

Developing a competency framework for integrated care working across healthcare, social care and allied professions

Abstract

Background/Aims For integrated care to truly become embedded in the UK health and social care system, there is need for a shared understanding of what integrated care looks like at the local level. This study aimed to identify the competencies and behaviours required for working across the full range of health and social care services in the Bedfordshire, Luton and Milton Keynes Integrated Care System.

Methods A multi-method approach was used to develop and refine the competency framework. An extensive evidence review of academic and practitioner literature was used to create the initial framework by synthesising previous frameworks. Four multi-agency focus groups were held to conduct utility testing and refine the framework. Quantitative testing was carried out using an 89-item online survey, including questions on the framework, a range of personal and work-related outcomes, and demographic characteristics. The survey was distributed to staff working across 13 different agencies within the integrated care system. Associations between variables were assessed using Spearman's Rho, using the Statistical Package for the Social Sciences.

Results The evidence review identified 21 relevant competency frameworks, originating from nine different countries, which were used to create the integrated care competency framework. A total of 91 staff members completed the survey, with results showing acceptable reliability and validity of the final framework (item total correlation >0.2 ; inter-item correlation ≤ 0.9). Differences were found between agencies and occupational groups in terms of their integrated care competencies. Those with shorter tenure described greater use of integrated care competencies. Those who demonstrated more integrated care competencies also saw their work as more meaningful and enjoyed greater levels of support from their peers.

Conclusions This is the first UK framework of integrated care competencies to be subjected to empirical testing. Initial testing supports the validity and reliability of the framework, as well as showing the positive outcomes associated with integrated working. This framework could be developed and rolled out on a wider scale to support integrated care working.

Key words: Competency framework; Integrated care system; Multi-agency working

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Introduction

Integrated care systems are partnerships that bring together healthcare, local government and other agencies to collectively manage service planning, improve health and reduce inequalities in their local area. A statutory requirement for all NHS and social care systems to be organised as integrated care systems came into effect in July 2022, resulting in the formation of 42 such systems in England. Integrated care systems are based on the belief that the NHS can help people to live healthier lives for longer and avoid preventable hospital admissions by working alongside councils and drawing on the expertise of other agencies, such as local charities and community groups.

Several factors make working in an integrated way challenging, including cultural differences between health and social care and a lack of understanding of different roles (Charles, 2022). Breakdowns among teams are the primary cause of errors and near misses in healthcare, with some analyses estimating that 60–70% of all serious patient

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incidents are caused by a lack of effective teamwork (Zajac et al, 2021). Working with team members from a wide variety of backgrounds can be particularly challenging because of differences in training, professional values and problem solving approaches, as well as unique personality and communication preferences, power differences during team decision making, unaligned funding models and tensions between work role boundaries (Hall, 2005; Fleissig et al, 2006; Goldman et al, 2010; Ambrose-Miller and Ashcroft, 2016; Bell et al, 2018). As recognised by MacNaughton et al (2013), placing healthcare providers of different professional backgrounds in a team does not necessarily mean that they will have the knowledge and skills required to work together effectively.

Understanding how multidisciplinary teams can work together effectively, particularly in teams that span healthcare and social care across several agencies, is vital for the success of the integrated care system. The development of a competency framework for integrated care could help to create a shared multi-agency understanding. A competency can be defined as the specific characteristics (knowledge, skills and attributes) and behaviour patterns that an employee is required to demonstrate in order to be effective in their role (Lewis and Zibarras, 2013). Defining an individual's role and the behaviours necessary for successful delivery of that role within the system could help staff to work more effectively in integrated care systems.

This study aimed to examine existing frameworks and models on behaviours related to integrated care, and use this understanding to develop and evaluate a competency framework that could apply to the full range of healthcare, social care and multi-agency services in Bedfordshire, Luton and Milton Keynes integrated care system.

Methods

A steering group was established to provide oversight of the project. A mixed-methods approach was used to allow the best available evidence and diverse perspectives to be drawn on in the development of the framework.

Developing the framework

An evidence review of academic and practitioner literature was undertaken using a systematic process. The aim of this review was to identify all publications that had empirically explored the development and/or use of competency frameworks in the delivery of integrated care. Searches were conducted in February 2022 using the Web of Science, Medline and Google Scholar databases, unrestricted by date. The search terms used are presented in **Table 1**.

