

Evidence scan:

Cross sector working to support large-scale change

August 2012

Identify Innovate Demonstrate Encourage

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Health Foundation evidence scans provide information to help those involved in improving the quality of healthcare understand what research is available on particular topics.

Evidence scans provide a rapid collation of empirical research about a topic relevant to the Health Foundation's work. Although all of the evidence is sourced and compiled systematically, they are not systematic reviews. They do not seek to summarise theoretical literature or to explore in any depth the concepts covered by the scan or those arising from it.

This evidence scan was prepared by The Evidence Centre on behalf of the Health Foundation.

Foreword

The Health Foundation promotes innovation to improve quality in healthcare. Large-scale change is often spoken about within health services, but it remains uncertain how to promote and sustain such change. The Health Foundation is embarking on a programme to explore whole health economy change.

As part of this work programme we were interested in learning about the main types of cross sector work that has been researched and the factors that may help and hinder transformational change.

This evidence scan was undertaken for us internally, to help us plan our work. We are making it available to a wider audience, but wish to emphasise a number of caveats.

Firstly, the material was prepared for our own internal purposes and therefore focuses on the things that interest us most.

Secondly, all conceptualisation, searches, analysis and reporting was completed over a two-week period in February 2012.

Thirdly, the scan did not aim to be exhaustive but rather to identify key themes for us to explore further in our work. We are aware that the scan does not cover all of the literature on this topic, but we are making the work accessible because we have found it helpful and think that others may also benefit from the lessons, particularly in terms of factors that facilitate or hinder the adoption and spread of large-scale change.

Over time, we will be undertaking more work on whole systems change which we hope will help support transformation at a practical level.

Key messages

Whole health economy or cross sector working is often promoted to support large-scale transformational change. This evidence scan provides empirical examples of cross sector working to improve care.

Approaches

The scan includes 139 empirical studies sourced from five bibliographic databases searched in February 2012. The broad approaches to cross sector working that have been researched include:

- merging organisations
- networks or collaboratives of individual organisations working together towards joint goals
- organisations providing services together or one-stop shops, with each organisation maintaining a distinct role
- joint appointments between organisations, such as joint directors in health and social care
- teams with personnel drawn from different organisations and sectors
- liaison or coordination roles.

There is little comparative information about the pros and cons of these approaches.

Facilitators and barriers

Factors that help or hinder organisations to work across sectors include:

Leadership and vision

- strong leadership and champions
- a clear vision and shared goals
- good change management
- engagement of stakeholders
- not taking a top-down approach

Culture and attitudes

- shared culture between organisations
- building relationships and communication
- allowing time to build relationships and trust
- buy-in from managers and clinicians
- avoiding jurisdictional battles.

Staff roles and training

- clear roles and responsibilities
- joint training and ongoing support for staff
- addressing challenges to professional identity
- avoiding role confusion.

Infrastructure and processes

- adequate time and financial resources
- systems to share information and IT
- co-location
- alignment of financial and other incentives
- joint processes, such as single assessment.

1. Scope

This evidence scan provides examples of large-scale change and more localised cross sector projects, showing how health organisations are working with others to innovate and improve the quality of care.

1.1 Purpose

There is widespread interest in working across health economies, sectors and organisations to provide more efficient and effective care.^{1,2} Policy documents and articles published around the developed world often espouse the potential benefits of cross sector work³⁻⁷ or suggest that large-scale transformational change is only possible when organisations work jointly.⁸⁻¹¹

However, despite such a focus on whole health economy and cross sector working, relatively little empirical evidence has described examples in any detail.

This evidence scan provides a picture of research into cross sector working to support innovation and change. It describes empirical examples of how organisations are working together, across disciplinary or sector boundaries, to support innovation or improve the quality of care in the UK and elsewhere.

The scan addresses the questions:

- What examples have been published about cross sector working to support change in healthcare?
- What evidence is available about the facilitators and barriers to cross sector working?

The aim was to identify:

- places that have set out to achieve transformational improvement on a system-wide scale
- how teams defined the system they were trying to change

- particular techniques and approaches used
- the results achieved
- the risks associated with improvement on this scale.

1.2 Scope

The scan provides a rapid collation of empirical research about cross sector or whole health economy working. We defined this as a change in systems or processes that involves joint work between organisations from different parts of the health service or organisations from other sectors such as social care, education or voluntary services.

We were particularly interested in studies that had certain characteristics relating to the stakeholders involved, the scope of the service and the level of change:

- **Stakeholders:** We were interested in studies that involved two or more sectors within a health and social care setting such as primary care and secondary care, local authorities and mental health services. Studies that included other partners, such as the voluntary sector, were also of interest.
- **Service scope:** We were interested in services that spanned more than one clinical area or covered just one clinical area but required multi-partner input.
- **Level of change:** Our primary interest was large-scale change involving fundamental shifts in the type of care offered, the way care was delivered or the processes and systems supporting the delivery of care. We were interested in initiatives that aimed to achieve ‘transformational’ improvement rather than merely a simple, known change in processes or structures.

Our search criteria were flexible to allow for the fact that few studies may be strong in all of these areas. The paucity of evidence available about large-scale change meant that we also included examples of cross sector working on a smaller scale, where organisations worked together to improve a certain service, care pathway or the support available for people with specific conditions. The rationale was that the lessons learned from this type of cross sector working may also be applicable when considering the facilitators and barriers of scaling up such change.

All of the evidence was sourced and compiled systematically, but the scan is not a systematic review and does not seek to summarise every study about this topic.

Examples fell into two broad categories: those that focus on large-scale change in systems and those that describe cross sector working to improve specific processes or services. The review is organised accordingly, with one section on each.

This section outlines the methods used to identify relevant research. The next section provides examples of large-scale systems change that have been described in the empirical literature. Following this, smaller scale examples of organisations or teams working together across sectors are explored. The scan concludes with a description of research into the facilitators and barriers to cross sector working.

1.3 Methods

The scan focused on research articles published in journals in the UK and internationally and was completed over a two-week period.

To identify relevant research, one reviewer searched five bibliographic databases for studies of any design published between 1990 and mid-February 2012. The databases comprised Medline, Embase, the Cochrane Library and Controlled Trials Register, Google Scholar and Web of Science.

Search terms included combinations of whole health economy, cross sector, across sector, organisational boundaries, joined up services, inter agency, multi-agency, whole system, large scale, integrated, network, seamless, cross organisation, inter sector, inter organisation, collaboration, health economy, health and social care, health and social services, transformational change, joint working, partnership work, multi organisation, voluntary sector, third sector, system level change and similes.

To be eligible for inclusion, studies had to be readily available empirical research from developed countries. Articles that described potential approaches to cross sector working but did not contain empirical data were not included.

Due to the paucity of empirical material available, descriptive case study material was eligible for inclusion if it provided sufficient empirical details about cross sector working.

More than 5,000 articles were scanned. In total, 139 empirical examples met the inclusion criteria and additional contextual material was also summarised.

Findings were extracted from all publications using a structured template and studies were grouped according to key themes to provide a narrative summary of trends.

For consistency, we used the term 'cross sector working' throughout the review, rather than large-scale change, partnership working, integrated care, whole systems approaches or other similes.

2. Large-scale systems change

This section provides examples of research about large-scale systems change designed to improve patient care.

A number of programmes are working across the health, social care, voluntary and private sectors and some large-scale structural changes have been undertaken to integrate care, particularly for older people, children and people with mental health issues in some parts of the US and UK.^{12–16} However, there are relatively few published research articles detailing this type of large-scale transformational change. These approaches may have been written about in policy and planning papers, internal documents, grey literature or unpublished evaluations but this type of material was outside the scope of this evidence scan. Thus readers should bear in mind that the examples contained in this section are limited and based only on empirical work that has been formally published in journals.

Furthermore, the available examples tend to include little detail about the approaches taken and the successes and risk factors.

The approaches to cross sector work to support large-scale change that have been researched include:

- merging organisations or setting up departments with personnel drawn from different organisations and sectors
- networks of organisations working in partnership towards joint goals. This may include organisations working together to provide services in partnership
- multidisciplinary teams of professionals drawn from different sectors
- joint appointments between organisations, such as joint directors in health and social care.

The majority of available evidence is about organisations working together to provide a specific service so this section is organised according to the sectors involved. The aim is to highlight key learning points and signpost the reader to publications where further information is available rather than providing full details of each initiative.

