, through shared forums and development) and informal (for example, networking) opportunities for the key players to engage with each other.
- Interprofessional education would still seem to be a potential means to develop better appreciation and understanding. This could be extended to post-qualifying courses as well as undergraduate degrees.

- Previous relationships will influence the success of future attempts to promote joint working, meaning that good ones can be built upon but legacies of poor relationships need to be sensitively but honestly addressed.
- The different eligibility and catchment criteria applied means there will be people who do not fit neatly into both services, which can be frustrating for both parties and most importantly the service user(s) concerned. A willingness to address such situations positively, through for instance being willing to work with a service user who is resident in another local authority, can lead to reciprocal flexibility in the future.
- GPs operate on a different financial basis to social workers and often work split shifts due to clinics – accepting and responding appropriately to these practicalities is vital.
- Co-location can contribute to better joint working but this is not guaranteed, and if introduced needs to be accompanied by organisational development across both agencies.

Implications for partnership working from this review

- Improving outcomes for local services users and their carers must be the focus for strategic and operational initiatives seeking to improve joint working with GPs.
- There needs to be a realistic view about what can be achieved within the resources available.
- Good ideas may not work in practice, and it is important to build in evaluation capacity to assess actual impact and then adapt approaches accordingly.
- It takes time for new integrated strategic and operational arrangements to settle in and become productive, and a degree of stability is therefore required.
- Operational staff need flexibility to respond to the issues arising from GP referrals – this may mean, for example, developing agreements with neighbouring authorities to assess their residents who are registered with a local GP practice and advising patients with issues that strictly lie outside of a social care remit (for example, benefits and housing).
- Relationships based on respect and trust are just as important at a strategic as at an operational level and these can only be built up through contact, time and a willingness to respond to the priorities and pace of the other party.
- New bodies such as the CSSs provide opportunities for bringing together health and social care functions and the possibility of adding value above and beyond such activities being carried out in isolation.

Implications for national policymakers

- Achieving better joint working across inter-agency and inter-professional boundaries takes time and it is therefore vital that the new arrangements are given time to bed in and are not disrupted by a further restructure.

- It is better to reward agencies for performing well than to put in place national penalty systems for those who are seen not to be achieving sufficient pace or impact.
- Much emphasis is placed on the potential of joint working to achieve better outcomes for less money, but the formal evidence base remains too under-developed to know whether or not this is achievable in practice. Indeed, none of the studies included in this review considered cost-effectiveness at all.

Priorities for future research

We suggest the following priorities for further research:

- Tracking how different local authorities approach integrated and partnership working under the new arrangements.
- Capturing the experiences of key players in relation to development of integrated and partnership arrangements to provide learning for other local authorities and in future restructurings.
- Evaluating the impact that different joint working arrangements have on service user and organisational outcomes.
- Encouraging common approaches to evaluating of outcomes and efficiencies to enable comparison and collation of case study based research.
- Joint research between medical school and social care based university departments, to ensure that findings and learning is relevant to both disciplines.

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APPENDIX A: PRO-FORMA USED FOR DATA EXTRACTION AND ANALYSIS

Authors and Year	
Brief summary	
Theoretical basis if applicable	
Clarity of research question	
Design	
Setting	
Population/participants	
Sampling	
Thoroughness of data collection	
Rigour of data analysis	
Key impacts of joint working (if any)	
Factors that helped	
Factors that hindered	
Implications for practice	

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