Studies from any country and any health or social care system, published at any time, were eligible for inclusion. Studies had to have aimed to identify competencies or characteristics of integrated (or similar) care and have been peer reviewed to be included.

Table 1. Search terms used in the evidence review by group

Group A	Group B	Group C
Integrated care	Competenc* framework	NHS
Accountable care	Competenc* model	National Health Service
Multidisciplinary care	Competenc*	Health service
Interdisciplinary care	Characteristics	Healthcare
Interprofessional	Knowledge	Health care
Collaborative care	Skills	Social care
Multi-specialty community providers	Behaviours	Hospital
Person-centred care	Traits	
Patient-centred care		

Searches covered all iterations, combining terms from groups A, B and C in each search. For example 'Integrated care' AND 'Competence framework' and 'NHS'*

Studies focusing on systems outside of health and social care, those that did not identify characteristics of integrated care, those that gave health and social care frameworks that were not related to integrated care systems (eg discipline-specific models) and those that had not been peer reviewed were excluded. Searches were conducted by author JD, with title, abstract and full-text screening carried out by authors JD and RL. Disagreements were resolved through discussion.

Included studies were analysed using thematic analysis, conducted by two authors (JD and RL) using the card-sort methodology to cluster and synthesise the competency headings from the literature review into themes. An iterative approach was used to develop the draft framework based on this evidence. Authors JD and RL developed the initial framework through discussion, then this framework was refined through consultation with author DW and input from the steering group.

Utility testing

Four focus groups with a total of 38 participants (8–10 participants per group) were held in off-site locations by authors RL, JD and DW, each lasting approximately 4 hours. Participants were recruited through a broad range of promotional communication, including LinkedIn, Twitter (X), internal networks and key contacts from across agencies within the integrated care system. Multidisciplinary groups were involved to ensure that the framework was applicable across a range of settings. Participants were invited to scrutinise and provide feedback on the initial framework using a ‘world café’ method (Löhr et al, 2020). This approach allows groups of people to engage in constructive dialogue around critical questions, build personal relationships and foster collaborative learning. Participants were given a brief presentation about the project’s background and the purpose of the day. Small groups of 3–5 people were formed, each rotated around four tables. Each table discussed one of the four competencies in the framework. Participants were also asked to discuss the barriers and facilitators of integrated care to gather insights that would help with implementation.

Participants were asked to record their thoughts on paper and post-it notes, and handwritten notes were taken by the facilitators. All data from the focus groups were recorded in an excel spreadsheet and thematically analysed to identify themes and patterns. These data were used to refine the framework. The refined framework was then shared with the focus group participants via email for further feedback.

Quantitative testing

An 89-item online Qualtrics survey was developed, divided into three sections. Section one included 62 items, each describing a behaviour in the competency framework, such as ‘I welcome and encourage opinion from others’. Participants were asked to rate their level of agreement with each statement using a 7-point Likert scale (7=strongly agree; 6=agree; 5=somewhat agree; 4=neither agree nor disagree; 3=somewhat disagree; 2=disagree; 1=strongly disagree), with higher scores indicating greater demonstration of integrated care competency.

Section two contained 15 items asking participants to rate how they felt about their work, drawing on established measures of job satisfaction (Nagy, 2002), meaningfulness at work (Arnold et al, 2007), engagement (Schaufeli et al, 2019), manager and/or peer support (Cousins et al, 2004) and emotional exhaustion (Gabbe et al, 2002). The items were rated using the same 7-point Likert scale used in section one, with higher scores indicating more positive feelings about their work.

Section three included 12 items about participants’ personal and employment demographic characteristics.

The survey was piloted with four internal Bedfordshire, Luton and Milton Keynes integrated care system staff members and two organisational psychologist colleagues. Feedback on the timing, structure, syntax and relevance of response options was incorporated into the final survey. The survey was then distributed to staff across agencies within the integrated care system by key contacts across the agencies and staff networks via email, and via Twitter and LinkedIn. The survey was available for 4 weeks in April 2021.

Following data cleaning, the responses were analysed following best practice steps for developing psychometrically sound measure recommendations (Rust and Golombok,

1999). Reliability analysis and descriptive statistics were calculated using the Statistical Package for the Social Sciences, version 23. Associations between variables were tested using Spearman's Rho.

