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 prospect

Coherence of the SHIP aims and goals

SHIP Aims and goals	Understanding	Strategies for promoting coherence
Strategic level aims: **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.
Values **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.
Intervention level **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 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.	SWs/SCWs can demonstrate collegiality and willingness to help by advising on the information necessary to achieve relevant referrals (achieved during the project). Shared information across sectors can also reduce staff anxiety and improve relationships.
Agreement about allocation of tasks and resources, hierarchies, definition of skill sets, autonomy of agents, quality of skills	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.	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.
Allocation of resource, distribution of risk, who has power, how work will be evaluated, who will be advantaged	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.	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.

We would like to thank all participants who gave their time to take part in interviews

Introduction

This report presents the results of the qualitative evaluation of the Govan Social and Health Integration Partnership (SHIP) project implemented within the Govan Health Centre, Glasgow. The overarching aim of the project was to facilitate integrated working between health and social care sectors, via the implementation of a multi component intervention. The main components of this intervention were linking social workers into the Govan Health Centre (GHC), initiating multidisciplinary teams (MDTs) and buying in GP locums in order to provide extra GP time for SHIP-related activities.

The Health and Social Care Partnership (HSCP) commissioned the research team to undertake this evaluation between April 2016-March 2017. The evidence presented in this report includes a synthesis of relevant documentary and policy sources, a literature review, two phases of interviews with health and social care professionals and observations made during attendance at MDTs.

Background to the Govan SHIP

Chronic physical and psychological morbidity account for 80% of all GP consultations (Scottish Government 2009), and in combination can lead to significantly poorer health outcomes and low quality of life (Naylor et al 2012). Recent primary care research finds increasing incidence and earlier onset of multiple morbidity in deprived areas (Barnett et al 2012), and GPs and Nurses working in deprived practices report that complex social need on top of these difficulties is a significant barrier to effective treatment and self-management of disease (O'Brien et al 2011).

GPs from the 100 most deprived practices in Scotland (GPs at the Deep End: http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/) identified areas of concern affecting Primary Care practitioners and patients in deprived communities (the 100 most deprived postcodes according to the Scottish Index of Multiple Deprivation (SIMD)). GPs at the Deep End have continued to investigate these areas and from 2009, have been developing ideas and proposals to try to address identified problems.

National and local policy context

The Govan SHIP initiative is taking place, and developing, in a dynamic policy environment as reforms, restructuring and new legislation take effect and policymakers look for evidence of cost effective new ways of working

The Healthcare Quality Strategy for NHS Scotland (2010) aims to change the focus of healthcare provision to person-centred, partnership working between NHS Scotland, Local Authorities, Third Sector and independent contractors, and to realise the overarching strategic narrative of the Scottish Government's 2020 Vision (Scottish Government 2013). Recognition of the impact of multiple long term conditions, poor mental health and an increase in the ageing population, in an environment of diminishing resources and increasing demand for both medical and social care, is one of the drivers for the vision. This narrative of longer healthier lives and the achievement of sustainable, quality health and social care through 'prevention, anticipatory care and supported self-management; treatment in a homely

setting, person centred decision making and integrated health and social care' informs the policy context of the project.

The 2020 vision also encompasses a move towards major change in the delivery of primary care services, in particular the expansion of general practice, multidisciplinary working and workforce planning to ensure the 'right people, in the right numbers in the right jobs' (Healthier Scotland 2013). While the 2020 vision appears to endorse the Deep End 'approach' and states an intention to target resources into the most deprived areas of Scotland, to date only 11 of the 100 most deprived practices have been provided with additional clinical capacity to address the needs of their patients (Deep End Report 30 www.gla.ac.uk/deepend). Co-location of social services and third sector providers with primary care teams where possible, and a wider range of professionals integrated with the practice-based structure of primary care, are among the aims of the National Clinical Strategy (Scottish Government 2016). A new GP contract for Scotland, operational from April 2017, includes significant change to the GP role with a new focus on Complexity, Undifferentiated Presentations and Clinical Leadership. Practices will be expected to work as Clusters from April 2017 and Clusters will have responsibility together with integrated authorities for the quality of all health and social care services in their locality (BMA/Scottish Government 2016). Initiatives to release GP capacity for these new roles, and develop multidisciplinary working models are in development.

The Scottish Government's reform and integration of health and social care services (the Public Bodies (Joint Working) (Scotland) Act 2016) became operational on 1st April 2016, as NHS and local authority care services merged the management of resources and became jointly responsible, as Health and Social Care Partnerships (HSCP), for the health and care needs of their local populations under the new Act. HSCPs are expected to work closely with GPs to 'shift the balance of care' from acute to community and primary care; policy aims include reduced hospital admissions and delayed discharges.

The Social Work (Scotland) Act (1968), requiring local authorities to provide services for people in need, is the foundation of social care provision in Scotland. Amendment of this Act by the NHS and Community Care (Scotland) Act (1990) transferred the responsibility for community care to local authorities. The resulting huge resource transfer created tensions between the NHS and social care departments, exacerbated by pressure on health boards to free hospital beds and on councils to manage accommodation with insufficient resources (Freeman & Moore 2008).This legislation also introduced compulsory competitive tendering, whilst councils were not given the power to ring-fence social care budgets. Current public services legislation includes a requirement to constantly seek cost efficiencies.

The 21st Century Social Work Review by the Scottish Government (Scottish Executive 2006) refocused professional roles towards statutory duties or high risk/high complexity cases. This perhaps echoes the current legislative requirement to work to the 'top of the licence' in health services, delegating 'lower level' support tasks and maximising professional expertise.

The national social policy direction towards personalisation, independence, rights and self-determination, together with a strategy of shifting to anticipatory care and prevention, fits closely with Social Work (and council) values, and is echoed in Glasgow City Council's strategy of providing social care 'in line with a vision of promoting independence'. It is also compatible with the need to manage services with dwindling resources and staff. (In Glasgow, FTE social worker posts have reduced by 25% since 2008).

The changes in health and social care are driven by national strategies designed to address an ageing population, increased demand for service and reduced resources, however the systems remain largely separate. The short-lived Community Health and Care Partnerships, a previous 'top-down' attempt at integration, failed to address incompatible recording systems, issues of consent and information sharing, or the organisational and professional tensions between social care and health, and between social work management and staff who feared a 'health takeover' (Freeman & Moore 2008). Joint working initiatives maintained separate management and governance arrangements. CHPs and CHCPs failed to engage with GPs in many areas; and the relationship in Glasgow has been described as 'poisonous' by some of our interviewees.

Budget disparities, a longstanding cause of tension, remain. The final report by Glasgow City Shadow Integration Joint Board in January 2016 pointed to continuing budget disparities on the eve of integration, with Social Work having a budget deficit due to overspend in Children and Families which would have to be recovered from spending on Adult Services. This was the political, strategic and financial landscape that was in place when the next phase in health and social care integration was launched with the Health and Social Care Partnerships.

Glasgow City Council (GCC) and NHS Greater Glasgow and Clyde (NHS GGC) became Glasgow City Health and Social Care Partnership on April 1st 2016. The body responsible for managing the integration scheme, the Integration Joint Board, produced a Strategic Plan for 2016-2019, as required by the new legislation, to ensure delivery of the functions of the new Partnership and to measure progress. Integration of health and social care services will be measured against the nine statutory National Health and Wellbeing Outcomes. Eleven Strategic Planning groups have been identified to direct and measure performance for 11 'care groups' - including older people, mental health, children and families, addictions and carers - and to link local operational indicators for each 'care group' to the national outcomes. Locally, there will be Partnership management teams for adult services, childrens' services, older peoples' services and health improvement, and care group planning groups. However, there is no 'care group' for complex need/multimorbidity. Furthermore, while addressing the 'inverse care law' is a core principle that lies at the heart of the Deep End philosophy, it is surprising that this is not highlighted as an aim of the integration agenda within the HSCP.

Among the initial priorities for the South Glasgow locality is:

'Taking forward the Govan integrated care project with four GP practices testing new forms of integrated service delivery with community health, social care and the third sector to support and prolong independent living in the community harnessing all available resources' (Glasgow City Integration Joint Board Strategic Plan 2016-2019, p35, https://www.glasgow.gov.uk/CHttpHandler.ashx?id=33418&p=0).

Developing Govan SHIP

The Govan Social and Health Integrated Partnership (SHIP), initially known as the Govan Integrated Care Project, developed from a series of meetings and consultations, between the CHP Director, the Director of Social Work and the Govan GPs. As the Scottish Government began to show interest, academic GPs associated with the Deep End began to contribute to the development of a proposal. As this progressed, the Director of the CHP encouraged further development of the SHIP proposal to go beyond the SW initiative to bring the Deep End 'agenda' to the fore with other aspects of care.

The Govan SHIP initiative, involving a cluster of the four practices based at Govan Health Centre, is an integrated care model designed to address a number of concerns within primary care. Emphases differ depending on the perspective from which the project is viewed. From a policy and planning perspective the aims are expressed as, variously: *to manage demand* (NHS GGC website 2015), *to reduce demand on acute and residential care* (Audit Scotland 2016), *to reduce the rates of unscheduled care at emergency departments and cut delayed discharge* (NHSGGC, newsletter August 2015), *to support and prolong independent living in the community* (Glasgow City HSCP Strategic Plan 2016-2019). From a medical or clinical perspective, the project aims to *draw up care packages for patients before they reach a crisis* (NHSGGC, newsletter August 2015), *devise appropriate anticipatory care plans (*Healthier Scotland 2016*) and improve chronic disease management* (Audit Scotland 2016). The Deep End perspective encompasses these aims but also places emphasis on developing capacity to address social need and health inequalities at practice population level. Within this perspective, it is also essential that integrated practice aims to address the Inverse Care Law (*the availability of good medical care tends to vary inversely with the need for it in the population served)* by targeting care, including anticipatory care, where it is most needed (GPs at the Deep End 2012, 2013).

Three groups of patients were identified as those with the greatest vulnerability, and who could benefit from preventive action and additional support - vulnerable children and families where childrens' health and development may be at risk, frail elderly people who are at risk of hospital or care home admission without intervention and adults with multiple and complex medical and social conditions who attend A&E frequently or have a high level of unscheduled care episodes.

Four subgroups (workstreams) were created to focus the development of the project: Vulnerable Children and Families, Frail Elderly, Unscheduled Care and an IT group to ensure collection of relevant data for evaluation.

New models of care being piloted to address identified vulnerabilities and increase clinical capacity included co-location of 2 social workers at the health centre, one for vulnerable children and families and one for adults, to work across the four practices (latterly replaced by 2 social care workers); monthly multidisciplinary team meetings in each practice; additional GP capacity facilitated by the addition of GP locums to allow senior GPs to offer extended consultations, attend case conferences or participate in other project-related activities.

Evaluation Approach & Research Methods

The approach to the evaluation

The research team conducted a qualitative process evaluation of Govan SHIP. This focused on exploring the following areas:

- identifying the barriers, facilitators and potential solutions to social work integration
- exploring the benefits and challenges of health and social care integration
- lessons and recommendations for future integrated working

The evaluation drew on an ethnographic approach informed by realist evaluation (Pawson & Tilley 1997). Ethnography is an approach suited to understanding complex settings and interventions, and aims to explore a research question or the implementation of an intervention within its 'natural setting' (Hammersley & Atkinson 1995). Thus, rather than simply seeking answers to pre-determined questions about what participants say that they do, an ethnographer seeks to explore what people actually do in practice (O'Reilly 2005). The realist approach to evaluation marries well with an ethnographic study design, given its focus on implementation contexts and the mechanisms by which outcomes are achieved. This evaluation is thus informed by the central realist question: 'What works, for whom and in what circumstances?'

Research Methods

The study involved two phases: a context mapping phase drawing on observations and unstructured interviews, followed by semi-structured interviews and continued observations.

Sampling and Recruitment: professional/stakeholder interviews

A purposive sample of staff working within/linked to the GHC and stakeholders with involvement in the integration agenda were identified. This included social workers, social care workers, practice and community-based nurses, GPs from each of the four practices, Community Links Practitioners (CLPs) and higher level stakeholders from health care management, social work and academic primary care. Table 2 illustrates the professional roles of those recruited.

