The King's Fund>

Ideas that change
health care

Supporting integration through new roles and working across boundaries

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1 Key messages

- Recent years have seen new roles emerge to support the delivery of integrated care. These roles aim to enable more holistic care, and facilitate continuity and co-ordination of care across organisational boundaries. Some of these new roles (such as care co-ordinators and case managers) have integration at their core, while others (such as extended support worker roles or personal assistants) build on established roles to facilitate integration.

- Our review of the evidence found few examples of truly innovative roles. The most notable examples are care navigators and community facilitators, enablers or link workers. These roles seek to enable individuals and, in some cases, professionals to access and navigate the range of support available from health, social care and the wider community.

- There is a lack of robust evidence on, and evaluation of, new roles. Most studies focus on the wider learning from programmes designed to integrate care, rather than the impact of individual roles. More evidence is needed on the key characteristics of new roles and their impact on outcomes if they are to be successfully replicated in other settings.

- There is also a need for more evidence about the cost-effectiveness of new roles. Key questions remain around the scale at which new roles need to be developed to demonstrate impact, be sustainable, and release cost savings elsewhere in the system. This is important given the investment needed to establish new roles.

- The successful development of new roles entails significant management challenges. A culture of protecting professional and organisational identities is one of the most prominent barriers to new ways of working, especially where established skills and roles are reconfigured. Other barriers include overestimating the capacity of individual roles to deliver integrated care, difficulties in making these roles sustainable over time, and poor accountability and oversight of staff in roles that do not fit into established structures.

- New roles to support integrated care by working across organisational boundaries are only effective when they are part of a system-wide process of integration. The support of senior leaders is crucial for establishing a framework for integration, legitimising new ways of working, and ensuring a climate and processes are established that enable practice to develop in the desired direction.

- Rather than assuming a need for new roles, the evidence suggests that valuing and reinforcing professional and organisational identities can help to develop trust and recognition, which can, in turn, facilitate closer teamworking across organisational boundaries. Building effective relationships and establishing a shared commitment to developing care around an individual's needs can support this process.

- The skills needed to deliver integrated care often already exist within the workforce; the issue is how these skills are shared and distributed as part of an overall integrated system of care that spans organisational boundaries. Skills in communication, management and creating relationships are vital, and may be required by professional and non-professional groups more broadly. Interdisciplinary training, training of managers as well as practitioners, and cross-organisational placements can help develop and spread the necessary skills and competencies.

- Developing an integrated workforce is an ongoing process. Where new roles have emerged, they have mainly done so as a consequence of developments in practice or to fill gaps in provision, which are more evident as services aim to become more integrated. New roles tend to involve new activities rather than a re-packaging of old ones. While many emerging roles share a common purpose, the specific competencies and skills required for individual roles are often determined by the local contexts in which they develop, which limits standardisation more widely. There are a range of approaches to developing an integrated workforce rather than a single model. These are influenced by local factors and are likely to develop further over time.

- Although there is currently a greater focus on integration of care, developing roles that span organisational boundaries is not a new endeavour. Some multidisciplinary teamworking, integrated care pathways and new models of

care have developed through existing staff working in different ways, rather than new roles being created. New roles may be needed in some cases; however, the need for such roles should be demonstrated rather than assumed, as part of a broader plan for integrating care.

2 Introduction

The NHS workforce comprises 1.318 million staff (**NHS Confederation 2016**), while an estimated 1.48 million staff make up the social care workforce (**Skills for Care 2015**). The workforce is intrinsic to quality of care and accounts for the greatest proportion of NHS costs. It is not surprising therefore that the role of the workforce in delivering a health and social care system able to meet the demands of the future is a key consideration.

The health and social care system has recognised a need to change considerably to respond to changing needs and demands, and workforce development is a central part of this process. National policy has highlighted three necessary changes: a shift in care from hospitals to the community; new care models that support the integration of health and social care; and a focus on preventing illness and promoting health and wellbeing (**NHS England** *et al* **2014**; **National Collaboration for Integrated Care and Support 2013**). These changes aim to put the individual at the heart of health and social care – to create an integrated system able to deliver holistic and person-centred care to meet people's changing needs, while empowering individuals to actively maintain their health and wellbeing within the community. It is hoped these changes will support greater efficiency and effectiveness, improve the outcomes of people accessing those services, and deliver cost savings.

Considerations of the future workforce have focused on how to meet staffing requirements of established professions and employ their skills to achieve the best outcomes (**Addicott** *et al* **2015**; **Robertson** *et al* **2014**). They have also highlighted the opportunity to restructure roles and the potential for new roles to emerge in order to meet changing needs (**Imison and Bohmer 2013**).

The ability to deliver specialist care in the community and generalist care within hospital settings has led to the development of new roles such as physician associates and advanced nurse practitioners within individual organisations. Now the aim of integrating care across organisations and sectors has prompted consideration of how this process can best be extended more widely. Seeking a workforce that can 'span

boundaries' will require innovative ways of working as well as the creation of new roles with an overt focus on supporting integration.

What is workforce boundary-spanning?

Creating effective mechanisms to support collaborative and joined-up working has been a longstanding aim of many organisations. Boundaries between staff in different services, organisations and sectors of care have been identified as a key barrier to delivering integrated care.

'Boundary-spanning' means reaching across organisational structures to build relationships, interconnections and interdependencies. It can be done at an individual level, to develop and manage interactions, and at an organisational level, by setting up policies and structures that facilitate and define the relationships between individuals and their respective organisations (Williams 2002). Developing a workforce that can span the boundaries that exist within and across health and social care requires due consideration of both levels – the organisational structures that influence how people work together as well as individual staff roles within those organisations.

About this report

In 2015, The King's Fund was commissioned by NHS Employers and the Local Government Association to produce an independent report on boundary-spanning roles to support integrated care. This included roles being developed to facilitate integration of care across distinct areas of practice in order to deliver more holistic care, and roles supporting greater continuity of care across organisational and sectorial boundaries. Roles within individual settings that aim to provide existing care but in a new way – such as physician associates, advanced nurse practitioners and assistant practitioners – were deemed outside the remit of this work unless they were distinctly established to span boundaries of practice – eg, spanning secondary care and community services.

The work aimed to identify examples of new roles being developed and an understanding of the evidence to support these roles, including impact, features of success and key challenges. The authors sought to address whether there is a need

to systematically develop new roles to support integration, and how new roles fit within the wider context of building an integrated health and social care system.

Reflecting the importance of integrating health and social care, there was a particular focus on efforts being made to span boundaries between services and organisations in these two sectors. However, the report covers a wider range of boundary-spanning activities that seek to support integration.

This report is based on the findings of a literature review and is structured around four main areas:

- examples of practice in which boundary-spanning roles have been documented

- the impact and outcomes of these new or extended roles

- the challenges and barriers to developing boundary-spanning roles

- the factors that can support boundary-spanning and facilitate the workforce to deliver integrated care.

The final section of the report explores the case for supporting future workforce integration and new roles, drawing together findings and recommendations from the literature with our own synthesis of the evidence.

3 Examples of new roles

The literature highlights a wide range of 'new roles' that have been developed to support the delivery of integrated care.

Change in focus or context of existing roles

Many of the roles identified use existing skills for a different purpose and within new contexts. The New Types of Worker programme highlighted a number of roles developed to span organisational boundaries, representing a re-labelling, re-packaging and re-creation of skills within existing roles (**Kessler and Bach 2007**). One area of focus for these roles is creating a point of liaison between services (*see* box for an example from Hampshire).

Hampshire's Sight Loss Adviser and Communication Rehabilitation Officer

The Sight Loss Adviser and Communication Rehabilitation Officer emerged as part of a major organisational change, alongside the development of an Early Intervention Service. This service required a role that sat (both procedurally and physically) at the interface between health and social care.

The national institutional framework for dealing with sensory impairment created a disconnect between diagnosis (health) and social support for the consequences of impairment (social services). These roles were developed to sit alongside clinicians and, through the formulation of a new referral process, generate awareness of and access to social care support.

Source: Kessler and Bach 2007

The liaison role bridges institutional gaps between health and other sectors that form part of a comprehensive care pathway. This includes ensuring the necessary sharing of information, providing support to staff in other services, and generating awareness of access to different forms of support available. A further area of focus is the development of dedicated co-ordination roles, which largely see staff taking

a more active role to improve co-ordination and management of care across boundaries (*see* box for an example from Scotland in relation to HIV services). Although these roles may lie within individual organisations, their remit is to actively create connections and facilitate care across organisational boundaries to ensure that individuals get access to appropriate care.

> ### Specialist nurses within Scottish HIV services
>
> The development of integrated care pathways for HIV services has seen the creation of a specialist nurse role within a collaborative multidisciplinary team. The specialist nurse plays a key role in overseeing the care pathway and co-ordinating care according to clinical need. Nurses develop and maintain partnerships between primary care, specialist care, psychological services, social care and third sector support services.
>
> **Source: Panton 2014**

Many of these roles span organisational boundaries by nature of facilitating a holistic response. However, there are a number of other roles that have been designed to explicitly span acknowledged boundaries between health and social care. Examples include:

- nursing within nursing homes – negotiating hospitalisation decisions and providing care for complex needs within care home settings to avoid hospital transfer (Abrahamson *et al* 2014)

- specialist residential care home nurse role – bridging and developing relationships across organisations to introduce services to each other and improve knowledge of what is available, as well as acting as a communication channel between NHS services and residential homes (Goodman *et al* 2013).

Change in individual skill-mix

A second prominent area in which new roles are emerging to support integrated care is through changing the skill-mix of individual roles and professions. A study of skill-mix changes as part of the primary care demonstrator sites identified four types of changes being made: role enhancement, substitution, delegation and innovation

(**NIHR CLAHRC Greater Manchester 2015**). The first two include extending the role or skills of a particular group of staff, or expanding the breadth of a job – in particular by working across professional divides or exchanging one type of worker for another. In contrast, the other two maintain traditional disciplinary distinctions but either delegate tasks to other disciplines, or introduce a new type of worker within this structure.

The extension of practice and roles reflects the impetus to share tasks more efficiently but also the aim of creating greater integration of care. Examples of extended nurse roles such as psychiatric mental health advance practice nurses in the United States (Delaney *et al* 2013) and ambulatory emergency care nurses in the community (**Centre for Workforce Intelligence 2011**) reflect the development of enhanced skills to support delivery of holistic care across settings. A common factor among many of the extended roles is the ability to work autonomously and at a higher level of practice, engaging in flexible cross-boundary partnership working (Bianchi *et al* 2012).

Skill-mix changes are particularly evident in the role of support workers within health and social care. Implementation of the NHS and Community Care Act (1990) has seen key developments in roles, including the emergence of personal assistants and community support workers, with a shift towards providing personal rather than domestic services. The delegation of health-related skills such as more 'routine' nursing and therapy tasks from nurses to community support worker roles, in clinical as well as non-clinical settings, is another common feature (**Manthorpe and Martineau 2008**). Examples include frailty support and wellbeing workers, and the extended use of support workers in intermediate care. In both cases, the support worker role is framed within a specific model or system of care that aims to support a more integrated approach. As such, these two roles aim to support patients alongside registered professionals as part of a multidisciplinary team, addressing an individual's social as well as health needs, and delivering a package of care as directed. The support worker role has been seen as particularly valuable in combining delivery of the clinical aspects of care with a person-centred, systems-working approach (**Bateson 2015**).

