

Integrated health and social care in the community: a critical integrative review of the experiences and well-being needs of service users and their families.

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Integrated health and social care in the community: A critical integrative review of the experiences and well-being needs of service users and their families

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Abstract

A need for people-centred health and social support systems is acknowledged as a global priority. Most nations face challenges in providing safe, effective, timely, affordable, coordinated care around the needs and preferences of people who access integrated health and social care (IHSC) services. Much of the current research in the field focuses on describing and evaluating specific models for delivering IHSC. Fewer studies focus on person-centred experiences, needs and preferences of people who use these services. However, current international guidance for integrated care sets a precedence of person-centred integrated care that meets the health and well-being needs of people who access IHSC services. This integrative literature review synthesises empirical literature from six databases (CINAHL; MEDLINE; AMED; TRIP; Web of Science and Science Direct; 2007–2019). This review aims to better understand the experiences and health and well-being needs of people who use IHSC services in a community setting. Twenty studies met the inclusion criteria and results were thematically analysed. Three overarching themes were identified, including relationships, promoting health and well-being and difficulty understanding systems. Findings of this review indicate that relationships hold significance in IHSC. People who access IHSC services felt that they were not always involved in planning their care and that there was a lack of clarity in navigating integrated systems; subsequently, this impacted upon their experiences of those services. However, service user and informal carer voices appear to be underrepresented in current literature and studies that included their views were found to be of low quality overall. Collectively, these findings support the need for further research that explores the person-centred experiences and needs of people who access IHSC.

KEYWORDS

community, experience, integrated health and social care, needs, relationships, service user

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1 | INTRODUCTION

Over the past decade, an increased focus on the way that integrated health and social care (IHSC) services are delivered and a growing demand for improved service user experience have driven forward improvements in worldwide health and social care (HSC; World Health Organization, 2016a). Person-centred IHSC systems aim to follow principles of participatory care and governance, which are coordinated around service user needs. These systems and strategies offer a balance between population health and well-being and ill-health prevention (Marks et al., 2011; World Health Organization, 2016b). Internationally, IHSC interventions aim to include meeting individuals' needs, disease-specific interventions and IHSC that spans across population health (World Health Organization, 2016a).

Across Europe, countries are at different stages of integrating their HSC services, with the common goal of delivering better outcomes of care through collaborative working (Expert Group on Health Systems Performance Assessment, 2017). IHSC services take many different forms to improve population health, with varying levels of coordination across geographical boundaries (Robertson et al., 2014; Wodchis et al., 2015). A lack of understanding of organisational cultures, repeated complex structural changes and ineffective communication are common barriers in IHSC (Burgess, 2012; Mason et al., 2015). These issues can impact upon the experiences of people who use IHSC, their families and professionals involved in their care, resulting in unmet needs (World Health Organization, 2018).

The aim of this integrative literature review was to explore the experiences of people who access IHSC services and their health and well-being needs. The overarching research question for this review asked, 'what are the health and well-being needs and experiences of people who use IHSC?'. For the purpose of this review, key terms and stakeholders in IHSC were defined and agreed by the reviewers (Table 1). Specific exploratory questions of the literature were constructed and iteratively refined to expand upon the overarching research question. Questions of the literature highlighted areas of researcher interest around experiences of IHSC and how people met their health and well-being needs through access to and utility of IHSC, in the context of a home setting (Table 2).

2 | METHODS

2.1 | Review Design

A critical integrative review methodology was used to guide the review process (Murray, 2017; Oliver, 2012). Review methodologies that favour quantitative analysis were considered (e.g. systematic reviews that focus primarily on experimental studies to investigate a specific intervention for a clinical problem; Whittemore & Knafel, 2005). However, researchers anticipated that evidence that was relevant to the research questions and the phenomenon of interest may be

What is known about the topic

- Providing health and social care (HSC) that is integrated and person centred can be challenging.
- A range of HSC models are adopted across nations and regions to deliver care.
- Current understanding of service user health and well-being priorities within integrated HSC is limited.

What this paper adds

- Current evidence is inconclusive in relation to the benefits of different models of integrated health and social care (IHSC) that meets the needs of people who utilise them.
- Service users expressed a need for collaboration, maintaining and developing roles in their personal life, effective communication and to develop trusting relationships.
- People who use IHSC had mixed experiences; data were limited and further research is recommended.

diverse in nature. As integrative review methodology advocates the inclusion and analysis of both experimental and non-experimental studies to explore perspectives of a phenomenon in depth, it was

TABLE 1 Agreed key terms and stakeholders in IHSC

Key term/stakeholder	Definition
Home	A permanent residential environment
Health and well-being needs	The needs that when met enable people to live healthier lives and feel well
Integrated health and social care (IHSC)	Where two or more organisations, across two or more sectors, work together to deliver health and social care well-being services; e.g. healthcare sector; social care sector or third sector (including community groups)
Service user	Individuals who access integrated health and social care services to meet their health and well-being (health and well-being) needs
Informal carer	An individual who provides help and support for a service user that enables the service user to meet their health and well-being needs in a non-professional or non-contractual capacity (e.g. family member; neighbour, friend)
IHSC staff member	An individual who provides health and well-being support for an IHSC service user, through a contractual obligation (e.g. a nurse; social worker; paid carer; physiotherapist)

Note: Agreed definitions of key stakeholders in integrated health and social care.

TABLE 2 Research question & questions of the literature

Overarching research question	
What are the health and well-being needs and experiences of people who use IHSC?	
Questions of the literature	Rationale
1. How do people access integrated health and social care (IHSC) at home?	To explore how people connect with health and social care that is delivered in an integrated way, in a home environment
2. What do people, who utilise IHSC at home, perceive as their health and well-being needs?	To explore perceived health and well-being needs, as defined by people who access IHSC services
3. How do people meet their health and well-being needs through their utility of IHSC?	To explore how access to IHSC can help people to meet their health and well-being needs
4. What are the experiences of people who access and receive IHSC at home to meet their health and well-being needs?	To explore the experiences of people who utilise HSC to meet their health and well-being needs

Note: Questions asked of the literature and rationale for their selection

judged to be the most appropriate methodological approach for this review (Souza et al., 2010; Whittemore & Knafl, 2005). Rigor in the review process was enhanced by monthly meetings of the review team and by following an 'integrative review framework' (Whittemore & Knafl, 2005). This integrative review framework included several steps; namely, identifying the research problem; literature search; data evaluation; data analysis and presentation of the findings. A PROSPERO protocol was published to outline the intentions of the research team in conducting this review and to promote objective reporting of findings (Booth et al., 2012; Sideri et al., 2018). Key stakeholders were offered an opportunity to express their views on the aim, review questions and scope of the review via a focus group (Boote et al., 2011). Additionally, stakeholders were also asked to offer their comments on interpretation of preliminary review findings, via a workshop seminar (Boote et al., 2011). Key search terms, topic focus and contextual settings for this review were iteratively refined as a result of their feedback (Boote et al., 2011; Kreis et al., 2013).

2.2 | Identifying relevant studies

2.2.1 | Search Strategy

To ensure that this literature review would be sensitive to picking up studies pertaining to relevant IHSC services, an initial scoping search was performed in October 2017 using a PICO framework (Moule et al., 2017) (Appendix S1). Subsequently, key terms were revised by researchers and the fields in which they were employed were iteratively refined within the search strategy (Table 3). The search for this review was performed across six digital databases between March 2018 and April 2018. Employing filters by abstract, language, time-frame and field initially generated excessive results that could not be screened meaningfully. These results largely appeared to relate to integration of a specific specialist health service into a wider health care service, which was not concurrent with the aims of this review. As researchers had iteratively refined the search terms throughout the scoping review process and were satisfied that these terms were appropriate for the purpose of this review, search fields were

reconsidered (Hewitt-Taylor, 2017; Oliver, 2012). Filtering field by 'Title' generated more specific results that were relevant to the wider context of IHSC services and the aims of this review.

2.2.2 | Inclusion and exclusion criteria

To ensure that the search was rigorous and transparent, inclusion and exclusion criteria were agreed (Table 4) and underpinned by the agreed definitions of key stakeholders in IHSC (Table 1). To mirror the researchers' particular area of clinical interest, inclusion criteria were based on the context of IHSC in a home setting. To reflect the context of a community setting, all papers that solely related to acute hospital-based services were excluded. Included papers were also required to relate to one or more of the following four questions asked of the literature. Namely, the experiences of people who use IHSC (service users, informal carers and their families); access to IHSC services; perceptions of health and well-being needs, or utility of IHSC services to meet health and well-being needs. Papers that were not published in English were excluded.

2.3 | Quality Appraisal

A triangulated approach was adopted to appraise the quality of each paper and facilitate systematic comparison of included studies. Firstly, papers were subject to screening assessment questions, enabling early identification of those relevant to key areas of interest. Secondly, the quality of evidence was appraised using the Critical Appraisal Skills Programme (CASP) framework (Critical Appraisal Skills Programme, 2018a, 2018b). CASP appraisal frameworks offered rigor to meaningful representation of the quality of each source. Each CASP quality appraisal was tailored to the methodological nature of the evidence, e.g. qualitative data or quantitative data sets (Hopia et al., 2016; Whittemore & Knafl, 2005). For papers using a mixed methodology, both qualitative and quantitative quality appraisal tools were utilised to maximise rigor in quality appraisal (Creswell & Plano Clark, 2018; Miles & Gilbert, 2006).

