

**An overview of the evidence concerning the effectiveness of services
delivered jointly by health and social care providers and related
workforce issues**

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An overview of the evidence concerning the effectiveness of services delivered jointly by health and social care providers and related workforce issues

1. Background and Introduction

The current focus on workforce redesign in Wales is one component of the strategy for implementation of the recommendations of Derek Wanless (1). These recommendations highlighted the need to shift resources from secondary care, particularly from hospitals - to care in the home and in the community (self care, primary care). This shift in the balance of care delivery will necessitate a change in working patterns and ultimately a shift in the balance of the workforce from secondary to community based care.

As an initial stage of planning this redeployment the Welsh Assembly Government commissioned the All Wales Alliance for Research and Development (AWARD) to carry out a review of research concerning the health and social care workforce interface, highlighting issues of best practice. This work was commissioned as a small scale study, to be completed within a short timescale in order to meet planning requirements.

Although the review was commissioned as part of the workforce redesign subgroup of the Wanless implementation committee, the work presented here has focussed primarily on service delivery rather than implications of service redesign for the health and social care workforce in Wales. This was dictated by the available literature on the effectiveness of joint delivery which in many cases did not explore workforce redesign issues involved in delivery. It should be noted however, that to plan effectively at local and national level, workforce redesign considerations need to be explored, through primary and secondary research.

Phase 1 of this work consisted of a scoping study identifying and summarising the quantity, type and focus of references concerning workforce issues at the health and social care interface. Following feedback from WAG on the scoping study results, Phase 2 consisted of an overview of the published literature concerning the effectiveness of joint working schemes and flagging up any workforce issues highlighted within these studies.

2. Aim

The aim of the study is to describe and appraise the evidence concerning effectiveness of services delivered jointly by health and social care providers, in order to highlight areas of good practice and to identify questions for further research.

2.1 Objectives

Objectives are to:

1. identify and describe published evaluations of the effectiveness of jointly delivered services
2. describe and appraise methods of evaluation used

3. identify specific workforce issues arising from the review
4. draw out implications for current service development and research

3. Methods

3.1 Phase 1: Scoping study methods

Eight electronic library databases including: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Caredata, British Nursing Index (BNI), Web of Knowledge (WOK), Medline, Applied Social Sciences Index and Abstracts (ASSIA), Health Management Information Centre (HIMIC) and System for Information on Grey Literature in Europe (SIGLE), were searched for references using the following search terms:

- Inter-professional issues
- Workforce redesign
- Examples of inter-professional working at the health and social care interface
- Workforce aspects of home care and direct care
- Organisation of health and social care services in Northern Ireland
- Continuity of care
- Service innovation
- Partnerships in the delivery of health and social care

In order to cast the net as far as possible, no date or country restriction was set for the search.

All documents returned were screened by one researcher (AP) to ensure that the study in question focussed on the interface between health and social care, and not only on one area. Duplicate articles were removed. Basic information (including authors and major themes) on all of the included references were entered into an Access database. In most cases, entry was based on abstracts and summaries, rather than the full paper. Where the abstract or summary was particularly thin or ambiguous, the full document was studied to provide the necessary information. References were graded using a hierarchy used in the recently completed review of the evidence concerning the burden of disease, and the organisation and delivery of services for gastrointestinal and liver disorders (2). This classification system was based on those developed by the Centre for Reviews and Dissemination (3) and NICE (4). The classification system is shown below in Table 1.

Table 1: Evidence Classification

Level of evidence	Type of evidence
1	High-quality or well-conducted meta-analyses, systematic reviews of randomised-control trials (RCTs), or RCTs with a low risk of bias and direct topic relevance.
2+	High-quality or well-conducted case-control or cohort studies with a low risk of confounding, bias or chance and a good probability that the relationship is causal; RCTs without direct topic relevance.
2-	RCTs, case-control, cohort studies, or surveys with a risk of confounding bias, or chance that the relationship is not causal.
3	Non-analytic studies (e.g. case reports, case series).
4	Expert opinion, formal consensus, and policy documents.

The major themes and workforce issues identified were summarised.

Before undertaking the review, a meeting was held with project commissioners from the Welsh Assembly Government in which the results of the scoping study were presented. Within the limited time available to complete the work, priorities were discussed. The direction for the review was agreed: to describe the evidence concerning effectiveness of services delivered jointly by health and social care providers, in order to highlight areas of good practice and to identify questions requiring further research.

3.2 Phase 2: Review methods

Based on feedback from the librarian assisting with literature searching and article retrieval, for the main review the following three search terms were added: chronic disease management, delayed discharge/bed-blocking, and early supported discharge. Documents identified from these studies were initially screened as above: those which were duplicates or did not concern the interface between health and social care were excluded. Included documents were added to the Access database. Some hand searching was also done, focussing on those journals from which articles had already been identified. The Wales Office for Research and Development (WORD) website was searched. Where possible, key references cited in papers were also retrieved. However, due to time constraints, it was not possible to retrieve individual studies included in the literature reviews identified. For these studies, information from the reviews only is described in this report.

Inclusion criteria for the review were refined on the basis of the discussion with WAG.

Studies should:

- be about services delivered jointly between health and social care
- encompass an evaluation of the effectiveness – to include outcomes, not just processes - of a joint scheme of working
- include primary data, or a synthesis of data from primary studies

A researcher (JP) then screened all abstracts and documents identified in the scoping study and in the searches afterwards, applying the inclusion criteria above. This exercise was repeated by the Project Lead (HS). Where there was disagreement, papers were reviewed and consensus was reached. All studies, and their reasons for inclusion or exclusion, were recorded in the Access database previously described. Included studies were then summarised in a table and graded (see Appendix 1).

4. Findings

4.1 Scoping study findings

The literature search for the scoping study produced 221 references. This total was reduced to 120 by excluding duplicates and those which were not relevant (e.g. because there were concerned *only* with the delivery of health services, rather than the interface). In addition, 5 references were identified through hand searches, giving a total of 125 references included in the scoping exercise. Over three-quarters of these had been published during or since 2001. The oldest reference dated from 1992.

Scoping study findings are presented in five sections: forms the interface can take, parties involved, types of needs being met at the interface, research methods employed and main issues discussed in the literature.

What forms can the interface take?

The literature suggested that a wide range of activities can take place at the interface between health and social care:

- Joint planning of services
- Joint commissioning of services
- Joint delivery of services, e.g. integrated care, intermediate care
- Unified assessment/single assessment process or other forms of joint working on access

Who are the parties involved in work at the interface?

