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How organisation theory may help us understand integrated care

Integrated care has come a long way. From its first tentative steps in the 1990s, it has now developed into a mature field of scientific inquiry with its own associations and think tanks, special interest groups and dedicated policies focussing on designing and implementing integrated care solutions within and across professional sectors. It has also spawned an enormous amount of conceptual and empirical research.

Despite all the progress, there remains a lingering question at the heart of the discipline. Why do organisations do integrated care? This is not to question personal motives for integrated care. We know that integrated care solutions deliver better conditions for professionals, which ultimately may lead to improved patient care. A recent systematic review indicated that integrated care models demonstrated positive impacts in at least two of the triple aims, access and patient care quality (Baxter et al., 2018).

But why would organisations want to embark on integration programmes as opposed to any other transformational programme? At a first glance, the answer to the question appears to be obvious. Organisations integrate because they have to. As often noted, most integrated care projects are instigated through top–down policy initiatives. Genuine bottom up integration is rare. And the preference for a top–down approach has consequences for the organisations mandated to integrate. Where the options of avoiding a policy are few, existing asymmetries of power and resources are often reinforced and cemented among participating services rather than mitigated.

On the other hand, the motivational glue that holds integrated care policies together is of course the desire to improve patient care. I have previously expressed some scepticism that this is the most powerful or, indeed even the most honest description of staff motivations when implementing integrated care (Kaehne, 2018). Two arguments counsel against blind faith in this often professed professional impulse; first, the relative paucity of evidence of integrated care on patient care quality; and second, the fact that integrated care solutions are just one among other options to improve patient care. In fact, the complexity of care integration is such that I doubt it would be the first choice of service managers and their staff when faced with the need to change. Integrated care is notoriously difficult to design, and its impact is difficult to predict. In addition, where organisational change reduces certainties, risks to core operational tasks are increasing. So why would anyone embark on a risky strategy if you could try out others, less risky ones first?

While this argument reveals the policy pressures that often underpin integration programmes imposed by central or local governments, there may be other perspectives that throw light on some issues that tempt organisations onto a path towards integration. Using organisation theory, I will detail a few below.

Despite all the useful conceptual research in the integration field, applications of organisation theory are relatively rare in health studies. This may be due to a reluctance to see parallels between commercial activity and healthcare. Yet, where organisation theory says something about how organisations change and why, it may give us additional insights into how healthcare organisations behave in the face of imposed change. While granting substantial differences between commercial organisations and healthcare services, there may still be some intriguing similarities that tell us more about integrated care programmes.

Contingency theory is probably the most obvious recent emanation of organisation theory to be applied in the healthcare context (McKinley and Mone, 2003). In effect, it says
that organisations operate under conditions of uncertainty which they are trying to reduce through adaptation. Where variables of contingency interject into an equilibrium (defined as market balance for commercial organisations), they try to change to make themselves “fit” to new circumstances. Recognising the terminological ambiguity of the construct “fit”, we can still use contingency theory as a heuristic device to structure the processes of change in a healthcare organisation as and when integration occurs. Integrated care projects are responses to variables that shift the policy framework within which all services operate. They are responses to contingent factors interjected into the system from outside, typically policies from the centre of political gravity.

A key characteristic of contingency theory in the commercial sector is that organisations react to external stimuli in such a way that protects their existence and maximises their profits (or utility). The key insight from looking at health services through the prism of contingency theory in moments of care integration is that we assume patient care to be the core utility of health providers and hence that their adaption to the contingency variable (the integration demand) would automatically lead to an improvement of care quality as organisations maximise their core business product. Yet, as Lipsky (1980) observed, the main utility to be pursued by healthcare organisations is their internal integrity and accountability to the various targets and objectives set by government and professional guidelines, not (necessarily) patient care.

So where care integration policies interject into business as usual in healthcare organisations, the main trajectory of the adaption process is more likely to be aimed at securing the integrity of the organisation and to re-establish effective rules of engagement between staff to create the equilibrium temporarily lost, rather than improve patient care. Of course, both are not mutually exclusive but neither are they necessarily correlated. More likely, there is an incidental relationship between the two where any organisational changes bring about some care quality improvements by virtue of disrupting some ineffective or detrimental practices as well as some effective ones.

The second useful offering from organisation theory may be resource dependency theory. Again, we would be after its heuristic function here rather than use it as a fully fledged explanatory theory. Strikingly, resource dependence theory does tell us something important about a key area of integration, interorganisational relations. Its core thesis is that where there is interdependence between organisations on issues such as supply of goods or services, organisations gravitate towards vertical or horizontal integration to reduce costs and increase efficiencies. A central theme in this re-organisation is the (re-)defining of boundaries, including or excluding others from access to resources. Like contingency theory, resource dependency theory rests on the assumption of managerial rationality as a core characteristic of operations. It also says something about the motivations and strategies to be employed to ensure the integrity and sustainability of the organisation. To survive, organisations collaborate or merge with others, building alliances, partnerships or “trusts” defined by mutual interest and shared objectives.

