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Social work's contribution to integrated primary health care teams in the UK for older adults with complex needs

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Abstract

Purpose – This study examined the contribution of adult social work in integrated teams in the UK.

Design/methodology/approach – The study design was realist, evaluation research using a mixed methods approach. Data collection methods included interviews and focus groups. Types of social work activities were extracted from older adults' case records and used to calculate costs of care. The presence or absence of indicators of care quality was recorded using the same sample of case records. Data were collected from three primary care teams in which social work was integrated. They were compared with data from three social-work-only teams in the same districts. Narrative data was analysed thematically. Inferential and descriptive statistics were used to compare costs and care quality.

Findings – When social work was embedded or attached to a primary care team, costs of care delivery were lower than in their social-work-only team and more indicators of good quality care outcomes were recorded. Results suggest that embedding social work in integrated primary care teams contributes to cost-effective, quality care for older people if certain conditions for integration are met.

Originality/value – This is the first study to triangulate three data sources to quantify the social work contribution to integrated primary health care teams for older adults.

Keywords Social work, Older adults, Integration, Primary care, Evaluation, Complex needs

Paper type Research paper

Introduction

In England integration remains at the forefront of the agenda for change in care delivery for adults aged 65 years and over with multiple needs. Reports suggest that of the population of older people in the UK, 40% or more need simultaneous support from health and social care services (Melzer *et al.*, 2012). In England this is problematic because healthcare is provided by the public funded National Health Service (NHS) while social care is provided by local government and is means tested. Integrated care models have been trialled to transform care delivery including nine "vanguard" sites in the UK (NHS, 2016). These sites have focused on bringing together General Practitioners (GPs) with NHS hospital and community services (NHS, 2014) to address the needs presented by older adults in a more coordinated way. This study was conducted in one of the vanguard sites.

Policy in England

The NHS Long Term Plan published in January 2019, states the integration of health and social care is needed to prevent unnecessary hospital admissions for older people with complex needs. Prevention is important because older adults tend to stay longer in hospital than their younger counterparts (NHS Digital, 2015) and are more likely to experience delayed transfers of care lasting on average for twelve days while waiting for a care package at home (Age UK, 2017; NHS Benchmarking, 2017). Older adults account for 46% of unplanned hospital admissions from A&E (Age UK, 2017).

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Whole person, integrated care guided the UK government's thinking ahead of the plan for health and social care (Department of Health and Social Care, 2021), and in 2021 the government's Health and Care Bill (2021) states that England will be divided into integrated care boards and partnerships to bring together NHS and local government that will deliver and commission services.

Previous research examining the social work contribution to integrated care for older adults

Despite a considerable body of research and policy there is a dearth of studies that have attempted a replicable, methodological approach for evaluating the adult social work contribution to integrated working. The reasons for this are three-fold:

First studies that describe and/or quantify the social work role within integrated care teams for adults that are not mental health teams, are limited (e.g. Beech *et al.*, 2013; Brown *et al.*, 2003; Davey *et al.*, 2005; McCrone *et al.*, 2005; Molyneux, 2001; Syson and Bond, 2010). With the exception of Brown *et al.* (2003) and McCrone *et al.* (2005) these studies are small scale, and offer a lack of robust evidence that enable us to (1) understand how social workers operate in integrated primary care teams working with older adults and (2) quantify and/or evidence the contribution they make. In Hudson (2015) described social work as the "forgotten piece of the integration jigsaw" (p. 96) and this reflects the fact that empirical studies which explore the contribution from social workers in adult services are scarce.

Secondly where studies have attempted to evaluate the adult social work contribution there is a bias in the way studies measured effectiveness qualitatively, typically by asking service users and staff about their experiences of delivering and receiving integrated care (Boudioni *et al.*, 2015; Beech *et al.*, 2013; Molyneux, 2001; Syson and Bond, 2010). Though important to capture such experiences, any realistic study of effectiveness needs to include an assessment of the relationship between service user and/or staff satisfaction and whether the outcomes of care delivery have improved.