The literature referred to each of the following groups of workers as playing some part in work at the interface between health and social care:

- General Practitioners
- Nurses (district nurses, practice nurses, hospital-based nurses)
- Occupational Therapists, physiotherapists
- Social workers
- Home care staff (statutory or independent sector)
- Residential home staff (statutory or independent sector)
- Voluntary sector staff and volunteers

In addition, there was a considerable literature considering the perspective of service managers and planners, and a smaller one considering the experience of patients/service users in relation to services delivered at the interface, particularly intermediate care.

What type of health and social care needs are being met at the interface?

Although the literature indicated the wide range of health and social care needs which are being met at the interface, certain topics dominated the literature. Particularly strong themes were mental health (nearly a quarter of all references) and older people. In terms of service delivery, intermediate care was the most commonly cited theme.

Thirty-four of the references dealt very broadly with principles behind the delivery of community care services or of public services more generally. The remaining 91 references are categorised below according to the dominant topic or health and social care need which they discussed. Five of the mental health references also included discussion of another topic, such as older people, primary care or learning disability.

Table 2: Topics of health and social care needs identified in the scoping study

Topic	Number of references
Mental health	29
Older people	21
Intermediate care	18
Primary care	8
Learning disability	4
Disabled children	4
Palliative care	2
Continuing care	1
Diabetes	1
Drug use	1
Emergency care	1
Occupational therapy	1

What sort of information do we have?

References tended to be concentrated at the lower levels of the hierarchy of evidence, in other words, there was a shortage of rigorous evaluations and systematic reviews, but a more plentiful supply of opinion and speculation. See Table 3.

Table 3: Grading of Studies

Level of evidence	Type of evidence	Number of Studies
1	High-quality or well-conducted meta-analyses, systematic reviews of randomised-control trials (RCTs), or RCTs with a low risk of bias and direct topic relevance.	3
2+	High-quality or well-conducted case-control or cohort studies with a low risk of confounding, bias or chance and a good probability that the relationship is causal; RCTs without direct topic relevance.	20
2-	RCTs, case-control, cohort studies, or surveys with a risk of confounding bias, or chance that the relationship is not causal.	19
3	Non-analytic studies (e.g. case reports, case series).	36
4	Expert opinion, formal consensus, and policy documents.	42
Guidelines	Guidelines set by clinical groups (e.g. NICE, BSG, AUGIS) – see quality assessment for an appraisal of these.	5

What are the main issues discussed in the literature?

Twenty six of the references took a primarily descriptive approach to the write-up of an innovation in service delivery, without explicit analysis of themes or issues. The remaining 99, focused on various issues, either potential problems to do with work at the interface, or ideals and values which might be thought to be promoted through some form of integrated working. These issues can be divided into two categories – those which were about the workforce, and those which were more general. Some of the references dealing with workforce issues focussed primarily on one sector, most commonly health.

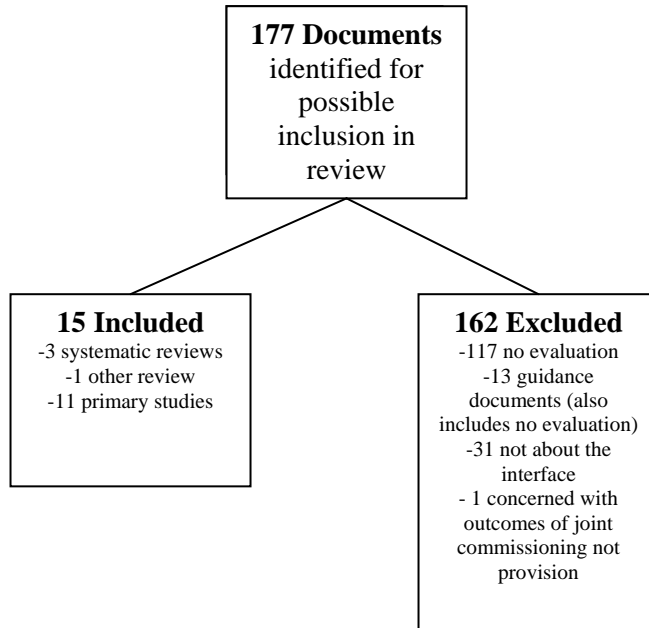
Table 4: Main issues identified in the Scoping Study

Issue	Number of references
<i>Workforce issues</i>	
Roles/role boundaries	21
Workforce planning	4
Training and education	3
Labour markets	1
<i>Other issues</i>	
Facilitators of/barriers to interagency working	11
Role of the voluntary/independent sector	7
Service quality	3
Service efficacy	6
Equity of access	2
Value for money	1

4.2 Review findings

At the start of the review there were 177 references. After applying the inclusion criteria, 162 papers were excluded. The majority of these were excluded because they did not contain an evaluation of the joint working scheme in terms of its outcomes. The breakdown of results can be seen in the following flowchart.

Flowchart 1: Breakdown of Papers



See Appendix 1 for a summary of each included study and Appendix 2 for a list of the excluded studies, grouped by reason for exclusion.

4.3 Results by objective

Findings are presented by objectives and are based on the 15 studies summarised in Appendix 1.

4.3.1 To identify and describe published evaluations the effectiveness of jointly delivered services

Fifteen studies were included in the review – all those that included outcomes of services for users, not just processes of service delivery. These fifteen studies have been summarised in Appendix 1, and arranged primarily in order of the grading received according to the hierarchy presented in Table 1.

Four of the studies were reviews (5-8), three of these following systematic review methodologies (5-7), including one Cochrane review which included randomised trials only (6). Studies included in these reviews were not retrieved individually due to time constraints. This overview therefore contains only information contained in the reviews for these studies.

None of the other 11 studies were randomised controlled trials, although 5 included a concurrent control group (9-13), with a further two utilising a ‘before and after’ comparison (14, 15). However, even in these studies details of sampling, recruitment, response rates and responses were lacking. Methods of evaluation in the other 4 studies were weak and often weakly described.

The meta analysis (6) was carried out in a specific field – the care of stroke patients, with trials of early supported discharge included in the review. This was the only study which reported clear benefits for patients, but only a minority of included studies were delivered jointly by health and social care providers and it is not possible to identify the benefits of these services separately from the paper. These individual studies could be retrieved and benefits described separately, given time and resources to do this.