TABLE 3 Search strategy

Search strategy	
Population	(Patient* OR client* OR "service user*" OR individual* OR staff OR employee* OR "healthcare worker*" OR manager* OR carer* OR relative* OR famil*)
AND	
Intervention	((integrat* OR amalgamate* OR partner* OR join* OR merged) AND (health OR healthcare OR "health care" or health-care) AND ("social care" OR "social work" OR care))
AND	
Context	(Experience* OR perception* OR attitude* OR view* OR feeling* OR outcome* OR "healthier li*" OR needs OR model*)
AND	
Setting	(primary OR community OR home)
Filters	
Language	English
Databases	CINAHL; MEDLINE; AMED; TRIP; Web of Science; Science Direct
Timeframe	1st March 2018 and 30th April 2018
Field	By title (after abstract field limiters produced excessive results)

Note: Search strategy: PICoS search terms and parameters.

TABLE 4 Inclusion and exclusion criteria

Exclusion criteria	
Sources	Books; grey literature
Language	Papers published in languages other than English
Timeframe	Papers published before 2007
Geographical location	Nil
Types of studies	Secondary research; Systematic reviews
Types of interventions	<ul style="list-style-type: none"> • Papers which outline 'Integration' that refers to the integration of one specific specialist service (e.g. specialist cancer service; specialist mental health service; specialist stroke service) into a mainstream generalised healthcare service (e.g. integration of a specialist mental health service to mainstream older adult healthcare) • Studies relating specifically to inpatient hospital healthcare setting
Types of participants	Children under the age of 18
Types of settings	Acute care; tertiary care; secondary care
Inclusion criteria	
Sources	Primary research; published in peer-reviewed journals
Language	English language papers only
Timeframe	Publication date 2007–2018
Geographical location	All geographical areas included
Types of studies	<p>For the purpose of this review, 'integrated health and social care' is defined as 'two or more organisations, each from a separate sector, work together to deliver health and social care well-being services (e.g. healthcare sector; social care sector or third sector, including community groups)'. Included papers will explore one or more of the below points:</p> <ul style="list-style-type: none"> • Two or more well-being services delivered across two or more sectors (e.g. healthcare organisation, social care organisation, third-sector organisation or community group) that are delivered in an integrated/amalgamated/joined/merged way ('integration') • Individual and/or family and/or carer's and or staff experiences of integrated health & social care (HSC) • Individual and/or family and/or carer's and or staff perceptions of health and well-being needs • Focus on primary care, community or home setting • Service user/family utility of integrated services to meet health & well-being needs • Access to 'integrated' HSC services, for individuals and their families
a. Types of interventions	All integrated delivery of health and social services
b. Types of participants	Adult's age 18 and over who access or deliver health and social care services
c. Types of context	<ul style="list-style-type: none"> • Experiences/perceptions/attitudes/views/feelings • Health and well-being needs • Models of integrated health and social care to meet health & well-being needs
d. Types of settings	Community, primary care and home

Note: Inclusion and exclusion criteria for search strategy.

Furthermore, each paper's original contribution to the academic and clinical fields of practice were also deliberated, with a final decision highlighting any intended progression to data extraction. All quality assessments were carried out by the lead researcher with a selection of assessments also being reviewed by the wider research team.

2.4 | Study selection, extraction and analysis

To ensure rigor and transparency in the selection of papers for inclusion during screening, all members of the research team met monthly between April and July 2018. Papers were screened by title or abstract by the lead researcher and one other member of the research team. Papers that were not agreed between first and second screener were discussed with the wider research team, to promote open lines of communication until an agreement was met. Data from included studies were extracted, quality appraised and then collated using Microsoft Word. The research design, aims, sample population, outcome measures and findings were extracted from each of the included studies. Quantitative findings were analysed through visual inspection of data trends; identification of outcomes; reliability and validity, heterogeneity and bias and the reporting and synthesis of findings (Creswell & Plano Clark, 2018; Critical Appraisal Skills Programme, 2018b).

Qualitative data analysis explored justification of study aims; sampling and recruitment strategies; rigor of data analysis strategies and the clarity of discussion to support findings (Critical Appraisal Skills Programme, 2018a). Initial thoughts on key findings were iteratively developed and new concepts derived on the basis of two or more papers reporting on it and mapped in a Thematic Matrix (Creswell & Plano Clark, 2018; Hewitt-Taylor, 2017; Ingram et al., 2006; Microsoft® Corporation, 2016). Themes were iteratively developed as researcher understanding expanded around emerging concepts, in accordance with similarity and perceived meaning (Ingram et al., 2006).

3 | FINDINGS

Search and screening pathways and outcomes are detailed in a PRISMA statement (Moher et al., 2009; Figure 1). A total of 435 papers were imported to 'EndNote X8.2' reference manager software (Calarivate Analytics, 2018). Twenty full-text papers were included, from seven countries worldwide. Included papers ranged from 2007 to 2017, reflecting the search parameters which were applied during the scoping and main searches and corresponding to the start of the review process in 2017. Nine quantitative, seven qualitative and four mixed-method studies were included. Key information from each study is presented in

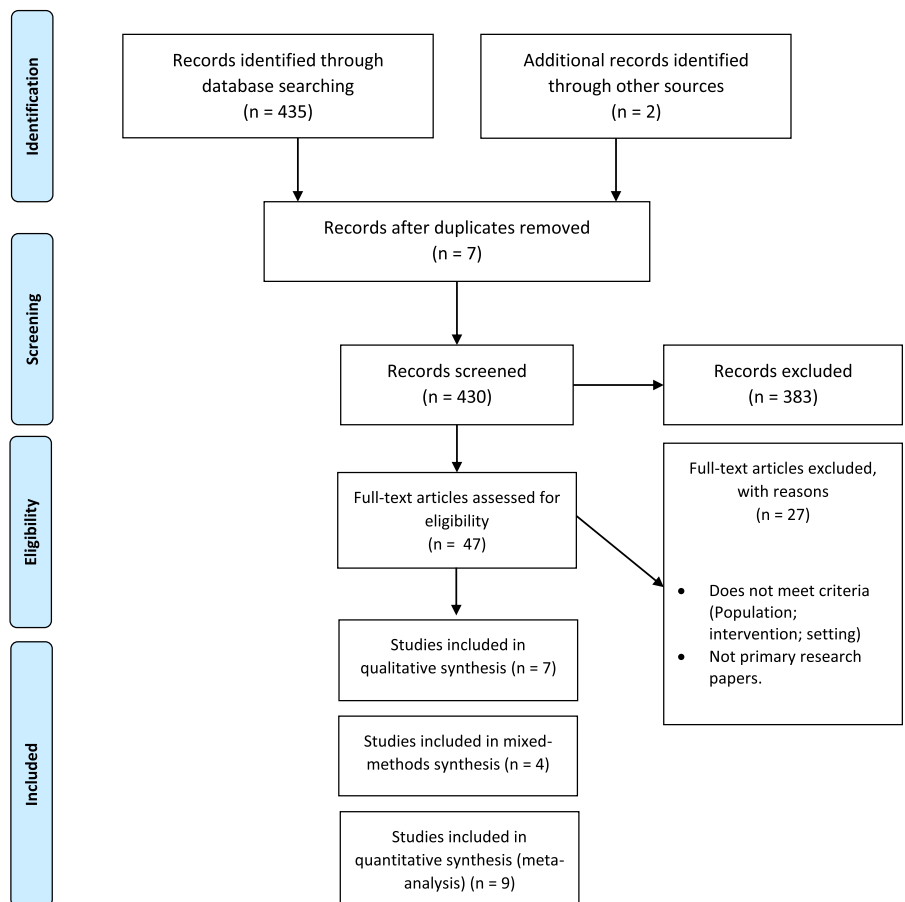


FIGURE 1 PRISMA statement [Colour figure can be viewed at wileyonlinelibrary.com]

TABLE 5 Table of evidence

References	Title	Journal	Vol./No./ Pages	Country	Study aim(s)	Sample characteristics (n)	Study design	Data collection	Key message (s)	Maintaining and promoting well-being through IHSC	Importance of effective co-production in IHSC to meet user	Relationships as a corner-stone of well-being in IHSC.
1	Baumann et al. (2007)	<i>Health and Social Care in the Community</i>	15 (4), pp. 295-305	UK, England, 4x southern (1 London) and 2 northern metropolia	To investigate discharge practice and the organisation of services at sites with consistently low rates of delay, in order to identify factors supporting such good performance	Total: 42. [Social services (n = 19), acute trusts (n = 14), intermediate care (N = 5) and PCTs (N = 4). Staff included: senior strategic managers (e.g. directors of nursing); operational management leads (social work) and operational staff (e.g. care managers and discharge facilitators)]	Qualitative	Semi-structured interviews	Participants identify outcomes that are important to them. They identify personal comfort outcomes; economic and social participation; autonomy outcomes and relationships are evident between these outcomes	x	x	
2	Bien et al. (2013)	<i>European Journal of Public Health</i>	23 (6), pp. 1032-1038	Germany, Greece, Italy, Poland, UK & Sweden	To compare health and social service use in older people who receive support from a family (informal carer), using data from a cross-sectional study of family (informal) carers in six European countries	Total: 2,629 (Family (informal) carers)	Quantitative	Cross-sectional survey	Southern-Eastern European countries appear to have the lowest level of social service use and the highest number of unmet care needs; with Northern-Western European countries appearing to offer a more socially oriented and greater variety of services, have the lowest levels of unmet care needs	x	x	
3	Bjerkkan et al. (2011)	<i>International Journal of Integrated Care</i>	11	Norway, Multi-municipal	To explore the use of Individual Care Plans in Norwegian municipalities that are responsible for primary care and social services	Total: 59 (Leaders in Health and Social Care (n = 32) and 'Professionals' (n = 27), across 61 Municipalities)	Quantitative	Questionnaire	Legislative care planning approach to integrated care; however, uptake and utilisation of individual care plans (ICPs) have been low, despite legislation. Service users and family (informal) carers do not often initiate ICPs (despite training and awareness raising). The study suggests ICPs are not meeting needs of service users and acknowledges that sustainable integration and cross-organisational working are complicated	x	x	