2.1 Health and social care partnerships

Structural integration

Merging health and social care organisations or specific departments has been tested as a way of improving effectiveness and efficiency. In England, the purchasing of health and social care services has been separated from delivery. There are different organisations for commissioning versus service provision. In some regions, health and social care commissioning functions are now undertaken by one organisation. Other organisations combine commissioning for all children's services. The assumption is that if two or more commissioners can jointly shape their programmes, they will be better able to promote integrated provision across a range of separate agencies and professions. However, despite much policy rhetoric about joint commissioning and cross sector working, evidence suggests a paucity of achievements to date.¹⁷

Children's services in England have also been undergoing structural reform. Children's trusts have been set up to provide integrated commissioning and delivery of health, education and social services for children. A three-year evaluation of 35 pilot children's trusts included 172 interviews, surveys and document review. All trusts appointed established boards with representatives from multiple agencies.

In most areas, different agencies jointly commissioned children's services, especially in the areas of mental health, disabilities and children's centres. However, health services were generally less involved in joint work than local authorities. Areas where local authorities and health organisations had shared geographical boundaries progressed best. The provision of multiagency and multiprofessional services increased over time. Professionals supported these changes, but found them stressful. The evaluators concluded that children's trusts enabled major changes in areas where local professionals and organisations were motivated and empowered. In other areas, the remit was sometimes too broad to overcome entrenched organisational and professional divisions.¹⁸

Joint roles

A number of services in England have tested the value of joint appointments for senior roles in health and social care. While articles have noted that these roles exist, little data are available about the value of such joint appointments or the barriers and facilitators.¹⁹

The development of primary care trusts in England provided an opportunity for more joined-up working between health and social care and between different types of health services. However, a survey and case studies found that social services representatives had limited input into primary care trust boards and decision making. Greater organisational stability and time was needed to form effective partnership arrangements.²⁰

Integrated teams

Another strategy for wider systems change involves co-locating services or supporting professionals from different organisations to work in combined teams. For example, two integrated and co-located health and social care teams were set up in a rural part of England to meet the needs of older people and their carers. Evaluation found that patients assigned to integrated teams may self-refer more and be assessed more quickly. In integrated teams, the assessment process was improved through better communication, understanding and exchange of information among different professional groups. This suggests that the 'one-stop shop' approach can

improve access to care. However, integration was not well developed in these teams and there was no impact on clinical outcomes. The researchers concluded that measures such as co-location are not sufficient to produce changes in outcomes for older people. More major structural changes may instead be required, including more efficient and compatible information systems between health and social care.²¹

Other countries have also tested programmes of joint work between the health and social care sectors including the Program of All-Inclusive Care for Elderly People (PACE) in the US and the *Système de services intégrés pour personnes âgées en perte d'autonomie* (SIPA) and the Programme of Research to Integrate Services for the Maintenance of Autonomy (PRISMA) in Canada.

In these programmes, multidisciplinary and multisector teams were associated with improved access to services, better care provision and quality, improved health status and high satisfaction among older people and their carers.²²

PACE is a government-funded community-based programme that aims to provide comprehensive acute and chronic care services coordinated by an adult day centre. An evaluation found improved health outcomes and decreased hospital inpatient and nursing home use but increased use of outpatient medical care, and home- and community-based services.²³

In Canada, the SIPA offered primary care services from a social services community centre, including case-managed care for frail elderly people who needed comprehensive acute and chronic care.²⁴ A randomised controlled trial found increased access to home- and community-based services, reduced hospitalisation of people who could be cared for elsewhere ('bed blockers'), decreased use and costs of A&E and inpatient care. There were no differences in health outcomes.²⁵

Another example from Canada is the more loosely structured Programme of Research to Integrate Services for the Maintenance of Autonomy (PRISMA).²⁶ This is a case-managed network of healthcare and social services for older people with a single point of entry. Evaluations suggest reduced institutionalisation but little effect on health service use or survival.²⁷

2.2 Health organisations working together

Structural integration

Structural integration in healthcare involves extending the scope of an organisation's activities, for instance when hospital and primary care services become part of a single organisation.^{28,29}

In the US, integrated primary and secondary care is standard in many regions, with managed care organisations providing a wide range of preventive, primary and secondary care. For example, the Kaiser Permanente model integrates prevention, diagnosis and treatment. Medical specialists work alongside general practitioners in multidisciplinary medical groups, rather than being tied to specific hospitals. Doctors have rapid access to diagnostic services in the outpatient setting, so many patients do not need to stay in hospital.³⁰

Integrating primary and secondary services in this way may improve health resource use and reduce costs. Comparisons of the Kaiser Permanente model of integrated care in the US versus NHS models have found that integrated care is associated with more comprehensive and convenient primary care, more rapid access to specialist services and less use of hospital services.³¹

Working collaboratively

Some countries have developed programmes that seek to take a whole systems approach regarding specific issues such as long-term conditions, children's services, older people's care or patient safety. For instance in the 1980s, Sweden set up the National Safety Promotion Programme and established a cross sector advisory group. There was a focus on developing cross sector initiatives to improve safety awareness and to measure and report on performance. In the 1990s, the programme was transferred to the National Institute of Public Health and then to the Swedish Rescue Service Agency. However, within the Rescue Service Agency the programme lacked a cross sector work orientation and was ultimately closed down.³²

In England the Early Support programme aimed to improve multiagency working for children aged up to three years with a disability. A national evaluation of 46 pilot programmes used repeated surveys nine months apart, focus groups with service providers and parents, and analysis of routine data and costs. The evaluation found that targeted provision can be useful within integrated children's service structures, but it is important to build in sustainability from the outset.³³

In Ireland the National Centre for Youth Mental Health facilitated changes in mental health services for children. Following a needs assessment, five demonstration sites were set up in four counties and a city neighbourhood. The sites undertook partnership work across sectors.³⁴

In the US a number of states have set up public health institutes and a national network is being created. For instance, the Louisiana Public Health Institute (LPHI) was set up as a cross sector governance structure for improving public health.³⁵

One US state has developed coordinated care systems for people with mental retardation and a different major mental illness. Joint mental health, developmental disabilities and substance abuse services have been set up to coordinate health, housing, social and vocational services. A single point of entry and interagency councils have been developed. A survey of 100 programme leaders found extensive partnership working and better access to care.³⁶

Elsewhere in the US, a centre has been set up to plan for crisis situations with nine teams drawn from public health, emergency medicine, emergency management, hospitals and public safety agencies. Each team works on a strategic issue for one year to build capacity within the region. There have been more integrated responses to crisis situations but barriers included different organisational cultures and issues with jurisdiction.³⁷

2.3 Other statutory partnerships

Cross sector work across other statutory services has also sought to make major systems changes. For instance, health and social care organisations are taking part in crime reduction partnerships in England. A review of crime reduction partnerships such as Drug and Alcohol Action Teams (DAATs), Crime and Disorder Reduction Partnerships (CDRPs), Multi Agency Public Protection Arrangements (MAPPAs) and Youth Offending Teams (YOTs) found that differences in ethical and professional outlook were a major barrier to partnership working and were the least likely factor to be addressed in planning and policy.³⁸

The Social Exclusion Unit in England was a government agency developed to work across organisational boundaries to address health inequalities. However, analyses suggest that centralised joint working was not effective and public health programmes were not well coordinated with wider government initiatives. Public health teams were excluded from much of the work around social exclusion, perhaps due to poor coordination between the Department of Health and the Cabinet Office and a lack of understanding among other services about the role of public health teams.³⁹

In the UK there are guidelines for early intervention services for people experiencing their first episode of psychosis. In order to implement these guidelines, integrated work is required from a number of organisations including health services, social care and child and adolescent mental health services (CAMHS). Interviews with 142 managers and clinicians and six focus groups with professionals showed that health services found it difficult to develop partnerships with CAMHS. The most successful approach involved developing a separate service focused on young people that included many sectors under one roof, such as education, employment guidance, social activities, pregnancy services and peer support. Factors that supported successful whole systems working included joint learning and training, senior people who championed the partnership, joint operational policy and protocols and using

link workers to liaise between organisations. The researchers concluded that top-down approaches do not work well to encourage cross sector work. The most successful model required an innovative approach to commissioning, policy implementation and service development.⁴⁰

In England, a network was set up of agencies and professionals supporting students in higher education with mental health needs. Cross sector working was thought to be the best way to help students with mental health needs continue their studies, but barriers included resource limitations, professional identities, work boundaries, role confusion, codes of ethics and confidentiality.⁴¹

