Health and Wellbeing Best Practice and Innovation Board

Integrated Care Workstream

The Determinants of Effective Integration of Health and Social Care

February 2013
### Document Information

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<td>Purpose</td>
<td>This document is one of the first products issued by the Integrated Care Workstream of the Health and Wellbeing Best Practice and Innovation Board. It has been commissioned by the Welsh Government to support integrated health and social care policy development, and provides all interested parties with a summary, based on a review of the available evidence, of the determinants of effective health and social care integration.</td>
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| Sponsor     | Paul Matthews  
Chief Executive  
Monmouthshire County Council  
(In his capacity as Integrated Care Workstream Lead  
Health and Wellbeing Best Practice and Innovation Board) |
| Target Audience | Welsh Government, NHS Wales; local government; third sector; independent sector; academia, all other interested parties. |
| Timing      | This document has been issued in February 2013 to support the development of the Welsh Government Framework for Integration. |
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The Determinants of Effective Integration of Health and Social Care

Purpose

The Health and Wellbeing Best Practice and Innovation Board (‘the Board’) has been established by the Welsh Government Minister for Health and Social Services to accelerate the adoption of innovation and the dissemination of best practice relevant to health and social care in Wales. In taking the work forward, the Board has used the learning from work undertaken in other parts of the UK\(^1\) to inform its initial work programme.

As one of its initial actions, the Integrated Care Workstream of the Board has been asked to provide advice to Welsh Government on the determinants to drive health and social care integration. This advice will be used to support national policy development, including the development of, and implementation of, a Framework for Integration. The Board will then act as a reference group in support of implementation.

This paper provides Welsh Government with the required advice, and, in addition to reflecting contemporary evidence on the determinants of effective health and social care integration, it includes the input and expertise of Board members and references a growing evidence base, much of which is contemporary.

Definitions – what do we mean by Integrated Care?

There are many definitions of integrated care, reflecting the degree of integration and the maturity of the collaboration and partnership relationships in place\(^2\). The English Integrated Care Network defines Integrated Care as ‘a single system of needs assessment, service commissioning and/or service provision’\(^3\), whilst the World Health Organisation recognises the different models that exist and describes a range of vertical and/or horizontal integration happening across organisational boundaries\(^4\).

Whatever definition is adopted, those organisational and cross sectoral service models in place include a number of key principles, whether explicit within definitions, or implicit. These have been summarised by a report in 2010\(^5\) as:

- The need to target integration where it is most needed – it is not a solution for all groups;
- The need to recognise and develop strategies to manage fundamental differences across sectors, such as the management and accountability mechanisms related to resources;
- The recognition that integration is not a ‘quick win’; it requires investment – both in time and resources - to establish and progress what can be complex cultural and systems change;
- It should be designed in partnership with service users, and have citizen centred services at its core;
- It requires local ‘buy in’ – policy statements alone will not result in an effective and sustained model of integrated services.
Reflecting policy requirements\(^6\), the Welsh Government ‘Case for Change’ – the reasons why we need to move towards integrated health and social care services for appropriate groups – is based on:

- recognition that person centred services delivered as a single model of service delivery provide better quality care and result in improved outcomes;
- demographic projections of an increasingly older population, both in numbers and as a proportion of the general population, with a significant increase in the very elderly – those aged 85 years and over\(^7\);
- the increased incidence of chronic conditions based upon an increasingly older population and poor lifestyle choices;
- the increased incidence of dementia that longevity brings – a 30% increase is projected in Wales in the coming decade alone. In some rural areas the numbers are projected to increase by 44%\(^8\);
- the need to provide co-ordinated, single service responses to promote and protect what can be fragile independent living.

Annex 1 provides a schematic representation of the Case for Change.

**Creating the Environment: the conditions for successful integration of health and social care**

Effective partnership working is essential if collaborative models are to be developed and sustained across health and local government partners. Reports commissioned by NLIAH\(^9\) suggest a wide range of factors and influences shape partnership working. The Figure 1 below\(^10\) illustrates these factors.