(Continues)

TABLE 5 (Continued)

References	Title	Journal	Vol./No./Pages	Country	Study aim(s)	Sample characteristics (n)	Study design	Data collection	Key message (s)	Maintaining and promoting well-being through IHSC	Importance of effective co-production in IHSC to meet user	Relationships as a corner-stone of well-being in IHSC.
4 Bonciani et al. (2017)	Is the co-location of GPs in primary care centres associated with a higher patient satisfaction? Evidence from a population survey in Italy	BMC Health Services Research	17, pp. 248.	Italy, Tuscany	To verify whether the co-location of General Practitioner's in Primary Care Centres is associated positively with service user satisfaction with the General Practitioner when their service users have experience of the multidisciplinary team	Total: 2,025 General practice service users	Quantitative	Cross-sectional survey	Co-location of GPs with other professionals in Primary Care Centres appears to be of benefit to service users and works particularly well for service users with complex needs. 'Multidisciplinary' working in both Primary Care Centre areas and non-Primary Care Centre areas was found to have higher rates of service user satisfaction	X	X	
5 Boudioni et al. (2015)	More than what the eye can see: the emotional journey and experience of powerlessness of integrated care service users and their carers	Patient Preference and Adherence	9, pp. 529-540	UK, England, London	To present the emotional journey and experience of powerlessness of integrated care service users and carers	Total interviews: 7 service users. Some participants were interviewed on an individual basis and some with a family (informal) carer. 2 interviews were with a carer only (both of whom had cared for someone who had died recently)	Evidence-Based Co-Design (NHS Institute for Improvement in England)	Audio-visual video interviews	Feelings of powerlessness were very common among integrated care service users and their carers in this study and informal carers can be anxious to talk about their experiences and how things can be improved. Carers were found to be outwardly caring towards their service user	X	X	
6 Brown and Howlett (2017)	A critical evaluation of the 'short stay project'—service users' perspectives	Housing Care and Support	20(2), pp. 71-84	UK, Rotherham	Critical evaluation of an integrated intermediate service (health, social and housing services) to explore the perceptions and experiences of the service users who accessed that service and consider the effectiveness of the service model	Total: 3 (participants who had been living in the 'short-stay apartments' for at least 2 weeks and have an identified Health, social or housing need)	Qualitative	Semi-structured interviews	Benefits of a 'short-stay project' are highlighted, in relation to the location and physical environment of the apartments. This study suggests that this model of integrated intermediate care can prevent hospital admission and facilitate discharge, with the psycho-social needs of participants (who access integrated intermediate services) also being highlighted. Psycho-social unmet needs and occupational balance/imbalance were highlighted and participants expressed distress at this	X	X	

(Continues)

TABLE 5 (Continued)

References	Title	Journal	Vol./No./Pages	Country	Study aim(s)	Sample characteristics (n)	Study design	Data collection	Key message (s)	Maintaining and promoting well-being through IHSC	Importance of effective co-production in IHSC to meet user	Relationships as a corner-stone of well-being in IHSC.
7 Challis et al. (2011)	Implementation of case management in long-term conditions in England: survey and case studies	Journal of Health Services Research & Policy	16, pp. 8-13	UK, England-wide	To highlighting the service characteristics of Primary Care Trust's for long-term condition case management and explore links with other services and self-support services	Survey (n = 56) of Directors of Nursing and Lead Practitioners in case management for people with LTC's. Case studies across four sites in England: semi-structured interviews with 1 service manager per site (N = 4); 1 focus group of 5-11 practitioners per site (participant N=?)	Mixed methods	Cross-sectional survey, interviews & focus groups	The model of care for service users with long-term conditions within this study (Case Management) includes some elements of integrated working. Funding and budgetary control does not lie with the case manager and this was acknowledged as a barrier to integrated service provision in this study. Local variations in service arrangements can affect care planning and integration of services in a case management model	X		
8 Cook et al. (2017)	Integrated Working for Enhanced Health Care in English Nursing Homes	Journal of Nursing Scholarship	49(1), pp. 15-23	UK, Gateshead	To explore the views and experiences of practitioners, social care officers and carers involved in the enhanced health care in a care home programme	Total: 35 [11 staff and managers from 16 care homes (where the model of integrated care is used); 27 NHS health care professionals & 7 social workers]	Qualitative	Interviews	This study outlines a model of IHSC delivery that appears to have been successful in areas where there is a shared culture of joined-up working, across organisations and professional boundaries. This model provides a whole system approach to integration, with key personnel who coordinate care and promotes cross-professional communication and problem-solving	X		
9 Craig et al. (2016)	Self-reported patient psychosocial needs in integrated primary healthcare: A role for social work in interdisciplinary teams	Social Work in Healthcare	55(1), pp. 41-60	Canada (urban)	To examine and review the critical factors in psychosocial needs of service users integrated Health & Social Care, as self-reported by service users	Total: 100 (new service users who had been referred to the social worker in a Primary Care Team)	Quantitative	Cross-sectional survey	Anxiety and/or depression are the most common psychosocial need self-reported in this paper and influenced priorities for service user access to social workers within the Primary Care Teams. Family and work relationships, poor health status and social support, and impaired task cognition were found to be significant contributors to anxiety and/or depression in this study	X	X	

(Continues)

TABLE 5 (Continued)

References	Title	Journal	Vol./No./Pages	Country	Study aim(s)	Sample characteristics (n)	Study design	Data collection	Key message (s)	Maintaining and promoting well-being through IHSC	Importance of effective co-production in IHSC to meet user	Relationships as a corner-stone of well-being in IHSC.
10	Curry et al. (2013)	<i>International Journal of Integrated Care</i>	13, e027	UK, London	To evaluate the introduction of a pilot integrated care delivery (across hospital, community, mental health and social care) in North West London locality of the UK.	Semi-structured interviews (n = 37) with senior leaders & General Practitioners (n = 11); 4 focus groups with care professionals & managers (participant n=2); health professionals survey (n = 51); service user survey (n = 405). Healthcare statistical harvesting of integrated care intervention service users (n = 1,236) & control group (n = 5,963)	Mixed methods	Multi-method: Interviews, focus groups, observation; survey and comparative healthcare statistical analysis	Service users in this study felt more involved in their care if they have an integrated care plan in place and a high proportion of service users felt they had better opportunities to develop a better relationship with their general practitioner during this pilot study and some felt that they were more involved in decisions about their care, if they had a care plan in place. Emergency admissions to hospital were not reduced in the Integrated Care Pilot intervention group	X	X	
11	Davson et al. (2014)	<i>Plos One</i>	9(5), pp. e95523	UK, Scotland and England	To understand the perspective of people living with advanced progressive illness and their caregivers, in relation to care coordination, and develop a model of care coordination	Total: 83 [56 service users and 27 linked unpaid caregivers; 29 service users interviewed alone, 27 unpaid carer dyads; 90 service user interviews and 60 unpaid carer interviews (either alone or with the service user) over the series]	Qualitative	Participant-led semi-structured interviews	The relationships that service users and their unpaid carers in this study had with professional staff appeared to influenced their experiences. Relationships that professional staff have with other professional staff; communication/ information exchange appears to impact upon the integrated coordinated care experiences of service users and their unpaid carers. In addition, the structural transparency and the way in which that structure works for the service user and their unpaid caregiver appeared to influence the service user's experiences of integrated coordinated care	X	X	

(Continues)

TABLE 5 (Continued)

References	Title	Journal	Vol./No./ Pages	Country	Study aim(s)	Sample characteristics (n)	Study design	Data collection	Key message (s)	Maintaining and promoting well-being through IHSC	Importance of effective co-production in IHSC to meet user	Relationships as a corner-stone of well-being in IHSC.
12 Elbourne and May (2015)	Crafting intermediate care: one team's journey towards integration and innovation	<i>Journal of Research in Nursing</i>	20(1), pp. 56–71	The UK, suburban setting	To explore how a Person-Centred Intermediate Care team developed and how effective it was	Total: 106 (Staff [n = 12] across varying agencies; service users [n = 94] admitted to the Intermediate Care (IC) unit for in-service user (step-up or step-down))	Mixed Methods	Multi-method: Semi-structured interviews & descriptive statistical analysis	Service users largely appeared satisfied with their care at the Person-Centred Intermediate Care Centre (PCIC). Care outcomes around functionality appeared to be positively influenced (increased functionality) for service users who accessed this intermediate service and a high proportion of service users who accessed the PCIC model could be discharged to their own home	X	X	
13 Hammar et al. (2007)	The effects of integrated home care and discharge practice on functional ability and health-related quality of life: a cluster-randomised trial among home-care patients	<i>International Journal of Integrated Care</i>	7, p. e29	Finland	Evaluation of the effects of a particular model of integrated care and discharge practice and consider the impact (as viewed by the service user) of integrated care, on functionality and quality of life, for older people	Total: 669 service users (integrated care intervention [n = 354], control [n = 314] over 22 municipalities)	Quantitative	Cluster randomised trial	Service user perceptions of functionality appear reduced, despite their functionality score remaining the same (at 6 months; both groups), with Activities of Daily Living and quality of life appearing unaffected. Largely, improvement of quality of life and functionality was not noted as a result of the intervention (with the expectation of physical mobility at 3 weeks)	X		
14 Hu (2014)	The impact of an integrated care service users: the service users' perspective	<i>Journal of Health Organization and Management</i>	28(4), pp. 495–510	UK, England, Cambridgeshire	To explore the impact that integrated services, in the Cambridgeshire area, have had on service users	Total: 127 service users	Mixed methods	Questionnaire & semi-structured interviews	Integrated care had met some of the needs of some participants in the study area (these tend to be discipline specific, e.g. occupational therapy, rather than with relation to integrated services as a whole); however, a high proportion of service user needs appear unmet	X	X	X