The three other reviews all purported to describe the effectiveness of joint working for users/patients. However, in the first of these (7), effectiveness is not further defined. In the second (8), effects on health service users are defined but evidence found is described as ‘sparse’. In the third (5), the focus was explicitly on the effects of collaboration between health and local government agencies on health outcomes, and attention was paid to attempting to separate out effects of joint delivery. This review, commissioned by the Wales Office for R&D in the late 1990s contains very useful summaries of all included studies, which may be of use to commissioners and those involved in service development. In all of these reviews the overwhelming conclusion is that most papers in this area focus on the processes of joint working or delivery of services rather than outcomes for patients, and even where outcomes are included it is difficult to attribute these to the joint working rather than some other aspect of the new service.

Outcomes included in the remaining studies included user views and satisfaction; staff views and satisfaction; independent living; access to services, response and interval to

treatment times; quality of life and disability measures. With weak study designs, clear evidence of impact on outcomes was lacking although there were suggestions in several studies that access to services, communication and waiting times were improved and that users valued the services. However, no clear impacts were reported on independence or health status. Despite some resistance to change, in general, service providers felt that jointly delivered services avoided duplication and improved access to services. Issues of increased workload and bureaucracy were also, however, raised.

4.3.2 To describe and appraise methods of evaluation used

As described in section 4.3.1 there were significant weaknesses in the research literature related to effectiveness of jointly delivered services reviewed in this paper. Some of these were not inherent to the research carried out – in some cases the focus of the research was not the same as that of this review, and the publications were included where the subject matter overlapped. In other cases, as described above, study designs utilised did not allow the attribution of effects to the joint delivery of the new service. Finally, in several papers, detail of methods and results was too sparse to allow appraisal of the validity of stated findings and conclusions.

4.3.3 To identify specific workforce issues arising from the review

The literature included in this review was concerned with the effectiveness of joint working between health and social care providers. Included studies reported evaluation results of multi-disciplinary working, and the majority did not focus specifically on workforce issues. Any good practice issues and barriers to success in workforce redesign described in the included articles are summarised in Appendix 1.

Cameron and Lart's systematic review (7) contained the most comprehensive information concerning workforce issues. The authors grouped factors identified as supporting or hindering joint working into three main themes: organisational issues, cultural and professional issues, and contextual issues. Organisational issues included sub themes: aims and objectives, organisational differences, roles and responsibilities, strategic support and commitment, communication/IT systems, co-location, personalities involved, strong management and professional support, resources and personnel and past history of joint working. Cultural and professional issues were broken down into negative assessments/professional stereotypes, trust and respect, joint training/team building and different professional philosophies or ideologies. Contextual issues included the political climate, constant re-organisation, co-terminosity and financial uncertainty.

Of the remaining studies, 8 highlight possible workforce redesign issues.

Good practice issues related to workforce redesign

Investing in leadership (8), (12), (14) and commitment of partners (8), (13), (14), was seen as essential in effective joint working. In terms of management structures there was a need to support an integrated, flexible approach. In joint working between health and social care providers in a mental health scheme in Scotland, it was concluded that services will be most successful in engaging clients in services if they are managed by statutory agencies and integrated into mainstream mental health services (12).

Agreement about the purpose of the partnership should be agreed (8). In one study it was recommended that a comprehensive service agreement between parties needs to be drawn up in advance, defining respective responsibilities for the management of budgets, administration and provision of materials. Appropriate mechanisms to maintain quality of work and a commitment to the professional development of the social worker must be put in place (13). In contrast, one study suggested that a ‘bottom-up’ approach may be beneficial in approaching integration (16).

A supportive environment was flagged up as important. Dowling et al identified good practice as suitable institutional and legal structures, satisfactory accountability arrangements and appropriate audit, assessment and monitoring (8). Supportive regional and national policy environments were also seen to be required for effective service integration at local levels (16). Effective communication channels, regular discussions and information sharing were seen as essential (14), (17), as well as shared decision making (12).

Related to the environment in which joint working occurred was the theme of relaxing boundaries. Through relaxing structural, organisational and financial boundaries (including separate funding streams, accountability arrangements, legal responsibilities, management and employment arrangements) progress towards integration can be assisted (16). In joint working in Somerset, staff were able to take on more roles and enjoyed greater variety of work (15). In the mental health joint working scheme in Scotland there was an absence of specific roles in the team and no discipline had primary importance (12).

Barriers to successful joint working

Lack of investment in service planning, training, team development and leadership from the start of the venture was highlighted as a barrier in several studies (12), (14), (15). Unclear leadership channels both in terms of team managers lacking inspiration from above and front-line staff being unclear where to turn to in uncertainty were raised as particularly problematic in respect to joint working in Somerset (15). In Scotland, different management structures and different terms and conditions of service for team members posed difficulties as well as the inability to offer more flexible working hours (12).

Difficulties with roles and boundaries were also highlighted as barriers in some studies. In particular, unequal power relationships and different understanding of roles, posed challenges (17). In Somerset, staff members reporting a ‘lack of autonomy and authority’ and an increased level of emotional exhaustion (15). In another study, lack of support led a social worker attached to a GP surgery to feel isolated and a loss of identity (13).

Inadequate communication channels including systems and processes were also identified as a hindrance to joint working (10), (12), (17). These resulted in poor methods of record keeping (10), and confidentiality and information sharing difficulties in a floating support scheme (17).

4.3.4 To draw out implications for current service development and research

Currently there is more focus on the successful process of partnerships rather than outcome issues. This indicates that more research is needed on testing joint approaches to delivery of services utilising rigorous study designs, as well as evaluating the outcomes of services implemented. With methodological challenges highlighted, a combined approach to evaluation including measures of both process and outcome is also needed. Inclusion of qualitative methods can also illuminate findings through gaining an understanding, alongside the quantitative findings, of how services are implemented and experienced by users and providers.

There is a clear gap in the literature that shows that end users have rarely been consulted about their needs and priorities, and about what they can gain from partnership working. There is an urgent requirement for devising methods for assessing whether these needs can be met through joint working.

Only one of the studies included in this review contained an economic component to the evaluation (9) although, many did recognise and highlight the need for a cost effectiveness evaluation to joint working.

This review has focussed on evidence concerning the effectiveness of joint delivery of services. As discussed, much of the literature originally identified for this review was subsequently excluded because outcome information for patients/users was not included. A great deal of this excluded literature focused on roles, boundaries and factors enabling or hindering partnership working. In order to gain a clearer understanding of the workforce issues present in joint working between health and social care, a further review, focussing on this topic would need to be undertaken.