![Figure 1: Factors Influencing Collaborative Working](image)

From a structural perspective, the evidence base for integrated services reflects the differing national policy contexts across the UK countries. In England much of the
published research on integration refers to primary and secondary healthcare integration, rather than fully integrated health and social care services for appropriate client groups. Comparisons between UK countries based upon headline “integrated services” models need therefore to be treated with some caution.

All UK countries are highlighting the anticipated value of integration, and promoting integrated services as an appropriate service model to deliver shared care to those client groups likely to be high users of health and social care services - older people, adults with a learning disability, and children with long term complex needs. Demographic projections of an increasingly ageing population with a range of chronic diseases, linked with the challenging resource position experienced by public sector services across the UK, make efficient shared service models that ensure the best use of public resources a priority. There are academic and policy studies that focus on England, Scotland and Northern Ireland. UK wide and country specific policy analysis has also been undertaken by national organisations including the King’s Fund, the Nuffield Institute, the School of Public Policy, and national social care organisations.

On an international basis, other research studies have looked at Finland, Denmark, New Zealand, Norway and Sweden. One key source for international information was a literature review carried out for the RCN in Scotland.

In Wales, there is increasing recognition within Government policy of the potential value of integrated service models in providing a more proactive approach to older people’s services, seeking to protect what can be fragile independent living via community based models of care that are person centred and delivered within the person’s usual place of residence.

The integrated health board model in Wales provides a structural health model to address primary/community and secondary healthcare interfaces, delivering healthcare across all locations to the population of Wales. The geographical footprint of the health boards, and the synergy with local government boundaries, also seeks to encourage and support partnership working.

The Key Determinants of Effective Integration of Health and Social Care

The evidence indicates that there are a number of determinants that influence the shape of effective integration of health and social care:

- **Clarity of strength of purpose** - having a shared vision, culture and values that deliver person centred services based on shared outcome frameworks;

- **Collaborative leadership** at all levels, with expert change management skills and the ability to drive cross sectoral working;

- **A culture of learning and knowledge management**, that seeks to support the sharing of best practice, improvement and service development across organisational and sectoral boundaries;
- **A supportive legislative/policy environment** that seeks to create the environment within which integrated services can develop;

- **Integrated management structures**, incorporating the use of joint appointments, with unified leadership and joint governance arrangements and accountability\(^{21}\);

- **Trust based interpersonal and interprofessional multidisciplinary relationships** across sectors, building on the strengths and unique contribution of each partner\(^{22}\);

- **Appropriate resource environments and financial models** seeking to ensure collaborative financial models, including the need for pooled budgets\(^{23}\);

- **Comparable IT and information sharing systems** that facilitate ease of communication;

- **Unified performance management systems** and common assessment frameworks;

- **Collaborative capabilities and capacities**, with all practitioners being skilled in integrated working and management.

These key determinants and the evidence base attributed to them are set out in the table below.

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<th>Determinant</th>
<th>Evidence / Literature</th>
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<td>Clarity of strength and purpose, with shared vision, culture and values</td>
<td>A shared vision and common goals are crucial to the success of integrated care, whatever the model. The Care Programme Approach to mental illness in England was undermined by the lack of a shared vision. (Simpson, Miller and Bowers, 2003)(^{24}).</td>
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<td>In Northern Ireland health and social care trusts have established professional forums to deal with problems arising from cultural differences. Forums focus on issues of professional development, training and governance. They also provide peer support and information on good practice and research. (Heenan and Birrell, 2006)(^{25}).</td>
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<td>The importance of clear, realistic and achievable aims and objectives, understood and accepted by all partners. Differences in organisational processes, priorities or planning cycles can create a climate for conflict rather than co-operation</td>
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Steve Woolgars\textsuperscript{27} defines innovation as “the art of interesting an increasing number of allies who will make you stronger and stronger”.