Ethical considerations

This research was conducted by a chartered psychologist and academics who followed the guidelines of the British Psychological Society and the Health and Care Professions Council, and the processes set out by the University of London (where they were also employed). Completion of the Health Research Authority decision tool indicated that NHS research ethics committee approval was not required, but ethical principles were followed throughout. The communication materials, survey web page and survey link described the project aims, purpose of the survey, structure it would follow, instructions for completion and information about how data would be stored, analysed and reported. Participants were informed that their participation was voluntary and that they could withdraw their data at any point. Participants were asked to provide their consent to taking part in the survey and advised of the confidentiality of their responses. All data was anonymised and held securely in a password-protected file that only the researchers had access to. Participants gave consent for their anonymised data to be used for the project, and for forthcoming research purposes and publications.

Results

Evidence review

A total of 258 titles were identified in the initial search, of which 72 were retained after title screening. Following screening of abstracts, 19 studies were included in the final review. From these 19 studies, 21 competency frameworks were identified from nine different countries. A variety of job types and populations were included, with most frameworks being developed in educational settings with the aim of developing interprofessional capabilities in students, with fewer practice-based applications.

A total of 23 different competencies were identified, with considerable overlap. Only three studies (two qualitative and one quantitative) observed the use of the competencies in real-world settings. The two qualitative studies, both set in Canada, focused on acute care units and surgical intensive care unit doctors, applying two competency frameworks (Hepp et al, 2015; Goldman et al, 2018). The quantitative study focused on hospital nurses in South Korea, exploring the self-reported associations between their competencies and performance in terms of patient-centred care (Hwang, 2015). Although limited in number, these studies highlighted the importance of team- and system-level facilitators, as well as barriers in determining how likely the competencies are to be demonstrated. Overall, the evidence review demonstrated a lack of research exploring the use of integrated care competency frameworks in real-world settings, with no studies looking at the use of these frameworks across multiple settings and occupations.

The framework

The structure of the draft framework was generally accepted as appropriate by all focus group participants, so no major amendments were needed. Valuable feedback was received regarding terminology, relevance and comprehensiveness of the framework. Framework headings and descriptors were amended in response to this feedback to ensure that the framework reflected the multi-agency nature of integrated working. The final framework is shown in **Figure 1**, with the items described in **Table 2**.

Quantitative results

Analysis of the mean scores, standard deviations and dispersion/central tendency for each item in section one of the questionnaire showed that central tendency did not present any issues. However, scores were negatively skewed towards the higher end of the scale, and the data revealed generally low standard deviation (meaning that there was little dispersion of scores). Item total correlation and inter-item correlations were used to test internal reliability. All items had an item total correlation of >0.2 and an inter-item correlation no greater than 0.9, meaning that they satisfied the conditions for both aspects of reliability (Rust and Golombok, 1999).