5. Discussion and conclusions

This review presents a broad overview of the current literature containing an evaluation of the effectiveness of the outcomes of joint working schemes between health and social care partners. Within these articles, where possible, issues concerning the workforce interface between health and social care were highlighted. Although the majority of the literature identified in the scoping study search focused on issues relating to partnership working many of these studies did not fit the inclusion criteria for this review - in particular, many did not have an evaluative component of the outcome of the effectiveness of joint working. As discussed, findings reported here focus on formally evaluated joint working schemes and methodological issues in the evaluation of these schemes. It is recognised that other evaluative work may have been undertaken or be currently underway in service settings. Unless the results of these studies have been published, it has not been possible to include them in this review preventing other service providers learn from these local findings.

From our review of studies and reviews that have addressed impact on outcomes we conclude that:

1. There is a clear gap in evidence concerning the effectiveness of joint working initiatives
2. Published evidence lacks rigour, tends not to include measures of impact on outcomes for users, and impact often cannot be attributed to joint delivery of services
3. Evaluation of impact on users is methodologically challenging
4. Evidence related to workforce issues in this literature is sparse

6. Recommendations

With the current focus on workforce redesign in Wales many local health boards are now undertaking initiatives of joint working between health and social care. It is not yet known how many of these new initiatives contain an evaluation component. Yet without an evaluation process to determine good practice and the effectiveness of partnership working, the ability to transfer methods and models of good practice to other areas and schemes is lost.

Recommendations for further research can be summarised:

1. New models of care that involve joint delivery of services across health and social care providers should be developed and tested within a formalised research setting, so that costs and benefits can be assessed and lessons learned shared across the community of health and social care provision.
2. Results of the systematic review of impact on health outcomes of collaboration across health and social care providers commissioned by WORD (5) should be used at local and national policy level to inform the planning of initiatives and their evaluation.
3. All new investment made by the Welsh Assembly Government in jointly delivered services should include a requirement for evaluation (recommended to be 10% of the overall budget, in line with WHO recommendations).
4. A survey should be undertaken across Wales to identify initiatives that are - or are to be - jointly delivered between health and social care providers. All such planned initiatives should be reviewed to ensure that appropriate evaluative work is incorporated into plans.
5. A further review should be undertaken to draw together research findings concerning factors which enable or hinder joint delivery of services across health and social care providers.
6. This review should be taken as a first step. Longer-term workforce issues need to be addressed in Wales in order to plan service reconfiguration effectively through primary/secondary research undertaken by specialists in the workforce planning field.

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Appendix 1: Summary of included studies

ID, Main author, setting, and year of study	Client group, Study design, Numbers included	Primary question/ theme	Level of evidence	Key evaluation results & conclusions	Good practice issues concerning workforce redesign and	Barriers to success concerning workforce redesign
Hayes et al ⁽⁵⁾ World-wide, 2000	All client groups Systematic review 11 reviews; 52 trials (18 randomised, 34 other comparative trials)	Effects of collaboration between health and local government agencies on health outcomes	1	<p>The systematic reviews focused on health promotion campaigns for children and young adults; effectiveness of chronic disease management; and the effectiveness of a specific profession (school nurse). Teams were described in general terms, with systematic details of collaborators reported in only 1 review. 4 reviews found evidence of health benefit, but in 2 of these the benefits were confined to only some of the outcomes measured, and in none of the 4 could the health benefit be attributed to inter-agency collaboration.</p> <p>Results from primary research studies (32 focusing on health promotion initiatives: reducing cardiovascular risk, injury prevention, tackling substance abuse, pregnancy related programmes, protecting the health of the frail elderly; 20 on disease management: improving outcomes for frail elderly, people with severe mental illness, childhood asthma and chronically ill children) were combined, with mean effect size for mortality outcomes -0.07 (95% CI -0.16, 0.08); morbidity outcomes 0.23 (95% CI 0.06, 0.30); and lifestyle outcomes 0.39 (95% CI 0.10, 0.58). Benefits were reported as likely to be skewed by publication bias.</p> <p>The reviewers concluded that good evidence of health gain had not been found, although this does not mean that some collaborative configurations do not work.</p>	The authors did focus not on workforce redesign issues.	The authors did focus not on workforce redesign issues.

