

Evidence Cluster: Organisational change for health and social care integration – impact on frontline staff

Issue As health and social care services become more integrated it is inevitable that there will be implications for frontline practitioners working within these services. An awareness of the research evidence can help organisations to ensure that staff have a positive experience of transitions towards greater integration and are able to anticipate and prevent any difficulties that may occur.

Content of this evidence cluster This evidence cluster explores the impact on frontline staff when organisations begin to work in a more joint or integrated way at a strategic or organisational level.

Studies are discussed in this evidence cluster if the impact of strategic level or structural change is explored. This can include, for example, the development of joint commissioning processes, joint planning boards, and pooled budgets. Organisations introducing joint working at a strategic level often introduce approaches to joint working at the frontline, such as multidisciplinary or integrated teams – our emphasis here is not on the impact of working in integrated teams, but on the impact of strategic level change.

Studies are discussed where they involve joint working between health and social care organisations, but they may also include other sectors such as housing or leisure.

Definition of key terms For the purposes of this evidence cluster, a range of terms are used interchangeably, including joint working, integrated care, partnership, multi-disciplinary working, interagency working and collaborative working. *A practical guide to integrated working*, recently published by the Care Services Improvement Partnership (Care Services Improvement Partnership/Integrated Care Network 2008), defines **integrated care** as 'a single system of needs assessment, service commissioning and/or service provision'. Health and social care partners can remain legally independent, but mission, culture, management budgets, accommodation, administration and records should be provided jointly. **Joint working** tends to suggest a looser form of collaboration between organisations which may include joint strategic planning and sharing information, joint service commissioning, and joint service provision (Cameron et al 2000). In a recently published series on *Better Partnership Working*, Dickinson and Glasby refer more broadly to **partnership working**. They emphasise the point that while there are a large number of varying definitions, the most important thing is that all key partners must mean and understand the same thing. Key issues and principles that are shared across all definitions are: added value, reciprocity, formal and ongoing relationships, a focus on the experience of people who use services, and a voluntary nature (Glasby and Dickinson 2008).

Policy background In 1997 the White Paper *The New NHS* explained that the internal market in existence at the time would be replaced by a system called 'integrated care', based on partnership and driven by performance (DH 1997). It emphasised the importance of effective collaboration between local NHS organisations and local authority social services departments. The Health Act 1999 introduced 'flexibilities' to enable health and social care organisations to work more easily in partnership, such as the ability to pool funds. In 2000, *The NHS Plan* introduced 'care trusts', which appeared in 2002 and were intended to be NHS organisational structures with the ability to commission and provide primary and community health care as well as social care (DH 2000). Further emphasising the government's dedication to improved joint working, *Our health, our care, our say* (DH 2006) set out a commitment to provide more integrated local health and social care services, suggesting that integration can lead to a number of advantages for both services and service users. These

advantages were thought to include improved use of resources and better coordinated support and care for individuals, helping them to remain in control and live independent lives.

The evidence – setting the scene A number of studies published in the last ten years have explored a range of outcomes of the development of joint or integrated working between health and social care, with some looking in detail at the impact on, response of, and role of staff in the transition towards greater integration. The studies are diverse in terms of their setting, the type of organisational change, and the methods of evaluation.

The impact of integration on frontline staff – key messages

Frontline staff may be resistant to health and social care integration

Frontline health and social care practitioners may be reluctant to accept moves towards greater integration. This is related to the widely accepted idea that there is a large cultural, professional and organisational gap between staff in health and social care services, which organisations will need to acknowledge when working towards better integration. Health and social care staff and services differ in their 'collective beliefs and ideology, commonly accepted ways of doing things, and the myths and rituals of the organisation' (Field and Peck 2003). One example of this comes from a study evaluating the impact of two policy initiatives (the integration of health and social care services through the creation of Primary Care Groups and Trusts, and legislation in the 1999 Health Act giving greater flexibility to organisations working jointly) on services for older people. Staff were reluctant to embrace more collaborative ways of working, probably because they perceived threats to their domains of influence, their organisational culture and their professional autonomy (Glendinning 2003). One study participant said that 'you just sense people are putting up barriers to try and fight this off...because of the need to protect their own little empires' (PCG chief officer).