Examples are also available from other countries. In Canada, the health and education sectors collaborated to provide wellbeing services in schools. The Pan Canadian Joint Consortium for School Health is a cross sector collaboration to coordinate policy and funding from the health and education sectors. Government departments worked together to reduce duplication and minimise gaps in policies and practices.⁴²

Canada has also set up a collaboration among mental health, alcohol and drug treatment services, corrections, forensic, and social and housing agencies to support people with complex issues. The aim was to improve interagency communication and develop controls to increase the efficacy of treatment and reduce the cost of care. Agencies referred clients to the Multi Service Network and people were then screened to ensure that there were no gaps or crossovers between agencies. Case conferences were used to develop individual service plans. Evaluation found improved information and communication between agencies and reduced cost of care.⁴³

2.4 Working with the voluntary sector

Large-scale change has been attempted with input from the voluntary sector. For instance, in Wales, an innovative approach was tested to transform systems and services in deprived communities. ‘Top-down’ approaches have not been successful for reducing inequalities in health so two areas in Wales used a community development approach

to support change. The initiatives built on existing community forums and focused on the whole community and its relationship with the statutory and voluntary sectors. Local people were trained to interview community members about their needs. The findings were used by cross sector panels to write action plans and these were disseminated to commissioning organisations. An evaluation using data collected before and after the initiative found that communities were able to produce and disseminate action plans based on locally identified needs. The process took longer than planned and in the short term there were few concrete changes. However, cross sector working developed and the process was well received by commissioners. The average cost of the initiative was £58,000 per community per annum.⁴⁴

2.5 Public and private partnerships

The NHS Local Improvement Finance Trust (LIFT) programme developed partnerships between the public and private sectors to increase investment in English primary care facilities. Researchers found that public and private sector organisations had different organisational cultures which impacted on joint working. However, partners in LIFT organisations tended to work well together, with neither side dominating. It was important to manage differences in organisational culture in order to sustain partnerships.⁴⁵

In the NHS, commercial organisations can be awarded contracts to deliver health services through the Independent Sector Treatment Centre programme. This strategy aimed to create large-scale change in elective care. Interviews with NHS managers and staff from an independent centre found that such centres have a different relationship with frontline clinicians because they counteract professional power relations. The centres introduced new routines that are not based on the norms of professional disciplines, but they may limit cooperation across organisational boundaries.⁴⁶

Another example is a pan-American forum of partners from the public and private sectors coordinating improvement efforts for people with long-term conditions. The Pan American Health Organization and the World Economic Forum have set up the forum in partnership with member countries, government departments and private sector organisations.⁴⁷

2.6 Policy and research partnerships

Cross sector partnerships have also been tested at a strategic level in the field of health policy and research. For instance in Canada, the Coalitions Linking Action and Science for Prevention (CLASP) initiative was set up to support research, practice and policy innovation related to cancer. The programme was implemented in three stages. The first stage included consultation and networking using concept mapping and workshops with more than 500 researchers, practitioners and policy specialists. This was important for encouraging knowledge exchange across jurisdictions and sectors. As a result of people's feedback, new priorities for cancer prevention and care were identified and new funding streams were developed.⁴⁸

This section has described examples of cross sector work that aimed to have relatively large-scale or system-wide impacts. The approaches tested most frequently include merging organisations and departments, sectors jointly providing integrated or coordinated services and multidisciplinary teams. There is little empirical evidence comparing the pros and cons of these different approaches.

3. Localised cross sector working

This section provides examples of organisations working together across disciplines or sector boundaries to improve patient care.

Research detailing whole-systems approaches to large-scale change is somewhat sparse. More has been published about how various organisations have worked together to improve specific services. This section provides examples of cross sector working to improve a specific service or care pathway. It is important to note that this section does not aim to be exhaustive. There are many examples available of how primary and secondary care have worked together, or how GP practices have worked with voluntary services or social care to support particular groups of people, for example. This section aims to provide a flavour of the examples of cross sector initiatives available, particularly where there are implications for whole-systems change.

The examples in this section are divided into:

- different levels of health services (primary and secondary care) working together
- health organisations working with other services to improve care
- cross sector working to improve training and development.

3.1 Health organisations working together

Cross sector work within healthcare takes place in a variety of ways, including:

- joint working between organisations to provide a specific service
- networks of organisations supporting improvement initiatives
- teams drawn from multiple disciplines or organisations

- new staff roles that coordinate care or provide links or liaison between services
- tools to support joint working such as integrated care pathways.

Examples of each type are described briefly in turn.

Organisational joint working

There are many examples of different levels of the health sector working jointly to improve care. Partnerships between primary care and hospital services are becoming common.

For instance, intermediate care was introduced to reduce the use of hospital services and long-term care in England. In one city, intermediate care comprised a multiagency joint care management team assessing patient needs and purchasing support and rehabilitation from sector-based teams. But a comparison of outcomes for a group of 800 older people before and 848 people after intermediate care was introduced found similar clinical outcomes, hospital and long-term care between groups.⁴⁹

Another example is a project spanning primary and secondary care which aimed to improve services for people with diabetes. Ninety-three GP practices in one part of England audited their records to establish the prevalence of diabetes and potential improvements in care. A citywide diabetes register was set up, referral guidelines were developed across primary and secondary care and a programme of integrated primary and secondary care services was tested.⁵⁰

Elsewhere in England an integrated nurse-led primary and secondary care service increased referrals to smoking cessation services and encouraged people to quit. Joint working was a key component as was training to ensure staff had a shared vision.⁵¹

In the US, a healthcare system offered dialysis services in a variety of settings including in hospital, on an outpatient basis and in the community. An evaluation found that it was useful to use clinical data to match patients with services that would best meet their needs, rather than assuming that everyone needed to be treated in hospital.⁵²

‘One-stop shop’ approaches to offering services are another example of whole health economy working. In Scotland a multidisciplinary clinic was set up to support pregnant women who used drugs. The majority of women reduced their drug use. Interviews with 12 women found that they preferred the one-stop shop to traditional antenatal care in general practice and thought that the multidisciplinary approach had helped them reduce their drug use.⁵³

Some examples focus on bringing secondary services into primary care venues. Genetics services have traditionally been offered in specialist care but there is a move to make these services more accessible through primary care. Eleven case studies in England tested integrating genetics into ‘mainstream’ primary care. Barriers included a lack of interest among primary care staff, national targets that focused the attention of primary care teams elsewhere and service structures that made genetics a peripheral concern.⁵⁴

In Norway, GPs took part in teleconsultations with hospital specialists. In one region teleconsultations were set up when GPs needed to discuss a particular issue with specialists. In another area they took place during the specialists’ daily morning meeting. An evaluation found that regular use of teleconsultation provided greater access to specialist services and increased knowledge for decision making.⁵⁵

Cross sector working between primary care and community services has also been tested. For instance, one region in England tested offering preventive health checks in community pharmacies rather than GP practices in order to target hard to reach communities. Interviews with primary care and pharmacy staff and managers suggested a number of challenges including IT barriers, greater

costs than expected, issues developing confident and competent staff and problems ensuring adequate volume and flow in pharmacies.⁵⁶

In Australia a programme was developed to facilitate teamwork between general practice and allied and community health professionals. Twenty-six urban practices took part. Data from record review and interviews found that facilitating teamwork across organisational boundaries was challenging. The quality of relationships between professionals was a key success factor.