Table 1: Sample by professional role

Professional Roles	Phase 1	Phase 2
GPs	1	6
Social Workers	2	2
Social Care Worker	0	2
District Nurse	0	2
Health Visitor	0	1
Practice Nurse	1	2
Practice Manager	3	0
Occupational Therapist	0	1
CLP	1	1
Stakeholders (HSCP, SW managers, Primary Care/Univ)	3	4
Total Staff Interviewed (n=32)	**11**	**21**

All potential participants received by email: a letter of invitation to participate; an information sheet about the evaluation; and a consent form. The email was followed by a phone call and, if willing, a convenient time and date to be interviewed was arranged with the research fellow (JMcG). Written consent was obtained after participants had been given the opportunity to ask any questions about the study. Five potential participants declined to be interviewed, primarily on the grounds of lack of availability or time to take part or because they felt that they had not been involved in SHIP-related activity.

Sampling and recruitment: patient interviews

The three practices actively participating in the SHIP project each provided details of patients who had been recipients of SHIP activity from which a sample of 10 patients were selected for invitation to interview. In order to preserve patient anonymity and confidentiality, the three practices were requested to select 10 patients each and provide contact details and brief details of reasons for selection to the research team. This would ensure that practice staff would not know who had been invited to participate in an interview. However, the patient sample submitted to the research team varied in number between practices: 27, 24 and 19 patients respectively.

Inclusion criteria:

Patients over 18yrs of age, with capacity to provide informed consent (as per the judgement of GP) were eligible to take part. Patients were eligible if they had been in receipt of extended consultations (either home visit or within surgery), had their care plan discussed within the MDT, or had support from social work or social care workers.

Exclusion criteria:

Patients under 18yrs of age who do not have capacity to consent were excluded. Patients who, in the opinion of the GP, were prone to violent or antisocial behaviour that may put the researcher at risk;

or those in receipt of social work intervention that led to criminal proceedings or the removal of children from the home were also excluded from the study.

Of those invited to take part, only one person was interviewed. Participants were given the opportunity to opt out via text message to the researcher's mobile phone and two people opted out prior to researcher contact. One person declined an interview due to current treatment and poor health and the remaining potential interviewees either refused to answer calls (n=1), were not contactable or remained unavailable after several calls (n=4), and finally one person had extreme speech difficulties and nominated their partner to be interviewed, who subsequently was not available to take the researcher's call.

There was insufficient time remaining to the project to request further contact details and undergo another wave of patient recruitment. However, lessons learned from this exercise suggest that the research team could have improved the recruitment rate if potential participants had been offered incentives such as shopping vouchers, which have facilitated recruitment in our projects with other 'hard to reach' groups (Jepson, Harris & Robertson et al. 2012). However, results from the single interview are used for illustrative purposes where appropriate, drawing cautiously on those views that can reasonably be interpreted as having wider resonance with this patient group. Recruitment data has been used to provide further context to the patient group targeted by the Govan SHIP initiatives.

Data collection and analysis

An initial scoping exercise was conducted in order to develop an 'intervention map' within the four GP practices that constitute Govan SHIP. This involved unstructured interviews (n=10) with staff from the four practices as well as relevant social work professionals. Interviews were supplemented by observations at MDTs hosted in three of the four practices, which took place during both phases of data collection. When an understanding of what was being implemented (or not) in the four practices were established, semi-structured interviews (n=20) were undertaken with health and social care professionals in a second phase of data collection. Table 2 illustrates data collection to date[1].

Table 2: Data Collection

	Numbers
Unstructured interviews (phase 1)	10
Semi-structured interviews (phase 2)	20
MDT observations (Fieldnotes)	6
Total data collection: 30 interviews & 6 MDT observations	

Unstructured interviews (in the first phase of data collection) aimed to target key health and social care professionals linked to the SHIP project in order to establish what the components of the intervention were and how they were being implemented in each practice. These (face-to-face) interviews were recorded as fieldnotes and analysis focused on mapping the contexts of the SHIP project, including variations in implementation across the four practices. As only three of the four

[1] Two interviews were conducted as paired interviews therefore there were a total of 30 interviews that included 32 individuals.

practices had implemented MDTs, observations were made in those three practices. These too were recorded via fieldnotes, concentrating on noting the range of health and social care professionals in attendance, multidisciplinary and cross sector working and the nature of interactions within these meetings. These observations have been incorporated into the semi-structured interview data related to MDTs.

Semi-structured interviews (either face to face (n=16) or by telephone (n=4)) were conducted in the second phase of data collection. These interviews ranged in duration from 30-80 minutes, with an average of 50 minutes. Individual topic guides were developed for patients (Appendix 1), health professionals (Appendix 2) and social workers/social care workers (Appendix 3) and the interviews followed an iterative approach, pursuing further detail on themes as they emerged from initial analysis. Semi-structured interviews were digitally recorded, transcribed verbatim and analysed using QSR NVivo (v11) software. The analysis followed the technique of constant comparison (checking experiences against those of others in the sample), to ensure that the themes represented a range of perspectives (Mason 2002, Miles & Huberman 1994, Pope & Zeibland 2011). Any contradicting or variable views were also explored in order to lend depth and variation to the analysis (Strauss & Corbin 1990). Unanticipated themes were also included (Pope & Zeibland 2011).

Ethical issues

The study adhered to ethical guidelines for good practice in research (BSA 2002). Ethical approval was awarded by the Research Ethics Committee of the Faculty of Health Sciences and Sport, University of Stirling. Additionally, advice was sought from the Research Ethics Committee of NHS Greater Glasgow and Clyde (GG&C) and formal clearance was not required on the grounds that this study was an evaluation. GG&C Research and Development office also advised that an honorary contract and letter of access was not required for this study.

Informed consent was sought and gained prior to the interviews. While we assured participants that confidentiality would be maintained, in this study anonymity could not be guaranteed given the small numbers of key professionals interviewed. However, where possible, we have tried to ensure that quotes or views were not attributable to individuals, although in a study of this nature this too is not always possible. Although this evaluation was initially designed to follow a case study approach, with each of the four GP practices representing a unit of analysis, we made the decision to abandon this in reporting the results of semi-structured interviews in order to protect the identity of those who gave important but potentially contentious views that were associated with particular roles. If we had linked these views to particular practices there was a high risk of making these participants identifiable. While we understand that much of what is reported here may have been already openly discussed among colleagues, nevertheless we approach reporting of potentially contentious views with caution.

The study data were only available to the University researchers. In this way we strove to maintain confidentiality as well as retain independence for the evaluation.

Data protection

The study complies with the terms of the Data Protection Act 1998. Participants were assigned a non-identifiable code and identifiable data (e.g. contact details) were held separately. This data will

not be used for any further purpose apart from contacting participants who indicated an interest in receiving a summary of the study results. At the end of the study all personal data will be destroyed.

Study data will be held securely on a single password protected university computer for a period of five years from the end of this study to facilitate any further dissemination of study results. This will then be destroyed. Any paper records (apart from consent forms) will be destroyed at the end of the study using University of Stirling confidential waste disposal.

Results

Initial unstructured interviews and observations were used to establish the intervention contexts. This is presented in tabular form in Appendix 1. All data sources were drawn on to inform the following results, with verbatim quotes from semi-structured interviews used where appropriate. We present an account of each of the major components of the SHIP project in turn: SHIP extra time, Social Work and Social Care Worker involvement, MDT working and finally, wider issues related to SHIP and the health and social care integration agenda. This section begins with an overview of the complex needs that are targeted by the SHIP initiatives.

SHIP Patient Contexts

A total of 69 patient details were provided to the research team, although seven were not eligible because they were under 18 yrs of age. This left a total of 62 patients. It is not known whether this was the total number of patients who had been recipients of SHIP extended consultations, SW or SCW intervention or had their cases discussed at MDTs. However the sample is notable for patient complexity in terms of health conditions and high levels of deprivation as indicated by the SIMD categories.

Of the 62 eligible patients in the sample, 49 were in SIMD category 1, which is the most deprived postcode area in Scotland. This fits with the GHC designation as belonging to the Deep End practices. Complexity is also represented with almost half of the sample having four or more conditions, with a range of 0-9 conditions. Depression was recorded for over 1/3 of patients. However, from the single interview done, we are aware that these data are not comprehensive and taking a wider range of conditions into account would see the morbidity count rise even higher. These findings are supported by the wider literature on Deepend contexts and areas of high deprivation, where complexity and multimorbidity are the norm, and are more severe (GPs at the Deep End 2012; Mercer & Watt 2007). Furthermore, mental health and psychosocial problems are more than twice as prevalent in deprived areas (GPs at the Deep End, 2014). Patients from deprived areas are also more likely to lack confidence in making health decisions and managing their illness and treatment (Chief Medical Officer's Annual Report 2014-15; Mercer et al. 2016); they are also more likely to have low health literacy and therefore need more support for self-management (Chief Medical Officer's Annual Report 2014-15).

The single patient interviewed confirmed our suspicions that the SHIP activity would have gone unnoticed by recipients of this attention. Although this person had multiple conditions and had been discussed at four MDTs, they had never heard of SHIP and had not noticed any difference in their care. Indeed when asked if they had noticed having longer consultations or home visits, the interviewee replied that the doctor was always the same: "*She never rushes me oot the door. … She took the time to listen".* In fact this participant repeatedly praised his GP who was '*brand new'* and health care more widely: "*I've nae complaints with the National Health at all* [mentions 4 hospitals]*…. Everybody done what they said they were gonnae dae within the time they said they were gonnae dae it*."

Ship Extra Time

> [T]*here isn't enough time to do what you want to do. I don't think there's even enough time to do what you need to do which is slightly worse again…*(Int 7, GP).

The above quote refers to the pressure on health care staff working within Deep End General Practice settings. Figure 1 below captures some of the key points from the literature related to working in Deep End General Practices as does the patient contextual information above.

Figure 1: Deep End General Practice Contexts

- Unmet need in deprived areas is significant, increasing demand and pressure on general practice (GPs at the Deep End 2009); and patients wait longer to access the care that they need and have lower levels of satisfaction (Mercer & Watt 2007)
- Mental health and psychosocial problems are more than twice as prevalent in deprived areas than affluent areas (GPs at the Deep End,2014) and yet clinical consultations is generally shorter (Mercer & Watt 2007)
- GPs in very deprived areas have insufficient time to address range & depth of patient problems (GPs at the Deep End 2009; Mercer & Watt 2007)
- GP stress is higher in deprived practices (Mercer & Watt 2007) and empathy with patients is lower, affecting patient outcomes (Mercer et al. 2016)

A recent report on the GP extra time at GHC (Watt nd.) explored the numbers and content of GP consultations arising from the 'extra time' initiative included within the SHIP project. This consisted of recruiting two locums to be shared within the four practices. This provided each of the 15 GP partners with time amounting to one session per week to be used as they saw fit. The majority of this additional time has been used to address the unmet needs associated with complex care. This has included, for instance, time for case review (in some cases within the MDT), extended consultations and time to attend case conferences (Watt nd.). There is an evident attention to addressing the inverse care law, by targeting additional capacity at those most in need of help. What follows represents some supporting data from qualitative interviews.

SHIP sessions (as many healthcare staff refer to the additional time) allow the time to focus on complex care planning. This enables GPs to explore both the health and social situations of patients and enables anticipatory care planning. One GP also referred to how the additional time enhanced patient centred care and shared decision making. This may well have also enhanced the doctor-patient relationship, allowing the GP to demonstrate enhanced empathy for the patient with more time to explore their issues.

> *But it's also been great to be able to say 'well I'm going to take extra time to find out more about your problem to understand the social situation better, to make plans with you'* […]. *It's been nicer to be able to do an anticipatory care plan that actually looks at not just the doctor's agenda* […] *but actually what the patient's priorities are, you know. The patient's main concerns at the moment might not be my worries about their critical*

diagnosis, it might be other stuff and being able to dig down that layer deeper has been great (Int 6, GP).

Two GPs stated that addressing the 'inverse care law' (Tudor-Hart 1971) was one of the major aims of SHIP, which was facilitated by the extra GP time: *I'd rank the inequality and inverse care higher than integration because I think I can actually deliver a lot of that by giving... I can give you more time now as an individual patient due to SHIP* (Int 10, GP). Staff also perceived that patients valued the extended consultations and that this made a big difference to them: '*patients really are aware they're having that little bit extra time'* (Int12 Practice Nurse). Again the perceived patient response suggests that the extra time allowed GPs to behave more empathically with patients, which (as noted in the literature above) has been shown to improve patient outcomes.

GPs spoke about using SHIP time to attend external case conferences or child protection hearings, where the person's medical history or that of family members made a valuable contribution to the hearing. Prior to SHIP, they often were only able to contribute comments via letter, email or telephone and sometimes missed the short deadlines for responding because of other time pressures. Interviewees revealed that other professionals valued this input and patients appreciated the supportive presence of their GP at these hearings.