Langhorne et al ⁽⁶⁾ Worldwide, 2004	Stroke patients Meta-analysis 11 trials (1597 patients)	Effects of early supported discharge (ESD) initiatives on stroke patients	1	There was a reduced odds of death or dependency equivalent to 6 fewer adverse outcomes for every 100 patients receiving an ESD service (p=0.02). Patients receiving ESD services showed an eight day reduction (p<0.0001) in the length of hospital stay. There were also significant improvements in activities of daily living scores, odds of living at home and reporting satisfaction with services. However, multi disciplinary teams were predominantly made up of health service professionals, with only 3/11 studies involving ESD services with joint working between health and social care, and it was not possible to identify outcomes for the studies in which these teams were involved.	The authors did not focus on workforce redesign issues; this study was included in the review because three of the multi-disciplinary ESD teams involved health and social care staff.	The authors did not focus on workforce redesign issues.
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<p>Cameron and Lart ⁽⁷⁾</p> <p>UK, 2003 (includes articles from 1983)</p>	<p>All client groups</p> <p>Systematic review</p> <p>32 papers met incl. criteria</p>	<p>Factors promoting and obstacles hindering joint working</p>	<p>1</p>	<p>Factors identified as supporting or hindering joint working were grouped into organisational issues (aims and objectives, organisational differences, roles and responsibilities, strategic support and commitment, communication/IT systems, co-location, personalities involved, strong management and professional support, resources and personnel and past history of joint working) cultural and professional issues (negative assessments/professional stereotypes, trust and respect, joint training/team building and different professional philosophies or ideologies) and contextual issues (political climate, constant re-organisation, co-terminosity and financial uncertainty).</p> <p>Models of joint working identified included:</p> <ul style="list-style-type: none"> • placement schemes • multi-agency teams and projects • case or care management • strategic-level working <p>The authors suggest that there is some relationship between the type of model of joint working and factors promoting or obstacles hindering joint working, although they do not elucidate or quantify the relationship. They point out that most studies focused on the processes of joint working and the perceptions of those involved rather than the effectiveness of joint working. The authors conclude that research needs to focus on evaluating the impact of new ways of working on patients.</p>	<p>Organisational Issues</p> <p>Aims and objectives need to be clear, realistic, achievable, understood and accepted by all parties.</p> <p>Through clearly defining roles and responsibilities, gaps in provision can be identified and overlaps in work prevented. Formal policies and procedures need to be developed and reviewed regularly</p> <p>Strategic support/ commitment needs to be demonstrated by key individuals. The difference between strategic commitment and commitment of front-line staff should be considered and both addressed.</p> <p>Regular, frequent and good communication is the bedrock of successful inter-agency working. This can be done either formally or informally.</p> <p>Many studies highlighted the significance of co-location as the basis for successful joint working. It increased the opportunity for communication and resulted in improved co-operation. As well, having immediate access to other professionals can heighten sensitivity to problems. There is a need to involve 'the right people' in joint working projects including experienced professionals with existing networks and appropriate skills. Involve key stakeholders in recruitment to secure their commitment.</p> <p>There needs to be strong management and appropriate professional support especially when there is joint management of financial and personnel issues. There needs to be access to supervision and training and on-going evaluation and audit.</p> <p>A past history of joint working indicated there was usually a greater likelihood of success in a new venture</p> <p>Cultural and professional issues</p> <p>Trust and respect are key ingredients to successful joint working and valuing and respecting different professions is often linked to clear understanding of roles.</p> <p>Several studies suggested on-going joint training/team building could improve inter-organisational working.</p>	<p>Organisational Issues</p> <p>Organisational differences (including different agendas and interests) and the complexity of planning processes in the NHS and local government are often difficult to synchronise</p> <p>Communication/IT systems can be a barrier including: complex and inappropriate documentation, lack of common referral systems, missing or inadequate record keeping, inadequate or incompatible IT systems</p> <p>Resources and personnel barriers include: frequent staff turnover and too much reliance on key personnel. A lack of suitably qualified staff or managerial experience in operating jointly managed services is also a barrier.</p> <p>Cultural and professional issues</p> <p>Negative assessments/professional stereotypes can cause misunderstandings due to a lack of knowledge of other professions. This can cause distrust, alienation and resentment. Several studies identified difficulties in working with GPs. Different professional philosophies or ideologies sometimes resulted in distinct working practices, working to different assessment procedures, distrust, professional rivalries, and defensiveness.</p> <p>Contextual issues</p> <p>The Political climate including central government's failure to resolve issues such as charging for social care and the on-going debates about the nature of continuing care are barriers.</p> <p>Constant re-organisation and the consequent lack of organisational stability can weaken senior management support for a project and undermine trust between organisations.</p> <p>The literature is inconclusive on Co-terminosity.</p> <p>Financial uncertainty including financial pressures and budgetary constraints could undermine willingness of agencies to be involved and cause distrust.</p>
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<p>Dowling et al ⁽⁸⁾ UK, 2004</p>	<p>All client groups Literature review- not systematic 36 papers</p>	<p>To assess the evidence on the effects of partnerships in health and social care and to investigate how partnership success is conceptualised</p>	<p>2+</p>	<p>The authors concluded that currently there is more focus on the successful process of partnerships than outcomes. Outcome issues were divided into two dimensions: 1) changes that result in the levels, organisation or delivery of services 2) improvements felt by service users. Outcomes considered included: improvements in the accessibility of services to users; improved equitability of services; improvements in efficiency, effectiveness or quality of services; improvements in the experiences of staff and informal carers; and improvements in the health status, quality of life or well-being experienced by people using services. However, they found a lack of 'firm and consistent evidence' that positive outcomes had been achieved by the partnerships concerned. The authors concluded that the literature is heavily skewed towards the processes of partnership working and the factors that contribute to success in terms of processes. They suggest that evidence that partnerships produce successful outcomes for staff, users or other stakeholders is very sparse. Their analysis suggests that outcomes are hard to measure and even more difficult to attribute to partnership working, but that this gap in the evidence base needs to be addressed through research and development of methods.</p>	<p>The review identifies possible dimensions of 'process success' and possible indicators of those successes. Successful partnerships are believed to be dependent on the level of engagement and the commitment of partners. They are considered to require agreement about the purpose of the partnership and are believed to involve high levels of trust, reciprocity and respect between partners.</p> <p>Successful partnerships are believed to be influenced by the environment. Favourable features include suitable institutional and legal structures, wider interagency activities with satisfactory accountability arrangements and appropriate audit, assessment and monitoring. Adequate leadership and management of the partnership is also essential.</p>	<p>Barriers to successful joint working were not highlighted in this study.</p>
<p>Trappes-Lomax T et al ⁽⁹⁾ Devon, 2002</p>	<p>Hospitalised older people, at discharge Quasi-experimental trial with cost-minimisation analysis N = 206 (94 intervention, 112 control)</p>	<p>To compare clinical and cost effectiveness of 2 models of service provision for older people discharged from a community hospital: joint social services/NHS short stay residential rehabilitation unit versus usual community services</p>	<p>2+</p>	<p>No difference in survival at home, time to readmission to hospital, health related QoL, general morale and well-being or coping scores. Costs were similar in the two groups, although fell more heavily on the NHS in the control group and on Social Services in the intervention group.</p>	<p>The authors did not focus on workforce redesign issues; this study was included in the review because one of the models of service provision was a joint health/social care residential rehabilitation unit for older people.</p>	<p>The authors did not focus on workforce redesign issues.</p>