The opportunity to upskill support workers has also been extended to those operating beyond health and social care settings – most commonly housing services – and, in some cases, to other members of the workforce. One example (*see* box) is a development programme for care home managers to provide enhanced health-

> ### Enhanced tenancy support workers
>
> As part of the Supporting People Health pilots, the Sex Workers Around Nottingham project Now Exiting the Sex Trade (SWAN NEST) developed an enhanced support worker role within housing associations to work with women wanting to exit the sex trade. Almost 80 per cent of the sex workers were known to be homeless and over 90 per cent were drug dependent. Both factors were identified as important in limiting access to health care and the ability to find work outside the sex industry.
>
> The role aimed to address many of the accommodation and health needs of this population. Training for the role was provided by a local mental health trust and housing associations to develop requisite skills in working with the population, understanding housing law and benefits, and awareness of the mental health issues experienced by sex workers. Staff also received an induction and training from the local Drug and Alcohol Treatment team.
>
> **Source: Cameron 2010**

related support for residents, including promoting engagement in self-care activities (NHS England *et al* 2015).

A final area of skill-mix development to support integrated care has been the creation of extended roles within social care. These include health and social care co-ordinators and care practitioners (Centre for Workforce Intelligence 2011). While these roles share many of the characteristics of other extended roles, they are distinctive in that the role is defined as 'intermediary', with an equal footing in health and social care practice and/or settings. These roles have largely been filled through role substitution and innovations in skill-mix.

Innovative roles

There are a limited number of truly new roles emerging, but one of the most notable is that of care navigators, now established in a range of health and community settings (*see* box). Their main role is to support individuals to plan, organise and access support, although their remit and extent of practice varies from giving advice and signposting to a more active role in supporting people to engage in activities. Provision of support is often time-limited. Care navigators are seen as playing a valuable role in supporting access beyond health and social care. However, in some

Greenwich care navigators

The care navigator role is a core part of delivering the Greenwich Co-ordinated Care vision of 'Right care, right time, right place', targeting adults at high risk of ill health and hospitalisation.

The role sits within a dedicated team aiming to co-ordinate resources to build a 'team around the person'. Other members of the team include GPs, the community assessment and rehabilitation service, the community mental health team, representatives of community organisations and carer support.

The care navigator is the first point of contact for the person and their family, and helps the person to say what they want from services and what is most important to them. Using the 'I statements' approach developed by National Voices, the care navigator ensures that the care plan and delivery of care remains person-centred.

Source: Greenwich Clinical Commissioning Group 2014

cases, they also serve as a fixed point of accountability for ensuring that individuals benefit from a holistic approach to meeting their needs.

A number of roles are developing that aim to support engagement between organisations at the community level. Community facilitators, enablers and link workers are all examples of roles that aim to share knowledge and/or provide a practical interface between services and the wider community. They are less formalised than care navigators; in some cases, these roles primarily support professionals to access resources in the community (such as support groups or exercise classes) on behalf of individuals. In other cases, the role is a more proactive one, including connecting individuals to service providers in the community, reaching out to communities to engage people in services, and creating bridges between public services and groups within the community who use those services.

The final new role to note is the health coach, which has arisen through a greater consideration of the role of the patient in an integrated care system. Health coaching represents a sizeable workforce in the United States but is still relatively limited in the United Kingdom. The role does not directly facilitate boundary-spanning between services or organisations, but rather serves to support and empower individuals to take an active role in managing their health and health conditions and, in turn, their engagement with health and social care organisations.

4 Impact and outcomes associated with new roles

Despite the interest in new roles, evidence to support practice is limited. Roles such as physician associate and assistant practitioner are probably the area in which evidence is strongest. In the United Kingdom, recent studies demonstrate that physician associates can increase capacity to manage demand and broaden the skill-mix in teams, and are likely to be cost effective (**Bienkowska-Gibbs** *et al* **2015**; Drennan *et al* 2015). Although these roles tend to be within individual organisations (primarily in health settings), evidence of their effectiveness reflects the fact that the role has been in existence for some time in the United States, as well as ongoing investment in the role in the United Kingdom.

Much of the evidence on the impact of other new roles, including those developed to support integrated care, has come from evaluations of the programmes from which they have emerged. However, these have largely focused on learning at the programme level rather than evaluating the roles themselves and their outcomes. Examples of roles that support boundary-spanning and have been associated with positive outcomes include the following.

- Role enhancement within primary care – including building on increased liaison between staff in health settings and care homes through in-reach and outreach, resulted in a more flexible and multi-skilled care workforce (**NIHR CLAHRC Greater Manchester 2015**).

- Care navigators providing local area co-ordination – geographical areas where navigators were active in supporting people with disabilities to plan, organise and access support in their community had an 81 per cent higher uptake of services than the national average (**Turning Point 2010**).

For other roles that support integrated care through creating a more holistic and joined-up approach, positive outcomes include the following.

- Nurses in primary care whose role was extended to assume responsibility for first contact care and management of chronic conditions were demonstrated to provide safe and effective care (**Bienkowska-Gibbs** *et al* **2015**).

- Pharmacists supporting GPs in primary care improved GP prescribing (**Bienkowska-Gibbs** *et al* **2015**).

One notable gap in the evidence concerns patient outcomes (**Bienkowska-Gibbs** *et al* **2015**; **NIHR CLAHRC Greater Manchester 2015**).

There are also a number of instances in which the evidence around role reconfiguration raises concerns. For example, in considering the provision of holistic care through extension of existing roles, research on pharmacists providing additional support to patients on self-management found that advice was often given regardless of an individual's competence or knowledge; this created difficulties when an individual challenged the pharmacist about the advice given, and could negatively impact perceived self-efficacy among older people (**Bienkowska-Gibbs** *et al* **2015**). There are also questions about whether some enhanced roles that focus on particular groups of people – eg, nurse cancer care co-ordinators – could result in some people receiving preferential treatment and thereby lead to inequity of access (Freijser *et al* 2015).

One of the key areas of interest is the cost-effectiveness of new or enhanced roles. In most cases, there is almost no evidence that new roles save money within the context of the wider health and social care system. A study of 'outreach' advisers (who link members of the community through information and advice to multiple support organisations) reported savings through a reduction of burden on local authorities and the NHS (**Citizens Advice Bureau 2009**), but the extent to which the new roles are cost effective is limited by the absence of data on costs before and after initiation of the service. An assessment of the evidence on care navigators noted that there was little evidence to support the business case for the role (**Turning Point 2010**).

One of the challenges of delivering integrated care through the development of new roles is efficiency. Roles developed for the purpose of strengthening integration by

reducing the number of different types of staff engaging with an individual in the community have often achieved this by employing qualified staff who are able to work autonomously and holistically. This reverses the trend for using the lowest-grade staff and so could cost more (**Erens *et al* 2016**). In other cases, where roles have been extended to provide care beyond the scope of traditional practice, roles were sometimes cheaper but less efficient, with staff requiring longer and more frequent contacts with the individuals to deliver the same care (**Bienkowska-Gibbs *et al* 2015**).

Many new roles are perceived as being able to deliver greater efficiency through their ability to deflect work from existing roles and services; however, there is limited evidence to support this. The primary care demonstrator sites found that although their skill-mix changes enabled increased input from other sectors to support integration, this could involve additional workforce costs, so only partial savings were made through the deflection of work (**NIHR CLAHRC Greater Manchester 2015**). The processes of organisational development further contributed to costs, often requiring additional posts to be created in order to cover and sustain existing as well as new positions. Even where individual roles could increase the potential for localised care that deflects work from professionals and secondary care (eg, substituting the oversight role of the GP in care homes with case managers), in order to be realised and sustainable, this service would need to be consistently provided across multiple care homes by more than one case manager. While deflecting work, the roles may not be a complete substitute for either service; hence partial duplication with increased costs, or 'saved' work does not completely cover the cost of the case managers. In practice, workforce cost savings require substantial changes such that some roles cease altogether or services are completely transferred to a different setting (**NIHR CLAHRC Greater Manchester 2015**).

One area that has received focused interest from researchers is the expansion of social care and support worker roles. Support worker roles that integrate health and social care activities give rise to better motivation and job satisfaction, and may be responsible for improved recruitment and retention rates (Manthorpe *et al* 2010). However, there are a number of concerns about the evidence to support developments in this area. Support workers are performing an increasingly important role in the delivery of social care services, yet the evidence base for effective workforce planning and development is lacking (**Manthorpe and Martineau 2008**). There is also little agreement on whether care workers in specific areas

such as housing represent a specialist workforce, what areas of specialism should be prioritised in developing boundary-spanning roles, and (importantly) on what works best for whom (Manthorpe and Moriarty 2011).

The focus on developing new roles and evaluating developments in relation to skill-mix changes to support integrated care has been primarily on describing new roles, detailing what is required to support them and, in some cases, their influence on practice. The lack of evidence on new roles reflects this approach. While focusing on individual roles may generate further insights, a lack of standardisation and agreement on the desired characteristics and effectiveness of such roles presents an additional challenge to developing a robust evidence base that is transferable more widely (Manderson *et al* 2012*)*.

⑤ What are the barriers to new boundary-spanning roles?

The key objective of creating an integrated workforce is to deliver better care through more integrated services. New roles have received considerable national interest, yet change on the ground has been patchy and limited. So what are the barriers facing organisations or services that are considering or developing new roles?

While it is recognised that the different roles are not generic and often serve different purposes, the lack of evidence creates a limitation in being able to identify specific issues – about the roles and the boundaries they span – beyond the context in which they were developed. However, a number of themes repeatedly arise in the literature that reflect strategic barriers to developing new roles, and these partly explain why delivering workforce solutions to integrated care is particularly challenging. Although some of these relate specifically to new boundary-spanning roles, others reflect challenges facing integrated care more widely.

Professional roles and role settings

One of the main barriers to creating new boundary-spanning roles is a fundamental disparity between different professional roles, and between those roles and the focus of different care settings. The challenge of professional identity is well documented and criticism of 'professional protectionism' has been levelled at several professions in relation to developing different roles and ways of working (**Christmas and Millward 2011**; **Gainsbury 2009**).

Studies of multidisciplinary working and the interface of multiple professionals highlight some of these key differences. For instance, nursing roles have been defined as having a sustained, direct and practical involvement with people

and providing a universal service, while social care professions are described as enablers of care, using brief interventions and in which care is defined by eligibility (Workman and Pickard 2008). Policy documents defining the role and tasks of social work demonstrate a strong emphasis on the social role of the workforce as opposed to a service delivery focus in the health sector, with the former including areas such as the dynamics of the relationship and social justice alongside special consideration of the management of risk (**Blewett *et al* 2007**). These fundamental differences in function and approach have left very little scope for the emergence of 'hybrid' roles between health and social care at this level, which are effectively able to span professional boundaries (Workman and Pickard 2008).

