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Multi-agency working

Research to support the Final Report of the Evaluation of the *Social Services and Well-being (Wales) Act 2014*

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Evaluation of the Social Services and Well-being (Wales) Act 2014

Multi-agency working

Research to support the Final Report of the Evaluation of the *Social Services and Well-being (Wales) Act 2014*

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Glossary

Acronym/Key word	Definition
Collaboration	'*as any situation in which people are working across organizational boundaries towards some positive end.'* It requires active management with two key concepts 'collaborative advantage' (successful collaboration) and 'collaborative inertia' (slow progress or death of the relationship), (Huxham & Vangen, 2005: 4)
Co-operation	It requires the minimum of communication and information exchange in order to enable people to work together across agencies (van Raak et al., 2003). It is useful in establishing coordination (Prammer, 2012).
Co-ordination	**Operational coordination** has been described in the past as **sequential** client flow (treated by one agency, service terminated and the person is referred to the next service). **Reciprocal** client flow (where the person is treated simultaneously by more than one agency) and **collective** client flow where the person is treated simultaneously by staff from several agencies who develop goals or plans together and systematically share tasks (Alter & Hage, 1993).
Multi-agency working	'work undertaken by different professionals with the same client and/or family, often requiring information sharing, coordination of service provision and joint visiting and/or assessment. Another context is the formal strategic arrangements between local partner agencies' (Peckover & Golding, 2017:41).
Integration of care	'*Integrated care is an organising principle for individual care [& support] delivery that aims to improve individual care [& support] and experience through improved coordination. Integration is the combined set of methods, processes and models that seek to bring this about'.* (Adapted from Nuffield Trust,2011: 7),

1. Introduction

1.1 The Welsh Government commissioned a partnership of academics across four universities in Wales and expert advisers to deliver the evaluation of the *Social Services and Well-being (Wales) Act 2014* (hereafter referred to as 'the Act').

1.2 The independent national evaluation – the IMPACT study[3] – has been running since November 2018 and is led by Professor Mark Llewellyn, Director of the Welsh Institute for Health and Social Care (WIHSC) at the University of South Wales alongside Professor Fiona Verity, Professor of Social Work and Social Care, Swansea University.

1.3 The partnership also includes colleagues from Cardiff Metropolitan and Bangor Universities and PRIME Centre Wales, and it is supported by the Study Expert Reference Group (SERG)[4] with its three citizen co-chairs.

Context

1.4 The Act sets out the Welsh Government vision to produce 'transformative changes' in social service policy, regulation and delivery arrangements across Wales. These changes are informed by five principles embedded across the Act's 11 parts. Aligned to it are also structures, processes and a series of Codes of Practice.

1.5 It is important to note the nature of the principles and how they are manifested in the experience of service users, carers and the workforce. The five principles do not operate in isolation – they are inter-related and inter-connected. There are overlaps between the underpinning philosophy of each, and as such in the experiences of people it is sometimes difficult to isolate one principle from another.

1.6 For example, it is almost impossible to conceive of how co-production, as a principle, can operate without first ensuring that people have voice and control over their care and support. Similarly, prevention often requires that a multi-agency 'offer' will be in place for people in order that prevention of crisis can occur. Finally, all of the principles ultimately aim to deliver better well-being outcomes for people, which is a principle itself.

[3] A bilingual introductory film explaining the structure of the study can be found here: Ffilm gwerthuso'r Ddeddf / Act evaluation film – WIHSC - YouTube

[4] For more on the SERG, see: Study Expert Reference Group | University of South Wales

1.7 As such, when reading this report, whilst it is focused on a single principle, there are occasions below when evidence concerning other principles is referenced. This reflects the inter-connected nature of the principles as noted above. Such evidence will be synthesised in the Final Report which draws material from this, and the reports produced on the other principles.

1.8 Alongside the five principles within the Act, we have identified five domains within which the principles of the Act 'meet' the people or organisations for whom the Act should be having an impact –individuals in need of care and support, their carers and family members, the communities in which they live, the workforce that supports them, and the organisations who have responsibilities and duties to discharge as outlined by the Act and associated Codes of Practice:

Table 1.1: Five principles of the Act, and the five domains of the study

Principles	Domains
Well-being	Citizens
Voice and control	Families and Carers
Co-production	Communities
Multi-agency working	Workforce
Prevention and early intervention	Organisations

1.9 The evaluation study represents an independent and objective assessment of the implementation of the Act and the way in which it has impacted the well-being of people who need care and support and their carers. In order to bring this about, we draw upon the approach espoused by Michael Patton (2018) in his 'Principles-Focused Evaluation' (P-FE) framework which we are using as the theoretical and conceptual underpinning of our study. [5] There are three key questions that Patton encourages us to consider as part of any P-FE (2018, pp.27-29):

1. To what extent have meaningful and evaluable principles been articulated?
2. If principles have been articulated, to what extent and in what ways are they being adhered to in practice?

[5] For more on P-FE see Patton, M. Q. (2018). *Principles-Focused Evaluation - The GUIDE*. New York: Guilford Press. For how P-FE relates to this study, see Chapter 2 in Llewellyn M., Verity F., Wallace S. and Tetlow S. (2022) *Expectations and Experiences: Service User and Carer perspectives on the Social Services and Well-being (Wales) Act.* Cardiff. Welsh Government, GSR report number 16/2022. Available at: Evaluation of the Social Services and Well-being (Wales) Act 2014: expectations and experiences.

3. If adhered to, to what extent and in what ways are the principles leading to the desired results?

1.10 There is a clear connection between Patton's questions, the areas for inquiry in our study, and the five principles underpinning the Act – of which multi-agency working is one. These connections are considered in detail on a principle-by-principle basis in this series of reports, of which this is one. These reports have been authored by sub-teams within the IMPACT evaluation study group who have an especial interest and expertise in the topic under consideration. This report focusing on the principle of multi-agency working was led by the multi-agency team.

Multi-agency working

1.11 The Act aims to promote person-centred, community-focused, integrated care and support through a new focus on multi-agency working. It requires people to continually think about how they or their organisation's actions influence others whilst promoting a culture of positive learning and transparency, thereby leading to better individual, inter-professional and inter-organisational communication, understanding of roles, and management accountability for nurturing multi-agency working.

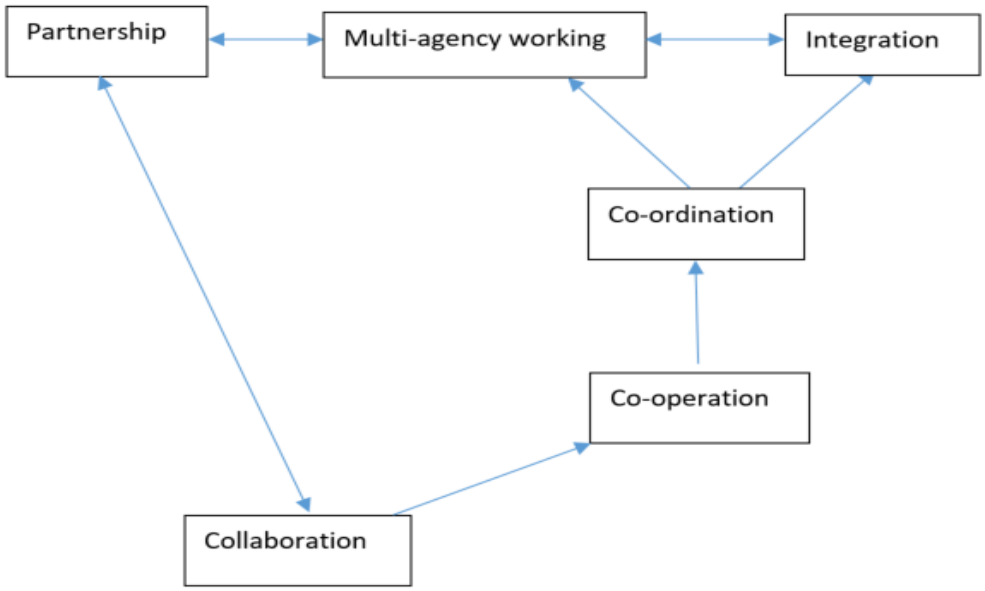
1.12 Pre-legislation preparation began in the Act's four priority areas for integrating services (promoting wellbeing, improve quality of care, contribute to prevention, supporting carers) to understand the legislative implications and enable implementation[2]. Davies et al (2016) argued that this preparation included: a) building collective responsibility for population health and wellbeing, b) a person-centred view of integration with patient outcomes placed at the centre of the vision, and c) a move towards shared decision making and complementary changes such as some restructuring and changing emphasis on service provision e.g. integrated processes.[6] This often means that individuals and organisations need to continually think about the impact of their individual or organisational actions on others.

1.13 A 'multi-agency working' international literature review which preceded this report (Wallace et al., 2020) asked, what are the characteristic success factors of multi-agency working in public and non-public services? It offered an understanding of

[6] Davies, N., Livingston, W., Owen, E., Huxley, P. (2016) "Social care legislation as an act of integration", *Journal of Integrated Care*,24 (3),139-149,

the many definitions of the terms used in the Act to describe how we work together: that is, multi-agency working, 'cooperation', 'integration of care', 'partnership' and 'joint arrangements'. The review demonstrated the relationship between these terms (through their characteristics) and how multi-agency working fits in the continuum between parallel working and integration (Figure 1).

Figure 1.1: Types of working together and their relationship with one another



1.14 We acknowledged that a complex world of working together is developed through relationship based care which includes the interaction of relationships at three levels, where the a) individual service user (local level) interacts with themselves, family and their provider, b) the care provider relationship with self (staff within their organisation) and c) the care provider's relationship with other care providers i.e. influencing knowledge and change in others (Koloroutis, 2004).

1.15 Multi-agency work was defined by Peckover and Golding (2017: 41) as 'work undertaken by different professionals with the same client and/or family, often requiring information sharing, coordination of service provision and joint visiting and/or assessment. Another context is the formal strategic arrangements between local partner agencies'. This is a definition which relates to the complex integration of relationships within and across multiple domains including individual, family, professional organisation, and strategic partnerships. There are multiple success factors which are common across multi-agency working, coordination, integration and partnership; and across statutory and non-statutory services, and private and not for profit sectors. These predominantly include organisational and individual

values of trust and equality, but also include others such as a common understanding or aim and information sharing.

1.16 In 2022, Thiam et al. published a conceptual clarification of Integrated Community Care (ICC) which they argue is a holistic type of care which aims to improve physical and mental health, well-being and social capital of individuals, families, groups and communities. The core concepts they argue are temporality (time), local area, health care, social care, proximity and integration. This is yet another definition to add to the variety of definitions for integrated health and social care identified by Cheng and Catallo (2020). They noted that after 20 years of integrated health and social care there was no standard definition.

1.17 The literature review highlighted examples of best practice across countries (Wallace et al., 2020). However, it concluded that not one study has sought to identify the success factors of a country's workforce working towards multi-agency working. Finally, despite multi-agency working requiring a person-centred approach, there remains a gap in the literature on the views and experiences of the individual, especially family and carers (Henderson et al., 2020).

Purpose and scope

1.18 The scope of this report is to draw the evidence around multi-agency working together, providing a focal point on this principle for those who may be interested in it. We draw such themes together in the summary of this document (Chapter 4) and provide recommendations that are specific to multi-agency working. These need to be seen in the context of the overall findings, conclusions and recommendations made in the Final Report (Llewellyn et al., 2023).

1.19 As noted above, the report will primarily focus on multi-agency working, but there may be reference to the ways in which some of the other principles of the Act (co-production, voice and control, prevention and early intervention and well-being) inter-relate with prevention in the evidence considered here.

1.20 The aim for this theme was to understand to what extent the Act has promoted integrated care and support for people in Wales. In doing so it sought to ask (see paragraph 2.1 for further details on questions answered and structure of report):

1. Has implementation of the Act promoted sustainable integrated care and support?

2. Which critical success factors are ‘most important and have most impact’?
3. When, how and for whom were multi-agency networks implemented?
4. What resources are required for multi-agency working to achieve the outcomes expected?
5. How have cross boundary governance arrangements supported people and agencies to work together?

2. Methodology

2.1 We originally planned to use three cycles of methods which consisted of: 1) the Group Concept Mapping to develop a framework of critical success factors identifying importance and degree of impact, 2) a Social Network Analysis (SNA) to whole system mapping social relationships between people groups and organisations and 3) focus groups and individual semi structured to discuss the findings from cycles 1 and 2. However, the COVID-19 pandemic necessitated us altering the methodology. The alteration particularly affected question 3 'When, how and for whom were multi-agency networks implemented?' because we were unable to undertake the SNA method. Therefore, this question has not been answered in this report.

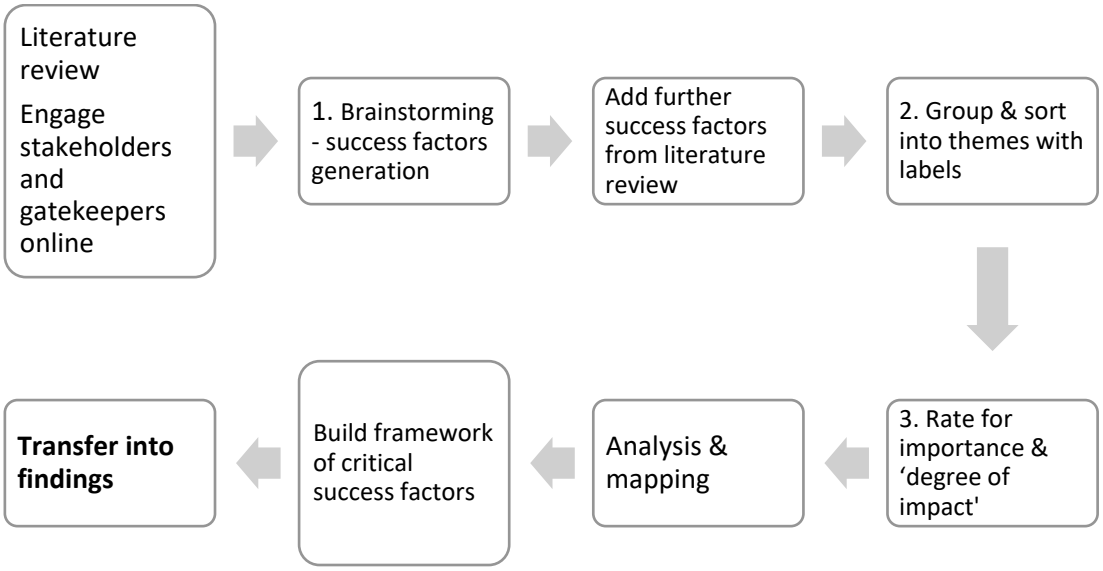
2.2 Two methods were employed: one involved using online software for Group Concept Mapping (GCM)and the other involved undertaking a secondary analysis of qualitative data already collected by the research team. This meant that we were reliant on answers from previous questions asked by other researchers within the IMPACT team and they were not questions directly related to our initial findings from the GCM.

