A Qualitative Evaluation of the Govan SHIP:

A Social and Health Integration Partnership Project

A report prepared by researchers from the Universities of Stirling and Glasgow.

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Executive Summary

Background

The SHIP project was developed in order to respond to the needs of patients with complex health and social needs living in the most deprived general practices in Scotland. The ongoing pilot/demonstration project is being implemented within Govan Health Centre, with the key aims of addressing the inverse care law via an integration model. This evaluation explores the key components of this model: linked social work (SW) and social care workers (SCWs), GP extra time and multidisciplinary team working (MDTs).

Methods

This evaluation took an ethnographic approach, informed by realist evaluation theory. Data collection consisted of unstructured (n=10) and semi-structured (n=21) interviews and non-participant observation at MDT meetings. The analysis drew on an interpretive approach and normalisation process theory (NPT) was used to frame the discussion.

Key Findings

MDT working, SW, SCW involvement and the additional time allocated to GPs worked in synergy to create an integrated model of working that shows promise for addressing the inverse care law. The extra time allows GPs to plan and address complex health and social needs, also drawing on the expertise of colleagues from other sectors within MDT meetings. The SW involvement in GHC met with key challenges that mainly arose from a lack of understanding of the current social work role, different perceptions of risk and vulnerability as well as a lack of knowledge about the eligibility criteria for access to services referred via SW. However, practice staff benefited from learning about these issues, resulting in GPs providing more incisively written referral requests that were more likely to meet SW criteria, as well as gaining an understanding of what patient issues might be better served by access to services within the third sector.

SCWs linked to GHC are a recent innovation that shows promise. There have already been examples of joint/collaborative working with practice/community-based staff that highlight the benefit to patients of working in an integrated way to prevent crises before they occur. The MDTs have also been adapted over time, revealing the propensity for the SHIP project team to learn and adapt the model over time. As the organisation and management of MDTs improves in efficiency, and with greater involvement of professionals across social work, secondary care and the third sector, the MDT offers a potential platform for integrated working.

Conclusions & Recommendations

The SHIP project met with challenges known to have affected integration projects elsewhere, namely, issues related to bringing together two formerly distinct sectors. However, there have been considerable benefits in gaining the knowledge and understanding crucial to moving forward with the integration agenda. As the SHIP project continues to evolve there are some key recommendations arising from this report that are worthy of consideration:

- The integration model would be better served by a wider constituency of professionals involved in planning and development going forward. Representation should go beyond GPs and SWs to include SCWs, nursing and key third sector organisations.
- There needs to be a stronger focus on planning prior to implementation in order to maximise staff engagement
- Key learning, achievements and successes should be shared with all associated staff

The tables below provide further detail of the learning gained from all stages of the project informed by Normalisation Process Theory, which is a theoretical framework that lends itself to presenting the lessons learned from complex interventions, from planning through to looking back at lessons learned from implementation. Following this approach, the recommendations are presented under the following headings:

- COHERENCE of the SHIP intervention model – initial understanding of aims and objectives
- COGNITIVE PARTICIPATION – investing or engaging in the intervention at the outset
- COLLECTIVE ACTION – the practical implementation of the model
- REFLEXIVE MONITORING – modifying and embedding the intervention and future prospects

Coherence of the SHIP aims and goals

SHIP Aims and goals	Understanding	Strategies for promoting coherence
<u>Strategic level aims:</u> **To promote integrated health and social care services via the GHC pilot; reduce hospital admissions and demands on GP time spent on social needs, anticipatory care.**	Differential understanding: GPs, SWs and stakeholders have full understanding; other practice and community staff focusing on integration of social work and general practice.	Involve all staff categories in planning, intervention development and pre-implementation activity.
<u>Values</u> **Addressing the inverse care law;** **Addressing the complex and health and social needs of GHC population;** **Better working relationships, better understanding.**	Although the core values and goals were agreed, the lack of consultation and involvement across all professional groups led to a variable understanding of what SHIP meant and *how* it would be implemented. Stakeholders and GPs use this language but the ethos of targeting care at those of most need also understood/valued by other staff.	Intervention planning should include matching goals to actions. Establish an intervention framework at the outset, matching elements of the intervention to *how* values/aims will be achieved.
<u>Intervention level</u> **SW linked to primary care**	All practice staff: expected rapid referrals/access to SW services; expected governance of SWs SW: advice, education re eligibility criteria; accountable to SW line management. Conflicting understanding at the outset undermined the potential to achieve shared goals.	**Example:** Planning *how* the MDT would work in practice. Consult staff from other disciplines to see what works in other sector MDTs such as community nursing, secondary care professionals.
SHIP time (GP extra time for extended consultations, case management, leadership and development)	Differential understanding: Addressing inverse care law; complex care planning for patient benefit (GPs and some other practice staff); some staff regard as exclusive GP benefit; variable equity of time distribution between GPs.	
MDT	Differential understanding: GPs: to achieve integrated working SW and other staff: adding to what already in place either formally or through informal networks	