Others spoke about how SHIP time was of wider benefit to practice staff simply because the extended consultation time either within surgeries or during house calls meant that a GP could tackle the range of health and social issues presented by a patient with multiple and complex needs, enabling a more incisive problem solving, thus:

It's taken a bit of pressure off the receptionists from that point of view, it's taken a bit of pressure off I think all the other GPs in the practice and potentially the trainees as well even though they don't have SHIP sessions because I'm more free to go and do that extended house call and actually address all the patient's problems rather than the patient phoning up two or three times a week because they still have an unmet need (Int 6 GP).

Similarly, some staff felt that the additional time spent in case review or in extended consultations had the potential to reduce A&E attendance as they had extra consultation slots to offer if a patient phoned with an injury.

Perhaps an unanticipated benefit of the extra time for GPs is that this may well reduce work-related stress and could help to mitigate the high 'burn out' in GPs working in areas of high deprivation (Mercer et al. 2016).

So there's an element of you feel now that you're in control to a certain extent of the workload which just felt completely chaotic before. There was absolutely no control of what happened to you during the day at all. Now I think for a profession to move forward and survive like general practice that's really, really important (Int 2, GP).

A usual day for a full time GP in GHC would begin at 8.30 in the morning and end at 7.30 or 8.00 pm in the evening with little or no time for breaks in between. Although the SHIP time didn't necessarily reduce the time GPs spent at work, it appeared to have an impact on wellbeing. As one GP put it, *I feel that I'm probably under less pressure and feel that you're actually getting things finished rather than... there always seems to be things that you're never quite, you know, finishing or are getting to* (Int 9, GP).

Indeed a Practice Manager was eloquent in her praise of the additional time for GPs. She felt that it reduced GP stress and enabled reports, referrals and telephone calls to be done during surgery time rather than extending the working day. She perceived the combined value of this to have led to an increase in social prescribing, with an increase in contact with external agencies. Thus, cross sector working was facilitated (Unstructured interview PM). Although the patient interviewed was not aware of having had any extended consultation, nevertheless he was aware of the pressures on NHS staff, including GPs: "*And these doctors are under pressure you know".*

There is some evidence that the ethos of targeting additional care at the most vulnerable in order to address the inverse care law has also motivated related activity within nursing staff (albeit without the benefit of SHIP time). For instance, one practice nurse talked about her work with the addictions group, explaining how she decided to give extra time to these patients in order to encourage them to accept treatment for Hepatitis C. She felt that the extra time had contributed to take up of treatment, '*it's all about trust and relationships and people don't get that, you've got to build it up and it takes time. You can't do it overnight'* (Int 12, Practice Nurse). However the extra time devoted by the practice nurse above was not related to SHIP time, but instead was time that she decided to prioritise within her existing workload.

Some practice staff perceived SHIP time as an exclusive benefit. While one GP argued that the benefits of being able to properly review a complex patient reduced the burden on other staff, some felt that the extra time made no difference to their daily work. However, there is little doubt that there are benefits for GPs and by exploring the extra time alongside other initiatives (such as the MDT), it is reasonable to assume that the additional time was also of benefit to patients. However, the allocation of time and how this was used by GPs varied considerably. For instance, one GP who worked full time explained that the extra time allocated meant that she had an additional 10 minutes on the end of each session. How much impact this would have had on sessions where there were a number of complex patients is questionable. Furthermore, it seems that some practices distribute the extra time equally between GPs regardless of their full time equivalent commitment. In this case, it would seem that what could be achieved by a part time GP would be far more than someone working full time where the additional time spread across their consultation sessions would only mean an additional 10 minutes per session.

Key Learning from SHIP time

Of benefit to GPs and patients:

- Addresses the inverse care law by providing additional health care to those with most need
- Facilitates complex care planning (also see use of time for MDT meetings)
- Allows GP attendance or more incisive engagement in external/multi-sector case conferences or hearings
- May reduce GP stress

Additional time can be easily 'swallowed up' by session time. Distribution of additional time according to number of GP sessions worked may be more equitable and allow for parity of potential impact across practices.

Because there is less obvious direct benefit to other practice staff – examples of benefit to patients should be shared/celebrated with all practice staff

Linked Social Workers

Bringing two social workers (one specialising in adults and the other in children and families) into the GHC to work across the four practices was core to achieving the aim of integrating health and social care. The original idea of social work integration reportedly (Int 20 Stakeholder) arose with one of the Govan GPs. Subsequently the local GP committee (including seven Govan GPs) approached the Scottish Government who were receptive to supporting a social work and health integration project. However, despite planning and discussions between primary care, the social work department and the Scottish Government that can be traced back several years, integrated working began with mismatched expectations coming from both social work and health care professionals. Initial experiences were charged with negative emotions, disappointment and ultimately, issues of mutual respect became a significant barrier to finding solutions to integrated working. Many of the issues reported by interviewees have been reported elsewhere, therefore summaries of this evidence will precede each of the major themes in this section.

A search of the literature on social work and primary care integration projects (from 1974-present) revealed that many of the papers discussed implementation or outcomes of social worker liaison or attachment schemes, or compared these models. Table 2 illustrates the comparison between these two models of integrated working. Appendix 5 provides key summary points from the literature search, some of which is also reported below.

Table 3: Comparison of Attachment and Liaison Models of Social Work in Primary Care, 1974 - 2015[2]

	Attachment	Liaison
Model	Medical Social Work Model	Social Services Model
Location	General Practice	Social Work office
Team	Primary Care team	Social Work team
Contact frequency & nature	Daily face to face contact with GPs, Nurses & Practice staff Regular formal meetings Opportunistic informal meetings or 'chats'	Contact mainly by phone or email May attend formal meetings Less contact with nurses Little face to face contact with practice staff
Referrals	Direct from Practice staff	Via usual Social Care referral channels
Main role	Generalist	Usually specialist
Practice focus	Practice population - patients identified by Practice staff Focus on casework	Specific care group eg elderly. May have continuing non-practice commitments eg caseload/duty rota. May or may not see Practice patients. May facilitate Practice referrals to other workers/teams or to screening centre Focus on statutory work or departmental priorities
Access	Universal; worker prioritises cases	Eligibility criteria; departmental constraints
Autonomy	Worker controls caseload & decides which approaches to use	Worker carries specified caseload, usually carrying out standardised procedures under managerial direction
Nature of referrals	Complex, psychosocial issues in addition to resource and practical needs	Practical or resource issues only for direct work; may pass on complex referrals to appropriate team
Tensions	Tensions between Social Workers & Primary Care professionals may be resolvable through time and discussion Tensions between attached Social Workers & Local Authority colleagues or management due to perception of succumbing to 'the medical model' or of departure from departmental priorities	Tensions between Social Workers and Primary Care professionals may be influenced by previous negative experiences of social care system, entrenched due to restriction of role and managerial control by Local Authority and lack of informal contact/time for discussion and learning Tensions may be resolvable through time and discussion but less evidence of this

In 1978, half of UK Local Authorities were involved in such schemes (Williams & Clare 1979, Corney 1985) and this continued until the 1990s (Cameron & Lart 2003).

Attachment was consistently preferred by GPs, nurses and social workers. Social workers reported more autonomy to work to professional ideals (Hudson 2002, Kharicha et al 2004); and GPs and social workers reported learning and changing practice positively (Lymbery 2006), even when the positive change had resulted from initial conflict. However, these schemes tended *not* to improve GP communications with Social Work Departments. GPs preferred to work with their known, named social worker and it has been suggested that fundholding GPs bought in social workers specifically to

[2] Sources: Corney 1985, Cameron & Lart 2003, Kharicha et al 2004

avoid dealing with the Departments (Lewis 2001). In turn, Departments were fearful that attached Social Workers would start to put Primary Care priorities above Departmental ones.

GPs and Primary Care staff generally perceived the liaison model as being less effective and more negative; with more conflict and communication problems. Liaison social work also involved simple practical/resource referrals rather than dealing with complex, psychosocial issues (Corney 1985). However, Social Work Departments appeared to prefer liaison schemes as these allowed them to retain managerial control (Cameron et al 2014).

Lymbery (1998) identified key actions in planning a successful attachment:

- review previous collaborations
- ensure the attached SW has more autonomy than in the Social Services Department
- develop referral methods that work for both the practice and the SW
- accept that LA eligibility criteria will limit the SW's ability to get funded resources
- ensure sufficient organisational development such that roles and responsibilities are clear from the outset

The SHIP model of SW integration

From both unstructured and semi-structured interviews it appears that SHIP adopted the liaison model of social work involvement in the GHC. Although initially the two social workers were purported to have had their posts 'backfilled' via funding from the SHIP project, nevertheless the picture of their involvement in the GHC appears to be one where they remained isolated from the health care 'community' and were perceived by practice staff as, on the whole, inaccessible. Referrals initially came from practice staff, but these came with unrealistic expectations and/or a lack of understanding of the social workers' roles, which then led to refusals to take action. It appeared that a perceived 'failure' to meet practice staff expectations swiftly degenerated into negative attitudes and relationships between the social workers and practice staff. Eventually the social workers scaled back involvement to two days per week each and their activity linked to the GHC became even less visible apart from their attendance at MDT meetings (reported further below).

One of the social workers noted: '*It was very clear I wouldn't be an attached social worker, I would be the link for social work and I think actually that fundamental part wasn't very clear to everybody and that's where lots of things for me went wrong*' (Int 1 SW). It seems that although there were presentations from social work to the steering group to explain what they could expect from the SW initiative, nevertheless there appears to have been either a lack of acceptance or a lack of understanding of what this would mean. While the literature cited above highlights clear definitions and role distinctions between attached and liaison models of SW, it is unsurprising that these terms may well have held no meaning for non-SW professionals. From the outset then, it seemed that the social workers were destined to fail to meet expectations as they entered GHC acting in the role of liaison social workers, while the GHC staff expected attached workers.

> *I realised that the two social workers would not be the people who were seeing the patients, they would be passing on messages to the people who would be seeing the patients and at a stroke the whole thing just collapsed in front of me because what I*

wanted, which was a relationship with the people who were working with the same people as me, wasn't going to happen (Int 7 GP).

This initial misunderstanding was at the root of the eventual breakdown in relationships that was to follow. The SHIP initiative experienced many of the challenges found in the literature on social work and health integration projects and evidence pertinent to understanding SHIP implementation is summarised in a series of Boxes, beginning with Figure 2 below.

Figure 2: General Practice - Social Work Attitudes and Understanding of Roles

- Little understanding or appreciation of the other's role on either side, & no change in this position over 40 years (Ratoff et al 1974, Cameron & Lart 2003)
- GPs have little confidence in the social care system and expect to be 'stonewalled' by indifferent officials (Mangan et al 2014, 2015, Hubbard & Themessl-Huber 2005)
- GPs sceptical about quality of SW assessment & have little knowledge of SW training or skills (Glasby & Miller 2015, Xyrichis & Lowton 2008, Mangan et al 2015)
- Negative stereotypes persist, reinforced by lack of meaningful communication: SWs see GPs as controlling, arrogant , disrespectful & intent on enforcing the 'medical model' whilst GPs see SWs as incompetent, unavailable, 'lefty tree-hugging do-gooders' & 'all about box-ticking' (Abramson & Mizrahi 1996, Griffiths & Glasby 2015, Hudson 2015, Mangan et al 2015)
- Relationship characterised by impatience, frustration, 'hostility & antagonism'; 'distrust and even contempt' (Williams & Clare 1979, Corney 1985, Cameron et al 2014)
- SWs felt GPs do not recognise they have established professional networks already – with Health Visitors, District Nurses, Midwives etc (Hudson et al 1997, Mangan et al 2015)
- GPs see SW role as accessing resources; SWs in 1980s described their role as therapeutic, by 2000 SWs reporting role as 'assessment' (Hudson et al 1997, 2002, Bliss et al 2000)
- SWs & GPs in successful schemes reported reciprocity and good relationships based on informal contact & discussion, 'despite the system' (Williams & Clare 1979, Hudson et al 1997, Lotinga 2015)

Initial expectations

It became clear that both the social workers as well as practice staff began their relationship without having a clear idea about what integration would mean and how it would actually be implemented. Indeed as one interviewee noted, '*it was woolly for everybody*'. Some staff based their initial expectations of the social workers on previous, extremely positive experiences of having a generalist social worker attached to GHC many years previously. Practice staff shared the belief that the social workers would take referrals and speed up the current access to services. Unfortunately, as the social workers explained, access to services is beyond the control of individual social workers as services are controlled centrally. Furthermore, as social work becomes increasingly specialised, referrals are passed to specialist teams so that, for instance, the children and families social worker would immediately refer on to a criminal justice team where appropriate rather than take any responsibility for those falling into this category.