2.3 GCM is a structured, online, multi-step process translating qualitative data into quantitative maps. We used it to develop a framework of critical success factors for multi-agency working, identifying which critical success factors were perceived as most important and which were perceived as having most impact. Despite severe constraints caused by the COVID-19 pandemic on obtaining a larger sample of participants, it helped us to answer all the questions but specifically questions 2, 'Which critical success factors are most important and have most impact?' and 4 'what resources are required for multi-agency working to achieve the outcomes expected?'

2.4 GCM is embedded in an online platform called GroupWisdom^{TM} meaning that participants were not constrained by time and place to participate. The method has three sequential parts – brainstorming, grouping/sorting, and rating – which participants complete online at a time convenient to themselves, when they have access to a mobile phone, tablet or computer. Figure 2.1 demonstrates the whole GCM process i.e. how the literature review fed into the three GCM activities, the researcher activities in between the GCM activities, culminating in the findings. We

used purposive (including maximum variation and typical case) and snowballing sampling strategies to recruit participants.

Figure 2.1: The GCM process



2.5 Of the 26 participants initially enrolled, 19 completed the participant questions, 14 finished the sorting activity and 12 finished the importance and rating activities. Participants were recruited via gatekeepers and champions including NHS Confederation, RIIC (Research Innovation and Improvement Coordination) Hubs and ABUHB (Aneurin Bevan University Health Board) Research and Development department. Meetings and presentations were provided for the gatekeepers in advance of recruitment. Limitations were acknowledged in the length of time it took to conduct the GCM, between December 2020 and March 2022. This was a much longer period of data collection than usual. Due to the COVID-19 pandemic, the data collection was disrupted several times. This affected the availability of people to act as gatekeepers and participants during a very challenging time. Further information can be found in Appendix A.

2.6 The second method used was a secondary data analysis of existing data gathered by the evaluation team in this study. Data collection methods included interviews, focus groups, workforce survey (Proforma), and Facebook replies undertaken for (Tables 2.1 and 2.2) the '*Expectations and Experiences'* report (Llewellyn et al.,

2022)[7] and the *Process Evaluation* report (Llewellyn et al., 2021).[8] Further detail on the methods used is available in both reports. The participants (n=319) included carers, service users, operational managers, frontline workers and senior managers.

Table 2.1: Numbers of service users and carer participants as reported in 'Expectations and Experiences' report

Participant type	Interviews / FGs	Facebook Group	Pro-forma	Total
Service User	33	8	6	**47**
Carer	42	41	18	**101**
Both	2	15	0	**17**
Other	4	0	0	**4**
No Response	0	0	1	**1**
Total	**81**	**64**	**25**	**170**

Table 2.2: Numbers of participants by type of role within the workforce as reported in the process evaluation

	Senior managers / strategic leaders	Operational managers / supervisors	Groups [incl. frontline workers]	TOTAL
National stakeholders	9	-	-	**9**
Locality 1	8	6	-	**14**
Locality 2	9	11	19	**39**
Locality 3	8	10	-	**18**
Locality 4	16	14	39	**69**
TOTAL	**50**	**41**	**58**	**149**

2.7 We used two approaches to analyse all the transcripts produced by the original interviewers. These are not mutually exclusive and can be used together. The first approach is called an 'analyst-constructed typology'. The second was a realist approach. The 'analyst-constructed typology' is a form of qualitative analysis *'a continuum or classification system made up by analysts to divide some aspect of*

[7] Llewellyn M., Verity F., Wallace S. and Tetlow S. (2022) *Expectations and Experiences: Service User and Carer perspectives on the Social Services and Well-being (Wales) Act.* Cardiff. Welsh Government, GSR report number 16/2022. Available at: expectations and experiences

[8] Llewellyn M., Verity F., Wallace S. and Tetlow S. (2021) *Evaluation of the Social Services and Well-being (Wales) Act 2014: Process Evaluation.* Cardiff. Welsh Government, GSR report number 2/2021. Available at: process evaluation

the world into distinct categories or ideal types' (Patton, 2015, p551). In this instance we used the map of multi-agency critical success factors developed by the GCM to initially organise the data within original transcripts. Once the qualitative data from the transcripts had been allocated to each cluster heading from the map, we then used a realist approach to analyse the data itself (further details on method in Annex B). This second method is grounded within generative causation, meaning that we attempted to understand whether or not multi-agency working is sustainable under the Act or not. It attempts to do this by inferring a causal relationship between multi-agency working and its outcome (O). In order to do that one must understand the underpinning mechanism (M) which is triggered from within the context (C) in which it occurs (Kastner, Estey et al., 2011). These are called CMO configurations. Each context, mechanism and outcome is evidenced by multiple extracts from the methods. Each similar evidenced CMO configuration is then brought together and translated into usable 'If-then' statements. The 'If-then' statements are presented with associated quotes from the participants throughout this report. Using this approach allows us to see connections within the dataset and produces a greater level of analysis than simply conducting a thematic analysis.[9]

2.8 The findings from the GCM and the secondary data analysis were then integrated using a meta-matrix (Wendler, 2001) and are presented in the main body of this report (see Figure 2.2). By using both of these approaches we were able to answer all of the remaining 4 questions.

Figure 2.2: Process of analysis leading to findings[10]

[9] For more information on the method visit Rameses Project

[10] Details regarding methods, process of analysis and findings for the GCM can be found in Annex A.

3. Findings

3.1 The findings are presented by answering the following questions:[11]

1. Has implementation of the Act promoted sustainable integrated care and support?
2. Which critical success factors are 'most important and have most impact'?
3. What resources are required for multi-agency working to achieve the outcomes expected?
4. How have cross boundary governance arrangements supported people and agencies to work together?

3.2 The preceding literature review (Wallace et al., 2020) stated that in the complex world of working together the term 'integrated care' was defined as ''*consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health [and support] systems that are organized around the comprehensive needs of people [rather than individual diseases], and respects social preferences'* (adapted from World Health Organisation (WHO), 2018).

3.3 The WHO explain that people-centred care is much broader than patient or person-centred care and encompasses the health and wellbeing of people living and being active in their communities. Czypionka et al. (2020, p1) have since identified through analysing evidence from 17 European integrated care programmes that a holistic view of the person (considering physical health, emotional health and 'social situation') was the most important category to delivering integrated care for people with complex needs. Therefore, a context of person or population-centredness is key to trigger mechanisms which result in the development and delivery of efficient and effective multi-agency services.

Has implementation of the Act promoted sustainable integrated care and support?

3.4 In this evaluation we found an example of an individual with complex needs who had experienced integrated team working and who spoke 'highly' of the

[11] References are made to both methods' results and to the supporting literature where appropriate.

professionals, using words such as ‘brilliant’ (Carer, South East Wales, Female, Older person).

3.5 A different individual in transition from parallel care to integrated care witnessed professionals from differing teams speaking with each other about their case to resolve long standing issues. In this second example, a two year wait for an assessment had come to an end ‘at long last’ because the new integrated team had communicated with another to resolve the issue (Carer, South East Wales, Female, Older person).

3.6 However, where multi-agency working was not employed, it was in the context of a vague understanding of the principles of multi-agency working required or a conflict with protecting resources which triggered separate assessment and delivery of services (parallel working), which in turn often resulted in service users not experiencing joined up person-centred care.

3.7 Hanga et al. (2017) refer to person centredness as an individually tailored, holistic approach to meeting a person’s needs and recognising the person requiring support as an active participant. What is evident is that to successfully employ and experience multi-agency working at all levels of the system, individuals, frontline workers, operational and senior managers need knowledge and understanding of the Act’s principles and the permission and ability to actively manage, operationalise and deliver this way of functioning.

If the most important principles of multi-agency working (such as person-centredness and interdependency) are vague or in conflict with protecting resources (c) then this triggers parallel working (separate assessment, planning and delivery of services) (m). This can result in individuals experiences not being understood and not receiving joined up person-centred care (o).

3.8 The key evidence for the statement above rests with the experiences of individuals and families who reported in the qualitative data that whilst the assessment process may have changed for some, services were not generally organised in a person-centred manner, meaning that they did not perceive that their outcomes were placed at the centre or moving towards shared decision making. Multi-agency working was described as ‘delivered very badly’ (Carer, Mid Wales, Female, Adult), ‘a blame culture’ (Carer, South East Wales, Female, Adult), ‘never seen any

evidence of any link or joined up thinking' (Carer, South West Wales, Female, Adult), and 'hitting brick walls' (Carer, South East Wales, Female, Adult).

3.9 The multi-agency working principle was said to have not been translated into practice or gave the impression that professionals did not understand the individual experience. These quotes provide examples of where conversations and actions were not meeting the individual's needs or what was important to them, but rather addressing professional or organisation agendas.

> *I said 'well you are going to have to start at the beginning here and not start with the funding, that's not important, let's start with what's the basis of the changes (Carer, North Wales, Male, Adult).*
>
> *…even though there's been a change in the way needs assessments/carers assessments are undertaken as in their focus around outcomes etc., when it then comes to actioning a service to deliver on the outcome it tends to be a very big 'standard business as usual service' i.e., either a council run provision or DP, it's not innovative or creative (Carer, South West Wales, Female, Adult)*

3.10 There was a clear discrepancy between individuals' (their families and carers) perspectives and managerial perspectives. Some insight from operational and senior managers showed that the multi-agency principles were thought to be 'very clear' and 'they value the individual where they are at and how they can live' (Operational Manager, LA, Locality 2) and they understood that the emphasis should be on 'what does a good day look like for Mr Jones?' (Senior Manager, LA, Locality 3). Therefore, understanding that the interaction between individual and provider needed to focus on a holistic approach to meeting the individual's needs. However, this was not being experienced by the individual.

If you have inconsistent attitudes, trust, relationships, poor communication (c) then this can trigger disagreement between professionals and organisations (for example over care responsibility) (m) which may result in people not receiving their right to support and health care (o)

Person-centred care

3.11 Multi-agency working relies heavily on having the right attitudes, trust and good communication. These often take time to develop not just between individual/carer and multi-professionals but also between the professionals themselves.

3.12 In this evaluation it was reported by both individuals and the workforce that there were fluctuating and inconsistent attitudes, trust and relationships between organisations and the attitudes of those people involved. This was described in one case as 'horrendous' with one agency apportioning blame on the other (Carer, South East Wales, Female, Adult), whilst another perceived that 'Some organisations clearly believe they are more important than others' (Workforce Survey response).

3.13 The workforce participants reported that this triggered disagreement between professionals, who were 'literally arguing over the heads of children and young people with complex needs, as they cannot agree who is responsible for their care' (Workforce Survey response). Both carers and workforce participants thought that these issues could result in individuals or their carers not receiving their right to support and healthcare or being placed in inappropriate or unregulated settings in order to keep them safe (Carer, South West Wales, Female, Adult; Workforce Survey Response).

3.14 There were repeated examples of services across the lifespan where people (including carers/family members) expressed that, in their experience of multi-agency working, their voices were not being heard and acted upon. To promote sustainable integrated care, the individual is an active participant and interacts with the provider moving towards shared decision making, therefore ensuring that their outcomes are centre staged.

3.15 Individuals, families/carers felt that there was a lack of working together; for example, 'No one seems to work with anyone that I can see'. 'There's no integration at all.' Individuals, families/carers felt that this was often due to a lack of communication between them and individual professionals, teams and agencies.

3.16 Participants used words such as 'didn't communicate well' (Carer, South East Wales, Female, Older person), 'complete lack of communication' (Carer, South East Wales, Female, Adult) and 'not really listening' (Carer, South West Wales, Female, Adult), which led them to feel as if they were in a 'fight' (Carer, South West Wales,

Female, Adult), having to ‘make repeated calls’ (Service user, North Wales, Older person), bewildered (‘but we don’t know what’), and ‘frustrated’ (Carer, South West Wales, Male).

3.17 Carers expressed that they did not feel that they were being supported in the complex situation in which they found themselves, ‘Team around the individual? What team?’ (Carer, South Central Wales, Female, Adult) and ‘struggling on my own’ (Carer, South West Wales, Male, Adult) and ‘Not only would our needs be met and understood I wouldn’t have to repeat myself over and over to the different people’ (Carer, Female).

If there is a miscommunication or lack of communication between agencies, families, carers and service users (c) then this can trigger feelings of frustration, disappointment (m) and result in dissatisfaction and a lack of timeliness and understanding as to what’s happening in the assessment and care process (o).

3.18 They also felt that professionals were not engaged or adequately interacting with the individual, with one individual describing staff as: ‘…I quite often feel that I know more than they do because they are coming at it from a theoretical viewpoint or because they are overworked’ (Carer, South Central Wales, Female, Adult). This meant that they were not listening, which resulted in ‘a lack of understanding’.

3.19 An example case study illustrated the family of a person living with dementia feeling frustrated as they tried to ‘piece everything together’ and tried to instigate the connections between professionals and services. This person living with dementia described in their own words the implications of not implementing person-centred multi-agency care, with a lack of communication occurring at two levels between individual and care providers and care providers’ communication with other agencies (Koloroutis, 2004).

3.20 In this case study the provider (social worker) was not listening to the family concerns (repeated calls). In addition, neither social work, social services, police or ambulance services considered the impact of their individual actions on the other organisations through providing feedback to the lead care provider, or their collective responsibility for the individual’s health and wellbeing (Davies et al., 2016). This resulted in what Alter and Hage, (1993) labelled as **sequential** client flow (treated by one agency, service terminated, the person is referred to the next

service) as opposed to **collective** client flow where the person is treated simultaneously by staff from several agencies who develop goals or plans together and systematically share tasks i.e. putting the patient outcomes at the centre:

> *I have been out at night and put myself at risk. My family have had to make repeated calls to the Social Worker and fight for a third call as I was being given my night-time medication at tea time by the carers so was falling asleep after tea then waking later and was confused so would go into the street in the early hours. The police have been called but they didn't report it to social services. On one occasion a member of the public rang the ambulance because I was upset, the paramedics came and calmed me, they said they couldn't believe I was living alone but they didn't make contact with the social worker so my family has to try to piece everything together then report to the Social Worker* (Service user, North Wales, Older person).