The challenges of professional identity are further reinforced and defined by the different cultures associated with individual settings. Studies of nursing homes, for example, show that staffing groups define the purpose of the care setting in different ways; nursing staff and GPs place particular emphasis on the home as a place for providing care and meeting complex needs, while care home staff highlight the importance of the home in providing relationship-driven, home-like care (Abrahamson *et al* 2014; **Goodman *et al* 2013**). These differences are, in part, associated with the fundamental differences in the models of care employed by different professions. However, they are also a reflection of the different models of care favoured by different sectors; the NHS tends to focus on diagnosis, treatment and episodic involvement, while social care prioritises ongoing support and relationships that foster a continuous review of care (**Goodman *et al* 2013**).

These different approaches can create tensions between staff working in health and social care settings and their perception of each other's ability to meet the needs of their clients. These tensions have been shown to exist even between individuals from the same profession (Morris-Thompson 2015). These differences not only influence how staff see each other's role, but also what they consider best practice (Abrahamson *et al* 2014). Furthermore, these findings are not unique to the boundaries of health and social care. A focus on providing more intensive health care versus promoting independence and prevention has also been noted at the interface of health and housing support (**Centre for Workforce Intelligence 2011**). Even within individual pathways, differences in the normative perceptions of care – such as have emerged from the differential policy objectives of hospital and community stroke services – create active barriers to integrated working (Baeza *et al* 2012).

The impact of these differences cannot be understated. The Integrated Care and Support Pioneers programme identified differences in language and respective conceptions of health and professional ways of working as the most common challenge in supporting cross-boundary integration between health and social care (Erens *et al* 2016). As a study of boundary-spanning between care homes and health services demonstrates, these differences can serve to denigrate the capabilities and motives of professions. Care home staff often perceive health professionals to be 'policing' rather than advising, while health professionals perceive care home staff as lacking in knowledge and expertise, and unwilling to change their practice (Bienkowska-Gibbs *et al* 2015). Furthermore, these differences can result in conflicts between the interests of staff, residents and clinicians, and competing priorities (Abrahamson *et al* 2014).

Many of these challenges represent not only a disparity between professions and settings but also a limited overlap in respective knowledge bases (Workman and Pickard 2008). This extends to familiarity with the structure and culture of other organisations and their shared knowledge and goals, as well as regulatory frameworks for collaboration (Kousgaard *et al* 2015; Nasir *et al* 2013). Each has proven to be a key barrier to engaging and encouraging staff from different organisations and professions to trust one another and their professional judgement (Erens *et al* 2015). Similarly, these differences act as barriers to implementing interventions that support closer integration (Nasir *et al* 2013).

The differences that define the identity of professional groups and settings and which subsequently influence the ability to work across those boundaries are also influential in supporting roles that span those boundaries. In an analysis of the future social services workforce in Scotland, Musselbrook (2013) reported that fears around job losses, the blurring of roles, and possible loss of professional identity and status all stand firmly in the way of new roles spanning health and social care. Community mental health teams arguably represent one of the best exemplars of boundary-spanning, but skill-mix changes and the adoption of generic working practices by staff within these teams has repeatedly arisen as a barrier to team continuity (Belling *et al* 2011). Recent pressures have also seen local authorities withdrawing social workers from mental health trusts as a result (Samuel 2011).

Skill-mix changes can result in both a loss of 'owned' roles and of favourite tasks (**Ling *et al* 2012**). Furthermore, an implication that new roles may change or replace existing roles can present a significant challenge to engaging staff in developing and supporting a boundary-spanning approach. The evaluation of one integration programme found that progress only went ahead on the explicit promise that there would be no promotion of overlapping roles (ie, no social workers would undertake nursing tasks and vice versa) and that integrated working would not result in fewer nurses or social workers (Workman and Pickard 2008).

These distinctions are visible beyond the interface of social work and health, with similar findings demonstrated in the development of skill-mix changes between community pharmacy and general practice, and between GPs and practice nurses within individual practices (**Freeman *et al* 2012**). Professions in which staff perceive that their skills and contribution to care are least well-understood or valued are those that have raised the strongest resistance to moves away from role distinctions on the basis of professional or occupational domains (**Huby *et al* 2010**). Ill-feeling and uncertainty around role overlap between non-clinical support workers and health professionals has also been related to levels of confidence among team members (**Manthorpe and Martineau 2008**).

The literature on professional roles and boundary-spanning contains a number of notable references to the concept of professional 'turf' and 'turf wars' (**Nasir *et al* 2013**; **Freeman *et al* 2012**). This is a fundamental barrier to developing skill-mix changes and innovative workforce roles, and the success of efforts to implement boundary-spanning and integrated working.

Training and development

Lack of training is a consistent theme raised in studies of skill-mix changes and new boundary-spanning roles to support integrated care. An evaluation of primary care demonstrator sites developing new roles found that many had neglected training and not allocated sufficient time or financial resources (**NIHR CLAHRC Greater Manchester 2015**). In other cases, the time commitment, need to obtain suitable cover for existing roles and access to appropriate resources (eg, a computer) have all been highlighted as limiting access to training (Belling *et al* 2011). Designing new roles without due attention to associated training requirements has led to staff being asked to undertake tasks they were not trained to do; some staff have been unclear whether they were

permitted to take on particular tasks or simply feel unprepared to take on new roles (**Ling** *et al* **2012**). Examples include practical tasks such as care home staff being required to support residents with physiotherapy exercises (**Goodman** *et al* **2013**), but others involve aspects of clinical care, including monitoring of medical effects and delivering aspects of social care (Belling *et al* 2011).

The nature of training was also noted to be important in supporting new roles. National policy on training has focused on developing core competencies and capabilities through 'task' completion. However, many of the developments associated with new roles require the flexible application of skills within new contexts – a characteristic of 'expert' practice in which learning is developed through the blending of formal and tacit knowledge, and for which training support is limited (**Huxley** *et al* **2011**). This situation is further confounded by a lack of knowledge relating to the competencies of the workforce (**Huxley** *et al* **2011**) and a lack of consistent curriculums and training standards for new and extended roles. Both of these shortcomings are key problems when considering the requisite training requirements for these roles at a more systemic level (**Bienkowska-Gibbs** *et al* **2015**).

The siloed nature of training for the health and social care workforce is another notable barrier to more integrated working and the development of boundary-spanning roles. An inquiry into integrated care in mental health raised this as a key concern for the future workforce alongside the increasing number of students choosing to specialise, which runs counter to requirements for generalist staff and teams able to deliver more holistic care (**Mental Health Foundation 2013**). Even in professions such as nursing, where students receive core skills training, poor utilisation of other settings such as social care for student placements creates tensions between nurses working in different sectors, and limits the ability to work across settings (Morris-Thompson 2015).

Beyond individual skill sets, there is also a lack of preparation for ways of working associated with the development of new roles such as generic working to support holistic care and collaborative skills to work effectively with staff across boundaries (Belling *et al* 2011; Williams and Sullivan 2009). Organisations that are developing integrated care and boundary-spanning roles acknowledge these issues but have found that the limited ability to influence training curriculums set by national accrediting bodies presents a major barrier (**Erens** *et al* **2016**).

One of the key challenges in considering the training and development needs for boundary-spanning roles is their conceptualisation. Given that they are often born of local transformation programmes or identified gaps in need, the emerging new and hybrid roles are a reflection of local requirements and, as such, are unique. The lack of recognition of these roles beyond this context and within the wider workforce leaves local agencies to identify and develop their own training, which as a result is also tailored to organisational demand rather than wider workforce needs (Cameron 2010). This has important implications for career structure and progression, which has proven problematic in the development of new roles (Bienkowska-Gibbs *et al* 2015). Career progression has been related to job satisfaction in areas such as social care (Huby *et al* 2010), but limited opportunities to progress to more senior roles have created a bottleneck, with many workers ultimately leaving the sector (Howat and Lawrie 2015).

The development of context-specific roles presents a further challenge if there is limited capacity elsewhere in the system for similar roles, and where the skills and competencies developed within such roles are insufficiently recognised and validated more widely. However, in some cases, although staff see generic roles as providing an opportunity to add to existing skills, they would not consider them as an alternative career path (Lindsay and Dutton 2012).

Capacity of individual roles

Although boundary-spanning roles can provide a key point of focus and, in many cases, accountability for integrating care, the roles alone cannot deliver integrated care. One of the key issues is the capacity of individual roles to support integration. Many roles, particularly those developed to support co-ordination of an individual's care, have arisen to facilitate care for those with complex and often unmet needs. The focus on an individual member of staff meeting those needs can lead to high caseloads with increasing complexity (Kendall-Raynor 2012).

Another challenge is that integrated care has been noted to be 'process heavy', dependent on building and supporting inter-agency working to achieve successful boundary-spanning (Erens *et al* 2015). Boundary-spanning roles – particularly those that support active liaison and co-ordination between organisations – are characterised by negotiation with stakeholders on a daily basis, an element that is not readily reflected in job descriptions or task definitions (Nasir *et al* 2013).

Furthermore, these roles often demand post-holders to develop new systems and, importantly, networks (**Kessler and Bach 2007**). For roles that span boundaries across more dispersed networks, the task of co-ordinating actions was often time-consuming and difficult to maintain (McEvoy *et al* 2011). These demands were exacerbated by dealing with other workers and professionals experiencing workload pressures (**Kessler and Bach 2007**).

In addition to working with staff across organisational boundaries, boundary-spanning roles often require individuals to work across different systems. In one example, staff in roles centred on co-ordinating care found that although they could negotiate resources for cases of exceptional need, securing co-operation of others and of organisational gatekeepers for non-urgent needs relied heavily on local knowledge, contacts and negotiation skills (McEvoy *et al* 2011). This places additional demands on those in roles that span those boundaries.

People in roles that rely on brokering care, such as care co-ordinators and case managers, are particularly at risk of being overloaded and stressed by others' reliance on them; people in liaison-type roles, where the focus is on bridging organisations, can struggle to maintain ties that often need more work and are hard to keep viable over time (**Long *et al* 2013**). An inability to meet the demands of boundary-spanning could result in deleterious consequences. A study of case managers, for example, found that to avoid debates about whether service users met eligibility criteria for specific services, co-ordinators often sought to fill the gaps themselves. This could leave them with insufficient time to concentrate on essential elements of co-ordination and reduce their ability to manage heavy workloads; in some cases it has resulted in some individuals effectively being 'parked', with little active input (McEvoy *et al* 2011). In practice, people in boundary-spanning roles are often stuck in the middle; building the necessary relationships to deliver integrated care and negotiating systems to access resources often results in demands that are insufficiently accounted for within the capacity of individual roles. This limits staff members' ability to be well co-ordinated with all the parties that might demand accommodation (Davison *et al* 2012).

A final area in which boundary-spanning has placed additional demands on capacity is in relation to the development of new roles through skill-mix changes to existing roles. Often perceived as spreading tasks or filling particular gaps, roles that are extended (for example) to support integrated care can result in individuals

absorbing any extra activity by having to do more within the same period of time unless they are able to change their original role (**NIHR CLAHRC Greater Manchester 2015**).

