



# **Applying behavioural insights to health and social care integration in Greater Manchester**

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November 2018

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# Executive summary

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## Policy Background

Local Authorities and NHS bodies across Greater Manchester (GM) are making substantial changes to the structure of the health and care system in the region. A core element of these plans is the creation of new integrated, 'neighbourhood teams' providing community health and social care services. Each 'neighbourhood team' will cover 30,000-50,000 people.

In Manchester City (Manchester), these neighbourhood teams are known as Integrated Neighbourhood Teams (INTs). Across England, many Integrated Care Systems (ICSs - places with advanced integration plans) are developing similar integrated health and social care teams at the community level (known as Primary Care Networks).<sup>1</sup>

## Project background

The Manchester Local Care Organisation (LCO) already plans to co-locate INTs. In this project, our goal was to identify specific ways to make it easier for health and care staff to work in a more integrated and collaborative way (beyond sharing a building). Our focus was on how a frontline professional's day-to-day behaviour should change once they become a member of an INT. This is a more operational perspective than has been taken in much of the literature on health and social care integration, where the focus is often on organisational design.

The findings from this report are based on fieldwork in three Manchester INTs and fieldwork in four other areas of GM. We interviewed over 50 staff and observed a range of different meetings. We also reviewed relevant academic literature. Finally we ran two feedback and collaboration workshops with staff from Manchester LCO. The workshops helped us design the scope of the project and sense-check our recommendations.

## Key themes and ideas

We have grouped our ideas to increase integration and collaboration in the INTs into three themes:

- 1. Improving team meetings.** There is good evidence that small changes to the way meetings are structured can have a big impact on the quality of decision-making. We have several ideas for improving MDTs and other types of multi-disciplinary meetings.
- 2. Increasing trust and social contact between staff.** Staff often feel that other professionals do not understand their role. We have several ideas, beyond co-location, for how Manchester LCO could improve both

the number of staff interactions and (by extension) trust between staff from different professional backgrounds.

- 3. Process and system changes.** Behavioural science shows that the details of processes and systems matter. While many of the process and system issues facing INTs are well-understood and difficult to address (e.g. integrated IT systems) we have several ideas about ways to reduce the ‘friction’ associated with working in an INT.

Our ideas are set out in Table 1. For more detail on these ideas, see Section 3 of the main report.

**Table 1: Summary of key themes and ideas**

Theme	Ideas
Improving team meetings	<ol style="list-style-type: none"> <li>1. Rotate the chair of MDTs each meeting to disrupt traditional power imbalances.</li> <li>2. Review the different types of meeting and refocus handovers, huddles and MDTs on their primary purposes.</li> <li>3. Create a clearer separation between MDTs and huddles by requiring all participants in the MDT to bring only one or two cases to discuss.</li> <li>4. Run MDTs in a way which reduces the risk of group-think.</li> <li>5. Embed good planning techniques into huddles and handovers.</li> </ol>
Increasing trust and social contact	<ol style="list-style-type: none"> <li>1. Set up joint visits or shadowing opportunities between staff in different professions.</li> <li>2. Remove referral forms and processes within the INT (encouraging in-person handover).</li> <li>3. Create opportunities for staff to have more informal conversations.</li> <li>4. Help staff understand the role of other professions.</li> <li>5. Increase trust by creating a system for team members to say thank you to colleagues from a different service.</li> <li>6. Move to an induction process which includes ‘deep cultural learning’.</li> </ol>
Systems and processes	<ol style="list-style-type: none"> <li>1. Automatically identify and connect staff working with the same person.</li> <li>2. Set up a dedicated staff resource for managing integration</li> <li>3. Fix the small stuff quickly to give staff a positive early experience of integration.</li> <li>4. Make it easier for staff to contact their colleagues from other professions.</li> <li>5. Remove visible signs of previous team boundaries</li> </ol>

## Recommendations

We make two sets of recommendations to reflect the different stages of health and social care integration in GM. The recommendations were chosen based on impact, feasibility and feedback from stakeholders:

- Recommendations which are specific to Manchester LCO which will be co-locating INTs in the coming months; and
- Points for other GM boroughs/places in England to consider when they are integrating health and social care. These are organised by the different stages of integration.

### *Recommendations for Manchester LCO*

There are some lower-cost ideas we recommend implementing immediately:

- **Fix the small stuff quickly to give staff a positive early experience of integration.** Details matter and many of the INTs we visited faced small bureaucratic problems. Set up a process for identifying and tackling these small issues (like insufficient key fobs for the building) quickly so they don't shape people's early experience of joining an INT.
- **Make it easier for staff to contact their colleagues** by setting up and circulating visual phone books, setting up group messaging systems and creating simplified diagrams or tools showing who does what.
- **Remove visible signs of previous team boundaries.** Many of the co-located teams we visited still had visible signs of previous team boundaries (e.g. multiple 'team milks' in the fridge). Removing these visible signs reinforces the fact that staff are all part of the same team.

The following recommendations are more complicated (so will cost more). As a result, we suggest testing them before introducing them across the INTs:

- **Automatically identify and connect staff working with the same people (preferred option).** We know that in Manchester (and many other areas in GM) truly joint case management and IT systems are still some way away. In the meantime, we think it would be worth testing the impact of connecting staff who are working with the same person. Currently, this information is technically available, but the hassle involved in accessing it is high (logging on to multiple IT systems regularly, and looking through your cases one at a time). We think that a weekly message highlighting who under your care has started seeing another service could encourage more collaboration.
- **Develop a new induction process for when INTs first move into the same building.** We visited several co-located INTs (one in Manchester and two outside). In all cases, co-location had been gradual and there had been minimal induction. There is evidence that inductions which involve 'deep cultural learning' - where staff consider the culture of their own team and the teams they are merging with - can improve

collaboration and promote shared purpose. In addition, there are also a range of activities which we think could help staff to understand the role of other members of the team (such as shadowing staff from different professions, completing joint visits or completing 'perspective-taking' exercises where they consider case studies from the point-of-view of another member of the team). We recommend that Manchester LCO design a new, more involved induction process which incorporates these insights.

- **Increase contact between staff by removing referral forms and processes within the INT (encouraging in-person handover).** Manchester LCO wants staff in INTs to speak to colleagues from different professions more regularly. However, staff still need to make a formal referral through the triage and duty systems. In other areas of GM, staff can refer people to a colleague in the INT with just a conversation. We think this is a good way to encourage staff to routinely talk to colleagues as this discussion becomes part of the referral process, rather than an addition to it.

We recommend choosing one of these interventions and rolling it out as a pilot across two or three of the INTs in GM for 6 months. We believe that starting with automatically connecting staff who work with the same person will be the most feasible. This is because it would not require a significant policy change (as getting rid of referrals would) or significant staff time (as an induction process would). In addition, introducing this change would provide a visible 'signal' of integration and demonstrate organisational commitment to tackling what is currently one of the most commonly cited staff frustrations across INTs.

At the moment a quantitative evaluation of these changes would be difficult because of the small number of INTs and the lack of good quality administrative data. We think the most feasible way of implementing the impact of these changes is a qualitative, implementation and process evaluation (IPE) to evaluate the changes. This should include interviews, focus groups and observations to understand how the change was implemented in practice, how it was perceived by staff and people receiving care and support. This will, inform any future scaling-up of the change. In addition, Manchester could track some quantitative measures (e.g. rate of repeat assessment or the number of people open to multiple services) and compare these between teams who have received the change and those who have not. These findings would only be indicative, but may reinforce the qualitative evaluation and provide extra assurance about the potential impact of changes.

### *Behavioural considerations for other GM boroughs (and other areas) looking at health and social care integration at the community level*

Health and social care integration is taking place across GM and England. There is significant variation in development and levels of integration across both GM and the 'first-wave' of ICS areas.<sup>2</sup>

This section sets out a list of behavioural considerations for people setting up integrated health and social care teams. The list is organised by the different stages of integration, from design and planning to operation after co-location.

**Table 2: List of considerations for behaviourally-informed integration**

	Considerations
Integration design & planning	<ul style="list-style-type: none"> <li>☑ Think about the specific staff behaviours you would like to change following integration. Do you want more shared assessments, fewer repeat visits or more informal discussion of cases? Consider how you could measure these behaviours.</li> <li>☑ If there isn't a shared IT system (even in the short-term), try and minimise the hassle of having separate systems. For example, set up a system to notify staff when another professional starts working on the same case.</li> <li>☑ Consider how the building/office layout may encourage or discourage unplanned interactions in places like corridors or kitchens (known in the literature as 'collisions').</li> </ul>
Teams about to co-locate	<ul style="list-style-type: none"> <li>☑ Begin introducing teams to each other a few months before co-locating, for example through joint lunches. Run a 'deep' induction programme which includes exercises like perspective taking when the teams first move into the same building.</li> <li>☑ Consider hiring someone (or allocating time to a group of existing staff) to manage integration activities like induction and logistics. Evidence from private sector mergers suggests that dedicated 'merger teams' are important to success.</li> <li>☑ Make sure that the move to the new office goes as smoothly as possible, e.g. have enough desks and entry fobs for the building on the first day and make arrangements for parking. These details can frame the team's early impressions of 'integration' and what it means for their day-to-day.</li> </ul>
Teams who are already co-located	<ul style="list-style-type: none"> <li>☑ Concentrate on ways you can encourage staff to have regular, informal interactions with their colleagues (e.g. by randomly pairing staff with a new person to meet once a fortnight or by setting up a cross-profession 'buddy system'). Do not assume this will happen naturally in a shared office, as many professionals spend most of their day out on visits.</li> <li>☑ Optimise meeting structures. This includes making the differences between huddles, handovers and multi-disciplinary team meetings clear. In addition, consider approaches to encourage better problem-solving in meetings, such as rotating the chair or nominating sub-groups of staff to challenge the consensus decision in a meeting.</li> <li>☑ Systematically collect feedback from residents about the impact of both integration and the role of specific professions and share this with staff. This is likely to boost morale and productivity and also give staff a clearer understanding of each person's role within the integrated team.</li> </ul>

# 01 / Policy background

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## 1.1 Health and social care integration in Greater Manchester

Local Authorities and NHS bodies across Greater Manchester (GM) are making big changes to the structure of the health and care system in the region. The goal is to integrate health and social care at all levels, with a region-wide Health and Social Care Partnership and a Local Care Organisation (LCO) in each borough. A core element of these plans is the creation of new integrated, 'neighbourhood teams' providing community health and care services. Each 'neighbourhood team' will cover a defined population of 30,000-50,000 people.