Joint training and direct communication between professionals helped to strengthen relationships. Practice nurses played a key liaison role between general practices and allied and community health services. Paper-based records acted as a barrier to building relationships and sharing roles.⁵⁷

A health promotion centre in Australia drew on professionals from different health organisations. Agencies voluntarily entered into relationships to pursue joint goals. A key success factor was setting up the centre as a coordinating unit and establishing and maintaining interactions between partner agencies. The centre emphasised the independence and power of members and sought to build trust and support. There was not a ‘top-down’ or centralising philosophy.⁵⁸

Other examples of cross sector working have occurred in mental health services. A survey of 376 managers of community mental health teams for older people in England found that there has been progress in integrated working across organisations, but most teams could not access local authority service user records. Health staff were usually not allowed to commission social care services. Teams with the lowest levels of integration tended to work across multiple local authorities, be managed by a nurse, have high referral rates and be located in formally integrated care trusts. The authors concluded that integration may improve if health and social care organisations shared information and delegated the power to arrange social care services.⁵⁹

Networks

Another form of cross sector work involves networking, either remotely or in person.^{60, 61} For example, managed clinical networks have been developed where multidisciplinary teams of healthcare providers work together to provide or evaluate care, cutting across organisational and professional boundaries.⁶²⁻⁶⁴ This approach is popular in Scotland. An example is the Scottish Home Parenteral Nutrition Managed Clinical Network, which is responsible for organising and quality assuring services. This clinical network focuses on collecting audit data and improving equity of access through guidelines and protocols.⁶⁵

Evaluations have found that it can take a great deal of time and effort to set up and maintain clinical networks.⁶⁶⁻⁶⁸ Commitment from professionals is a key success factor and 'mandating' clinical networks is rarely useful.⁶⁹ To be most effective, research suggests that networks should be developed from frontline staff upwards and focus on building communication and trust.⁷⁰

Integrated health services networks have been studied in Canada. One project found that GPs should be involved in any healthcare network. GPs were more likely to participate if they thought that the networks had positive impacts, if the implementation process was easy and if they had good relationships with other network members. Barriers to GP participation included a lack of information about networks and difficult relationships with hospital colleagues.⁷¹

In Sweden 'chains of care' networks have been set up whereby providers from different organisations and teams work together to deliver care and support, often virtually.⁷² In contrast to clinical networks in Scotland and other places, in Sweden there are contractual relationships between commissioners and providers taking part. Commissioners set up a 'chains of care' agreement which specifies planned volumes and costs. Payments are based on the care provided across the whole system so that there are incentives to develop cost-effective care pathways.⁷³ A key barrier to these types of networks is lack of buy-in from clinical and managerial staff, especially doctors.⁷⁴

Studies in the Netherlands found that both hospital specialists and GPs prefer informal networks with each other rather than structured approaches.^{75,76}

Multidisciplinary teams

There are many examples of teams being set up across parts of the healthcare system, particularly combining hospital and primary care professionals.^{77,78} This may involve professionals working together day by day or more 'virtual' teams, where care is coordinated across multiple professionals who remain in their distinct organisations.

There is some evidence that sharing care between multidisciplinary teams can improve outcomes. A systematic review of 11 randomised trials with 2,067 people with heart failure found that multidisciplinary programmes reduced admission to hospital compared with conventional care.⁷⁹

Another meta-analysis of multidisciplinary follow-up programmes for people with heart failure included 11 randomised trials of joint work by family doctors, heart specialists, nurses, pharmacists, dieticians, physical therapists and social workers. Multidisciplinary follow-up programmes were cost effective and were associated with fewer hospital admissions.⁸⁰ A number of other studies have found positive changes^{81,82} and suggested that multidisciplinary care is cost effective.^{83,84}

But not all evidence is positive. Other trials and reviews have suggested that improvements may be mixed or small scale at best and that teams of professionals from varying organisations do not improve overall health service use and outcomes.⁸⁵⁻⁹⁰

Staff roles

Professional roles have been developed or expanded to support cross sector work. Discussion sessions with 113 nurses, midwives and health visitors in England identified many examples of cross-boundary working but professionals said that there were strong intra-organisational boundaries across the health service.⁹¹

In response to staff shortages and funding issues, support worker roles are being developed in rehabilitation and intermediate care services in England. A joint project between a primary care trust, a hospital trust and social services in one region introduced 30 support workers in rehabilitation services. Training took 18 months. Fifty-five interviews with patients, support workers and other professionals found that the new role was well regarded. Several factors influenced the acceptance and integration of the new role including prior experience and the degree of role change, familiarity, relationships with other staff, role distinction, role contribution, resources and management.⁹²

Tools to support integration

Integrated care pathways are a tool that may support cross sector working. Such pathways map out a patient's journey to improve coordination. They aim to show how the 'right people should be doing the right things, in the right order, at the right time, in the right place, with the right outcome.'⁹³

A review of five studies found that integrated care pathways can ensure that people who suffer a stroke receive relevant assessments or clinical care in a timely manner, and can improve the documentation of rehabilitation goals and communication with patients, carers and GPs after discharge. Integrated care pathways may help to clarify role boundaries and provide a shared understanding of the work. They may also help to improve professional behaviours. However, such pathways can create additional workload and in situations where multidisciplinary working is already effective, they may have limited additional benefits.⁹⁴

But integrated care pathways may not overcome wider organisational barriers to cross sector working. A study of an integrated care pathway to support joint working in community mental health teams in Scotland found that staff and managers had positive views about joint working and the potential of integrated care pathways in theory, however teams were not implementing the care pathway in practice. Barriers included a lack of integration at higher organisational levels

which created conflicts within the teams, a lack of resources for ongoing support, insufficient team development and a lack of change management.⁹⁵

Another study of community mental health teams in one Scottish region and care of the elderly rapid response teams in three Scottish regions found that the impact of integrated care pathways was shaped by organisational dynamics. In community mental health teams a prescriptive management-driven integrated care pathway was introduced and was resisted by teams. In rapid response teams a flexible, team driven pathway was introduced. This approach fitted with the autonomy and task sharing in rapid response teams and uptake was good. However, management did not engage with the pathway.⁹⁶

3.2 Other statutory partnerships

Health and social care

There are many examples of cross sector working between health and social care to deliver specific services in England.

The National Service Framework for Older People requires health services and local authorities to agree on programmes to promote wellbeing in older people. An evaluation of one interagency health and social care team delivering health promotion in primary care found that multiagency partnerships have the potential to improve the quality of life of at-risk older people.⁹⁷

Integrated care pilots were also set up in England to transform the way people experience health and social care. One area developed a multidisciplinary project focusing on memory loss and dementia in older people. Professionals thought that there were many benefits from working as part of a cross sector team, including increased knowledge, wider experience and support.⁹⁸

In England, housing support workers are part of social care teams and aim to work across organisational boundaries. However, an evaluation of the Supporting People Health Pilots found that it is challenging to work in cross organisational roles due to culture, funding and operational issues.⁹⁹

Another programme in England was set up to offer housing support and outreach services for homeless people with HIV. There were challenges working across housing, health and social care boundaries. Interviews and document review emphasised the importance of the local joint working context, the involvement of the voluntary sector and the role of the support workers in facilitating positive outcomes.¹⁰⁰

Elsewhere in England, a children's disability team was set up to provide an integrated health and social care service for children with complex learning and physical disabilities. An evaluation found that training and supervision was important for sustaining the service.¹⁰¹

Another example is a multiagency consultation group set up for social workers and allied professionals working with looked after children in England. The group helped create a shared understanding of a child's behaviour and needs across agencies and ensured that relevant agencies were informed and appropriately involved.¹⁰²

Education and children's services

Health services are increasingly working with schools and broader children's services.¹⁰³ In England, Sure Start programmes for young children and their families have been developed to cut across professional and agency boundaries. One Sure Start programme developed a project with staff from health, social work, education and clinical psychology backgrounds who worked in a shared location. The project used regular meetings to develop a team ethos, but cross sector working had an emotional impact on staff and increased professional anxiety.¹⁰⁴

One secondary school in England offered sexual health services through multiagency drop-in sessions. Family planning nurses and school nurses ran the drop in sessions.¹⁰⁵

Another school in England set up a programme whereby local parents brought their babies into the classroom to talk about aspects of baby care and development. Team members included teachers, a senior cross school education manager, family health visitors, a senior children's health nurse and parents. People thought that the programme

was beneficial but professionals from health and from education had differing priorities. Health professionals tended to be more critical.¹⁰⁶

In the US, four schools took part in a multiagency programme to reduce childhood obesity and one school acted as a comparison group. The programme was offered jointly by health and education professionals. It included dietary advice, changes to school lunches, physical activity and wellness initiatives. Over a two-year period there were improvements in body mass index, blood pressure and academic scores in the intervention schools, particularly among low income Hispanic and White children.¹⁰⁷

Other researchers in the US explored cross sector working to provide services for families with severely emotionally or behaviourally disturbed children. Focus groups with 26 agency collaborators found that the process of developing collaboration consisted of making initial contact, a trial period and developing trust. Interpersonal and professional qualities were key ingredients of collaboration.¹⁰⁸

Justice sector

In Wales Multi-Agency Risk Assessment Conferences (MARAC) were set up to support very high risk survivors of domestic violence. The MARACs aimed to provide ongoing communication between agencies and victims, risk assessments, advocacy to survivors and help in holding perpetrators to account. More than four in 10 survivors reported no further violence one year after the MARAC. Survivors said that having cross sector support was important once they were ready to change their situations.¹⁰⁹

Other partnerships

There are many examples of other cross sector work among statutory services. For instance, after September 11 2001, the US established a 'one-stop shop' to provide services for affected families. The centre provided mental health, spiritual, counselling, financial, legal, and benefits support from a wide range of agencies.¹¹⁰