How new roles sit within the wider system

Delivering integrated care relies on much more than staff performing individual roles; it is underpinned by factors such as group and team dynamics (Davison *et al* 2012). The literature demonstrates that the success of new and hybrid boundary-spanning roles depends on their legitimacy and on the support given to their activities more widely.

Professionals with enhanced expertise but in new boundary-spanning posts may not be readily accepted 'either socially or politically' by colleagues, making system integration slow (**Nasir *et al* 2013**). As noted previously, legitimacy was in part defined by perceived clinical and professional boundaries; however, support was also influenced by organisational and cross-organisational agreements. Particular issues included whether gaps in provision were best met by new roles or better co-ordination among existing professionals (**Erens *et al* 2015**), and the remit of roles and operating considerations, including employment and management arrangements (Smith and Barnes 2013). Insufficient attention to working through these agreements led to a lack of credibility for new roles and created practical challenges to fulfilling their remit (Blakely and Dziadosz 2013). This also limited the ability to generate wider awareness and buy-in around new roles and an understanding of their purpose and support for specific activities. This could limit the impact of such initiatives, or mean they are dismissed by other professionals, which can undermine what staff in new roles are trying to achieve (Segar *et al* 2013).

In other cases, boundary-spanning roles were limited by a lack of clarity and formal consideration of the exact tasks involved (**Kousgaard *et al* 2015**), as well as a lack of agreement around operational matters and levels of responsibility (Smith and Barnes 2013). Difficulties as a result of ambiguous and overlapping spheres of responsibility, poor communication and contested role boundaries resulted in some staff muddling through while trying to steer clear of conflict (McEvoy *et al* 2011).

Employment considerations

A number of organisations attempting to implement new and hybrid roles to support integrated care reported difficulties in recruiting to these posts. Extended roles were identified as challenging to recruit to because of the high degree of demand associated with the routine job responsibilities (**Nasir *et al* 2013**). The unusual requirements and uncertainties associated with new posts also made recruitment more difficult (**Kessler and Bach 2007**). Nor were these roles immune to wider influences on recruitment, with organisations highlighting problems such as general skills shortages and insufficiently attractive reward offers (**Centre for Workforce Intelligence 2011**; **Kessler and Bach 2007**).

Issues around employment options have also been raised in relation to roles that span organisational boundaries, particularly those spanning health and social care settings. Different national or local terms and conditions between employers – which in turn impose contractual variations on pensions, standard hours and employment policies – have proved particularly challenging. A Frailty programme in Gwent, for example, developed a support and wellbeing worker role across agencies, which required setting up a single management structure to ensure harmonisation through Transfer of Undertakings (Protection of Employment) Regulations and secondments (Barber and Wallace 2012).

The transfer of staff between different public services also brings a requirement to protect terms and conditions of employment (**Kessler and Bach 2007**) and the need to engage with trade unions from an early stage (**Roberts and Cameron 2014**). While these considerations do not preclude the successful development of boundary-spanning roles, they demonstrate the systematic approach and investment required in recruiting staff to these roles and ensuring that the appropriate employment requirements are met.

Resources

Resource limitations were also found to have affected boundary-spanning roles in addition to inter-agency approaches (Leach and Hall 2011). In their study, Williams and Sullivan (2009) found that few resources were dedicated to these roles; most dedicated posts were reliant on external and time-limited funding, and there was a strong presumption that collaborative working was an extra duty to be added to an already heavy workload.

Differences in funding and resource inequity between organisations and sectors represent another common structural barrier. Different charging, workforce and funding streams within NHS and social care services have proved problematic in supporting hospital, community and care home staff to work alongside one another in order to deliver integrated care. This affects individual payments and funding, but also reflects differences in status, training, rewards and resources (**Manthorpe 2011**). Local commissioning and funding arrangements can impede boundary-spanning activities by driving a distinction between 'care' and 'support' according to who is paying for what (Blood 2013). Furthermore, where overall arrangements for social care funding impede the delivery of quality and timely care, this could leave nursing staff to fill gaps in provision (**Royal College of Nursing 2014**). There are concerns that local authority cuts in response to financial pressures may place further demand on nursing services and, in some cases, result in boundary-spanning roles also being cut (Kendall-Raynor 2012). Alongside the impact of resource limitations in different sectors, net funding also presents a risk to the sustainability of new roles. Continuation of funding beyond pilot studies was noted as a key challenge, with roles in voluntary and community sector organisations most vulnerable to cessation due to the reliance on contingent forms of funding (**Kessler and Bach 2007**).

Sustainability

Although in part a consequence of factors such as employment considerations and resources, the wider issue of sustainability deserves due mention. It is notable that despite the impetus to develop new and hybrid roles, they remain marginal within the wider health and social care workforce. Sustainability of new roles and the associated innovations from which they have tended to arise is a key challenge. Boundary-spanning roles that require the development of locality-specific relationships or require individuals to hold specific skill sets and knowledge have presented a particular challenge (**Goodman *et al* 2013**). Reliance on individual leaders and staff, as well as high staff turnover, has led to difficulties in sustaining individual roles and to a waning of support for boundary-spanning activities when staff moved on to different organisations or left altogether (**Nasir *et al* 2013**). A review of skill-mix changes also found that often, the people in these roles are 'exceptional' – more experienced or more committed than the average person in that role – and, as a consequence, the role could not be replicated (**NIHR CLAHRC Greater Manchester 2015**). Finally, while new roles may serve to meet identified needs or gaps in provision by spanning boundaries of care, in practice many have proven to be transitory in nature. They have disappeared or

assumed different forms after achieving their goals, or been swallowed up by broader initiatives in which they take on a different character (**Kessler and Bach 2007**).

Accountability and regulation

Issues relating to accountability and regulation arise primarily where new roles involve an overlap or extension of traditional roles. Professional registration not only defines the roles and tasks of individual professions but also validates that a given individual has the requisite skills and capability to undertake their role in a safe and effective manner. Regulation tends to be 'territorial', which poses problems for roles that do not fit neatly within existing regulatory and training frameworks (Cameron 2010). As a consequence, many new and extended roles that seek to work across traditional professional boundaries lack appropriate formal regulation (**Bienkowska-Gibbs** *et al* **2015**).

Legal frameworks have a particular impact on boundary-spanning between health and social care; although health staff are relatively flexible in where they can deliver care, social workers are restricted from providing care outside their local authority boundary (**Royal College of Nursing 2014**). This presents a challenge to cross-organisational working when there is limited congruence between organisational boundaries.

Like professional regulation, the regulation of care homes also defines what care can be provided, limiting the type of health-related tasks that staff can engage in, even when there are nurses on site to provide the appropriate care (**Goodman** *et al* **2013**). The development of greater boundary-spanning roles within this context can also present a risk to the registration of services such as housing services; putting greater emphasis on health support within these settings can result in a requirement for care homes to undergo re-registration, which in turn has financial implications for the provision of care (**Centre for Workforce Intelligence 2011**).

Accountability and regulation have formed a key point of focus within the social care workforce. Developments arising from the Health and Social Care Act (2012) and efforts to improve integrated health and social care in the community have seen an increasing emphasis on role extension in the support worker role, a profession that remains unregulated. Differences in registration and regulation are fundamental to the contested responsibilities between 'care' and 'support' staff.

Boundary-spanning in this sector has typically envisaged an extended scope for the support worker role, to engage in health-related areas of care; but there is no agreement on which basic tasks are suitable (**Wild** *et al* **2010**), with particular concerns among nursing staff about accountability, liability and competency (**Manthorpe 2011**). Although this can be perceived as professional defensiveness, there is a strong argument that these systems have been established to provide appropriate quality of care and safeguarding of individuals as well as to protect care workers (**Centre for Workforce Intelligence 2012**; **Manthorpe 2011**). Registration of care workers has been suggested as one way of tackling this (**Wild** *et al* **2010**); indeed, it was one of the key recommendations of the Francis Inquiry into the provision of safe and compassionate care (**Mid Staffordshire NHS Foundation Trust Public Inquiry 2013**). Subsequent development of the Care Certificate goes some way to support standardisation of the basic foundations of training (**Skills for Care** *et al* **2016**), but there is not yet a consensus on the importance of formal regulation.

Accountability often acts as a parallel mechanism to registration and regulation. As a consequence of providing care across boundaries, or within alternative settings, mechanisms for providing accountability are not always suitably aligned. Concerns have been raised around nurses working within NHS settings but having social workers as their line managers within multidisciplinary teams (Kendall-Raynor 2012). Other concerns relate to the sharing of functions such as safeguarding among wider staff, or within a line management structure, but in which accountability lies with a registered professional (**Musselbrook 2013**).

In many cases, organisations have sought to develop mechanisms of accountability that include agreed protocols for working and responsibility. However, examples from case law demonstrate that issues of shared or agreed accountability are far from clear cut, and organisations engaged in joint working can find themselves with more extensive legal obligations to staff of partner organisations than anticipated (**Centre for Workforce Intelligence and Institute of Public Care 2013**; Mitchell 2012). Furthermore, although staff may seek to provide a role that spans organisational boundaries, this often leaves them facing dilemmas of multiple accountability, at times struggling with the diverging perspectives and interests of the various organisations and individuals involved. In practice, research has shown that people in boundary-spanning roles mainly see themselves as accountable to the organisation that employs them, which may give undue priority to the agenda of that organisation (**Kousgaard** *et al* **2015**).

A special note on social care roles

The issues arising from boundary-spanning roles in social care mostly reflect those associated with professional roles in health and social work. However, a number of challenges are unique to social care settings, which warrant special consideration. First and foremost is an acknowledgement that 'social care' is provided from several roles, but there is limited understanding of those roles and their responsibilities (Huxley *et al* 2011; Manthorpe and Moriarty 2011; Manthorpe *et al* 2010). A scoping study of social care staff found an ambiguity over role clarity, with only 40 per cent of employers providing staff with formal job descriptions. This can threaten other health professionals or result in stifling of social care roles by other professions (Manthorpe *et al* 2010). Training provided through National Vocational Qualifications (NVQs) has been described as inadequate for the roles and tasks social care staff are engaged in, and there is a lack of standardised training across the sector (Royal College of Nursing 2014; Manthorpe and Martineau 2008). There is also a perception that formal training is less valuable than experience (Manthorpe *et al* 2010).

Large proportions of the social care workforce are in private or third sector organisations and, as such, provision and access to training is largely seen as the responsibility of individual providers. The absence of any specific source of funding for role preparation and mentorship means that any training provided remains ad hoc (Manthorpe *et al* 2010). Employers of social care staff have not uniformly provided additional money to foster new learning and responsibilities, and the resource gap remains significant.

Upskilling support workers requires an investment in both training and management support to prioritise and evaluate skills acquisition to ensure safety, quality and efficiency of care (Hughes and McCririck 2012). However, these costs and subsequent remuneration of workers may prove prohibitive (Musselbrook 2013). Although there have been suggestions that further training should support a shift from task-focused roles to recovery and relationship-focused roles, and involve greater clinical input, in reality there is little understanding of what types of training are most effective for frontline care workers (Moriarty *et al* 2011). High staff turnover in the social care workforce remains a challenge to maintaining staff skills and knowledge (Royal College of Nursing 2014; Goodman *et al* 2013), and extending the roles of care home staff cannot be safe if staffing levels are too low (Manthorpe 2011).