Between 2002 and 2005 Warne and colleagues carried out the three year study, 'Shaping the Future', in which they ran a survey and a series of semi-structured interviews with primary care staff (Warne et al 2007). Staff felt they were working within a 'constantly turbulent organisational and practice environment' resulting from the modernisation of the UK primary health care service and the drive to work in more integrated ways. The authors suggested that 'integrated health and social care is about the multiplicity of different agencies that all use different languages...different languages are the reality of joint working, but make joint working more difficult' - demonstrating why some staff might feel pessimistic about the transition to joint working.

Where the gap between health and social care cultures is not recognised and addressed by organisations, this can further widen the gap and so hinder the transition to joint working. In a study exploring practitioners' perspectives on joint working, Hiscock and Pearson carried out in-depth interviews with 98 health and social care workers across four sites. They found that the previously mentioned gap had actually *deteriorated*, potentially because of a lack of acknowledgement of it at the strategic level (Hiscock and Pearson 1999). Respondents reported a lack of or decline in motivation for joint working, and professionals were reported to have adapted by working 'in parallel' rather than jointly. Similarly, Field and Peck (2003) in a review of the literature relating to mergers and acquisitions in the private sector, wrote that 'far from achieving the local aspiration for a shared culture, the anxieties of some groups of staff were leading to more pronounced professional boundaries within the new organisation'. They suggested that the degree of cultural fit can strongly influence the extent of the success of the merger, and that 'a poor cultural fit can create considerable stress and result in staff experiencing a loss of morale, and of commitment'. As a solution to this problem, Glendinning recommended that for full integration to take place, differences in the terms and conditions of employment of local authority and NHS staff, including rights to employment security, pension entitlements and access to occupational welfare benefits, must be reconciled (Glendinning 2003).

Organisations' approaches to change can have an important influence on staff experience and morale

The evidence from the range of studies explored here demonstrates that organisational change can have one of three effects on staff morale: it can have a negative impact, decreasing morale; it can have a positive impact and result in increased staff satisfaction; or it can in fact have no impact at all, in cases where frontline staff perceive no change to their everyday roles and experiences.

There are a number of examples of cases where increased integration resulted in a decline in staff morale. Field and Peck (2003), in their review of private sector mergers, found that staff morale can decrease after a merger - 'the experience of company mergers suggests what to expect when health and social care organisations merge: that is, strategic objectives are rarely achieved; financial savings are rarely attained; productivity initially drops; staff morale deteriorates; and there is considerable anxiety and stress among the workforce'. Gulliver and colleagues (2003), in a longitudinal study exploring the impact of the creation of an integrated mental health and social care provider on the morale of staff members in Somerset, reported that one year after the creation of the Trust, staff reported poorer role clarity and job satisfaction, and an increase emotional exhaustion and depersonalisation for staff members involved. While Freeman and Peck found, using a pre-post survey of a merger, that staff perceptions of team effectiveness *increased* across Hertfordshire following the adoption of integrated provision (Freeman and Peck 2006), there were variations between localities – in particular the North-West and South-East regions seemed to report decreasing job satisfaction, which may have been linked to staff shortages and increased workload.

However, strategic level change does not necessarily have any noticeable impact at all. In a case study of the creation of a Mental Health NHS and Social Care Trust, Dickinson and colleagues carried out semi-structured interviews with 23 individuals including service users, unpaid carers, clinical, practitioner and operational staff, managers, executive and non-executive board members, and external partners. They reported that 'staff in the front-line services...did not perceive significant change' (Dickinson 2007).

Sometimes organisational change appears to result in a positive staff experience, but this is particularly noticeable in examples where organisational change was linked to new ways of delivering services at the frontline. For example, Hudson reported an evaluation of the Sedgefield Integrated Team, which brought together Sedgefield Primary Care Trust, Sedgefield Borough Council and Durham County Council to provide more integrated housing services, social care and community nursing services. In this project, staff working in mixed teams found that things happened more quickly in an integrated service, as channels of communication and access to shared information were better (Hudson 2007). This positive experience may have been accelerated by co-location, which was an important factor found by many studies to facilitate effective joint working. Staff who are co-located tend to experience greater mutual understanding and better communication, and more generally have enhanced working relationships (Hudson 2007; Freeman and Peck 2006). They may find that they share professional values which enable them to work together – Warne and colleagues reported in their Shaping the Future study that there was a commitment to working interprofessionally, with many respondents agreeing that individuals keep each other informed about what they are doing, the problems they experience, and progress towards shared objectives (Warne et al 2007).

