Research and Theory

Integrated team working: a literature review

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Abstract

Introduction: This literature review was conducted to provide a background understanding of the literature around integrated health and social care prior to a research project evaluating two integrated health and social care teams in England, UK.

Methods: A systematic literature search of relevant databases was employed to identify all articles relating to integrated health and social care teams produced in the last 10 years in the UK.

Results: Sixteen articles were found and reviewed; all were reviewed by the first reviewer and half by the second reviewer.

Discussion: Key themes identified were: drivers, barriers and benefits of integrated working; staff development; and meeting the needs of service users.

Conclusion: Recommendations for integrated working include; a focus on the management of integrated teams; a need to invest in resources for the successful integration of teams; a need for the development of clear standards for monitoring the success and failure of integrated teams; and the need for further empirical evidence of the processes used by integrated teams. These findings will be valuable for practitioners who are establishing services or want to improve integrated care in their own practice.

Keywords

integrated, health, social, care, inter-disciplinary, service user, needs

Introduction

This paper provides an overview, a macro perspective of the literature on integrated care in health and social care in the United Kingdom (UK); directed to an international audience to inform it of the key issues relating to integrated care. This review was undertaken to provide an understanding of the literature relating integrated working prior to commencing an evaluation of two different models of integrated working in community settings in England, UK [1]. Integration of both national health services and local government adult services is at the heart of national policy, from both a commissioning and provision of services perspective. The development of commissioning in this area is a high priority for many Primary Care Trusts and Councils within the UK.

The City Council that commissioned this research was experimenting two models of integration; one co-located health and social care team serving a specific neighbourhood, and the other a city wide service employing 'dedicated lead workers' who navigate ser-

vices on behalf of individual service users across the city. This literature review provided an overview of integration and informed the evaluation of the service.

Definition of integration

There are numerous definitions of integration [2] but for the purpose of this paper integration is seen as the assimilation of organizations and/or services into single entities, allowing for greater transparency between partners as well as enhanced benefits for service users [3]. Through integration of services it is believed that fragmentation between providers can be minimized, this being of greatest benefit to service users, especially those with complex needs [3].

From an international perspective the idea of integrated care is relatively new, yet within the context of health care reform throughout the world, it is also very necessary. This paper provides a systematic review of current literature in this context; explores how integrated care has developed in the UK; articulates the main themes to emerge from this; and contributes by providing an understanding of the issues that impact integrated care, suggesting ways of overcoming the barriers to its success. Thus providing an insight into how internationally policy might be changed to facilitate integrated care for it to be successfully realized in practice.

Methods

A systematic literature review was conducted to investigate the evidence regarding the development of integrated health and social care teams for adults and older people in the UK. Prior to devolution, differences in health policy across the four countries had been minimal. Devolution has provided the four countries of the UK (England, Scotland, Wales and Northern Ireland) with the freedoms to pursue and develop their own health and social care policy. Subsequently, there are differences in the way integrated care has been interpreted and developed in each country of the UK [4, 5].

Search strategy

The literature search involved collating information from peer reviewed articles published from 2000 onwards, to ensure up to date and relevant research was included. Multiple databases and search terms were used; search terms included 'integrated', 'inter-professional', 'health and social care', 'multi-agency', 'joint working' and 'shared services'. Databases searched were: Web of Science; the Allied and Complementary Medicine

Database (AMED); the Cumulative Index to Nursing; Social Care Online; PubMed; and Allied Health Literature (CINAHL).

The inclusion criteria used were that the articles had to be research based or literature review papers about integrated health and social care teams, providing services to adults and older people in the UK. Excluded articles were those connected to children and families, and the private sector.

Results

The initial cross database search revealed 488 search results (see Table 1).

A further search using Social Care Online and PubMed exposed a further 1570 articles (see Table 2).

Titles and abstracts were read and articles were included or excluded using the criteria above. One article was unavailable and could not be retrieved by inter-library loan. A hand search revealed one additional paper [2] published following the initial database search.

The final literature review is based on 18 articles. Three of these articles [6–8] were based on the same data and so combined into one discussion point. Following in-depth reading of the articles one further paper was rejected [9]. This paper discussed the possible issues for holistic care in black and minority ethnic communities but little information was provided therefore the article was unsuitable for review. All the literature was reviewed by one reviewer (AB), and the second reviewer (SM-P) reviewed half of these. A critique of the selected 18 articles is discussed in Table 3 below.