The critical aspect of resource dependency theory for healthcare, however, lies in the way in which it conceptualises the path to integration (or dis-integration). The dependence of an organisation on another organisation to deal with contingencies is a crucial deciding variable as to how integration (i.e. defining organisational boundaries) plays out for everyone involved. Those who adapt well to contingent external factors accrue coping capabilities that are in turn translated into power to determine where the organisational boundaries fall.

The resemblances with integration processes across the health and social care sectors are striking. If we understand the term resource broadly, in terms of status, access to financial resources or discursive hegemony in public debate, we can see how healthcare organisations accrue substantially more adaptive capacities than other care organisations. The result is
integration on the basis of a widening influence of health systems, encroaching into the
delivery domains of social care and preventative services, often on the basis of the medical
model. Examples would be multi-speciality providers merging with, or expanding into,
community provision, or large hospital trusts arrogating services to themselves that
hitherto were separately provided by community care providers.

Resource dependency theory reminds us that policy is first and foremost the injection of
uncertainty into a system by changing the power distribution between organisations. In this
sense, resource dependency theory tells us something about the likely dynamics of how
integration plays out in contexts marked by significant power, status and resource
asymmetries. The intriguing insight is, once again, that patient care figures surprisingly
little in this integration scenario. Whichever organisation copes better with the uncertainties
of the policy landscape will determine the shape of the integrated care eventually delivered
on the ground.

Where organisational capacity to develop effective coping strategies with
contingencies and resource dependencies determine the setup of care delivery, patient
preferences will struggle to make themselves felt. Surely, they are important to healthcare
organisations as a parameter for measuring service outcomes, but given infinite demand,
the main benchmark of managerial strategy is creating certainties in the system, rather
than the quality of patient care.

Admittedly, these are not empirically evidenced insights into how integration happens or
why. But they can shape our conceptual map of integrated care programmes. And, crucially,
they should inform our expectations about care integration, plausibly attenuating our hopes
of radical patient care improvements through organisational change.

Axel Kaehne

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What is the relevance of policy transfer and policy translation in integrated care development?

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Abstract

Purpose – The purpose of this paper is to document the influence of policy transfer on integrated care development, its global occurrence and shifts towards integrated care. It highlights the influence of supranational forces, and the roles and relevance of policy transfer and policy translation in the development of integrated care.

Design/methodology/approach – This paper presents the findings of an international review of the policy transfer of integrated care, and the relevance of policy translation in integrated care development.

Findings – The global occurrence in integrated care, as evinced in this paper, can be seen in the global shift towards integrated care in various countries. However, studies exploring the actual mechanism of policy transfer and policy translation in relation to integrated care across countries are limited. The study of integrated care through the lens of policy transfer is important, as it for example, explores the structural elements, including environmental and cognitive obstacles in the policy transfer process. Policy translation offers a social constructivist approach to explore the travel of ideas, and considers the multiple spatial and scalar contexts in which integrated care policy is implemented.

Originality/value – This paper aims to advance policy transfer and policy translation as complementary frameworks to explain integrated care development. Second, it seeks to make novel and useful contributions to the debate about the development of integrated care, and to the wider arguments on policy transfer and policy translation and integrated care in other parts of the world.

Keywords Health and social care, Integrated care, Policy implementation

Paper type General review

1. Introduction

Current literature on integrated care has focused largely on the enablers and barriers in the development of integrated care, often at organisational levels, and does not explicitly explore and examine the policy transfer and policy translation of integrated care across countries and jurisdictions, and their associated challenges and implications (see e.g. Cameron, 2016; Spice, 2012; Humphries, 2015). This is in spite of the presence of, as evident in the literature, the borrowing of integrated care ideas and policies across jurisdictions, and the cross-jurisdictional learning that takes place among policymakers, policy entrepreneurs, governmental organisations, think tanks and integrated care managers.

Dolowitz and Marsh (1996, p. 344) defined policy transfer as: a process in which knowledge about policies, administrative arrangements, institutions, etc., in one time and/or place is used in the development of policies, administrative arrangements and institutions in another time and/or place (Dolowitz and Marsh, 1996, p. 344). In addition to policy transfer, other writers have suggested the concept of policy translation as a more relevant concept, particularly in depicting the significance of policy agents in the process of the travel of ideas (Clarke et al., 2015; Lendvai, 2015; Mukhtarov, 2014). Policy translation refers to the “process of modification of policy ideas and creation of new meanings and designs in the process of
the cross-jurisdictional travel of policy ideas” (Mukhtarov, 2014, p. 76). It locates the policy agents and emphasises the complexity and ambiguity of policy processes with an interpretive approach (Shore and Wright, 2011).