(Continues)

TABLE 5 (Continued)

References	Title	Journal	Vol./No./Pages	Country	Study aim(s)	Sample characteristics (n)	Study design	Data collection	Key message(s)	Maintaining and promoting well-being through IHSC	Importance of effective co-production in IHSC to meet user	Relationships as a corner-stone of well-being in IHSC.
15	Kehusmaa et al. (2012)	<i>BMC Health Services Research</i>	12, pp. 204	Finland	To develop an understanding of why people (elderly) are using health and social care in Finland, and the equitability of access to these services	Total: 732 frail, elderly persons (from a variety of Health & Social Care settings; across 41 municipalities)	Quantitative	Randomised controlled trial	A clear link between the use of health and social care services appear to be evident in this study and access to social services appeared inequitable in the study areas; access to health services appears as more equitable. The administrative structure does not appear to ensure positive effects of integration and informal care and support appeared to be instrumental in supporting social care services around service user functionality and financially	X		
16	Lewis et al. (2017).	<i>Clinical Interventions in Aging</i>	12, pp. 985–993	Ireland, North Dublin	To determine if an integrated Community Virtual Ward reduces presentation to the emergency department and hospital admissions	Total: 54 (older people, over 65 years old)	Quantitative	Descriptive statistical analysis	The Community Virtual Ward model of care within this study met some needs of older people who are at high risk of admission and ED presentation. Service users who were living with someone correlated with more presentations at the emergency department and hospital admissions	X	X	
17	Murphy et al. (2017)	<i>Health & Social Care in the Community</i>	25(2), pp. 492–504	UK, Wales	To establish if attending an integrated health & social care day centre affected functional mobility, the number of prescribed medications and physical/psychological well-being.	Total: 281 [Service users: intervention (n = 207); comparator (n = 74)].	Quantitative	Cohort comparison statistical analysis	Physical well-being appeared to improve, with input from the Integrated Day Centre (IDC), in the intervention arm while it declined in the comparator arm. Mental health appeared to reduce less quickly for those attending an IDC, in the intervention arm	X	X	

(Continues)

TABLE 5 (Continued)

Included papers		Vol./No./Pages	Country	Study aim(s)	Sample characteristics (n)	Study design	Data collection	Key message (s)	Maintaining and promoting well-being through IHSC	Importance of effective co-production in IHSC to meet user	Relationships as a corner-stone of well-being in IHSC.
18	Petch et al. (2013)	<i>Health & Social Care in the Community</i> 21(6), pp. 623–633	UK, England & Scotland	To explore whether integrated health and social care partnerships (HSCPs) are delivering the outcomes that are important to people who access them and develop an effectiveness tool from the interview schedule	Total: 20 (service users)	Qualitative	Semi-structured interviews	Participants have highlighted services as a key element of access, sharing information, communication, and social and emotional, physical and mental health well-being. Relationships with others were highlighted as participant need and also as a feature of partnership working. Participants experienced safety, both emotional and physical, knowing help was on-hand form their health and social care partnership	X	X	X
19	Spiers et al. (2015)	<i>Health & Social Care in the Community</i> 23(5), pp. 559–568	UK	To identify health and well-being outcomes that are important to people who have a long-term neurological condition	Total: 35 people with a long-term neurological condition (across five Neuro-Rehabilitation integrated teams [NRTs] site; more than half of whom had Multiple Sclerosis)	Qualitative	Semi-structured interviews	Participants identified three domains of outcomes that are important to people with long-term neurological conditions; namely, personal comfort, economic and social participation, and autonomy outcomes. Service user-derived outcomes appear to contribute to assessing the effectiveness of health and social care integration in this study	X	X	X
20	Peters et al. (2013)	<i>Journal of Health Services Research and Policy</i> 18(1), pp. 28–33	UK	To assess the experiences of service users with a long-term neurological condition, with relation to health and social care	Total: 2,563 service user members of leading third-sector charities (Multiple Sclerosis Society [n = 1,157]; Motor-Neuron Disease Association [n = 505]; Parkinson's UK [n = 901])	Quantitative	Cross-sectional survey	A mixed picture of experiences is presented in results and many problems, with integrated health and social care, being reported by participants. People with Multiple Sclerosis appeared to be more likely to report problems with their integrated care; however, people with MS appeared to be over-represented in the overall results	X	X	X

Note: Table of studies included in this review.

a Table of Evidence (Table 5). A large proportion of papers originated from the UK (total 13). Seven papers were from England and one was from Wales, in the UK. Two UK papers included study-sites across Scotland & England and three papers did not outline where in the UK the studies had been carried out. Geographical locations and service delivery models of included papers have been summarised in Table 6.

Quality appraisal of qualitative data revealed that a description of samples and justification for their selection was not always clear (Brown & Howlett, 2017; Challis et al., 2011; Curry et al., 2013; Petch et al., 2013). Additionally, the researcher-participant relationship was not always considered (Challis et al., 2011; Cook et al., 2017; Curry et al., 2013; Elbourne & Le May, 2015; Hu, 2014; Petch et al., 2013; Spiers et al., 2015). For papers that included quantitative data, quality appraisal, methods of randomisation were not always highlighted (Bien et al., 2013; Bjerkan et al., 2011; Challis et al., 2011; Craig et al., 2016; Elbourne & Le May, 2015; Kehusmaa et al., 2012; Lewis et al., 2017; Murphy et al., 2017; Peters et al., 2013); attrition was not always stated (Craig et al., 2016; Curry et al., 2013; Elbourne & Le May, 2015; Hu, 2014; Kehusmaa et al., 2012; Lewis et al., 2017) and consideration of bias was not always identified (Bien et al., 2013; Challis et al., 2011; Craig et al., 2016; Curry et al., 2013; Hu, 2014; Kehusmaa et al., 2012; Lewis et al., 2017; Murphy et al., 2017; Peters et al., 2013). Overall, the quality of papers varied but was generally observed to be low. However, low-quality papers do not necessarily indicate ineffectual evidence (Health Protection Scotland, 2017). Therefore, papers were not excluded on the grounds of low quality.

A large proportion of included studies incorporate service user data (15 papers; Bonciani et al., 2017; Boudioni et al., 2015; Brown & Howlett, 2017; Craig et al., 2016; Curry et al., 2013; Daveson et al., 2014; Elbourne & Le May, 2015; Hammar et al., 2007; Hu, 2014; Kehusmaa et al., 2012; Lewis et al., 2017; Murphy et al., 2017; Petch et al., 2013; Peters et al., 2013; Spiers et al., 2015). Data from staff who deliver IHSC are represented in six papers (two qualitative, one quantitative and three mixed methods; Baumann et al., 2007; Bjerkan et al., 2011; Challis et al., 2011; Cook et al., 2017; Curry et al., 2013; Elbourne & Le May, 2015). Three of the 20 included papers include families and informal carer data in their study (Bien et al., 2013; Boudioni et al., 2015; Daveson et al., 2014). This suggests that there is need for further exploration of the needs and experiences of informal carers.

This literature illuminates how health and well-being is influenced through IHSC services, including a degree of understanding of some of the needs and experiences of people who use them. Three overarching themes were identified; namely, relationships as a cornerstone of well-being in IHSC, maintaining and promoting well-being through IHSC and delivering services to meet health and well-being needs. Sub-themes incorporate emerging key concepts and distinguish the essence of meaning around each theme (Hewitt-Taylor, 2017; Spencer et al., 2014; Table 7).

3.1 | Relationships as a cornerstone of IHSC and well-being

This overarching theme focuses on relationships as a cornerstone of IHSC and well-being. Seven papers from the UK and Canada explore the significance of relationships that people who access IHSC have with others (Boudioni et al., 2015; Brown & Howlett, 2017; Craig et al., 2016; Daveson et al., 2012; Hu, 2014; Petch et al., 2013; Spiers et al., 2015). The importance of relationships in IHSC was also considered along with maintenance and promotion of familial relationships and friendships, being a part of the wider community and relationships with IHSC staff (Boudioni et al., 2015; Brown & Howlett, 2017; Craig et al., 2016; Petch et al., 2013; Spiers et al., 2015). Three papers included qualitative service user data (Brown & Howlett, 2017; Petch et al., 2013; Spiers et al., 2015); two included qualitative data from service users and informal carers (Boudioni et al., 2015; Daveson et al., 2014); one included quantitative service user data (Craig et al., 2016) and the last used mixed methodology to collect service user data (Hu, 2014). Quality appraisal indicated that six of these papers were of low quality (Boudioni et al., 2015; Brown & Howlett, 2017; Daveson et al., 2012; Hu, 2014; Petch et al., 2013; Spiers et al., 2015) and one paper was of average quality (Craig et al., 2016; Critical Appraisal Skills Programme, 2018a, 2018b).

