MANCHESTER 1824
The University of Manchester

Understanding and supporting the integration of health and social care at a neighbourhood level in the city of Manchester.

Report part A: Rapid scoping review

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NIHR CLAHRC Greater Manchester

(The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, or the Department of Health and Social Care)

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Report part A: Rapid scoping review

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1.0 Introduction

This rapid scoping review (Report Part A) examines the topic of integrated health and social care in the UK, which accompanies a thematic analysis of semi-structured interviews (Report Part B - see separate report). This review has been carried out in order to inform the integration of health and social care at this neighbourhood level in the City of Manchester, and has been conducted by the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care Greater Manchester (NIHR CLAHRC GM) on behalf of Manchester Health Care Commissioning (MHCC). The background to health and social care integration, and an explanation of the National context within the UK and the regional Greater Manchester context are provided in this review.

1.1 What is integration?

There is no single definition of integrated health and social care, indeed a review from 2009 identified 175 different definitions in the literature.[1] Kodner and Spreeuwenberg for example describe it as “a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors”.[2] The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long term problems cutting across multiple services, providers and settings. The result of such multi-pronged efforts to promote integration for the benefit of these special patient groups is called ‘integrated care’ while Rosen et al define it as “a set of methods, processes and tools to support the alignment and coordination of health and care services”, adding that the term “describes both a set of activities and the ability to coordinate functions and activities across separate teams and operating units.[3] Integrated care describes the end products of integration in terms of services, designed around patients’ needs to deliver high-quality, cost-effective care and high levels of patient satisfaction."

Categorisation is frequently used in attempts to define integration. Stokes et al differentiate between approaches to integrated care which are ‘outcome based’ (focused on patient/service user perspective and person-centred coordinated care) or ‘process based’ (focused on health system adaptations to deliver complex care) defining integration as involving “processes that overcome fragmentation of care through better linkage and co-ordination of services and seeks to improve outcomes for those with complex needs”.[4] One systematic review classifies studies into four main categories looking at: first, those focussed on improving patient care directly; second, those focussed on making changes to

organisations and systems; third, changes to staff employment or working practice; finally, the financial and governance aspects of integration.[5] Integration of care has also been categorised by levels: team, service or organisation depending on its focus and form.[6] For example, Singer et al split integration into five types: structural, functional, normative, interpersonal, and process. “Structural and functional refer to organizational features related to how structures and systems are set up; interpersonal and normative types describe social features related to what people believe and how they behave together; and process integration describes a course of care delivery actions or activities such as referral management and use of shared care plans”.[7] Ahgren and Axelsson include vertical integration between different hierarchical organizational levels and horizontal integration between organizations at the same hierarchical level.[8]

Willumsen et al bring together several existing models for measurement and form two dominant categories of integration; inter-organisation and inter-professional.[9] *Inter-organisation* integration refers to the linking of existing organizational units and full integration in this form means that resources from different organizational units are merged in a newly established organization. In contrast full segregation would be no contact between service providers. Between these on the spectrum of integration is what is described as “co-operation” where coordination of networks occurs to improve contact between the organizations, but these units remain organizationally independent.

It is also important to consider national contextual differences and, in the case of this report’s focus, regions of the UK. Contextual differences mean that a single model of integrated care, however defined, may not be appropriate in all areas due to factors such as existing systems, commissioning arrangements, and organisation set ups.[10]

The multiplicity of understandings of integration can make analysis and measurement of integrated health care policies problematic and difficult to compare.[6,11] In addition a clear definition of what is meant by integration in different contexts is important for successful implementation and evaluation.[2]

For the purposes of this review, a broad definition of integration will be used to explore the integration of the neighbourhood teams in the City of Manchester as part of the NIHR CLAHRC GM process evaluation (Report Part B).

1.2 National context

The drive to introduce integrated care within the NHS is due in part to the current financial and service pressures in the UK NHS as well as a desire to improve care outcomes and

patient experiences.[12-14] The well-documented pressures on the health and social care sector of an ageing population and people living longer with co-morbidities have highlighted the need to change the delivery of health and social care to make it sustainable.