The empirical verification of policy transfer, and necessarily policy translation, in integrated care between countries at the global level can be traced through the observation of the transmission mechanisms of policy learning, as articulated by Dolowitz et al. (2000). These include research publications, articles available in the public domain, a state’s activities and involvement in international organisations related to integrated care, and its officials and politicians going on overseas study or tours. The presence of policy transfer in integrated care is also evidenced in comparative studies on integrated care policies and practices (Calciolari and Ilincia, 2011; Mur-Veeman et al., 2008; Oliver-Baxter et al., 2013; Spice, 2012); financial incentives and integrated resource management systems (European Observatory on Health Systems and Policies, 2013; Mason et al., 2014; The Scottish Government, 2010); and the development of models of integrated care (Nicholson et al., 2013; Suter et al., 2009). These studies are accessible online and are also testament to the efforts that countries have made to understand the phenomenon of the policy occurring elsewhere and how they compare. They are relevant as they may be seen as representing opportunities for policy transfer to occur.

The aim of this paper is to define and describe the roles of policy transfer and the relevance of policy translation in integrated care development. It documents the presence of policy transfer on integrated care development, its global occurrence, the influence of supranational forces and the global shifts towards integrated care. The paper then advances policy translation as a complementary and necessary framework that needs also to be considered, beyond policy transfer, to explain integrated care development. The paper also seeks to contribute to the debate about the development of integrated care, and to the wider arguments on policy transfer and policy translation and integrated care in other parts of the world.

2. Defining policy transfer and policy translation

The areas of study of policy transfer include the description (how policy transfer is done), explanation (why policy transfer occurs) and prescription (how policy transfer should be done) are commonplace in normal policy analysis (Evans, 2010a). Within the policy transfer analysis framework, the foci of study can be organised and expressed as seven fundamental questions (Dolowitz, 2003; Dolowitz and Marsh, 2000): why engage in transfer, who is involved in transfer, what is transferred, where from, what is the degree of transfer, what constrains and facilitates the policy transfer process, how is the transfer process related to policy success or failure?

The objects of policy transfer include policy goals, policy structure and content, policy instruments or administrative techniques, policy programmes, institutions, ideology, ideas, attitudes and concepts, and negative lessons (Dolowitz and Marsh, 1996). Evans and Davies (1999) proposed a dialectical approach involving a multi-level interdisciplinary perspective to understand the policy transfer process, highlighting three broad sets of variables that may constrain policy transfer and policy-oriented learning. They comprised “cognitive” obstacles in the pre-decision phase, “environmental” obstacles in the implementation phase and increasingly, domestic “public opinion”.

Evans (2010b) explained that “cognitive” obstacles refer to the process by which public issues are recognised and defined in the pre-decision phase, the breadth and detail of the search conducted for ideas, the receptivity of existing policy agents and systems to policy alternatives and the complexity of choosing an alternative. “Environmental” obstacles refer to the absence of effective cognitive and elite mobilisation strategies deployed by policy transfer agents, and include considerations such as broader structural constraints (institutional, political, economic and social) that impinge on the process of lesson-drawing, and the technical implementation constraints that inhibit or facilitate the process of lesson-drawing (Evans, 2010b).
Building on policy transfer, policy translation augments policy transfer as it considers the translation that takes place in policy transfer. This is largely attributable to the critiques of policy transfer framework. For example, policy transfer is said to imply mechanistic assumptions and a linear model of messaging from A to B in the policy transfer process, although what is translated is often somehow inferior, unreal and unoriginal (Lendvai and Stubbs, 2007). The definition of successful policy implementation may also be unclear, and a policy that succeeds in one dimension or for one set of people may fail in another dimension or for another set of people (Dolowitz and Marsh, 2012). Additionally, the distinction between where policy transfer begins and ends may also not be obvious (Stone, 1999), as policy innovation may also rely in part on prior knowledge (Hudson and Lowe, 2009).

Primarily, policy transfer is seen as lacking acknowledgement of the uncertainty, centrality of practice and complexity in the policy translation process (Freeman, 2009; Stone, 2012), and is thus associated with diminishing analytical returns (Peck and Theodore, 2015). Mutation, as a result of endogenous forces, often occurs from prior learning processes in the translation of ideas, standards or programmes, where the processes occur in a complex web (Peck and Theodore, 2015; Stone, 2012). Moreover, ideas about organisational forms or policies are also translated through modification, simplification and editing, and are transformed so that they can travel across contexts more easily (Dussauge-Laguna, 2013). The policy transfer literature also fails to address the issue of the politics of scale, whereby the levels of any study are scaled up to a level at which power can be exercised more effectively (Lendvai and Stubbs, 2007; Lendvai and Stubbs, 2009; Mukhtarov, 2014).