Cognitive Participation: establishing engagement and buy in to the intervention

Mechanisms	Outcomes	Strategies for promoting cognitive participation
Initiation **Are key personnel working together to drive the initiative forward?**	All key personnel from senior stakeholders (SW, HSCP) through to frontline SWs, GPs, nursing and AHP staff are on board at the outset.	Shared goals and values ensure that all personnel are engaged from the outset.
Enrolment **Has engagement been achieved with key personnel?**	Initial enthusiasm for SHIP from all staff until they realise that they had misunderstood what would happen in practice.	Consensus building & ownership of shared values, understandings & outcomes is essential at all stages.
Legitimation **Is engagement such that others believe that they can contribute?**	Differential legitimation: GPs are fully invested and are driving the steering group. Project manager from HSCP has referent authority to manage change. However other categories of practice and community staff are not consulted/involved. SWs are initially involved in the steering group led by the GHC GPs. Engagement and planning at too high a level to prepare for implementation.	Interprofessional training & professional development is required to address poor understanding of others' roles. Top-down, policy-driven change may result in resentment and unwillingness to share tacit knowledge; need to involve all constituents in driving implementation at every stage.
Activation **Is engagement in the project maintained?**	Senior stakeholders and GPs continue to be engaged. SWs linked to GHC are removed from the steering group (perhaps a sign of deteriorating relationships). There is a change in project manager who has potential to act as boundary spanner but change is driven by GP led steering group. Increasing resentment from nursing as initiatives (e.g. MDT) regarded as a time burden with little perceived benefit.	Networking between historically hostile professional groups may help to build relationships. 'Boundary spanner' (neutral to professional interests) needed to drive change; has the ability to understand different cultures of working and facilitate positive relationships and networks.

Collective Action: the impact of implementation in practice

Mechanisms	Impacts	Strategies for promoting collective action
Shared goals and expectations about the form of work, what is a legitimate object of work, roles of participants, rules of conduct, beliefs about meaning of work, shared expectations about outcomes	***Different expectations*** about the form of social work (attachment/liaison) *Varying goals* - social workers aimed to clarify, share info and advise, GPs wanted them to react by accessing services or providing assessments, community nurses wanted a closer working relationship with social workers, joint planning etc. ***Different philosophies of care***: social workers feel their role is to identify strengths and promote independence (partic in adult work) whilst HPs believed SW role is to prevent risk *Different expectations of behaviour* – HPs and practice staff expected SWs to actively engage with them and become part of the practice; SWs expected to attend MDTs and that practice or NHS staff would consult them if necessary GPs and nurses wanted informal discussions; SWs avoided informal contact & wanted formal meetings ***Different beliefs about legitimacy of MDT*** – GPs feel they are essential focus for anticipatory planning; nurses felt they were generally not relevant to their practice ***Different meanings of SW priorities between SW practitioners and senior mgmt.*** – values & practice issues vs 'budgets and boundaries' SCWs seem to share HP expectations about early intervention, direct support, active navigation of SW system, patient focus, direct referral. Also seem to share beliefs about what are legitimate referrals SWs/team leaders disagreed that their role should include joint working, felt this was a luxury; SCWs felt joint working with DNs and HV was essential GPs, PNs, PMs unaware of SW knowledge or expertise or how they were using it. Lack of mutual respect between SWs and HPs for assessment of risk and vulnerability. SW dept felt the project required very experienced qualified workers who could use their experience to articulate and educate re SW roles, practices wanted workers who could navigate and explain the system, address vulnerabilities not yet eligible for SW intervention, say 'how can we help? SCW knowledge and contribution fits this expectation much more closely. Over time, (and increasingly) MDTs appear to demonstrate agreement about the expertise and usefulness of participants, accept practice as valid and create a collegiate environment (although not the case earlier)	Attention to joint CPD/shared learning would help to ensure all share realistic expectations of what can be achieved. Joint learning must emphasise different philosophies of care; achieve a shared understanding of risk, vulnerability and capacity; limitations on service access and eligibility criteria for SW referrals. Mutual respect is vital to effective integration, this may be fostered by joint learning sessions where all contributors are equally valued. SWs/SCWs require more autonomy to deliver 'enabling' social work practice. MDTs require careful planning and organisation in order to reduce time burden, demonstrate relevance and ensure that engagement is maintained across all roles/sectors.