Integration has been high on the national agenda for successive governments; the Darzi review in 2008 and the NHS Five Year Forward View (5YFV) in 2014 illustrate different attempts to move this agenda forward.[12,15] The Darzi Report[12] launched a national, UK-wide initiative to reorganise health and social care services, with the aim of delegating control out from a central core to local primary care services. Integration was advocated as a means for addressing the needs of an aging population that is without adequate social care resources in place to meet the needs of people with long term health conditions but who do not need to spend time in hospital. This plan was not implemented by the incoming Coalition administration in 2010, who undertook significant legislative change in 2012 in the form of the Health and Social Care Act.[16] This act introduced Clinical Commissioning Groups (CCGs) with responsibility for commissioning most services locally in the English NHS, overseen by a new organisation, NHS England. In 2014, NHS England published the NHS 5 Year Forward View (5YFV)[15], setting out guidance on how the NHS and its services would change to meet the future needs of the population. The idea put forward saw an increased focus on community care, prevention, and population health and an integration of these, often focused on the goal to reduce hospital admissions and length of hospital stay. This goal was prioritised on the understanding that a reduction in high-cost hospital activity would deliver greater financial stability for the NHS as a whole. Across England sites were funded to trial and test different models of integration. These 'New Models of Care' (NMC) are currently under evaluation; however there is already evidence suggesting that integrated care is not happening as quickly or successfully as planned.[3,17-18]

The aspirations of the 5YFV and NMC are ambitious, with a goal to achieve financial sustainability by 2020 and to provide more effective and efficient care. Moving care from acute to community through integrated service provision from health and social care is thought to reduce hospital admissions and delayed discharges, be more efficient and provide more person-centred care.[17,19-20] This in turn is often assumed to be cost saving, a key objective of the proposed model of integration. Some have argued, however, that the predicted financial sustainability of the integration model is likely in reality to be more complicated than anticipated by policy makers.[18]

2.0 Methodology

In this review we seek to build on existing evidence on integration and tailor it to the regional questions facing the integration of health and social care in Manchester.

We searched the academic and grey[1] literature for studies relating to integrated health and social care. We chose to focus on studies in the UK to ensure our findings were relevant for the UK context. A broad range of databases was used to search the academic literature (e.g. health services, medical and social sciences). Our search spanned publications between 2000 and 2018 in published English. The results of the search terms in each of the databases can be seen below in Table 1.

Table 1: Search terms used in various academic literature databases to inform this literature review

Data base	Initial hits	Kept
PubMed	Integrated health and social care: 3583	Integrated health and social care: 65
	Multidisciplinary teams: 2085	Multidisciplinary teams: 12
	Interdisciplinary teams: 2548	Interdisciplinary teams: 10
Cochrane	Integrated health and social care: 882	Integrated health and social care: 4
	Multidisciplinary teams: 126	Multidisciplinary teams: 0 (outside geographic area or health only focused)
	Interdisciplinary teams: 518	Interdisciplinary teams: 0 (outside geographic area or health only focused)
NHS Evidence search	Integrated health and social care: 19	Integrated health and social care: 2 (plus 2 previously identified)
	Multidisciplinary teams: 200	Multidisciplinary teams: 1
	Interdisciplinary teams: 785	Interdisciplinary teams: 3 (plus 1 previously identified)
Scopus	Integrated health and social care: 6064	Integrated health and social care: 37 (plus 13 previously identified)
	Multidisciplinary teams: 2432	Multidisciplinary teams: 1 (plus 1 previously identified)
	Interdisciplinary teams: 1242	Interdisciplinary teams: 6 (plus 1 previously identified)
Total	20483	158

[1] 'Grey' literature is material "produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers" (http://www.greylit.org/about), including various kinds of reports and similar outputs.