3.1.1 | The importance of relationships and their impact on well-being

This sub-theme explores the importance of relationships and their impact on well-being. Informal carers acknowledged a need for support with their caring role (Boudioni et al., 2015; Daveson et al., 2014; $n = 4$ and $n = 27$). When interviewed, service users and informal carers highlighted familial and informal carer relationships as important sources of support in coping with changing healthcare needs (Boudioni et al., 2015; Spiers et al., 2015). However, service users found that the logistics required to maintain and establish relationships were difficult to achieve (e.g. transport and equipment; Boudioni et al., 2015; Petch et al., 2013). Timely access to equipment and environmental adaptations were reported as particular challenges in maintaining relationships (Boudioni et al., 2015; Hu, 2014; Petch et al., 2013).

Service users spoke of their need for logistical support in order to develop new skills and maintain relationships within the wider community (Boudioni et al., 2015; Petch et al., 2013; Spiers et al., 2015; $n = 10$; $n = 35$; $n = 20$). There were mixed reports of social isolation and differing models of IHSC in the UK and Canada. Some service users reported social isolation while accessing IHSC services on an intermediate basis and in a wider context (Brown & Howlett, 2017; Craig et al., 2016; Petch et al., 2013). Social isolation experienced by some service users accessing IHSC had a negative correlation with emotional health and well-being (Brown & Howlett, 2017; Craig et al., 2016; Petch et al., 2013). However, in the UK, relationships with IHSC staff were seen to help combat this

TABLE 6 Service delivery models

Author(s)	Title	Journal Name	Journal Vol./No./pages	Country	Integrated health and social care model/structure
1 Baumann et al. (2007)	Organisation and features of hospital, intermediate care and social services in English sites with low rates of delayed discharge	<i>Health and Social Care in the Community</i>	15 (4), pp. 295–305	UK, England, 4x southern (1 London) and 2 northern metropolises	Outlines how people access integrated health and social care via hospital, intermediate services and primary care trusts (within 4 sites in England) when their discharge from acute hospital services has been delayed
2 Bien et al. (2013)	Disabled older people's use of health and social care services and their unmet care needs in six European countries	<i>European Journal of Public Health</i>	23(6), pp. 1032–1038	Germany, Greece, Italy, Poland, UK and Sweden	Outlines distinctive health and social services for 'disabled' older people by highlighting the range of different professional services used in each nation and the number of areas of unmet needs that correspond to the range of integrated professionals delivering care; reduced use of social services corresponds with higher unmet needs
3 Bjerkan et al. (2011)	Integrated care in Norway: the state of affairs years after regulation by law	<i>International Journal of Integrated Care</i>	11	Norway	Norwegian government legislative approach; Individual Care Plans, as a model of collaborative integrated working in health, social care and beyond to other public services (e.g. teaching, etc.) and is mandatory for all service providers equally throughout Norwegian municipalities
4 Bonciani et al. (2017)	Is the co-location of GPs in primary care centres associated with a higher patient satisfaction? Evidence from a population survey in Italy	<i>BMC Health Services Research</i>	17, p. 248.	Italy, Tuscany	Co-location of general practitioners and wider multi-agency team within a Primary Care Centre
5 Boudioni et al. (2015)	More than what the eye can see: the emotional journey and experience of powerlessness of integrated care service users and their carers	<i>Patient Preference and Adherence</i>	9, pp. 529–540	UK, England, London	Integrated care system of health and social care that includes primary care, community matrons, social workers and the voluntary sector; designed to respond to identified cases of high-risk individuals with long-term, multiple and age-related conditions who needed preventive interventions
6 Brown and Howlett (2017)	A critical evaluation of the "short stay project" – service users' perspectives	<i>Housing Care and Support</i>	20(2), pp. 71–84.	UK, Rotherham	Outlines intermediate access to integrated health and social care services within a community setting, housed in local authority housing environment with generic environmental adaptations, supported by referring professional and the Enabling Team
7 Challis et al. (2011)	Implementation of case management in long-term conditions in England: survey and case studies	<i>Journal of Health Services Research & Policy</i>	16, pp. 8–13	UK, England-wide	Case management model with personal care plans and self-care support services, for people with a long-term condition. Includes elements of integrated working between Primary Care Trusts and local authority social care services, although not widespread

(Continues)

TABLE 6 (Continued)

Author(s)	Title	Journal Name	Journal Vol./No./pages	Country	Integrated health and social care model/structure
8 Cook et al. (2017)	Integrated Working for Enhanced Health Care in English Nursing Homes	<i>Journal of Nursing Scholarship</i>	49(1), pp. 15–23.	UK, Gateshead	Outlines a multi-sector whole-system approach to integrated care in the Gateshead Care Home Programme (enhanced healthcare in care homes with nursing beds) and explores multi-professional working, with link General Practitioners, nursing home team and the Older Peoples Specialist Nurse being key practitioners
9 Craig et al. (2016)	Self-reported patient psychosocial needs in integrated primary healthcare: A role for social work in interdisciplinary teams	<i>Social Work in Health Care</i>	55(1), pp. 41–60.	Canada (urban)	Interdisciplinary Primary Health Teams that include social workers, physicians, nurse practitioners, pharmacists and dieticians, all based in one physical location or through a 'hub'
10 Curry et al. (2013)	Integrated care pilot in north-west London: a mixed methods evaluative	<i>International Journal of Integrated Care</i>	13, e027	UK, London	Model of integrated care pilot North-West London that includes primary and secondary healthcare providers, social care providers, mental health providers and non-government organisations who work collaboratively in the Integrated Management Board to coordinate care, through operational and multi-disciplinary groups
11 Daveson et al. (2014)	The real-world problem of care coordination: a longitudinal qualitative study with patients living with advanced progressive illness and their unpaid caregivers	<i>Plos One</i>	9(5), pp. e95523	UK, Scotland & England	Care coordination model for partnership working across health and social care is generated using the data from the study, encompassing influential factors in coordinated working: clinical; resourcing; views on entitlement; relationships and systematic clarity and function
12 Elbourne and Le May	Crafting intermediate care: one team's journey towards integration and innovation	<i>Journal of Research in Nursing</i>	20(1), pp. 56–71	UK, suburban setting	Intermediate care delivered by health and social care services in conjunction with a third-sector charity for step-down/up care and rehabilitation; offered within a 20 bedded unit that encompasses a variety of living environments (independent, warden-assisted or rehabilitation beds), to promote early discharge or prevent hospital admission
13 Hammar et al. (2007)	The effects of integrated home care and discharge practice on functional ability and health-related quality of life: a cluster-randomised trial among home-care patients	<i>International Journal of Integrated Care</i>	7, pp. e29	Finland	Integrated health and social care encompassing multi-professional teamwork, with the addition of a 'paired case manager' consisting of two different professionals (one health and one social care) who coordinate and manage integrated care for each patient jointly
14 Hu (2014)	The impact of an integrated care service on service users: the service users' perspective	<i>Journal of Health Organization and Management</i>	28(4), pp. 495–510	UK, England, Cambridgeshire	Unified care system that is delivered by integrated locality teams, consisting of health and social care staff (community nursing, therapies, social care and intermediate services) that uses a single key-worker model to guide care

(Continues)

TABLE 6 (Continued)

Author(s)	Title	Journal Name	Journal Vol./No./pages	Country	Integrated health and social care model/structure
15 Kehusmaa et al. (2012)	Factors associated with the utilisation and costs of health and social services in frail elderly patients	<i>BMC Health Services Research</i>	12, p. 204	Finland	Municipality model of health and social care in use within Finland which promotes autonomy and can lead to fragmentation of services; these are instrumental in universal access and variation in the way in which municipalities deliver their services
16 Lewis et al. (2017)	A community virtual ward model to support older persons with complex healthcare and social care needs	<i>Clinical Interventions in Aging</i>	12, pp. 985–993	Ireland, North Dublin	Community Virtual Wards that consist of an integrated team, with a nursing Clinical Case Manager appointed to oversee, connect and coordinate services; direct access to integrated team (wider integrated team consists of General Practitioner, Public Health Nurse, Occupational Therapist, Physio Therapist, Social Worker and Pharmacist) and the day hospital, for rehabilitation services
17 Murphy et al. (2017)	Health benefits for health and social care clients attending an Integrated Health and Social Care day unit (IHSCDU): a before-and-after pilot study with a comparator group	<i>Health & Social Care in the Community</i>	25(2), pp. 492–504	UK, Wales	Day centre unit that provides single-location integrated health and social care interventions to outpatients and includes assessment, individualised tailored programmes of treatment, coordination of care within a multi-professional team, nutritional support and activities to combat social isolation
18 Petch et al. (2013)	Partnership working and outcomes: do health and social care partnerships deliver for users and carers?	<i>Health & Social Care in the Community</i>	21(6), pp. 623–633	UK, England & Scotland	Services operating as a 'mainstream' partnership (partnership agreement in place) involving health and social care as lead organisation, with regular routine contact between professionals (who fulfil differing roles to meet the needs of individuals and are accountable to health & local authority); shared mission, objectives, assessment/consultation and information systems with a single point of entry and joint management, planning and pooled/aligned budgets
19 Spiers et al. (2015)	What outcomes are important to people with long-term neurological conditions using integrated health and social care?	<i>Health & Social Care in the Community</i>	23(5), pp. 559–568	UK	Neurological Rehabilitation Team's that adopt a joint working arrangement with social, secondary care and a multi-disciplinary team (both formal and informal agreements)
20 Peters et al. (2013)	Patients' experiences of health and social care in long-term neurological conditions in England: a cross-sectional survey	<i>Journal of Health Services Research and Policy</i>	18(1), pp. 28–33	UK	Integrated health and social care model is not outlined/defined within this study

Note: Models/structures of IHSC described in each study (if available).