Excluding frontline staff from the development of integration may reduce acceptance by, and benefits to, practitioners

Where organisational integration is imposed without consultation with practitioners, it is possible that integration may be less well received. If care is not taken, frontline social workers and healthcare staff can be excluded from experiencing the benefits of integration.

In Hudson's study, it was found that socialization to an immediate work group can override professional differences amongst staff but it was acknowledged that this worked particularly

well with this project as individuals were in the teams through choice: 'most of the team was "self-selecting" and there is the possibility that it may be unrepresentative of the wider professional communities' (Hudson 2007).

One study reported on the impact of a 'locality/area-based commissioning' model of joint health and social care commissioning upon professionals, service users and their families. In this model, GPs and other members of the Primary Care Trust became involved in commissioning all the health and social care services within a given locality (Rummery 1998). The author found that, while joint commissioning helped to foster inter-professional working as key commissioners had the chance to learn more about each other's roles and responsibilities, with greater awareness leading to reduced delays and frustration between professionals and an end to the 'them and us' culture; joint commissioning did not address the problems faced by professionals working at the frontline. Improvements in interprofessional working were not experienced by those staff who did not have commissioning responsibilities; gains were 'limited to the partners who were directly involved in joint commissioning'.

Where continuity is perceived, staff may be more likely to accept organisational change

Where continuity is perceived by staff, as opposed to organisational turbulence and disruption, practitioners are more likely to report a positive experience of organisational change – or indeed, as reported above, to experience no noticeable change at all.

Dickinson (2007) reported that in Stratham, the constant reassurance of continuity was important, as was an ongoing rhetoric about 'keeping the best of both' previous organisations, which reassured audiences that the new organisation would be better but familiar. The author suggested that the focus seems to be on creating comfort and consensus', an approach which was successful: 'at an operational level, the transfer of social care staff into the Care Trust was met with mostly positive feedback; indeed the management of this staff transition was widely believed to have been handled very effectively'. Conversely, however, too much continuity was perceived by some to be a negative thing: 'a chance to do things differently may have been missed by a perceived need to maintain continuity'.

Organisational commitment to change must be sustained, and followed through with careful planning at the frontline

A visible and clearly stated commitment to change at organisational level must be accompanied by careful preparation and planning, sustained funding and effective leadership, all of which must be maintained in order to ensure that frontline staff do not lose interest and motivation. One participant in the study by Warne and colleagues said that 'we are struggling on with our service redesign but we are not making much progress...over time it has become noticeable that many staff are no longer engaged in the process of trying to make it work...they seem to have lost interest and don't attend any of the meetings' (Warne et al 2007).

Projects must be considered as mainstream and long term. For example, Hudson reported that 'the development of the SIT team was funded in the short term by monies from an external source – the Neighbourhood Renewal Fund – and this made an important difference to what could be achieved' (Hudson 2007).

Where a commitment to change is maintained at organisational level, it must be followed through with relevant changes to support this change at a frontline level. As reported in Rummery's study, joint working at commissioning or strategic level is desirable but frustration is caused for frontline professionals by the failure to co-ordinate the planning and providing of services on the ground. In this study, it led to duplicated assessment visits, gaps in services provision, and failure to share vital information – so vulnerable service users were placed at risk (Rummery 1998).

Effective communication is crucial throughout the transition process

Where organisational change takes place, a clear message about what is happening and why needs to be communicated to all levels of staff in the organisation. Where this does not happen, it can lead to confusion and frustration. Warne and colleagues reported some negative experiences: 'I used to know what other people did, but its changed now and so many people have new titles and these don't mean anything to me so I no longer know what people do...if you don't know what people do you can't work together'. Another participant said that 'we need more clarity about our joint decision making processes, particularly joint decision making between different organisations', while a further interviewee reported that 'we don't get told anything; we are just expected to get on with whatever new change is flavour of the month' (Warne et al 2007).