Mechanisms	Impacts	Strategies for promoting collective action
Agreement about knowledge required, expertise and contribution of participants, what practice is valid, useful, authoritative ***Agreement about allocation of tasks and resources, hierarchies, definition of skill sets, autonomy of agents, quality of skills*** **Allocation of resource, distribution of risk, who has power, how work will be evaluated, who will be advantaged**	Agreement was reached pre-project but without clear understanding No agreement between GPs, SWs and other HPs about either nature of SW tasks or whether these could/should be allocated by MDTs, taken on by SWs at MDTs or allocation reserved to SW managers. Different levels of autonomy between participants; SWs and nurses have insufficient autonomy to be full partners. SCWs seem to have more autonomy than SWs. Skill sets of SWs/SCWs not understood by other professionals. Skills/expertise (eg around workstreams, MDT working) not recognised or shared. Project manager not given due authority to act as boundary spanner and drive change. Resources seen (by nurses particularly) to be allocated mainly to GP partners Different sources of authority – GPs, SW managers, community health managers Disagreement about who should have control. Project manager had only referent authority. SW dept/SWs had greater risk as more exposed to public scrutiny/misunderstanding, less well resourced, more uncertain about place in integrated services. Little advantage to SW dept Nurses felt little advantage to them GPs seen as main beneficiaries; some HP acknowledgement of patient benefit.	SWs/SCWs can demonstrate collegiality and willingness to help by advising on the information necessary to achieve relevant referrals. Shared information across sectors can also reduce staff anxiety and improve relationships. Leadership should be driven by an individual without vested interest in either professional group/sector where possible. The 'boundary spanner' should be given the power to drive implementation processes. Care should be taken to demonstrate benefit for both key sectors and to all personnel. Patient-centred care should be emphasised as a shared value and goal at every opportunity.

Reflexive Monitoring: looking back at the experience of implementation

GPs and stakeholders within the HSCP, academic general practice and the social work department show development and learning from this experience:

- a positive change in knowledge, attitudes and behaviours
- benefit restricted to GPs and senior management with capacity to maintain cross sector networks. Unfortunately, many of the other staff linked to the GHC adhere to negative attitudes towards SW and feel increasingly frustrated and disempowered by an intervention that affected them as individuals but over which they had little or no ability to change. Team leaders in SW are the exception to this, as they appear to have maintained a commitment and positive attitude towards the project and continue to play an important role in generating improved relationships.

Reconfiguration

This aspect of SHIP demonstrates the dynamic nature of the remaining SWs involved and the GPs in three of the four practices who remained engaged in the intervention. Adaptations have been made to MDTs to reduce the time burden on attendees and there are indications that they may eventually become more collaborative in organisation and leadership rather than remaining solely GP led. This may help to maintain or revitalise engagement across all professional groups. The introduction of SCWs also highlights a positive response to an initially 'bruising' encounter between SW and general practice and there are early indications that many of the initial (misguided) expectations of SWs may now be met by SCWs. The caveat remains that access to services will still require meeting eligibility criteria, although it is clear that GPs at least now understand the pressure on services and the thresholds for access to these. Shared learning has also taken place to ensure improved quality of information provided in SW referral requests and time will, it is hoped, no longer be wasted by poor information provision or a lack of understanding of risk thresholds. Unfortunately, it appears that this learning has not been shared more widely, and although there have indeed been some positive examples of collaborative working between SWs/SCWs and other HPs within GHC, nevertheless work remains to be done to undo negative perceptions, disappointments and frustrations experienced by other staff during the course of SW integration.

Strategies for promoting reflective monitoring

Shared learning events and dissemination (highlighted in several sections above) may help to address remaining tensions and negative experiences.

Efforts should be made to involve all categories of staff in consultations and planning going forward in order to maximise learning from other professional, integrated networks such as those pre-existing among nursing staff and SW/SCWs.