In England, a project was set up to share data about excess alcohol consumption. Anonymised information was shared between health, police, social services, university experts and local authorities and working groups including these stakeholders were set up. This created a clearer picture of the extent of the problem and suggested strategies for intervention.¹¹¹

In Wales a food and health strategy was developed to increase the uptake of a healthy, safe and sustainable diet. Methods included appraising food initiatives, establishing a multiagency working group and producing a strategy document. There were significant benefits from setting up the strategy working group, leading to a more integrated approach to food and health.¹¹²

Researchers in Australia examined the relationships needed to deliver joined-up services to young people experiencing homelessness and unemployment. Case managers built relationships with housing and employment services, but most relationships were cooperative rather than collaborative. Stronger relationships were associated with more joined-up care.¹¹³

3.3 Broader partnerships

Examples of relationships between health and the voluntary and private sector have been documented. For instance, one region in England set up a multiagency team to support people with impaired vision. The team included staff the hospital sector, private sector, voluntary sector, education services and healthcare trust. There was a high level of patient satisfaction.¹¹⁴

The Peers Early Education Partnership (PEEP) Early Explorers project is an example of building partnerships across the statutory and voluntary sectors to improve outcomes for children in England. Early Explorer clinics are run by health visitors and PEEP practitioners. Evaluation of two clinics located in areas of high deprivation found that the two organisational stakeholders had different objectives in terms of their goals for the clinic, but were working together effectively. Mothers identified many benefits from the service

but stakeholders did not think that there was a true partnership between health and voluntary services.^{115,116}

Elsewhere in England, health services worked with the voluntary sector to set up licensed community premises for early medical abortion. At an assessment appointment women were offered counselling, chlamydia testing and a contraceptive package. Partnership with the voluntary sector worked well to reduce stigma.¹¹⁷

As with cross-boundary working within the health services, liaison workers or navigator roles have also been tested to support linkages across a broader range of sectors. For instance, a randomised trial examined the effects of coordinating health, local authority and voluntary sector services for people terminally ill with cancer in England. In total, 554 people expected to survive less than one year were randomised over a three-year period. Those in the coordination group received help from two nurse navigators whose role was to ensure that people received appropriate services tailored to their individual needs. There were few significant differences between groups. Those in the coordination group were less likely to report some symptoms and more likely to report effective treatment for side effects. The coordination group and their family members were also more likely to have accessed some services. However the researchers concluded that, overall, the coordinating service made little difference to patient or family outcomes and that this may be because the service did not have a budget with which it could obtain services for people.¹¹⁸

3.4 Training partnerships

Cross sector work has also taken place in the realm of healthcare training.

In England, Local Safeguarding Children Boards provide joint training for interagency working to promote the welfare of children. An evaluation was undertaken based on document review, observations of meetings and interviews with stakeholders from eight boards. The researchers found that the 'mandated partnership' imposed on boards by central government meant that organisations had to work together to deliver joint

training. This top-down approach affected the dynamics of partnerships. The effectiveness of the training planning group determined the success of the organisation and delivery of training. There were significant variations between areas in the number of courses, the focus and the cost per course.¹¹⁹

In England, interprofessional problem-based learning was developed to foster collaborative working among 40 students of midwifery, nursing and medicine. All students enjoyed the opportunity to learn in an interprofessional team and reflect on each other's roles. Interprofessional training improved student midwives' views of whole systems working.¹²⁰

In Australia a two-day course was developed to increase awareness among professionals about the determinants of mental health. The sectors targeted included health, local government, community arts, sport and recreation, justice and education. Over a two-year period more than 1,000 professionals took part. Evaluation found improvements in reported knowledge, skills and practice. Cross sector understanding and collaborations increased. An important success factor was recruiting trainers from diverse sectors.¹²¹

There are many other examples of how organisations have worked across sectors to innovate and improve care. This chapter merely provides a flavour of the main approaches that have been researched, namely organisational integration, organisations jointly offering services, teams combining personnel from different organisations, integrated care pathways and training to support joint working.

4. Facilitators and barriers

This section outlines factors that may help or hinder joint working between organisations seeking to improve the quality of care.

While there are relatively few published examples that describe in detail whole systems approaches to change, much more has been written about the potential facilitators, barriers and risks to cross sector working. For example, a study of a partnership between social services and primary care in England identified five types of barriers: structural, procedural, financial, professional and legitimacy.¹²²

This section describes research about the factors that may help or hinder the implementation of cross sector working to improve the quality of care. The review suggests that facilitators and barriers can be categorised in terms of leadership and vision, culture and attitudes, staff roles and training, infrastructure and processes (see Box 1).

4.1 Leadership and vision

Research suggests that having strong leadership, good change management and clear shared goals is important for cross sector working. For instance, a literature review and case studies about integrated health and social care work in England found that rather than focusing solely on structural reorganisation, joint working requires integrated systems of goal setting, authority and multidisciplinary delivery.¹²³

In England, the Supporting People Health Pilots programme developed integrated housing support, health and social care services. Data from reviewing documents and interviews with managers, professionals and service users suggested that success factors for working across organisational boundaries included a shared vision across agencies regarding the purpose of the joint venture, a history of joint working, clear and efficient governance structures, the extent and nature of statutory sector participation and whether or not the service

was defined by a history of voluntary sector involvement. Voluntary sector agencies were less constrained by organisational priorities and more able to respond flexibly to meet people's individual needs.¹²⁴

A review of facilitators and barriers to multiagency working for children and families identified having clear aims, roles and responsibilities, having timetables agreed between partners, a multiagency steering group, commitment at all levels of the organisations involved, staff training about new ways of learning and good systems of communication and information sharing.¹²⁵

Researchers in the US examined cross sector working among professionals transferring elderly patients across the continuum of care. Alignment of goals, co-agency dynamics and shared information systems were all important in ensuring cross sector working.¹²⁶

Other researchers in the US conducted case studies in 12 high performing healthcare systems to explore transformational change. Critical elements for transforming patient care included having an impetus to transform, leadership commitment, improvement initiatives that actively engaged staff in problem solving, alignment to achieve consistency of organisation goals and actions, bridging traditional intra-organisational boundaries, improving culture and norms and ensuring adequate operational functions and infrastructure.¹²⁷

A study of the influence of leadership practices on US health departments' partnerships found that departments with highly innovative leaders who had positive attitudes were more likely to achieve physical changes to the built environment.

Leaders who updated staffing, structure and strategy tripled interagency and cross sector collaboration. Success factors included establishing a vision, cultivating innovation, supporting and empowering staff, engaging in processes with partners, establishing direct contacts with directors in other departments and leveraging leaders' professional reputation.¹²⁸

In Sweden, organisations collaborating on a rehabilitation project found that it was possible to cooperate across organisational boundaries, but there were obstacles related to organisational and cultural differences, divided loyalties of managers and limited resources. The commitment of individual managers was essential.¹²⁹

Researchers in Italy examined how internal drivers foster organisational change in healthcare. Case studies suggested that characteristics of the personnel involved, including their motivation, leadership and commitment, are all key success factors, as are the quality of relationships among staff and how the resources dedicated to manage change are used. Innovations take time to spread and require strong commitment and managerial stability.¹³⁰

A study of developing a multiagency sports injury prevention programme in Australia found that facilitating factors included a credible industry leader, investment in partnership management and a consultative approach. Challenges included maintaining focus and efficiency, time constraints, ensuring commitment from all relevant organisations and sector diversity which limited consensus.¹³¹

Box 1: Factors that may help or hinder cross sector working for large-scale change

Facilitators

Leadership and vision

- clear vision and shared goals¹³²⁻¹⁴¹
- focus on outcomes^{142,143}
- strong leadership¹⁴⁴⁻¹⁵⁴
- senior champions^{155,156}
- good change management¹⁵⁷⁻¹⁶²
- clear decision-making processes¹⁶³
- engagement of stakeholders¹⁶⁴⁻¹⁶⁸

Culture and attitudes

- positive organisational culture¹⁶⁹⁻¹⁷²
- developing good relationships and communication¹⁷³⁻¹⁸²
- allowing time to build relationships and trust¹⁸³⁻¹⁸⁶

Staff roles and training

- clear roles and responsibilities¹⁸⁷⁻¹⁹⁰
- competence and capacity building¹⁹¹⁻¹⁹⁴
- joint training about issues, partners and benefits¹⁹⁵⁻²⁰⁵
- link workers or coordinators²⁰⁶⁻²⁰⁸