3.21 Managing interfaces between the individual, carers, professionals, and organisations is challenging because of the 'different traditions, culture and work logic' (Prammer and Neugebauer, 2012).

Interdependence

3.22 To deliver person-centred care in the context of multi-agency working, professionals and their agencies need to understand the notion of interdependence or symbiotic relationships. This can be between organisations where they can bring complementary attributes. Alternatively, there is also interpersonal interdependence, defined as the process by which interacting people influence one another's experiences (i.e., the effects individuals have on other people's thoughts, emotions, motives, behaviour, and outcomes) (Van Lange & Balliet, 2015).

3.23 This concept is known to be a struggle for care organisations internationally as they try and work across statutory and non-statutory or private organisations to support people centred multi-agency working (Alter and Hage, 1993; Prammer and Neugebauer, 2012) and the same could be said here within multiple layers of the system. There were also examples of where agencies struggled with multi-agency working and creating that symbiotic relationship was exacerbated by protecting resources and the effects of funding cuts.

What we are finding is that education are trying to protect their resources, health are trying to protect their resources because they are so limited and that does create real problems (Frontline Worker, LA Locality 4).

3.24 An example was given where a restructuring of a multi-agency team due to funding issues had resulted in a reduction in team size. After an increase in workload, the team then had to acquire funding and purchase the (human) resource they needed externally which meant that methods of communication and the interpersonal interdependence required for complex working together (Koloroutis, 2004) with the whole team were not the same and joint working within the newly expanded team was 'difficult'.

3.25 There also appeared to be a number of disconnects between the multi-agency principles of the Act and understanding how to operationalise them. Public services are made up of social networks (relationship of varying types) in order to achieve the cooperation and coordination required to resolve social problems. The horizontal structure (multi-level relationships between providers has directional integration which contributes to learning) of aiming towards having one joint assessment and one joint plan was described as 'woolly and vague', which resulted in a parallel working in practice where professionals 'go off and we do our work, education go off and they'll do their own and [a] separate piece of work and draw up their plan and health likewise' (Operational Manager, LA, Locality 4).

3.26 In addition, vertical organisational frustration (multiple levels such as between commissioners and providers, users/beneficiaries/customers) was evident where operational and senior managers felt frustrated as professionals and councillors failed to see the consequences of how decisions (or lack of engagement) in one part of the system influenced another. In the complex world of working together the level of interaction requires a commitment by all members to accept responsibility for establishing and maintaining healthy multi-agency relationships and this includes considering the impact of individual and organisational decisions on others.

You never exclude a looked after child from education because by them being at home with their foster carer it's very likely that tensions can arise to a point where that relationship breaks down (Operational Manager, LA, Locality 2).

Co-ordination

3.27 Co-ordination, the alignment and harmonising of processes, is also an essential feature of multi-agency working. Peckover and Golding (2017: 41) remind us of this in their definition.

3.28 In the preceding literature review (Wallace et al., 2020), we were also reminded that collaboration followed by co-operation appeared to be the precursors of coordination (Figure 1.1) and the types of working together all have some shared characteristics (Table 3.1, p.34) with multi-agency working and require active management, within which operational workforce and senior managers alike need clarity of language and purpose, a culture of trust, honesty and reciprocity in order to manage expectations, obtain permissions and manage processes and structural differences across organisations. Nicolaisen (2016) recommended that there should be communication between all levels of the system; for example, leaders and coordinators, whilst addressing barriers should communicate their knowledge. This is required in order to develop the collective client flow referred to earlier i.e. a form of operational coordination (Alter and Hage, 1993).

If you have a culture of clarity of language and purpose, 'balanced relationships', trust, honesty, reciprocity and multi-level communication (c), this can trigger an ability to manage expectations, permission to manage process and structures across agencies (m), which may result in multi-level coordination (o).

3.29 In this evaluation we found an example model where three levels of coordination were part of ongoing work within one single local authority geographical footprint:

- local area coordination (community),
- individual operational coordination, and
- strategic (leadership) local area coordination (Operational Manager, LA, Locality 4).

3.30 The three-level example model demonstrates both vertical and horizontal multi-agency working. This model started in a small way as a pilot in 2014 and has slowly grown over the last eight years. Operationally staff exercise a lot of reflective practice (including challenging each other's practice and team reflection on cases) to ensure that they are working towards the principles of the Act, avoiding 'mission

drift' and continuing to drive the cultural change from a paternalistic service delivery to a prevention model. In 2010, Hansson found that joint coordination in networks for their mental health services and social care consortium in Sweden was assisted by a history of local and personal informal cooperation, evidence of shared responsibilities, implementing joint coordinators and having the ability to adapt. These characteristics are found within the following three level case study.

Local area coordination (community)

3.31 This level has been in place since before 2015. In this model each coordinator (known as an '*alongsider*') works with a local population of 12-14,000 people. There are currently 16 of them with a maximum of 24 required for the local authority footprint. They are agile community workers and not office based. Their aim is to build *'more confident, resilient connected communities that are welcoming to everyone'*. Therefore, in the complex world of working together and developing that interaction between service user and provider, the role of the local area coordinator is to develop relationships with local people through meeting them, spending time with them, identifying their strengths (as opposed to need) and helping them to acknowledge that they have skills to help themselves to move forward.

3.32 The coordinators develop the next level of interaction by working with partner organisations to grow and facilitate community events e.g., a free community meal working with a local school, a third sector organisation and a well-known supermarket brand. It is suggested (local evaluation) that this results in individuals being better connected in their communities, more confident, identifying and sharing individual skills with others in their community. It also suggests that it helps to release GP time where they work with individuals who are high intensity users (3-4 visits per week) of primary care services (Operational Manager, LA, Locality 4), therefore considering the impact on the wider health and care system.

3.33 The preceding multi-agency literature review (Wallace et al, 2020) discussed the importance of building relationships with common language and purpose to create trust. Key to the relationship building is the idea of a 'balanced relationship' and a change in language to support it. For example, in this case study, they receive 'introductions' to people as opposed to referrals – the latter suggesting an 'imbalanced relationship in terms of power' where the referrer is perceived as the expert referring to another expert. In this model the introductions are made between

the ‘alongsider’ and any professional (e.g., GP, social worker), member of the community (e.g., local hairdresser, post office worker, neighbour) or the individual themselves.

3.34 The people who are introduced to the ‘alongsider’ will be facing a personal challenge e.g., loneliness, isolation, just moved into a new area, recently discharged from a health or care service, recently bereaved, in transition from being a full-time carer to just being themselves. All these examples are people who need help to reconnect with their community (Operational Manager, LA, Locality 4). A close working relationship with the third sector (national and local organisations) is essential to delivering this part of the model.

3.35 In order to develop the level of interaction required for complex multi-agency working interaction the care provider consistently maintains the service user as a central focus which takes time to develop. In this case, following the introduction, the ‘alongsider’ will meet the individual in their own home and ask person-centred questions such as ‘‘What matters to you, how can we help you achieve that?’ ‘What makes a good life and how can we help you achieve that?’ ‘What’s really good about your life, and what have you got to offer, and how does that fit in with your community?’ Generally, the type of responses they receive are ‘I want to have more friends’, ‘I want to get out more’, ‘I want to live with meaning and purpose’, ‘I want to feel like I’m doing something useful with my life’. This type of conversation provides the coordinator with the information required to understand how the individual needs may be addressed by multi-agency providers. Identifying the next level of interaction with multi-agency providers takes time and so in this model there was not a time limit on engagement (Operational Manager, LA, locality 4).

Individual operational coordination

3.36 The staff working as ‘operational coordinators’ at individual level work with external partners e.g. British Red Cross, tenancy support organisations, drug, and alcohol organisations. Their role is to help a person through talking to the partner organisations to ensure that the individual does not fall through the gaps or end up repeating themselves. They achieve this through communicating (talking mostly and avoiding duplication of effort) with the partners, and developing and maintaining healthy relationships with them (Operational Manager, LA, Locality 4).

The strategic (leadership) local area coordination group

3.37 This group was initiated as soon as the ‘local area coordination’ initiative started. Its purpose is to help embed local area coordination by sharing out some of the responsibilities and getting support from other organisations. It met monthly/bimonthly though at the time of the evaluation interview, it was going through a re-organisation. The group comprised membership from health, police, local universities, housing associations, social services, registered social landlords. Key to maintaining the partnership was demonstrating the benefit to each type of business (Operational Manager, LA, Locality 4).

3.38 The group member organisations have funded the local coordinators over the years. The biggest challenge until recently had been obtaining a contribution from health members at all levels of the sector. Recently the model received short term Welsh Government grant funding from their GP cluster members.

> *We tried at different levels. I know [name] tried it at a high, strategic level, and we’ve tried at local level. It’s only really now that we’re starting to get some money through from that operational level, from the GP cluster networks because they’ve had access to Welsh Government money (Operational Manager, LA, Locality 4).*

3.39 The local universities fund one of the posts in addition to supporting several students to undertake identified projects required by the group to market their unique skills to private companies in order to access corporate social responsibility funds. The challenge now is to find long term funding, avoid losing the operational staff who are key to the relationship building, and ensure the aim of ‘building community resilience and confidence’ is not undermined.

> *…it’s got to be a long-term approach, so we can’t have people in post for 12 months and then have them disappear again because after 12 months they’ve just got to know an area, they’re just getting to know people and building relationships (Operational Manager, LA, Locality 4).*

3.40 Person-centred care or ‘people centred care’ is a success factor for co-ordination and integration, and co-ordination in turn, is a characteristic of multi-agency working and integration (Wallace et al., 2020). Multi-agency collaboration and integration is conducive to achieving person centred care (Dowling et al, 2007), and as stated by Goodwin (2016), the ‘ability to co-ordinate care and services around people’s needs

is integrated care's "compelling logic"'. What this, the previous case study, and our GCM study (Question 2) shows us is that if there has been a history of established person-centred care, then multi-agency working *can* become custom and practice when it coordinates the care of different services, from the perspective of service users' (Burdett & Inman, 2021). The preceding literature review (Wallace et al, 2020) provides examples such as the PRISMA coordinated type' model in Quebec which has been developing and delivering prevention and support services over the last 20 years to meet the needs of frail and disabled older people (Hebert, 2015; Dubuc et al., 2016). It has a working principle of established person-centred care.

If there has been a history of established and actively-managed, person-centred, coordinated care (as opposed to process centred) (c), then this may trigger a willingness to help one another, risks being well managed together, coordinated networking (m), resulting in multi-agency working becoming custom and practice. individuals accessing more services (o).

Co-location

3.41 Co-location was identified as a crucial factor in enabling successful multi-agency working (Dickinson & Neal, 2011; Kaehne & Catherall, 2012). Lalani & Marshall (2020) have defined co-location as 'different professional groups situated in the same workspace'. It has been found that co-location is an effective enabler for service integration providing a basis for joint working, fostering improved communication and information sharing if conditions such as shared information systems and professional cultures (shared beliefs and values) are met. It results in more prosperous social working relationships, overcoming issues of professional culture which all may result in positive outcomes for clients.

3.42 Baginsky and Manthorpe (2021) explored multi-agency working between children's social care and schools during the COVID-19 pandemic in England and found that it led to new improved ways of communicating and professional behaviours due to the increased use of online methods.

3.43 For one team (in this evaluation) co-location had triggered informal 'joint working' with other teams and a willingness to help each other out when needed.

We just need to shout at them, they are all here, because we are on the same floor. They see us, we see them, there isn't anything that we can't do together type of thing (Operational Manager, LA, Locality 1).

3.44 Another operational manager gave examples of expanded multi-agency teams co-located and working well together, including nurses, social care workers and police officers. They also spoke about social care workers working in health environments (Operational Manager, LA, Locality 2). Another spoke about how co-location was strengthening teams as they understood each other's roles a bit better (Operational Manager, HB, Locality 1).

3.45 Other teams had been co-located since the early 1980s and 90s (learning disabilities and mental health) and stated that for those people working in the team, 'that's all they know really, they don't know anything different' and that it was about 'focusing on that approach about it being about the person rather than it being about a process' (Operational Manager, LA, Locality 1).

If you practice co-location (c) then it may trigger informal joint working through an increased understanding of roles and an increase in communication (m). This can result in a focus on the person as opposed to the process when providing support and healthcare (o).

3.46 However, other operational managers stated that just because they were co-located, it did not mean that they were integrated. They realised that co-location was merely one element required for successful holistic integrated team working which they desperately wanted to achieve (Operational Manager, LA, Locality 2).

'we've got (a) multidisciplinary team….you know we are all in the same corridor you know, primarily social services is on one side of the corridor and we've got nurses in one room and all the therapists are in another room so we banter, we go back and fore, we ask questions....do you know so and so has happened, can you support with this... you know we do work as a multidisciplinary team but I think the next level as in getting the input into meetings, decision making and actually getting continuous healthcare is the difficulty isn't it...' (Operational Manager, LA, Locality 4)

A need for joint training

3.47 A joint approach to core training and upskilling of the workforce was identified as a success factor for multi-agency working in the preceding literature review (Wallace et al, 2020). However, in the Group Concept Mapping (GCM) study it was not identified by participants within the top 30 most important success factors (Table 3.1, p.34). In the literature, Rozansky et al. (2017) recognised it as an enabler for sustained integration. It helps to engender confidence for safe delegation when developing integrated health and care roles (Barber and Wallace, 2012).

3.48 In this evaluation there was recognition by both staff and carers that more multi-agency training is required at all levels of practice, management, and wider organisations to learn about how to deliver sustainable multi-agency working for the future. Senior Managers acknowledged that it made sense to learn from their partners in a 'learning culture' (Senior Manager, Regional, Locality 4).