Additional snowball searching was also conducted with bibliography searches of articles found and recommendations from colleagues with expert knowledge on the topic. This rendered a further 19 articles. Following a further review of the texts for suitability, 116 were kept.

3.0 Findings

3.1 Evidence in UK

While integrated health and social care is a current aspiration in both the UK and more broadly across Europe, its successful achievement is still a long way off.[21-23] Most cases of integration that have been implemented and researched in the UK have been small in scale, often pilots, with a focus on a specific group of patients within a given geographical area or organisation.

Geographically, integration motives and approaches are diverse and are often subject to the specifics of a given context. Across the UK such attempts are found to often be carried out in silos (even within organisations or geographical areas), with little consistency in approach and frequently no learning from previous experience elsewhere.[23] Geographical areas studied in the literature include Salford, Central Manchester, North West England, Scotland, Birmingham, Devon, North West London, Northern Ireland and Ireland.[24-40]

Integration efforts could be differentiated into two approaches; either integration for a specific subset of users or patients or integration of all services for all users/patients, with the former being far more frequent. Integration was frequently used as a targeted attempt to improve services and reduce costs for a specific groups; the elderly[26,41-45], diabetes patients, obesity patients, heart disease patients, mental health patients and those suffering from multiple morbidities[46-48] were all groups frequently targeted through integration. Multiple studies investigating the use of integration to tackle issues facing the care of elderly patients who required care in the community reported a reduction in both hospital admissions and GP usage.[41] Other examples of integration for a range of aforementioned patient groups are reported to have resulted in increased or improved access to services and assessment when needed.[26,42-45]

Similarly, integration undertaken in Central Manchester as part of the Practice-Integrated Care Teams (PICT) project saw a reduction in secondary care admissions and patients reporting a preference for the personal approach they felt they had received as well as increased patient satisfaction with services overall.[25] Salford City Council and Salford

Primary Care Trust undertook a larger pilot project of integration from 2005, establishing eight 'integrated health and social care teams' across the city. These teams supported older people and vulnerable adults and were aligned with GP practice-based commissioning clusters. The evaluation of the initial pilot also identified improved access to and delivery of services in primary care.[28]

In cases where a geographical area was targeted rather than a specific patient group, certain groups were identified as having benefitted more than others.[26,41-45] The evaluation of an integration programme being carried out in South West England[47] found that the group which most benefitted from integration and where the most cost saving could be identified were those with multi-morbidity.

In several of these cases, there is evidence of positive outcomes, such as improvements to the process of service delivery (patients seeking help, being assessed, access), cost savings, improved satisfaction with services, continuity of care and reduction of secondary care admissions. However, meta-reviews looking at this evidence basis on integration have observed that many are not generalisable due to their small scale and specificity of context as well as arguing the evidence base in this literature is often weak.[49-50] In addition, there are also numerous cases where the intended outcomes of integration have not been proven; for example financial savings have not been evidenced, or improvements in patient outcomes or care has been found to be inferred rather than demonstrated.[51] Finally, in some cases, even when impacts were achieved, it was found that organisations and teams returned to old ways of working in absence of ongoing financial incentives or action to sustain new ways of working.[27]

While models of integration may improve patient satisfaction, perceived quality of care and access to services, evidence for reductions in service cost are unclear.[5] In addition, increased access to care could put greater strain on existing services.[5]

3.2 Enablers/ barriers/ lessons

Though varied in aim, scale and context, similarities in barriers and enablers of integration were evident within the literature and have been catalogued by those who have already carried out reviews of this topic.[5,11,24,26] These are clearly important issues to consider for those designing and implementing integration in the future and for ongoing integrated services, especially given the widespread, evidenced failure to learn from existing experiences of integration in the UK context.[23]

In this section we have categorised the enablers and barriers identified in the literature into four main categories: 1) communication of the integrated vision and buy-in, 2) professional identity and the boundaries of work, 3) team work, intra-professional relationships and communication, and 4) context (organisational, professional, regional and national).