<p>Davey et al ⁽¹⁰⁾ England, UK, 2005</p>	<p>Older people Interviews with older people at baseline and after 6 months in intervention and control areas 79 older people, 47 carers</p>	<p>An exploratory study assessing the feasibility of comparing two models of joint working and to examine the relative impact of personal characteristics, service use and co-location on the likelihood of older people remaining in their community</p>	<p>2+</p>	<p>Factors affecting this outcome were degree of cognitive impairment, intensity of homecare received, and whether the person lived alone. The influence of client health status was greater than anticipated, and the authors conclude that any effect of co-location would need to be large to offset this effect. They suggest that optimism regarding impact of structural changes may be misplaced although they recognise that large scale studies would be needed to confirm this.</p>	<p>In relation to workforce there was a focus on issues of location and types of communication. Co-location may alter the extent of direct face-to-face communication but not the overall style or direction of communication. There was more informal face-to-face contact between social workers and GPs in the co-located site which suggest that co-location may affect the mode of communication between GPs and social workers. However, face-to-face contact with nurses and social workers was higher in the non co-located site due to more prearranged meetings.</p>	<p>Overall contact with social care was under-documented. This needs to be addressed if partnership working is to be maximised.</p>
<p>Brown et al ⁽¹¹⁾ UK, 1999 – 2000</p>	<p>Older people Non-randomised comparative design with interview follow up 393 patients</p>	<p>To establish whether integrated teams are more clinically effective than a traditional non-integrated team</p>	<p>2-</p>	<p>There was no difference in the proportion of people living independently in the community at 18 months, functional ability or mental functioning. Patients in the integrated group were more likely to have self refer red. Speed of response was quicker in the integrated teams, but there were more admissions to residential care in this group, and quality of life and depression scores were lower (due to a more medical model of management?). More patients died in the traditional site, reasons for this are unclear. There were no clear differences in users' perceptions of the services between models. Overall, findings suggested that in the integrated teams, the initial stages of seeking help and assessment improved through better communication, understanding and information exchange. However the degree of integration in these teams was not sufficiently well-developed to have an impact on the clinical outcomes for patients and did not result in a greater number of patients living independently in the community. The authors suggests that benefits might come if greater integration can be achieved through more structural changes (integrated management and pooled budgets) and better information systems.</p>	<p>The authors did not focus on workforce redesign issues.</p>	<p>It may be that measures such as co-location are not enough to produce changes in the outcome for older people.</p>

<p>Cunningham G et al⁽¹²⁾</p> <p>Aberdeen, Scotland, 2001</p>	<p>People with mental health problems</p> <p>Interviews with staff and users of jointly provided 'assertive outreach service' compared to those of the traditional model of outreach</p> <p>N = 4 pilot staff, 5 control service staff; 5 pilot clients, 7 control service clients; 3 managers, 4 steering group members; 9 members of staff in other statutory and voluntary agencies; 4 carers</p>	<p>Evaluation to inform local service development, not further defined</p>	<p>3</p>	<p>Assertive Outreach Approach was defined as a flexible, client-centred approach to reach those people who are most disengaged from mental health services. No comparative data presented. Co-ordinated approach to care in pilot group; perception of increased stability in clients' lives through frequent contact, provision of advice and information as well as emotional and practical support.</p>	<p>There was an absence of specific roles in the team and no discipline had primary importance. Shared decision-making and shared responsibility of team members was highlighted as good practice. Clients were offered a relationship with the service not with a team member and there was one point of access to the team. All contact took place on client's turf. The staff to client ratio was 1:5.</p> <p>The evaluation identified that the team approach would be further enhanced through developing a shared philosophy of care and set of values, training in particular areas and further sharing of responsibilities. In terms of leadership, it was suggested that the establishment of a team leader would minimise the potential for divisions in the team, reinforce a coherent team, act as an advocate for the team in relation to other services and maintain motivation and inspiration.</p> <p>In terms of management structures there was a need to support the integrated, flexible approach. It was concluded that services will be most successful in engaging clients in services if they are managed by statutory agencies and integrated into mainstream mental health services. There is a need to ensure close working arrangements with all sectors and agencies.</p>	<p>Time and budgetary pressures meant there was limited early investment in service planning, training and team development.</p> <p>Issues to be resolved related mainly to the systems and processes. Different management structures and terms and conditions of service for team members posed difficulties as well as the inability to offer more flexible working hours.</p>
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<p>Le Mesurier N et al ⁽¹³⁾ Worcester shire, 2001</p>	<p>Older people Comparison of logged activities of general practice based social worker with other social workers in area, plus interviews with staff</p>	<p>To assess the effectiveness of a single social worker attachment to a GP surgery</p>	<p>2-</p>	<p>Increased workload for social worker attached to GP practice, improved processes of referral and screening; and of communication with other professionals. Perceived improvements included opportunity for preventative work and continuity of care</p>	<p>There needs to be strong commitment from the PCG/PCT and the social services department and a willingness for the social services department to devolve responsibility. A comprehensive service agreement between parties needs to be drawn up in advance, defining respective responsibilities for the management of budgets, administration and provision of materials. Appropriate mechanisms to maintain quality of work and a commitment to the professional development of the social worker must be put in place.</p> <p>There needs to be access to Internet technology to allow links with databases and facilitate updating records.</p>	<p>Effective support is needed to prevent social worker from feeling isolated and losing social work team identity.</p>
<p>Peck et al. ⁽¹⁴⁾ UK, 1999, 2000, 2001</p>	<p>Mental health service users Interviews with services users; questionnaires to staff both in the years 1999, 2000 and 2001 96 service users, 207 staff members in 1999, 124 in 2000 and 151 in 2001</p>	<p>To evaluate the impact a fully integrated mental health service in England on service users, their carers and staff</p>	<p>2-</p>	<p>Overall satisfaction of service users worsened with users reporting that access to services, efficacy, types of interventions and engagement with relatives had deteriorated. Although service user self esteem did rise, the proportion of users negotiating their own care plans fell from 60% in 1999 to 49% in 2001. Carers perceived staff as having limited understanding of their needs and problems. For staff, overall job satisfaction decreased between 1999 and 2000 but levelled off in 2001. However, staff felt their workloads had increased and the organisation was more bureaucratic. Benefits of the scheme were unclear, and the authors concluded that there had been no shift of power towards users.</p>	<p>A Joint commissioning board was established as a vehicle for sustaining commitment to mental health, including financial commitment. The Board was to act as a method of bringing openness and public accountability to the project. There was doubt however, as to whether the JCB was fulfilling its role as some of the core decisions were made elsewhere.</p> <p>In joint commissioning, it is advised not to oversell the early benefits as things may get worse before better. As well, organisational changes must not be confused with real changes in services. All players must be engaged: partnership is significantly weakened if it does not involve all the intended beneficiaries. Invest in leadership, organisational and staff development.</p>	<p>In this study the innovation was not complemented by adequate investment in the leadership, organisational development and training processes. There were concerns over the capacity of team managers to deliver change, increased pressure on these managers and tensions between locality management and the trust leadership.</p>