3.49 This was considered not only important for the task in hand, that of implementing the Act, but also in refocusing staff on joint aspirations, joint goals and joint alignment and sharing opportunities to improve services. One senior manager recognised it as a 'cultural change', recognising that there was still 'a way to go [in achieving it] but we can see a way forward with strategy and continue joint training', as it was being supported by senior management (Senior Manager, Regional, Locality 4).

3.50 There was mention of multi-agency training and learning opportunities for example in the form of workshops for collective teams

> *'to work together ….on being able to understand both what the Act was and also to understand what the potential implication of the Act would be..'. (Senior Managers, HB, Locality 4)*

3.51 In one example where a regional multi-agency approach to training staff on the Act was taken, this 'helped standardise the kind of training and implementation across the region' and dispel a 'challenging' perception – which was seen throughout this evaluation – that the Act (due to its title) was only for social services.

> *…but we had to consistently say, no, this is the Act for both agencies, both organisations to implement and it affects both, rather than it just being the social services' responsibility (Operational Manager, HB, Locality 2).*

3.52 Using a professional adviser was seen as useful in sustaining the multi-agency learning and continually improving through the learning cycle. The example role in a local authority (professional social work advisor) focussed on implementing the Act and helping staff move towards the new integrated information system, 'reviewed the social work assessment forms, and developed task and finish groups'. (Operational Manager, HB, Locality 2). An important component to improve communication and information sharing across professions and agencies (Lalani and Marshall, 2020, p.388). This type of role was also reported by O'Halloran (2016) where the Change Academy in London used a 'change navigator' to develop and coach staff in their new approach to delivering a person-centred, integrated care service. The Change Academy programme included modules on: leading across boundaries, problem solving techniques, data to improve how care is delivered, dealing with conflict and health coaching.

3.53 However, there were other components which supported learning such as a strong collaborative regional approach. Nevertheless, on reflection one health board operational manager felt that there had been too much emphasis on preparing social workers at the expense of other members of the multi-agency team.

> *'[T]here was learning and organisation departments for social care for each of the three local authorities and the learning and development for health were working on implementing training packages. People were feeling very prepared. One thing I would say is that looking back on our preparations, we focussed an awful lot on social workers, because obviously, I think at the time, there was the belief that the assessments and strength-based approach was more around social work. But being in an integrated service, I think professions like occupational therapy, we could have done a bit more with those kinds of professions. Because even though their assessments are strength based, it is all about, as I said, maximising independent living skills and focussing on the family networks. They still had to put that in the context of the social services and the legislative framework. I think we've done that far better for social workers than we did for other professions' (Operational Manager, HB, Locality 2).*

In summary – reflecting on the role of the Act

3.54 The Act itself appears to have been a trigger for some organisations and professionals to consider a different way of working together and '*accelerated that pace of change'.* For those that understood the need for multi-agency working and have worked well together, there is evidence that they discuss, reflect and negotiate how to resolve conflicts across organisations to ensure practice improves in future.

3.55 Some frontline workers expressed an appetite to understand the expectations of multi-agency working, learn from one another and compare operational and managerial practice. They appreciated that, although they had different roles and different ways of working, they all had a contribution to make. They could all 'bring their own sort of good piece of information that we can use [to] give us [a] different perspective on things'.

3.56 A recent example was given of a case (young person) where health and social care professionals were arguing about whether it was a medical responsibility or a social care responsibility. The issue had been 'dealt with' but on reflection they felt that they could have managed it in a better way. They were of the view that children in similar cases needed to be 'much better looked after and provided with the right resources and support'. They appreciated that the type of situation they found themselves in would likely be repeated and now planned to meet to discuss what had happened with a view that they 'need to know how we better work together' (Frontline Worker, LA, Locality 4).

3.57 Some operational managers in the third sector stated that there has always been a 'sort of commitment' to partnership working which they have benefitted from. Others thought that they could see partners at a strategic level starting to respond to the multi-agency requirements of the Act. It 'provided a lot more structure for that conversation' at different levels, particularly strategic engagement, helping with 'multi-agency politics' (Operational Manager, LA, Locality 4).

3.58 Some new staff including those who had moved from England to practice in Wales may have missed out on multi-agency training for the Act and had to catch up. The recent COVID-19 work had exposed that some staff were 'only now actively learning about each other's working cultures and 'truly understanding each other's values and our interdependence' (Survey Response, Workforce). The reasons for this are not clear from the available secondary data.

3.59 What is apparent on reflection is that individuals and families generally report that multi-agency working is not working for them for various reasons. The agencies struggle with delivering person-centred, multi-agency care where there is not a history and culture of doing so or where there are tensions around resources. They also struggle with the concepts of interdependence and coordination. Training and actively managing multi-agency working should slowly change the culture and demonstrate the benefits to individuals, carers, frontline staff and their agencies of working differently together. Walker (2018) argues that multi-agency training should be seen as a series not just as a one-off event in order to achieve these outcomes.

Which critical success factors are most important and have most impact?

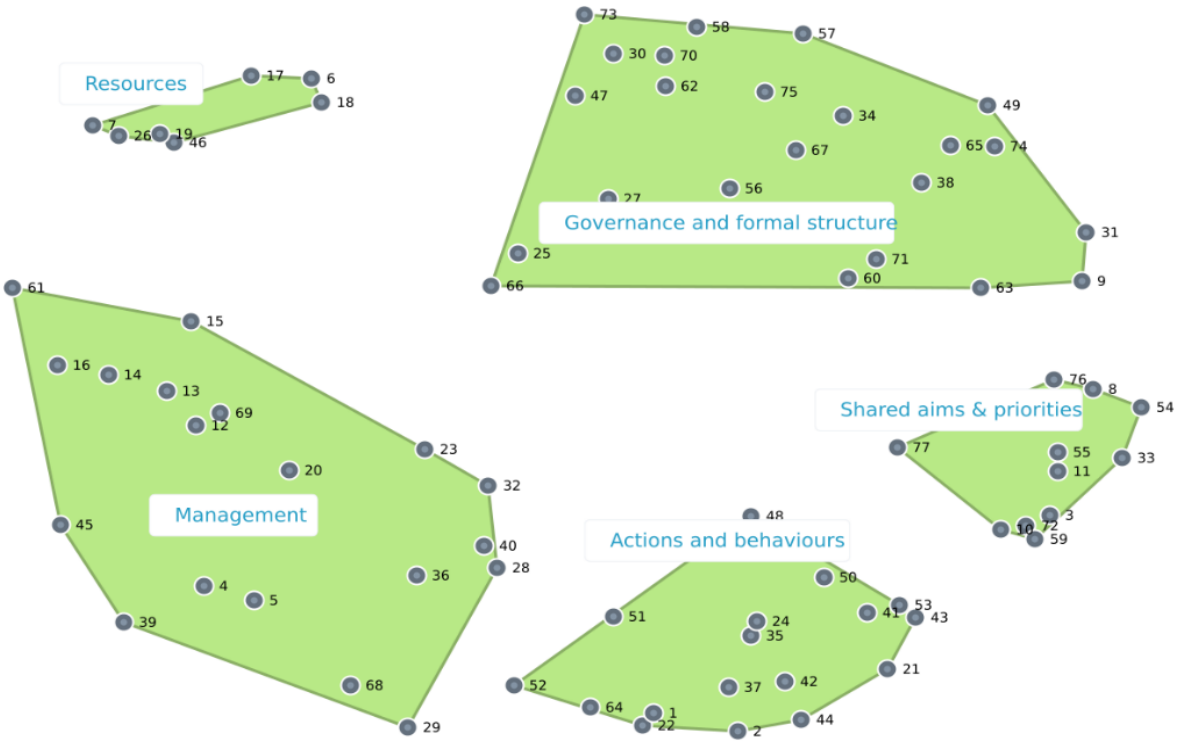
3.60 In answering this second question, we have drawn primarily on the GCM method (see Appendix A for more detail), as opposed to qualitative methods used previously. At the end of this section, GCM findings are mapped against the success factors for multi-agency working identified from the proceeding review (Wallace et al., 2020).

3.61 The GCM activity identified 77 success factors in response to the single prompt "Multi-agency working within the context of the Social Services and Well-being (Wales) Act will be successful if….". These were then given numbers and organised into groups by the participants. The software then analysed the individually organised groups and their labels (provided by the participants) and offered a number of cluster maps to be considered by the study team. The study team agreed on a five-cluster map because the success factors grouped within them were best represented as such. The five clusters (Figure 3.1) identified were resources, governance and formal structures, shared aims and priorities, actions and behaviours, and management.[12]

3.62 Participants identified which success factors were thought to be most important through rating each statement for importance. The hierarchical cluster analysis used then grouped the individual statements on the point map into clusters of statements to reflect similar concepts (Kane & Trochim, 2007). This is then presented as a cluster map with average cluster ratings.

[12] These were the clusters of success factors used to later analyse the secondary qualitative data – see Appendix B.

Figure 3.1: Cluster map with labels from the participant grouping exercise



3.63 The cluster-rating map in Figure A4 and A5 (Appendix A) shows that the 'Resources' cluster was considered the most important (4.48 average rating) and had the most impact (4.37 average rating). The 'Management' cluster came second in importance (4.28 average rating) and degree of impact (4.05 average rating). When considering importance, this was followed by 'Actions and behaviours' (4.11 average rating) and 'Shared aims and priorities' (4.09 average rating). Both these clusters scored 3.87 (average rating) when rated for 'degree of impact'. The cluster 'Governance and formal structures' was considered the least important (3.83 average rating), with the least impact (3.64 average rating). This cluster included success factors which were considered important characteristics of multi-agency working in the peer reviewed articles included in the literature review (Wallace et al., 2020).

3.64 Thirty critical success factors identified as most important with most impact for multi-agency working in the context of the Social Services and Well-being (Wales) Act 2015 were identified. See Table 3.1 for the critical success factors displayed in rank order, and further detail and explanation can be seen in Appendix A.

Table 3.1: 30 most important success factors as identified by participants which have most impact, in rank order

No.	Critical Success Factors
13	Citizens voices are heard, respected and acted upon
26	Investment in social care has parity with NHS investment
69	We work comprehensively and co-productively with individuals and families
46	We have sufficient resources including time and capacities
7	There are resources to support it
42	We have commitment
12	Citizens remain in control
19	Financial resources are well aligned to avoid duplication and deliver seamless responses
37	Have the right attitude
23	Front line is empowered to find collective solutions to meet citizen needs, with freedom to innovate
36	We have the right people in the team
3	We work collaboratively with realistic aims and objectives to ensure the desired outcomes are delivered
45	We have good communication- senior level management engagement
25	Performance measures relate to outcomes for citizens rather than units of activity
1	There is a willingness to help each other out
17	Human and financial resources are well aligned to avoid duplication and deliver seamless responses
16	Risks are shared with a focus on empowered citizens
27	The aims of SSWB Act are recognised across Wales
6	There is time to support it
5	Organisations divest themselves of power and control and genuinely embrace co-production
39	We have strong leadership
54	We have common goals
77	Work together jointly
53	We have shared values
71	Working together jointly both strategically and operationally
67	We coordinate service provision
14	Risks are managed well, with a focus on empowered citizens
20	Organisational and professional differences are respected and used to deliver citizen/patient focused service models
41	We have shared motivation
68	We acknowledge individual knowledge and expertise

3.65 By examining the 30 data critical success factors (the most important and most impact) we saw that the characteristic rated most important, with most impact was no. 13 ‘Citizens voices are heard, respected and acted upon’, which had a mean average of 4.70835. The second characteristic considered most important, with most impact was success factor no. 26 ‘Investment in social care has parity with NHS investment’, also with a mean rating of 4.70835 (see Table A8, Annex A). All five clusters are represented within the 30 critical success factors. The critical success factors were sorted within their respective clusters. These are the statements which have been identified as most actionable i.e. the most important which have most impact.

3.66 Table 3.2 maps the n=77 statements generated from the GCM study against the successful factors for multi-agency working, generated by the proceeding literature review (Wallace et al., 2020). Factors should not be considered in isolation; the breadth of GCM statements do not necessarily fit neatly across to those identified from the literature and there is inevitably overlap which is consistent with the multifaceted understanding of, and range of factors considered as being required for successful multi-agency working (Wallace et al., 2020).

3.67 Overall, as Table 3.2 shows, GCM statements were consistent with the literature, with the exception of two; ‘Investment in social care has parity with NHS investment (26)’, and ‘The aims of SSWB Act are recognised across Wales (27)’. Whilst statement 26 is broadly related to ‘sufficient resources’ (row 9 of Table 3.2), this statement indicates that it is the equality of funding between health and social care which is a factor for successful multi-agency working (rated as the second most important factor with most impact). Statement 27 can also be connected to e.g., ‘Shared vision/common goals/aims/purpose’ (row 7 of Table 3.2). Yet, as highlighted earlier in this report (paragraph 3.7) realising this factor requires ensuring the Act and its aims are consistently understood at all levels of the system, and the permission and ability to actively manage, operationalise and deliver multi-agency working.