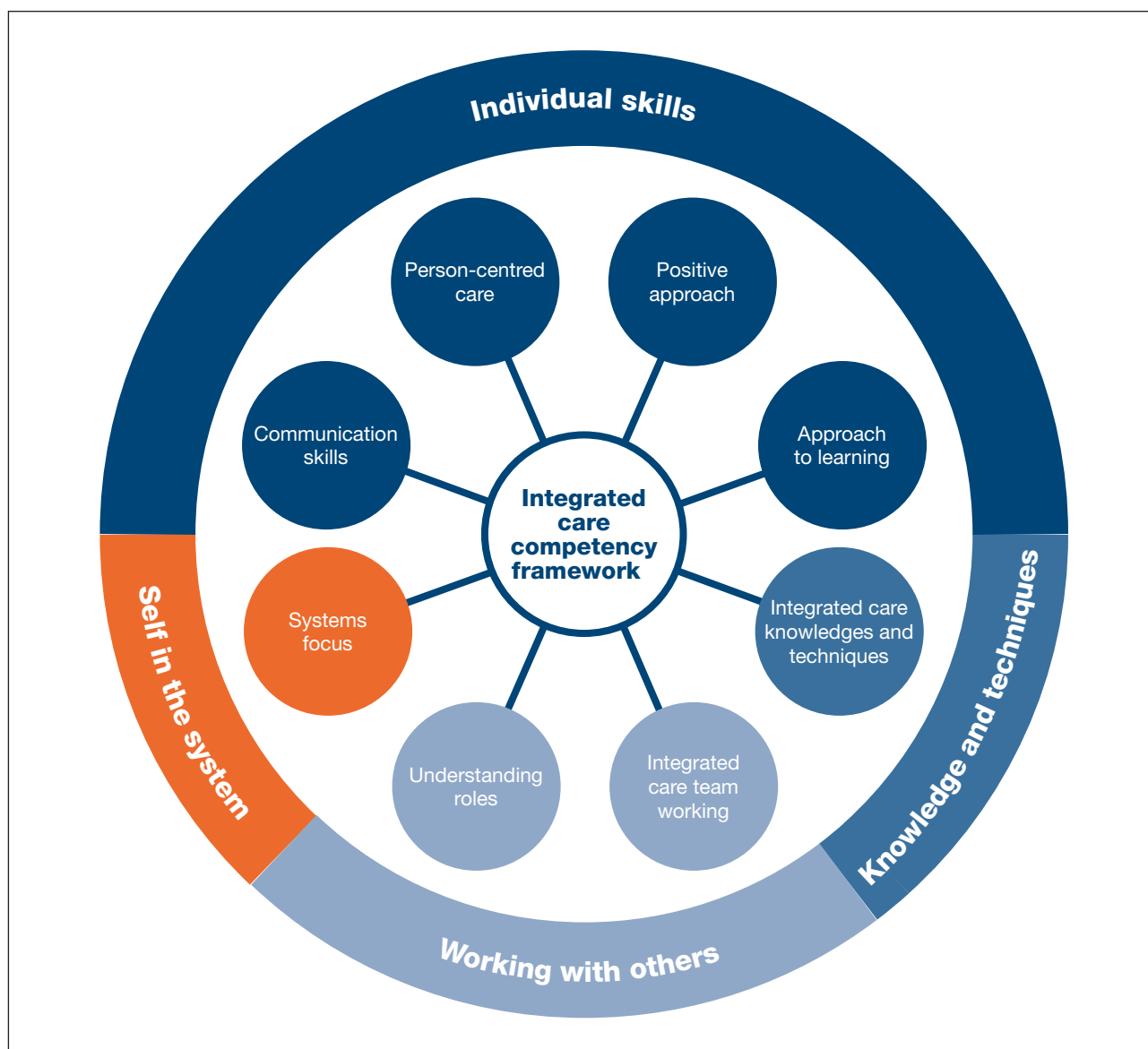


Figure 1. Integrated care competency framework.

A total of 91 participants responded to the questionnaire. **Table 3** shows the demographic breakdown of the sample. The majority of respondents (80.2%) were women and nearly two-thirds (64.9%) were aged 38–57 years. The occupational group with the highest proportion of responses (38.5%) was nursing and midwifery. In terms of tenure, 61.6% of respondents had worked for their organisation for 10 years or less.

Table 4 shows respondents' mean overall integrated care working score and mean scores on each domain relating to feelings about work. **Table 5** shows the associations between demographic characteristics and mean scores for integrated care competency and feelings about work. Spearman's Rho showed statistically significant positive associations between respondents' scores in section one and section two of the survey, indicating that those who demonstrated greater integrated care competencies were more likely to perceive themselves as successful in integrated care working ($r=0.579$, $n=86$; $P<0.01$), have a greater sense of meaningfulness of work ($r=0.23$, $n=86$; $P<0.05$) and higher levels of peer support within teams ($r=0.22$, $n=86$; $P<0.05$). A significant negative association was found between respondents' integrated care competencies and tenure ($r=-0.31$, $n=86$; $P<0.01$), indicating that participants with shorter tenures had higher overall self-reported integrated care competency scores than those with longer tenures.