Another issue that immediately soured relationships was the fact that the adult social workers were constrained by their departmental eligibility criteria for referrals, imposed as a result of dwindling

resources. Whilst the children and families social workers had some scope for preventive work, this was also limited by resource requirements. Early interviews with practice staff revealed the perception that the social workers held up their eligibility criteria '*like a shield*', that acted as a barrier to taking action. Again, the lack of understanding of how referral processes worked and the high thresholds that had to be met for eligibility led to resentment on the part of health care staff and negative behaviour towards the social workers. As time went on negative perceptions became entrenched and a social work team leader began attending meetings in the place of the adult social worker, who experienced the most negative reactions, partly due to the higher risk threshold and even less access to referrals than within children and families.

Governance and disciplinary boundaries also may have played an important part in skewing initial expectations, as has been found elsewhere (see Figure 3).

Figure 3: Status and autonomy

- GPs' professional status established & unchallenged. SWs' professional status threatened due to managerial control; lack of autonomy reduces the ability to develop new networks & ways of working (Hudson et al 2002, Johnson et al 2003, Kharicha et al 2005, Lymbery 2006)
- SWs' low status attributed to working with poor & socially excluded groups (Lewis 2001)
- GPs seen as 'drivers of spend' – essential partners in integration– so continue to have high status and power but nevertheless feel under attack and overworked (Leutz 2006, Hutchison 2015)
- GPs see themselves as leaders & are seen that way by others; nurses felt less able to speak up, particularly when employed in General Practices (Elston & Holloway 2001, Xyrichis & Lowton 2008)

As one senior manager explained:

> [T]*he GPs... and this is putting it at its crudest, I mean, were basically looking to direct the social workers and it was clear that wasn't going to happen in the sense that the social workers still had a line management back in social work and... what that led to was the service manager having to participate in the MDTs and always some negotiation taking place and clarification taking place about what social work... the social work staff who were going to be regularly present could and couldn't do* (Int 18 Stakeholder).

Indeed there was a serious clash in both culture and power, as with the integration effort, two powerful partners were brought together.

> *I think there are definite cultural differences and that Govan has exposed some of those and exposed, if you like, the lack of understanding that exists between different services about how they operate and the constraints around them, and I think that's come to be much better appreciated. I think it's also tested maybe the extent to which... professionals across multidisciplinary working actually work in an environment of mutual respect, and I don't think that's what Govan started from, I think it's moved towards that but it's been a tough battle and a bruising one* (Int 18 Stakeholder).

Philosophies of care

One of the areas of 'culture clash' between health and social work was in the perception of risk and individual choice, which was ultimately derived from different philosophies of care (see Figure 4).

Figure 4: Philosophies of Care

- Professional training & identity shapes philosophy of care. Professional identity reinforced by tacit or implicit knowledge which confers power but excludes others (Ratoff et al 1974, Hudson et al 1997,Bliss et al 2000, Cameron & Lart 2003).
- Medical training emphasises personal competence, accountability & decisiveness; a curative approach. SW training emphasises exploratory assessment, identification of strengths, enablement of choice & rights (Kharicha et al 2005, Williams 2012, Bliss et al 2000).
- Rescue v empowerment: very different attitudes to risk and urgency. GPs tend to seek immediate response & elimination of risk (eg residential care for a frail patient); SWs tend to aim for management of an acceptable level of risk in order to facilitate patient choice (eg remaining at home in a less than ideal environment) (Kharicha et al 2004, 2005, Hubbard & Themessl-Huber 2005).
- Language use - the same word (eg 'enablement') may be interpreted very differently by GPs, Nurses & SWs (Lymbery 1998, Bliss et al 2000).

One of the contentious areas was in the ways in which needs were perceived. As reported in the literature (above), the social workers spoke of an 'enablement' and a 'rights-based' approach to addressing need. There were many instances where social workers refused to take action when health care staff had identified risk and vulnerability. What constitutes 'risk' was a contested category, and considerable frustrations were expressed on both sides. For instance, one patient was referred to a social worker because the referrer thought the person didn't have the capacity to take care of themselves. However, on investigating, the social worker found that despite learning difficulties, this person had supportive neighbours and in fact did not meet a threshold for incapacity that would warrant social work referral. In another example, an interviewee spoke of the way that their professional judgements were undermined and although there were real benefits of working together, this could have been obscured within tense relationships.

> *"the social worker's not done this, the man needs a service" and "social work aren't doing their job" and you're like…"has he got capacity?", you know, that's not my role. But you're like, "he's got capacity, yes it's a shame he's choosing to live his life like that but it is his life and we can't intervene" and interestingly enough that was the one that ended up removing the children and you think "that's not come to my attention yet, but you're bringing up about..."* (Int 2 SW).

However, there were understandable concerns expressed by nurses, health visitors and GPs that they could predict a downwards trajectory of a patient that would inevitably lead to repeated hospital admissions unless some form of preventive action were taken. As one practice manager stated in one of our early interviews, "Sometimes people in very deprived areas don't fit into boxes, so how can they make an assessment based on general criteria?" Unfortunately, with management

and budgetary constraints such as they are, there was little that social workers were able to offer in terms of preventive care.

Another issue was that of prior consent to intervene. This also highlighted a different approach to the delivery of care. Whereas health professionals would routinely make decisions about what a patient needed and advise them accordingly, social workers (unless circumstances such as adult or child protection were involved) require potential clients to consent to engage in social work processes and cannot 'force' people to accept services that they do not agree to. As one senior stakeholder elaborated: '*a social worker does not have the right to come in and take over and control someone's life'* (Int 11 Stakeholder).

Enablement was also a term used by social workers to contrast their practices with health care colleagues. '*I think sometimes it was about they were wanting us to do things for people instead of we would say, "No, they can do that themselves, what reason is it they can't do that themselves?"*' (Int 1 SW). They gave examples of a perceived ethos of care that in some cases promoted dependency on health professionals, such as doing things for patients rather than supporting them to do things themselves. However, the language of enablement appeared to be one that was not always demonstrated in practice, as there was (particularly in terms of adult social work) little evidence of supportive and enabling social work on the ground. Indeed one of the CLPs pointed out (in an unstructured interview) that signposting to services does not work with this population, "If you give them a leaflet and tell them to go to such and such a service, they won't do it. There are too many barriers and they would just give up." Nevertheless it is important to understand this point within the context of the constraints on current models of social work and possibly the impact of degenerating relationships.

Comparison with Links worker

One feature of the social work involvement was the unfavourable comparison made between the social workers and the Community Links Practitioner (CLP), otherwise known as the Links worker. There were two Links workers based in two of the four GHC practices. The Links workers were an external initiative running alongside the SHIP project and there had been considerable pre-implementation planning, as well as careful attention to recruitment and training of the CLPs. Mostly recruited from community development backgrounds, the CLPs had the training and experience to do what, unfortunately, GHC staff hoped the social workers would do. The one major difference would be that they expected a gold plated service: someone who would work within the community with complex patients, but also be able to undertake social work assessments and referrals. This comparison, alongside the misguided expectations, contributed further to negative relationships with the social workers.

The CLPs were universally highly regarded and there was some evidence of boundary maintenance work between the two professions from the outset, with tensions developing around roles and expectations of what collaborations might mean. Furthermore, the CLPs also understood risk and vulnerability very differently to the social workers and this too caused tensions in their relationships. However, there were examples of some positive joint working between the CLPs and social workers. For instance, one family required social work intervention but did not like/mistrusted social workers. Since the CLP already had a good relationship with the family, they accompanied the social worker on a visit and together they managed to achieve a resolution.

> *There'd been some other issues that had presented that were flagged up by the police, so the social worker was able to come to me and say 'look, we've got this extra report in, we need to go back out, will you come with me?'* (Int 4 CLP)

Benefits of social work involvement

Although the history of social work involvement in the GHC experienced challenges, nevertheless there were benefits and many lessons were learned (on both sides) over the time that the two social workers were in place. As the initial social workers returned to their previous posts, social work team leaders stood in, providing a fresh start and a more positive environment prior to bringing in two social care workers to replace the social workers. The tone of staff responses changed dramatically from early interviews to those conducted later in the evaluation, demonstrating that with time to reflect, lessons had been learned and there had been a shift in attitudes. This meant that interviewees were able to see the positive aspects of social work involvement that may initially have been obscured by the negative relationships.

In crisis situations (particularly where there was a statutory role involved), the social workers were reported to act swiftly, professionally, collaboratively and their efforts were highly valued. These situations were also ones where the social workers may have repaired some relationships.

> *But equally the health visitor in* [practice name] *was excellent and I would say we'd done a good piece of work with a referral that had come that would've went to social care direct for a notification of concern,* […] *that came on my desk on the Monday, so very quickly I'd got that, whereas* […] *that would've went through to social care direct, there would've been a delay before I got, well whoever got that to follow that up, but myself and the health visitor were able to act on that immediately and she was, I've got a lot of respect for this particular health visitor, so I have had positive* [experiences] *and it's really important to highlight that* (Int 2 SW).

And from a GP perspective there were also acknowledgements of the value of the collaboration with social workers:

> *So I think that whole process probably worked a little bit better because we knew the social workers and they had been working alongside us and we'd been sort of working towards this kind of crisis so when it happened at five o'clock at night we were able to... we have the confidence in each other to just go out and sort it out* (Int 9 GP).

Hospital discharge planning was also facilitated by relationships between social workers, GHC staff and the hospital-based team, although there also were examples of some tensions around perceived needs on discharge.

Social work presence at MDT meetings improved information sharing between the health and social work systems, which is explored further in the section below. However, this was an area of mutual learning that could inform future practice.

> *I do think there's faults on both sides and I think one of the things as well is that it was obvious is we don't actually feedback to primary care, you know, the referral comes in and they don't know what happens with it in social care direct, there's no feedback, we're not the best at that I think* (Int 1 SW).

Some of the GPs acknowledged gaining an understanding of the eligibility criteria and working with the social workers to learn more about *how* to make referrals and the level of detail required was of significant benefit. It led to improved information provision to social work, which in turn was more likely to achieve a positive result for the patient. Furthermore, as one GP noted:

> *So I suppose there's a positive to it both in terms of* […] *you know, making a better referral but also knowing that a referral's not going to be accepted means that I don't have to waste energy trying to have it accepted and I can divert that energy into looking for other solutions for the patient* (Int 6 GP).

Finally, while there were also improvements in understanding of SW roles and eligibility criteria, after a 'bruising' start, ultimately it appeared that relationships were also improved with the social work department.

> *I think probably eventually better relationships between general practice and the social work department and I think a better understanding from our side of what can be expected and what they can offer, and maybe better signposting to other organisations that might be able to help* (Int 9 GP).

Social Care Worker Initiative

By November 2016 the two social workers had returned to their previous roles and team leaders attended MDTs in their place. The learning from the social work involvement led to the understanding that what would better fit the needs of GHC and patients was a social care worker (SCW) model, where the worker was expected and able to engage with patients to do the kind of 'social work' that had been a feature of generalist social working in the past. However, they would also be able to access social work information systems and share information as well as do assessments and make referrals.

> *We didn't realise just how specialised that* [social workers] *had become, but also how separate they'd become from third sector, voluntary sector, homecare type services. So as the project has evolved it became clear to us that it wasn't fully qualified social workers that we actually needed, but what we needed was social work care workers who could give us access to the social work system* (Int 5 GP).

At the time of interviewing, the SCWs were only recently in post, although one of them had attended MDTs some months previously in order to provide some SW input when the adult SW left GHC. Thus, she was able to make initial observations that cast light on the change over time:

> *I think the approach from everyone's completely different from before, so I don't know what came around or what happened or whether higher management decided 'this is what needs to be done', and I suppose at the very beginning it was a learning curve, everybody... you know, although you're going forward with something it's all new to*

everyone, so it's about, you know, and mistakes we'll be making and maybe you know, people's attitudes change or whatever (Int 14 SCW).

Implementation and inception issues

It appears that the implementation of the new SCW initiative has happened with little notification or involvement for the GHC staff. For instance, two health visitors (HV) were unaware that a SCW had attended the MDT, pointing to the need for more pro-active engagement and information sharing both on the part of SCWs as well as senior GHC staff. As one of the HVs noted:

The problem is when you go to these meetings there's no introductions so I don't know who half of them are, honestly...(Int 13 HV).

There appears to have been little information provision to practice nurses (PNs), HVs or District Nurses (DNs) as well as to a member of the Rehabilitation Team that was interviewed. Given the previous history with social work, it would appear essential that the way forwards is prepared for collaborative working and encouraging the development of relationships. As one DN said, '*Well they've not came to see me and I've not gone to see them, so again maybe that's something that I should make the effort to do'* (Int 15 DN).