TABLE 7 Overview of themes

Over-arching themes ↓	Corresponding sub-themes ↓	Key concepts that run through multiple themes/sub-themes ↓
1 Relationships as a cornerstone of integrated health and social care	The importance of relationships and their impact upon well-being	<ul style="list-style-type: none"> • Collaboration (co-production) • Service user voice, having a say • Working together • Communication • Relationships and trust • Community and social roles and contacts
2 Maintaining and promoting health and well-being through integrated health and social care	Feeling able and learning to cope with changing health and social care needs Promoting well-being through improved quality of life; inclusion, feeling safe and functionality	
3 Understanding and navigating integrated collaborative systems of care	Collaborative services and communication in integrated care Connecting with services and providers to achieve health and social well-being	

Note: Overview of thematic findings of this review.

(Petch et al., 2013; n = 20). Service users perceived that maintaining and promoting positive and supportive relationships between themselves and IHSC staff was important (Daveson et al., 2014; Hu, 2014; Petch et al., 2013).

Multiple sources in the UK provided evidence of the value of staff continuity as a requirement for building trusting relationships (Boudioni et al., 2015; Daveson et al., 2014). These were linked to service users' perceptions of 'good' relationships or 'special bonds' (Boudioni et al., 2015; Hu, 2014; Petch et al., 2013). Where relationships were built on trust and respect, the level of care coordination was enhanced (Boudioni et al., 2015; Daveson et al., 2014). Furthermore, UK service users living with an advanced progressive illness and their informal carers indicated that 'good' relationship with staff influenced not only their improved experiences of IHSC but also participant outcomes (Daveson et al., 2014; Spiers et al., 2015).

To summarise, findings indicated that maintenance and promotion of both existing and new relationships were fundamental cornerstones of IHSC for service users, their informal carers and IHSC staff. Relationships were closely linked to health and well-being and service users needed extra support to maintain familial and social relationships. Communication and maintenance of trusting relationships with professionals and family appear to influence experiences of IHSC and well-being. Continuity of staff was important in maintaining trusting relationships with professionals and these relationships hold significance in IHSC, being considered as a cornerstone of well-being.

3.2 | Maintaining and promoting health and well-being through IHSC

This overarching theme focuses on maintaining and promoting health and well-being through IHSC. It encompasses 'feeling able and learning to cope with changing HSC needs' and 'promotion of

well-being through improved quality of life, inclusion, feeling safe and functionality', for service users and informal carers. Of the 11 papers relating to this theme, five papers present quantitative service user-derived data in Canada, Finland, Ireland and the UK (Craig et al., 2016; Hammar et al., 2007; Lewis et al., 2017; Murphy et al., 2017; Peters et al., 2013). Three papers present qualitative UK service user-derived data (Brown & Howlett, 2017; Petch et al., 2013; Spiers et al., 2015). One paper presents mixed-methods service user data (UK; Hu, 2014). One paper presents qualitative service user and informal carer data (UK; Boudioni et al., 2015) and the final paper offers UK service user and IHSC staff data (Elbourne & Le May, 2015). Quality appraisal indicated that 10 of these papers were of low quality (Boudioni et al., 2015; Brown & Howlett, 2017; Elbourne & Le May, 2015; Hammar et al., 2007; Hu, 2014; Lewis et al., 2017; Murphy et al., 2017; Petch et al., 2013; Peters et al., 2013; Spiers et al., 2015) and one paper was of average quality (Craig et al., 2016) (Critical Appraisal Skills Programme, 2018a, 2018b).

3.2.1 | Feeling able and learning to cope with changing HSC needs

This sub-theme focuses on feeling able to cope and learning to cope with changing HSC needs. Findings across Europe indicate that service users wanted to feel able to cope with their changing HSC needs and strengthen their own sense of well-being (Boudioni et al., 2015; Brown & Howlett, 2017; Craig et al., 2016; Elbourne & Le May, 2015; Hammar et al., 2007; Hu, 2014; Lewis et al., 2017; Murphy et al., 2017; Petch et al., 2013; Peters et al., 2013; Spiers et al., 2015). They cited autonomy and control as important in achieving this (Brown & Howlett, 2017; Craig et al., 2016; Spiers et al., 2015). Service users and informal carers in the UK and Canada also reported concerns about coping with their changing HSC needs and subsequent decisions about their care. This caused them to experience uncertainty,

anxiety and stress (Boudioni et al., 2015; Brown & Howlett, 2017; Craig et al., 2016; $n = 9$; $n = 3$; $n = 100$). In addition, UK service users wanted their voices to be heard in directing their own care (Boudioni et al., 2015; Brown & Howlett, 2017; Hu, 2014; Petch et al., 2013; Spiers et al., 2015). Autonomy, control and decision-making were key factors in determining experiences of IHSC (Peters et al., 2013; Spiers et al., 2015; $n = 35$; $n = 2,563$). However, a lack of control over IHSC services was acknowledged by service users and informal carers (Boudioni et al., 2015; Brown & Howlett, 2017; Hu, 2014; Petch et al., 2013; Peters et al., 2013; Spiers et al., 2015).

Furthermore, UK service users and informal carers appeared to hold a 'sense-of-self', confidence building, decision-making and independence as important to their emotional well-being (Boudioni et al., 2015; Petch et al., 2013; Spiers et al., 2015). Service users linked confidence to resilience and they associated the ability to 'get out of the house' with maintaining independence (Petch et al., 2013; Spiers et al., 2015). Some service users felt a loss of dignity and respect when accessing IHSC (Boudioni et al., 2015; Hu, 2014). However, some service user and informal carer participants in qualitative interviews felt that these feelings changed over a 6-month 'emotional journey'; as time progressed they felt more content and relaxed about their changing healthcare needs (Boudioni et al., 2015; $n = 10$). Arguably, this could signify that participants who are new to accessing IHSC may have a different experience to those participants who have received IHSC for a longer period.

Overall, service users felt anxiety and stress about their changing HSC needs and they wanted to be able to cope with these changes. Dignity, respect, autonomy and control over their own services were identified as important to service users. Both service users and informal carers valued joint decision-making with IHSC professionals.

3.2.2 | Promoting well-being through improved quality of life: inclusion, feeling safe and functionality

This sub-theme explores some of the strategies used by service users as they accessed IHSC services to promote their well-being through improved quality of life. Studies relating to this theme were based in Canada, Finland, Ireland and the UK (Brown & Howlett, 2017; Craig et al., 2016; Elbourne & Le May, 2015; Hammar et al., 2007; Hu, 2014; Lewis et al., 2017; Murphy et al., 2017; Petch et al., 2013; Peters et al., 2013; Spiers et al., 2015). Factors that helped service users to promote their well-being included: continuing in previous roles and preserving personal safety. Additionally, avoiding isolation through the maintenance of social roles and contacts, maintaining functional abilities and preserving quality of life also helped them to promote their well-being. The UK literature relating to service users indicates that they also sought to maintain their psychological well-being through continuing to fulfil previously held occupational roles both within their community and on a more personal level (Boudioni et al., 2015; Brown & Howlett, 2017; Hu, 2014; Petch et al., 2013; Peters et al., 2013; Spiers et al., 2015).

The ability to maintain housework routines within the home environment was important to UK service users. They cited feelings of helplessness and self-resentment when they were no longer able to fulfil these roles due to functional decline (Brown & Howlett, 2017; Hu, 2014). UK service users felt that appropriate housing environments, allowing access to all areas of the house with necessary adaptations, were important (Brown & Howlett, 2017; Hu, 2014; Spiers et al., 2015). Participants experienced frustration at the inaccessibility of every-day items such as washing machines and work-top spaces when they were awaiting further equipment and adaptation. These frustrations provoked negative perceptions of reduced levels of confidence, social inclusion and self-esteem, emphasising the multifactorial nature of psychosocial well-being (Boudioni et al., 2015; Petch et al., 2013; Spiers et al., 2015).

Environmental adaptations were seen by service users as crucial in maintaining social contacts and previous roles, affording an opportunity to be able to get 'out and about' independently (Hu, 2014; Spiers et al., 2015). Service users from the UK and Canada acknowledged the importance of maintaining social contacts with others while using IHSC (Boudioni et al., 2015; Brown & Howlett, 2017; Craig et al., 2016). They highlighted that environmental adaptations, personal safety and routines (such as showering) are linked to independence, self-confidence and well-being (Petch et al., 2013; Spiers et al., 2015; $n = 35$; $n = 20$). Additionally, service users and their informal carers highlighted the importance of financial and emotional security and the knowledge that help was available (Craig et al., 2016; Petch et al., 2013).