<p>Gulliver P et al⁽¹⁵⁾</p> <p>Somerset, England, 2001</p>	<p>People with mental health problems</p> <p>Structured interviews with service users and staff survey at baseline and 9 months; and workshops</p> <p>n = 96</p>	<p>To identify the impact of joint commissioning and combined service provision, combination of care management and the care programme approach, including exploration of impact of changes on service users and carers</p>	<p>2+</p>	<p>People interviewed twice appeared to be less well; more were employed or attending college courses (25% to 31%); satisfaction fell; (numbers, scales used and scores not reported).</p>	<p>Some staff took on more roles and enjoyed greater variety of work. There was a feeling of appreciation among staff for being involved in joint assessments. It was felt that achievements were predominately a result of co-location although having locality managers may have helped.</p>	
<p>Glendinning C⁽¹⁶⁾</p> <p>England, 2002</p>	<p>Older people</p> <p>Postal survey of first 32 sites and structured interviews with key staffing ten case study sites</p> <p>32 sites; number of interviewees not specified</p>	<p>Evaluation of the impact of the 'Health Act flexibilities' in integrating services for older people</p>	<p>2+</p>	<p>Interviewees emphasised the important symbolic impact of the flexibilities, and the 'striking effects on attitudes towards partnership and collaboration' of senior colleagues. Excuses for not working together had been removed. Benefits were seen as: clarity and transparency about the amount of resources available; an increase in leverage in negotiating for resources; new opportunities to invest budgets, and utilise each others resources; ability to put together complex care packages for highly dependent clients; reduction in duplication; increased efficiency of some previously marginal services. However, several barriers were still perceived and most services were undergoing change rather than delivering new services jointly. Staff were sometimes reported to be resistant to change, and GPs were reported to be particularly reluctant to engage in collaborative ways of working. Whilst these views mainly related to processes of care delivery, impact on outcomes for older people are unclear and there is little evidence that older people are being consulted about their needs.</p>	<p>Although it is too early to tell what impact integration is having on older people, some tentative conclusions about joint working can be drawn. It is believed that a 'bottom-up' approach may be beneficial in approaching integration. As well, relaxing structural, organisational and financial boundaries: including separate funding streams, accountability arrangements, legal responsibilities, management and the employment arrangements assist progress towards integration. Service integration at local levels requires some supportive regional and national policy environments.</p>	

<p>Sharples A et al ⁽¹⁷⁾</p> <p>England, 2002</p>	<p>Single vulnerable people</p> <p>Mixed methods: Analysis of routine data on users, interviews with users, focus groups</p> <p>123 users, 11 interviews, 4 focus groups</p>	<p>Aim: to describe and explore the impact of a floating support scheme for single vulnerable people as perceived by clients</p>	3	<p>A floating support scheme provided by a local housing association which enabled vulnerable people to live in their homes was evaluated from the perspectives of clients. Users valued the service which they saw as friendly, caring and confidential. They reported that the support worker was able to access better accommodation, enabled them to live independently, and gave advice on benefits, finances as well as practical support. Participants saw the support worker as a member of the community and felt they were approachable and acceptable, with good local knowledge of services, and with strong links with referrers, as well as time for regular contact with clients. However some limiting issues were raised, concerned with joint working – unequal power relations with colleagues in other services, issues of confidentiality and information sharing as well as risk management. With positive outcomes for clients reported, the impact of these limitations is unclear, but is highlighted for further exploration in other studies.</p>	<p>Good practice issues identified were: taking time to build understanding between all parties, regular discussions with consensus reached, information sharing and development of local protocols.</p>	<p>Barriers identified were: unequal power relationships and different understanding of roles. Confidentiality and information sharing were sometimes a difficulty because of unclear communication channels.</p>
<p>Ogundipe & Bloor ⁽¹⁸⁾</p> <p>North Staffordshire England, 2001</p>	<p>Drug misusers</p> <p>Pilot scheme case study</p> <p>10 week time period, numbers of patients not specified</p>	<p>Are multi-agency meetings more effective than traditional ways of working in treating patients who drug misuse?</p>	3	<p>After 10 multi agency meetings, patients were reported to be satisfied with reduced waiting times for treatment and the resource implication was minimal. Patient numbers, response rates and method of assessment were not specified. The authors conclude that an economic evaluation of multi-agency meetings compared to the traditional method is required.</p>	<p>The authors did not focus on workforce redesign issues.</p>	<p>The authors did not focus on workforce redesign issues.</p>
<p>Simpson & De Silva ⁽¹⁹⁾</p> <p>North Yorkshire, England, 2003</p>	<p>Older people with mental health problems</p> <p>Questionnaire surveys to patients, GPs and community mental health team (CMHT) members</p> <p>Service 1: 29 patients; GPs and CMHT member numbers not specified Service 2: No numbers given</p>	<p>Evaluating two different models for Community Mental Health Teams (CMHT) in old age mental health services</p>	3	<p>Service 1: Patients, GPs and CMHT members were reported to be happy with the service, which had resulted in the removal of waiting lists.</p> <p>Service 2: Gaps between referral and date seen dropped over the three years of the intervention despite an increase of 50% in referrals.</p> <p>The authors concluded that both schemes have succeeded in increasing the capacity for assessing older people, resulting in the removal of waiting lists, and apparently without lowering the quality of assessment. They highlight the need to measure the effect of the innovation on other parts of the system through further research.</p>	<p>The authors did not focus on workforce redesign issues.</p>	<p>The authors did not focus on workforce redesign issues.</p>

Appendix 2: Excluded studies with reason for exclusion

No Evaluation of outcomes of joint working scheme

No.	Author
(20)	Abbott S, Lewis H. (2002)
(21)	Allen D, Griffiths L, et al. (2001)
(22)	Andrews J, Manthorpe J, et al. (2003)
(23)	Ansari WE, Phillips C, et al. (2001)
(24)	Appleton P, Boll V, et al. (1996)
(25)	Apsitis Y, Jones E. (2002)
(26)	Asthana S, Richardson S, et al. (2002)
(27)	Atwal A. (2001)
(28)	Black N, Rafferty A, et al. (2004)
(29)	Boavida J, Espe-Sherwinot M et al. (2000)
(30)	Brown B, Crawford P, et al. (2002)
(31)	Brown B, Crawford P, et al. (2000)
(32)	Byrne J. (1999)
(33)	Caan W, Strend I, et al. (2000)
(34)	Callaghan J, Young B et al. (2003)
(35)	Campbell J, McLaughlin J. (2000)
(36)	Caris-Verhallen W, Kerkstra A. (2001)
(37)	Carpenter J, Schneider J, et al. (2003)
(38)	Cashman S, Reidy P, et al. (2004)
(39)	Challis D, Hughes J, et al. (2003)
(40)	Chilver K. (2001)
(41)	Clements L, Smith P. (1999)
(42)	Cohen, Z. (2003)
(43)	Cointet S, et al. (2001)
(44)	Cook G, Gerrish K, et al. (2001)
(45)	Cornes M, Clough R. (2004)
(46)	Costongs C, Springett J. (1997)
(47)	Cowley S, Bliss J, et al. (2002)
(48)	Crawford P, Brown B et al. (2001)
(49)	Crawford M, Jonge E, et al. (2004)
(50)	Crosby G. (2004)
(51)	Davies P, Frowen B. (2005)
(52)	Douglas S, Machin T. (2004)
(53)	Emerson T. (2004)
(54)	Enderby P, Stephenson J. (2000)
(55)	Farrell M, Schmitt M, et al. (2001)
(56)	Firth M, Dyer M, et al. (2004)
(57)	Gibb C, Morrow M, et al.(2002)
(58)	Glasby J. (2004)
(59)	Glasby J. (2004)
(60)	Glasby J. (2004)
(61)	Glendinning C. (2002)
(62)	Glendinning C, Abbott S, et al. (2001)