Hither to our research, three studies have attempted to use mixed methods to measure whether social work integration can be demonstrably linked to better outcomes for older people. These studies were conducted more than 10 years ago and report mixed results.

For example, Brown *et al.* (2003) compared outcomes for a group of older people aged 65 and over served by an integrated site in primary care (2 teams), with those served by a "traditional site" attached to GP surgeries. Brown *et al.* (2003) found no evidence that the integrated teams were more clinically effective than the traditional teams. Typically, service users' satisfaction with the social work contribution was more to do with being given information so that they could access a social work assessment, rather than whether this was provided from an integrated or specialist team.

Davey *et al.* (2005) set out to test the feasibility of comparing co-location of social workers, GPs and District Nurses with traditional social work teams on outcomes for adults aged 75 and over. Davey *et al.* found that, co-location did not automatically lead to increased, integrated working. Whether older adults remained at home was more related to their degree of cognitive impairment, receipt of intensive home care and whether they lived alone rather than whether services were integrated or not.

McCrone *et al.* (2005) is the only study to date to examine the costs associated with care delivered by social workers in integrated health and social care services in England. McCrone *et al.* demonstrated that higher costs were incurred in less integrated services. This finding offers a degree of support for the integration of social workers as a more cost-effective way of working. However, McCrone *et al.* offered no comment on whether the quality of care older adults received was any different as a result of greater or lesser social work integration.

Finally although there has been an exponential increase in the body of research on health and social care integration *per se* studies continue to be concerned with what Dickinson (2014) refers to as the "science" of the approach (the enablers that facilitate and

barriers that hinder integration) rather than the working practices (the "craft or graft") of those delivering it (p. 190). While investigating the science of integration or the craft and graft of those delivering it are both useful approaches, neither considered in isolation answer the question regarding which types of integration leads to better care outcomes, a conclusion advanced previously by Glasby and Miller (2015). Arguably then, the increase in the volume of research on health and social care integration should not be confused with the strength of evidence for the effectiveness of the approach.

Current study

Given the above we still know very little about how and what social workers in adult services contribute to integrated working in primary care. This paper presents the findings from a mixed method evaluation that explored the contributions that social care workers make to integrated primary care teams for older adults with complex needs.

Following from the work of McCrone *et al.* (2005) we identified the importance of including data relating to the cost of social care when quantifying the contribution of the social care worker. Because McCrone *et al.* offered no comment on whether the quality of care older adults received was any different as a result of greater or lesser social work integration we compared different levels of integration in relation to a number of proxy care quality outcomes. These were informed by previous research (e.g. Brown *et al.*, 2003) and included outcomes such as living at home independently, and speed of response from referral to assessment. Guided by previous studies (Brown *et al.*, 2003; Davey *et al.*, 2005) we also included interviews with service users and carers and focus groups with staff as a way of understanding how these outcomes were experienced from their perspective.

During the last decade there has been a significant change in the social work workforce in adult services in England. There are now significantly greater numbers of non-professionally affiliated staff, employed in roles such as Community Care Officers (CCOs). In England, the designated title of Social Worker is protected by law and any person using it must be qualified and registered Social Work England (SWE) as the professional body. CCOs need to be educated to NVQ Level 3 and receive no training recognised by SWE. . However, in England CCOs in adult social work teams work with older adults with complex needs in much the same way as qualified social workers. The key difference is that only qualified social workers are permitted to carry out statutory work, such as safeguarding investigations and mental capacity assessments. In the remainder of this paper we refer to the "social work" contribution to include the work of adult social workers and CCOs, as both types of workers featured in the teams included in the study and were conducting assessments and care planning tasks with older adults.

This aim of this study was to compare the contribution of adult social work in integrated teams with social-work-only teams in England to evidence the extent to which integration delivers cost effective and quality outcomes for older adults with complex needs.