3.2.1 Communication of the integrated vision and leadership

Clear communication of the vision of integration - what is meant by integration in this context, why it is beneficial and how it will be implemented - has been identified as a necessary element for successful integration and positive outcomes. Where a clear vision of integration was effectively shared and from this a joint vision built, the workforce was found to be more engaged in the process, becoming in some cases ambassadors for integration and change.[52] The engagement of clinical and professional leaders is identified as vital for this to occur.[34] Where communication from leadership has failed the workforce was found to be less likely to buy in to the concept of integration and thus resist the changes required for its happening.[25,43,53] Part of the challenge faced in regards to leadership is a lack of experience of bringing different services and professions together.[21] The literature suggests it is incumbent on management to understand the experience of change from the perspective of the whole workforce and thus provide more support within their organisations to help adaptation to new ways of working.[30] This is needed to ensure the workforce is not only aware of the vision but also buys into it.

3.2.2 Professional identity and the boundaries of work

The barriers and enablers in this group relate to the challenges in bringing different professions and organisations together in regards to identity, interdisciplinary approaches to work and boundaries of work and profession.

A lack of understanding between different professions across all levels, about their roles and remit, competencies and contributions, statutory and legal obligations and values, was found to be a common obstacle to integration.[54-56] This lack of understanding occurred between various different professions, specifically health care practitioners (GP, district nurse) and care home staff, healthcare practitioners and social workers and within healthcare (GPs, nurses, occupational therapists, psychiatrists, speech therapists, physios etc.). Unaddressed, this lack of understanding was found to result in tensions and conflict within teams, inappropriate work allocation and difficulty in agreeing responsibility across the skill mix of staff and poor utilisation of skills.[48,54-56]

Adding to poor relations between different professions working together in integrated models of care, it was noted that the hierarchy between different professions (and within them),

particularly within medicine, further exacerbated the difficulty of interdisciplinary work. In some cases the design of integrated care was found to be geared more towards medicine with social work marginalised, making adaption of work harder for the marginalised professions and also creating a feeling of being undervalued, both by other professions and by leadership.[33,57] In some cases this impacted negatively on communication, with professions such as nurses, occupational therapists and physiotherapists feeling unable to voice their opinions and challenge doctors within integrated teams.[35,40,58]

3.2.3 Team work, intra-professional relationships and communication

Teamwork and good intra-professional relationships were factors found to be key to the success of integration across the literature.[35,52,59-61] In the literature it was clear that there are often assumptions that teamwork will occur unproblematically, enabling smooth transition to integrated ways of working between different professions, organisations and teams. Co-location was frequently equated to the achievement of integration of workforce and successful team work, but co-location was found to be insufficient in itself.[45,62-63.]

Integration was found to be most successful where time was given to integrate new teams through shared education and learning, both formal and informal, the creation of a positive culture with respect for the different contributions of all professions, and an understanding of each other's roles and positions by all those with a stake in integration.[64-65] Given that different professions assess patient need differently, this training was seen as particularly important to ensure common understanding within teams.[66] Prior conceptions and bias were seen by some to hinder integration and teamwork, particularly by those evaluating integration from a psychological perspective.[67] Earlier exposure to intra-professional working at medical school was identified by some as facilitating teamwork.[68] Doctors were found to be particularly capable of bringing others on board as their opinions were frequently valued higher than those of other professions, due to the hierarchical nature of intra-professional teams in medicine.[59]

3.2.4 Context (organisational, professional, regional and national)

Attempts to integrate health and social care are of course always grounded in a specific context which informs all aspects of integration. Context can be conceptualised on multiple levels: for instance, organisational, professional, regional and national. The research literature underlines the importance of acknowledging the significance of context when planning integration as a necessary element for practical, sustainable change.

At an organisation and regional level, available finances and resources, existing workforce capabilities and the strategic approach to integration adopted were all key factors.