Another issue worth highlighting is that there appears to be a lack of clarity around accountability and governance of the SCW. While the SCW clearly understands that they will continue to be line managed by the social work department, because they are employed via SHIP project funding, this may not be clear to others. For instance, a SCW mentioned that on an early visit to GHC she was asked to do photocopying for a member of staff, which she promptly refused to do. While this was not reported with bad feeling, it is important to establish issues of accountability at the outset to avoid the potential for misunderstandings to occur. As one GP admitted, '*I think... you see they're employed by the project but I think it's through the HSCP they're employed – I don't know, I don't actually know the contract, I'm not sure...'* (Int 2 GP).

The social care worker role

The SCWs communicated a great deal of enthusiasm for their new roles and talked about their hopes and expectations of what they could do going forward. One highlighted the importance of joint working and information sharing thus:

A lot of parents' vulnerabilities affect kids but it won't be known to Social Work. Also, in A&E, when kids are taken to hospital, A&E contact the GP. Frequent contacts about kids being taken to A&E may be indicative of something else going on, maybe just ignorance of health and safety, maybe some other risk. If I find out about that at the MDT, I can go to see them, offer support, again its preventative. […] *If we can intervene and offer support, it might prevent a child protection situation and show people Social Work has a support side as well* (Int 16 SCW).

GPs also expressed expectations that the social care workers would be able to engage with patients in a way that was not appropriate for social workers, while also maintaining access to social work information systems and referrals.

Well I think that we learned from the year that we've already had that they understand their role, that they're able to work autonomously, and when I mean autonomously I mean they're able to work beyond specific criteria and protocols that they can take referrals and they can because they're a sort of generic practitioner (Int 2 GP).

Potential benefits

There is evidence that SCWs are already working with patients to find solutions to complex problems. An example was given of a SCW working collaboratively with nursing staff to address the needs of a frail elderly patient in a way that would not have been possible or appropriate for a qualified social worker.

I linked in with his housing officer, she got a deep clean carried out in the house, got it all... we were able to get furniture, we were able to get different things, you know, he accepted homecare, got him into a daycare centre, a wee gentleman who was 91 who told me it was true, daycare centres were all full of old people [laugh] but he agreed to go once a week and we got him a befriender and that was a great working (Int 14 SCW).

Key Learning from Social Worker and Social Care Worker Initiative:

Social work attachment and generalist rather than specialist social work better fits the needs of primary care. Social care workers are potentially a more appropriate way to meet the needs of complex patients.

Social workers are constrained by budgetary imperatives, managerial control and have to work within scarce resources.

Eligibility criteria for referrals are non-negotiable, but working with social workers helps to establish higher quality referrals that have a greater likelihood of a positive outcome.

Mutual respect and inter-professional understanding with clear shared goals are key to successful integrated working.

Accountability and line management needs to be clearly defined and agreed between sectors at the outset.

Nursing and allied health professionals routinely work closely with social work and third sector organisations therefore should be involved in planning and actively engaged in implementation in order to facilitate understanding and improved communication.

Multidisciplinary Team Working (MDT)

There was much support for MDT working and for MDT meetings, although there were also some suggestions for improvements. While there were some clear benefits, reservations were expressed, some of which were addressed over time. This highlighted the capacity for adaptation and innovation that is sometimes identified as a hallmark of General Practice. Early on in the SHIP project, one of the four practices withdrew from this initiative so our observations were only pertinent to the remaining three that took part in MDTs. Meetings were held monthly and brought a wide range of health, social work and third sector professionals together to discuss complex patients. The three practices varied considerably in the ethos of meetings, some appearing more collaborative/collegiate than others, and also displaying a different range of external professionals' involvement.

As only two MDTs were observed in each of the practices, we simply present here observations across the board of what worked well, what the facilitating factors may have been as well as identifying challenges to be overcome. Observations are supplemented by commentary from both phases of interviews.

MDT Working Pre-SHIP

Some interviewees pointed out that MDT working was not new to them. Particularly DNs, HVs and SWs had been involved in *cross sector* MDTs for many years, albeit in meetings without GP involvement. It is perhaps unfortunate that nursing and other professionals had not been consulted or involved in planning the MDTs as the new initiative might have been informed by their prior experiences. In contrast, while GPs had varying degrees of experience with MDTs, this tended to be with GPs, PNs, HVs and DNs, for instance, rather than including members of social work or third sector. Secondary care appeared to routinely benefit from MDTs with social work or SCW involvement.

One stakeholder contextualised the potential value of the SHIP model of MDTs for complex patient care:

> *[M]ultidisciplinary teams weren't discovered by the Govan SHIP, I mean, there are plenty of examples elsewhere. I think what the Govan SHIP has tried to do is to give them a much higher profile and make them much more essential for complex cases and had consideration about the range of services that need to be involved* (Int 18 Stakeholder).

GP-led MDTs with social work involvement were an innovation new to all, despite varying levels of prior exposure to MDT working.

> *[I]t has become more formalised and more structured and obviously the big difference is having the attached social worker at the meetings to be able to access social work records which we couldn't do before. And through their laptop thankfully we can access Care First*. (Int 2 GP).

Benefits and strengths

When the MDT works well, it provides a positive platform for integrated working, establishing and fostering cross sector relationships.

> *[Y]ou build up networks over the phone with social workers but you never really get to see these people and it's actually nice at the MDT you can actually put a face against a name and you can start to sort of engage and build up a rapport with the social workers.* […] *I think, networking's got to be good, it's got to be good and it's all done for the good of the patients, so ultimately it's them that we're here for* (Int 15 DN).

One of the major benefits is that the MDT enhances complex health and social care planning by bringing professionals from a range of disciplines together to inform patient care. This is another illustration of the implicit attention to addressing the inverse care law that runs throughout the SHIP initiatives. By bringing together a range of professionals to address the needs of complex patients, this served to once again target considerable additional resources to those in most need. Patient care was facilitated by the sharing of information between those attending the meeting, each of whom may have had different encounters with the patient.

> *[J]ust to discuss patients within the MDT was been very useful because you get a lot of background social information from having the social workers there, and equally we're able then to share information with them about patients. So it's a lot more joined up I think and I think that's a positive* (Int 3 OT).

The MDT also appeared to facilitate anticipatory care planning prior to hospital discharge. In one meeting the SW was able to update the team that a patient, who was complex with continual changes in circumstances, was being discharged from hospital. Being able to then describe SW and housing actions allowed a GP to then plan a review with the patient. The information sharing that took place at these meetings was enhanced partly through tapping into wider networks (in this case the SW links with the hospital-based social worker) or through gaining access to the SW information systems via the social worker's laptop. This was widely regarded as beneficial to staff and patients alike.

While SW involvement (at least initially) in the MDTs did not lead to referrals, with the SCWs came the ability to work with patients within the community at a level that was below risk and eligibility criteria thresholds. One SCW spoke enthusiastically about the benefits of receiving referrals from colleagues within the MDT,

> *Social Work would never have got this as a referral, it came up at the* [MDT] *meeting. So it wouldn't have been picked up that there was a young mum maybe not coping, until there was a crisis…* (Int 16 SCW)

Another benefit of MDTs was the positive impact on staff wellbeing (with the caveat that this was when there were no unpleasant or tense encounters between staff). The MDTs were perceived to have a supportive role, breaking down isolation.

> *[Y]ou can feel quite isolated and feel that you're the only person feeling that way and then when you're round the table and there's other folk round that table that have had the same problems, you know, and ultimately sometimes that's even just a support to hear that* (Int 15 DN).

Furthermore, there was the potential to reduce worry and anxiety about patients by getting feedback about patients who were a long-standing concern.

[W]e had someone came along from the money advice service for a particular patient that we've been struggling with for a long time with housing issues, with benefit issues, with various issues tied up to chronic ill health throughout most of his adult life, and it was great to have them come in and say "Right well actually I've been working with him, we've found this, we've found that, I've made contact and the go to person at his housing association is this person, pop that in his notes so that if you ever have an issue in the future…" That's been brilliant (Int 6 GP).

Facilitating factors for positive MDT working

From observations of meetings with more positive ethos as well as outcomes, a number of factors were identified as facilitators or active mechanisms. These gradually became more obvious over time with an observed improvement in relationships across the sectors:

- A welcoming atmosphere with staff introductions at the beginning
- Encouraging all members to engage in discussion and contribute views
- Being respectful of others' views and disciplinary perspectives
- Social workers/SCWs providing advice and reassurance regarding patients even when direct action/referral were not possible
- Being willing to build and maintain relationships and a willingness to learn from other disciplines
- Being adaptive to change and receptive to criticism (see adaptations below)

Adaptations and improvements

Over time a number of improvements were made to the format and organisation of MDTs. Firstly, agendas were better planned to allow staff to drop in and out according to relevance. This was also facilitated by preparing and disseminating an agenda and list of patients for discussion in advance of meetings in order to facilitate information gathering prior to the meetings as well as timing of attendance.

So you need to be, obviously cause they're really busy people, so you need to organise it so that you've got the people that you need to talk to them about perhaps at the one time, cause they obviously don't have the luxury of coming sitting for a meeting for two hours, that's been, you know, like trying to make sure that everybody gets their say (Int 12 PN).

Challenges

One senior manager explained how the SHIP MDTs were a work in progress, acknowledging the organisational challenges posed by large meetings including a wide constituency of professionals:

I think about whether Govan has necessarily found the most efficient way to do that and I think when you always have meetings with a wide membership the task is often about making sure you utilise that most efficiently, and I know Govan has been searching for ways to make the best use of everybody's time (Int 18 Stakeholder).

Nursing staff in particular expressed concerns that they were less involved in the meetings, some stating that they did not have the opportunity to suggest patients for the list in advance of the meeting. It would seem that attention should be paid to ensuring participation across all disciplinary groups. However, there are differences across practices, reflecting perhaps different team relationships between GPs, PNs, DNs, HVs and AHPs. Indeed one GP spoke explicitly about the fact that although the MDT was currently GP-driven, his wish would be that this need not always be the case:

> *I could see a situation and I would hope for a situation in the future if an MDT like this works well, where a social worker would bring your patient along and saying 'we're seeing this patient, they've not seen the GP for a while but they have been seeing the district nurse, can we get some feedback from the district nurse?' and actually I have nothing to contribute there, that would be great. That would be the MDT working well, it'd actually be where an interaction happens between health and social care that isn't GP driven* (Int 6 GP).

Time devoted to meetings versus a perceived patient benefit requires to be maximised in order to fully engage all who are invited to the MDT. This poses significant challenges and there is a need for further and more collaborative planning across health, social work/care, third sector and any other professional groups that may have involvement in these meetings.

One further issue that poses a challenge is the issue of sharing information of a confidential nature by accessing social work or general practice electronic databases. This was mainly highlighted by social workers and SCWs and was yet another bone of contention in some MDTs. However, this challenge appears to have been addressed to a certain extent by limiting the amount of information passed on to, for instance, reassuring that a patient was in the system or already allocated to a social worker rather than divulging full details. While some GPs found this frustrating and deemed it unnecessary, nevertheless given legal restrictions on the sharing of personal information, this is one challenge that should be carefully considered, with perhaps the need to work on agreements between sectors about data sharing.

Finally, while important work can be done during these meetings, several participants pointed out that these meetings are only monthly and '*a lot can happen in a month'.* While the time investment suggests that more frequent meetings may not be feasible, perhaps the more extended networks might devise informal, ad hoc arrangements to facilitate more regular cross sector involvement where required (such as the informal cross sector networks already used by some DNs and HVs).

Wider Issues Related To Ship Initiatives

There were some other wider benefits of the SHIP initiatives. One GP suggested that the positive impact of the SHIP initiative had made the practice an attractive prospect to GPs and had facilitated recruitment during a period where practices across Scotland were facing GP shortages. Furthermore, general practice can be regarded as a site for innovation, because of the relative autonomy enjoyed by GPs.

> *[B]ecause we are self employed and employ people or staff, you know, we can be quite... you know, we are working in a managed environment but we've got more opportunity to be dynamic and think 'let's change how we work within those parameters'. Social work I don't think have got the same liberty* (Int 10 GP).

However, some professional groups expressed concerns that GPs were not necessarily the best placed to lead the integration agenda, and that SHIP required a driving leadership that was neutral in terms of the two key sectors/professions. A stakeholder interview revealed that in fact SHIP had initially been led by a project manager within the HSCP, which would have ideally placed them in a neutral managerial role. However this person moved on and another project manager was brought in who, by all accounts '*did a terrific job*' of picking up the pieces and attempting to rescue what by then may have deteriorated into a difficult situation.