In Manchester, the 'neighbourhood teams' are known as Integrated Neighbourhood Teams (INTs) and twelve new INTs were created across the city in April 2018.<sup>3</sup> The ambition is for the team members of each INT to be based in the same office (co-located) to encourage more collaboration. Currently, one INT in Manchester is based in the same office, with the rest aiming to do so in the coming months.<sup>4</sup> The goal of the INTs is to encourage staff to improve the health and wellbeing of residents by working as "one team" and engage in "new ways of working including single trusted assessment, integrated support and care plans, [and] person-centred care."<sup>5</sup>

Both in Manchester, and more widely across GM, 'neighbourhood teams' will support residents with more complex health and social care needs, such as frail older people or people living with long-term conditions. Each team will include a mix of both health and social care staff e.g. district nurses, occupational therapists and social workers. Longer term the plan is also to bring in other professions, teams or services, from the local authority, NHS or voluntary sector. These are likely to be staff who support people with a broader range of issues (like debt, social isolation or physical inactivity) which are also determinants of health and wellbeing. Each borough is responsible for deciding its own approach to creating these teams, including the specific structure, the professions involved and the operational model. Generally, there is a core of services and teams (district nursing, therapy and elements of social care) that almost all places plan to include.

## 1.2 National policy

NHS England has committed to pursuing integrated care through place-based partnerships with local authorities. NHS organisations (both commissioners and providers) and local authorities in 44 defined geographical areas will work together on improving the delivery of health and social care to their population (these are known as Sustainability and Transformation Partnerships). Nine areas of England (including GM) have been asked to go further and develop an 'integrated care system' (ICS) as a new structure for coordinating integrated health and social care.<sup>6 7</sup>



Many ICSs are developing integrated community health and social care teams which cover the same population size (i.e. 30,000-50,000 people) as GM neighbourhoods (known as Primary Care Networks).<sup>8</sup> The unifying theme among these integrated community teams is that they bring together professionals from different services to keep people in their homes and out of hospital. Beyond that, they are all different: they bring together different sets of services and they have different core goals. Much of this variation is by design, with policymakers (in GM and nationally) recognising the importance of allowing places to design a system which works for them.<sup>9</sup>

### 1.3 Integration in practice

Based on our research on health and social care integration in GM, the UK and elsewhere, we have created a taxonomy of three different types of integration in health and social care:

- 1) **Link worker:** where a single professional from one service is based within a different service, e.g. a social worker is based in a resident discharge unit at a hospital.<sup>10</sup>
- 2) **Specific issue team:** a new team staffed with professionals from different services which has a specific area of focus, e.g. a rapid response team for helping people who require immediate attention but who do not require hospitalisation.<sup>11</sup>
- 3) **Geographic area team:** two or more teams are combined to serve a specific geographic area rather than having a specific service or clinical focus. For example, a team of district nurses and a team of reablement workers are brought together to work in a specific geographic area.<sup>12</sup>

### 1.4 Barriers to integration

We looked at how integrated teams operate in practice and what common barriers to integration are identified in the literature. We found that there was little consensus about what factors were important for an integrated health and social care team to be most effective.

Most studies cite a range of important barriers which teams need to overcome if they are to integrate successfully. However, there is no good, experimental or quasi-experimental evidence to suggest which of these factors is most important. Existing studies tend to be based on extended case studies, or qualitative studies. These studies only consider correlation between different factors and are not able to measure the specific impact of different factors. Table 3 summarises some of the most common barriers identified in the literature. For more detail, including a description of how we saw some of these barriers during our fieldwork, see Annex A.

**Table 3: Barriers to health and social care integration**

Type	Barrier	Description
Institutional	Lack of (access to) shared IT systems	Not having shared IT, or access to each other’s IT systems was the most commonly cited barrier in the literature. <sup>13</sup> This results in unclear data sharing protocols, which in turn creates barriers to collaboration because information is not shared. <sup>14</sup>
	Unclear or unintegrated aims	One case study hypothesised that specific issue integrated teams were more successful at creating commitment than teams based on a geographic area because of the addition of clear, shared aims. <sup>15</sup>
	Unclear roles and responsibilities	Role clarity is correlated with stress levels and job satisfaction for employees, which means that the lack of clarity following integration had negative impacts on the lives of staff. <sup>16</sup>
	Unaligned processes	Unclear or unintegrated process, from referral pathways to assessments to care planning, were identified as hurdles to integration. <sup>17</sup>
	Imprecise or ill-defined policy	Policy and regulation were mentioned as the root cause of some of the other structural barriers (i.e. data sharing, reporting, etc.). <sup>18</sup>
	Separate reporting requirements	Having separate performance indicators and reporting requirements indicates that organisations do not have shared priorities. This signals to the rest of the organisation that teams are still separate. <sup>19</sup>
	Differing employee terms	Motivationally, being in the same team as someone who has a different benefits package (e.g. more annual leave) can cause frictions <sup>20</sup> and reduce motivation. <sup>21</sup>

<b>Situational</b>	Teams who are not co-located	Co-location of teams helps to increase informal communication between health and social care workers in an integrated setting and several case studies mention co-location as important for success. <sup>22</sup>
	Lack of adequate resources	Not having resources allocated to managing change and coordination meant that already stretched services had difficulties prioritising integration goals. <sup>23</sup>
	Insufficient training and teambuilding	Joint training and teambuilding are important for integration, both to ensure staff have the skills they will need <sup>24</sup> but also to signal a change in the way the team will work in future. <sup>25</sup>
	Incompatible team structures	Health and social care workers may have separate shift schedules, opening hours, and hierarchies which can make activities such as attending a joint meeting difficult. <sup>26</sup>
	Imbalance of power	The imbalance of power between different groups is cited as an important barrier to successful integration. For example, these imbalances could be between social workers and primary care staff <sup>27</sup> or between the community and acute sectors. <sup>28</sup>
<b>Dispositional</b>	Distinct working cultures	Many studies noted how different ways of working were a barrier to integrated working. <sup>29</sup> These distinctions included vocabulary, <sup>30</sup> risk tolerances <sup>31</sup> and degrees of decision-making autonomy. <sup>32</sup>
	Concern about professional identity	In the literature, health workers often reported feeling that they could do the job of the social worker, but that the reverse was not true, making them doubt the value of integration. <sup>33</sup> Likewise, social workers reported feeling that health workers did not value their perspective. <sup>34</sup>
	The impact of funding structures	Structural differences in the funding of health and social care can cause animosity between the two groups. Social care workers feel that their services are squeezed by budget constraints while health workers feel that social care is not doing its fair share or is unloading social care tasks onto them. <sup>35</sup>

## 02 / Project background

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Manchester is encouraging professionals from different services in the INT to collaborate by co-locating everyone in the same building. The goal of this integration through co-location is to improve outcomes for residents<sup>i</sup> through less duplication and more person-centred care.<sup>36</sup> The assumption is that professionals in the INT will work in a more collaborative way once they are formed into a single team and co-located. Co-location can increase informal communication between professions. However, the evidence is that co-location alone is not sufficient to encourage greater collaboration and multi-disciplinary working.<sup>37</sup>

### 2.1 The challenge of identifying target behaviours

In most BIT projects we aim to identify the ‘target behaviour’ we want to change (e.g. reduce late payment of tax, or increase attendance on college courses). For this project, we initially planned to explore how behavioural insights could be used to increase use of ‘trusted assessment’ (a process where health and care assessments are shared across professions to minimise duplication and encourage a more integrated approach).

Following an initial workshop (see below for more detail) this focus was broadened to understanding how behavioural insights could support more joined-up working within INTs. Our focus was on identifying what staff should be doing differently after joining an INT, that is, how should a frontline professional’s day-to-day behaviour change? This is a more operational perspective than has been taken in much of the literature on health and social care integration, where the focus is often on organisational design.

We found it difficult to identify these specific behaviours. Many of the people we spoke to knew what they hoped integration would achieve for residents (i.e. less duplication, more holistic care etc.) However, few could articulate many specific examples of how a professional’s day-to-day behaviour should change. The key to identifying target behaviours is that they are *behaviours*, we do not just want to change people’s beliefs or intentions. Target behaviours should refer to specific actions (e.g. completing more joint visits) and we should be able to measure whether they are happening.

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<sup>i</sup> Note: The appropriate terminology here is difficult. Different services and organisations use many different terms to refer to members of the public who are receiving support (patients, citizens, service users etc.). Our general preference is to just refer to ‘people’ and, where we can, this is the term we use in this report. However, this sometimes made our writing ambiguous. We have therefore opted for the term ‘resident’ as a neutral option where using the term ‘people’ is not clear.

After engaging in fieldwork and hosting a workshop with practitioners and policy leads, we compiled the following list of possible target behaviours:

- Attendance at joint team meetings (e.g. huddles & MDTs).
- Engagement in problem-solving and task allocation at team meetings.
- Having informal conversations with colleagues from other professions.
- Engaging in 'bursty' communication. This is a condensed period of quick back and forth exchanges, such as an instant message chat.
- Conducting more visits jointly by two (or more) professionals.
- Using trusted assessment.

This list was not comprehensive but helped us to narrow the scope of the project. Our goal was to identify specific changes that Manchester could introduce to make it easier for staff to engage in these behaviours. This project therefore looks at what initiatives Manchester (and other areas looking to increase joint working) can put in place to help staff from different services to collaborate more effectively and reinforce the benefits of co-location.

## 2.2 Methodology

The findings from this report are based on four research activities:

1. **Fieldwork visits within Manchester.** Most of our research time was spent with three INTs across Manchester North, Central and South (CASS, Gorton and Patch 2 respectively). We spent several days in each area observing the office environment and team meetings (i.e. huddles and handovers) and interviewing staff. Wherever possible we interviewed staff from all levels across the teams, including management (programme managers and community matrons), team leaders (from both health and social care) and frontline staff (including district nurses, reablement workers, therapists, social workers and administrative staff). Where possible, we interviewed staff from each of the main professional groups in the team. Finally, we observed several multi-disciplinary team (MDT) meetings at GP practices in Manchester. In total we interviewed 29 members of staff and observed three MDTs. For more information see Table 4.
2. **Fieldwork visits to other areas of GM.** We supplemented our fieldwork research in Manchester with visits to four other areas of GM (Bury, Rochdale, Tameside and Wigan). These areas of GM were selected because they were at different stages of health and social care integration. Visiting each of them allowed us to identify similarities to Manchester's INTs as well as to observe how teams develop over time, after co-locating. We interviewed strategic leads, team leaders and frontline staff. In total we interviewed 25 members of staff. For information on the composition of each team see Table 4.

3. **Academic literature review.** We conducted a review of academic research relevant to integrated teams in adult community health and social care. However, we found the literature on health and social care integration to be relatively nascent and consisting primarily of exploratory case studies which do not provide strong levels of evidence. As such, we complemented our research with evidence from other sectors which faced similar challenges (e.g. research on integration and managing diversity following corporate mergers and acquisitions).
4. **Feedback and collaboration workshops.** We ran two workshops with staff across Manchester during our project. The first workshop, held at the start of the project, brought together 30-40 frontline staff and managers. The session provided an introduction to behavioural insights and the goals of the project. We also used the session to begin consulting on the target behaviours staff felt we should concentrate on. It was this workshop that led to us broadening the scope of the project from the original framing around trusted assessment specifically. We then held a second workshop with 10-15 staff toward the end of this project. This workshop helped us to prioritise our ideas, sense-check our thinking and seek input on our suggested changes.