In organisational terms, the lack of an identifiable entity for social care organisations such as care homes at a local level means there is no one place for NHS commissioners and managers to go to engage with the sector or establish contracts for more than an individual or group of services (**Goodman** *et al* **2013**). At the same time, local commissioners have relatively little direct control over the total social care workforce (**Centre for Workforce Intelligence and Institute of Public Care 2013**). This presents a significant challenge that requires investment in developing processes to support integrated working.

1 2 3 4 5 **6** 7 8 9

6 What factors can support boundary-spanning?

The evidence base on the role of the workforce in supporting integration is growing, and particularly what factors support boundary-spanning. This evidence provides useful insights into what works and, in many cases, highlights an alternative approach to workforce roles that can circumvent the barriers identified previously. In this section, emerging themes about the factors that can facilitate workforce integration have been drawn from across the literature reviewed.

Systemic support for integration

One of the main findings from programmes to develop integrated care is that workforce solutions are only effective within a wider process of systemic and organisational integration (**Skills for Health and Skills for Care 2015**; **Aungst *et al* 2012**; McEvoy *et al* 2011). Initiatives such as at Torbay Care Trust (*see* box) have seen the emergence of new health and social care co-ordinator roles as part of a whole systems model of integration. In this case, workforce solutions have stemmed from an ongoing programme to integrate care, which in itself was built on strong relationships between the primary care trust (PCT) and council, reflecting sustained political and organisational commitment to improvement (**Centre for Workforce Intelligence 2011**). In other examples, the development of integrated services on the ground has led the way, but not without a requirement for buy-in from stakeholders involved to facilitate that process (Blakely and Dziadosz 2013; **Centre for Workforce Intelligence 2011**). In both cases, local and national policies that support integrated care have been key, while agreement on a common cause, value or goal can really help build trust between stakeholders, encouraging them to temporarily set aside organisational and professional identities (Shirey and White-Williams 2015). This collaboration and buy-in among stakeholders is crucial to legitimise subsequent activities and support the development of policies and organisational arrangements

necessary to facilitate new ways of working. Success is underpinned by the alignment of both strategic and operational interests (Patru *et al* 2015).

Creating an integrated health and social care system in South Devon and Torbay

Developments in Torbay reflect a longstanding commitment among stakeholders to develop integrated care (dating to 2002). It saw the legal establishment of Torbay Care Trust, an integrated NHS organisation responsible for providing community health and social care services, from which Torbay Council commissions its adult social care services.

In recent years, this work has continued as part of the Integrated Care Pioneers programme, with the development of a service model based on multidisciplinary teams working closely with primary care and specialist health services. A health and social care co-ordinator role was created to provide a single point of contact for patients, their carers and practitioners. The role serves to co-ordinate responses and build relationships, set up packages of care, and refer complex cases to the multidisciplinary team.

A second support worker role sits within an intermediate care service, working alongside but independently of qualified nurses and therapists. Staff in that role receive training in nursing, physiotherapy, occupational therapy and social work skills. These developments have formed part of a systemic process that has seen the development of a model of shared governance between system leaders across health and social care. Partners have pooled budgets, secured strategic public involvement, invested in IT, undertaken a programme of workforce and organisational development (including investment in local leadership), and developed integrated general management.

Source: Integrating Care and Local Government Association 2013

The need to create a culture of integration in order to support boundary-spanning emerges at every level. Expanding the responsibility for boundary-spanning beyond individual roles is at the very heart of building the increased trust and collaboration required to deliver integrated care (NIHR CLAHRC Greater Manchester 2015). Examples such as the Partnership for Older People model show how the co-location and engagement of staff from health, social care and the voluntary sector enabled staff to identify systemic boundaries and create links to broach them (Smith and Barnes 2013). Working together as part of an interdisciplinary team can also influence professional practice, supporting standardisation of different approaches (Stampa *et*

al 2014). In the case of the primary care demonstrator sites, this approach has led to teams developing the skill-mix changes required themselves through increased liaison between staff in different sectors (**NIHR CLAHRC Greater Manchester 2015**).

A final consideration is the context in which roles that span boundaries sit. As a participant in one study noted, 'Boundary-spanning is a team sport that is enabled by shared playing fields, rather than the lonely individual (who often dies young and misunderstood)' (**Aungst** *et al* **2012**). Individual roles that are set up to span boundaries of care, such as case managers, are most effective when they are part of a team approach. One of the strengths of a team approach, and especially one which is multidisciplinary, is that different competencies and points of view can be brought to bear when addressing a specific problem, enabling the team to acquire a comprehensive vision, as well as providing support and generating confidence (**Stampa** *et al* **2014**).

A further benefit of embedding boundary-spanning roles within a wider team is being able to share information pertinent to cross-organisational working with staff more widely (Freijser *et al* 2015). In a study of integrated care for older people, the multidisciplinary team approach was found to have enabled the case manager to develop their new role and interdisciplinary competencies (**Stampa** *et al* **2014**). The extent to which staff across organisations are engaged in supporting boundary-spanning has been highlighted as an important factor in the sustainability and rolling out of new roles (**NIHR CLAHRC Greater Manchester 2015**).

Managing organisational and professional identities

In considering workforce integration, there is a need to appreciate the significance and impact of different cultures, professional responsibilities, power relationships, priorities and concerns of different sectors (**Goodman** *et al* **2013**). Ironically, although organisational and professional identities can act as barriers to boundary-spanning, developing an understanding of and respect for the values, roles and responsibilities of different professions can also underpin successful integration (Shirey and White-Williams 2015; Blood 2013; Baeza *et al* 2012; Lindsay and Dutton 2012; Walker *et al* 2009).

Trust is a key factor in developing workforce boundary-spanning. Identifying where boundaries associated with identity and relationships exist, and strengthening these

boundaries, can support staff to build better relationships across those boundaries (**Lee _et al_ 2014**). Mutual respect for and reflection on defined boundaries can also allow groups to look across boundaries, as well as understanding other people's point of view and identifying potential areas of collaboration (Shirey and White-Williams 2015). This supports groups to move beyond areas of practice deemed 'safe', to explore spaces at the intersection where groups collide, with the potential for more creative workforce solutions (Shirey and White-Williams 2015).

Valuing and respecting professional and organisational role boundaries can also facilitate boundary-spanning through greater collaboration with other professions. Secure professional identity within multidisciplinary teams is associated with higher levels of perceived integration. While divergence of ideologies and approaches between nursing and social work colleagues in integrated teams has been described as a mix that was not always comfortable, the creativity it gives rise to has been associated with higher ratings of quality of care by service users (**Huxley _et al_ 2011**).

Mutual recognition and understanding of the skills and capabilities people bring to their work also plays an important role in determining how people experience their work within teams (**Huby _et al_ 2010**). It can also enhance confidence in the value of their contribution and strengthen integrated working when the benefits are evident (Workman and Pickard 2008). A further function of professional and organisational identity was found to be an affirmation that individuals were competent and accountable for their actions through the ethical and managerial arrangements to which they were bound (Walker _et al_ 2009).

One might expect that professional or organisational identity is less important in boundary-spanning roles, particularly where the role does not reflect traditional distinctions. But this is not the case. In fact, professionals engaged in activities that seek to span boundaries usually maintain a strong professional identity (**Kousgaard _et al_ 2015**). In the Pathways to Work scheme, for instance, occupational therapists, physiotherapists and nurses were able to adopt generic roles to address their clients' health and employment needs as part of a condition management programme precisely because they understood their new work as remaining rooted in a sense of professional identity defined by clinical expertise and trust (Lindsay and Dutton 2012).

Increased acknowledgement of the strengths of individual roles can also support blurring of role boundaries – for example, nurses in multidisciplinary teams

were found to have acted as informal reviewing mechanisms on behalf of the local authority (reflecting their ongoing contact with an individual patient). They also provided a means of screening and referring people on to specialist social workers when required (Workman and Pickard 2008). Indeed, mutual respect and understanding can result in greater role flexibility, such that professional and occupational identity become a malleable concept (Lindsay and Dutton 2012; **Huby et al 2010**). Far from being a process of simply defining changed roles, boundary-spanning should be an active process of continually defining and clarifying boundaries and overlap in relation to activities, roles and tasks. As one study of a project supporting integration to provide appropriate care for older people with high support needs in residential care homes found, there are certain prerequisites to effective integration – which in this case included clarifying the boundaries between staff in each organisation regarding which tasks to share, when, where, and to what effect and, when put into action, that there is active acknowledgement of any breach of those agreed boundaries (Blood 2013).

Building relationships to support boundary-spanning

The quality of relationships is crucial in role configuration and the development of boundary-spanning activities (**Aungst et al 2012**; **Huby et al 2010**). Creating a culture of boundary-spanning that aligns colleagues from different professions and organisations is a key factor in this process (**Aungst et al 2012**; Hughes and McCririck 2012). One mechanism for achieving this is through an ethos of shared values and outcomes (British Medical Association 2012). Common organising concepts and visions that have proved effective in supporting integrated care include the chronic care model, managing frailty and rehabilitation (Blakely and Dziadosz 2013; Barber and Wallace 2012), and a focus on the individual through personalisation or person-centred care (**Erens et al 2016**; **Longpré and Dubois 2015**; Delaney et al 2013; Smith and Barnes 2013; **Centre for Workforce Intelligence 2012**). These models are not just about workforce reconfiguration but about how staff, teams and organisations operate around the individual, working to achieve the best outcomes (**Skills for Health and Skills for Care 2015**; Blood 2013).

Quality relationships were also built by simply working together. People's natural reaction is to be protective; allocating time for joint work provides the opportunity to create shared understanding and shared perspectives, priorities and limitations so that people feel comfortable in their role and with the role of others (**Carlisle**

2015; Skills for Health and Skills for Care 2015). For example, in a collaborative project to implement telehealth interventions for people with chronic obstructive pulmonary disease (COPD), housing officers and NHS case managers learnt more about each other's role and became a 'telehealth team'. While being clear about their different responsibilities (case managers making clinical decisions, housing officers supporting tenants to use the equipment), they also recognised that there was value in bringing together their knowledge of the tenant and of managing clinical conditions (Bailey *et al* 2015). The ability to bring staff together also features among the main points of learning from those developing integrated care across diverse economies as part of the Integrated Care Communities (*see* box below). The value of supporting staff to develop good working relationships and mutual learning by staff from different teams and organisations in order to facilitate integration cannot be understated (Goodman *et al* 2013).

Key lessons from the Integrated Care Communities (ICC) 2 programme

The Integrated Discovery programme was a pilot to explore how the theory of integrated care could be applied in practice. The ICC2 programme, which ran for 18 months, built on this work, expanding the group to include 12 (rather than the original 8) local economies. Both programmes comprised learning and leadership from the Advancing Quality Alliance (AQuA) and The King's Fund.