Methods

Our study was designed as evaluation research located in the realist tradition to address what Pawson and Tilley (2004) describe as "the different layers of social reality which make up and surround programmes of change" (p.4). The methods of data collection were deployed in accordance with a tried and tested multi-level, realist evaluation framework (Bailey, 2002, 2007; Bailey and Kerlin, 2015; Bailey and Mutale, 2020; Ward and Bailey, 2015) that combines context and input level evaluation proposed by Warr *et al.* (1970) with an evaluation of outcomes (Kirkpatrick, 1994). Table 1 below illustrates the levels of the evaluation, and the mixed-methods approach to data collection. Table 1 shows there are 3 levels to the evaluation (context, social care inputs and outcomes). It lists the data collected that will specifically

Level of Evaluation	Data Collection Methods	Understanding
Context	Qualitative data collected from: • Observations of integrated care team meetings • Stakeholder events • Interviews with integrated care Team Leaders • Interviews/focus groups with integrated care team staff	Power and relationships influencing the social work contribution Facilitators and barriers to social work contribution to integrated health and social care teams
Inputs (social care inputs delivered by the teams)	Qualitative data collected from: • Interviews with service users/carers • Interviews/focus groups with integrated care team staff • Interviews with integrated care Team Leaders	Craft and graft of social work and health colleagues delivering integrated care and how this was experienced by service users and carers
Outcomes (benefits for service users and carers) (change in practice at team and organisational levels)	Qualitative data collected from: • Interviews with service users/carers • Interviews with integrated team staff • Stakeholder events Quantitative data collected from: • Indicators of care quality • Social care costs	Relationship between cost, quality of care, service user/carer satisfaction and outcomes Estimated Costs of Providing Social Care Quantitative Data ↔ Experiences of Receiving/Delivering Social Care Qualitative Data ↔ Indicators of Care Quality Quantitative Data

Table 1.
Levels of the realistic evaluation framework employed

evidence the social care contribution to integrated care and explains what understanding of the social care contribution to integrated working this will give us.

Participants

Prior to any data being collected, the study was granted ethical approval by the hosting University's ethics committee and the research and development department of the relevant NHS Healthcare Trust. Consent from service users, carers and staff was obtained prior to interviews and focus groups being conducted. All case records were rendered anonymous before members of the research team were permitted access to extract data from them.

Teams
Six teams from three different districts within one local government's catchment area were selected to take part in the study. Three integrated primary health care teams (denoted i) were purposively selected; based on the length of time that they had been operating as an integrated team. Three social-work-only teams in the same districts (denoted d) provided a comparison group. According to the 2011 Rural Urban Classification, two of the districts were classified as Largely Rural and one district as Urban Minor Conurbation. All three districts covered a mix of affluent and deprived neighbourhoods.

The integrated primary care teams were established to reduce hospital admissions, by providing coordinated health and social care at home to adults aged 65 years and over who had complex needs. The teams included district nurses, specialist nurses (including; diabetes nurse, Chronic Obstructive Pulmonary Disease (COPD) nurse, heart failure nurse), mental health nurses, occupational therapists, physiotherapists and at least one social worker. The three matched district teams were adult social work teams that dealt with cases of similar complexity to the integrated teams. The district teams consisted only of social workers and CCOs and referrals to these teams were triaged through a Customer Service Centre.

Service users
A sample of 60 service users were purposively selected from the teams to take part in the study (10 from each team). Purposive sampling was employed using given selection criteria (see below) to ensure that all service users included in the study had the same level of complex needs. The selection criteria were designed with a Project Steering Group and confirmed through discussion between the service user's allocated case worker and a member of the research team. The final sample of 60 service users was reviewed by both members of the research team and the Project Steering Group. The criteria for inclusion were:

(1) Service user has 3 or more professionals involved including either a social worker or CCO.
(2) Service user has at least two but no more than 5 health and/or social care needs. *Examples of health care needs: COPD, diabetes, mental illness and chronic kidney disease. Examples of social care needs: refusing help, social isolation, carer stress, not eating and struggling to manage medication/daily routine*
(3) Service user is 70 years or older (although the teams worked with adults aged 65 and over most service users were over the age of 70)
(4) Service user is recorded as a complex case on a social worker or CCO's workload
(5) The sample of service users from each team includes at least two who require a complex social care assessment because of concerns relating to safeguarding issues or the need for a mental capacity assessment.