Table 2. Integrated care competency framework items

Item	Sub-heading	Description	Example behavioural descriptor
Individual skills	Communication skills	Communicates in a clear, respectful and compassionate way; adapts style to situation and person; encourages opinions from others	<ul style="list-style-type: none"> Adapts communication style to the person Explains clearly and respectfully what they say and why they say it Able to have difficult conversations sensitively, conveying messages that people do not want to hear
	Person-centred care	Delivers non-judgemental, inclusive care for all; focuses on the positives; encourages the patient towards self-management and self-reliance	<ul style="list-style-type: none"> Explains the role of self and of each agency involved in the patient's care Looks for positives, focusing on what the patient can do, not what they cannot do Shows curiosity and bravery in asking questions
	Positive approach	Acts with optimism, integrity, flexibility and humility; promotes one's professional code of ethics; asks for support when necessary	<ul style="list-style-type: none"> Recognises and manages impact of self on others (from how they feel, think and behave with others) Demonstrates flexibility and innovation in approach Maintains professionalism, even if facing adverse treatment from others
	Approach to learning	Engages in continual professional development, including use of new technology; seeks feedback on practice; assists in building capabilities of others	<ul style="list-style-type: none"> Both seeks and accepts feedback on own practice Helps with building the capability and knowledge of others Encourages change to improve how things are working
Knowledge and techniques	Integrated care knowledge and techniques	Shows an understanding of the meaning and importance of integrated care; shows an awareness of the interplay between physical health, mental health and social circumstances	<ul style="list-style-type: none"> Demonstrates awareness of health and social conditions in the local population Assesses the whole person, including mental capacity, environmental and social circumstances Connects the patient with multiple agencies, providers and resources via the care plan
Working with others	Integrated care team working	Works collaboratively and transparently with the multi-agency care team, building positive, non-competitive relationships	<ul style="list-style-type: none"> Establishes links, shares decisions, breaks down barriers and avoids duplication across the multi-agency care team Strives to be physically present with others in the multi-agency care team ('get everyone around the table') Celebrates success of multi-agency care team outcomes
	Understanding roles	Understands the contributions and priorities of different agencies; shows professional curiosity about others' scope of practice	<ul style="list-style-type: none"> Demonstrates an understanding of the contributions and skills that different agencies bring Shows an understanding of who is responsible for each element of a patient's care
Self in the system	Systems focus	Understands the impact that a range of factors can have on individual patients; delivers services that balance the health and social care needs of the population with the resources available	<ul style="list-style-type: none"> Understands the impact that a range of social, economic and environmental factors can have on individual outcomes Demonstrates awareness of differences in structures and working practices across locations, agencies and providers

Discussion

Identifying ways for multidisciplinary teams to work together more effectively is vital for the success of integrated care systems. The integrated care competency framework developed in this study, using a multi-method approach, is the first of its kind in the UK and the third to be subjected to empirical testing worldwide. The results of the questionnaire indicated

Table 3. Demographic and work-related characteristics of survey respondents (n=91)

Characteristic		n (%)
Gender	Male	13 (14.3)
	Female	73 (80.2)
	Prefer not to say	2 (2.2)
	Missing data	3 (3.3)
Age (years)	18–27	6 (6.6)
	28–37	16 (17.6)
	38–47	27 (29.7)
	48–57	32 (35.2)
	58–62	7 (7.7)
	Missing data	3 (3.3)
Occupational group	Allied health professional, healthcare scientist and/or scientific and technology staff*	15 (16.5)
	Medical and dental staff	3 (3.3)
	Emergency service staff	10 (11.0)
	Public health staff	1 (1.1)
	Registered nurses and midwives	35 (38.5)
	Nursing or healthcare assistants	12 (13.2)
	Social care staff	9 (9.9)
	Wider healthcare team (administrative, clerical, corporate)	1 (1.1)
	General management	1 (1.1)
	Missing data	4 (4.4)
Tenure in organisation (years)	1–2	26 (28.6)
	3–5	11 (12.1)
	6–10	19 (20.9)
	11–15	10 (11.0)
	16–20	9 (9.9)
	21–25	4 (4.4)
	26–30	3 (3.3)
	31–35	3 (3.3)
	≥36	1 (1.1)
	Missing data	5 (5.5)

*Eg radiographer, speech and language therapist, technician

Table 3. Demographic and work-related characteristics of survey respondents (n=91) (continued)

Characteristic		n (%)
Hours worked per week	15–20	3 (3.3)
	21–25	8 (8.8)
	26–30	11 (12.1)
	31–35	1 (1.1)
	36–40	44 (48.4)
	41–45	12 (13.2)
	46–50	7 (7.7)
	≥50	1 (1.1)
	Missing data	4 (4.4)

*Eg radiographer, speech and language therapist, technician

Table 4. Mean scores and standard deviations on section one (integrated care competency) and section two (feelings about work) of the survey

Item (number of respondents)		Mean	Standard deviation
Section one (n=91)	Overall integrated care working	6	0.7
Section two (n=86)	Overall, I successfully work in an integrated way	5.9	0.8
	Job satisfaction	5.8	1.3
	Meaningfulness at work	5.9	1.1
	Engagement at work	5.9	1.2
	Support from manager	5.6	1.3
	Support from peers (within team)	5.9	1.1
	Support from peers (outside team)	4.9	1.1
	Emotional exhaustion	4.3	1.5

Scores were given on a 7-point Likert scale where 7=strongly agree; 1=strongly disagree. Higher scores indicate higher levels of competency and more positive feelings towards work.

initial support for the reliability of the framework, while the multidisciplinary nature of the creation of the framework suggests that it could be applied to a range of settings.