Story-telling and narrative databases are more powerful in moving knowledge around organisations and communities than guidance notes, instructions and codes of practice\textsuperscript{28}.

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<th>Collaborative capabilities and capacities</th>
<th>Managing and working in integrated settings differs from unorganisational settings, and needs different skill sets (Getha-Taylor, 2008\textsuperscript{29}; San Martin Rodriguez et al, 2005)\textsuperscript{30}</th>
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<td>Joint training is considered central to building a shared culture. Cross-agency secondments also helped to prepare people from different agencies and professional backgrounds for integrated working and to appreciate other people’s roles and perspectives. (Stewart, Petch and Curtice, 2003)\textsuperscript{31}.</td>
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<th>Collaborative leadership</th>
<th>There is a key role for leaders at all levels exercising the types of leadership that work across organisational and sectoral boundaries to create the environment within which integration can flourish. The skills and challenges of working across sectors to deliver a single service model will need to be identified and supported through a single knowledge management approach\textsuperscript{32}.</th>
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<td>Leaders are also pivotal in ensuring that organisations and systems learn from others, both within and outside their sector.</td>
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<td>In 2013/14, the Board will provide advice on leadership, culture and climate determinants.</td>
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| Learning and knowledge management | The integration of health and social care is an exercise in learning and knowledge management, because it involves the ‘collision of diverse stakeholders searching for new ways of working’ (Williams, 2012)\textsuperscript{33}, (Nicolini et al, 2008)\textsuperscript{34} |

| Integrated management structures | There are two parts to this: ‘soft’ issues such as culture, training and attitudes, and ‘hard’ issues like employment terms and conditions (Hultberg et al 2005)\textsuperscript{35}. |
In Norrtälje (Sweden) in which a single organisation administers a combined health and social care budget to purchase services from a second, integrated provider of health and social care services leading to a flatter management structure, and greater integration of primary, secondary and tertiary care with social care (CEEP, 2007)\(^6\).

Focusing on improving patient care in integrated structures helps to overcome professional boundaries (Heenan and Birrell, 2006).

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<th>Resources, incentives and pooled budgets</th>
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<td>Health and social care sectors are facing resource challenges that are unprecedented, and the consequences of austerity upon integration and collaborative working will need to be considered, reflected and addressed within a national framework. The opportunities that austerity brings to innovate and develop truly groundbreaking models of cross sectoral working should be exploited(^7).</td>
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Incentives have a strong part to play, with financial incentives having an ability to shape behaviour and influence practice.\(^8\)

Specific to pooled budgets, experience from Northern Ireland suggests a single source of funding, used to deliver integrated care is a significant success factor. In separate organisations, funding earmarked for either health or social care cannot easily be redirected from one service to the other as managers cannot commit resources from budgets they do not control (Heenan and Birrell, 2006)\(^2\).

Where a single budget exists, the medical profession and a medical model of care can lead to funds being diverted from community-based services to support hospital services as acute care takes priority. This has been observed in Northern Ireland (Heenan and Birrell 2006) and New Zealand (Ham et al, 2008)\(^9\).

Integrated structures and are not enough in themselves to secure integrated service delivery. Budgets need to be integrated too. (Reilly et al 2003)\(^10\).

Pooled budgets succeeded in improving interdisciplinary working in Sweden although negative attitudes towards other professions took some time to decrease (Hultberg et al,
| **Trust based interpersonal and interprofessional relationships** | Good inter-professional collaboration is associated with success measured by lower hospital admission rates, fewer GP visits and improved patient function in studies of people with long-term conditions (Reed et al, 2005)\(^42\).

Sharing office space and client groups makes integrated working easier. (Wistow and Hardy 1991)\(^43\).

Outcomes from a care programme approach were better when clinical staff worked in multi-disciplinary teams with social care staff (Hofmarcher, Oxley and Rusticelli, 2007)

The perceived lower status of social care staff compared to healthcare staff created significant difficulties in developing integrated systems (Coxon, 2005).