Infrastructure

- adequate resources²⁰⁹⁻²¹¹
- umbrella structures or shared processes to guide coordinated strategy, management and service delivery^{212,213,}
- IT infrastructure²¹⁴⁻²²⁴
- co-location (in some instances)^{225,226}
- alignment of financial and other incentives²²⁷⁻²²⁹

Processes

- joint processes such as a common assessment system²³⁰⁻²³⁵
- single point of entry into system²³⁶

Barriers

Leadership and vision

- undertaking change solely to reduce costs²³⁷⁻²³⁹
- poor coordination^{240,241}
- top-down approaches²⁴²⁻²⁴⁵

Culture and attitudes

- different cultures and goals²⁴⁶⁻²⁶¹
- lack of buy-in from clinical and managerial staff²⁶²⁻²⁶⁷
- using different terminology²⁶⁸⁻²⁷⁰
- jurisdiction battles²⁷¹⁻²⁷⁴

Staff roles and training

- power relations²⁷⁵⁻²⁸¹
- challenges to professional identity and anxiety²⁸²⁻²⁹⁰
- role confusion²⁹¹⁻²⁹⁴
- lack of incentives or alignment with issues of importance for clinicians²⁹⁵
- lack of focus on clinicians' needs²⁹⁶

Infrastructure

- lack of joint incentives²⁹⁷⁻²⁹⁹
- national targets that act as disincentives^{300,301}
- lack of resources³⁰²⁻³⁰⁵
- lack of time³⁰⁶
- issues sharing information³⁰⁷⁻³⁰⁹

Processes

- organisations using different processes^{310,311}
- ethical and confidentiality concerns³¹²
- audit and monitoring demands³¹³⁻³¹⁵
- short-term targets³¹⁶

4.2 Culture and attitudes

Agreeing on common goals and having strong leadership are essential for cross sector working but research suggests that this is not enough. When planning large-scale change it is important to explicitly consider organisational culture and staff engagement. Organisational culture refers to the norms, taken for granted processes and terminology that create ‘the way we do things’ within a group.³¹⁷

Interviews with 34 primary care and social care professionals in Scotland examined views about joint working to support older people’s care. Professionals said that cross sector working required a fundamental change in thinking, examination of professional roles and identities, new ways to share and create information and strong organisational infrastructure.³¹⁸

Interviews with 115 professionals in England found that staff were very positive about working in multiagency teams to support disabled children. Cross sector working was thought to have improved professional development, communication, collaboration with colleagues and relationships with the families of disabled children. Professionals thought that they were able to offer families a more efficient service, but felt that cross sector working had limited impact on disabled children and their families overall.³¹⁹

Other researchers in England explored partnership working in public health. Seventy managers and decision makers from health organisations, local authorities, universities, the third sector and the Department of Health took part in interviews or focus groups. There was support for cross sector working in principle, but barriers were identified including cultural issues such as a lack of shared values and language, the complexity of cross sector collaboration and macro issues including political and resource constraints. The breakup of established networks was seen as a key risk during times of reorganisation.³²⁰

Another study compared cross sector working in England and the Netherlands. It found that integrated care is difficult to achieve due to having a complex system with various stakeholders with different roles, tasks, interests and power relations.

Factors affecting cross sector working included the social, economic and political context, the local context, the legal context, funding, procedural and structural arrangements and the collaborative culture and tradition. The researchers suggested that these factors manifested differently in England and the Netherlands. In the Netherlands there was an emphasis on bargaining in non-hierarchical structured networks. In England, hierarchies played a more dominant role.³²¹

Researchers in Wales explored meetings between professionals from a Child and Adolescent Mental Health Service and social care and education. Agencies were hindered from working more closely together because they did not have a common language for use in multiagency meetings and tended to have different understandings of the terminology used.³²²

A focus group with mental health hospital staff, community mental health teams and an assertive outreach team in Wales identified professionals’ attitudes towards whole system working in adult mental health services. Professionals thought that whole system approaches were more successful for some patients than others. They also thought that whole system approaches may shift responsibility in order to manage workers’ anxiety rather than responding to people’s needs.³²³

Research from outside the UK also emphasises the role of organisational culture in cross sector work and large-scale change. A review of integration between primary and secondary care in the US found that allowing time to develop a coherent culture within the organisation was a key success factor. There was limited success where acute hospitals sought to incorporate or assimilate primary care practices and community hospitals solely to improve economies of scale.³²⁴

Other researchers in the US examined factors contributing to conflicts across organisational boundaries in healthcare. Thirty interviews suggested that organisational power, differences in the status of the individuals handling the conflict and previous interactions all influenced conflicts.³²⁵

Elsewhere in the US, a mental health authority initiated strategies to improve integration. A key barrier was organisations guarding their

jurisdictions and boundaries and struggling for power and control. Informal networks of staff among local provider agencies were set up to address this.³²⁶

Similarly, a case study of mental health services in Canada examined factors influencing transformational change. Critical strategies included maximising the roles of governance and leadership, shifting the organisational mindset, balancing strategy and action through a culture of accountability and using strategic communication opportunities.³²⁷

A survey of managers in Swedish healthcare examined the characteristics of organisations implementing successful improvement initiatives. Successful organisations were more likely to be patient focused, measure outcomes, feed data back to providers, collaborate with other organisations, emphasise learning and knowledge, have good communication, have a positive culture, and develop strong administration and management systems.³²⁸

Researchers in Australia explored critical factors for forming and maintaining relationships between organisations in order to provide integrated care for young people. They concluded that structural and process considerations are necessary but not sufficient to successfully built interagency partnerships. Organisational culture and staff engagement can be a significant challenge.³²⁹

A study of collaboration between private and public sector primary and community health services providing diabetes care in Australia found that cross sector working was influenced by factors relating to the benefits and costs of collaboration and support mechanisms. Perceived benefits included achieving common or complementary health or organisational goals. Costs were incurred when bridging differences in organisational size, structure, complexity and culture. Collaboration was easier between private sector organisations than between the private and public sectors. Financial incentives did not overcome organisational barriers. The researchers concluded that to achieve whole systems working, structural changes are needed to better align the funding mechanisms, priorities and accountabilities of different organisations.³³⁰

4.3 Professional roles

Cross sector working can impact on professional identity and this can be challenging for staff.³³¹ This can be both a risk and a barrier to cross sector working, in that professionals may push against any changes thus creating a barrier and because changes to professional identity may carry risks in terms of uncertainty and instability during periods of change.

An evaluation of two collaborative community nursing schemes in England explored the way health and social care professionals constructed their identities and relationships during joint working. Focus groups and interviews found professional identity and roles changed in response to cross sector working. In some instances this led to role ambiguity, role erosion and role extension.³³²

Social work managers, social workers and GPs were interviewed about cross sector working in England. Social workers and GPs were positive about the need for joint working, but each group had different understandings of this concept. Each profession wanted the other to change its organisational culture. Co-location of health and social care was seen as desirable, but was also threatening to social work staff. There were concerns about differences in power and hierarchical authority. The researchers concluded that resources and professional skills may be more important than organisational arrangements in cross sector working.³³³

Researchers from Scotland examined challenges during multiagency and multiprofessional work. Interviews, participant observation and documentary analysis were used to examine multiagency work on a health promotion project to prevent drug-related harm. Processes for securing funding led to multiple competing project aims. Personnel changes and internal reorganisation of agencies impacted on project membership and reduced shared understandings of key priorities. The need to keep group members 'onside' and committed competed with differentials in power between members and between agencies.³³⁴

4.4 Training and support

Training and support for staff may be crucial for cross sector working.^{335,336} In Northern Ireland, health and social services are jointly commissioned. A study of joint working to support people with learning disabilities found that facilitators of cross sector working included building relationships among participants, showing the benefits of multiagency work, creating opportunities for partnership working and increasing the capacity of individuals and organisations to work together.³³⁷

Researchers in the Netherlands analysed how an integrated healthcare network developed to see how workers from different organisations crossed professional and organisational boundaries. Social contact and joint learning experiences helped to build relationships. Professionals learned to speak each other's language, learned how other organisations worked and learned to look at patient care from an overarching perspective rather than solely from their own professional or organisational perspective. There was value in using direct contact to share information and ensure continuity in care.³³⁸

A university in England ran courses to promote collaborative working among public sector middle managers. Evaluation interviews found that middle managers had improved attitudes, greater confidence and plans to implement collaborative projects. However, managers said that they felt 'out of alignment' with their organisation and that there was poor support for interagency working.³³⁹

4.5 Infrastructure

Research suggests that three main types of infrastructure may support whole systems approaches: shared organisational structures, facilities that allow co-location of services and information systems to allow shared access to records.