Discussion

The literature review provides an understanding of the relevant literature relating to integrated health and social care teams providing services for adults and older people in the UK. In order to develop a clear narrative of the key issues, the articles are discussed using key themes evident to the authors. These themes are: models of integrated working; drivers and barriers to integration; the benefits of integrated working; issues around staff development; and important issues for service users.

Models

There is no universal definition of integration and there are multiple models of integration [2]. Coxon [10] differentiates between two models of integration—stand

Table 1. Table to show the initial databases searched, dates searched, search terms used and number of journal articles available (Total number=488)

Database	Date	Search terms	Hits
AMED via EBSCO	16/01/09	Interprofessional and integrated	2
AMED via EBSCO	16/01/09	Interprofessional and health and social care	4
AMED via EBSCO	16/01/09	Interprofessional and joint working	0
AMED via EBSCO	16/01/09	Interprofessional and shared services	0
AMED via EBSCO	16/01/09	Integrated and health and social care	16
AMED via EBSCO	16/01/09	Integrated and multi-agency	4
AMED via EBSCO	16/01/09	Integrated and joint working	3
AMED via EBSCO	16/01/09	Integrated and shared services	0
AMED via EBSCO	16/01/09	Multi-agency and joint working	1
AMED via EBSCO	30/01/09	(Integrated or interprofessional) and health and social care and (multi-agency or joint working or shared services)	7
AMED via EBSCO	30/01/09	(Inter-professional or interprofessional) and health and social care	22
AMED via EBSCO	30/01/09	Integrated and health and social care	16
CINAHL via EBSCO	16/01/09	Inter-professional and integrated	12
CINAHL via EBSCO	16/01/09	Inter-professional and health and social care	9
CINAHL via EBSCO	16/01/09	Inter-professional and multi-agency	1
CINAHL via EBSCO	16/01/09	Inter-professional and joint working	1
CINAHL via EBSCO	16/01/09	Inter-professional and shared services	0
CINAHL via EBSCO	16/01/09	Integrated and health and social care	149
CINAHL via EBSCO	16/01/09	Integrated and multi agency	34
CINAHL via EBSCO	16/01/09	Integrated and joint working	23
CINAHL via EBSCO	30/01/09	(Integrated or interprofessional) and health and social care (multi-agency or joint working or shared services)	16
CINAHL via EBSCO	30/01/09	Inter-professional and integrated	12
CINAHL via EBSCO	30/01/09	Inter-professional and health and social care	9
CINAHL via EBSCO	30/01/09	Integrated and multi-agency	33
Web of Science	07/02/09	(Integrated or interprofessional) and health and social care (multi-agency or joint working or shared services)	114

Table 2. Additional databases searched, dates searched, search terms used and number of journal articles available (Total number=1570)

Database	Date	Search terms	Hits
Social Care Online	25/01/2010	Interprofessional and integrated	80
Social Care Online	25/01/2010	Interprofessional and joint working	112
Social Care Online	25/01/2010	Interprofessional and shared services	0
Social Care Online	25/01/2010	Integrated and multi agency	31
Social Care Online	25/01/2010	Integrated and joint working	173
Social Care Online	25/01/2010	Integrated and shared services	0
Social Care Online	25/01/2010	Multi-agency and joint working	43
Social Care Online	25/01/2010	(Integrated or interprofessional) and health and social care (multi-agency or joint working or shared services)	0
Social Care Online	25/01/2010	(Inter-professional or interprofessional) and health and social care	411
Social Care Online	25/01/2010	Integrated and health and social care	661
Pubmed	25/01/2010	(Integrated or interprofessional or inter-professional) and health and 'social care' ('multi-agency' or 'joint working' or 'shared services')	19
Pubmed	25/01/2010	(Integrated or interprofessional) and health and 'social care' (multi-agency or joint working or shared services)	40

Table 3. Details collected from the reviewed articles (n=18)