### 2.3 Structure of this report

The remainder of this report is split into two main sections:

1. **Key themes and ideas.** In this section of the report, we set out a broad range of ideas for using behavioural science to improve integration. These are structured around three key themes: improving team meetings, increasing trust and social interaction and improving processes and systems.
2. **Recommendations.** In this section, we set out which of these ideas we recommend Manchester LCO consider first. On the basis of our ideas, we also provide suggestions for things other GM boroughs (and other areas of the country) should consider at different stages of the integration journey (from initial planning through to full co-location).

**Table 4: Overview of teams visited as part of fieldwork**

Area	Team name	Membership										Co-located since	Line management	Integration type	
		Health				Social care				Other					
		District Nurses	Other nurses	Occupational therapists	Physiotherapists	Social workers	PAT assessors	Social care workers	Reablement	Occupational therapists	Rapid response	Non-health & social care			
Manchester South	Gorton INT	✓	✓			✓	✓		✓				2016	Separate	Combined
Manchester Central	Patch 2	✓		✓	✓	✓	✓						Not yet	Separate	Combined
Manchester North	Manchester Community Response North			✓	✓				✓		✓		2016	Shared	Specific issue
Greater Manchester Bury	N/A												Not yet; to pilot co-located & virtual	To be determined	To be determined
Greater Manchester Rochdale	Littleborough INT	✓	✓		✓			✓				✓	May 2017 nurses & social care Sept 2017 physios & others	Nursing & physio shared Social care & others separate	Link worker
Greater Manchester Tameside	Locality West	✓	✓			✓	✓			✓			2015 for social care; 2016 for non-health & care; May 2018 for nurses	Separate	Combined
Greater Manchester Wigan	Integrated Community Services – Wigan Central	✓		✓	✓	✓		✓	✓	✓	✓	*	2016	Joint	Specific issue & combined

\*Wigan's Service Delivery Footprints (SDF) include a wide range of non-health and social care staff co-located with Integrated Community Services

## 03 / Key themes and ideas

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The body of this report is structured around three key themes that we think are crucial for improving joint working and collaboration within INTs and other community-level, integrated health and care teams:<sup>ii</sup>



### 3.1 Improving team meetings

Using ideas from behavioural science to make multi-disciplinary team meetings (MDTs), huddles and handovers more effective.



### 3.2 Increasing trust and social contact between staff

Changes designed to improve trust and understanding between staff from different professions and increase the frequency and regularity of informal social interactions.



### 3.3 Improving systems and processes

Changes to processes and systems designed to make integration tangible to staff and remove barriers to effective collaboration.

Many of the ideas presented in this report will be easier to implement (and more effective) in fully co-located teams. However, the majority will be applicable to teams which are not yet fully co-located. We wanted to ensure that teams at any stage of health and social care integration, including areas where co-location has yet to take place or is not planned, would be able to benefit from this report.

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<sup>ii</sup> Throughout the remainder of this report, we will refer to INTs (as the term used for integrated, neighbourhood health and care teams in Manchester). However, we have tried to make sure our ideas can apply to any neighbourhood-level team which aims to integrate different health and social care professionals around a place.



When we developed our ideas, we were wary of relying too much on in-person interaction in the office. Frontline staff in community health and social care teams spend most of their day doing visits and attending meetings, and can rarely be in the office. Through our fieldwork, we also found that different services have different schedules and 'rhythms' to their day (some do home visits first thing in the morning, others do paperwork first and visits in the afternoon). This means that even co-located staff can spend surprisingly little time in the office together. Therefore, our ideas consider how to promote integration, collaboration and joint working even when staff do not spend lots of time working physically alongside one another.

### 3.1 Improving team meetings

#### Summary of ideas to improve team meetings

1. Rotate the chair of MDTs each meeting to disrupt traditional power imbalances.
2. Review the different types of meeting and aim to remove 'information sharing meetings' and refocus huddles and MDTs on their primary purposes.
3. Create clearer separation between MDTs and huddles by requiring all participants in MDT to bring only one or two cases to discuss.
4. Run MDTs in a way which reduces the risk of group-think
5. Embed good planning techniques into huddles and handovers.

During our fieldwork, we observed three main types of interdisciplinary meetings: the handover, the huddle and the multi-disciplinary team meeting (MDT). In theory (and in the literature), these three meeting types serve distinct purposes (see Table 5).

During our fieldwork we observed meetings which were branded as all three of these types. In practice, all the meetings we observed tended to function primarily as information sharing forums. Given the lack of shared IT and case management systems, this information sharing is necessary. However, we felt that using multi-disciplinary meetings primarily for this purpose may mean that the MDT in particular no longer performs its primary functions: facilitating truly joint decision-making and problem solving.

**Table 5: Types of team meeting we observed in fieldwork**

Meeting Type	Description
Handover	Used to pass information about residents from one shift to the next. These are usually held only with members of one service (e.g. within the district nurse team) to update colleagues on residents' care and progress, to get advice on issues that could not be resolved, and to plan for the rest of the day and the next shift.
Huddle	Used to identify issues for the upcoming shift and determine a plan of action (solve, delegate, mitigate, escalate). <sup>38</sup> These are often a meeting across services (e.g. participants from nursing and social care). Not all issues can or should be resolved in a huddle, but teams should leave with an action for every issue brought. <sup>39</sup> Huddles should be of limited duration (ideally less than 10 minutes). <sup>40</sup>
MDT	Multi-disciplinary team meetings (MDTs) are used to create care plans based on joint clinical decision-making and to monitor delivery of those plans. <sup>41</sup> In community settings these are often hosted by the GP (and were in all the places we visited in GM). They are attended by several professionals (MacMillan nurses, district nurses, GP practice nurses, pharmacists, etc.). In the UK, MDTs tend to be organised around conditions involving complex decision-making, such as cancer. <sup>42</sup>

We believe that there are relevant findings from behavioural science that could be used to help these different meetings to better perform their respective functions. There is a significant body of evidence in behavioural science that looks at our behaviour in meetings.

When one person disagrees with what is being said in a group, the likelihood that this person speaks up and disagrees depends on several factors. For example, there may be pressure to self-censor. A prominent book reviewing the behavioural science of group decision-making posits that this pressure stems from two key effects: informational influence (we doubt our own belief because we assume others around the table have good reasons for not sharing it) and social influence (we may continue to hold our belief but worry about the social consequences of speaking up).<sup>43</sup> It then argues that these two effects can lead to group reinforcement (driven by informational influence and social pressure) which result in several group behaviours that hinder good decision making:<sup>44</sup>

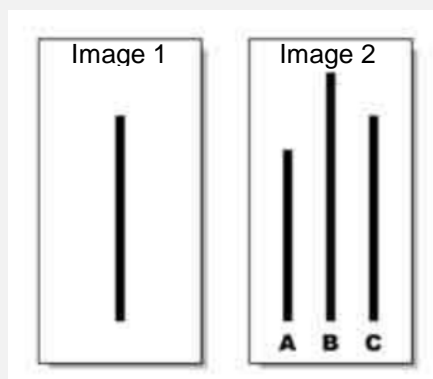
- **Cascading:** when initial contributions strongly influence the direction of the entire group discussion and important ideas and opinions may not even get discussed. For example, when senior managers speak first

this can often result in other contributors deciding not to share their contradictory ideas.

- **Amplification:** when a group focuses on the information that is shared by the most people rather than the information that is most relevant for the issue at hand (this is because we often subconsciously substitute the idea that something is common with the idea that something is important). In an MDT this could take the form of concentrating on clinical facts known and understood by the majority of attendees, even if these are less important than some crucial information held by only one or two professionals in the room.
- **Polarisation:** when a group of people who share an opinion can end up with a more extreme view than the group members have individually (i.e. the group ends with two sub-groups who are more polarised than they were before they started). This is because when surrounded by people who agree, we start to see the issue as more polarising than we did originally, and we start to ascribe negative traits to those who disagree.<sup>45</sup>

### Box 1: The power of informational influence and social pressure

In a now famous series of laboratory experiments,<sup>46</sup> a participant was asked to identify which of the lines from Image 2 corresponded to the length of the line in Image 1.



Participants were asked to answer this question either alone or in a group of people. The catch was that the group was made up of actors who had been told beforehand what answer to give. In groups where all actors gave the same wrong answer, a third of participants followed suit and gave the same wrong answer, compared to no wrong answers for participants who answered alone. The participants in these studies

were young, male university students in the 1950s. Since then, it has been shown that cultural context can influence the strength of the results, for example, people from collectivist cultures have been found to be more likely to respond to these pressures than people from more individualistic cultures.<sup>47</sup>

The suggestions in this section aim to reduce the risk of these biases having an impact in MDTs, thereby improving the quality of decision-making in these meetings. More generally, they also explore how behavioural science could be used to help MDTs, huddles and handovers to best perform their respective roles.

### *3.1.1 Rotate the chair of MDTs each meeting to disrupt traditional power imbalances*

This aim of this idea is to ensure that the person who is perceived as the most authoritative or senior in the room (often the GP) does not always speak first or chair all MDTs. During our fieldwork, we observed that the clinician perceived as the most senior person in the room (usually a GP) can quickly dominate discussions. This aligns with research (see above) which shows that the person who chairs a meeting, or the person who speaks first, can have a big impact on how the meeting subsequently runs. These elements of reinforcement are particularly prevalent in hierarchical settings. This may be less of a problem in meetings which are primarily about information sharing. However, the effectiveness of MDTs (which are ideally about joint decision-making) may be jeopardised if not everyone around the table is supported to contribute.

For INTs, we think it is important to consider how the dynamics of hierarchy and professional status may influence people's willingness to contribute in MDTs.<sup>48</sup> One way of limiting the impact of such group reinforcement is to ensure the most authoritative or senior person in the room is not chairing or leading every discussion.

We know that Manchester currently plans for the new 'Neighbourhood Leads' - non-aligned, independent staff who are not from a specific clinical background - to run meetings. We think this correctly identifies the potential problem of professional hierarchy. However, we believe there is a risk that in the long-term Neighbourhood Leads may start to be perceived as a more senior or authoritative figure, and the same problems could re-emerge. To avoid this happening we suggest INTs consider a rotating chair for key meetings (like MDTs). This rotation should include all staff attending the meeting (including support and clerical staff) as the goal is to disrupt traditional power imbalances.

### *3.1.2 Review the different types of meeting and aim to remove 'information sharing meetings' and refocus huddles and MDTs on their primary purposes.*

One of the tools that many integrated teams use to increase communication across professional boundaries is the huddle. However, as we have previously outlined, we think that many meetings branded as 'huddles' are in practice used for information-sharing between teams. In addition, we think that INTs are may be facing challenges caused by the fact that they are breaking new organisational ground. Because INTs bring together staff from multiple professions, and cover geographical areas of 30,000-50,000 people, it may just not be feasible for all staff to be involved in a meeting which discusses all active cases (or even everyone being seen that day). In many meetings we observed, this list ran up to and over 100 people.

Working through this long list of people unfortunately seemed to leave little time for value-adding discussions about cases. In addition, staff can quickly come to resent valuable time spent in a meeting discussing many cases which are not relevant to them. Meetings which were originally conceptualised as being quick opportunities to problem-solve across professional boundaries

(huddles), or pass crucial information between shifts of common professionals (handovers) may no longer be serving these purposes.