The use of the collaborative, rigorous and iterative methodology enabled the framework to be co-developed and informed by multiple stakeholders. This led to a greater focus on ethical practice from a wide range of perspectives, as well as more of a whole system approach than reflected in previous frameworks, which tend to focus on one occupational group (eg Hepp et al, 2015; Hwang, 2015; Goldman et al, 2018). This suggests that the current framework may be particularly useful for delivering integrated care, especially as it emphasises the need for individual actions to be aligned with the overall strategic goals and initiatives of the system.

The association between participants' responses to the questionnaire and their overall success in integrated care working demonstrated that the framework comprehensively measures integrated care competencies (ie good construct validity). Respondents who demonstrated more integrated care competencies also reported seeing their work as more meaningful and perceived greater levels of support from their peers than those who do not work in as integrated a way. This suggests that the framework is related to relevant integrated care outcomes (ie good criterion-related validity).

Table 5. Correlation between mean integrated care competency scores and respondents' feelings about work

Variables	Correlation co-efficient (P value)									
	Overall, I integrated care working	Overall, I successfully work in an integrated way	Job satisfaction	Meaningfulness at work	Engagement at work	Support from manager	Support from peers (within team)	Support from peers (outside team)	Emotional exhaustion	
Overall integrated care working	1.000	0.579, (0.000)	0.037 (0.735)	0.233 (0.031)	0.181 (0.096)	0.012 (0.911)	0.217 (0.045)	0.088 (0.422)	-0.141 (0.195)	
Overall, I successfully work in an integrated way	0.579 (0.000)	1.000	0.122 (0.262)	0.163 (0.133)	0.048 (0.664)	0.070 (0.520)	0.114 (0.294)	0.180 (0.098)	0.063 (0.562)	
Job satisfaction	0.037 (0.735)	0.122 (0.262)	1.000	0.719 (0.000)	0.574 (0.000)	0.424 (0.000)	0.436 (0.000)	0.219 (0.042)	0.323 (0.002)	
Meaningfulness at work	0.233 (0.031)	0.163 (0.133)	0.719 (0.000)	1.000	0.642 (0.000)	0.489 (0.000)	0.439 (0.000)	0.233 (0.031)	0.318 (0.003)	
Engagement at work	0.181 (0.096)	0.048 (0.664)	0.574 (0.000)	0.642 (0.000)	1.000	0.464 (0.000)	0.460 (0.000)	0.231 (0.032)	0.289 (0.007)	
Support from manager	0.012 (0.911)	0.070 (0.520)	0.424 (0.000)	0.489 (0.000)	0.464 (0.000)	1.000	0.620 (0.000)	0.311 (0.004)	0.324 (0.002)	
Support from peers (within team)	0.217 (0.045)	0.114 (0.294)	0.436 (0.000)	0.439 (0.000)	0.460 (0.000)	0.620 (0.000)	1.000	0.395 (0.000)	0.217 (0.045)	
Support from peers (outside team)	0.088 (0.422)	0.180 (0.098)	0.219 (0.042)	0.219 (0.031)	0.231 (0.032)	0.311 (0.004)	0.395 (0.000)	1.000	0.056 (0.607)	
Emotional exhaustion	-0.141 (0.195)	0.063 (0.562)	0.323, (0.002)	0.323 (0.003)	0.289 (0.007)	0.324 (0.002)	0.217 (0.045)	0.056 (0.607)	1.000	
Age	0.009 (0.932)	0.066 (0.543)	0.206 (0.057)	0.095 (0.383)	0.036 (0.744)	-0.027 (0.803)	-0.037 (0.736)	-0.206 (0.057)	0.084 (0.443)	
Gender (female)	0.083 (0.445)	0.019 (0.865)	0.104 (0.342)	0.082 (0.4500)	0.045 (0.682)	-0.007 (0.949)	-0.019 (0.865)	-0.118 (0.280)	-0.034 (0.758)	
Tenure	-0.308 (0.004)	-0.134 (0.218)	0.180 (0.081)	0.055 (0.617)	0.107 (0.326)	-0.013 (0.907)	-0.122 (0.263)	-0.004 (0.970)	-0.004 (0.970)	
Working hours	-0.169 (0.120)	-0.130 (0.231)	0.081 (0.458)	-0.021 (0.846)	0.040 (0.717)	-0.101 (0.354)	0.006 (0.956)	-0.006 (0.960)	-0.045 (0.681)	