Integration was also framed in light of the specific challenges that it was intended to address in each context.[6,11,69] As organisations merged, the need for good integrated information systems and assessment process was cited to enable flow and sharing of information and to stop duplication across multiple systems. The need for good systems was in part because of an acknowledgement that multiple approaches to integration and work can result in a fragmentation of services, with service users falling between the cracks.[70]

The governing terms and conditions of existing and new staff from across the professions was seen as significant, with equity across contracts and conditions needed to prevent resentment and rifts.[71] Organisational culture and the support offered to staff in bringing about integration was also seen as important to acceptance and engagement.[34,72]

Within organisations, structural change was repeatedly cited as necessary to achieve the full potential of integration, and to address the aforementioned issues in this section. Structural change however is often unachievable without legislative support, placing a cap on what can be done locally.[73] In practice integration was often found to be left to individual innovators or 'boundary spanners' acting as key drivers of change limiting progress and making integration vulnerable to staff changes.[33,74]

More broadly the historic relationship between health and social care in the UK was found to be a limiting factor on integration.[37] Health and social care within the UK are funded separately, measured by different performance frameworks, with different priorities and governance systems and separate information systems. While efforts have been made to address this via joint commissioning, the effects of this are limited by the fact that health and care commissioners still have different statutory responsibilities which cannot be shared or given away, placing a limit on the potential for joint commissioning.[40,75-77]

The wider national political, economic and social context of the Scotland, England, Wales and Northern Ireland UK was also found to be a key limiting factor for all forms of integration reviewed in the literature.[6,69] Ongoing cuts, downsizing and a shortage of workforce in health (particularly primary care) and social care were all found to severely limit the potential of integration to make the intended improvements to services across the board.[21,40,74] For example when looking at integration in North West London for the WSIC programme, Wistow et al[74] found that it was national barriers that slowed progress, specifically difficulties obtaining data-sharing agreements and establishing information governance arrangements, separate payment systems and governance structures between sectors; and organisational fragmentation. In addition, devolved administration across the countries of the UK provide different contexts, for example it is argued that the emphasis on competition in the Health

and Social Care act 2012 in England creates greater barriers to integration in England than in the other devolved administrations (Scotland, Wales, Northern Ireland).

3.3 Measurement and evaluation

In order to evaluate integration for improvement and development, measurement is needed. Poor measurement of integration, as well as a failure to share or learn from findings of previous evaluations of integration, was identified in the literature as a weakness both within the UK and internationally. Existing evaluations and evidence were found by those carrying out reviews of integration to often be of poor quality.[49-50,78-80] In addition, the tools and models used to measure integration, and indeed what measures were adopted, varied and so assessments are based on different notions of success and failures.

Before effective measurement of integration can take place, a clear definition and understanding of what is meant by integration in each case needs to be understood, as discussed earlier. Those seeking to address the issue of poor measurement argue that integration exists on a continuum and falls into different categories which need to be identified before meaningful measurement can take place.[8]

Once the form of integration has been established, different models of measurement for integration are based around the conception of what full integration in that form would look like.[81] For example, Willumsen et al[9] note that the degree of integration relates to the level of differentiation (the degree of difference in orientation and formality) between bodies of services; a high degree of differentiation requires a high level of integration, and vice versa. This continuum is then transformed to form a measurement instrument called Scale of Organizational Integration (SOI). This can be used for the analysis of integration both within and between organizations, that is, intra- and inter-organizational integration. In co-ordination with this they also use Ødegård's[82-83] conceptual model Perception of Interprofessional Collaboration Model (PINCOM) and measurement instrument (PINCOM-Q), which uses 12 factors that professionals perceive as central aspects of collaboration. These fall into three categories: individual factors (work motivation, role expectations, personality and professional power); group factors (leadership, coping, communication and social support); organisational actors (organisational culture, organisational aims, organisational domain, organisation environment). Similarly Exworthy et al (2017)[11] developed a model called TAPIC (transparency, accountability, participation, integrity and capability) which identifies the five mutually exclusive attributes of governance that are thought to influence integration outcomes.