We suggest that Manchester consider reviewing the different meetings which happen in and around INTs; redefining and reinforcing the differences between them. This should aim to ensure that meetings do not become excessive and that professionals do not need to spend significant amounts of time in meetings where they do not need to contribute. As well as efficiency savings, we think this is likely to spill over into better group decision-making where it matters (as people get used to being expected to speak at the few MDTs or huddles they attend) and more positive attitudes toward integration generally (which does not become partly synonymous with big increases in meetings).

One challenge with this approach is that the 'information-sharing meetings' we observed happening in practice clearly serve an important purpose. However, we believe that discouraging them in their current form may instead encourage those conversations to happen on a one-to-one basis between professionals. A nice side-effect of this is that this may encourage more frequent interaction between professionals (something we know is likely to promote trust and collaboration – see Section 3.2 Increasing trust and social contact between staff).

### *3.1.3 Require all participants to bring one or two cases to discuss at the MDT*

The MDTs we observed during our fieldwork had long resident lists to get through, which meant each individual case did not receive enough time for discussion. This structure meant that MDTs functioned very similarly to handover meetings, and seemed to act as an information sharing forum rather than a problem-solving setting. This structure also meant that some MDT participants barely spoke.

We therefore recommend restricting the number of cases each professional can bring to the meeting as a rule-of-thumb designed to prevent a spiralling agenda. We suggest asking each participant to bring only their one or two most pressing cases. In addition to limiting the agenda, it enforces a degree of equality between different attendees, with no single professional dominating what and who is discussed.

### *3.1.4 Use 'red teaming', sequential contribution and anonymous feedback to tackle group-think in MDTs*

MDTs are meant to facilitate inter-disciplinary decision-making for the benefit of people receiving care and support. During the MDTs we observed, the discussion centred on updates and actions for individual cases and we did not observe much significant debate between professionals about the care plan. To get the most benefit from the multidisciplinary setting, we believe MDTs could be structured to encourage more constructive problem-solving and debate.

The risk of opening up MDTs to more debate and discussion is that, without it being carefully managed, there is evidence to suggest that the group will not

come to a sensible compromise position. As outlined earlier, group debates can actually lead people to become more, not less, polarised and can fail to aggregate the best information available to the group.<sup>49</sup>

We think there are three approaches worth considering here:

- **Red teaming** is an exercise used in the military to create space for constructive criticism in a group.<sup>50</sup> It involves some members of the team splitting off to form a 'red team' tasked with finding weaknesses in a proposal; the goal is to create opportunities for critically analysing the proposal in a way that cannot easily be dismissed. We suggest that Manchester could explore how this principle could be applied in MDTs and inter-disciplinary care planning. For example, in an MDT a small group of professionals could be selected ahead of time to form a 'red team' and encouraged to critically challenge and examine the conclusions of the multi-disciplinary discussion.
- **Sequential contribution.** One of the major challenges in group situations is encouraging people to speak up. As outlined in the introduction to this chapter, both informational and social influences can lead to people with crucial information remaining silent during meetings. One simple way to tackle this could be implementing sequential contribution in meetings – all attendees must say something, in a pre-specified order, about each case. This might feel bureaucratic at first, but it could help ensure that the group draws on all relevant information. Note that this would only be feasible in MDTs focussed on a small number of cases.
- **Anonymous feedback.** There are a number of reasons why, especially early on, some INT members may not feel comfortable contributing in MDTs. One way of tackling this would be to create a way for staff to anonymously contribute ahead of time. For example, BIT often does this during meetings by allowing some time for a ThinkGroup – where people anonymously write ideas and concerns down into an anonymous Google Document.

### *3.1.5 Embed good planning techniques into multi-professional meetings*

Many multi-professional meetings we observed were mainly about coordination and action-planning. Staff discussed cases and made plans about what would happen next and who would take action. As INTs grow larger, we think there is a risk that these actions are not taken forward. Most health and care professionals are very busy. While they may have every good intention of following through, we know that people often suffer a gap between their intentions and actions: even motivated people can forget or procrastinate about important tasks they know they should complete.<sup>51 52</sup>

There is a wealth of evidence from behavioural science about how simple planning techniques can help people to follow through on their goals.<sup>53</sup> Goal-setting and planning are well-studied in the behavioural science literature, and there are several techniques that can make plans much more effective.

- **Make sure tasks and specific and time-bound.** SMART (Specific, Measurable, Agreed, Realistic and Time-Bound) is an acronym which is often used to help people think through their goals and there are good reasons from behavioural science for thinking SMART is an effective tool. For example, we find it easier to follow through on our plans when they are specific and we have a clear deadline; otherwise we can be tempted to procrastinate.<sup>54</sup>
- **Set implementation intentions.** So-called ‘implementation intentions’ can help people to follow through on planned actions.<sup>55</sup> Setting an implementation intention involves creating ‘if-then’ plans about when you will take action (e.g. ‘If Mr Smith’s resting heart rate goes above 90, I will bring the case back for discussion at MDT’).
- **Make clear commitments.** Making public commitments, or simply writing down exactly what we commit to doing, can help us to follow through on our intentions. For example, a small study found that postmenopausal women were more likely to reach their activity goals after six weeks if they signed a contract, committing to the activity they would do, with their health coach.<sup>56</sup>

### 3.2 Increasing trust and social contact between staff

#### Summary of ideas to increase trust and social contact

1. Increase ‘formal’ social contact by setting up joint visits or shadowing opportunities between staff in different professions
2. Increase ‘formal’ social contact by removing referral forms and processes within the INT (encouraging in-person handover)
3. Increase ‘informal’ social contact by establishing randomised coffee pairs, or setting up a cross-profession ‘buddy system’
4. Help staff understand the perspective of other professionals by completing perspective taking exercises and getting feedback from residents on the value of different professions
5. Increase trust by creating a system for team members to give public recognition and small rewards to colleagues from a different service
6. Get a head start by moving from a ‘shallow’ to a ‘deep’ induction process

Teams can be defined in several ways, as social constructions (defined by how team members behave and how they relate to each other), as units on an organisational chart or as groups of people performing set tasks.<sup>57</sup> However they are defined, the purpose of teams is to bring together groups of people to work together in ways that make them more productive than if they each worked individually (i.e. they are ‘more than the sum of their parts’).<sup>58</sup>

Effective teamwork requires trust between team members, which can either be conditional (‘tit-for-tat’) or unconditional (wide-ranging and based on shared values and goals).<sup>59</sup> Unconditional trust has been shown to strengthen interpersonal cooperation and teamwork. This is because it increases team

members' confidence in one another, encourages them to get help from colleagues and promotes information sharing.<sup>60</sup> Without trust (or with only conditional trust) colleagues face higher transaction costs every time they interact with someone (i.e. they need to spend time or effort 'checking' the other person is following through on their end of the bargain).<sup>61</sup>

There are several ways to help build unconditional trust in teams:

1. **Having a shared identity.** Identifying as part of a group can increase our unconditional trust for other members of the same group.<sup>62</sup> Shared identity can be encouraged by generating a shared purpose and shared goals, deciding on a shared approach to problem solving, committing to shared values, focusing on an origin story and maintaining rituals and traditions.<sup>63</sup>
2. **Promoting psychological safety.** In addition to person-to-person trust, group-level trust is also important. In the literature, 'psychological safety' is how comfortable people in the team feel about speaking up or taking risks.<sup>64</sup> Team perceptions of psychological safety have been found to be positively associated with learning behaviours (like seeking feedback, asking for help and acknowledging mistakes, which in turn improve team performance).<sup>65</sup> Supportive and inclusive leadership,<sup>66</sup> positive office relationships,<sup>67</sup> safe spaces for discussion,<sup>68</sup> and less hierarchical teams<sup>69</sup> all tend to have more psychological safety (though inclusive leadership may be able to overcome the impact of formal or informal hierarchies<sup>70</sup>).
3. **Trust also builds through regular interaction.** Pure familiarity (how many times people have worked with each other) has an impact on team performance.<sup>71</sup> In the following section, we define 'Formal' social contact as interactions which are more task-focused and work-oriented (i.e. joint visits, discussions about a particular case), and 'Informal' social contact as interactions which do not relate to a specific work task (i.e. chatting in the kitchen or making general small talk). We think both are important for promoting trust and teamwork.

### **Box 2: The 'paradox of diversity'**

We think that a focus on team-building, group cohesion and trust is particularly important in INTs because of the nature of their role. In the private sector, multi-disciplinary teams are sometimes set up to develop new products (including people from marketing, production, distribution etc.). A study of 93 such teams found that teams with a broader range of professions involved had better outcomes.<sup>72</sup> However, this increased functional diversity was also associated with increased stress and lower cohesion. The flipside of the diversity dividend is that being surrounded by people who see the world differently and challenge your assumptions can be tiring.

We think this finding is highly relevant to INTs and highlights the importance of changes which improve the day-to-day experience of both staff and the residents they serve.



As highlighted above, one of the main ways teams can build trust is through regular interaction. This can mean communicating well with each other. Good communication is important for knowledge sharing and thus for productivity.<sup>73</sup> However, not all communication is equal, and the way colleagues in a team communicate with each other and with those outside their team matters.<sup>74</sup> Researchers have identified several promising patterns of communications that are associated with increased productivity:

- **In-person interactions:** Studies have found correlations between the number of in-person interactions that team members have and team productivity.<sup>75</sup> High performing teams have more in-person interactions, and interaction levels are evenly shared across the team.<sup>76</sup>
- **Informal interactions or ‘collisions’:** Increasing informal interactions among people in an organisation has been shown to improve cooperation across teams and positively impact creativity.<sup>77</sup> These ‘collisions’ or unplanned encounters have been shown to increase productivity in a number of private sector settings.<sup>78</sup>
- **‘Bursty’ communication:** ‘Bursty’ communication is a condensed period of quick back and forth exchanges, such as an instant message chat. This is in contrast to exchanges that are drawn out, such as discussing over email. A recent study on effective communication indicates that ‘bursty’ communication may help improve the quality of collaboration in teams.<sup>79</sup>

In the INTs we visited, there were varied levels of informal and in-person interactions between INT members. In part, this is because frontline staff spend a lot of their time out of the office visiting people in their homes. Different services also have different ‘rhythms’ to their day (e.g. reablement workers may be helping residents get ready in the morning, but physiotherapists would come into the office in the morning to plan their visits and head out mid-morning). Many of the professionals we spoke to ate lunch in their cars between visits. This means there are fewer opportunities for people to interact at the office itself, even if teams are co-located.

Finding ways for team members from different services to meet each other more, both formally and informally, could help further integration through increased contact and communication.

### *3.2.1 Increase ‘formal’ social contact by setting joint visits or shadowing opportunities between staff in different professions*

Staff from different professions in INTs can have limited opportunities to interact, understand each other’s roles and understand how these contribute to people’s recovery and well-being. In theory, the opportunity to conduct joint visits is always available. In practice, setting up joint visits requires time and effort. This means that professionals rarely get the chance to see what other people’s work looks like in practice. Furthermore, even when they conduct a joint visit, this is almost always because a case is particularly complex. A case like this is, by definition, not the ‘bread and butter’ of either profession involved.