Table 3.2: Critical success factors for multi-agency working

	GCM (statement number)	Literature
1	Individuals divest themselves of power and control and genuinely embrace co-production (4) Organisations divest themselves of power and control and genuinely embrace co-production (5) Risks are shared with a focus on empowered citizens (16) Understand each other's statutory responsibilities (31) Agree Formal strategic assurance/arrangements (65) Working together jointly both strategically and operationally (71) Formal working arrangements (74) Work together jointly (77)	Working together jointly Information sharing Formal strategic assurance/arrangements
2	We work collaboratively with realistic aims and objectives to ensure the desired outcomes are delivered (3) Common objectives with shared accountability for delivery is the norm (8) Risks are managed well, with a focus on empowered citizens (14) Risks are understood with a focus on empowered citizens (15) We conduct joint visiting or assessment (66)	Joint visiting or assessment Formal strategic assurance/arrangements
3	Individuals divest themselves of power and control and genuinely embrace co-production (4) Organisations divest themselves of power and control and genuinely embrace co-production (5) Citizens remain in control (12) Citizens voices are heard, respected, and acted upon (13) Front line is empowered to find collective solutions to meet citizen needs, with freedom to innovate (23) We work comprehensively and co-productively with individuals and families (69)	Working with individual or family
4	There is a willingness to help each other out (1) We have good governance structures/manuals (47) We provide training and support for individuals, community, and workforce to understand the prevention agenda (61)	Training & support
5	We include non-traditional partners for greater knowledge and resources (60) Access to statutory sector databases by third sector (73)	Non-traditional partners
6	Performance measures relate to outcomes for citizens rather than units of activity (25) Shared IT systems (30)	Data Integrated referral system

	GCM (statement number)	Literature
	We monitor individual and systemic outcomes (56) We have clear care pathways linked to referral systems (57) We use an integrated referral system (58) Access to statutory sector databases by third sector (73)	Monitoring individual and systemic outcomes Care pathways
7	We compromise if needed (2) Common objectives for delivery are the norm (9) Everyone is invested in shared objectives (10) Everyone is invested in shared priorities (11) Organisational and professional differences are respected and used to deliver citizen/patient focused service models (20) Organisational differences are respected (21) Professional differences are respected (22) We have a history of collaboration with shared vision or goals (33) We have informal cooperation (50) We have common goals (54) We share a vision (55) We share desired outcomes (59) Sharing realistic aims (72) Have a shared desirable outcome (76)	Shared vision/common goals/aims/purpose Informal cooperation Shared desired outcome Flexible process e.g., sequential, or concurrent
8	We have network coordination (38) We have a formal structure rather than informal structure of network (49)	Formal structure rather than informal structure of network
9	There is time to support it (6) There are resources to support it (7) We have sufficient resources including time and capacities (46) We have time to build relationships- through co-production (51) We have time to build relationships- through consensus (52)	Sufficient resources including time and capacities Time to build relationships
10	We have shared motivation (41) We have commitment (42) We have shared energy (43)	Strong commitment and motivation

	GCM (statement number)	Literature
	We have strong shared norms commitment (44)	
11	Relationships are strengthened, creating trust and common endeavour (24) We understand our roles and responsibilities (28) We have a clarity in roles and responsibilities (32) We have Trust – not building expectations which create mistrust (35) We have the right people in the team (36) Have the right attitude (37) We have People in the team knowing and happy with their defined role (40) We have good communication- senior level management engagement (45) We have shared expertise (48) We have shared values (53) Understand the processes by which trust is built up and maintained (64) We acknowledge individual knowledge and expertise (68)	People in the team knowing and happy with their role/ defined role/shared understanding Having the right people in the team - personalities and specialist roles Shared expertise Trust Good communication
12	Timely planning (7) Human and financial resources are well aligned to avoid duplication and deliver seamless responses (17 & 18) Financial resources are well aligned to avoid duplication and deliver seamless responses (19) Leadership and followership are present (29) We have Strong leadership (39) We have good governance structures/manuals (47) We coordinate service provision (67)	Strong leadership and network coordination Coordination of service provision Good governance
13	Have a comprehensive multi-agency plan to meet population needs (34) We understand Specific needs – including individual, population (general and specific) to each agency (62) We share an understanding of need across agencies (63)	Specific needs

What resources are required for multi-agency working to achieve the outcomes expected?

3.68 The preceding literature review (Wallace et al, 2020) identified that sufficient and shared resources including time to build relationships and capacities, and shared expertise were essential for successful collaboration (Tong et al., 2018). Most recently Thiam et al. (2022) stated that there are two concepts that are central and give structure to integrated care. Time was important for people and carers when assessing, planning and coordinating care and it influenced its success. Care givers' relationship with time was linked to the realities of the institutions from which they received professional help and to their collective need. For professionals and organisations, timeframes (a specific period of time within which they work across agencies) are important for agreeing funding arrangements, service delivery, and especially with regards to cross sector working.

3.69 The results from the GCM activities (Annex A) have shown that participants thought that the 'Resources' cluster was the most important, with the most impact for successful multi-agency working. Success factors in the 'Resources' cluster can be seen in Table 3.3. Six out of seven of the most important success factors, with the most impact, were within the 'Resources' cluster (Nos, 26, 46, 7, 19, 6, 17 in ranked order). The GCM identified that time, resources (both financial and human), were needed to support multi-agency working. In the view of participants, these should be well aligned to avoid duplication and conflict and deliver seamless responses.

Table 3.3: Success factors in 'Resources' cluster

Success factors no.	Success factors
6	There is time to support it
7	There are resources to support it
17	Human and financial resources are well aligned to avoid duplication and deliver seamless responses
18	Human resources are well aligned to avoid duplication and deliver seamless responses
19	Financial resources are well aligned to avoid duplication and deliver seamless responses
26	Investment in social care has parity with NHS investment
46	We have sufficient resources including time and capacities

If there is time in a shared space to develop multi-agency relationships and practice (C) then this can trigger meaningful conversations (M) which result in a common understanding and a desire to work together to achieve the common aim (O).

3.70 The GCM statements of success factors and characteristics identified in Table 3.3 have identified that working together needs time (as a resource) to develop. In the qualitative secondary analysis it found that for some it is those 'conversations in the office' (Operational Manager, LA, Locality 2) that 'drip positive influence on your colleagues…Then slowly you'll change the culture' (Senior Manager, Regional, Locality 4). Other examples provided were of a social worker and nurse conducting a joint visit with an individual at home and having meaningful shared conversations, 'and everybody is on the same page' (Operational Manager, LA, Locality 2).

3.71 In Table 3.3 statements 17, 18 ,19 identified by the participants that an alignment of human and financial resources was important to avoid duplication. However, within the qualitative secondary data analysis, conversations which did not seem to have changed over time were the ones about joint commissioning and funding, especially for people presenting with very complex needs, for example continuing care.

> *We have got nowhere near resolving that. I'm in a meeting tomorrow afternoon which I don't expect to make any progress on. In fact, I think things have gotten more difficult at times (Operational Manager, LA, Locality 2).*

3.72 Staff who had moved to work in a different locality felt that even though the law was the same, the experience of working within the same policy context differed. They stating that joint commissioning, especially in children's services, was 'few and far between' in their new locality (Operational Manager, LA, Locality 2).

3.73 Nevertheless, there was evidence of some difficult but positive discussions and agreements about financial settlements in some areas of multi-agency working where partners had tried to find alternative solutions. The partners relied on their 'good relationship' and looked for 'what's of least impact', trying to continue what they could that had the 'biggest impact for our population', whilst also considering risk. By doing so they were trying to 'beg, borrow and steal to carry on (Operational Manager, HB, Locality 1).

3.74 There was a perception that human and financial resources are not well aligned, leading to duplication of information giving, variable responses and conflict, although experiences seem to be changing, (Senior Manager, HB, Locality 2).

It was centred about what financial benefits partners might see, returning to 'a sense of accounting, trust, ownership'. Described as a 'tricky balance to try and achieve in a situation where certain partners in particular feel aggrieved about the settlements they are getting or did get (Senior Manager, HB, Locality 2).

'And I'd say the situation has improved over the last 12 months and their new Director of Finance has said we'll sort this so we are a lot better than we were 12 months ago or two years ago but there is still this lack of trust between us and them.' (Senior Managers, LA, Locality 1).

How have cross boundary governance arrangements supported people and agencies to work together?

3.75 Cross boundary governance arrangements are broader than coordination (Henttonen et al. (2016). The contextual issues they identified were cultural organisation, the stage of network development, human capital, and financial resources. The preceding literature review (Wallace et al., 2020) identified that formal strategic assurance/arrangements and good governance structures/manuals (Tong et al., 2018), joint governance (Dickinson and Neal, 2011), and data sharing (Choca et al., 2004) were success factors for multi-agency working. In the literature section on policy and governance, eighteen articles provided an insight into successful multi-agency working.

3.76 The results from the GCM activities (Annex A) show us that participants thought the 'Governance and formal structures' cluster was the least important of the five clusters, with the least impact (Table A5). Of the 23 success factors identified within the 'Governance and formal structures' cluster, only four success factors were among the 30 most important factors, with most impact (Table 3.4). However, this may just reflect the views of this small number of participants but also their level of understanding of multi-agency working.

Table 3.4: Most important success factors, with most impact for successful multi-agency working within the 'Governance and Formal structure' cluster

No.	Data item/Success factors	Mean rating	Ranking
25	Performance measures relate to outcomes for citizens rather than units of activity	4.375	11
27	The aims of SSWB Act are recognised across Wales	4.25	15
71	Working together jointly both strategically and operationally	4.1667	21
67	We coordinate service provision	4.16665	22

If there is a multi-agency working environment without a shared template of robust evaluation and monitoring frameworks (with reporting standards) (c) then this can lead to an inability to collect meaningful multi-agency data (qualitative and quantitative) (m) and result in reduced workforce and citizen confidence in decision making (o).

3.77 In the qualitative data there were concerns about the robustness of performance measures, outcomes and evaluation information to inform joint decision making:

> *'If there is that push towards more qualitative forms of intelligence and evidence, how well set up is WCCIS to handle all of that? Is it gonna cause a system problem if in two, three, four, five years' time we've shifted the system so that there is a much different set of performance measures that we're collecting than perhaps we're collecting now?' (Operational Managers, LA, Locality 4).*

3.78 The WCCIS (Wales Community Care Information System) is the national IT programme enabling health and social care professionals to share care records electronically, information and outcomes across adult and child services; to deliver improved integrated support and services for people in Wales. It has been identified as key to Welsh Government's *'ambition of an integrated and person-centred health and social care services.'* (Audit Wales, 2020:12). However, it has some identified issues such as lack of functionality, differences in the way it's being used and a varying development of national data standards (at different stages across different service areas). These are all required to realise the benefits of an integrated IT system and so are considered barriers to integrated working.

3.79 It was also acknowledged that it is a whole system responsibility to ensure that outcomes are achieved:

> *'whole council recognising well-being outcomes won't be achieved unless we all work together' (Operational Manager, LA, Locality 2).*

3.80 The preceding literature review (Wallace et al., 2020) found a 10-year service evaluation of the Adolescent Multi-agency Specialist Service (AMASS) which aimed to develop an intervention model which aims to attend to the needs of both the family and the allocated social worker. They reported routinely collected outcome measures and found that this wrap around multi-agency whole team approach had positive results for families. One of the survey questions in this evaluation asked, 'thinking about the care and support the person you care for receives, what could be done to improve their well-being and yours as their carer?' The answer given by one participant was 'Outcome focussed care, with clear targets'' (Carer, Adult). This reflects the top success factors found in Table 3.2, 'Performance measures relate to outcomes for citizens rather than units of activity.' Although at times the outcome was satisfactory, the process was reported as not necessarily so for either carer or for frontline workers, indicating that the multi-agency model of delivery is as important as achieving outcomes. (Carer, South West Wales, Adult, Male).

3.81 However, when Alderwick et al. (2021) conducted a systematic review on the impacts of collaboration between local health care and non-health care organisations, they found that there was little convincing evidence to suggest that collaboration between local health and social care organisations improves health outcomes. They concluded that the benefits of collaboration were apparent in theory but less in the reported evidence that currently exists. Highlighting the importance of having the ability to collect the right data across multi-agencies.

3.82 In this evaluation, the challenge and concern regarding robust outcome measures revolves around the evidence base and looking for 'powerful' alternatives to evidence this gap. An operational manager identified that they 'struggled' with getting the evidence base around prevention and a consensus around acceptable and robust measures. They continued with building case study evidence, 'The power of the spoken word of the person who has experienced life, it's powerful, isn't it? Far more powerful than a graph' (Operational Manager, HB, Locality 2).

3.83 Alderwick et al (2021) further highlighted that local collaborations should be understood within their macro-level political and economic context, as interventions interacting with one another within the whole system to ‘shape population health’. In this evaluation, the process of evaluation was viewed by the workforce as ‘not particularly tight’, ‘not common place in statutory services’ (Survey Response, Workforce) and linked to other decisions around short term funding models which meant that people were not necessarily making the shift required in practice by the Act.

3.84 In addition, it was also considered ‘only as good as the last person that came and filled in the evaluation form’. Asking individuals, carers and children to be included in the design, implementation and evaluation were viewed as ‘less evident’ (Survey Response, Workforce). Engaging with them for feedback was described as ‘based more on how they feel as they are referred to us and then afterwards’. Respondents were honest, stating that sometimes they did not get the opportunity to collect the end of service information but carry out ‘random evaluation and feedback’ relating to the service they receive rather than the individual themselves (Survey Response, Workforce).

3.85 A 4 year European study (SUSTAIN- Sustainable Tailored Integrated Care for Older People in Europe) identified that an approach to integrated care improvement was needed which was ‘intelligent, sensitive, responsive and adaptive’ (SUSTAIN, 2019:62). Goodwin (2019) acknowledges these principles and the challenges of collecting data through technology for multi-agency working. He states that what is required is ongoing measurement of progress and providing effective feedback. This should be embedded within integrated care services which act as tools for quality improvement, enabling complex integrated care issues to be resolved in ‘real time’ (Goodwin, 2019).

4. Summary

4.1 The importance of working together through multi-agency working cannot be underestimated. When a carer was asked what was the most important thing they would like to tell policymakers in Welsh Government about what needs to be considered, done differently and prioritised, they replied:

> *I think agencies working together, I don't understand why they can't work together (Carer, South West Wales, Female, Adult).*

4.2 In this evaluation we found a degree of inconsistent practice and perceptions around multi-agency working, meaning we are not able to conclude that the objectives of the Act are being met yet. There are examples of good practice. However, there is also a difference between the expressed experience of individuals and their carers and the expressed best efforts employed by frontline staff, operational and senior managers. Individuals and their families are not experiencing the perceived benefits of multi-agency working that frontline staff are experiencing.

4.3 The GCM and the preceding literature (Wallace et al, 2020) identified that a success factor of multi-agency working is developing good relationships which includes having the right attitude, equal status and trust. A key component is that multi-agency working is a holistic view of the person which is a relationship-based concept and relies heavily on having the right attitudes, trust and good communication (Koloroutis, 2004). The interaction required for multi-agency working is at multiple levels. These often take time to develop not just between individual/carer and multi-professionals but also between the professionals and agencies themselves. In this evaluation it was reported by both individuals and the workforce that there were fluctuating and inconsistent attitudes, trust and relationships between organisations.

4.4 Sustainable integration or multi-agency working has a number of critical success factors of which we identified 30 as most important, with the most impact. In order to deliver multi-agency care, professionals and their agencies need to understand the concepts of person-centred care, of interdependence and coordination, co-location, time as a resource, and the need for joint training as well as recognising that the individual and family are active participants.

4.5 The Act has certainly triggered conversations at different levels and across agencies; however, agencies still struggle with delivering person centred multi-agency care where there is not a history and culture of doing so or where there are tensions around resources.