Data collection
Expert reference group. Peopletoo acted as an expert reference group for the study. Peopletoo are a national organisation that have worked with multiple Local Authorities and health organisations to develop integrated care models. Peopletoo:

(1) Gave guidance and reached agreement with us on which activities were costed and how this was achieved in a standardised way
(2) Contributed to the Project Steering Group discussion which informed the purposive sampling of complex cases
(3) Agreed indicators of care quality and how these were measured

(4) Reviewed the emerging cost data. This ensured that the data were robust and could be compared across the Integrated and District Teams with confidence.

Data collection tools for interviews and focus groups. Semi-structured interview topic guides were developed for the interviews and focus groups, informed by a literature review and two observations of team meetings in both the integrated and district teams. These were then further modified in response to feedback from Peopletoo. These topic guides were also piloted with one social worker and one CCO in an integrated team that was not included in the study. The pilot allowed for questions to checked for relevance and ease of understanding.

Data collection for cost and care quality data. Quantitative data relating to the costs and care quality associated with social work involvement, were calculated based on information extracted from service users' case records and in discussion with the case worker. We identified the type of social work activities to be costed through a series of observations of multidisciplinary meetings in one of the integrated teams and through discussions with social workers and CCOs in an integrated and district team. These observations and discussions helped us to understand and describe the main types of social work/care activity that service users and their families experienced when receiving support. The social work activities to be costed were reviewed by the Project Steering Group and by Peopletoo. Costs calculated for each service user were:

(1) Social worker or CCO contact time from the point of referral to case closure, or from referral to the point of data collection if the case was still open. A standard hourly rate was provided by the local government's finance department and used in the calculations.

(2) The actual cost of a care package at home; typically for domiciliary, day care and/or night response.

(3) The actual cost of residential/nursing care for each period of a short or long-term stay.

(4) A 45-min, "referral" phone call for service users being referred through the Customer Service Centre. A standard cost for this was provided by the local government's finance department and used in the calculations.

Care quality outcomes recognised best practice identified from a literature and evidence synthesis (Bailey *et al.*, 2019) Outcomes of high quality care were;

(1) Independence maintained at home by the provision of low-level or preventative services

(2) An at-home care package using assistive technology

(3) Less time taken from assessment to referral/s

Outcomes of lesser quality care were;

(1) Unplanned hospital admission/s

(2) Unplanned admission to residential/nursing care – temporary/short term placement

(3) Unplanned admission to residential/nursing care – permanent/long term

(4) Longer time period from referral to assessment

Data analysis

Qualitative data

Interviews and focus groups were audio recorded and transcribed verbatim. These were analysed thematically (Lincoln and Guba, 1985). This process involved the identification

of themes and sub-themes that were coded independently by members of the research team. This was followed by a joint review involving both members to arrive at a consensus for the clustering of overarching themes and sub-categories. Both researchers are psychologists by background and had received training in the coding of qualitative data.

Cost and care quality data

Data relating to the cost of the social work contributions were analysed in IBM SPSS statistics and were subjected to an analysis of covariance (ANCOVA) to identify any differences between the integrated and non-integrated teams. The data met the assumptions of ANCOVA (normally distributed residuals, homogeneity of variance, linearity, independence of errors and independence of the covariate and the effect) meaning ANCOVA was suitable to be used for the data set. The presence or absence of indicators of care quality in each service user's case notes were recorded. The care outcome data was analysed using simple descriptive statistics.