Organisational structure

Some commentators suggest that merging organisations and departments or other forms of structural integration is important to promote large-scale change. However, empirical evidence about whether structural integration is the best policy for cross sector working is sparse.³⁴⁰

Some studies suggest merged organisations provide more effective and efficient care.³⁴¹⁻³⁴⁶ But not all evidence is positive. Researchers in the US compared two approaches for integrating services for homeless people with mental health and substance abuse issues. One model involved an integrated team and the other comprised a collaborative relationship between agencies. Interviews with 1,074 homeless people, a survey of case managers and analysis of outcomes found that the integrated team was not more effective than interagency collaborations.³⁴⁷

The best structural approach to support cross sector working remains uncertain.

Co-location

A review of barriers and facilitators to cross agency working to provide care for children with complex or special needs found that factors commonly associated with effective working included co-location, key workers, appreciation for other agencies and communication and information sharing. Meetings, strategies to explicitly improve working relationships and developing communication networks worked well when used together.³⁴⁸

On the other hand, a feasibility study tested two models of joint working to support older people to remain in the community. Before and after interviews were undertaken with 79 people aged 75 or older with complex needs in England. Co-location of health and social care services did not necessarily lead to closer interprofessional working in terms of more contact between social workers and GPs or social workers and community nurses. The characteristics of older people, for example if they lived alone, were more likely to influence outcomes than co-location.³⁴⁹

Information systems

Researchers in England examined examples of multiagency working for children with complex needs and their families. Interviews and discussion groups found that sharing information, decision making, communication, accessibility, collaboration, respect and sharing a common vision were key success factors.³⁵⁰

Systems that help organisations share information may be a key operational issue.³⁵¹ Case studies with health and social services providing care for people who experienced a first stroke in Wales identified success factors for multiagency working including flexible working, the need for a lead professional and the need for shared access to high quality data.³⁵²

Researchers in the US explored interagency collaboration for young people simultaneously involved with the child welfare and juvenile justice systems. Issues emerging included jurisdiction, lack of shared information systems and lack of access to services. Data from a national survey found that having a single agency accountable for young people's care and interagency sharing of administrative data increased the likelihood that young people would receive behavioural health services.³⁵³

4.6 Processes

Cross sector working can take a variety of forms, from the creation of unified structures, such as care trusts in England, to more localised arrangements for joint working between individual professionals. Regardless of the structural arrangements, research suggests that having shared processes can be useful. For instance, case studies of community care in Scotland suggested that operational factors had a key role to play in cross sector care.³⁵⁴

In England, the Single Assessment Process (SAP) is designed to support cross organisation sharing of information. A review of developing shared assessment for community services in the UK found that shared assessment can result in improved communication, service user and carer involvement, partnership and joined up working.³⁵⁵ But examples from two programmes, one run by health and the other by social care, found that implemented shared assessment is challenging in practice.³⁵⁶

In the US, 11 sites participated in a multiagency programme to improve the coordination of services for homeless people. Over a four-year period there were significant improvements in system integration, joint planning and coordination and trust and respect. The use of shared operational practices resulted in more service integration.³⁵⁷

Voluntary services are being relied on more heavily to fill gaps in health and social care provision, but governments are also imposing more regulations and accountability mechanisms while not increasing voluntary sector funding. Interviews with voluntary and statutory sector providers in a remote part of Canada found that people thought that there was an escalating incursion of the state into local voluntary sector affairs. There was an emerging ethos of accountability, efficiency and competition in the voluntary sector and increasing pressure to centralise volunteer services. This may lead to a reduction in the traditional flexibility and personalisation of the voluntary sector.³⁵⁸

Research suggests that there are many disincentives for the voluntary sector such as short-term funding, the administrative burden of writing funding applications and the performance management processes required by the health sector. A study of health managers' views about the funding, role and responsibilities of voluntary organisations in Scotland found that the extent and method of funding voluntary agencies differed across each health board. Managers thought that policies for financial and other relationships with the voluntary sector were often not explicit. Some health boards requested accountability through audited accounts, annual reports and site visits but others thought that this type of performance management was inappropriate for small organisations. The administrative burden of the monitoring process and funding applications was acknowledged. The researchers suggested that uncertainties about long-term funding may impact on how voluntary organisations contribute to healthcare. There is a tension between accountability requirements and the ability of small voluntary organisations to provide the necessary documentation.³⁵⁹

4.7 Key drivers

It is possible to categorise the facilitators and barriers to large-scale change in a multitude of ways. A review of 39 articles about large-scale change initiatives in hospitals and healthcare grouped drivers for change into four key categories: planning and infrastructure; individual, group, organisational and system factors; the process of change; and performance measures and evaluation (see Figure 1).³⁶⁰

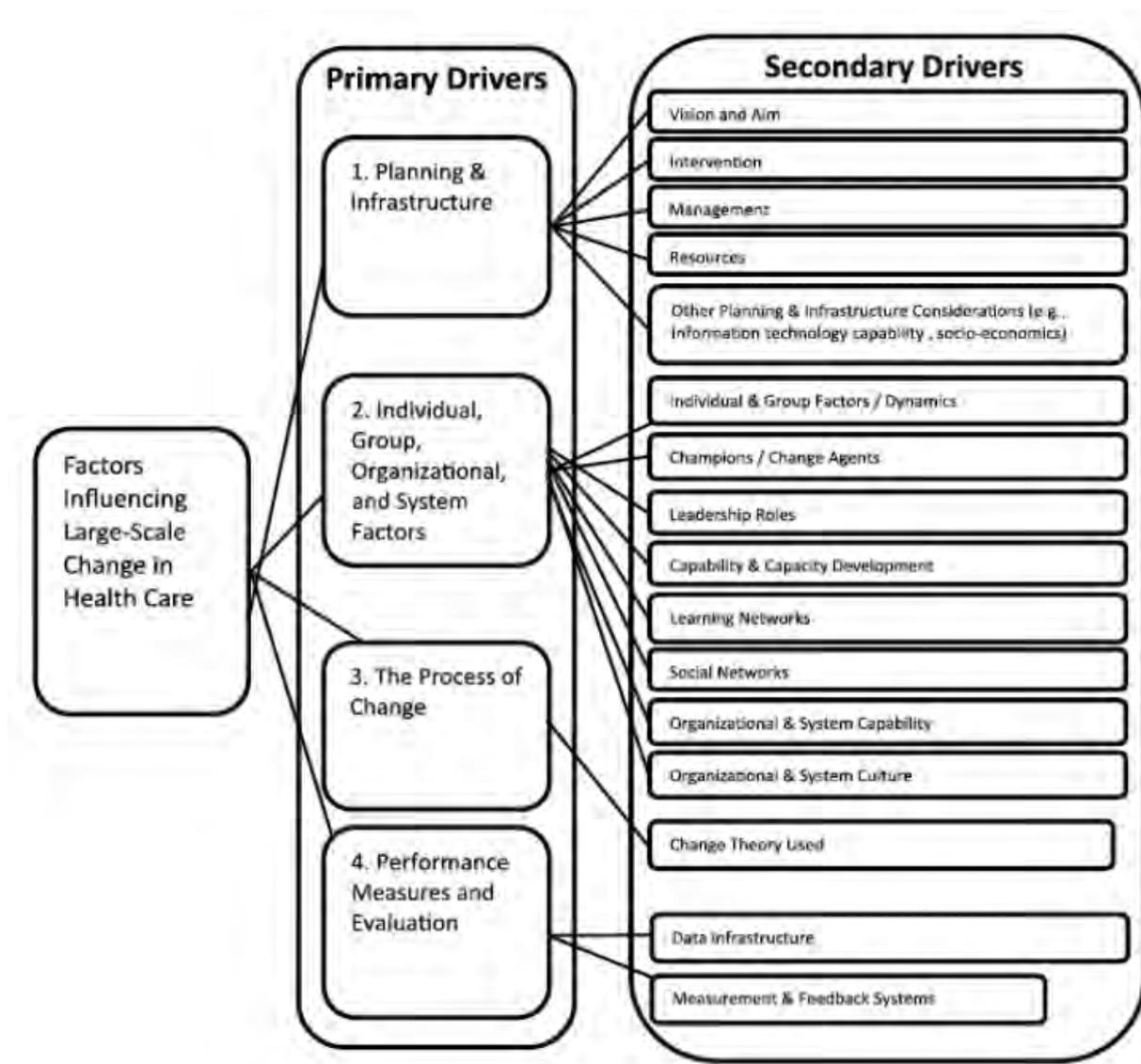
The review found that in order to be most successful, large-scale change initiatives must have a compelling vision and provide explicit guidance to organisations and teams about **how** to change, rather than just what needs to be altered.