A number of studies have concluded difficulties in securing GP involvement. (Cameron and Lart’s literature review 2003)\(^44\). |
| --- | --- |
| **A supportive legislative and policy context** | Much of the commentary on integrated care highlights the importance of a legislative and policy framework that consistently supports and encourages integration. Danish authorities took care to avoid perverse financial incentives that would otherwise promote institutional care and these acted as a further incentive to develop community-based care services (Stuart and Weinrich, 2010)\(^45\).

The need to align policy, evidence and practice is also highlighted in an analysis of the policy position in England and Scotland (Petch, 2012)\(^46\). |
| **Compatible IT and information sharing systems** | Good communication improves the ability of teams to work together successfully (Howarth, Holland and Grant, 2006)\(^47\).

Clear communication structures are needed to keep all staff aware of, and involved in, the processes surrounding integrated care, design and implementation.\(^48\)

Complex documentation, poor record keeping, incompatible IT systems and differences in referral arrangements cause problems (Cameron and Lart, 2003).

Robust information systems for rapid communication between sectors/organisations and within teams including using a single record gathered from shared assessments (Reed et al, 2005)\(^41\). |
Unified performance management systems and common assessment framework

The need for unified performance systems, and a single approach to assessment has been identified as essential for over a decade\textsuperscript{49 50 51}.

In Wales, the need for a unified outcomes based approach to measuring success, along with a common assessment process and the introduction of national eligibility criteria are reflected within developing legislature\textsuperscript{52}.

\textbf{Conclusion}

This paper has set out the determinants for the effective integration of health and social care services. It is being submitted to the Directorate of Strategy and Policy, Department for Health, Social Services and Children, Welsh Government in February 2013 in support of the development of the national Framework for Integration.

In addition to the determinants set out above, there is, as yet, no Integrated Care Network specific to Wales that could act to support and guide change. The development of a cross cutting and interactive learning and knowledge management network across health and social care could promote engagement from those involved in service delivery, seeking to develop a robust learning and development environment to drive sustainable change. Such a network could also serve to signpost emerging models and innovative approaches being progressed from national organisations such as the Kings Fund, the Nuffield Institute, and the Public Services Academy, University of Birmingham. The Board recommends the development of such a network in Wales.

\textbf{Next Steps for the Best Practice and Innovation Board}

Having delivered the initial advice on the key determinants, 2013/14 will see the Board focus on:

- The leadership, culture and climate needed to promote integration;
- Effective employee engagement in this agenda;
- Providing more evidence based case study material on the effective integration of health and social care in Wales.

The Board will also act as a Reference Group for the roll out of the Framework for Integration.
Demographic projections of an increasingly ageing population as a proportion of the general population

Poor lifestyle choices leading to poor health and an increase in the numbers with chronic conditions

Unstable health and social care systems – limited capacity in the face of increasing demand, reduced workforce, reduced funding

Inability to deliver person centred services.

Increasing gap between demand and capacity to meet need.

Limited ability to focus on preventative models of care that support independent living.

Increasingly reactive model of health and social care delivery, with an inability to plan for and meet growing need.

Poor outcomes, increasing reliance on high levels of care and support and constantly reacting to increasing need.

Disjointed care delivered in a poorly co-ordinated way.

A workforce that is unable to operate across sectoral boundaries.

* Adapted from Transforming your Care: A Review of Health and Social Care in Northern Ireland (2011)
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8. Ibid

    Learning to Collaborate: Lessons for Effective Partnership Working in Health and Social Care, Cardiff. NLIAH (2007)

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33 Williams, P. M. (2012) "Integration of Health and Social Care: a case of learning and knowledge management" Health and Social Care in the Community, vol 20, issue 5, pp 550-560


48 Innovation, Health and Wealth, Department of Health 2011


50 Designed for Life, Welsh Government, 2006


52 The Social Care and Wellbeing (Wales) Bill.