4.6 The following eight 'if-then' statements were identified whilst answering the theme questions. They provide some insight into why agencies cannot or do not work together. They identify the context (c) which trigger mechanisms (m) which result in the outcomes (o) which were identified within this evaluation of multi-agency working.

If the most important principles of multi-agency working (such as person-centredness and interdependency) are vague or in conflict with protecting resources (c) then this may trigger parallel working (separate assessment, planning and delivery of services) (m). This may result in the individual's experience of not being understood and not receiving joined up person-centred care (o).
If you have inconsistent attitudes, trust, relationships, poor communication (c) then this may trigger disagreement between professionals and organisations (for example over care responsibility) (m) which may result in people not receiving their right to support and health care (o)
If you practice co-location (c) then it may trigger informal joint working through an increased understanding of roles and an increase in communication (m). This may result in a focus on the person as opposed to the process when providing support and healthcare (o).
If there has been a history of established and actively managed person-centred coordinated care (as opposed to process centred) (c), then this may trigger a willingness to help one another, risks being well managed together, coordinated networking (m) which may result in multi-agency working becoming custom and practice, and individuals accessing more services (o).
If there is a miscommunication or lack of communication between agencies, families, carers, and service users in the context of multi-agency working (c) then

this may trigger feelings of frustration, disappointment (m) and results in dissatisfaction and a lack of timeliness and understanding as to what's happening in the assessment and care process (o).
If you have a culture of clarity of language and purpose, trust, honesty, reciprocity and multi-level communication (c), this may trigger an ability to manage expectations, permission to manage process and structures across agencies (m); which may result in multi-level coordination (o).
If there is time in a shared space to develop multi-agency relationships and practice (c) then this may trigger meaningful conversations (m) which may result in a common understanding and a desire to work together to achieve the common aim (o).
If there is a multi-agency working environment without a shared template of robust evaluation and monitoring frameworks (with reporting standards) (c) then this may lead to an inability to collect meaningful multi-agency data (qualitative and quantitative) (m) and may result in reduced workforce and citizen confidence in decision making (o).

4.7 In closing, we offer the following as a basis for further discussion on how the effectiveness of multi-agency working can be improved:

1. **Performance measures, outcomes and evaluation information need to be more robust to inform decision making.** At present, the development of effective outcome measures is an ongoing issue. Determination of effective methods at an organisational level needs to be coupled with consideration of how agencies can adopt measures on the basis of joint accountability.
2. **Multi-agency and cross-border processes should be clear to individuals, their families and carers**. Navigating the health and social care "system" is difficult for people seeking access to care and support. It is made more difficult when that care and support is provided by more than one agency.
3. **Further guidance on how to achieve sector-leading multi-agency working should be produced**. This should be developed for use by Regional Partnership Boards and agencies, and include a multi-agency 'checklist' of

critical success factors that are considered most important with most impact, thereby facilitating a sense-check of where they are in relation to achieving excellence.

4. **A community of practice across Wales should be established to share ideas and solutions for challenges encountered**. The development of communities of practice for other purposes, such as achieving implementation of the national models of care being supported through the Regional Integration Fund, should be extended to include fulfilment of the Act's aspirations for improved multi-agency working, alongside the other principles.

5. **A champion for multi-agency working should be identified within each Regional Partnership Board across all population groups**. This should be undertaken with the Commissioners for Older People, and Children and Young People.

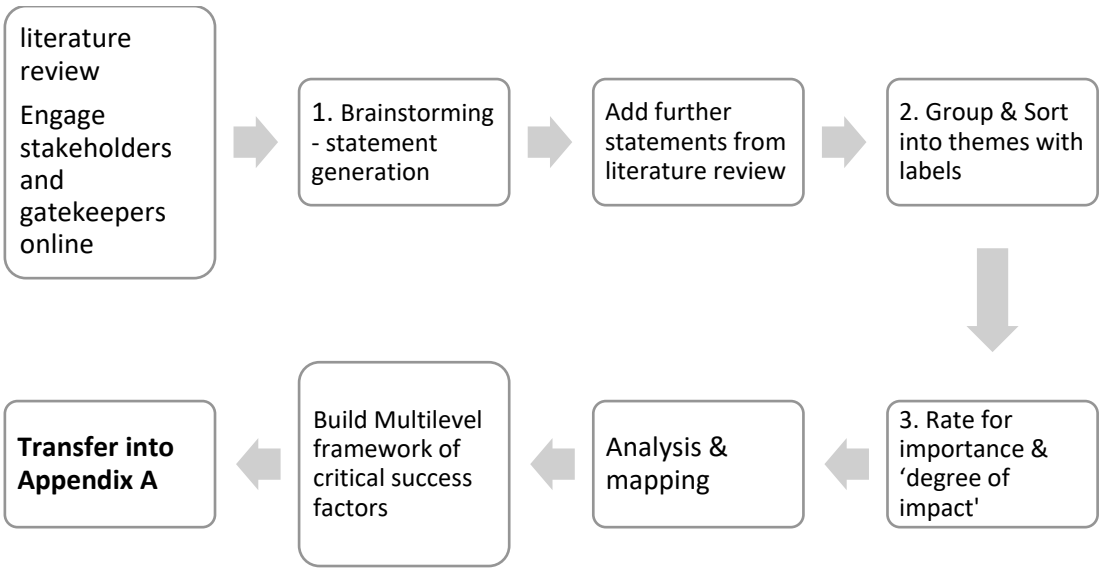
6. **Mandatory refresher training on the Act should be provided for all operational and strategic partners, in a multi-agency setting, together**. In addition, mandatory training on multi-agency working should be provided through inter-professional education (IPE) and through higher education and further education professional programmes in health and social care.

Appendix A: Group Concept Mapping (GCM) method and full results

Method and approach

The GCM activities explored participant perspectives on successful multi-agency working. GCM involved three activities: brainstorming, grouping/sorting and rating (Figure A1). Brainstorming asked participants to generate success factors in response to a focus prompt. Once the success factors were generated, participants grouped and sorted all of the success factors that were generated into themed 'piles' which they labelled. Finally, participants were asked to rate each success factor. In this study, the rating scales were for 'importance' and 'degree of impact'. The study was conducted bilingually in Welsh and English but participants only participated in English.

Figure A1: The GCM process



The GCM was conducted between December 2020 and March 2022. This was a much longer period of data collection than usual. Due to the COVID-19 pandemic, the data collection was disrupted several times.

We used a strategy of purposive (including maximum variation and typical case) and snowballing sampling strategies to recruit participants and to ensure typical and specific in-depth knowledge. Snowballing involved the researcher starting with one or two relevant information-rich participants and then asking them for additional appropriate contacts who can provide further information (Patton, 2015). Gatekeepers and champions were sought to help with recruitment including NHS Confederation, RIIC Hubs and ABUHB Research and Development department. Ethics approval was sought and given by the University of South

Wales, Faculty of Life Science and Education low-risk ethics panel. Permission to enrol NHS participants was given by all health boards in Wales.

A ‘multi-agency working’ international literature review had preceded this GCM method (Wallace et al., 2020) which asked, what are the characteristic success factors of multi-agency working in public and non-public services? It identified 32 working success factors and characteristics for multi-agency working that were not already identified. Therefore, following the brainstorming success factors activity in this GCM, these factors and characteristics were added to the those generated.

Participants answered three background questions on entry to the online software. These could have been used to analyse the data if the sample size had been larger:

- How would you most describe yourself in the context of the Social Services and Well-being (Wales) Act?
- In which Welsh local authorities have you the most multi-agency experience? (e.g., where you work or receive services)
- How long have you been delivering, commissioning or managing care?

The GCM method was facilitator-led and used Group Wisdom™ software for data collection, data integration, and analysis. The results were later presented to the study team.

The online software was used to conduct four steps of data analysis following data review, cleaning and acceptance processes:

- Step 1 – Three participant demographic characteristics were analysed using descriptive statistics.
- Step 2 – A similarity matrix was created from the participant sorted success factors This shows how participants grouped the statements. It also demonstrated the number of participants who sorted the success factors together.
- Step 3 – Multidimensional-scaling analysis (run by the GroupWisdom software) of the similarity matrix produced a success factor point map. Each participant success factor was allocated a point on a two-dimension (XY) axis (Figure A2).
- Step 4 – Ward’s algorithm was used in a hierarchical cluster analysis of success factors. It used the x-y coordinate data obtained from the multi-dimensional scaling to form a number of hierarchical clusters to produce a cluster map with cluster labels (see Figure A3), cluster rating (Figures A4 and A5), Go-zone analysis (Figure A6) and pattern matching report (Figure A7). The Go-zone analysis enabled us to identify

which critical success factors were perceived as most important and which were perceived as having most impact. These were the factors used to develop the framework of critical success factors for multi-agency working presented in Table A8.

Findings

Who were the participants?

Twenty-six participants were recruited, gave consent and were enrolled onto the Group Wisdom™ software. Of these enrolled participants:

- n=19 completed the Participant Questions
- n=14 finished the Sorting activity
- n=12 finished the Importance Rating and the impact rating activities

Due to the COVID-19 pandemic, only 26 participants were included in this method of data collection, with only 14 completing the sorting and 12 completing the rating scales It is noted that these participants are not representative of the whole workforce. The GCM process was strictly adhered to throughout the study. Kane & Trochim (2007) argue that in GCM there is no strict limit to the numbers of participants, and groups can range from small (8–15) to much larger. Rosas & Kane (2012) later argued in their review of 69 GCM studies (with participants ranging from 6-90) that gaining a broad range of participants was important in addition to closely adhering to the GCM process. They acknowledged Jackson & Trochim's (2002) recommended number of 15. The dataset had a final stress value of 0.3122, with the acceptable range being 0.205-0.365. Stress value is considered similar to reliability (Kane & Trochim, 2007). This GCM's stress value indicates that there is a good relationship between data input, the matrix similarities developed from the grouping task and the distance represented on the point map (Annex A).

The participants who responded were broad ranging in terms of roles. Table A1 summarises the different roles of participants. 'Other' included an academic, a professional body representative, director of a housing association, researcher, provider representative, other practitioner, course leader, policy, workforce regulator, politician, and care inspectorate representative (see Table A1).

Of the 26 who enrolled on the study, the majority identified themselves as having most multi-agency experience (e.g., where they worked or received services) in south-east Wales (65.39%) (Table A2).

Table A1: How would you most describe yourself?

Option	Frequency	%
Front line worker/practitioner	5	26.32%
Manager	3	15.79%
Other	11	57.89%
Total	**19**	
Did not respond	*7*	*26.92%*

Table A2: In which Welsh Local Authority have you most multi-agency experience?

Option	Frequency	%
Bridgend CC	1	3.85
Caerphilly CBC	3	11.54
City of Cardiff Council	2	7.69
Denbighshire CC	1	3.85
Monmouthshire CC	3	11.54
Powys CC	1	3.85
Rhondda Cynon Taf CC	4	15.38
Torfaen CBC	3	11.54
Vale of Glamorgan Council	1	3.85
Did not respond	7	26.92
Total	**26**	

Most (30.77%) who answered the question regarding delivering, commissioning or managing care identified as doing so for 37 months or more (Table A3).

Table A3: How long participants had been delivering, commissioning / managing care

Option	Frequency	%
Less than 12 months	1	3.85
13-36 months	2	7.69
37-72 months	1	3.85
73 months plus	7	26.92
Not applicable	8	30.77
Did not respond	7	26.92
Total	**26**	

Identifying the critical success factors for multi-agency working in the context of the Social Services and Well-being (Wales) Act 2015.

Activity 1 Brainstorming

During this activity (figure 1), 11 participants provided 65 success factors to complete the single online focus prompt ‘‘Multi-agency working within the context of the Social Services and Well-being (Wales) Act will be successful if….”. Following cleaning where no success factors were discarded, reframed or split, the success factors were mapped across to the literature review (Wallace et al., 2020) to identify missing success factors which should be included. A further 12 success factors were identified giving a total of 77 success factors (see Table A4).

Table A4: Full list of 77 success factors

Success factors number	Success factors
1	There is a willingness to help each other out
2	We compromise if needed
3	We work collaboratively with realistic aims and objectives to ensure the desired outcomes are delivered
4	Individuals divest themselves of power and control and genuinely embrace co-production
5	Organisations divest themselves of power and control and genuinely embrace co-production
6	There is time to support it
7	There are resources to support it
8	Common objectives with shared accountability for delivery is the norm
9	Common objectives for delivery are the norm
10	Everyone is invested in shared objectives
11	Everyone is invested in shared priorities
12	Citizens remain in control
13	Citizens voices are heard, respected and acted upon
14	Risks are managed well, with a focus on empowered citizens
15	Risks are understood with a focus on empowered citizens
16	Risks are shared with a focus on empowered citizens
17	Human and financial resources are well aligned to avoid duplication and deliver seamless responses

18	Human resources are well aligned to avoid duplication and deliver seamless responses
19	Financial resources are well aligned to avoid duplication and deliver seamless responses
20	Organisational and professional differences are respected and used to deliver citizen/patient focused service models
21	Organisational differences are respected
22	Professional differences are respected
23	Front line is empowered to find collective solutions to meet citizen needs, with freedom to innovate
24	Relationships are strengthened, creating trust and common endeavour
25	Performance measures relate to outcomes for citizens rather than units of activity
26	Investment in social care has parity with NHS investment
27	The aims of SSWB Act are recognised across Wales
28	We understand our roles and responsibilities
29	Leadership and followership are present
30	Shared IT systems
31	Understand each other's statutory responsibilities
32	We have a clarity in roles and responsibilities
33	We have a history of collaboration with shared vision or goals
34	A have a comprehensive multi-agency plan to meet population needs
35	We have trust – not building expectations which create mistrust
36	We have the right people in the team
37	Have the right attitude
38	We have network coordination
39	We have strong leadership
40	We have people in the team knowing and happy with their defined role
41	We have shared motivation
42	We have commitment
43	We have shared energy
44	We have strong shared norms commitment
45	We have good communication- senior level management engagement
46	We have sufficient resources including time and capacities
47	We have good governance structures/manuals
48	We have shared expertise
49	We have a formal structure rather than informal structure of network