Study	Aim	Method and sample	Outcomes	Conclusions
Armitage, G.D., Suter, E., Oelke, N.D., and Adair, C.E. (2009). Health systems integration: state of the evidence. *International Journal of Integrated Care*, 9, 82–91.	Identify definitions of integration, models, measurement tools indicators and outcomes of integration and universal principles common to successful integration.	Systematic literature review.	Significant gaps in the research literature. No universal definition of integration and multiple integration models. Lack of standardized, validated tools to evaluate integration.	Need for; clear standards for monitoring success and failure of integrated health systems; validated measurement tools; comprehensive case studies; comparative analyses of different approaches to integration.
Brown, L., Tucker, C., and Domokos, T. (2003). Evaluating the impact of integrated health and social care teams on older people living in the community. *Health and Social Care in the Community*, 11, 85–94.	Comparison of users serviced by integrated team and traditional care arrangements.	Non-randomized comparative design over 18 months.	More people died in the traditional team than in the integrated team; more people in the integrated team went into residential placement. Integrated teams were significantly quicker to respond than non-integrated although relatively high level of missing data. Service users were older and more depressed—might explain why more went into residential care. Service users had little interest in who organized their services, as long as they received what they felt they were entitled to	There is a need for integrated services to be embedded and for efficient and effective information systems.
Cameron, A., Macdonald, G., Turner, W., and Lloyd, L. (2007). The challenges of joint working: lessons from supporting people health pilot evaluation. *International Journal of Integrated Care*, 7, 1–10.	Understand the process and outcomes of the interventions. To determine what works, for whom and in what circumstances.	Evaluation of six pilots funded by 'Supporting People' services. Data collection: project evaluation reports, semi-structured interviews with key stakeholders and service users.	Success assisted by: a shared understanding of the purpose of the joint venture; past history of joint working; and clear governance arrangements. The extent and nature of statutory participations and a history of voluntary sector involvement affects the success of the integrated partnerships. Voluntary agencies are less inhibited by organizational structures and agendas, allowing more flexibility towards the needs of the service user.	Increase the role of the voluntary sector in health and social care services. Reorganization of agencies is a constant threat and changes in personnel unsteady partnerships created.
Campbell, J., and McLaughlin, J. (2000). The 'joined up' management of adult health and social care services in Northern Ireland: lessons for the rest of the UK? *Managing Community Care*, 8, 6–13.	Describe and critically analyse the development of integrated service in Northern Ireland.	Review of the literature.	Need for research of integrated service. Resources required for implementation of integrated care/teams. Needs of user and carers.	Need for further research.
Coxon, K. (2005). Common experiences of staff working in the integrated health and social care organizations: a European perspective. *Journal of Integrated Care*, 13, 13–21.	The common experiences of staff working in integrated health and social care organizations across Europe.	Qualitative methodology: questionnaire led interviews and focus groups. 18 case studies across Europe.	Benefits of integrated working: job satisfaction, improved team working, good communication and enhanced co-operation with other agencies. Disadvantages were social care staff working alongside medical staff and the divide between these disciplines. Organizational boundaries included staff feeling; unrealistic expectations of integrated working provided the tools to identify client problems, financial limit on what could be tackled with the resources available. Short-term contract working, a lack of clear career structure, limited opportunities for promotion.	Trade-off between present job satisfaction and future career progression for staff in integrated care teams.

Table 3. *(Continued)*

Study	Aim	Method and sample	Outcomes	Conclusions
Davey, B., Levin, E., Iliffe, S., and Kharicha, K. (2005). Integrating health and social care: implications for joint working and community care outcomes for older people. *Journal of Interprofessional Care*, 19, 22–34.	Comparison of two models of joint working.	Standardized interviews. Compared co-location and non co-location.	Cognitive impairment of older people is key factor in their ability to remain in their own homes. Contact with social care in general practice records frequently under-documented.	Address under documentation of the contact with social care. Emphasis on process of team working at individual level. Take account wider context: characteristics, circumstances, services received by older people.
Heenan, D., and Birrell, D. (2006). The integration of health and social care: the lessons from Northern Ireland. *Social Policy and Administration*, 40(1), 47–66.	Identify and discuss key issues associated with integration based on experiences in Northern Ireland.	Exploratory qualitative research. Semi-structured interviews.	Degree of integration varies with programme of care. Duplication of services is avoided through a coordinated approach and single point of access. Integrated management leads to parity of esteem between professions. Forum for affective management of tensions between professions. Health model is dominant over social services.	Integrated services in Northern Ireland (NI) are under researched. Successes in should be duplicated, e.g. shared funding; goals and objectives; work places; and management. Need for integrated disciplinary training. Equality in health and social services is needed—health model dominate.
Holton, M. (2001). The partnership imperative: joint working between social services and health. *Joint Management in Medicine*, 6, 430–455.	Exploration of the partnership between social services and primary care.	Case study. Use of theoretical framework. Semi-structured interviews with a range of stakeholders.	Transformational leadership skills. Erosion of traditional boundaries. Warmth of cross agency relationship.	Functional links and tackling cultural issues.
Hubbard, G., and Themessl-Huber, M. (2005). Professional perceptions of joint working in primary care and social care services for older people in Scotland. *Journal of Interprofessional Care*, 19, 371–385.	Health and social care professionals perceptions on joint working for older people in Scotland.	Qualitative methodology. Interviews.	Difference between managers and front line staff. Managers focused on policy implications of changes to services. Front line staff need to improve the practicalities of joint working.	Biggest challenge 'fundamental change in thinking' at a policy, management and service delivery level. Team building activities, promotions, co-location and formalization of links between the services are required. Environment to be conductive to collaborating; need for clear strategic vision; planning and a whole systems way of thinking; ability to exchange knowledge easily; effective IT system. Include service user perspective.