Key enablers for integration identified from the programme evaluation include the following.

- Co-location and daily meetings facilitate collaborative working and information-sharing.

- It is worthwhile investing time in developing an integrated culture between frontline staff.

- Common goals/tools can be helpful in aligning different professionals.

- Engaging frontline staff in service redesign is important for support.

- Maintaining focus on the patient and outcomes breaks down a culture of competition between agencies.

Source: Roberts and Cameron 2014

Often, boundary-spanning is as much about creating relationships to facilitate integration as it is about integrating care and practice. In boundary-spanning roles across health and social care, the ability to make things happen often depends on

personal relationships and networks (Williams 2011), while informal networks are vital for staff in providing information, support, ideas and quick responses (Skills for Care *et al* 2014). The creation of diffuse networks has also been found to be most efficient in spreading information; it is also less likely to result in individuals becoming overwhelmed by roles in which they alone serve as gatekeepers to specialist knowledge and resources (**Long *et al* 2013**).

Designing boundary-spanning care

An examination of skill-mix changes and new roles found that most emerged to support new activities, rather than simply re-labelling old roles or re-packaging established tasks (**Kessler and Bach 2007**). New roles have also been created to fill gaps in skills and capacity that have emerged from programmes to develop integrated care across boundaries. This is particularly the case in relation to provision of practical care as part of a multidisciplinary team approach (**Roberts and Cameron 2014**; Barber and Wallace 2012). Some roles have emerged to support more complex provision, where clients' situations do not fit (and should not be made to fit) neatly into categories (**Huby *et al* 2010**). This suggests that even among organisations focused on developing integrated care across boundaries, skill-mix changes and new roles do not in themselves provide a solution; rather, they are a response to identified gaps in capacity and capabilities built on a detailed understanding and consideration of local need.

The success of these roles often depends on understanding where they sit in relation to other roles, as well as the success of integration, planning and commissioning processes (**Musselbrook 2013**). In many cases, the skills gaps that emerge can be met by recruitment, training or developing existing roles through skills transfer and role extension rather than creating new roles (**Centre for Workforce Intelligence 2012**, **2011**). One notable exception is the emergence of new roles in social care in which changes to social work brought about by the NHS and Community Care Act 1990 resulted in a gap in the ability to deliver direct personal care at a national scale (Cameron 2010).

Identifying the best workforce approach is also dependent on context and organisational approach. In a study of boundary-spanning roles between academia and health care, researchers found that in organisations driven by their own agendas, roles that sought to bridge boundaries by sharing information in discrete events with designated individuals were most effective. Conversely, roles that placed

less emphasis on boundaries between stakeholders and created a more continuous process of information-sharing were most effective when there was a shared goal, and when organisations were committed to a less-specified approach (Evans and Scarbrough 2014). Even when organisations had staff in the same roles, the way those individuals behaved was framed by the organisational approach.

Roles are often implemented in vastly different settings and across inter- and intra-organisational boundaries such that a one-size-fits-all approach to conceptualising these roles fails to capture the reality in which they operate. Roles designed to span boundaries need to be tailored to the specific context and have the flexibility to adapt according to changing needs and the service system (Freijser *et al* 2015; Taylor *et al* 2011).

> ## Designing a 'support and wellbeing worker' role in the Gwent Frailty programme
>
> The Gwent Frailty programme (2009 to 2011) adopted the concept of 'frailty' as a single unifying theme across seven agencies. The multi-agency frailty service comprises community resource teams co-locating different professionals, including community geriatricians, nurses, physiotherapists, occupational therapists, social workers, and support and wellbeing workers. The latter was a new role, designed by staff across the agencies to support the programme. It was designed by a dedicated Frailty Workforce Group through liaison with staff across each of the stakeholder organisations.
>
> To ensure that elements valued by older people were captured and used to configure the role and competency skill set, staff were asked to identify which care and re-ablement tasks they did for older people. Using this information, a role profile was drawn up and shared for further engagement and consultation. This process enabled staff to consider how their own role fitted with the aim of delivering an integrated service for frail older people and to identify any gaps or areas that required additional support. The role was thus designed with the appropriate skill requirements to meet those needs.
>
> Source: Barber and Wallace 2012

Skills for boundary-spanning

Adequate preparation for new boundary-spanning roles is crucial to effectiveness (Cameron 2010). The skills of the workforce need to be relevant to the care and support needs of individuals and what individuals want (Skills for Care *et al*

2014). Many of the skills and capabilities required for new roles already exist within the workforce, but are now being envisaged in new contexts or for use by different professional groups. New roles for support workers commonly include a requirement for clinical and technical skills (such as carrying out minor nursing procedures) or supporting individuals with health-related tasks and issues that would require additional training and support. Skill considerations are also important in boundary-spanning roles that involve a change in focus or context of care delivery. It is important to note that within professional groups there is a high degree of variance in competencies, which means that individuals are not interchangeable (NIHR CLAHRC Greater Manchester 2015). Understanding the previous experience and professional background of staff is a crucial component of this. A number of specific areas for skills and knowledge development emerge as important in supporting boundary-spanning and integrated care.

The first is ensuring that staff have knowledge that is relevant to the role, the organisations they will be engaging with, and the needs of the client group. A study of enhanced housing support worker roles aimed at delivering more holistic care for instance highlighted a need for knowledge on housing issues, welfare benefits, and relevant legislation, as well as an understanding of health and social care services (Cameron 2010). Having the requisite knowledge was often a key component of roles established to create a bridge or liaison point between organisations, including in-depth knowledge of pathways, offers of other teams and services, and their criteria for access (Centre for Workforce Intelligence 2011).

A further area of development reflects many of the overarching aims of integration, which are often at the heart of the new roles. This includes personalisation and management of chronic conditions, and a focus on providing holistic care, which all place new skill requirements on staff. The development of new roles in social care to place a greater focus on supporting the health needs of individuals represents a move from task-focused care to recovery and relationship-focused care (Musselbrook 2013). Professional groups seeking to provide more co-ordinated and holistic care increasingly require new skills in case management, empowerment, advocacy, brokerage and, in some cases, community development (Centre for Workforce Intelligence 2012, 2011). As much as developing new skills, this reflects a need to develop new ways of working.

Increased skill demands were particularly notable for roles working with people with high support needs or requiring more complex care, and those that extended care delivery beyond the setting in which it was originally developed (**Freeman et al 2012**; **Centre for Workforce Intelligence 2011**). Staff providing complex care were often expected to provide a fuller service requiring an enhanced skill set, while those in responsive roles required both generalist skills to cope with a range of situations they might face, as well as some specialist skills to meet the specific needs of individuals (**Centre for Workforce Intelligence 2011**). There is a particular need for enhanced skills to support community working, including the ability to work independently, enhanced decision-making skills and risk assessment skills (**Centre for Workforce Intelligence 2011**).

The need for strong communication and managerial skills also emerges strongly from the literature on boundary-spanning. A study of integrated care between GP surgeries and care homes found that roles were built on social competencies and positioning in local professional networks, supported by ongoing processes of formal and informal negotiations (**Kousgaard et al 2015**). Although these requirements may be more prominent for roles that involve liaising, co-ordinating or managing care across boundaries, the relational requirements of activities that span boundaries place greater emphasis on staff in these roles having a wide range of communication skills (**Nasir et al 2013**). Key facets of roles spanning health and social care include: the ability to manage and influence through facilitation and convening; building and sustaining inter-professional relationships constructed around trust and networking; working with diversity and different cultures arising from a variety of different interests and agencies; managing different behaviours and governance structures; and managing conflict as much as collaboration, which requires diplomacy and negotiation skills (Williams 2011).

The management requirements for staff in roles that span boundaries include managing multidisciplinary input and teamworking, a greater level of decision-making associated with people with high support needs and resource management, and a greater focus on organising, planning and co-ordinating different parties (Blakely and Dziadosz 2013; **Centre for Workforce Intelligence 2011**; Williams 2011). The skill-mix changes and extension of roles associated with boundary-spanning can result in a greater need for these skills within roles previously considered as having limited managerial responsibility. Finally, the role of managers is not only important in supporting collaborative and integrated working (**Huby et al 2010**), but

also because management style has been found to be a predictor of team integration (**Huxley** *et al* **2011**).

While most of these skills can be taught or developed, experience and individual qualities may also be beneficial for particular boundary-spanning roles. Many integrated care models require staff with generalist skills to cope with a range of health and social care needs in order to provide more holistic care, for which a diverse experience base is valuable (Hughes and McCririck 2012). A study of community link workers found that people's work backgrounds and experience mattered, with staff from community development backgrounds and individually focused services best able to apply their skills in the new role (Smith and Barnes 2013). Furthermore, the ability to empathise with specific client groups and an awareness of how health interacts with socioeconomic factors that are pertinent to that group have been found to enable staff to adopt the advocacy and advising roles required to co-ordinate care across boundaries (Lindsay and Dutton 2012).

Experience also plays a prominent role in supporting active mediation across boundaries. Individuals with experience of both worlds – knowing what each stakeholder does and does not know about each other but also being familiar with both – could increase trust and collaboration (**Long** *et al* **2013**). At the same time, those who have already established credibility in an area may find it easier to garner support for more innovative boundary-spanning activities than those who are new or unknown (**Aungst** *et al* **2012**; Williams 2011). Finally, studies have demonstrated that individuals who are successful at engaging in activities that span organisational boundaries often have a strong sense of agency, an inclination towards innovation and risk, and personality traits that facilitate their activities (Williams 2011; Williams and Sullivan 2009).

Training requirements

The creation of new roles is inseparable from learning the skills needed to fill those roles (**Huby** *et al* **2010**). Preparation and training is crucial to the effectiveness of new roles and should be addressed early on (Blakely and Dziadosz 2013; Cameron 2010). The emergence of roles as part of specific integration and boundary-spanning activities has largely led to skills and training requirements being addressed at a local level. Understanding how the skills and experience required relate to existing staff roles within an organisation was found to be important in identifying the right

staff for the job and their training needs (Cameron 2010). Programmes seeking to develop support worker roles to work across boundaries of health and social care have identified a need to ensure consistency through core training (Barber and Wallace 2012) as well as providing training specific to the service change requirements (Ling *et al* 2012). In the development of integrated working, staff tended to learn more quickly through on-the-job practice (which included informal training as well as picking up skills from others) than through translating theory into practice (Blakely and Dziadosz 2013; Huby *et al* 2010).

The extended skill requirements of many professional boundary-spanning roles were also reflected in the identified training requirements. These included building and managing relationships, co-ordinating networks of service providers, teamworking, problem-solving, conflict resolution, communication and leadership (Longpré and Dubois 2015; Mental Health Foundation 2013; McEvoy *et al* 2011; Huby *et al* 2010). The value of training staff from different professions and settings together was particularly noted in supporting an integrated approach as good preparation for working across different systems of care (Delaney *et al* 2013; Centre for Workforce Intelligence 2012). These skills were important for individual roles as well as for staff more widely to support the requirements associated with developing and managing integration processes.