50	We have informal cooperation
51	We have time to build relationships- through co-production
52	We have time to build relationships- through consensus
53	We have shared values
54	We have common goals
55	We share a vision
56	We are monitoring individual and systemic outcomes
57	We have clear care pathways linked to referral systems
58	We use an integrated referral system
59	We share desired outcomes
60	We include non-traditional partners for greater knowledge and resources
61	We provide training and support for individuals, community and workforce to understand the prevention agenda
62	We understand specific needs – including individual, population (general and specific) to each agency
63	We share an understanding of need across agencies
64	Understand the processes by which trust is built up and maintained
65	Agree formal strategic assurance/arrangements
66	We conduct joint visiting or assessment
67	We coordinate service provision
68	We acknowledge individual knowledge and expertise
69	We work comprehensively and co-productively with individuals and families
70	Timely planning
71	Working together jointly both strategically and operationally
72	Sharing realistic aims
73	Access to statutory sector databases by third sector
74	Formal working arrangements
75	Formal information sharing agreements
76	Have a shared desirable outcome
77	Work together jointly

Activity 2 – Grouping/sorting

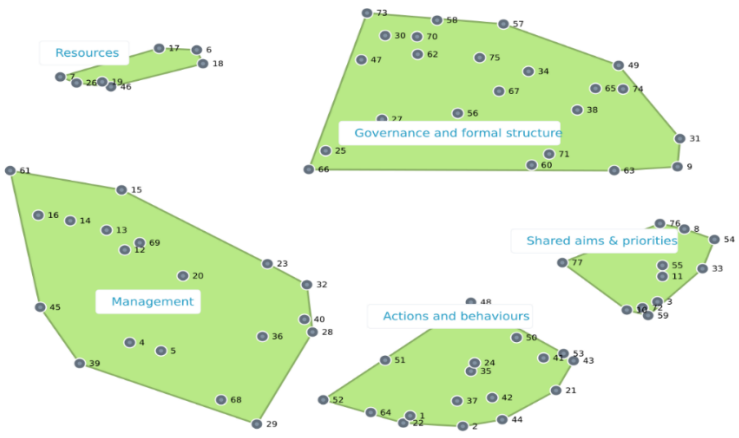
In this activity participants were asked to sort and group all the success factors into piles and provide each pile with an individual label. From this, the software generated a point map showing all the 77 success factors (Figure A2).

Figure A2: Computer generated point map of 77 success factors with examples of point-point relationships.

The dataset had a final stress value of 0.3122, with the acceptable range being 0.205-0.365. Stress value is considered similar to reliability (Kane & Trochim, 2007). The stress value here was in the higher mid-range and considered to be a relatively good fit. A specific point on the map refers to a specific success factor. The distance between each specific point indicates how frequently the success factors were sorted together by participants.

Several cluster maps were then generated showing the distribution of success factors within all the clusters. A selection of maps were considered by the study facilitator and discussed with the study team. A map with five clusters was finally chosen as this best reflected the success factor groups found in the pool of 77 final success factors. The clusters were: Resources, Governance and formal structures, Shared aims and priorities, Actions and behaviours, Management (see Figure A3).

Figure A3: Cluster map with labels from the participant grouping exercise



The ‘Governance and formal structures’ cluster had the most success factors (n=23), whilst Resources (n=7) had the least success factors. Table A5 shows the number of success factors per cluster, cluster average importance and cluster average for degree of impact. Table A6 shows three success factor examples per cluster.

Table A5: Cluster characteristics

Construct	Actions and Behaviours	Shared aims & priorities	Management	Resources	Governance and formal structures
Number of success factors	17	11	19	7	23
Average rating of importance for inclusion in multi-agency critical success factors	4.11	4.09	4.28	4.48	3.83
Average rating for ‘degree of impact’	3.87	3.87	4.05	4.37	3.64

Table A6: Example success factors from each of the five clusters

No.	Wording
Action and behaviours	
1	There is a willingness to help each other out
37	Have the right attitude
64	Understand the processes by which trust is built up and maintained
Shared aims and priorities	
3	We work collaboratively with realistic aims and objectives to ensure the desired outcomes are delivered
55	We have common goals
77	Work together jointly
Management	
4	Individuals divest themselves of power and control and genuinely embrace co-production
28	We understand our roles and responsibilities
69	We work comprehensively and co-productively with individuals and families
Resources	
6	There is time to support it

No.	Wording
18	Human resources are well aligned to avoid duplication and deliver seamless responses.
46	We have sufficient resources including time and capacities
Governance and formal structures	
9	Common objectives for delivery are the norm
57	We have clear care pathways linked to referral systems
75	Formal information sharing agreements

Activity 3 – Rating of the 'importance in the context of successful multi-agency working' and 'degree of impact' of each factors on the success of multi-agency working

In this activity participants were asked to rate all 77 success factors using the two Likert type scales. The cluster-rating map in Figure A4 and A5 (and Table A5 above) shows that the 'Resources' cluster was considered the most important (4.48), with the most impact (4.37). The 'Management' cluster came second in importance (4.28) and also degree of impact (4.05). When considering importance, this was followed by 'Actions and behaviours' (4.11) and 'Shared aims and priorities' (4.09). Both these clusters scored 3.87 on 'degree of impact'. The cluster 'Governance and formal structures' was considered the least important (3.83), with the least impact (3.64).

Figure A4: Cluster rating map – 'Importance in the context of successful multi-agency working'

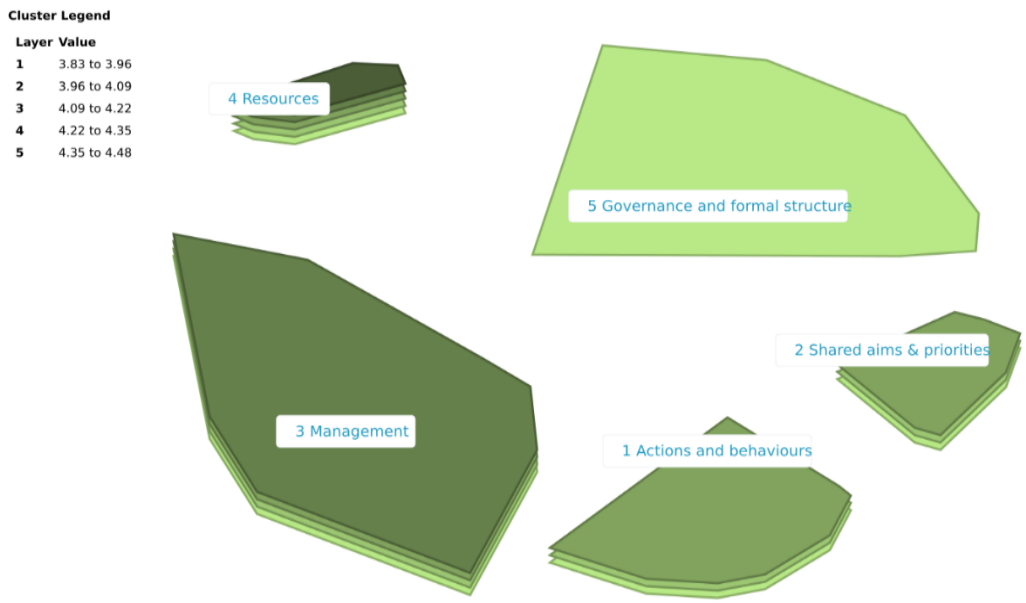
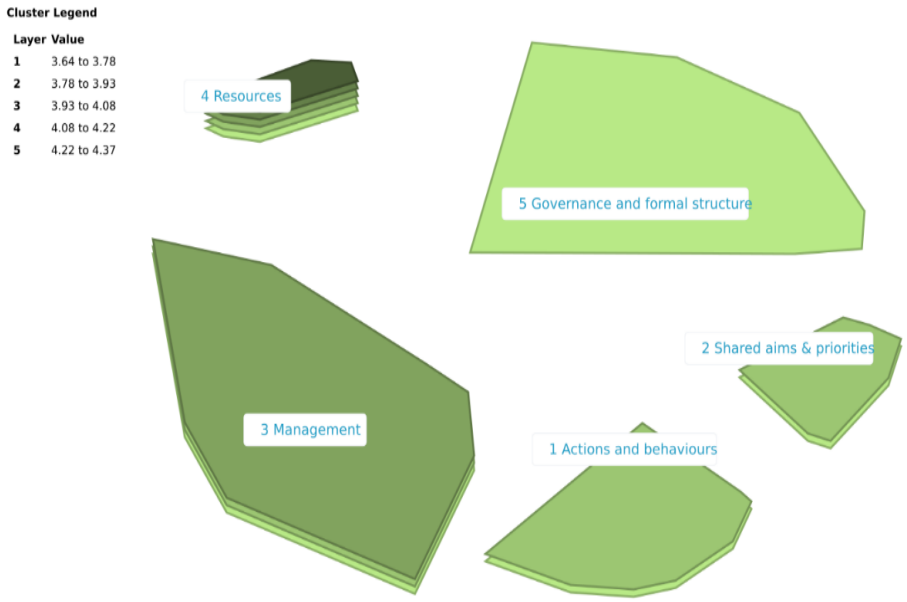


Figure A5: Cluster rating map -'degree of impact'



We then used both the cluster map and the rating scales to develop an all-participant Go-Zone (Figure A6) which provided us with an opportunity to identify the multi-agency characteristics which were perceived as most important, with the most impact. We can interpret with caution that there is a strong correlation (r=0.84) between the two variables (i.e., importance and degree of impact), meaning that the relationship between the two is positive where an increase in one variable is related to an increase in the other.

Figure A6: Go-Zone report displaying how each success factor is rated in relation to 'importance in successful multi-agency working' and 'degree of impact'

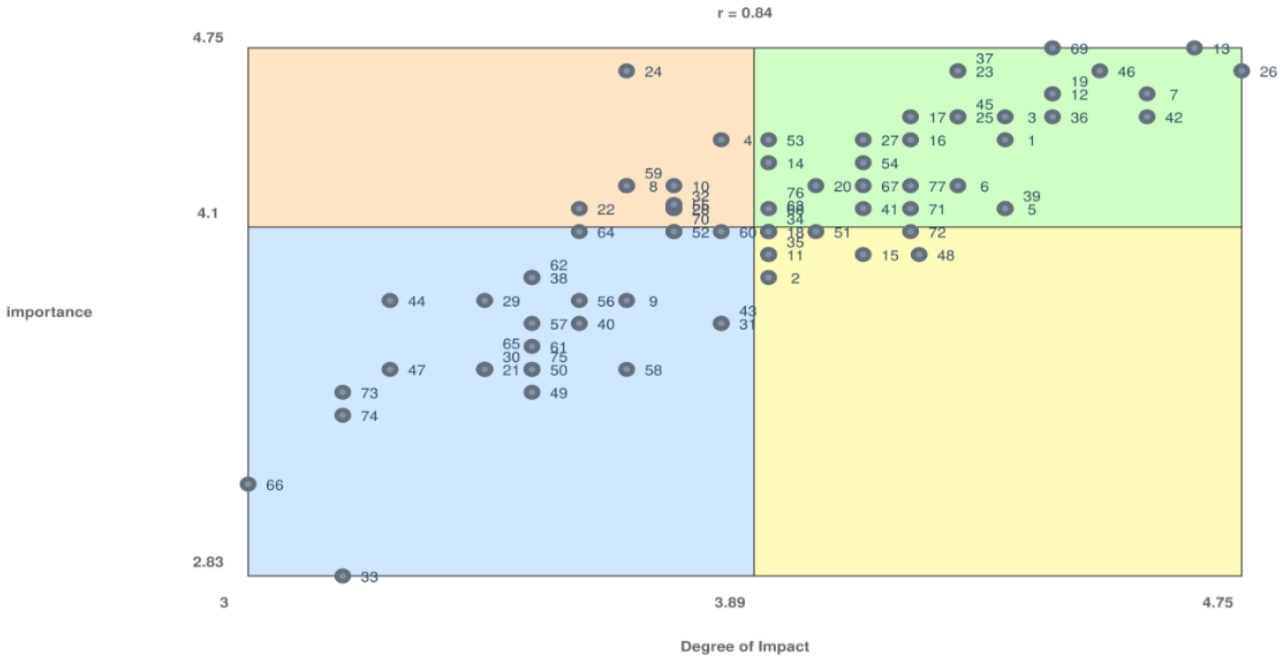


Figure A6 above shows which success factors were above or below the mean (average) across the two chosen rating criteria of *'importance in the context of successful multi-agency working' and 'degree of impact'.* Success factors above the importance mean (4.1) were the most important and are in the orange and green zones. Success factors above the 'degree of impact" mean (3.89) are the success factors which participants felt had most impact i.e. the green and yellow zones.

Figure A6 shows that the success factors presented in the green zone are success factors which are perceived both as the most important and having most impact. Those in the orange zone were seen as most important but having less or least impact. Success factors in the yellow zone were seen as least important but as having more impact. Those in the blue zone were seen as least important and also as having less or least impact. Example success factors from each quadrant can be seen in Table A7. These zones may be of interest to stakeholders when considering education and training to improve multi-agency working in the future.

Table A7: Example and total number of success factors from each quadrant

No.	Wording
GREEN QUADRANT [n=30]	
1	There is a willingness to help each other out
26	Investment in social care has parity with NHS investment
77	Work together jointly
ORANGE QUADRANT [n=9]	
4	Individuals divest themselves of power and control and genuinely embrace co-production
24	Relationships are strengthened, creating trust and common endeavour
59	We share desired outcomes
BLUE QUADRANT [N=27]	
9	Common objectives for delivery are the norm
52	We have time to build relationships- through consensus
75	Formal information sharing agreements
YELLOW QUADRANT [n=11]	
2	We compromise if needed
34	Have a comprehensive multi-agency plan to meet population needs
76	Have a shared desirable outcome

By examining the 30 success factors from the green quadrant (most important and most impact) we can see that the characteristic no. 13 ‘’Citizens voices are heard, respected and acted upon’, is ranked the highest. It has a mean average of 4.71 (see Table A8). The second success factor considered most important with most impact is no. 26 ‘Investment in social care has parity with NHS investment’, also with a mean rating of 4.71.