Table 3. (*Continued*)

Study	Aim	Method and sample	Outcomes	Conclusions
Hudson, B. (2002). Interprofessionality in health and social care: the Achilles' heel of partnership? *Journal of Interprofessional Care*, 1, 7–17. **Hudson**, B. (2006). Integrated team working: you can get it if you really want it: Part 1. *Journal of Integrated Care*, 14, 13–21. **Hudson**, B. (2007). Pessimism and optimism in the inter-professional working: the Sedgefield Integrated Team. *Journal of Interprofessional Care*, 21, 3–15.	Two models of inter-professional working.	Literature review. Case study. Mixed methods (documentary analysis, questionnaires, interviews).	Co-located team evaluation at two time points over one year. Focus on 'whole person'. Difference in culture does not impede shared approach. Important factors: team selection (choice), parity of esteem, co-location, reorientation of professional affinity. More effective service delivery and user outcomes, speed, flexibility and creativity.	Support for optimistic model, successes results from—right people, right place, right time; and self selected team members.
Hudson, B. (2005). Grounds for optimism. *Community Care*, 01.12.05, 34–35.	Report the findings of the Sedgefield integrated teams programme.		Optimistic findings of the success of integration. Team members showed: parity of esteem; acceptance of the judgement of others; reorientation of professional affinity.	Transformational change is possible. Need for the government to develop integrated performance targets.
Hultberg, E–L., Glendinning, C., Allebeck, P., and Lönnrothet, K. (2005). Using pooled budgets to integrate health and welfare services: a comparison of experiments in England and Sweden. *Health and Social Care in the Community*, 13(6), 531–541.	Prevent evidence of the impact of budget pooling in England and Sweden.	Postal survey. In depth-interviews with key stakeholders.	Importance of clear legal and financial frameworks. Short-term funding is difficult to manage in pooled budgets. Pooled budgets highlighted areas of duplication by health and social care staff. Staff problems arise in terms of: 'soft' issues (culture, training and attitudes), and 'hard' issues (employment terms and conditions). Differing IT systems led to information sharing problems.	Services focus on needs covered by their own budget: shared budgets may reduce this barrier to integration. Lack of evidence for beneficial outcomes, i.e. improvements for patients. Pooled budgets have the potential to transform organizational perspectives.
McCallin, A. (2001). Interdisciplinary practice—a matter of teamwork: an integrated literature review. *Journal of Clinical Nursing*, 10, 419–428.	The development of interdisciplinary practice.	Literature review.	Changing inter-professional interactions; role definition, support from management and appropriate training, and engagement in change management.	More research: processes which teams use in current context of health care; whether interdisciplinary practice improves outcome management.