We recommend systematically setting up joint visits or shadowing opportunities between staff from different professions in the INT. As well as giving staff permission to learn about each other's roles this will also make it easy for them to do so. Permission alone is important but unlikely to be enough. Actually setting up and mandating joint visits reduces the risk that inertia or procrastination kick in and the visits never happen.

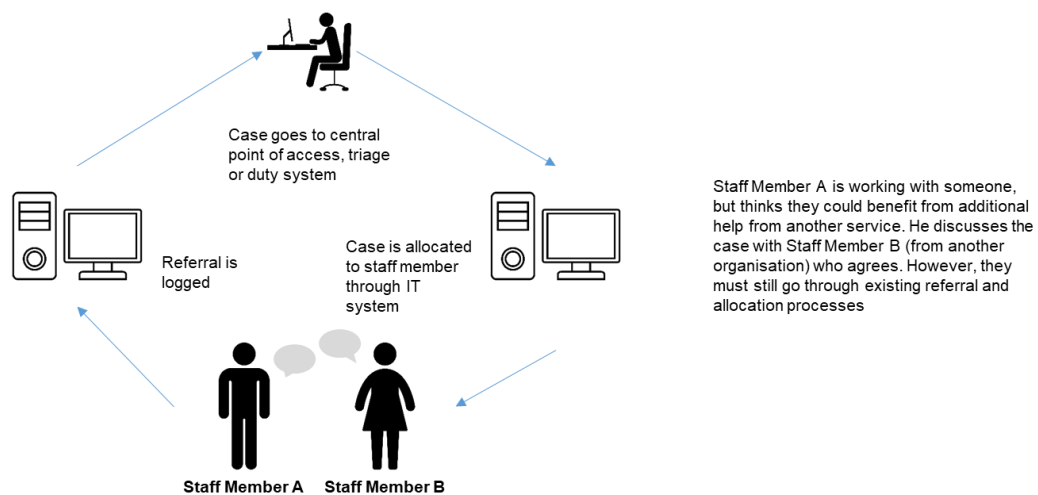
*3.2.2 Increase 'formal' social contact by removing referral forms and processes within the INT (encouraging in-person handover)*

One of the potential benefits of integration is the opportunity to collaborate on cases across services, organisations and professions. The theory is that co-location lowers the threshold for staff taking the time to discuss a case with colleagues, promoting for 'formal' social contact and creating new spaces and opportunities for different organisations to jointly discuss and plan care.

However, most of the integrated teams we visited had maintained the same referral and triage processes they had in place prior to integration. These referral processes made collaboration difficult. They also meant that there was often limited value in direct professional-to-professional discussion about cases. While professionals could discuss a case, referrals still had to go 'up and round' through a single point of access or duty allocation system.

We therefore suggest that Manchester consider removing formal referral processes within integrated teams. Instead, team members could refer people to other professions within the team directly. Two of the INTs we visited outside Manchester (but within GM) had done this. If a member of the INT wanted to refer a resident to another professional, they had a conversation with the relevant professional (either over the phone or in-person). The decision about whether or not to refer was made in that conversation. This not only cut referral times in the team, but also encouraged more interactions among INT members from different services. The downside is that this did, in effect, create a two-tier waiting system, where certain cases could 'skip the queue' if they were brought up at certain neighbourhood meetings.

**Figure 1: Typical referral and allocation process**



### *3.2.3 Increase 'informal' social contact by establishing randomised coffee pairs, or setting up a cross-profession 'buddy system'*

Co-location can have an impact on the number of informal interactions that occur between different team members. However, it is not the only factor that determines whether or not people interact. People also need to feel they have permission to engage in informal, in-person conversation.<sup>80</sup> This permission is based on the culture and norms of the team: do you feel at ease making small talk in the kitchen? Does your manager send you looks when you've been away from your desk for too long? These factors can be as important as the physical environment (e.g. the presence of shared spaces like kitchens).<sup>81</sup>

We think there are two ways INTs could encourage more informal social contact across professional boundaries:

1. **Randomised coffee pairs.** Every month, each staff member in an INT or patch is automatically paired with a colleague. Each pair fix a mutually convenient time and have a 30 minute conversation during the next month. Doing this signals the value the organisation places on informal, in-person conversations and helps staff 'break out' of their current social circles at work (because the randomisation forces them to get to know new people) . Finally, automatically connecting staff and strongly encouraging (or even mandating) the meeting ensures that it will actually happen, even if people are busy and inertia kicks in.
2. **A cross-profession buddy system.** Alternatively, INTs could set up a 'buddy system' when the teams first co-locate, pairing each team member with someone of a different professional background. This approach is less likely to persist over time, but may help break initial professional silos. It may also give staff a named person they can approach with more 'formal' questions about cases.

### *3.2.4 Help staff understand the perspective of other professionals by completing perspective taking exercises and getting feedback from residents on the value of different professions*

Several of the INT members that we spoke to, from a range of different professions, felt that their service was the 'service of last resort'. District nurses felt that they were the 'last resort' because they have to see anyone who is referred to their service and do not have thresholds. Social care staff felt that they were the 'last resort' because anything that did not neatly fall into a set of clinical criteria was referred to them. More generally, this reflected the fact that INT team members often do not know what their colleagues in other professions do on a day-to-day basis.

Two findings from behavioural science show particular barriers that may impede successful collaboration:

- **The illusion of similarity.** We tend to think of ourselves as objective and unbiased. Particularly when we are experts in an area, we assume that if people had all the information we had, they would come to the

same conclusion that we have come to, and they would feel as strongly about it as we do.<sup>82</sup> By extension, we assume that anyone who is given the same information and comes to a different conclusion must be either ignorant or biased. This is known as the *illusion of similarity*<sup>83</sup> and can make it difficult for us to understand the viewpoints of others.

- **The fundamental attribution error.** We tend to recognise the situational factors (the random factors like being tired, busy or distracted) that affect our own behaviour. However, we assume that other people's behaviour is driven much more by their disposition (their core personality). This *fundamental attribution error* can lead us to view other people's behaviour less sympathetically than we view our own.<sup>84</sup>

In bringing together staff from different services, INTs will have to deal with both the illusion of similarity and the fundamental attribution error as barriers to collaboration. We think there are two ways INTs could tackle these barriers:

1. **Perspective taking exercises.** These exercises could help INTs tackle these barriers by helping staff to understand the reasoning and day-to-day experience of their colleagues from other services.<sup>85</sup> In perspective taking exercises, participants get information about another group (e.g. by interviewing each other) and then complete a task from the other person's perspective (e.g. role play an interaction with a challenging resident, write a short paragraph about how that person would experience a team meeting, etc.).
2. **Testimonials from residents.** Residents could be invited into team meetings to explain how staff from a particular profession improved their lives. This could help staff understand the value of different professions from the outside point-of-view of people receiving care and support. As well as helping them to understand how other professionals contribute to a shared goal (the wellbeing of Manchester residents) this could also have positive spillover effects into general team morale and productivity. Studies have shown that providing staff with a real in-person interaction with someone who has benefited from their work can improve morale and productivity.<sup>86 87</sup> While health and care staff see residents regularly, by definition they often stop seeing them when things have improved. This means they do not always have the chance to see the impact of their work.

### *3.2.5 Increase trust by creating a system for team members to give public recognition and small rewards to colleagues from a different service*

Gratitude has been shown to be important to collaboration. Having someone say thank you for a favour increases the likelihood that a person will do an additional favour for either the same or another person.<sup>88</sup> When someone thanks us, we feel that we are valued.<sup>89</sup> We also are more likely to think that the person thanking us is a warm and cooperative person, which makes us more likely to form a relationship.<sup>90</sup>

Google have a system (called gThanks) where employees can publicly thank their colleagues for going 'above and beyond'. They also have a system where employees can give inexpensive rewards to colleagues without management sign-off. They have found this system is not generally abused, and staff really value acknowledgement from their peers.<sup>91</sup>

We suggest creating an easy way for staff to publicly recognise the contribution of other members of the team (e.g. an 'appreciation wall' where staff can put thank you notes up for other team members). Building on this idea, we believe it would be even more effective to give staff the opportunity to give small rewards (such as a voucher), funded by Manchester LCO, to colleagues from another profession who have gone 'above and beyond.'

### 3.2.6 Get a head start by moving from a 'shallow' to a 'deep' induction process

We spoke to several staff about what had happened when they first joined the INT (i.e. when they were first co-located or formed into 'patches'). At most, some staff remembered one or two 'away days' with traditional games (like lining up in birthday order) and speeches from senior management. Most people felt these sessions were nice, but not particularly effective.

We think this is important because of a well-studied effect in private sector mergers known as the 'merger syndrome'. This affects the employees of two organisations who are merging, and refers to the stress that arises from the certainty that change is coming but the uncertainty about what it will entail. Aversion to uncertainty is well-documented in behavioural science,<sup>92</sup> and has been shown to cause people to withdraw from situations such as medical treatments.<sup>93</sup> With the merger syndrome, it is hypothesised that the stress caused by uncertainty creates an unwillingness to collaborate with others, which has a negative impact on team performance.<sup>94</sup>

#### **Box 3: Shallow and Deep Cultural Learning**

A 2005 study looked at how to decrease conflicts in integrating units during a private sector acquisition; testing whether changes to the induction process during integration could affect communication and cooperation between teams. The study tested three induction processes:<sup>95</sup>

- *Deep cultural learning*: a joint family picnic, perspective taking exercises and weekly follow-up unit meetings.
- *Surface level cultural learning*: a management presentation on values, vision and strategy, followed by a Q&A session.
- *No cultural learning*: acquisition announcement only

The four plants receiving either deep cultural learning or surface level cultural learning interventions had teams that would be integrated following the acquisition, whereas the two no cultural learning plants would remain autonomous. The study found that deep cultural learning led to better cultural understanding, communication, cooperation and commitment to the combined organisation compared to 'surface level' and no cultural learning.

This may require more time and effort up front; both from staff members participating and for the person organising and leading the sessions (who should be someone outside the team who is not doing it on top of day-to-day duties). However, there is good evidence to suggest this up-front investment will pay off later. We also recommend that Manchester think carefully about the logistics and practicalities of such sessions, particularly concentrating on how to ensure the majority of staff are able to attend.

### 3.3 Improving systems and processes

#### Summary of ideas to improve systems and processes

1. Automatically identify and connect staff working with the same people
2. Set up a dedicated staff resource for managing integration
3. Fix the small stuff quickly to give staff a positive early experience of integration.
4. Make it easier for staff to contact team members using a visual phone book, group messaging systems and simplified diagrams showing who does what
5. Remove visible signs of previous team boundaries

Throughout our fieldwork in different areas of Manchester and GM, it was clear that co-location was only one step towards integrating professionals from different services. In most teams, processes and systems had remained the same as they were prior to integration. Lack of shared IT systems, unchanged referral pathways and inadequate estates could all discourage integration.