Results

Cost data and care quality outcomes

The costs data were analysed using ANCOVA with type of team and location as between subjects' factors and duration of case length as the covariant. The results showed that the covariate, duration, was significantly related to the mean total costs for each team, $F\,(1.53) = 95.73$, $p = 0.000$, $\eta p^2 = 0.64$. Controlling for the effect of duration, analysis of the data showed that there was no significant main effect of type of team on mean total social care costs, $F\,(1.53) = 2.13$, $p = 0.15$, $\eta p^2 = 0.04$. A significant main effect of team location on mean total costs was found, $F\,(2.53) = 3.34$, $p = 0.043$ partial $\eta^2 = 0.11$. There was a significant interaction between type of team and location, $F\,(2.53) = 3.29$, $p = 0.045$, $\eta p^2 = 0.11$. The significant interaction suggests that social care costs were affected by the type of team (integrated vs district) but that this was not apparent in all areas. This is demonstrated in Figure 1 which reveals that total social care costs were lower in Team 1i and Team 3i when compared with Team 1d and Team 3d respectively. However, this was not found in Teams 2i and Team 2d. The qualitative data is used to explore this finding further.

Descriptive statistics relating to the care quality indicators for service users sampled in the teams are shown in Table 2. This reveals that service users from Team 1i and Team 3i had more proxy indicators of high-quality care than their matched Team 1d and 3d comparators. This was less evident in Team 2i.

Qualitative findings

A total of nine focus groups were held with health and social care staff with at least one taking place in each of the six teams. In total 42 members of staff (23 in the integrated teams and 19 in the social-work-only teams) participated in focus groups.

The social workers in the 3 integrated teams were interviewed individually to explore how they contributed to integrated working with health care staff. In addition, 3 GPs from two of the integrated teams were interviewed. Interviews were conducted with two of the managers responsible for the social workers in the integrated primary care teams. Fourteen service users and carers also participated in interviews, these were sampled from the 60 service users selected to take part in the evaluation.

From the focus groups and interviews we identified three inputs that were qualitatively different between the integrated teams; (1) sharing information, (2) mutual learning and educating and (3) attitudes to integration. These inputs characterised the ways that social

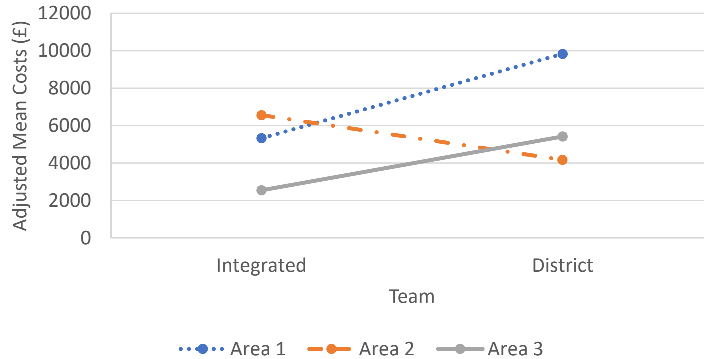

Figure 1.
Adjusted mean costs for all teams

Table 2.
Care quality outcomes by team

	Team 1(i) (n = 10)	Team 1(d) (n = 10)	Team 2(i) (n = 10)	Team 2(d) (n = 10)	Team 3(i) (n = 10)	Team 3(d) (n = 10)
Negative indicators						
Number of admissions to short-term care	2	8	4	4	4	7
Number of admissions to permanent care	1	0	2	2	1	3
Number of hospital admissions	2	3	4	3	5	8
Positive indicators						
Number of uses of assistive technology	3	0	0	3	2	2
Number of times independence maintained at home	5	2	4	1	5	1
Mean number of days from referral to assessment	6.8	6.89	8.2	6.3	3.3	8.8

workers, CCOs and primary health care colleagues contributed to and benefited from integration. This is shown in Table 3.