Table 3. *(Continued)*

Study	Aim	Method and sample	Outcomes	Conclusions
Scragg, T. (2006). An evaluation of integrated team management. *Journal of Integrated Care*, 14, 39–48.	Evaluation of integrated team management (ITM) in a health and social care trust.	Questionnaire semi-structured interviews. Third stage, meetings with two groups of service users.	Themes and relationships identified.	Need to continually reinforce vision of integrated working. Organizational and personal development opportunities should be provided for staff. Impact of different systems and processes should be acknowledged. Access to professional supervision and support is crucial to ensure professional standards. Services need to identify meaningful ways of involving service users in process of service change.
Stewart, A., Petch, A., and Curtice, L. (2003). Moving towards integrated working in health and social care in Scotland: from maze to matrix. *Journal of Interprofessional Care*, 17, 335–350.	Drivers and barriers to integrated working.	Case studies (9) of community care practices in Scotland. Expert Witness Panel. Scenario Planning Workshops. Interviews with range of key stakeholders.	Drivers: national policy frameworks, local planning contexts, and operational factors. Barriers: timing, planning and no history of joint working. Successful cultural aspects for integrated working; teams that are open, ready to learn, and prepared to allow for both risk and failure. Establish agreed roles and responsibilities, supported with training, rewarded for successes. Encouraged to work creatively, given a high level of trust, take risks and challenge current ways of working.	Recording positive experiences and successes and feeding these back to staff members can help to reassure staff. Early involvement of relevant stakeholders promotes shared vision and ownership of the process.
Warne, T., McAndrew, S., King, M., and Holland, K. (2007). Learning to listen to the organizational rhetoric of primary health and social care integration. *Nurse Education Today*, 27, 947–954.	Moving to a fully integrated health and social care service.	Survey, semi structured interviews. Stake holder workshops. Analysed using descriptive statistical analysis. Interviews and workshops were transcribed and submitted to context and content analysis.	Survey: organizational roles, strategic working, tactical working, operational working, interpersonal relationships, cultural integration, educational integration, best practice. Workshops and interviews: team working, communication, role awareness, personal and professional development, partnership working, and practice development and leadership. Rhetoric: rational, technical, normative, fantasy.	Taking time out—away days. Opportunity to engage. Invest in personal, professional and organizational development.
Wistow, G., and Waddington, E. (2006). Learning from doing: Implications of the Barking and Dagenham experience for integrating health and social care. *Journal of Integrated Care*, 14, 8–18.	Evaluation of integrated provision and services.	Mixed methods: questionnaires, semi-structured interviews, documentary analysis.	Conflicting patterns of central and local relationships; tension structure and culture.	Routes to improved outcomes; integrated governance.

alone organizations and cross-agency integration. Stand alone organizations provide the integration of health and social care to form a new service provided alongside mainstream services, while cross-agency integration brings together different disciplines in a virtual way to collaborate at service user level.

Policy drivers

A variety of drivers to integrated working had been identified in the literature. The need for clear governance arrangements has been highlighted as an important factor for integration [11, 12]. There is a need for successful management of the tension between structure and culture at a local and national level, and a recognition of the fundamentally different principles of governance [12]. Another driver was the need for a shared understanding of the purpose of the joint venture and a mutual understanding of, and commitment to, the vision of the venture across the organizations involved [11–16]. It is important for integrated services to work together across agency boundaries; this has been facilitated by the removal of structural constraints through the Health Act 1999, permitting pooled budgets and integrated provision [15]. Integrated teams must be able to exchange knowledge easily between agencies; effective shared information technology (IT) systems are key to the success of integrated working [13, 14].

Further drivers to integrated working included: the development of a shared culture [13]; establishment of new roles to support new ways of working [14]; co-terminosity of boundaries for health and social care services [15, 16]; exhibiting a past history of joint working [11]; recognition of grey areas in policy and organizational terms and encouraging local agencies to work together in those areas [15]; and the promotion of professional values of service to users and socialization into the immediate work group [6–8]. There is mixed evidence for the importance of co-location as a key driver for integration; while many studies have asserted that co-location is a necessary factor [6–8, 13, 15] others have reported this is not always the case [17].

With regards to these drivers it is important to understand the different priorities of front line staff to management. Managers have been found to focus on issues related to the policy implications of changes, while front line staff emphasize the need to improve the practicalities of joint working [13].

Barriers

The literature review revealed a number of barriers to integrated working. One example was social care staff working alongside medical staff, and the divide between these disciplines [10]. This was illustrated in a number of ways including: the differences in geographical boundaries, communication boundaries, and status inequalities [11, 15]. In addition, the mismatch in cultures, behaviours and understanding of services creates a divide between the disciplines [12]. Organizational boundaries resulted in staff feeling pressured, and the process of collaborative working led to unrealistic expectations being placed on staff [10]. Other barriers included a lack of clarity of purpose for integration, and a failure to agree partnership outcomes [12].

The lack of understanding and clarity of others' roles was also highlighted as a barrier [2, 18]. Lack of clarity regarding management roles and responsibilities can lead to conflict between team managers; and lead professions; imbalance of power and poor communication were obstacles [18]. Scragg [19] reports that commissioners and team managers considered the lack of control given to team managers and some not being fully committed to team working, instead being more detached. Ambivalence of some medical staff has been a barrier to integration in cross agency working [10].

Whilst integrated working provides the tools to identify client problems there is a financial limitation as to what can be addressed with the resources available. Personnel related concerns including: short-term contract working, lack of clear career structure, and limited opportunities for promotion (unless they left the service) created a dilemma—a trade-off between present job satisfaction and future career progression for staff in integrated care teams [11, 16]. Warne et al. [20] discuss the difficulties of moving to fully integrated health and social services—highlighting the difference between the team vision (which was overwhelmingly positive) and the findings. They argue that rhetorical claims are used to contain the good and the bad aspects of the organizational experience.