While systems and processes may seem like inconsequential details which people can overcome if they have enough motivation, behavioural science has shown that the details of processes and systems can really matter in numerous ways. Some of these details are:

- **Hassles and frictions.** Small additional steps or irritations in a process can have disproportionate effects on our behaviour.<sup>96</sup> For example, a US study found that potential students from low-income backgrounds greatly benefited from just a few hours of support to help them to fill in financial aid forms (those who received support were 29% more likely to end up to register and complete at least two years of college).<sup>97</sup>
- **Simplification.** The clarity of written communications matters a lot. Complicated or unclear instructions will often be ignored or put off and forgotten. Using plain English, highlighting key actions, removing unnecessary detail and lowering the reading age of a document can all have surprisingly large effects on behaviour. For example, A BIT project with the Irish Tax & Revenue Commission that used a simplified version of a letter to get those who had not yet filed their income tax to do so led to a 5-6 percentage point increase in subsequent filing compared to the standard letter.<sup>98</sup>

- **Reducing (or helping people to navigate) choice.** Intuitively, increasing the number of choices people have available should increase the likelihood that there is one which works for them. It should therefore promote action. However, ‘choice overload’ is a well-studied behavioural phenomenon in which people, when faced with too many choices, end up locked in indecision and procrastination and fail to take action.<sup>99</sup> Ideally, people should be presented with a few, well-chosen or personalised choices. If this is not possible, people should be given tools or techniques for quickly narrowing down a choice-set to a manageable number of options. For example, price comparison websites help people to navigate hugely complex markets (like insurance) by answering a few simple questions and providing the ability to rank options on different dimensions (price, average review etc.).
- **Timely prompts.** We face many competing demands on our time and attention. Even with the best of intentions, we can often simply forget to follow through on planned actions when the time comes. Giving people timely prompts, at the point when they need to take action, has been shown in many contexts to be an effective way of helping people to follow through on their actions. For example, a lot of research demonstrates the positive effect of SMS reminders,<sup>100 101 102</sup> postal communications,<sup>103</sup> and phone calls<sup>104</sup> on attendance at health appointments.

Co-locating staff in INTs aims to encourage more collaboration and joint working across services. However, without changes to processes and systems, staff face unnecessary and surprisingly consequential barriers to working in this way. We saw several examples of this during our fieldwork:

- Without shared IT systems, professionals cannot easily access information about which other professionals are working with a particular resident. While staff can, in theory, access shared resident records, this is a difficult process with a lot of friction and hassle. Getting registered on such a system is difficult, it can only be accessed on certain computers, it does not have a very intuitive user interface, and accessing the relevant information can be cumbersome.
- Without changes to referral processes, staff do not save any time if they talk to a colleague from another service because the paperwork still needs to be filled in and sent through a triage system. This extra friction is likely to weigh (perhaps only unconsciously) on staffs’ decision about whether to have that additional 10-15 minute chat before getting started on the (often quite extensive) paperwork.
- Inadequate estates mean that, for many frontline staff, integration entails moving into a new office without enough desks, without enough parking spaces and without enough space in the fridge. These hassles may seem trivial and transient but can add up to make it more difficult for staff to work differently; the realities of their day-to-day may have either not changed much or may be worse.

Getting the systems right and making it easier for staff to collaborate is likely to have a significant impact on the behaviours which integration aims to encourage. We are mindful that many of these issues (IT and estates for example) are well-understood and also very difficult to address. In this section, we have provided some ideas about actions which we think Manchester could take in the short-term to address some of these barriers. Longer-term, we would still strongly encourage Manchester LCO to invest in more systematic solutions to some of these problems (e.g. through real, shared case-management systems).

### *3.3.1 Automatically identify and connect staff working with the same people*

The main methods of sharing information across services in INTs we visited were through the Yellow Folders in the people's homes and handover meetings/huddles. In some areas, even the Yellow Folders were not used consistently because some services had gone paperless and only recorded information on their own case management system. Several interviewees mentioned that they only realised they were working with the same resident by coincidence – when they overheard the name being mentioned across the room by someone from another service (one interviewee referred to this as the 'meerkat effect' because of how people would pop up from their desk when they heard a name they recognised). This meant that actually working in an integrated way on shared cases required a lot of effort and in practice happened on an ad-hoc basis.

Providing professionals with shared access to common case management systems is a large infrastructure project that is likely to take many years. In the meantime, we recommend borrowing a strategy from agile product development: making a minimum viable product. Agile is a method of product development used in the IT sector to develop user-friendly solutions to problems. Many Agile development principles have roots in behavioural science, such as the idea that you need to make it as easy as possible for the end user. The point of a minimum viable product is not to produce an ideal product. It is to build a low-cost, scaled down version which focuses on a core functionality.<sup>105</sup>

In this instance, the idea is to set up a system (perhaps operated manually by business support or clerical staff to start) which automatically tells staff when another professional or team starts working with the same resident. This could be prototyped using a lookup function on an excel spreadsheet (to identify residents on more than one list) and then sending an email or text message to whoever is assigned that person with the contact information of other professionals also providing support. Even without access to case notes, simply knowing who else is engaged with a case could prompt a discussion between the professionals involved. In addition, because the process requires no effort from frontline staff (messages are automated) and gives timely, easy-to-understand information (*'Sarah Hanes (Physiotherapy) has stated working with John Doe. You can call her on xxxx'*) we think it is likely to have a surprisingly large effect on behaviour.



### *3.3.2 Set up a dedicated staff resource for managing integration*

Many of the staff we interviewed could easily articulate what health and social care integration means for residents: it means less duplication, more holistic care and better outcomes. Both professionals and corporate policy staff found it harder to articulate what health and social integration means for staff themselves. They often struggled to identify what frontline staff should do differently in their everyday work to further integration other than to 'work together more'. Frontline staff already have full-time jobs prior to integration; asking them to continue doing their day job while managing change is a big ask, especially when the change we are asking for is difficult to define.

In the private sector, there is a lot of research on integrating teams from different functions or organisations. For example, during a merger (when two private sectors firms merge) or an acquisition (when one firm buys another firm), companies need to manage the process of integrating two different organisations into one. This often entails balancing two contradictory goals: combining elements of the two separate firms to achieve efficiencies of scale (combination) and retaining the complementary skills and capabilities of each company (complementarity).<sup>106</sup> We think this is analogous to health and care (combining social workers, district nurses and therapists to achieve efficiencies while recognising the unique professional contribution of each group).

Making these decisions requires both sides to negotiate what aspects will be integrated and how. To balance these competing goals, firms often set up a temporary transitional team, formed of staff from both companies, to manage the process of deciding what aspects will be integrated and how. The temporary team is dedicated to managing the transition only, gathering data from the organisations as needed. The key is to separate business as usual management from the task of managing the integration process.<sup>107</sup>

INTs should consider having a staff resource dedicated to managing integration in the same way. This person or team would help coordinate any integration-specific initiatives, such as an induction process, shadowing and joint visits. This person would also be responsible for helping the new team to work together and to define what integration means in practice for them.

### *3.3.3. Fix the small stuff quickly to give staff a positive early experience of integration.*

While the theoretical benefits of integration for people receiving care and support are well understood, the reality of integration can be less positive for staff themselves. For many staff, co-location means moving into a different office or having a large number of new staff move into your office. This means integration is associated with moving into a potentially crowded office space, having to wait months for your access fob to arrive, and having to double park on your new colleagues because there are not enough parking spaces (all examples we came across during our fieldwork).

These frustrations are often some of the first meaningful differences you experience in your working life after integration. For example, one team we observed had spent several months going through a long approvals process to get a relatively small amount of funding for new access fobs for the building.

We know that if people can see that progress is being made, they are more likely to continue engaging in that behaviour.<sup>108</sup> We therefore think that staff may be more likely to engage with integrated working when they can see real, concrete progress. To achieve this, management could set up a process for getting feedback on what is and is not working in new INTs, and ensure that practical steps are taken to address these concerns. A small discretionary fund could be reserved for programme/team managers to address some of this feedback directly without getting tied up in approvals and bureaucracy.

#### *3.3.4. Make it easier for staff to contact team members using a visual phone book, group messaging systems and simplified diagrams showing who does what*

As mentioned previously, staff did not always have much contact with other members of the INT due to varying schedules and shifts. Services such as reablement and district nursing are usually quite large teams, meaning it is more difficult to know everyone from ad hoc kitchen conversations.

From our interviews and observations, it seemed many people did not know the names of people in other services. It may be hard to feel like you are a part of a team if you do not know who the other team members are.<sup>109</sup> Furthermore, senior managers often seemed relatively clear about the different teams and services in a neighbourhood and the distinction between them (enhanced primary care, care navigators, link workers, integrated neighbourhood services, integrated neighbourhood team etc.). However, we often found that middle managers and front-line staff confessed in private to some confusion.

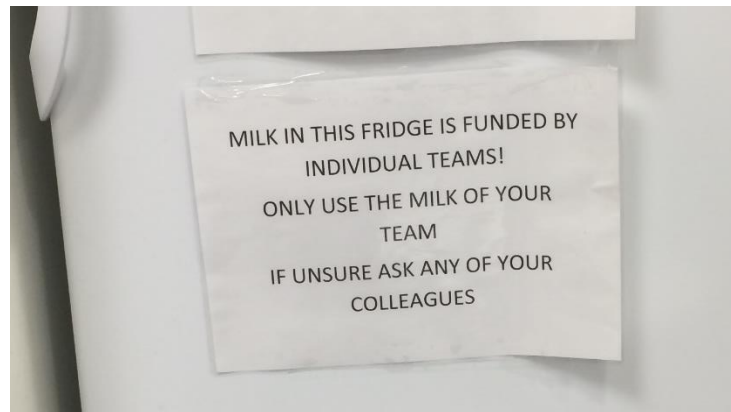
We think that there are three possible ways that INTs could make it easier for staff to contact other professionals when necessary:

- Putting a visual phone book on the wall of the office with photos and contact information of all INT staff. While this sounds simple, that is the purpose. Busy health and care staff have lots of demands on their time. An accessible place where they can go to put a face to a name, and get contact details, may be the small change they need to encourage more regular contact with other staff.
- Setting up a group messaging system. Some communications need to go to an entire team rather than a single person. Group emails can easily be lost in a mass of other messages and may also not be received for some time. Most work mobile phones are now basic smartphones, which means that Whatsapp (a group messaging app) could be installed and a Whatsapp group set up for each team.

- Simplified diagrams showing who does what. One thing that struck us when going to INTs were the numerous organograms, care pathway diagrams and other pieces of paper on the walls detailing who should be contacted and when. These have clearly evolved over time. However, we suggest Manchester invest in producing a simple tool which is available online, which includes the most regularly contacted teams or services in each area and which uses simple drop down questions to help professionals quickly find the right person to contact. Otherwise, we think professionals may risk facing ‘choice overload’ and put off contacting other teams or making referrals of them.