Although the literature on integrated workforce roles focuses on health and social care practitioners, it should not be assumed that senior managers and professionals have the knowledge and skills to deliver; they should therefore be engaged in training and development approaches as relevant (Skills for Care *et al* 2014).

Boundary-spanning roles were more often defined by skills rather than qualifications (Centre for Workforce Intelligence and Institute of Public Care 2013) and there is a need to effectively recognise and record this. The concept of the 'skilled care professional' has been described based on an individual's portfolio of experience and training (Huby *et al* 2010). Portfolios for social care professionals in integrated health and social care settings often include professional and vocational training as important elements, but roles were not defined by such training. Such approaches were identified as important in supporting continual professional development and adapting to new ways of working, as well as allowing for career progression and encouraging people to stay in the sector.

Organisational management of workforce integration

Key to creating boundary-spanning mechanisms and roles is the need to align systems, policies and procedures. Bringing together frontline workers without integrating all of the systems that support and enable those workers is not sustainable; it can create conflict as well as practical difficulties and make workers feel unsupported (Skills for Care *et al* 2014). Integrating resources, responsibilities and control creates a clear message that organisations are committed (Skills for Care *et al* 2014; **Aungst *et al* 2012**). Co-ordination and integration at an organisational and systems level is key to supporting the capabilities of roles to bridge gaps in services and fragmentation at a clinical level (Freijser *et al* 2015).

The organisational requirements associated with developing new roles to span organisational boundaries of care cannot be underestimated (*see* box below). Policies can support this process; however, on their own, policies and organisational arrangements can either help or hinder, and most successful efforts have involved building protocols alongside building relationships (Blood 2013). Other organisational developments such as the creation of shared workplace procedures, agreed pathways and common referral and assessment procedures have also proved important in managing internal stakeholders. Shared systems, tools and discrete resources could also support greater alignment and collaboration among different professionals (**Roberts and Cameron 2014**; Blakely and Dziadosz 2013; **Kessler and Bach 2007**).

Boundary-spanning activities require appropriate financial arrangements to support implementation (Blakely and Dziadosz 2013) and there is some evidence that pooling of budgets can support the allocation of staff to multidisciplinary working (**Huxley *et al* 2011**). Beyond this, financial incentives such as payment reforms on care co-ordination or outcomes are likely to be necessary to promote substantial change (Taylor *et al* 2011).

Evidence on the support required beyond the level of participating organisations is limited. However, alignment between boundary-spanning activities and commissioning agendas, health and wellbeing strategies, and Local Education and Training Boards (LETBs) is likely to be important (**Centre for Workforce Intelligence and Institute of Public Care 2013**). Innovative ways of working are contingent on having an appropriately skilled and available workforce (**NIHR CLAHRC Greater Manchester 2015**). There is a link between workforce planning and development of a market

Factors most important in influencing the implementation of a nurse cancer care co-ordinator role

- Job description

- Defined scope of practice

- Support from multidisciplinary team

- Stakeholder buy-in

- Network of nurse cancer care co-ordinators

- Opportunities for peer support, shared learning and mentoring

- Formal and informal support systems

- Professional development

- Infrastructure support (eg, databases, assessment tools)

- Funding arrangements

- Job security

- Time/workload

- Recognition of role

- Ability to demonstrate the value of the role through outcomes

Source: Freijser *et al* 2015

within commissioning that is able to support boundary-spanning (Centre for Workforce Intelligence and Institute of Public Care 2013).

Accountability and governance

The focus of developing boundary-spanning roles within individual organisations has, for the most part, resulted in local arrangements for accountability and governance. The design and scope of roles requires sensitivity to statutory regulations (Kessler and Bach 2007), but good governance in itself can facilitate integration by supporting professionals to feel able to delegate (Barber and Wallace 2012).

Line management and supervision play an important role in supporting people in boundary-spanning roles in their day-to-day practice. The formal distinction between line management and clinical supervision is important to ensure that the latter is provided by someone with the appropriate knowledge base (Workman and Pickard 2008), and can also support the retention of professional identity (Belling *et al* 2011). Managers need to understand what the new roles entail and what they are expected to be accountable for (**Centre for Workforce Intelligence 2011**), as well as having the capacity to prioritise time to support and evaluate staff in acquiring the necessary skills to perform the role effectively (Hughes and McCririck 2012). In a number of examples, the role of extended support workers to provide health and social care was defined as supporting registered professionals. The scope of the role and tasks involved are therefore determined by the clinical team, which serves as informal governance.

Training plays a key role in ensuring that any treatment is provided according to guidelines for professional staff (**Centre for Workforce Intelligence 2011**). Organisations that have formally developed new extended roles have drawn up job descriptions with specific local training, and formalised arrangements through the establishment of apprenticeship schemes and vocational qualifications (**Skills for Care 2015**; Barber and Wallace 2012). In other cases, this has been used to retrospectively map competencies to National Occupational Standards (**Bateson 2015**).

Inter-organisational governance mechanisms are used to different extents. Locating social workers in mental health trusts is a longstanding arrangement that has been largely governed by the establishment of a Section 75 agreement by both parties; however, informal arrangements to support boundary-spanning have often employed honorary contracts between organisations to bypass challenges with information governance.

More recent efforts to support boundary-spanning as part of programmes to deliver integrated care appear to have largely rejected new public management governance, characterised by performance management, in favour of a more flexible form of public sector partnership working (Lindsay and Dutton 2012). These partnership arrangements, focusing on a specific policy issue, have given professionals from both sectors the space to develop innovative ways of working.

7 New roles or a new workforce approach to integration?

The idea of delivering a vision for the future integrated workforce by identifying roles able to span traditional boundaries of care and developing them more systematically is an enticing one. Our review of the literature highlights a wide range of 'new' roles that have emerged to support integrated care. However, the question of whether these roles would benefit from focused development and standardisation raises a number of key issues.

Categorisation of these roles demonstrates that the majority represent an extension of the context and focus of existing roles, or the enhancement, substitution or delegation of skills within existing roles. It is therefore challenging to define the distinct nature of individual roles. Many of the roles characterised by skill-mix changes are visible in other parts of the system. For instance, the practice of community mental health teams has long been defined by the sharing of generic tasks across professional groups (**Huxley** *et al* **2011**), while many community and senior nurses already deliver total packages of care working closely with other agencies without formal integration (Gillen 2013). These roles suggest that the skills required for new models of care and ways of working already exist within the workforce but are insufficiently available or inefficiently distributed.

In other areas, there is evidence that the skills may exist but have been devalued within current systems of care. The subsequent location of roles within whole-system approaches has, in some cases, supported a re-vitalisation of ways of working such as 'old-fashioned social work'. It has also seen the relocation of practices from one sector to another – for example, prevention roles now seen in the voluntary and community sector are similar to those previously undertaken by statutory organisations (Smith and Barnes 2013). Even those roles that appear to be new can be seen as focusing on or giving greater priority to particular tasks within existing

roles ([Mental Health Foundation 2013](#)). This suggests that there is little requirement to define new roles per se, but that there is benefit in recognising the existing skills of the workforce and identifying how these can be better shared and distributed as part of an integrated system of care across organisations.

A second area that challenges the need to develop specific new roles is that although they may have some parallel aims, the skills required and how they are formulated is highly dependent on local context. Key influences include the individual organisations and professions involved, the support available from the wider system for implementation, and local staff engagement in the process. It is also vital that the purpose and function of the role be considered as part of a broader process of developing activities that span boundaries of care. To some extent, this has precluded organisations defining the key characteristics of individual roles and standardising them for replication to other settings. Furthermore, given the considerable barriers to new roles, the focus on local development has also proven a valuable mechanism for addressing these barriers while at the same time ensuring that appropriate training and governance arrangements are in place, which are relevant to the specific requirements of each role and the stakeholders involved.

A final and widely acknowledged barrier to defining new individual roles is the impact of professional groups and role settings, and there is an implicit assumption of the need for more flexible and less-defined boundaries. The evidence, however, demonstrates that strong boundaries and the increased liaison between professions and organisations within practice can be the foundation for collaborative processes supporting both integrated care activities and boundary-spanning roles. Although new roles may serve to fill gaps in care or provide a mechanism to span organisational boundaries, a process in which new roles are developed and implemented systematically bypasses the very processes that enable the flexibility that is key to effective integration.

As with the development of integrated care, the development of roles to support boundary-spanning is in its infancy. A number of similar roles with common skills or practices are evident in different settings, but designating these as distinct clinical or professional roles risks creating standardised definitions and boundaries that are no longer relevant to the local context in which they will be applied. Doing so may also compromise the underlying workforce relationships that are crucial to enabling and sustaining boundary-spanning practices. Creating new boundary-spanning

roles and roles that aim to deliver integrated care should not be abandoned, but at this point there is little evidence to suggest that there should be investment to define and develop any particular role or types of role more systematically, and they should not form a focus for delivering integration.

8 Supporting the development of an integrated workforce

The findings of this report and broader evidence demonstrate that the development of an integrated workforce is most successful when part of a more systematic framework for developing integrated care. Our own work in this area has highlighted the need for organisations to not only establish shared agendas, visions, narratives and systems of leadership but also to engage staff and service users in identifying solutions, while aligning resources, contracting mechanisms and outcomes to reflect the aims of integration (Ham and Walsh 2013). It is now recognised that without sustained investment and support to facilitate change and tackle systemic barriers at local and national levels, progress in delivering integrated care will be limited (Erens *et al* 2016).

In 2012, the government made a commitment to make evidence-based integrated care and support the norm within five years (Department of Health 2012). Our review of the literature demonstrates that many of the developments in workforce integration are most prominent within health settings, while in social care the potential of support workers for delivering holistic care and supporting clients' health needs has been the main focus. An increasing emphasis on delivering integration across systems of care through the new care model programme vanguard sites – and most recently on place-based systems of care as epitomised by the development of sustainability and transformation plans – requires a greater focus on the wider workforce and on NHS and local authority systems.

Finally, there is a need to acknowledge that workforce solutions to support integrated care form part of a wider picture of effective workforce development and planning. Recent research argues for a large-scale redesign of the NHS workforce to reflect the workforce roles, skills and training required to deliver new models of care and to support integration across health and social care (Imison *et al* 2016). Similar

requirements have been identified in adult social care to support transformation in line with the Care Act (2014) and there is a need to consider how these processes can be aligned to support the delivery of integration across sectors.

Key lessons from our analysis

The overarching framework of organisational and workforce development is fundamental to considering what is required to support boundary-spanning. However, in working out how to achieve this in practice, our research highlights a number of key areas for further attention. This final section draws on findings from areas that have been developing boundary-spanning practice, as well as from independent evaluations of integration programmes and our own synthesis of the wider literature. We outline a number of ways to support organisational boundary-spanning, requirements for creating workforce solutions to integrated care, and the support and development needs of staff to equip a future workforce to deliver integrated care.

Using models of care and service delivery to support boundary-spanning practice

One of our key findings is that there are many ways to deliver integrated care without the explicit requirement for new boundary-spanning roles, as long as roles can develop more flexibly. Many of the following examples drawn from the literature reflect the application of frameworks and mechanisms that have been created to facilitate boundary-spanning activities.