Research data present a mixed picture of service users' functional abilities and the impact of functionality upon quality of life when accessing IHSC (Brown & Howlett, 2017; Elbourne & Le May, 2015; Hammar et al., 2007; Hu, 2014; Lewis et al., 2017; Murphy et al., 2017; Spiers et al., 2015UK; Finland; Ireland). Largely, functionality for service users who used IHSC was inconclusive. International studies reported little or no improvement in participant functionality while accessing IHSC services, in comparison to those who were not accessing IHSC (Hammar et al., 2007; Hu, 2014; Lewis et al., 2017; Murphy et al., 2017). For example, a cluster randomised trial in Finland showed a reduction in participants' activities of daily living which corresponded to a service user-perceived reduction in their quality of life in comparison to those in a control group (Hammar et al., 2007; $n = 669$). Furthermore, service user participants who were accessing an IHSC Day Unit once weekly showed no improvement in functionality in comparison to the control group who accessed weekly care from community nurses (Murphy et al., 2017). However, when some UK service users accessed IHSC and suitable housing and environmental aids were put in place, their functionality was enhanced (Hu, 2014; Spiers et al., 2015).

Overall, research findings here suggested that the benefits of IHSC in relation to service users' functionality were mixed. Where appropriate environmental adaptations and aids were provided, some activities of daily living were maintained or restored and potentially resulted in enhanced social inclusion and psychosocial well-being.

These adjustments were essential for service users to maintain their own personal safety. Hence security, safety, functionality and social inclusion appeared to be intrinsically linked and their absence had a negative impact upon service users' experiences of IHSC.

3.3 | Understanding and navigating integrated and collaborative systems of care

This overarching theme focuses on issues related to understanding and navigating integrated collaborative care systems. It encompasses care delivered through collaboration and communication between IHSC services and the connections between service users and providers that can enhance health and well-being. Nineteen papers discussed elements of understanding and navigating integrated collaborative systems of care. Thirteen papers focused on services in the UK (Baumann et al., 2007; Boudioni et al., 2015; Brown & Howlett, 2017; Challis et al., 2011; Cook et al., 2017; Curry et al., 2013; Daveson et al., 2014; Elbourne & Le May, 2015; Hu, 2014; Murphy et al., 2017; Petch et al., 2013; Peters et al., 2013; Spiers et al., 2015). Six papers explored services in wider European countries including Norway, Finland, Germany, Italy, Greece, Poland, Ireland and Sweden (Bien et al., 2013; Bjerkan et al., 2011; Bonciani et al., 2017; Hammar et al., 2007; Kehusmaa et al., 2012; Lewis et al., 2017; Table 6). Quality appraisal indicated that all 18 papers were of low quality (Baumann et al., 2007; Bien et al., 2013; Bjerkan et al., 2011; Bonciani et al., 2017; Boudioni et al., 2015; Brown & Howlett, 2017; Cook et al., 2017; Critical Appraisal Skills Programme, 2018a, 2018b; Curry et al., 2013; Daveson et al., 2014; Elbourne & Le May, 2015; Hu, 2014; Kehusmaa et al., 2012; Lewis et al., 2017; Murphy et al., 2017; Petch et al., 2013; Peters et al., 2013; Spiers et al., 2015).

3.3.1 | Collaborative services and communication in IHSC

This sub-theme focuses on the factors that enhance collaborative services and interprofessional communication systems in order to deliver IHSC across Europe. It considers a diverse landscape of models of IHSC that promote collaboration and communication between service users, informal carers and IHSC staff. It also explores the importance of clarity and information giving and the influence that these can have upon the experiences of people who use and deliver IHSC (Baumann et al., 2007; Bien et al., 2013; Bonciani et al., 2017; Challis et al., 2011; Cook et al., 2017; Curry et al., 2013; Murphy et al., 2017; Petch et al., 2013).

In comparison with those accessing non-integrated HSC models of care, service user satisfaction was improved for people living in Italy when they frequently accessed an IHSC 'Primary Care Centre (PCC)' model (Bonciani et al., 2017; $n = 2,025$; $p < 0.01$). Furthermore, psychosocial well-being was thought to be improved for service user participants who accessed an IHSC Day Unit model of care,

in comparison to those who accessed community nurse care alone (Murphy et al., 2017; $n = 63$). Geographical and regional comparisons between services and models of IHSC that were included in this review, presented a mixed picture of IHSC models (Baumann et al., 2007; Bien et al., 2013; Bjerkan et al., 2011; Challis et al., 2011; Kehusmaa et al., 2012). Some researchers explored utility and access to models of IHSC, identifying organisational arrangements, strategic priorities and the location of staff as instrumental in the provision of IHSC (Baumann et al., 2007; Challis et al., 2011).

Models of IHSC varied across different regions and nations (categorised in Table 6). In a randomised-control trial across Finland, the experiences of frail elderly service users highlighted the relationship between the effective use of social services and an improvement in their health status, in comparison to those who accessed non-integrated services (Kehusmaa et al., 2012; $n = 732$). However, informal carer participants in a multi-European nations cross-sectional survey highlighted fragmented and uncoordinated services (Bien et al., 2013; $n = 2,629$). They found that involvement of multiple social services did not invariably result in less unmet needs. Intermediate IHSC services (that look to facilitate discharge from or prevent admission to hospital) were found to go some way to addressing the fragmentation of IHSC.

In the UK and Ireland, intermediate service models offered a 'whole-system' approach that supported collaborative communication across organisational and professional boundaries (Cook et al., 2017; Lewis et al., 2017). UK service users indicated that fragmentation was reduced when practitioners who specialised in a particular condition became involved. This was indicated even though these specialist practitioners were not regular members of the IHSC team (Petch et al., 2013; $n = 20$). This suggests that the most effective way to ensure that service users' needs are met could be to involve a subsection of the IHSC team, along with specialist input for a particular condition as required (e.g. a long-term condition specialist practitioner). From a survey of service users in Italy, co-location was believed to reduce fragmentation for people with complex care needs who frequently access IHSC, in comparison to those who did not have access co-located services ($n = 2,025$; Bonciani et al., 2017).

Co-located services offered an opportunity to develop close working relationships, better understand the roles of other staff and increased patient satisfaction (UK; Boudioni et al., 2015; Curry et al., 2013; Daveson et al., 2014; Elbourne & Le May, 2015; Hu, 2014; Petch et al., 2013). Nevertheless, service users, informal carers and IHSC staff prioritised 'effective' communication over co-location (Baumann et al., 2007; Daveson et al., 2014; $n = 42$; $n = 83$). The clarity of IHSC systems and the information provided about them were also identified as essential to achieve effective IHSC (Baumann et al., 2007; Bien et al., 2013; Bonciani et al., 2017; Challis et al., 2011; Cook et al., 2017; Curry et al., 2013; Murphy et al., 2017; Petch et al., 2013). Transparency was found to be important in facilitating the coordination and delivery of IHSC services (Baumann et al., 2007; Curry et al., 2013; Daveson et al., 2014; Elbourne & Le May, 2015). Lack of clarity could lead to increased feelings of powerlessness and difficulties for service

users when attempting to navigate the systems that had been set up to coordinate and provide their care. This had a negative impact on their experience (Boudioni et al., 2015; Daveson et al., 2014).

Overall, the quality of service users' experiences of IHSC is influenced by several organisational factors. IHSC services can be fragmented but intermediate services and co-location of professionals appeared to reduce this. Collaborative interprofessional communication was perceived as beneficial by service users and staff alike, whether the latter were based in one or several locations. Collaborative services should be organised in a way that can be easily grasped so that clear information can be given about them. Transparent communication channels must exist between professionals. Equally, communication about IHSC systems must be clear between informal carers, service users and IHSC professionals.

3.3.2 | Connecting with services and providers to achieve health and social well-being

This sub-theme explores how individuals connected with services and providers to achieve health and social well-being. It encompasses three elements; firstly, the need for effective communication for collaboration between people who use and deliver IHSC (UK and Norway; Baumann et al., 2007; Bjerkan et al., 2011; Boudioni et al., 2015; Challis et al., 2011; Cook et al., 2017; Curry et al., 2013; Daveson et al., 2014; Elbourne & Le May, 2015; Hu, 2014; Petch et al., 2013). Secondly, it considers the value of promoting trust and enhancing the quality of care for service users through professional knowledge (UK; Baumann et al., 2007; Boudioni et al., 2015; Challis et al., 2011; Cook et al., 2017; Daveson et al., 2014; Peters et al., 2013). Finally, it considers the importance of service users being able to access the right professional at the right time (multi-national; Bien et al., 2013; Cook et al., 2017; Kehusmaa et al., 2012; Lewis et al., 2017; Petch et al., 2013; Peters et al., 2013; Spiers et al., 2015).

Early communication between service users, their families, informal carers and professional services added to the success of IHSC services (UK; Baumann et al., 2007; Boudioni et al., 2015; Curry et al., 2013; Daveson et al., 2014; Elbourne & Le May, 2015; Hu, 2014). Data from service users and informal carers also suggested that wherever communication was ineffective and decision-making was not shared, the service users felt a sense of powerlessness (Boudioni et al., 2015; $n = 10$). Care planning for IHSC provided a way to facilitate cross-organisational communication and was found to follow diverse forms. Some researchers investigated 'individualised care plans' led by local authorities in Norway (Bjerkan et al., 2011; $n = 59$). Some areas of the UK adopted a 'case management' approach to care planning (Challis et al., 2011; $n = 56$). However, the effectiveness of these approaches in relation to meeting service users' needs was not explored. Nevertheless, a single-shared assessment process, as part of a 'partnership working' approach to IHSC, was found to positively influence service user-identified and valued outcomes (Petch et al., 2013; $n = 20$).