### *3.3.5 Remove visible signs of previous team boundaries*

We visited one co-located, integrated team with the following sign on the fridge:



While this is a small detail, it signals a larger problem. While teams are integrated on paper, the reality on the ground can be more mixed. Small details like this can be both symptoms and causes of a lack of integration and they send a signal about the prevailing culture. We therefore recommend that INTs ensure that hot drinks and milk are shared across the team – either by centrally funding or creating a shared fund for tea, coffee and milk. This is a small step to encouraging employees to feel as though they are part of the same group. Though building trust is hard and can take time, incorporating details that signal ‘we are all part of the same group’ can help bring the changes in organisational charts to life on the ground.

## 04 / Recommendations

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In Section 3, we provided a wide range of ideas for how Manchester LCO could use behavioural science to support neighbourhood-level health and social care integration. In this section, we set out which of these ideas we recommend Manchester LCO consider first. On the basis of our ideas, we also provide a list of the considerations which we think the rest of GM boroughs (and other areas of the country) should consider at different stages of the integration journey (from initial planning through to full co-location).

In forming our recommendations, we considered the feasibility and potential impact of the different ideas set out in Section 3. To help us do this, we also held a workshop with staff from Manchester LCO. This workshop included corporate policy staff, strategic managers and frontline professionals from both health and social care. In this workshop, we explored our interim findings and potential recommendations, giving staff the opportunity to comment on, contribute to and rank our suggestions.

This section is structured around two sets of recommendations:

- Recommendations which are specific to the current situation and context of Manchester Local Care Organisation (LCO), which will be co-locating INTs in the coming months; and
- Considerations for other GM boroughs (and other areas), who are all at different stages of health and social care integration. These are organised by the different 'stages' of integration, from initial planning to co-location.

### 4.1 Recommendations for Manchester INTs

We make two sets of recommendations for Manchester LCO: simple, lower-cost ideas that we recommend Manchester should aim to implement immediately, and more complex interventions that we recommend testing before they are rolled out.

#### 4.1.1 *Simple interventions to implement immediately*

Several of our recommendations are relatively low-cost, unlikely to backfire and can therefore be implemented across INTs without testing. These are:

1. **Fix the small stuff quickly to give staff a positive early experience of integration.** Details matter and many of the INTs we visited faced small bureaucratic problems (like insufficient key fobs for the building) which had a disproportionate effect on staff morale and could shape people's early experience of joining an INT. Setting up a process for

identifying and tackling these issues (including a small amount of money to fix things quickly) could help reduce initial frustrations.

2. **Make it easier for staff to contact their colleagues from other professions.** Because of different schedules and shifts, staff often did not know who was in the INT beyond members of their immediate team. Putting INT members' names, faces and contact information on the wall (a visual phone book), setting up group messaging systems (such as a Whatsapp group) or creating a simplified organisation chart of who does what (preferably online) could help professionals identify who to speak to more easily.
3. **Remove visible signs of previous team boundaries.** Many of the co-located teams we visited still had visible signs of previous team boundaries. For example, some still had multiple 'team milks' in the fridge. Removing visible signs like this (for example by ensuring tea, coffee and milk are paid for jointly) reinforces the fact that staff are all part of the same team.

#### *4.1.2 More complex interventions to test before rolling out*

The ideas in this section are more complex, intensive or difficult to implement, and therefore more costly. While we think there are good reasons to think they will be effective, we recommend that Manchester test them in a subset of INTs before rolling out more broadly across the city. These interventions are:

- **Automatically identify and connect staff working with the same resident (Preferred option).** We know that in Manchester (and many other areas in GM) truly joint case management and IT systems are still some way away. In the meantime, we think it would be worth testing the impact of connecting staff who are working with the same resident. This information is technically available, but the hassle involved in accessing it is high (logging on to one or more IT systems regularly and looking through your caseload one at a time). We think that a weekly message highlighting who on your caseload has started seeing another service is likely to encourage more collaborative working.
- **Develop a new induction process for when INTs first move into the same building.** We visited several co-located INTs (one in Manchester and two outside). In all cases, co-location had been gradual and there had been minimal induction. There is evidence that inductions which involve 'deep cultural learning' - where staff consider the culture of their own team and the teams they are merging with - can improve collaboration and promote shared purpose. In addition, there are also a range of activities which we think could help staff to understand the role of other members of the team (such as shadowing staff from different professions, completing joint visits or completing 'perspective-taking exercises where they consider case studies from the point-of-view of another member of the team). We recommend that Manchester LCO design a new, more involved induction process which incorporates these insights.

- **Increase contact between staff by removing referral forms and processes within the INT (encouraging in-person handover).**  
Manchester LCO wants staff in INTs to speak to colleagues from different professions more regularly. However, staff still need to make a formal referral through the triage and duty systems. In other areas of GM, staff can refer people to a colleague in the INT with just a conversation. We think this is a good way to encourage staff to routinely talk to colleagues as this discussion becomes part of the referral process, rather than an addition to it.

We recommend choosing one of these interventions to start and our suggested choice is automatically connecting staff who work with the same person. This is because we believe that this idea has the potential to increase the number of 'formal' interactions between different professionals by reducing the friction involved and providing regular, timely prompts. In addition, introducing this change would provide a visible 'signal' of integration and demonstrate organisational commitment to tackling one of the most commonly cited staff frustrations in INTs (lack of shared IT). Finally, this recommendation would not require a significant policy change (as getting rid of referrals would), nor would it require extensive frontline staff time (as an induction process would).

Traditionally, BIT recommends trialling ideas as rigorously as possible. In particular, we often suggest that organisations consider using randomised controlled trials (RCTs), a rigorous form of quantitative evaluation. In this case, we do not feel that such an evaluation is possible. The number of staff and INTs involved is not large enough for a quantitative evaluation to provide much confidence. In addition, much of the data which might provide outcome measures for such an evaluation is not currently available in digital form.

As such, we suggest rolling this intervention out as a pilot across two or three of the INTs in GM for 6 months. Ideally, these teams should be chosen randomly. This is because teams who volunteer are likely to be different in some way (perhaps being more enthusiastic or established) than those who don't. We then suggest Manchester LCO use a qualitative, implementation and process evaluation (IPE) to evaluate the changes. This should include interviews, focus groups and observation to understand how the change was implemented in practice, how it was perceived by staff and residents and to learn lessons about any future scaling up of the change.

In addition, Manchester could track some quantitative measures (use of trusted assessment, rate of repeat assessment, number of people open to multiple services, number of visits that residents receive each week or the number of unplanned hospital admissions) and compare these between teams who have received the change and those who have not. These findings would only be indicative, but in combination with the qualitative evaluation may provide extra evidence about the potential impact of changes.

#### **4.2 Behavioural considerations for other GM boroughs (and other areas) looking at health and social care integration at the community level**

This project is jointly commissioned by Manchester City Council, GMCA and the Greater Manchester Health and Social Care Partnership. The recommendations above are aimed specifically at Manchester and considered the specific organisational context in the city at the time of publication.

There is significant variation in development and levels of integration across both GM and the 'first-wave' of ICS areas.<sup>110</sup> This section therefore sets out a list of behavioural considerations for people setting up integrated health and social care teams. The list (see Table 6) is organised by the different stages of integration, from design and planning to operation after co-location.

**Table 6: List of considerations for behaviourally-informed integration**

	Considerations
Integration design & planning	<ul style="list-style-type: none"> <li>☑ Think about the specific staff behaviours you would like to change following integration. Do you want more shared assessments, fewer repeat visits or more informal discussion of cases? Consider how you could measure these behaviours.</li> <li>☑ If there isn't a shared IT system (even in the short-term), try and minimise the hassle of having separate systems. For example, set up a system to notify staff when another professional starts working on the same case.</li> <li>☑ Consider how the building/office layout may encourage or discourage unplanned interactions in places like corridors or kitchens (known in the literature as 'collisions').</li> </ul>
Teams about to co-locate	<ul style="list-style-type: none"> <li>☑ Begin introducing teams to each other a few months before co-locating, for example through joint lunches. Run a 'deep' induction programme which includes exercises like perspective taking when the teams first move into the same building.</li> <li>☑ Consider hiring someone (or allocating time to a group of existing staff) to manage integration activities like induction and logistics. Evidence from private sector mergers suggests that dedicated 'merger teams' are important to success.</li> <li>☑ Make sure that the move to the new office goes as smoothly as possible, e.g. have enough desks and entry fobs for the building on the first day and make arrangements for parking. These details can frame the team's early impressions of 'integration' and what it means for their day-to-day.</li> </ul>
Teams who are already co-located	<ul style="list-style-type: none"> <li>☑ Concentrate on ways you can encourage staff to have regular, informal interactions with their colleagues (e.g. by randomly pairing staff with a new person to meet once a fortnight or by setting up a cross-profession 'buddy system'). Do not assume this will happen naturally in a shared office, as many professionals spend most of their day out on visits.</li> <li>☑ Optimise meeting structures. This includes making the differences between huddles, handovers and multi-disciplinary team meetings clear. In addition, consider approaches to encourage better problem-solving in meetings, such as rotating the chair or nominating sub-groups of staff to challenge the consensus decision in a meeting.</li> <li>☑ Systematically collect feedback from residents about the impact of both integration and the role of specific professions and share this with staff. This is likely to boost morale and productivity and also give staff a clearer understanding of each person's role within the integrated team.</li> </ul>



## 05 / Conclusion

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Health and social care integration is one of the core policy challenges facing local government in the coming decade. Local authorities, NHS trusts, Clinical Commissioning Groups and others across the country are grappling with how to provide more joined up and integrated care to their residents, both to improve outcomes and to make financial savings. In many ways, the challenge is structural, designing ways to join up two sets of services with different histories, organisational designs, funding systems and purposes. However, we also think that there is a more operational, day-to-day set of challenges that local decision-makers will need to address.

In setting up 'neighbourhood teams', we think both Manchester LCO and other areas in GM are breaking new ground. As far as we are aware these teams are unprecedented both in the range of professions they involve and in the number of cases they oversee. We think their size makes the task of integration particularly challenging (like how to ensure efficient information-sharing and multi-disciplinary decision-making).

Some of these difficulties are systemic and will require institutional responses (for example, estates and shared IT systems). However, we think that others could be addressed (at least in part) by lighter-touch, behaviourally-informed approaches. In this project, we have spent time observing and interviewing members of staff in community health and social care teams, running workshops to explore these topics with key staff and reviewing relevant academic literature on integration, teams and collaboration. Bringing these findings together, we have identified changes which aim to improve collaboration and integration in three ways:

1. Improving team meetings
2. Increasing social trust and informal social contact
3. Improving systems and processes

We have concluded with specific recommendations for Manchester LCO, with both simpler ideas we believe they should implement immediately and more complex ideas which we think they should test. These recommendations reflect the specific context in Manchester at the time of publication.

However, we have also included a list of considerations for staff who are overseeing the process of setting up similar integrated health and social care teams (whether in GM or elsewhere). We believe that small, incremental changes at key points in the process of integration (early planning, immediately before co-location and after co-location) could have surprisingly large effects on how these new teams work together.