Field and Peck reported that an appropriate response to staff concerns is crucial to success of mergers: 'staff want managers to communicate openly, to be sensitive to employees' concerns, to provide clear information about changes to the running of the organisation'. They found that clear and consistent information flows to staff can minimise the negative effects of change on motivation levels – organisations can see a fall in productivity of between 25 and 50 per cent during large scale change (Field and Peck 2003).

Gulliver and colleagues suggested that 'adequate communication of organisational aims and objectives is necessary to ensure team members remain focused on their role...team managers who express uncertainty about the function of the new organisation, as was the case in Somerset, are unlikely to be able to provide support by communicating the organisational goals to staff members'. In this case study, senior management acknowledged that managers and other staff members were inadequately prepared for integrated service provision, resulting in uncertainty being expressed about roles and the objective of the Trust (Gulliver et al 2003).

Positive and supportive management can play a key role in helping staff understand and accept changes

Effective management that is positive and supportive can help to improve frontline practitioners' experience of joint working. Leadership plays an important role: 'managers can shape perceptions of change' (Dickinson 2007).

The idea of 'organisational turbulence' was mentioned briefly above – this can be a negative factor, worsening staff perceptions of increased integration. Warne and colleagues (2007) wrote that practitioners' exposure to organisational turbulence needs to be contained; otherwise 'rhetorical defenses' are developed. They suggested that 'to effect changes in how individuals experience organisational turbulence, the manager is a crucial leader in physical and psychological terms in offering support and understanding to staff'. Organisations need to develop approaches that are about nurturing and respecting the individual during times of organisational turbulence and change. Similarly, Field and Peck (2003) argued that the behaviour of managers is important in determining how well staff adjust to change, and that staff need to be supported throughout the transition, while Glendinning (2003) wrote that 'major reconfigurations of services carried the risk of destabilising local provider organisations, including major disruptions to the professional staff who worked in them', and that 'organisational integration...needs to be accompanied by very considerable investment in supporting change among the people who deliver services directly to older people'.

The impact of other organisational changes on frontline staff must be considered

Often, organisational change relating to increased integration takes place among other types of change that have an impact on the working life and sense of job stability experienced by frontline staff (Dickinson 2007). Organisations must acknowledge these other influences that may make it difficult for staff to prioritise working towards integration, and explore ways of supporting them. Hiscock and Pearson found that preoccupation with instability and change within professionals' own organisations (i.e. perceptions of instability) make joint working a low priority. Where there is too much additional structural change going on, or indeed any other issues affecting people's daily working lives (e.g. changing workloads, environments, demands and expectations, feeling of job insecurity), 'the establishment of smooth and cordial

joint working with other agencies, which would require considerable investment of effort, was a low priority for professionals feeling stretched to the limits by other aspects of the health and social care reforms' (Hiscock and Pearson 1999).

Conclusion Organizational transitions towards more integrated health and social care services can affect practitioners in a range of both positive and negative ways, depending on the way the transition is facilitated. The following recommendations, based on the evidence described above, may help organisations to support practitioners in order to achieve a smoother transition:

- Organisations need to acknowledge and respond to the reality that some staff will be reluctant to accept greater integration
- The existing cultural and professional gap between health and social care must be recognised and addressed in order to make a successful transition
- Efforts must be made to support frontline practitioners during the transition period and in the subsequent months, to ensure that job satisfaction, role clarity, and morale do not decline
- Continuity and stability should be aimed for where possible
- Frontline practitioners should be involved, consulted and communicated with at each stage of the development of more integrated services, in order to feel a sense of ownership, rather than imposition, of change
- The momentum of change and organisational commitment to it must be maintained, and change at a strategic level must be accompanied by careful planning in terms of what will happen at the frontline
- Managers need to provide support to staff throughout the change process, encouraging a positive response to the transition towards more integrated services and helping staff adjust
- Organisations need to try to be aware of other factors that may have an impact on practitioners' working lives, and respond sensitively to these while taking developments forward

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