Service users and IHSC staff in the UK & Ireland emphasised the importance of gaining access to the right professional at the right

time via a coordinated team (Cook et al., 2017; Lewis et al., 2017; Petch et al., 2013; Peters et al., 2013; Spiers et al., 2015). Several factors enhanced communication in collaborative care. The use of inter-disciplinary meetings (including the housing department) enabled services to meet and communicate simultaneously (Challis et al., 2011; Cook et al., 2017). Service users and IHSC staff highlighted reduced duplication when service users held their own records or when a single-assessment process was adopted (Brown & Howlett, 2017; Challis et al., 2011; Craig et al., 2016). In addition, service users and IHSC staff also indicated that specialist practitioners played a key role in coordinating inter-disciplinary communication and care that was tailored to an individual's specialist needs (e.g. practitioners that focus on one specialist area of practice; Cook et al., 2017; Petch et al., 2013; $n = 35$; $n = 20$). However, even when specialists were not involved, service users wanted the professionals providing their care to have a good level of expertise in their condition and needs. Regular multi-organisation meetings provided valuable opportunities for enhancing knowledge (Baumann et al., 2007; Boudioni et al., 2015; Peters et al., 2013).

Overall, models for delivering IHSC services were diverse. No consensus could be found regarding which of the many models for delivery of IHSC best met service users' needs. Early communication and accessing the right professional at the right time was important to service users who accessed IHSC. Professionals were expected to have a high standard of knowledge about the service user's condition and a lack of knowledge had a negative influence on the experiences of some service users.

4 | DISCUSSION

Co-ordinated integrated person-centred care is at the forefront of HSC in communities across the world (World Health Organization, 2016a). Existing scientific reviews of IHSC largely focus on the characteristics of IHSC systems, exploring models of care, values of IHSC and their impact and effect upon service delivery outcomes (Baxter et al., 2018; Kelly et al., 2020; Robertson et al., 2014; Zonneveld et al., 2018). Many reviews explore integrated ways of working, policy drivers, implementation strategies and funding (Billings & De Weger, 2015; Cameron et al., 2014; Maslin-Prothero & Bennion, 2010; Mason et al., 2015; Rout et al., 2011; Rummery, 2009; Weatherly et al., 2010). Service user needs and experiences of IHSC are explored in part; however, specific contexts limit the scope of some of these reviews; for example, service users who are homeless or living with long-term conditions (McGilton et al., 2018; Omerov et al., 2020). This review adds an important new perspective to the wider body of research knowledge, relating to needs and experiences of service users, informal carer and staff key stakeholders in IHSC.

Access to IHSC at home was reported to rely on effective collaboration between all three stakeholders. International sources suggest that effective collaboration can be facilitated through co-location of services, which can enhance professionals' understanding of each other's roles (Baumann et al., 2007; Bien et al., 2013; Bonciani et al., 2017;

Challis et al., 2011; Cook et al., 2017; Curry et al., 2013; Murphy et al., 2017; Petch et al., 2013). However, UK IHSC staff highlighted inter-professional communication as important to collaborative working, regardless of co-location (Baumann et al., 2007). This corroborates the suggestion in wider literature that communication is an underpinning driver for IHSC (Baumann et al., 2007; Bien et al., 2013; Bonciani et al., 2017; Challis et al., 2011; Cook et al., 2017; Curry et al., 2013; Kaehne & Catherall, 2012; Mackie & Darvill, 2016; Murphy et al., 2017; Petch et al., 2013; Scheele & Vrangbæk, 2016).

There are clear links to service users' need for environmental adaptations and aids to meet their functionality and personal safety needs, which can also be linked to emotional well-being. Review findings are inconclusive about the relationship of IHSC and improved functionality for service users. It cannot be assumed that the provision and utility of IHSC invariably results in improved service user functionality. Fulfilling previous roles (such as completing housework and gardening tasks) and remaining independent can result in significant improvements in emotional well-being, facilitating maintenance of social contacts (Brown & Howlett, 2017; Hu, 2014; Petch et al., 2013; Peters et al., 2013; Spiers et al., 2015). Equally, people who utilise IHSC at home expressed a need to have their voices heard and be involved in making decisions about their own care (Boudioni et al., 2015; Brown & Howlett, 2017; Hu, 2014; Petch et al., 2013; Peters et al., 2013; Spiers et al., 2015). Feeling empowered and prepared when dealing with the uncertainty of changing health and care needs is important to service users and informal carers. It could be argued that this is an integral role of professionals who deliver IHSC (UK; Boudioni et al., 2015; Brown & Howlett, 2017; Spiers et al., 2015).

Helping stakeholders meet their needs through a collaborative approach to IHSC is challenging for many IHSC providers, with a diverse range of strategies evident in the wider literature (Expert Group on Health Systems Performance Assessment, 2017; Marks et al., 2011; World Health Organization, 2016a, 2018). A lack of papers that explored the benefits of IHSC models of delivery, through comparison to non-integrated HSC, was noted. However, many papers considered different models of IHSC. IHSC providers must pay careful attention to levels of continuity of staff and the degree of coordination within their services (Baumann et al., 2007; Bien et al., 2013; Boudioni et al., 2015; Curry et al., 2013; Daveson et al., 2014; Elbourne & Le May, 2015; Hu, 2014; Petch et al., 2013; Peters et al., 2013; Spiers et al., 2015). Fragmentation of systems and services should be avoided since this has a negative impact on the experiences of users of IHSC. The use of intermediate IHSC services along with more effective coordination can potentially go some way to address this issue (Cook et al., 2017; Lewis et al., 2017).

Service users and informal carers experienced reduced levels of autonomy, self-worth and confidence and a lack of dignity and respect when utilising IHSC services, resulting in unmet health and well-being needs (Boudioni et al., 2015; Hu, 2014; Petch et al., 2013; Peters et al., 2013; Spiers et al., 2015). Maintaining and promoting existing and new relationships can be seen as a fundamental cornerstone of IHSC that influences the experiences of people who use IHSC and should be considered when planning IHSC services

(Boudioni et al., 2015; Eastwood et al., 2019; Petch et al., 2013; Spiers et al., 2015). Relationships are closely linked to promotion of well-being, reducing social isolation and a foundation of trust among service users, informal carers and professional staff (Boudioni et al., 2015; Brown & Howlett, 2017; Cameron et al., 2014; Craig et al., 2016; Daveson et al., 2014; Glasby, 2014; Hu, 2014; Petch et al., 2013). It could be argued that a gap exists in the current body of knowledge with further scope to explore the significance of these supportive relationships in IHSC.

Overall, the quality of papers included was generally low. Some studies that employed mixed-method data collection focused upon quantitative data under-reported important qualitative elements; others were unclear regarding sampling methodology. Seven papers consider qualitative data, two of which included staff data (Baumann et al., 2007; Cook et al., 2017). Three of these qualitative papers included service user data (Brown & Howlett, 2017; Petch et al., 2013; Spiers et al., 2015) and two offered service user *and* informal carer data (Boudioni et al., 2015; Daveson et al., 2014). It could be argued that there is a pressing need to further explore needs and experiences of IHSC that combines all three stakeholders. Two papers in this review explore service user health and well-being needs as defined and perceived by the service user (Petch et al., 2013; Spiers et al., 2015). Further research that explores service user-derived health and well-being needs would add to the current body of evidence.

4.1 | Strengths and limitations

The strength of this study lies in its underpinning integrative methodology. While a systematic review methodology may have produced differing results, integrative review methodology and rigorous data analysis represent the complexity of the research questions and the diversity of data that are key to developing evidence-based practice in this field (Hopia et al., 2016; Whittemore & Knafl, 2005). Rigorous adherence to the underpinning integrative framework of this review and transparency were promoted among researchers through monthly meetings for the duration of the review, thus, reducing the potential for bias. The results of this review present a level of understanding around experiences of IHSC services and highlight gaps in current IHSC practice.

A further strength of this study lies in the involvement of stakeholders in identifying the review topic and the interpretation of results (Boote et al., 2011; Kreis et al., 2013). However, time constraints meant that stakeholder involvement was not possible throughout the *whole* review process and is acknowledged as a limitation of this review. While researchers strove to ensure that results could be meaningfully screened by filtering of 'Title' field, they recognise that the scope of this review may have been limited by their decision. Identifying relevant studies from abstract, rather than the title alone, may have highlighted further studies for inclusion. In addition, researchers also acknowledge that papers that have been published since the literature search was performed in 2018 are not included in this review. The scope of this review is

also limited by the exclusion of papers that related solely to inpatient setting as they were more likely to represent integration of a specialist healthcare service to another acute healthcare service (e.g. the integration of a singular specialist health service into another pre-existing health service). Nevertheless, it is recognised that excluded literature may have offered additional examples of IHSC.

5 | CONCLUSION

Overall, findings from this review outline that the potential impact of relationships between professionals and service users must not be underestimated; these grow stronger when providers approach care planning with involvement and collaboration. Difficulties in navigating the integrated systems can be overcome by ensuring that new and existing structures are clear. More evidence is needed on the effectiveness of IHSC as an intervention that promotes health and well-being and its impact on the experiences of those who receive it. Further research that focuses upon the needs of people who use IHSC services, as defined by those people themselves is also warranted. Research that explores supportive relationships and involves participation of all three IHSC key stakeholders would provide valuable insights to enhance knowledge in the field and support future developments in IHSC practice.

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CONFLICT OF INTEREST

Authors have no conflict of interest to declare.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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