- Multidisciplinary teams such as single point of access or hospital at home teams (Centre for Workforce Intelligence 2011) have the benefit of defining new roles and job descriptions within a team context but without diluting or undermining existing roles (Workman and Pickard 2008). There is an established evidence base to support teamwork of this kind and examples such as these demonstrate new ways in which this evidence can be applied to support integration.

- 'Medical neighbourhoods' were established in the United States, creating relationships between organisations to facilitate co-ordinated care. While the name suggests a focus on health aspects of care, it is recognised that achieving this requires a holistic approach. 'Neighbours' often include a wide range of organisations, from health and social care providers to community groups and

employers. Co-ordination relies on establishing inter-organisational routes for the flow of information, joining up different sources of information to facilitate continuity and safe care, boundary-spanning roles to integrate care across organisations, and mechanisms to support communication, negotiation and decision-making as part of a process of shared accountability (Alidina *et al* 2016). Workforce is one component of creating a co-ordinated approach (Taylor *et al* 2011).

- The 'Buurtzorg model', developed in the Netherlands, is a unique, district nurse-led system. A team of nurses cover a neighbourhood, planning and delivering integrated health and social care in collaboration with GPs. Teams are independent and self-managing. Typically, the model focuses on older people with complex needs, dementia, chronic illnesses and those recently discharged from hospital (Ling 2015). Although it relies on a single profession, it is an example of how team-based approaches can facilitate integration. Many of the components of this model can also be seen in other team-based approaches such as assertive community treatment teams in mental health, but which bring together different professions and sectors of care.

- Integrated care pathways such as the pathways to work scheme provide a good example of how setting up an integrated care pathway as part of a condition management programme can support integration and boundary-spanning between different sectors (Lindsay and Dutton 2012). There are several similar examples, and the Centre for Workforce Intelligence (2011) has produced a number of useful tools and reports to support workforce development as part of this approach.

- Upskilling staff within a system of support, including developing protocols around roles and engagement between professionals to optimise integration of care. One example is a falls prevention programme in supported housing in North Tyneside (Marston *et al* 2014). NHS Emergency Care Practitioners and the Admission Avoidance Resource Team NHS support housing officers to develop skills around falls prevention and assessment of risk. They are in turn provided with a direct referral process to the team. The NHS service also provides telephone advice to sheltered housing officers on behalf of tenants.

These models create many of the conditions that are conducive to integrated working and boundary-spanning. However, alone the models are unlikely to deliver integrated care. There must be greater recognition of the underlying processes involved in building the relationships, systems and governance needed to support boundary-spanning as well as ensuring that there is support from the wider system.

Engaging the workforce right from the outset

The evidence suggests that boundary-spanning activities are more effective and successful when staff are engaged in developing the relationships, networks and activities or roles right from the outset. This inevitably takes time and therefore requires active investment from the organisations involved. Without this investment, activities developed to support integration are unlikely to be effective or sustainable.

Delivering person-centred care and outcomes as a focus for workforce development

Ultimately, most approaches to integrating care are about improving the delivery of services to best support the needs of individuals. While valuable within systems of care, roles such as navigators and co-ordinators – if developed in isolation – could arguably be at the expense of creating a more integrated system. An explicit focus on identifying the needs of specific client groups and considering how best to meet those needs as part of a systemic approach to the development of integrated care has an added benefit in supporting boundary-spanning by creating shared values and aims that can bring professions and organisations together. This method can be seen to operate at the level of the individual, in supporting effective care co-ordination and case management, as well as at the organisational level, in developing integrated care pathways. Efforts are focused on meeting needs, while improving outcomes provides another clear focus for evaluating effectiveness.

Supporting and developing 'the skilled care professional'

The evidence around new roles to support boundary-spanning places a strong focus on skills. Furthermore, a key facet of effective boundary-spanning is the capacity for flexibility. We have already seen that this limits the ability to identify distinct roles and to standardise the requirements for these roles. However, at the same time, many of these roles involve staff developing new skills, often within a unique local

context, or applying extended skills developed through expertise and experience. It may, therefore, be helpful to consider requisite workforce changes in terms of new job descriptions rather than new 'professional' roles (Centre for Workforce Intelligence 2011).

Valuing and recognising 'the skilled care professional' would require: a focus on professional and vocational training that emphasises the skills required for ongoing learning and adaptation to collaborative working through practice; flexible avenues of learning and career-building; and mechanisms to recognise and document changing skill sets (Huby *et al* 2010). A vital component of this approach among unregistered staff would be a requirement to ensure the standardisation and quality of core training as a basis for further development. Engagement in the Qualifications and Credit Framework (QCF) has been noted as a key priority (Manthorpe and Moriarty 2011).

Developing boundary-spanning skills across the workforce

Promoting a separate profession for staff in roles that span boundaries is both contradictory and unlikely to succeed. There must be sustained efforts to include boundary-spanning management and competencies within existing professional and inter-professional programmes (Williams 2011). Many of the skills associated with developing and supporting boundary-spanning activities go beyond the clinical and professional skills acquired through traditional training and education. The most notable are communication and management skills. Although these skills may be associated with more senior roles, teamwork and boundary-spanning activities can result in staff at all levels assuming some of the coaching, supervision and co-ordination functions previously performed by frontline managers (Meyer *et al* 2014). It is therefore important that these skills are addressed across the workforce at the appropriate level.

Enabling cross-professional and cross-organisational training

One of Health Education England's objectives is to ensure that it trains and develops a workforce with skills that are transferable between different care settings (Centre for Workforce Intelligence and Institute of Public Care 2013). A frequent recommendation of workforce research and integrated care programme evaluations is the need for cross-professional and cross-organisational training. Understanding the roles, capabilities

and governance of other professions and organisations is a key factor in developing trust to support boundary-spanning activities, as well as creating and maximising the capabilities of individual professions, organisations and networks. Joint training initiatives between NHS and care home staff have proven valuable in supporting the development of comprehensive knowledge of local services to signpost appropriately (Centre for Workforce Intelligence and Institute of Public Care 2013). Cross-fertilisation of skills among professions and interdisciplinary training can also support the development of boundary-spanning skills, make services more efficient, and maximise the time of highly qualified staff (Centre for Workforce Intelligence 2011). Similar calls have been made in relation to cross-boundary training and education (Mental Health Foundation 2013).

Community Education Provider Networks are proving to be one mechanism for facilitating this by providing training placements for staff across a wider range of organisations and sectors. There has been particular emphasis on supporting nurses with placements in the community in addition to the acute sector, also extending to include social care and voluntary sector providers. However, these networks remain limited and provider engagement has been variable. There is a need to consider how inter-professional and inter-organisational education and training can be embedded right from the outset in order to support integrated working practices.

Evaluating the effectiveness of new roles

One of the main limitations of the development of new roles as part of a process of integrated care and boundary-spanning is lack of evidence of their impact on outcomes (Bienkowska-Gibbs *et al* 2015; Huxley *et al* 2011). In part, this appears to be borne of a perception that such roles are inherently beneficial, but this assumption should be treated with caution. Many of the challenges professionals raise to the development of new roles are founded on legitimate concerns and examples of practice in which people's experiences, clinical and social outcomes have been negatively impacted. Evidence suggests that similar caution should also be applied to the issue of cost-effectiveness, particularly given the current financial climate. Efforts to build on existing evidence should focus on individual outcomes and cost-effectiveness.

1 2 3 4 5 6 7 **8** 9

Better dissemination of current learning and evidence

An underlying assumption in approaching the literature was that there was limited evidence to support workforce development for integrated care and new boundary-spanning roles. Contrary to expectation, we found a number of robust evaluations of developments and a wealth of research exploring the wider sphere of organisational boundary-spanning. While this paper goes some way to highlight that evidence and draw together key lessons, there is a need to recognise and share more widely the lessons from current or previous programmes. These include the Integrated Care and Support Pioneers and primary care demonstrator sites. Where appropriate, relevant learning and resources should be drawn together to support current programmes of transformation such as the new models of care vanguards.

9 Conclusion

Creating an integrated system of care has long been highlighted as important for providing holistic support to meet people's needs. More recently, it has been associated with improving the experience of individuals and the efficiency of health and social care provision. National programmes such as the Integrated Care and Support Pioneers and vanguard sites reflect not only the perceived value of future integration of the NHS and social care, but the importance of boundary-spanning between sectors as a key component.

At the heart of delivering integrated care is the role of individual members of the public and the wider health and care workforce. Our work suggests that focusing on a vision of integrated care from the service users' point of view and designing a workforce best able to meet those needs is likely to be an effective mechanism for creating a common sense of purpose and capitalising on the capabilities of the existing workforce to support boundary-spanning activities. It is clear that many of those skill requirements already exist within the workforce; however, creating a truly integrated workforce requires greater consideration of how those skills are utilised to support boundary-spanning activities. The unique ability to span those boundaries is dependent on the needs of the service users in question and the objectives of the stakeholders involved. New roles may form part of local systemic approach, but pre-judging what those roles look like and their purpose can undermine many of the factors on which success is built.

As the research in this report demonstrates, there have been a number of good attempts to develop integrated care across services. While systems and services have provided a focus for change, it is the staff working in health, social care and the voluntary sector that represent the largest asset in delivering care that spans boundaries. Learning lessons from previous experience and engaging the workforce in current design processes should play as important a role as creating a new vision for the future.

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About the author

Helen Gilburt joined The King's Fund in 2013 as a fellow in health policy. While at the Fund, she has led on a number of publications including *Transforming mental health, Mental health under pressure, Supporting people to manage their health* and *People in control of their health.*

Previously she worked at the Institute of Psychiatry at King's College London, where she remains a visiting researcher. Her research has included a national study of alternatives to hospital, implementation of recovery-orientated care in the community, and a trial of assertive outreach treatment for people with alcohol dependence.

Helen has expertise in health service research and a particular interest in mental health and service user and carer involvement.

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**Ideas that change
health care**

New roles have been emerging to support the delivery of integrated care, but what value do they add and what are the most effective ways to develop an integrated health and social care workforce? NHS Employers and the Local Government Association commissioned The King's Fund to identify examples of these new roles and to understand the evidence supporting them, including the impact, features of success and key challenges.

Supporting integration through new roles and working across boundaries highlights how new roles that extend the skills of existing staff to provide more holistic care, co-ordinate and manage care across boundaries, and support individuals to navigate and access support from across health, social care and the wider community are emerging.

It finds that:

- where new roles have emerged, it has tended to be as a result of developments in practice or to fill gaps in provision

- the extent to which new roles improve patient outcomes and are cost-effective is as yet unclear

- many of the skills required to deliver integrated care already exist within the workforce, and that those skills need to be used more effectively to support activities that span organisational boundaries

- engaging staff in cross-professional and cross-organisational working can support mutual respect and role flexibility while team-working models and person-centred care can facilitate integrated working practices without the explicit need for new roles.

The report concludes that developing integrated care has to be part of a system-wide process, of which workforce integration is one component. The need for new roles should be demonstrated rather than assumed, but in many cases new ways of working and models of care are likely to prove most effective.