With the impending move towards GP cluster working, the imperative to find management solutions to continuing the SHIP journey become even more pressing. In addition to this, there needs to be a widening of consultation and involvement in planning of services. Currently, only GPs appear to have been involved in cluster planning and development. Concerns were expressed thus:

> *And we haven't been* [involved] *at all and the practice managers have been excluded as well. Now when you're... you know, the people who run the practice are the practice managers and the practice nurses, the GPs do not run the practices, so I mean, if they want the clusters to be a success they need to be bringing in definitely the practice managers and... And practice nurses* (Int 12 PN).

However there was a definite enthusiasm for cluster working and a perception that this would be beneficial for both staff and patients.

> *Yeah I think the cluster's the way to go isn't it, it's to have like your midwifery clinic in the cluster and your health visitor. I mean, it used to work really well, we used to have the midwife clinic and the health visitor clinic running at the same time so the health visitor got to see the girls that were pregnant and the girls that were pregnant got to see who the health visitor was and everybody knew who everybody was and we all knew who everybody was [laugh], but it's not like that now* (Int 12 PN).

It was also felt that cluster working could facilitate the integration agenda as it would maximise scarce resources and professional capacity. Furthermore, cluster working was regarded as an opportunity to disseminate the learning from SHIP more widely to other GP practices.

I think the fact we're moving forward to neighbourhoods and communities and clusters model, again that's ideal for us, we're not going to be able to send a social worker to every single MDT, so how do we make sure the learning from this event and from our project is shared with the other GPs, how do we build that understanding? And it won't be any one thing, it'll be a whole combination of things all coming together to make a difference (Int 11 Stakeholder).

Discussion

While the SHIP project has experienced considerable challenges, ongoing adaptations to various components of the intervention demonstrate benefit from the lessons learnt along the way. This discussion focuses on synthesising our findings, informed by normalisation process theory (NPT). NPT offers an analytical framework to unravel the implementation issues inherent in complex interventions, it: *'focuses on the social processes and work that people do, individually and collectively, to make an intervention work'* (Bamford et al. 2012: 2). The key components of NPT are as follows:

- 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.

The following sections are structured under these NPT headings, with each section referring to the integration and change management literature that is also presented in summary tables in Appendix 6. Borrowing from the approach used by Bamford and colleagues (2012), the SHIP evidence is synthesised in tabular format with potential strategies for overcoming challenges highlighted as appropriate. These strategies are informed both by the analysis and available evidence. Recommendations informed by the literature are synthesised in Appendix 7.

Coherence: initial understanding, values, and shared goals

The cultural dynamics of NHS and Local Authority organisations have been identified as a "major barrier" to integration (Hutchison 2015), and there is evidence that changes in reaction to political agendas are frequently under-researched and undermined by short-termism, restrictive deadlines, and lack of support for building collaboration (Lewis 2001, Williams & Sullivan 2010, Hudson 2015, Drumm 2012). Lack of time for organisational development, preparation, training and support can cause initiatives to fail; while unclear distinction between integrated organisations at the strategic level), integrated working (at the level of organisations) and integrated care (at the patient-focused level) is unhelpful (Dickinson & Glasby 2010, Griffiths & Glasby 2015, IRISS 2012, Glasby & Miller 2015, Petch 2012). There has been insufficient research on integration and inter-professional working, despite being a constant theme since the 1970s. Indeed the existing literature highlights a lack of knowledge and skills to achieve integration (Cameron & Lart 2003, Davey et al 2005, Valentijn et al 2015).

Key to the issue of coherence of the SHIP project was that although senior managers from the HSCP and Social Work Department along with the GP partners within GHC had long established planning relationships, the aims did not appear to have been worked through into *how* the social work and health integration would be implemented. Although the core values and goals were agreed by all, 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.

There seemed to be some variance in understandings of how core values might feed into action, particularly around health inequalities and the Inverse Care Law. All participants recognised, from their practice or management perspectives, the reality of many patients' lives: premature multimorbidity and widespread psychological problems, exacerbated by deprivation and complex social need. Research evidence suggests that these factors, resulting in low patient confidence and enablement (O'Brien et al 2011, Mercer & Watt 2007, Mercer et al 2016), are a major barrier to the current strategic aims of improved self-management, lifestyle modification and shared decision-making (Scottish Government: Healthcare Quality Strategy 2010, National Clinical Strategy 2016). In addition, it is asserted that the consequent increase in unmet need impacts primary and social care co-ordination and results in more patients accessing acute care (GPs at the Deep End 2010).

Addressing the Inverse Care Law is a core project aim from the Deep End perspective and that of the practices, particularly the GPs – however, whilst the Strategic Plan commits to supporting primary care approaches to tackling inequalities, addressing the Inverse Care Law (by whichever actions) is not an explicitly stated aim of the HSCP. Whilst improving health outcomes and enablement by targeting care on the most vulnerable were universally shared values, *how* this would be actioned and *what* short-term outcomes could be achieved varied in the responses from participants.

It is clear that having more time to address the complex needs of vulnerable patients reduces GP stress and may improve recruitment and retention in deprived practices; and it is likely that longer consultations will support relationship-based care (Scottish Government 2010). As recent research has suggested (Mercer et al 2016), this may also help to prevent decline in patients' quality of life. Clearly a qualitative study cannot answer whether the extra time is *effective* in meeting the goals of intervention, but the quantitative data collection that is ongoing within the GHC practices may be able to link data collected on GP extra time with patient outcomes.

Table 4: Coherence of the SHIP aims and goals

SHIP Aims and goals	Understanding	Strategies for promoting coherence
Strategic level aims: 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.
Values Addressing the inverse care law Addressing the complex and health and social needs of GHC population Better working relationships, better understanding	Stakeholders and GPs use this language but the ethos of targeting care at those of most need also understood/valued by other staff.	
Intervention level SW linked to primary care	All practice staff: rapid referrals/access to SW services; governance of SWs SW: advice, education re eligibility criteria; accountable to SW line management	
SHIP time	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.	
MDT	Differential understanding: GPs: a mechanism to achieve integrated working SW and other staff: adding to what already in place either formally or through informal networks	

Cognitive Participation: engagement and buy in to the intervention

The next stage of pre-project work is that of engaging all of the relevant professional groups in order to encourage 'buy in'. Evidence from previous studies suggests that this stage of intervention development is crucial, given the challenges identified in the integration project. While practitioners are often supportive of joint working, the default position of managers may be self-interest and turf protection (Williams & Sullivan 2010, IRISS 2012, Ham et al 2013, Cameron et al 2014) and given the budgetary constraints on social work in particular, and potentially behind the scenes protectionist activity instigated by the wider integration agenda, it is unsurprising that ultimately there were mismatched expectations between/across sectors. Professionals may also have high levels of scepticism and protectionism due to fear of losses in the process of policy-driven change (Cameron & Lart 2003) and this may well have been the starting point for social workers entering into GHC, which was clearly led by a group of GPs who were seen to be driving change.

Mechanisms	Outcomes	Strategies for promoting cognitive participation
<u>Initiation</u> 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.
<u>Enrolment</u> 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 (Rummery & Coleman 2003, Petch 2012).
<u>Legitimation</u> 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 essential to address poor understanding of others' roles, stereotypes and culturally reinforced attitudes (Mangan et al. 2015). Top-down, policy-driven imposition of change may result in resentment and unwillingness to share tacit knowledge (Williams & Sullivan 2010, Dickinson & Glasby 2010, Ahlgren & Axelsson 2011); need to involve all constituents in driving implementation.
<u>Activation</u> 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 regarded as a time burden with little perceived benefit.	Networking between historically hostile professional groups must be facilitated to build relationships (Glasby et al. 2013) 'Boundary spanner' in a leadership position has the ability to understand different cultures of working and facilitate positive relationships and networks (Greenhalgh et al. 2004, Williams and Sullivan 2010).

Collective Action: the impact of implementation in practice

Often it is only this phase of complex interventions that is more visible, that is, the implementation activity itself. As the intervention gained traction, the mismatched expectations of the two key sectors led to professional confrontations and rapidly deteriorating relationships. These issues have been noted elsewhere in studies of integration projects (reported in the results) and bear repetition. Historically, there has been little understanding or appreciation of each other's roles (GPs and SWs) and this has not changed in over 40 years (Ratoff et al 1974, Cameron & Lart 2003). While the literature states that GPs were sceptical about the quality of SW assessment and have little knowledge of SW training or skills (Glasby & Miller 2015, Xyrichis & Lowton 2008, Mangan et al 2015), our data reveal that this attitude persisted across all of the professional groups linked to GHC that were interviewed. However, the literature also suggests negative stereotypes held by SWs persist, regarding GPs as controlling, arrogant, disrespectful and intent on enforcing the 'medical model' whilst GPs see SWs as incompetent, unavailable, and 'all about box-ticking' (Abramson & Mizrahi 1996, Griffiths & Glasby 2015, Hudson 2015, Mangan et al 2015). The interviews certainly revealed this still to be the case and the project proceeded along a trajectory reported elsewhere, with relationships characterised by impatience, frustration, 'hostility & antagonism'; 'distrust and even contempt' (Williams & Clare 1979, Corney 1985, Cameron et al 2014). Finally, another aspect highlighted by the literature is that historically, SWs felt that GPs did not recognise that SWs had pre-existing professional networks with Health Visitors, District Nurses, Midwives and so on (Hudson et al 1997, Mangan et al 2015). This also proved to be the case here.

Mechanisms	**Impacts**	**Strategies for promoting collective action**
<u>Interactional workability:</u> 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	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. 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

Mechanisms	Impacts	Strategies for promoting collective action
	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	and organisation in order to reduce time burden, demonstrate relevance and ensure that engagement is maintained across all roles/sectors. 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.
<u>Relational integration: credibility of practice within the network</u> Agreement about knowledge required, expertise and contribution of participants, what practice is valid, useful, authoritative	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)	
<u>Skill set workability: definition of agents and tasks & ability to deploy</u> *Agreement about allocation of tasks and resources, hierarchies, definition of skill sets,*	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	

Mechanisms	Impacts	Strategies for promoting collective action
autonomy of agents, quality of skills <u>Contextual integration: control over resources and agents</u> Allocation of resource, distribution of risk, who has power, how work will be evaluated, who will be advantaged	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 clear to project. 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.	

Reflexive Monitoring: looking back at the experience of implementation

In this section we explore the capacity to reflect, adapt and learn from the SHIP project. Rather than set this in tabular format as above, we instead report under the NPT headings: systematization, communal appraisal, individual appraisal and reconfiguration.

Systematization

This item concerns how those involved in an intervention determine impact through data collection. At the whole project level, the commissioning of this qualitative evaluation demonstrates a willingness for independent scrutiny and it is hoped that this document will promote further reflexive monitoring across the community involved in the SHIP project. At the GHC level, data collection instruments/processes have been implemented in order to measure quantitative outcomes and this is ongoing. Thus the project will benefit from learning and reflection regarding key outcomes achieved in future. This evaluation may contribute towards understanding some of those outcomes within the context in which they are achieved.

Communal and individual appraisal

Communal reflection and appraisal appear to have been confined to the community of GPs and stakeholders within the HSCP, academic general practice and the social work department. Interviews with these participants revealed a sea change over the course of the project indicating a change in knowledge, attitudes and behaviours that bode well for future integrated working within the GHC. However, the learning that has driven this positive change has again involved the capacity to reach out to senior managers across sectors and to benefit from the ability to have an impact on the direction of travel. 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.

Study limitations

While this evaluation has taken a multi-strategy approach to exploring the implementation of the SHIP project, as a qualitative study it can only present data on implementation views and experiences. While qualitative methods are ideally suited to achieving an understanding of the finer nuances and processes inherent in a complex intervention, they cannot provide an answer to the question of effectiveness, which is better suited to randomised controlled study designs. Furthermore, the evaluation was commissioned when the initial SWs were ending their involvement in GHC therefore we were mainly informed by retrospective accounts, some of which remained coloured by negative experiences and emotions. The analysis has paid careful attention to variations in views and experiences, thus we urge caution in attributing views of one health care professional to all who share that role as indeed has this report. Finally, this report does not benefit to any extent from the views of those who might benefit most from the SHIP project, namely, GHC patients. However, due to the nature of the SHIP interventions, it is possible that further patient interviews would simply confirm findings from one patient, that while they were extremely positive about their health care, they were unaware that anything had changed at GHC.