Table A8: The 30 most important success factors which have most impact in rank order

No.	Data item/Success factors	Mean rating	Ranking	Cluster
13	Citizens voices are heard, respected and acted upon	4.71	1	Management
26	Investment in social care has parity with NHS investment	4.71	2	Resources
69	We work comprehensively and co-productively with individuals and families	4.58	3	Management
46	We have sufficient resources including time and capacities	4.58	4	Resources
7	There are resources to support it	4.58	5	Resources
42	We have commitment	4.54	6	Actions and behaviours
12	Citizens remain in control	4.5	7	Management
19	Financial resources are well aligned to avoid duplication and deliver seamless responses	4.5	7	Resources
37	Have the right attitude	4.46	8	Actions and behaviours
23	Front line is empowered to find collective solutions to meet citizen needs, with freedom to innovate	4.46	8	Management
36	We have the right people in the team	4.46	9	Management
3	We work collaboratively with realistic aims and objectives to ensure the desired outcomes are delivered	4.42	10	Shared aims & priorities
45	We have good communication- senior level management engagement	4.38	11	Management
25	Performance measures relate to outcomes for citizens rather than units of activity	4.38	11	Governance & formal structure
1	There is a willingness to help each other out	4.38	12	Actions and behaviours
17	Human and financial resources are well aligned to avoid duplication and deliver seamless responses	4.33	13	Resources
16	Risks are shared with a focus on empowered citizens	4.29	14	Management
27	The aims of SSWB Act are recognised across Wales	4.25	15	Governance and formal structure
6	There is time to support it	4.25	16	Resources
5	Organisations divest themselves of power and control and genuinely embrace co-production	4.25	17	Management

No.	Data item/Success factors	Mean rating	Ranking	Cluster
39	We have Strong leadership	4.25	17	Management
54	We have common goals	4.21	18	Shared aims & priorities
77	Work together jointly	4.21	19	Shared aims & priorities
53	We have shared values	4.17	20	Actions and behaviours
71	Working together jointly both strategically and operationally	4.17	21	Governance & formal structure
67	We coordinate service provision	4.17	22	Governance & formal structure
14	Risks are managed well, with a focus on empowered citizens	4.13	23	Management
20	Organisational and professional differences are respected and used to deliver citizen/patient focused service models	4.13	24	Management
41	We have shared motivation	4.13	25	Actions and behaviours
68	We acknowledge individual knowledge and expertise	4.04	26	Management

Where success factors have the same mean rating across both importance and most impact, further analysis has been completed to understand which of the items is higher with regards to importance as opposed to impact. For example, success factor 13 has a mean importance of 4.75 whereas success factor no 26 has a mean importance of 4.67. Hence success factor 13 ranks higher than success factor 26. Where more than one success factor have the same mean rating for importance and impact they have been ranked at the same level. For example, success factors no. 12 and no.19.

Each cluster (group of participant perceived related characteristics) is represented within the 30 success factors; however, the focus is clearly on Management (n= 12). This is followed by Resources (n=6), Action and Behaviours (n=5), Governance and formal structure (n=4), Shared Aims and Priorities (n=3). The average rating of importance for all 30 items is above 4.1667.

We further examined the success factors in the orange zone. Here the success factors were plotted above the importance mean (4.1) i.e., were considered important but plotted below the ‘degree of impact’ mean (3.89). Nine success factors were identified (see Table A9), most of which are found in the Shared aims & priorities cluster (n=4). The remainder were found in the Management cluster (n=3) and Action and Behaviours cluster (n=1). Further

exploration and discussions are required to understand why these important success factors were perceived as having less or least impact.

Table A9: The 9 success factors which were considered important but with less or least impact

No.	Data item/Success factors	Mean rating	Ranking	Cluster
24	Relationships are strengthened, creating trust and common endeavour	4.17	27	Actions and behaviours
4	Individuals divest themselves of power and control and genuinely embrace co-production	4.13	28	Management
10	Everyone is invested in shared objectives	4	29	Shared aims & priorities
55	We share a vision	3.97	30	Shared aims & priorities
8	Common objectives with shared accountability for delivery is the norm	3.96	31	Shared aims & priorities
59	We share desired outcomes	3.96	31	Shared aims & priorities
28	We understand our roles and responsibilities	3.96	32	Management
32	We have a Clarity in roles and responsibilities	3.96	32	Management
22	Professional differences are respected	3.88	33	Actions and behaviours

Appendix B: **The Secondary Data Analysis Method**

This annex explains the method of secondary data analysis, which used in the first instance 'analyst-constructed typology' to organise the data (Patton, 2015, p551), and then a realist approach to analyse the data itself. The secondary data analysis was of existing data gathered by the study's evaluation team for the process evaluation (March 2020) and a report on the expectation and experiences of service users (November 2021)[13]. Methods included interviews, focus groups, workforce survey and Facebook replies. Total participants (n=319) included carers, service users, operational managers, frontline workers, Senior Managers (see Tables 2 and 3, p.13).

Patton (2015, p551) describes 'analyst-constructed typology' as a 'classification system made up by the analysts to divide some aspect of the world into distinct categories or ideal types.' Using the cluster map identified from the GCM study (Annex A, Figure 3) the clusters ('action and behaviour', 'shared aims and priorities', management, resources, 'governance and formal structures') were used as categories and the success factors within them were used to identify patterns of evidence within the qualitative secondary data. Following this, the identified script was used to answer the questions posed. For example, to answer question 4 'What resources are required for multi-agency working to achieve the outcomes expected?', the cluster labelled resources and the success factors within it were used to identify the patterns of evidence within the secondary qualitative data.

The aim of a realist approach is to understand how a programme or in this case how multi-agency working, does or does not work. It identifies a 'set of assumptions of programme designers (or other actors involved) that explain **how and why they expect** the programme to reach its objective(s) and in which conditions' (Emmel et al., 2018). A realist approach often comprises of multiple methods of enquiry (Emmel et al., 2018; Jagosh, 2019). It is a method grounded within generative causation, meaning that in order to infer a causal relationship between a programme (or intervention) and outcome (O), one must understand the underpinning mechanism (M) which is triggered from within the context (C) in which they occur (Kastner, Estey et al., 2011). The CMO configurations are then translated into usable If-then statements.

These two approaches aim to answer the following questions:

- Has implementation of the Act promoted sustainable integrated care and support?

[13] Evaluation of the Social Services and Well-being (Wales) Act 2014: expectations and experiences.

- Which critical success factors are most important and have most impact?
- What resources are required for multi-agency working to achieve the outcomes expected?
- How have cross boundary governance arrangements supported people and agencies to work together?

References

Alter, C. & Hage, J., (1993). *Organizations working together*. Newbury Park, Ca. Sage Publications.

Barber, K., & Wallace, C. (2012)."Happily independent" – configuring the Gwent frailty support and wellbeing worker, *Journal of Integrated Care,* Vol. 20 Iss 5, 308 – 321.

Burdett, T. & Inman, J. (2021), "Person-centred integrated care with a health promotion/public health approach: a rapid review", Journal of Integrated Care, Vol. 29 No. 3, pp. 357-371. https://doi.org/10.1108/JICA-02-2021-0010.

Cheng, S.M., & Catallo, C. (2020). Conceptual framework: factors enabling collaborative healthcare and social services integration, *Journal of Integrated Care,* 28, 3, pp. 215-229.

Choca, J.M., Minoff, J., Angene, L., Byrnes, M., Kenneally, L., Norris, D., Peam, D., & Rivers, M.M. (2004). Can't Do It Alone: Housing Collaborations to Improve Foster Youth Outcomes, *Child Welfare*, Vol LXXXIII, No 5, pp.469-492

Czypionka, T., Kraus, M., Reiss, M., Baltaxe, E., Roca, J., Ruths, S., Stokes, J., Struckmann, V., Hacek, R.T., Zemplenyi, A., Hoedemakers, M. & Rutten-van Molken, M. (2020). The patient at the centre: evidence from 17 European integrated care programmes for persons with complex needs, *BMC Health Services,* 20, pp. 1102.

Dickinson, H., & Neal, C. (2011). Single Point of Access to Third Sector Services: The Conwy Collaborative Approach, *Journal of Integrated Care*, 19:2, pp.37-48

Dubuc, N. et al (2016). Development of a Computerized Integrated-Care-Pathway System to Support People-Centred and Integrated Care: Usefulness of the Participatory Design Method. *International Journal of Integrated Care*, 16(6) A91, 1-8.

Emmel, N. et al. eds. (2018). *Doing Realist Research.* London: SAGE Publications.

Goodwin, N. (2016). Towards People-Centred Integrated Care: from passive recognition to active co-production?. *International Journal of Integrated Care*. 16(2):15.

Goodwin, N. (2019). Improving Integrated Care: Can Implementation Science Unlock the 'Black Box' of Complexities?. *International Journal of Integrated Care*. 19(3):12.

Henttonen, K., Lahikainen, K., & Jauhiainen, T. (2016). Governance Mechanisms in Multi-Party Non-Profit Collaboration, *Public Organisation Review*, 16, 1-16.

Hanga, K., DiNitto, D.M., Wilken, J.P. & Leppi, L. (2017). A person-centred approach in initial rehabilitation needs assessment: experiences of persons with disabilities. *ALTER, European Journal of Disability Research, 11*, 251-266.

Hebert, R. (2015). Evaluation of the Implementation of PRISMA, a Coordination-Type Integrated Service Delivery System for Frail Older People in Québec, *Journal of Integrated Care*, 16:6. pp. 4-14.

Henderson, L., Bain, H., Allan, E., & Kennedy, C. (2020). 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, *Health and Social Care in the Community*, 29, pp. 1145-1168.

Jagosh, M. (2019). Realist Synthesis for Public Health: Building an Ontologically Deep Understanding of How Programs Work, For Whom, and In Which Contexts. *Annual Review of Public Health:* Vol. 40.

Kane, M. & Trochim, W.M.K. (2007) *Concept mapping for planning and evaluation* (Applied Social Research Methods Series), vol. 50. Thousand Oaks, CA: Sage.

Kastner, M., Estey, E., Perrier, L., Graham, I.D., Grimshaw, J., Straus, S.E, Zwarenstein, M. & Bhattacharyya, O. (2011). Understanding the relationship between the perceived characteristics of clinical practice guidelines and their uptake: protocol for a realist review. *Implementation Science* 6 (1): 69.

Koloroutis, M. (ed.) (2004). *Relationship-based Care: A Model for Transforming Practice*. Minneapolis, MN: Creative Health Care Management.

Lalani, M. & Marshall, M. (2020). Co-location, an enabler for service integration? Lessons from an evaluation of integrated community care teams in East London in *Health and Social Care in the Community,* 30, pp. 388-396.

Llewellyn M., Verity, F., Wallace, S. & Tetlow, S. (2021). *Evaluation of the Social Services and Well-being (Wales) Act 2014: Process Evaluation. Summary Report*. Cardiff. Welsh Government, GSR report number 02/2021. Available at: Evaluation of the Social Services and Well-being (Wales) Act 2014: process evaluation.

Llewellyn M., Verity F., Wallace S. & Tetlow S. (2022). *Expectations and Experiences: Service User and Carer perspectives on the Social Services and Well-being (Wales) Act.* Cardiff. Welsh Government, GSR report number 16/2022. Available at: Expectations and Experiences .

Llewellyn M, Verity F, Wallace S, Calder G, Garthwaite T, Lyttleton-Smith J, and Read S (2023). *From Act to Impact? Final Report of the Evaluation of the Social Services and Well-being (Wales) Act 2014.* Cardiff. Welsh Government, GSR report number 36/2023. Available at: Final Report.

Nicolaisen, A. (2016). Implementing integrated care in a fragmented health care system. *International Journal of Integrated Care,* 16(6): A268, 1-8.

O'Halloran, K. (2016). Developing Integrated Care Teams Across the North West London System. *International Journal of Integrated Care*, 16(6):A150, pp. 1-8.

Patton, M.Q. (2015). Purposeful sampling and case selections: overview of strategies and options. In: Patton M. *Qualitative Research & Evaluation Methods*. 1st ed. Thousand Oaks: SAGE Publications; p. 264-272.

Pawson, R. & N. Tilley (1997). *Realistic Evaluation*. Thousand Oaks CA, Sage.

Peckover, S. & Golding, B. (2017). Domestic abuse and safeguarding children: critical issues for multiagency working. *Child Abuse Review*. 26; 40-50.

Prammer, K. & Neugebauer, C. (2012). Consulting organizational Change Cooperation - Challenges, issues and Solutions in Theory and Practice. *Journal of Management and Change.* 29, p24-45.

Rozansky, D., Johnston, L., Dussin, L., King, E., & Hunter, T. (2017). *Developing an integration scorecard: A model for understanding and measuring progress towards health and social care integration,* Social Care Institute for Excellence.

SUSTAIN (2019). *Sustainable Tailored Integrated Care for Older People in Europe: The Roadmap* – available at: Sustainable Tailored Integrated Care .

Thiam, Y., Allaire, J.-F., Morin, P., Hyppolite, S.-R., Doré, C., Zomahoun, H.T.V. & Garon, S. (2021). A conceptual framework for integrated community care. *International Journal of Integrated Care, 21(1)* 1–13. DOI: https://doi. org/10.5334/ijic.5555.

Tong, C., Franke, T., Larcombe, K. & Sims-Gould, J. (2018). Fostering Inter-Agency Collaboration for the Delivery of Community-Based Services for Older Adults, *British Journal of Social Work*, 48, 390-411.

Van Lange, P. & Balliet, D. (2015) Chapter 3; Interdependence theory In Mikulincer, M. & and Shaver, P. R. (Eds). *APA Handbook of Personality and Social Psychology*: Vol. 3. Interpersonal Relations.

Walker, G. (2018). Working together for Children: A critical introduction to multi-agency working. Bloomsbury Publishing.

Wallace, C., Orrell, A., Garthwaite, T., Tetlow, S, & Wallace, S. (2023) Multi-agency literature review. In Llewellyn, M., Verity, F. and Wallace, S (eds) (2023). *Evaluation of the Social Services and Well-being (Wales) Act 2014: Literature Review*. 2nd Edn. Cardiff. Welsh Government, GSR report number 42/2023. Available at: Literature Review.

Wendler, M.C. (2001) Triangulation using a meta-matrix. *Journal of Advanced Nursing,* 35(4), 521-525.

World Health Organization (2018). *Declaration of Astana: Global Conference on Primary Health Care: Astana, Kazakhstan, 25 and 26 October 2018*.World Health Organization. Available at: Declaration of Astana.