Rather than provide a model, Kharicha et al[84] highlight a checklist of good measurement practices they argue to be necessary for a valuable evaluation to be possible. These were: study populations to be comparable; details of how services are actually delivered to be obtained and colocation not be assumed to mean collaboration; care packages in areas of comparable resources examined; both destinational outcomes and user defined evaluations of benefit should be considered; possible disadvantages of integrated care also need to be actively considered; evaluations should include an economic analysis.[84]

Irrespective of the model chosen, there was a shared acknowledgment in the literature of the importance of research that is embedded and feedback into integration systems.[85-86]

3.4 Regional Context

This scoping review of the evidence for integration of health and social care has been carried out to inform the ongoing development and evaluation of integration of health and social care in the City of Manchester. It is therefore important to identify the unique context of the City of Manchester when considering the existing available evidence and how this may impact on the progress of integration, identifying possible barriers and enablers from evaluation of other integrated care systems. Manchester has particular challenges likely to impact on health and social care. These include significant health inequalities and deprivation compared to the rest of England (Greater Manchester Health and Social Care Partnership 2017[87]), an increasing population across all age ranges (Greater Manchester Health and Social Care Partnership 2015[88]), a lower life expectancy and a poor healthy life expectancy with higher levels of long-term conditions and disability when compared to the rest of England (Greater Manchester Health and Social Care Partnership 2017[87]).

Devolution, as formalised in 2015 in Greater Manchester, has been a driving force to transform health and social care with the opportunity to carry out a strategic re-design to develop a place-based approach for integration.[22] One ambition to emerge from devolution and integration given the levels of health inequalities in Greater Manchester was to embed population health and well-being more broadly with an emphasis on preventative work.[89] This related specifically to ensuring those living with long-term health conditions will be treated by specialists in the community where possible with the intention of reducing hospital admissions. Research on devolution in Greater Manchester has however highlighted its limits, including for integration. Specifically a recent report on devolution[73] noted that the GM Partnership has few formal levers to use over NHS organisations, and even fewer in relation to local authorities due to the limited devolvement of powers received.

It is important to note that while devolution has enabled the transformation of integration, from 2015, Greater Manchester has been working towards integration for many years. In the lead up to devolution in Greater Manchester, several pilot programmes were commissioned by the three Clinical Commissioning Group (CCG) areas of North, Central and South Manchester to develop and evaluate integration of health and social care in the City of Manchester. Interestingly these three pilot programmes targeted different populations, tested out different processes and systems with different measures all evaluated in different ways but reported similar recommendations.

North focussed on a single team and targeted patients with high risk of admission to hospital.[90] The evaluation of the North Manchester Integrated Neighbourhood Care pathway found integrated work improved during the project, led to better communication and was valued by most. The key worker role was viewed as important and patients were considered to have benefitted from the key worker drawing on other professionals' expertise when needed. Concerns were raised over the risk stratification tool not being understood, a perception of increased paperwork and the need to justify or account for the increased time taken to work in an integrated way. For some patient groups they found self-care was not always possible. The evaluation was hindered by the lack of integrated IT systems and data throughout the service and could not evaluate the wider impact of integration. Issues to take forward included: selection of patients to focus on; how to approach risk-profiling; how the key worker role can be most effective; the involvement of other services such as GPs and mental health; self-care of patients which is a culture change that needs more development and training for staff.

Central focussed on multiple integrated teams and targeted patients with complex needs including those with Chronic Obstructive Pulmonary Disease (COPD), likelihood of falls and end of life care.[91] They found increasing enthusiasm for the key support worker role and although there wasn't evidence yet to show impact on patient care, there were signs of improved communication between practitioners. This evaluation reported the need for a clear, shared vision, increased understanding of patient independence and more work around the risk stratification tool. They suggested that although the commitment to the principles of integrated care was strong they felt that staff needed to be convinced that integration was intended to improve quality of life not just to save financial resources. Involving other teams such as mental health, specialist services and ensuring sustainability of GP involvement were all recommendations.