Furthermore, it is essential to understand the **cognitive dimension** of spread: how people and groups think about, are affected by and react to change. Being sensitive to organisational norms and local culture is key to planning and sustaining change. Champions, change agents, strong leadership and social networks can be an important part of this.

The review found that the **process** used to roll out large-scale change has at least three dimensions: the extent to which changes are actively ‘pushed’ to participants, the underlying change theory driving the innovation and the mechanism used to spread the intervention, such as social movement approaches. Published literature does not tend to compare the pros and cons of different approaches empirically.

Finally, most studies in this field recognise the importance of having appropriate infrastructure to collect data for monitoring, evaluating and feeding back on performance. It is essential to understand the extent to which changes are taking place and their impacts to maintain momentum.

Figure 1: Key drivers for large-scale change identified in a literature review³⁶¹



Source: Perla RJ, Bradbury E, Gunther-Murphy C. ‘Large-scale improvement initiatives in healthcare: a scan of the literature.’ *Journal Healthcare Quality*, Published online September 2011

5. Summary

5.1 Key lessons

Places that have set out to achieve cross sector working

Many health organisations are working across boundaries and with partners in social care, mental health and the voluntary sector.^{362,363} There are policy papers, toolkits and guidance documents aiming to encourage joint working between health and social care or across hospital, community and primary care sectors.^{364,365} The Department of Health has also released a toolkit to support joint working with the pharmaceutical industry.³⁶⁶

Cross sector work for large-scale change may be described in notes from meetings, websites, strategic plans and internal documents, but few areas have published research or evaluations about their whole health economy work.³⁶⁷

The examples described in this review illustrate that whole systems working can take a variety of forms, from 'one-stop shop' services to joint organisational structures.³⁶⁸ It can include primary care and secondary services working together, as well as partnerships with social services, education, justice and the voluntary sector.

Research about cross sector working is most commonly available from the UK, Europe, North America and Australasia.

Defining systems

The Health Foundation was interested in how teams defined the system they were trying to change in cross sector projects. There is limited research evidence available about this. Published examples tend to describe cross sector working in terms of the organisations involved (such as health and social care), but are not explicit about naming the wider systems impacted.

Techniques and approaches used

Approaches tested to support cross sector working for large-scale change include:

- health organisations working with other sectors
- different types of health organisations working together
- health organisations merging with each other or with other sectors
- individual professionals or teams working across organisational boundaries
- integrated care pathways
- networks or communities of practice
- joint training of professionals from different organisations
- roles to support coordination of services or liaison between organisations
- joint appointments such as directors or board members who span health and social care.

The best way to facilitate whole systems working or cross sector initiatives remains uncertain. We identified few high quality studies comparing different approaches to implementing large-scale change. Most research focuses on describing a particular approach, rather than considering alternatives.

However, reviews suggest that structural integration does not necessarily lead to service integration and strong cross sector working.³⁶⁹

Co-locating services may help to improve access, but not all studies suggest that co-location is essential to support whole systems change.^{370,371}

Importantly, mandating that organisations should work together or that there should be whole systems change does not promote the most effective partnerships. Research suggests that cross sector working for large-scale change is more likely to be effective and sustainable when stakeholders share a joint vision and see that working together will help them achieve that vision rather than being mandated in a top-down fashion.³⁷²⁻³⁷⁵

Impact of cross sector work

Many policy papers, journal articles and opinion pieces espouse the potential value of cross sector working for facilitating large-scale change. Research suggests that benefits may include improved communication and coordination, better access to care and potentially more streamlined services.³⁷⁶⁻³⁷⁸

In fact, partnership working across organisations and between different types of professionals is often assumed to be a panacea for improving access to and the coordination of care. But some studies question this assumption. For example, a literature review of health and social care partnerships in developed countries suggested that outcomes for patients may be largely unaffected or even negatively affected by whole health economy working.³⁷⁹

Risks of cross sector working

Cross sector working is not without potential risks. Negative impacts noted in some research include increased staff anxiety, challenges to professional roles, limited buy-in from managers and clinicians and more steps in the care pathway, leading to delays or frustration for patients.^{380,381}

A major risk is assuming that cross sector care is always effective. While cross sector working can improve access to care and the coordination of care, it should not be assumed that such initiatives will always improve clinical outcomes for patients or reduce costs.³⁸²

Another risk is assuming that cross sector working is easy. Research suggests that it can take a great deal of time and commitment.^{383,384}

Helpful and hindering factors

The evidence suggests that it is important that all organisations and disciplines involved in joint initiatives are clear about the purpose of the change or service and know what their roles are.^{385,386}

Local change champions can be a good way of motivating staff to buy-in to the vision for whole systems working.^{387,388}

Training staff may be a key success factor when implementing whole systems approaches. Staff at all levels need to be informed about the purpose of joint working, the benefits for them and their patients and the roles expected of them.³⁸⁹⁻³⁹²

Working together takes time, resources and commitment. There are often differences in organisational cultures and expectations as well as the attitudes of different types of professionals.^{393,394} Things that one organisation takes for granted may not be seen as normal or appropriate by an organisation from another sector. Joint training can help build relationships between team leaders and professionals, and identify differences in attitudes and understanding.³⁹⁵⁻³⁹⁷

Practical issues, such as using compatible IT systems that allow shared access to patient records, can help or hinder implementation.³⁹⁸⁻⁴⁰⁴

In summary, factors that may help or hinder organisations to work across sectors include:

Leadership and vision

- strong leadership and champions
- clear vision and shared goals
- good change management
- engagement of stakeholders
- not taking a top-down approach.

Culture and attitudes

- shared culture between organisations
- positive organisational culture
- good relationships and communication
- allowing time to build relationships and trust
- buy-in from managers and clinicians
- avoiding jurisdictional battles.

Staff roles and training

- clear roles and responsibilities
- joint training for staff
- ongoing support for staff
- addressing challenges to professional identity
- avoiding role confusion
- addressing clinicians' needs.

Infrastructure and processes

- adequate resources and infrastructure
- IT systems that allow shared information
- co-location (in some instances)
- alignment of financial and other incentives
- joint processes such as single assessment processes to avoid duplication.

5.2 Caveats

This evidence scan has provided examples of cross sector work to improve healthcare. When interpreting the findings it is important to bear in mind several caveats.

Scope: Firstly, the scan is not exhaustive. It presents examples of empirical studies about cross sector working. It does not purport to represent every study of this nature. The purpose is to give a flavour of available research rather than to summarise every existing study in detail.

It is also important to note that only studies explicitly focused on cross sector work of some form were included. A number of other studies have tested collaborative working, but this may not have been a primary outcome.

Quantity of research: Secondly, there are relatively few examples that provide real details about the change process. The cost effectiveness of various strategies is also uncertain.

Quality of research: There are also some issues with the quality of the studies included. A number of studies have been conducted at single sites and include small numbers of patients or professionals. Very small case studies are common and these may be subject to potential bias and limited detail.

Making comparisons: Finally, it is difficult to make comparisons between studies because various definitions of cross sector work are used and the studies differ in scope, research methods and quality. Furthermore, they took place in widely differing healthcare contexts. While much of the research is drawn from the UK, studies from North America and Europe may not be generalisable to the UK context as the healthcare systems, legislation and norms of practice vary significantly.

Even the scope of the research is similar and geographic contexts can be compared, the level of detail reported in most individual studies is insufficient to make meaningful comparisons. This limits the extent to which we can suggest that one approach to cross sector working is more effective than others.

One area where there is a lot of detail, however, involves the facilitators and barriers to cross sector working in health economies. A key finding of the review is that strong leadership, shared vision, good change management, shared organisational culture, staff training and shared systems and processes are important for sustainability. When planning cross sector work, there may be a focus on the best structures or systems to implement,^{405,406} but this review suggests that it is essential to pay attention to other factors such as building shared understandings and buy-in from managers and professionals. This process takes time, commitment and resources.^{407–412}

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The references included in this scan fall into two categories: those that provide direct examples or contextual information about cross sector working and those that provide supporting material and examples, but are not the key focus of the review. To differentiate these references, hyperlinks (underlined in red) to the published abstracts of those of most relevance have been inserted.

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