Conclusions

This report has drawn on qualitative methods to explore the implementation of the SHIP project in the GHC. The SHIP project has met with considerable challenges posed by bringing together two formally distinct sectors. Boundary maintenance and protectionism underlie much of the tensions experienced here and elsewhere in integration projects and the members of the SHIP team are to be congratulated from moving from a position of negative, entrenched views and hostility towards a shared understanding and new learning. However, as highlighted above, more needs to be done to engage a wider constituency of professionals in SHIP project implementation in order to maximise benefit from the wide range of expertise and experience within health, social work and third sector organisations. Ultimately, SHIP began with an ethos shared and valued by all: to develop new ways of working to address the complex health and social needs of the GHC population. With time, it is hoped that a further iteration of the NPT cycle reported above, might reveal a reflexive monitoring where all constituents remain engaged, invested and full contributors of the SHIP integration model.

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Appendix 1: Interviews with patients – topic guide

PERSONAL BACKGROUND

1. I'd like to start by finding out a bit about you. How long have you been living in this area? Do you have family living in this area?
2. Please could you tell me a bit about how you use the health centre?

   Explore:

   - Care needs (in brief), frequency of visits
   - What health care professionals they generally seek help from at **the surgery** (e.g. practice nurse, GP, physiotherapy etc)
3. Who would you want to talk to if you were having difficulty coping?

   Explore:

   - Whether they would approach someone in the healthcentre
   - Whether they feel able to discuss problems, anxieties and who with

IMPACT OF GOVAN SHIP

4. Your GP practice is part of something called Govan SHIP. Have you heard anything about this?
   Explore:
   - What they may have heard (if anything) and any expectations associated with this
5. In the last year, have you noticed anything different in your experience of using the practice?
   Explore:
   - Time with GP/accessibility of health care staff
   - Did they know about the social workers, when in post?
   - Aware of the social care workers before they were referred?
6. Thinking about the changes that we've talked about – have they made any difference to you or your family?

LONGER GP APPOINTMENTS/HOME VISITS

7. Some patients are being offered longer appointments (or home visits) with their GPs under certain circumstances. Were you aware that you had an extended appointment with your GP? (NB We will know if this is why they were selected by their GP for interview)
8. How would you compare this appointment/visit with your normal experience of seeing the doctor?

   Explore:

   - if they know why they were offered an extended apt or visit?
   - how was it different?
   - any benefits, such as addressing other issues? What worked well (if anything) for you?
9. Since extended GP appointments are something new, we would be keen to hear what you think of this, also if there is anything you think could have worked better?

SOCIAL CARE WORKER INVOLVEMENT

10. Social care workers were recently brought in to work in the Health Centre and you may have had some contact with them. Please can you tell me a bit about that?

    Explore:

    - how they made contact and why; did they initiate contact/were referred by a HP?
    - what was achieved (if anything) e.g. improved ability to cope; access to community resources or information, referral to other services

11. (If appropriate) …. How would you compare the help that you received from social workers in the past to your recent experience with social care workers linked to the Health Centre?

    - Referral time ; possibility to self refer/bypass health care team?
    - Benefits of being within the health care team (if any)

12. Thinking of your recent experience that you had of social care involvement, what (if anything) worked well for you?

13. Since having social care workers within the health centre is something new, we would be very keen to also hear what could have worked better. Can you tell us what might have made the new social care worker system work better for you?

15. How would you sum up your experience of having an extended appointment with/home visit from your GP?

FINAL THOUGHTS…

16. What else would you like to see developed in the health centre?

17. Finally, is there anything that we haven't talked about in relation to what's going on in your practice that you'd like to add?

Appendix 2: Interviews with health professionals: topic guide

INTRODUCTION

1. Please can you tell me a bit about your role in this practice?
   Explore:

   - Length of time with practice; any specific role related to SHIP

2. What would you say are the aims of the Govan SHIP project?

EXPECTATIONS & EXPERIENCE OF SOCIAL WORK INVOLVEMENT

3. What were your expectations of having social workers linked to the health centre?
   Explore:
   - Previous contact with social workers/knowledge of their expertise
   - Involvement in planning integration of service (*how did this initiative come about?*)

4. How did the involvement of social workers in your practice work out in practice?
   Explore:

   - Impact (if any) on multidisciplinary team working (*were SWs part of the MDT?; relationships between SWs and rest of team*)

   - Decision-making and patient care (*involving SW perspective, SW referral times, access to social care/benefits/housing advice etc; accountability of SWs)*

   - Capacity issues related to patient care (*e.g.potential to release HP time)*; finance and resource issues (cost:benefit?)

   - Lessons learned

EXPECTATIONS AND EXPERIENCES OF ATTACHED SOCIAL CARE WORKERS

5. Since the social workers left the Health Centre, social care workers (SCWs) have been brought in. Please can you tell me a bit about your **initial** experience/expectations of this initiative?

   Explore:

   - Did experience with the SWs impact on attitude towards social care workers?
   - Involvement in planning for the new roles; any planned integration with existing local service/ any planned roll out of how to involve the SCWs?

6. Now I'd like to ask you about the impact (if any) of having SCWs attached to the Health Centre. Please can you tell me what sort of role they are fulfilling in your practice?

   Explore:

   - Clarify distinction between SCWs and Link workers if appropriate
   - Involvement in MDT?
   - Benefits (if any) – give examples/case studies
   - Challenges (if any) – give examples

7. How would you sum up your thoughts on the involvement of social care workers in your practice?

BROADER IMPACT OF GOVAN SHIP

8. We spoke earlier about the aims of Govan SHIP and your role(s) in the SHIP initiative. Can you tell me more about the activities your practice has been involved in with SHIP – what does it mean on a day to day basis for you?

9. What would you say has worked well – and less well? What would you like to retain or enhance?

10. What difference has Govan SHIP made? How do you know it has made an impact?

11. What other (similar) initiatives would you like to see developed?

12. Finally, is there anything that we haven't talked about in relation to current initiatives in Govan/your practice that you'd like to add?

Appendix 3: Interviews with social workers/social care workers topic guide

INTRODUCTION

1. Can you tell me a bit about yourself and your current role?
   Explore:

   - Was this the role they returned to after Govan attachment?
   - Model of social work ??

BACKGROUND TO THE GOVAN HEALTH CENTRE ATTACHMENT

2. I am interested in exploring the background to your attachment to the Govan Health Centre. First of all, could you tell me what your understanding was of the aims of the Govan SHIP initiative more generally?

   Explore:

   - Knowledge of health and social care integration agenda (policy/practice level)
   - Social work landscape at the time of introducing this
   - Any consultation/involvement in planning or implementation prior to taking up the role
   - Knowledge of/contact with Link Workers

3. How did you come to be selected for the role of social worker located in Govan Health Centre?

   Explore:

   - Selection process: voluntary, mandatory placement etc
   - Motivations (or not) and potential engagement in the initiative
   - How the role was presented to them (if not involved in planning/consultation); their expectations

EXPERIENCE OF WORKING IN THE GOVAN HEALTH CENTRE

4. Can you tell me about your experience of being introduced to the Govan Health Centre – can you talk me through those first few weeks in post?

   Explore:

   - Perceived model of working within the practice
   - Involvement in the practices (or not); integration into the MDT (or not)
   - Expectations of practice staff; their understanding of SW role

- Initial workload

ACCOUNTABILITY AND GOVERNANCE

5. While you were at the health centre, who were you accountable to on a daily/weekly/monthly basis?
   Explore:
   - Autonomy/restrictions on practice; potential conflict between needs of health and social work sectors
   - Potential conflict between biomedical and social care/social justice approach
   - Capacity to engage with primary care population

6. How was contact with patients initiated?
   Explore:
   - Referral process within the health centre
   - Referral times
   - Referrals from other sources? (existing case load, if applicable)

EXPERIENCES OF SOCIAL WORK INTEGRATION

7. What was the impact (if any) of having social workers linked to the Health Centre?

   Explore:

   - Challenges encountered; structural/infrastructure/organisational barriers; 'culture clash' between social work/medicine?

   - Were there any benefits to being located in the Health Centre?

8. In the light of your experience, what would you have done differently?

   Explore:

   - What could have been different on a personal practice level

   - How the experience might inform planning/implementing another social work and health integration project?

   - Whether they see any benefits to pursuing this model in future, albeit with adaptations?

VIEWS OF THE SOCIAL CARE WORKER INITIATIVE

9. The health centre is now introducing social care workers into the practices. Did you have any involvement in planning or implementing these new roles?

   Explore:

   - Did they know about this; were they involved in planning the new roles

- Have they had contact with the SCWs; any involvement in preparing/advising them

10. What would your advice be to the SCWs going forward? How might their expertise best be drawn on to maximise the care and wellbeing of people with complex needs?

11. Finally, is there anything that you'd like to add that we haven't spoken about?

Appendix 4: Cross case comparison of interventions

Intervention	Green	David Elder	Blue	Yellow	Comments
Additional GP time	4 SHIP sessions : 1 shared session to facilitate MDT attendance Some SHIP time used to keep 2 slots per surgery for 'breathing space' or unplanned longer consultations, home visits Double appts for patients with multimorbidity Physical space constraints impact on practice	4 SHIP sessions 1 per GP partner Home visits Case review/conferences Follow up on social prescribing Some physical space constraints	4 SHIP sessions 1 per GP partner + 1 additional session shared by 2 GPs Text reminder system reduces DNA Home visits Case review/conferences Follow up on social prescribing	Not participating at present – seeking locum	*Positively regarded by practice staff* *Increased GP capacity evidenced, felt to have improved patient outcomes/reduced crisis appts/ improved links with external agencies* *Strong relationships with GP trainees = familiar & reliable locums with investment in SHIP*
MDT meetings	GP partners attend DN attends PN attends some meetings HV attendance impacted by staffing shortage External workers attending (Rehab OT) CF SW & Adult SW TL attend SWs have laptops: CareFirst CLP attends EMIS available on MDT pc - GP shares with MDT & records discussion Sept 2016: SCWs attending in place of SWs	GP partners attend GP trainees attend DNs attend PN attends HV attendance impacted by staffing shortage External workers attending (Pall Care Nurse, CFSW) CF SW & Adult SW TL attends SWs have laptops: CareFirst CLP attends EMIS on large screen Lunch/refreshments provided Sept 2016: SCWs attending in place of SWs	GP partners attend PN does not attend DNs attend but attendance variable due to staffing issues HV attendance impacted by staffing shortage External workers attending (Community Staff Nurse, Rehab OT) SW attendance variable EMIS not on screen Sept 2016; Rehab OT attending SCWs or other SWs attending in place of SWs	Not participating at present	*MDT meetings observed to vary in terms of attendance, duration, external workers.* *Attendance observed to be increasing for all practices* *Observation was limited to 2 MDT meetings for each practice*

Intervention	Green	David Elder	Blue	Yellow	Comments
	Admin: HSCP	CPNS (CMHT) have attended Admin: HSCP	Admin: HSCP		
Social workers Adults/elderly 1 WTE CF 1 WTE	Elderpark Clinic Mon & Fri Attend MDT meeting Very low practice profile Adult SW remit limited by eligibility criteria CF SW undertaking some limited preventive work Some joint working CFSW/CLP Sept 2016: SW co-location discontinued, replaced by SCWs	Elderpark Clinic Mon & Fri Attend MDT meeting Very low practice profile Adult SW remit limited by eligibility criteria CF SW undertaking some limited preventive work Some joint working CFSW/CLP Sept 2016: SW co-location discontinued, replaced by SCWs	Elderpark Clinic Mon & Fri Attend MDT meeting Very low practice profile Adult SW remit limited by eligibility criteria CF SW undertaking some limited preventive work Sept 2016: SW co-location discontinued, replaced by SCWs	Not participating at present – not holding MDT meetings as no locum. SWs not involved in other ways	*Widely seen as an unsuccessful initiative by practice staff/HPs* *Viewed as more successful by SW staff* *Some GPs felt it had limited success* *Some communication issues around language, attitudes to risk, understanding/acceptance of roles* *Sept 2016:* *Some of above issues resolved, issue of consent to share information ongoing*
Social care workers Adults/elderly 0.25 WTE CF 0.5 WTE	Elderpark clinic Mon & Fri Sept 2016: Attend MDT meeting Remit to share CareFirst & some direct support work	Elderpark clinic Mon & Fri Sept 2016: Attend MDT meeting Remit to share CareFirst & some direct support work Some joint working SCW/CLP	Elderpark clinic Mon & Fri Sept 2016: Attend MDT meeting Remit to share CareFirst & some direct support work	No - not holding MDT meetings as no locum. SCWs not involved in other ways	*Both very experienced* *Appears more scope for preventive or supportive work with patients* *Appear keen to build relationships with practice, community health & Links workers*
Links worker attached?	Yes Attends MDT meeting Based in practice	Yes Attends MDT meeting Based in practice	No	No	*Highly regarded by clinicians* *Practices report increased knowledge*