There is some evidence of integrated working improving clinical outcomes when measured by the number of older people continuing to live independently in the community following care [21]. However, Davey et al. [17] reported that regardless of care type (co-located or non co-located) it was the cognitive impairment of service users themselves that was the key factor in the clinical outcome.

Benefits

Benefits for service users and staff have been highlighted in the literature, these include: increased job

satisfaction; greater team working; development of a shared culture; improved communication; and enhanced co-operation with other agencies—allowing teams to meet clients needs more easily [10]. More specifically, cross-agency working can improve collaboration while, in contrast, stand alone agencies have problems collaborating with traditional services [10, 22]. The speed of response from referral to assessment can be quicker in integrated teams, and the initial stages of the process may be improved through better communication, understanding and exchange of information amongst different professional groups [21].

Mental health service users have reported that integrated team management has resulted in services being more responsive, with reduced waiting times and increased explanation of treatment by clinicians [19]. Service users also highlighted the need to include support outside of clinical areas, particularly in the areas of housing and benefits [19]. Holtom [15] noted the positive effects of transformational leadership skills, the need for an erosion of traditional boundaries, and the importance of the promotion and encouragement of positive cross agency relationships. A key factor in this may be the personality of team managers and their ability to develop positive relationships with a wide range of staff from different disciplines [12].

Staff development

It is acknowledged that some staff members may view engaging in inter-professional practice as risky; however, establishing agreed roles and responsibilities may overcome some of the conflicts that arise for professionals [18, 23]. Stewart et al. [18] suggest that the use of joint training and cross agency secondments may help prepare staff to appreciate each others roles and responsibilities.

Managers need to be aware of rhetorical defences which may be used by staff to protect themselves from the conflicts resulting from change; by encouraging staff to take time out—for instance in the form of away days—managers can provide an opportunity to engage and invest in personal, professional and organizational development, which may reduce the conflict created through integrated working [20]. By providing support and training to enable staff to work creatively, a culture that fosters integrated working maybe developed [18]. Focusing on managing multi-professional teams would help managers to understand their role, and to reach out beyond the team, to leadership within the localities, developing broader partnerships with organizations and commu-

nity groups [19]. It is also important to provide personnal and organizational development opportunities for staff, including joint activities, which may increase understanding of other disciplines [19]. One issue to be addressed is non-documentation of contact with social care; this could be addressed by the development of staff, highlighting the importance of recording all contacts made [17].

For many staff in integrated teams there appears to be a trade-off between job satisfaction and career progression [10]; the specific skills developed by integrated care workers need to be rewarded through formal pay and career structures [10]. This is supported in the findings in the final report to Stoke City Council [1].

Service users

Only two of the studies reviewed included the views of service users themselves as part of the evaluation. Scragg [19] reports that integrated service management results in services being more responsive to service users. Brown et al. [21] report that the key issues for service users were around obtaining initial access to services; many were confused about what level of support they were entitled to, and perceived the manner in which they were refused services as insensitive [21]. For those receiving care, service users reported strong bonds between themselves and their home care workers [21]. To facilitate improvements for service users there is a need for integrated services to be embedded, and for efficient and effective information systems [21], which may seem at odds with the current policy drive to personalized care.

Conclusion

Recommendations in the literature include the need for a focus on the management of multi-professional teams. This would help team managers understand their role and to enable them to reach out beyond the teams to leadership within the localities developing broader partnerships with organizations and community groups [19]. Integration of services requires considerable investment in the resources required for successful implementation of integrated care teams, as well as meeting the needs of service users [24]. There is a need for clear standards for monitoring the success and failure of integrated teams including validated measurement tools, comprehensive case studies and comparative analysis of different approaches to integration [2]. More research is needed to provide empirical evidence, grounded in

practice, of the processes which teams use as they work and interact together in the current context of health care, and to assess whether effective inter-disciplinary practice improves outcome management [25]. Limitations to this review are the challenge of ensuring that all relevant articles had been included, this is because of the wide range of terms used in the literature for 'integration'. This paper has given a systematic and critical interpretation of the key issues relating to integrated care in health and social care settings in the UK and provides an overview of key issues that need attention in integrated care; this review has been used to inform and guide an evaluation of two integrated teams in one City Council in England.

Reviewers

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