We were able to identify a continuum of social work integration which spanned "embedded" in Team 3i (most integrated), through to "attached" in Team 1i and "aligned" in Team 2i (least integrated). Embedded integration in Team 3i was qualitatively different to Teams 1i and 2i and was supported by the identified inputs. These inputs reflect how the organisational and team context supported social care worker embeddedness through the structures and processes employed.

An indication that these contributions had impact was the presence of an observable and reported level of collective knowledge that was especially evident in Team 3i and was greater than the knowledge held individually by respective team members. This collective knowledge benefitted the whole team, by informing more appropriate and timely referrals. It emerged because social care workers educated health care professionals about the social care worker role and, vice versa.

The more timely response between an integrated and district team was acknowledged by social care workers in the district teams. In Team 1i the social care workers had been

Major themes	Description	Example quotes
Sharing information	Co-location of team members	“We often come across things that you just want to run by a social worker so it was nice to be able to just talk to somebody instead of having to try and get them through the [customer care] number and get the Duty social worker and frequently you can’t get anybody” (Health professional Team 1i)
	A shared ICT system in use	“You’ve [social worker] got a different perspective on things, from a social perspective, than what we do as health providers and so just having you [social worker] there to be able to talk to you, to bat things off, get your thoughts on it . . .. and it stops us panicking a little bit I think sometimes” (Health professional Team 3i)
	Regular team meetings Security of funding for the social care role	“The communication between the professionals was excellent. They all seemed to be completely on the ball, knowledgeable. They were all very consistent in their approach . . .. Mum didn’t feel threatened by them at all” (Carer Team 2i)
Mutual learning and education		“I can speak directly with ****[social worker] because I know him well I can be much more frank about what I expect him to do. Or he can be very frank with me about what he’s intending to do and to offer and what might be available to this person. Than, I would be necessarily with the District Teams who I don’t know so well” (GP Team 3i)
	Team members level of trust in, and respect for, the judgements made by colleagues who work in a discipline that is different from their own	“You can pick their brains about things, even something as simple as how you access a piece of equipment which you wouldn’t know about, which would take us a week to find out about” (Health professional Team 1i)
	Cases are discussed in team meetings Joint assessment is practised	Because I’ve taught them effectively, they’ve learnt, and vice versa. . . . I learn about all sorts. . . . I’ve learnt how big catheter tubes are.”(Social care worker Team 3i)
Attitudes to integration		“I think we have got better at being more holistic as well, I think. Because we all work together, we kind of jump outside the box, you know, and we do look differently. You know, we don’t just look at what we’re doing . . .” (Health professional Team 3i)
	Team members understanding of integration - their understanding of the benefits and difficulties Security of funding for the social care role Dedicated team training	“We’ve had issues since the beginning with the senior management at social services not recruiting to the posts in the same way as the healthcare posts, were recruited to. Which has meant that we’ve lost one really experienced social worker because she was put on a temporary contract . . . It would be brilliant if it worked well and if it was properly resourced” (Health professional Team 2i)

Table 3.
Emerging themes

co-located with the team initially and then because funding from commissioners had been withdrawn these workers had moved back to the Team 1d. The social care workers' involvement with the integrated team had continued in an "attached" way but health colleagues really missed being co-located.

We found that the extent to which social care and health workers engaged in the process of mutual learning and educating depended on their level of *trust in*, and *respect for*, the judgements made by colleagues who worked in a discipline that was different to their own; whether or not complex cases were discussed in *team meetings* and whether or not *joint assessments* were undertaken. In Team 3i social care workers attended regular multidisciplinary meetings with GPs which led to trust being built. Whereas in Team 2i contact between GPs and the social care worker was reportedly more limited. The extent to which team members shared information about service users across and within disciplines depended on whether there was *co-location* of team members, a *shared electronic record* system in use, *regular* multidisciplinary *meetings and security of funding* for the social care role. Team members' attitudes to integration depended on their *understanding of integration* (including its benefits, and difficulties), whether *funding was secure* for the social care role; and the availability of *dedicated team training* supported by management. In Team 2i there was no secure funding for the social care role and a perception that this role was not supported by management. Team 2i had experienced a very different context for management support compared to Team 3i where this had been in place since its inception and where the social care worker role was funded by the commissioners. This impacted on the team's attitude towards integration:

Discussion

Taken together the findings suggest that steps can be taken to optimise the social work contribution to integrated primary care teams for older people in ways that support quality outcomes for service users and cost-effective care delivery. Optimisation of the social work contribution hinges upon the degree to which it is integrated into the primary health care team. In the teams in this study when the social worker was embedded this demonstrably had the most effect on cost savings, and proxy indicators of care quality outcomes. Reportedly this was achieved through the ongoing interactions between social work and health colleagues, supported by a frank exchange of information that allowed care packages to be put in place promptly. These care packages were experienced by service users and their carers to be put in place quickly, tailored to the service users' complex needs and enabled them to live independently at home.

The themes we were able to identify for greater or lesser integration of the social work contribution are supported by the wider body of literature relating to integrated team working. For example, shared access to electronic records is a condition for integrated working highlighted by Coxon (2005) and Hickey (2008). Co-location and regular team meetings are also highlighted as significant contributors to integration (Coxon, 2005), and Molyneux (2001) draws attention to the personal characteristics of staff as important in the success of integrated teams. The realistic evaluation methods employed point to these "coordinates" interacting so that together they deliver better outcomes for service users and staff in integrated teams. This interactive effect reflects Bailey's (2012) explanation of how mental health teams move beyond multi-disciplinary working to inter-disciplinary working. The latter may be optimised in adult care through workforce recruitment, development and training that goes beyond bringing disciplines together, and "wires in" greater emphasis on interactivity. This requires further longitudinal research, including whether current government policy which is focused on the governance and accountability of Integrated Care Systems, really delivers the change in frontline health and social practice to achieve better outcomes for people who use services.

A significant outcome of embedding the social work contribution in integrated primary care teams for older people with complex needs in this study was the emergence of a "collective knowledge" that reportedly acted as a mutual enabler to all team members. The importance of collective knowledge features in the wider literature on interprofessional education and team working (Carpenter and Dickinson, 2016).

Reportedly collective knowledge in this study rendered the craft and graft of integrated working that Dickinson (2014) refers to as qualitatively different. It speeded up response times and informed holistic care plans that enabled service users to remain at home and were experienced positively by them and their carers.

Our evaluation builds on previous studies (Brown *et al.*, 2003; McCrone *et al.*, 2005) by employing a larger sample of teams and by employing a multi-level, realistic evaluation approach. The inclusion of interviews with service users, carers and staff was also able to offer a degree of assurance that differences in costs were not at the expense of service users or carers receiving lesser quality care delivery.

We acknowledge that this evaluation was conducted with one local government provider in the UK and that our evaluation methodology while providing rich description and triangulation of three sources of data, is limited in terms of generalisability. The criteria used to select the sample was designed to ensure that as far as possible the level of complexity of need was equal across all teams. However, it is possible that differences across the samples were still present and that certain health conditions, which were not controlled for, are related to the higher costs of care delivery. Future research would need to include more detailed selection criteria and a larger sample. In addition, factors unrelated to integration may have affected the findings. Factors such as the level of experience of the social workers and CCOs was not controlled for across the teams meaning that some teams may have benefited from having more experienced workers, resulting in better outcomes and lower costs.

Conclusions

In conclusion social work is more likely to contribute to a qualitatively different experience of integrated working with primary care colleagues when the social worker or CCOs are fully embedded in the team. As a result of the findings from this study the local government organisation involved has redeployed its social workers and CCOs in older adult services to reflect the coordinates for attachment in the primary care teams for older adults as a minimum. This evaluation highlights the specialist contribution that social work in adult services can make and is of importance to the transformation agenda in integrated health and social care in the UK and beyond. Further research is needed to evidence how this important social work specialism can be sustained in integrated services in the future.

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