Intervention	Green	David Elder	Blue	Yellow	Comments
	Strong identification with practice	Strong identification with practice			*of local resources CLPs having to take on complex case management roles Yellow Practice was keen to have CLP*

Appendix 5: Key points from the General Practice and Social Work Integration Literature

Themes	Summary	Source
CULTURAL/ PROFESSIONAL		
Philosophies of Care; Aims & values	Professional training & identity shapes philosophy of care. Professional identity reinforced by tacit or implicit knowledge which confers power but excludes others Medical training emphasises personal competence, accountability & decisiveness; a curative approach. SW training emphasises exploratory assessment, identification of strengths, enablement of choice & rights. Rescue v empowerment: very different attitudes to risk and urgency. GPs tend to seek immediate response & elimination of risk (eg residential care for a frail patient); SWs tend to aim for management of an acceptable level of risk in order to facilitate patient choice (eg remaining at home in a less than ideal environment) Language use - the same word (eg 'enablement') may be interpreted very differently by GPs, Nurses & SWs	Ratoff et al1974 Hudson et al 1997 Bliss et al 2000 Cameron & Lart 2003 Kharicha et al 2005 Williams (2012) Bliss et al 2000 Kharicha et al 2004, 2005, Hubbard & Themessl-Huber 2005 Lymbery 1998, Bliss et al 2000
Understanding of roles; attitudes	Little understanding or appreciation of the other's role on either side, & no change in this position over 40 years GPs have little confidence in the social care system and expect to be 'stonewalled' by indifferent officials GPs sceptical about quality of SW assessment & have little knowledge of SW training or skills Negative stereotypes persist, reinforced by lack of meaningful communication: SWs see GPs as controlling, arrogant , disrespectful & intent on enforcing the 'medical model' whilst GPs see SWs as incompetent, unavailable, 'lefty tree-hugging do-gooders' & 'all about box-ticking' Relationship characterised by impatience, frustration, 'hostility & antagonism'; 'distrust and even contempt' SWs felt GPs do not recognise they have established professional networks already – with Health Visitors, District Nurses, Midwives etc GPs see SW role as accessing resources; SWs in 1980s described their role as therapeutic, by 2000 SWs reporting role as 'assessment' SWs & GPs in successful schemes reported reciprocity and good relationships based on informal contact & discussion, 'despite the system'	Ratoff et al1974 Cameron & Lart 2003 Mangan et al 2014, 2015 Hubbard & Themessl-Huber 2005 Glasby & Miller 2015 Xyrichis & Lowton 2008 Mangan et al 2014, 2015 Abramson & Mizrahi 1996 Griffiths & Glasby 2015 Hudson 2015 Mangan et al 2015 Williams & Clare 1979 Corney 1985 Cameron et al 2014 Hudson et al 1997 Mangan et al 2015 Hudson et al 1997, 2002 Bliss et al 2000 Williams & Clare 1979 Hudson et al 1997 Lotinga 2015
Status & autonomy	GPs' professional status established & unchallenged. SWs' professional status threatened due to managerial control; lack of autonomy reduces the ability to develop new networks & ways of working	Hudson et al 2002, Johnson et al 2003 Kharicha et al 2005 Lymbery 2006

Themes	Summary	Source
	SWs' low status attributed to working with poor & socially excluded groups	Lewis 2001
	GPs seen as 'drivers of spend' – essential partners in integration– so continue to have high status and power but nevertheless feel under attack and overworked	Leutz 2006 Hutchison 2015
	GPs see themselves as leaders & are seen that way by others; Nurses felt less able to speak up, particularly when employed in Practices	Elston & Holloway 2001 Xyrichis & Lowton 2008
ORGANISATIONAL		
Budget disparities	Funding disparity between Health and Social Care continues to be a barrier to collaboration; constant restructuring & service cuts entrench negative & fearful attitudes	Lymbery 2006 Williams & Sullivan 2010 Dickinson & Glasby 2015 Hudson 2015
	Means-testing, charging & eligibility introduced in Social Work/Social Care in 1980s and has become increasingly constrained, resulting in resources being reserved for those in critical or substantial need only; preventive work difficult or impossible in adult services	Kharicha et al 2004 Johnson et al 2003
	Social work management fear of cost-shifting (in frail elderly care) or losing their budget to the competing organisation, caused resistance to, or even sabotage of, collaborations with 'Health'	Hudson et al 1997, 2002 Cameron & Lart 2003 Johnson et al 2003
Models of control & influence	Local Authorities answer to politicians, so are dependent on what is politically prioritised; concern that elected members have too much influence & do not support collaboration due to fear of loss of territory	Lewis 2001 Rummery & Coleman 2003 Griffith & Glasby 2015
	GPs value informal network-based communication; In Social Work the introduction of performance management requiring managerial approval for all decisions removed workers' autonomy & capacity to develop networks	Hudson et al 2002 Banks 2004 Kharicha et al 2005 Lymbery 2006
	Bureaucracy v 'Adhocracy': Hierarchical bureaucracies place value on rules, control, processes & internal stability; GP Practices can prioritise versatility, innovation & adaptability.	Drumm 2012
	Interface between GPs as independent contractors & rival bureaucracies competing for money is problematic	Hudson et al 1997 Rummery & Coleman 2003
	SWs felt 'swamped' by bureaucracy	Mangan et al 2015
POLITICAL/ STRUCTURAL		
	While Primary Care continues to be generalist, generalist Social Work was phased out in the 1980s in favour of 'client groups' and specialisation; incompatible with General Practice	Hudson et al 1997, 2002
	The NHS & Community Care Act 1990 introduced a care management model in Social Service departments, replacing social casework with technical tasks, standardised assessment procedures & routine care plans, discouraging creativity & discretion	Kharicha et al 2004 Lymbery 2006

Themes	Summary	Source
	Quasi-market model introduced by the 1990 Act required SW departments to outsource social care, resulting in fragmentation and SW having an 'enablement' & signposting rather than direct support role	Lewis 2001 Johnson et al 2003
	Joint Futures (in England, NHS Plan 2000) & similar initiatives have had little positive impact on interprofessional relationships due to continued budget conflicts particularly in area of chronic conditions & frail elderly, outsourcing of 'traditional' SW to the growing Third Sector & disempowerment of practitioners and MDTs, preventing innovation	Johnson et al 2003 Glasby et al 2013
	Insufficient research on interprofessional relationships in general & GP/SW relationship in particular	Cameron & Lart 2003 Glasby et al 2013 Valentijn et al 2015

Appendix 6: Key Points in Health & Social Care Integration and Change Management Literature

Key Points	Summary	Source
Organisational & professional cultural barriers are a significant problem, but can be addressed by skilled & transparent collaboration leadership	Cultural dynamics of NHS and Local Authority organisations are a "major barrier" to integration	Hutchison 2015
	Existing social and professional networks influence attitudes to change & should be valued	Greenhalgh et al 2004, Cameron & Lart 2003
	Professionals have high levels of scepticism and protectionism due to fear of losses in process of policy-driven change	Cameron et al 2014
	Consensus building & ownership of shared values, understandings & outcomes is essential at all stages	Rummery & Coleman 2003, Petch 2012 Mangan et al 2015
	Practitioners often keen on joint working, but default position of managers may be self-interest & turf protection; bureaucratic management models are often unsupportive of change	Wiliams & Sullivan 2010, Drumm 2012
	Interprofessional training essential to address poor understanding of others' roles, stereotypes and culturally reinforced attitudes	Ratoff et al1974, Corney 1985, Elston & Holloway 2001, Cameron & Lart 2003, Glasby et al 2013, Mangan et al 2014
	Interprofessional working most effective when professionals retain clear roles but "put on the team jersey" in the MDT	Hubbard & Themessl-Huber 2006
	Requirement for leaders to be honest, flexible & transparent in engaging with their staff & counterparts.	Hutchison 2015 Iriss 2013
Change as a reaction to political agendas, with "delivery deadlines", can be detrimental to outcomes	Change in reaction to political agendas are frequently under-researched & undermined by short-termism, deadlines & lack of support for building collaboration	Lewis 2001 Williams & Sullivan 2010, Hudson 2015 Drumm 2012
	Lack of time for organisational development, preparation, training and support can cause initiatives to fail	Dickinson & Glasby 2010, Griffiths & Glasby 2015, Petch 2012, Glasby & Miller 2015
	Unclear distinction between integrated organisations (strategic), integrated working (organisational) & integrated care (patient-focused) is unhelpful	Petch 2012
	Insufficient research on integration & interprofessional working, despite being a constant theme since the 1970s, means the knowledge & skills to achieve integration are lacking	Cameron & Lart 2003, Davey et al 2006, Valentijn et al 2015
Change is emergent; new knowledge can be synthesised & new networks & processes can be constructed; MDT	Integration in complex systems takes time, and can only work through continued practice, experimentation and reflection	Hubbard & Themessl-Huber 2006, IRISS 2012 Williams 2012
	Sense-making is a central activity in all organisations & is retrospective	Checkland 2007
	Synergistic outcomes may include new networks & processes which build social capital for both project & participants	Williams & Sullivan 2010

Key Points	Summary	Source
working can become part of a new professional identity		
Integration is more successful if practitioner-led	Horizontal networks more likely to implement change & necessary for effective collaboration; hierarchies are a barrier to change	Greenhalgh et al 2004, Johnson et al 2003, Bliss et al 2010
	Integration is more successful when operational decision-making is devolved to practitioners or MDTs	Greenhalgh et al 2004
	Lack of practitioner autonomy in Social Work perceived as a barrier to integration	Hudson et al 2002, Johnson et al 2003, Lymbery et al 2006
	Most effective collaborations are between equal networks of autonomous practitioners; empowering participants with less power in the MDT (eg nurses & social workers) is likely to produce more effective integration	Hudson et al 1997, Lymbery 1998, Leutz 2006, Bliss et al 2000.
	Top-down, policy-driven imposition of change may result in resentment and unwillingness to share tacit knowledge	Williams & Sullivan 2010 Dickinson & Glasby 2010 Ahlgren & Axelsson 2011
Relational mechanisms are key to effective integration	Relationships more important than structure & function	Valentijn et al 2015 Williams & Sullivan 2010
	Engagement & communication with all relevant stakeholders necessary from an early stage	Rummery & Coleman 2003 Petch 2011
	Historical relationships influence attitude to change; Empathy, humility & respect necessary to improve historically difficult relationships	Petch 2012, Drumm 2012 IRISS 2013 Mangan et al 2014
	Trust essential for sharing of tacit knowledge necessary for interprofessional working	Hutchison 2015 Williams 2012
	Informal networks support relationships crucial to integration	Glasby et al 2013
	Networking between historically hostile professional groups must be facilitated to build relationships	Glasby et al 2013

Appendix 7: Recommendations from literature on integration of health & social care & relations between general practice & social work 1974-2015: Structure & Agency

Recommendation	Source
STRUCTURE	
Adaptivity & flexibility in organisational structures	Greenhalgh et al 2004
New primary care focused social work teams aligned with GP clusters	Mangan et al 2014 Lotinga 2015
Workers with linking role between medical and social care	Leutz 2006
Sufficient development capacity, particularly around organisational cultures, trust and attitude	Williams & Sullivan 2010 Petch 2011
MDTs with control of resources	Johnson et al 2003
Support for existing horizontal networks	Hudson et al 1997 Bliss 2000 Cameron & Lart 2003 Greenhalgh et al 2004
Time to learn by doing and synthesise knowledge	Hubbard & Themessl-Huber 2005 Williams & Sullivan 2010 Williams 2012
AGENCY	
Co-location	Williams & Sullivan 2010
Interprofessional differences should be addressed at planning stage	Rummery & Coleman 2003
Support continuous experimentation and reflection to facilitate learning	Williams & Sullivan 2010 Williams 2012
Shared training & interprofessional development	Ratoff et al 1974 Corney 1985 Elston & Holloway 2001 Cameron & Lart 2003
Conscious team building (& resources to do this)	Lymbery 1998 Cameron & Lart 2003
Empowerment: Social workers/nurses need more autonomy to vary practice to suit primary care setting	Lymbery 1998 Leutz 2005
Empathy and humility on both sides	Mangan et al 2014
Collaboration leadership - “boundary spanners” – individuals in leadership positions with the ability to understand multiple cultures and create relationships and connections	Greenhalgh et al 2004 Williams & Sullivan 2010