(63)	Glendinning C, Coleman A, et al. (2002)
(64)	Glendinning C, Coleman A, et al (2001)
(65)	Greig R, Poxton R. (2001)
(66)	Halliday J, Asthana S. (2004)
(67)	Hammond B. (2000)
(68)	Hampson M, Johnson H, et al. (2000)
(69)	Hargadon J. (2000)
(70)	Harper H, Minghella E. (1997)
(71)	Hawthorn C. (2000)
(72)	Holtom M. (2001)
(73)	Hubbard G, et al. (2004)
(74)	Hudson B. (2002)
(75)	Hudson B. (2003)
(76)	Hudson B, Lewis H. (2000)
(77)	Hughes L, James C, et al. (2002)
(78)	Hunt S. (2001)
(79)	Jaglal S, Santaguida L, et al. (2002)
(80)	King N, Ross A. (2004)
(81)	Kneafsy R, et al. (2004)
(82)	Kumar A, Parkinson G. (2001)
(83)	Lapidos S, Rothschild S. (2004)
(84)	Larivaara P, Taanila, A. (2004)
(85)	Le Mesurier N, Cumella S. (1999)
(86)	Lehane M, Carver L. (2002)
(87)	Lillywhite A, Atwal A. (2003)
(88)	Long A, Kneafsy R, et al. (2003)
(89)	Lyne P, Allen D, et al. (2001)
(90)	Mackay A. (2003)
(91)	Martin G, Peet S, et al. (2004)
(92)	Martin V, Rogers A. (2004)
(93)	McKelvie D. (2004)
(94)	McLaughlin H. (2004)
(95)	McMillan I. (2000)
(96)	McNally D, Peet J. (2003)
(97)	McNally D, Cornes M, et al. (2003)
(98)	McWilliam C, Coleman S, et al. (2003)
(99)	Milligan C. (1998)
(100)	Mountain G. (2001)
(101)	Nancarrow S. (2004)
(102)	Nancarrow S. (2004)
(103)	Nancarrow S. (2003)
(104)	Nandan M. (1997)
(105)	NHS Confederation. (2003)
(106)	Nykanen P, Karimaa E. (2002)
(107)	Outhwaite S. (2003)
(108)	Paley C. (2004)
(109)	Parkin P. (1999)
(110)	Peck E, Norman I. (1999)
(111)	Peck E, Towell D, et al. (2001)

(112)	Petch A. (2003)
(113)	Petch A. (2003)
(114)	Pethybridge J. (2004)
(115)	Pratten B. (2001)
(116)	Reilly S, Challis D, et al. (2003)
(117)	Richards M, and Vostanis P. (2004)
(118)	Roe B. (2003)
(119)	Rummery K. (1999)
(120)	Rummery K. (2003)
(121)	Rummery K, Coleman A. (2003)
(122)	Scholes J, Vaughan B. (2002)
(123)	Secker J, Hill K. (2001)
(124)	Sibbald B. (2000)
(125)	Snell J. (2003)
(126)	Stewart A, Petch A, et al. (2003)
(127)	Sweeney J, Stead J, et al. (2000)
(128)	Swinkels A, Albarran J, et al. (2002)
(129)	Tanti V, Blackman G. (2001)
(130)	Taylor A, Rubin R. (1999)
(131)	Vaughan B. (1998)
(132)	Wagner E. (2000)
(133)	Ward D. (2001)
(134)	Wilson A, Parker H. (2003)
(135)	Withington S, Giller H. (2000)
(136)	Wyatt M. (2002)

Concerned with outcomes of joint commissioning not provision

(137)	Greig R. (2001)
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Guidance Document (also contained no evaluation of outcomes)

No.	Author
(138)	Alcock J, Lavender T. (2003)
(139)	Association, Local Government. (2003)
(140)	DoH. (2003)
(141)	DoH. (1998)
(142)	DoH. (2003)
(143)	DoH. (2003)
(144)	DoH. (2003)
(145)	DoH. (2003)
(146)	Hamer L. (2004)
(147)	Health Development Agency. (2004)
(148)	Health Development Agency. (2003)
(149)	Monmouth Multi-professional Development Group. (2000)
(150)	Ormiston H. (2002)

Not about the Interface between Health and Social Care

No.	Author
(151)	Anstiss T. (2004)
(152)	Bailey N. (2003)
(153)	Barnett M. (2004)
(154)	Benson L. (2004)
(155)	Benson L, et al. (2004)
(156)	Black N. (2004)
(157)	Booth J, Roberts J, et al. (2004)
(158)	Brandis S. (2000)
(159)	Bubb S, et al. (2003)
(160)	Cornes M, Andrews J, et al. (2003)
(161)	Cunliffe A, et al. (2004)
(162)	Dixon J, Lewis R. (2004)
(163)	Donnelly M, Power M. (2004)
(164)	Gerrish K. (1999)
(165)	Gilbert P. (2000)
(166)	Glasgow R, et al. (2003)
(167)	H. M. Treasury. (2002)
(168)	Kunkel B, Yowell T. (2001)
(169)	Land M, Sanderson D. (2002)
(170)	Lane L. (2000)
(171)	Lymbery M, Millward A. (2004)
(172)	Merrell J. (2000)
(173)	Perry J, Felce D. (2003)
(174)	Reed D. (1992)
(175)	Rothman A, Wagner E. (2003)
(176)	Schmid H. (2004)
(177)	Stone R. (2004)
(178)	Vetter N. (2003)
(179)	Victor C, Healy J, et al. (2000)
(180)	Ware P, Todd M. (2002)
(181)	Woodhead H, Fortey Y. (1997)