In the South of the city they focussed on a single multidisciplinary team (MDT) called a neighbourhood team with a key worker.[92] They targeted the management of those with long-term conditions and who needed care at home. This evaluation reported improved patient outcomes particularly around the success of the key worker role. They found a reduction in unnecessary hospital admission, readmission and length of hospital stay. Unreliable IT systems hindered provision across services. There were difficulties implementing self-care and integration of professionals due to system boundaries rather than individuals. Future concerns related to recruiting high quality staff as well as justifying cost savings for preventative outcomes that are harder to quantify. The need for integrated care to be sustainable, particularly embedding ongoing GP involvement, was of concern going forward.

These three different proposed integrated pathways and evaluations found several common themes supporting progress and similar concerns around what might hinder integration now or in the future. All three areas found the key worker role was successful and could be developed further. North and Central evaluations indicated that the risk stratification tool had not been successful and would need further development. North and Central also found that the attempt at improving self-care had not always been feasible to implement due to the complexity of this, a lack of understanding and a need for a culture change to embed this in routine care. Both North and Central felt there needed to be more work around the vision of integration to get better buy-in from clinicians and to ensure this was seen as better for patients not just a financial need. The involvement of other services such as mental health and continued provision of GP resource were also considered key to the future of integrated care pathways. There were concerns raised in all locations around information system support.

Integration of health and social care has been described by the Mayor of Greater Manchester, Andy Burnham, as a “big test for devolution” with national and international interest into the progress of this radical transformation of services being organised around neighbourhoods. There has been a history of working towards integration and more recently pilot sites to evaluate various models of integration across the city.[90-92] The city of Manchester has complex challenges to face with the health inequalities, but has an opportunity to transform the way it delivers health and social care with a vision to improve the health and well-being of its citizens. This ambitious aim will also strive to meet the public health plan to support people to take control of their own health and the health of others.[87]

4.0 Conclusion

This rapid scoping review has examined the topic of integrated health and social care in the UK in order to inform the current initiative for the integration of health and social care in the city of Manchester.

The review has shown that key to implementation of integration is a clear definition and understanding of what is meant by the term. This means identifying what is specifically meant by integration in this setting, including the scope and aims of integration, and defining this in a way which is meaningful to all stakeholders. This then needs to be communicated and understood across all levels to maximise engagement and commitment to these changes.

Given the difficulty identified in integrating different professions and organisations, investment and planning of this interpersonal level of integration is important. This entails improving understanding of the scope and focus of other professional groups, their statutory obligations and core values, and articulating and challenging tacit assumptions of hierarchies between professions. Co-location and shared education and learning initiatives were found to support this process. It is also crucial that the wider socio-economic and political landscape be considered, including governance, finances and other resources, existing workforce capabilities and the strategic approach to integration adopted. Even where responsibility for health and care has been devolved, wider national legal and financial barriers and the historical divide between health and social care will constrain what can be achieved at a regional level.

Assumptions of what integration will deliver need to be considered carefully. While some positive outcomes have been identified elsewhere, so far these have not always been found to be generalisable and so caution needs to be taken when applying these to Manchester. In addition, approaches to integration in the research literature have been predominantly process focused, meaning direct effects on patients in many cases are not known as the emphasis has been on the impact on working practices and the workforce. While research has shown care can be improved through integration, this does not necessarily mean cost savings, a factor which needs to be budgeting for in planning.

Existing literature on the integration of health and social care tends to focus on targeted groups of patients at a micro level, hence less is known about organisational and macro system level integration. In addition, how integration will affect a geographic area when a specific group has not been targeted is also less known.

This summary findings inform the analysis conducted as part of the process evaluation of the implementation of integrated health and social care in the City of Manchester, which is presented in **Report part B: Process evaluation.**

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