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The evidence review conducted at the beginning of this study showed a lack of research on integrated care competencies, with the few relevant studies identified largely being conducted in the context of professional education. An interesting observation from the present study was that participants who had joined their organisation more recently were more likely to report that they demonstrated integrated care competencies. This may be a result of newer employees having fewer experiences of incidents that adversely affected their confidence. Conversely, it may be because newer employees feel less confident in their abilities, and are thus more likely to engage and work with others in a non-judgemental way. Embedding integrated care competencies into multi-occupational or multi-professional group training could help to formalise and recognise this way of working among newer workers, while also introducing these ways of working to those who have longer tenure.

Recommendations

The rigorous and collaborative methodology used for the development of this framework followed a best-practice approach. Therefore, it can provide a solid grounding for future work in this area. The authors believe that the framework could be used as a tool for team development and facilitate discussions between individuals, teams within the same occupational group and multi-agency teams about what integrated care working means to them and how they could work in a more integrated way. It could also inform a gap analysis to identify any disparities between existing competency frameworks and current ways of working.

As this framework was developed in such a large and diverse integrated care system, there may be an opportunity to use it more widely, across a broader range of healthcare, social care and multi-agency providers. With further testing and development, this tool could be applied at all levels of employment, from onboarding to performance appraisal, selection and assessment, and development and promotion.

Limitations

This study has several limitations. First, the data were captured in February 2021, during one of the acute stages of the COVID-19 pandemic, which may have impacted recruitment to the study. The sample size of survey respondents was relatively small and there was a level of missing data, which limited the opportunity to conduct multivariate statistics. A larger sample would have allowed a more robust analysis and examination of differences between occupational groups and other demographic characteristics, such as age and gender.

Second, the data displayed a significant negative skew. This may have occurred because the individuals who responded to the questionnaire were already engaged in the practice of integrated care, and were thus more likely to demonstrate good practice. It may also have been a result of the self-report methodology used, as self-assessment of competence is vulnerable to self-serving bias, with scores being higher than those that would be given by others (Kromrei, 2015). Future applications of the survey should test the competencies using peer or manager ratings to avoid self-serving bias (Facteau and Craig, 2001).

Third, some systemic issues limited the study in a way that may limit its future application. From both the evidence review and the focus groups, it was clear that there was a wide range of perspectives about what integrated care could or should include, with no clear or consistent definition. The iterative and collaborative research design attempted to create wording that would make sense to all, but the lack of overall consistency around the understanding of the concept represents a substantial risk for the rollout of this framework. As two empirical papers (Hepp et al, 2015; Goldman et al, 2018) highlighted, contextual factors play a critical role in both facilitating and preventing the demonstration of integrated care competencies. The research design did not enable empirical examination of the role of contextual factors in the relationship between integrated care competencies and outcomes. Further research should examine the impact of the wider context of working within an integrated care system.

Key points

- Understanding how multidisciplinary teams can work together effectively, particularly when teams span healthcare, social care and allied professionals, is vital for the success of integrated care systems.
- The integrated care competencies framework presented in this study is the first of its kind to be created and tested across multiple health and social care agencies through a multi-method approach.
- Initial testing supported the reliability and validity of the framework, and showed that working in an integrated way can have positive outcomes for perceived meaningfulness at work and peer support.
- The framework could be used as a resource for team development and facilitation, and as a resource to map and compare existing competency frameworks, providing a platform for future research.

Conclusions

The integrated care competency framework developed and tested in this study is the first of its kind in the UK and the third framework globally to be empirically tested for reliability, validity and utility. It is also the only framework globally that has been tested for validity across multiple occupational groups and agencies in a real-world setting, exploring a range of outcomes.

Initial testing supported the reliability and validity of the framework, showing that working in an integrated way can have positive outcomes for perceived meaningfulness at work and peer support. The authors believe that this framework can be developed further as a tool for inter-professional working that could be used across a number of professions in health and social care.

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Conflicts of interest

The authors declare that there are no conflicts of interest.

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Data sharing statement

All data are available from the corresponding author on reasonable request.

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