# Annex A: Barriers to integration

The bulk of the literature on health and social care integration focuses on barriers and/or key success factors to achieving integration. The literature overwhelmingly consists of qualitative research through case studies. This means there is very little good, experimental evidence about the relative strength and importance of the different barriers and success factors. Existing literature reviews on health and social care include comprehensive lists and models rather than rankings or assessments.<sup>111</sup> Nevertheless, based on the literature, it is possible to divide the barriers to integration into three groups:

- **Institutional:** Refers to the structures and systems surrounding integration of HSC (institution-level)
- **Situational:** Refers to the context and circumstances of the teams involved in integration (organisation-level)
- **Dispositional:** Refers to the attitudes and perceptions of teams or team members (individual or team-level)

In this Annex we talk about some of the key barriers identified in the literature in each of these groups. We also provide commentary about what we saw during our fieldwork, both in Manchester and GM, on each of these topics.

## Institutional barriers to integration

- **Lack of shared IT systems:** Not having shared IT, or not having access to each other's IT systems, was the most commonly cited barrier in the literature.<sup>112</sup> This tended to result in unclear data sharing protocols which meant resident information was not shared, creating further barriers to collaboration.<sup>113</sup> Lack of a shared IT system also came up in practically every interview we had during our fieldwork. This caused problems both at the individual case level, but also at the level of team management (making it very difficult for team managers to identify which people were being supported by several different professions or teams within the INT).
- **Unclear or unintegrated aims:** Having unclear or unintegrated aims was cited as a barrier to integration.<sup>114</sup> One case study of integrated community mental health teams (CMHT) in Somerset found that specific issue integrated teams were more successful at creating commitment than the teams based on a geographic area because of the addition of clear, shared aims. Although both types of teams were co-located, under shared management, and using shared processes, members of the geographically integrated teams reported feeling a lack of shared aims; while those in the specific issue integrated teams did not.<sup>115</sup> Another case study of integrated CMHT from the North East of England also found that shared aims were important to the success of

integration, this time in a combined team based on a geographic area that was co-located and included specific link workers.<sup>116</sup> During our fieldwork, we noted that integrated teams focused more narrowly on intermediate care (i.e. on keeping people out of hospital) were much clearer on the aims of integration than those operating more generally across a neighbourhood.

- **Unclear roles and responsibilities:** Lack of clarity on roles and responsibilities was also cited as a common barrier to health and social care integration.<sup>117</sup> Role clarity is correlated with stress levels and job satisfaction for employees, which means that the lack of clarity following integration had negative impacts on the lives of staff.<sup>118</sup> While any organisational change can result in uncertainty surrounding roles and responsibilities, this is a particular issue for health and social care integration, where the purpose of the integration is to blur the lines between professions to allow for a more cohesive, flexible service for residents.<sup>119</sup> This came up early on in our project, in our first workshop many staff raised concerns about how integration might undermine their professional role and responsibilities.
- **Unaligned processes:** Unclear or unintegrated process, from referral pathways to assessments to care planning, were identified as hurdles to integration.<sup>120</sup> None of the places we observed dealt with this comprehensively, suggesting that a more centralised approach might be necessary. While some places had started to integrate referral, assessment and triage processes; in every place elements of this process were still not as joined up as they could be.
- **Un-pooled budgets:** Joint commissioning and pooled budgets, while not sufficient in and of themselves to building an integrated team, seem to have a positive impact on the design on integrated services.<sup>121</sup> Joint funding and budgets forced policy makers and senior managers to view programmes in a more integrated way, identifying synergies across services.<sup>122</sup> Without shared resourcing, it is hard for managers to decide who should pay for share priorities or projects with shared benefit.<sup>123</sup> Some physical manifestations of un-pooled budgets were clear from our fieldwork visits, such as securing fobs for the new colleagues moving into a co-located space. These may seem like small details, but it may make it difficult for staff to envision themselves as an integrated team when they see examples of how separated they are all around them.
- **Imprecise or ill-defined policy:** Policy and regulation were mentioned as the root cause of some of the other structural barriers (i.e. data sharing, reporting, etc.).<sup>124</sup> Not including enough detail on how collaboration will work in practice creates costly workarounds and can impede collaboration.<sup>125</sup> Having separate yet mandatory procedures slows down collaboration.<sup>126</sup> This came up in our early workshop on the project, with staff raising concerns about how working practices in the new INTs would interact with the requirements of their professional registrations.

- **Separate reporting requirements:** Having separate performance indicators and reporting requirements indicates that organisations do not have shared priorities and signals to the rest of the organisation that teams are still separate.<sup>127</sup> In addition, standardised reporting facilitates integration through decreasing staff workload and duplication.<sup>128</sup> At one INT we visited, administrative staff on the NHS side had to compile separate information for each team as part of reporting to separate line management. All this work had to be done manually, as case management systems did not have the functionality to extract the required KPIs.
- **Differing employee terms:** Having separate terms and conditions for staff in health and social care services can cause frictions both operationally and motivationally. Operationally, moving NHS staff to local government payroll (or vice versa) encounters substantial issues, such as transferring pension entitlements.<sup>129</sup> Motivationally, being in the same team as someone who has a different benefits package can cause frictions<sup>130</sup> and reduce motivation.<sup>131</sup> One specific place where this surfaced regularly in our fieldwork and conversations with staff was around financial support with parking and travel.
- **Privatisation:** The introduction of private providers into social care in particular results in multiple provider relationships, which complicates health and social care integration as it means there are additional people who provide care and support but are outside the team.<sup>132</sup> This was less of an issue in many of the teams we observed, as reablement is both commissioned and delivered by local authority staff. However, as neighbourhood teams grow to include more local authority adult social care staff we expect this to become a bigger issue.

### **Situational barriers to integration**

- **Teams who are not co-located:** Co-location of teams helps to increase informal communication between health and social care workers in an integrated setting. Several of the case studies of successful health and social care integration mention colocation as important for success.<sup>133</sup> The layout of a co-located building has been shown to have an impact on interactions in health settings: having less central space and larger distances between teams negatively correlates with interactions.<sup>134</sup> We saw both the absence of co-location, and the physical layout of the building where the co-located team was based, having an impact on integration during our fieldwork (e.g. by creating a physical 'separation' between district nurses and social care staff in one building).
- **Lack of adequate resources:** Overall funding levels and the short-term nature of funding were both mentioned as barriers to health and social care integration. Not having resources allocated to managing change and coordination meant that already stretched services had difficulties prioritising integration goals.<sup>135</sup> Securing only short-term financing for health and social care integration can demotivate staff and

reduce buy-in.<sup>136</sup> More directly, health and social care integration pilots can be discontinued when short-term financing dries up, as was the case with a South Manchester integrated care pilot.<sup>137</sup>

- **Insufficient training and teambuilding:** Joint training and teambuilding are mentioned as important for integrating health and social care teams, both to ensure staff have the skills they will need for more integrated work (e.g. integrated assessments)<sup>138</sup> but also to signal a change in the way the team will work going forward.<sup>139</sup> Team building in particular was seen as important for understanding new roles and responsibilities, creating a new shared culture, and getting to know each other's working styles.<sup>140</sup> We have addressed this topic directly with our recommendations, as we found that in many areas there had not been many joint induction, training and teambuilding exercises.
- **No prior experience working together:** Having a shared history of joint working was identified as a success factor in several of the case studies.<sup>141</sup> A successful history of working together informally can help speed up the process of developing shared priorities<sup>142</sup> and trust.<sup>143</sup> Previous, negative experiences can lead to scepticism among staff towards new attempts at integration.<sup>144</sup>
- **Lack of time:** Time is noted as a key factor in integration. Managers and staff need to be able to devote time to navigate change,<sup>145</sup> to create a new team,<sup>146</sup> and to coordinate activities,<sup>147</sup> among others. The general passage of time is also needed for people in integrated teams to redefine their own professional identities and to create a new shared team identity.<sup>148</sup> During our fieldwork at a team that had been co-located for a year, some of the professionals we interviewed mentioned that, with time, they had gotten to know their colleagues from other services better and that this had facilitated more joint-working.
- **Incompatible team structures:** Health and social care workers may have separate shift schedules, opening hours, and hierarchies which can make activities such as attending a joint meeting difficult.<sup>149</sup> Having different lines of accountability (i.e. no shared management) can undermine integration through competing priorities and lack of coordination.<sup>150</sup> On the other hand, having a shared line manager means that you may no longer have a senior professional to consult on issues, which could hamper decision making<sup>151</sup> and result in staff continuing to work in the way they did before integration.<sup>152</sup>
- **Imbalance of power:** The imbalance of power between different groups, such as between social workers and primary care staff<sup>153</sup> or between the community and acute sectors,<sup>154</sup> is seen as a barrier to integration and joint working. This was referenced frequently in our interviews, particularly with regard to a perceived imbalance between community and acute services. In one area of GM they had sought to tackle this at a board level by appointing a number of practicing GPs to the board of the local acute hospital trust.

- **Inadequate staffing:** Staff shortages and high turnover create barriers to joint working. Leadership vacuums make it difficult to proceed,<sup>155</sup> and turnover can result in lost skills and commitment.<sup>156</sup>
- **Poor leadership:** Leadership commitment and engagement was cited as important for successful HSC integration, including active support for new initiatives,<sup>157</sup> empowerment of staff.<sup>158</sup> Lack of leadership can lead to uncertainty, which encourages teams to retreat back into silos.<sup>159</sup>

### **Dispositional barriers to integration**

- **Distinct working cultures:** Many studies noted how different ways of working in health and social care were a barrier to integrated working.<sup>160</sup> These distinctions ranged from vocabulary,<sup>161</sup> definitions of concepts like quality<sup>162</sup> or urgency,<sup>163</sup> risk tolerances,<sup>164</sup> and degrees decision-making autonomy.<sup>165</sup> These varying cultural norms, stemming from different professional standards, can cause conflict and stress, which leads people to retreat back into their silos.<sup>166</sup> This also makes it more difficult to craft a new, joint culture in the integrated team.<sup>167</sup> This is a well-recognised challenge in health and social care integration and we were not surprised that we also came across it during our fieldwork. An important nuance was that these different working cultures were found both *across* health and social care, but also *between* different healthcare professions. In particular, we were surprised at the degree of difference in working cultures between district nursing and therapy services.
- **Concern about professional identity:** In the health and social care integration literature, health workers often reported feeling that they could do the job of the social worker, but that the reverse was not true, making them doubt the value of integration.<sup>168</sup> Social workers reported feeling threatened because health workers did not value their perspective.<sup>169</sup> This came up during our fieldwork, when social workers often reported feeling that their attendance at MDTs or INT huddles was 'tokenistic' or that they were uncomfortable being the only non-clinician in the room.
- **The impact of funding structures:** Another source of frustration stems from the structural difference in the funding of health and social care: social care workers have to ration care (since social care is not free at the point of use), while health workers do not. This can cause animosity between the two groups, as social care workers feel that their services are disproportionately squeezed by budget constraints; whereas health workers feel that social care is not doing its fair share and is unloading responsibilities onto them.<sup>170</sup> Similar frustrations were raised in the evaluation of the South Manchester Neighbourhood Team pilot.<sup>171</sup>

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