Beyond policy transfer, policy translation emphasises the complexity and ambiguity of policy processes from an interpretive approach (Shore and Wright, 2011). It explains how policy ideas morph and are transformed as policy actors act on a particular geographical scale within the contingencies of the relevant politics and context (Clarke et al., 2015; Mukhtarov, 2014).

Policy translation is often associated with and used in conjunction with concepts such as policy assemblages, mobilities and mutations (McCann and Ward, 2013). It is akin to a social constructivist approach in the travel of policy ideas (Mukhtarov, 2014), and is associated with the "interpretive", "constructionist/constructivist", "cultural", "linguistic" and discursive 'turns in policy studies (Clarke et al., 2015). It acknowledges the complex interactions between the multiple factors that influence the process (Mukhtarov, 2014; Stone, 2012), and argues against monocausal and linear accounts of agency and action (Clarke et al., 2015).

Policy translation seeks to unpack the socio-spatial complexities and multiplexities of movements, from transportation to migration, rather than a linear straightforward point A to point B transfer of policy (Jones et al., 2014; McCann and Ward, 2013). For example, Singapore had to adapt in modelling Wisconsin–Works in the USA (Ng et al., 2012) to establish the work support programme in 2006. It also had to modify Japan’s management techniques work improvement teams (WITs) and quality control, and New Zealand’s executive agency model (Common, 2004) in the translation process. Contextualising policy-making behaviours matters in policy translation, and it is productive of associations and articulations, and shapes how policy is imagined and interpreted when it travels from one context to another, across spatial and scalar fields (Clarke et al., 2015). Policy translation thus adds insights into understanding how varying policy agents at various scales, space and time, and offers a useful augmenting lens for integrated care scholars to explore the development of integrated care in their context.

3. Integrated care and the global occurrence of its policy transfer
The thrusts towards integrated care among countries could be attributed to the global shared experience of a rapidly ageing population (UN, 2015; WHO, 2014a), an increasing burden of chronic diseases (WHO, 2014b, 2016), increasing healthcare costs (Chapman et al., 2014),
a decreasing old-age support ratio across the nation (DOS, 2016) and a rising demand for healthcare (Cheah et al., 2012; Grone et al., 2001; MOH, 2014). Indeed, countries experiencing similar pressures and common shocks provoking similar national reactions look to other political systems for knowledge and ideas about institutions, programmes and policies, in order to explore their adoption and adaptation (Dolowitz et al., 2000; Freeman, 2006; Obinger et al., 2013).

The turning to other countries in response to the demographic and epidemiological changes, and drawing lessons from them to explore integrated care approaches, represents a form of policy transfer. This notion of improving policy making by looking abroad and adopting policies from elsewhere is regarded as a common response to addressing policy issues (Carroll and Common, 2013), and can be seen as a strategy for transforming the state (Evans, 2010b). The underlying assumption is that policies that are successful in one country might also be successful in another (Dolowitz and Marsh, 2000). This idea is premised on the potential of policy transfer to improve the effectiveness of government operations, and is concerned with how it relates to policy outcomes (Marsh and Sharman, 2010).

The concept of integrated care has gained traction globally over the years. Policy shifts and health transformations towards integrated care through policy transfer are evident in policy articulations and initiatives in many countries. These are in part due to supranational forces in bringing about its development. As early as 1999, the WHO European Region proposed the strategy of integrating health services (WHO, 1998, 1999). This was followed by the establishment of the WHO European Office for Integrated Health Care Services, whose stated aim was to encourage and facilitate changes in healthcare services to achieve quality, accessibility, cost-effectiveness and participation (Grone et al., 2001). The WHO (2003) exhorted nations to adopt integrated care as one of the key pathways to improving primary care. In 2004, the European Commission declared integrated care to be crucial for the sustainability of social protection systems in Europe (Lloyd and Wait, 2005). Following this, the WHO (2005) European Region stated the need to adopt a more general approach or “Health for All” vision, involving a broad partnership approach to health to strengthen national health systems (p. 17).

The influence of supranational organisations has considerable implications for nations (Bennett et al., 2015; Obinger et al., 2013; Pal, 2014; Savi and Randma-Liiv, 2013) and reflects the “transnationalisation of policy” (Stone, 2010, p. 270). Such transnational governance is framed through norms, practices and discourses, and is a complex, fragmented, unstable and highly contested arena (Kennett and Lendvai, 2014). These forces introduce an arguably negotiated policy transfer in action, and effective health governance at work. Such pressure demonstrates the influence that supranational forces have on countries in terms of achieving global objectives. It shows how policy making can take place within the economic context of globalisation and the political context of global governance (Massey, 2010). Supranational forces such as the WHO thus constitute a form of global health diplomacy, and function as an interface between health, foreign policy and trade (Pang et al., 2010; Payne, 2008), where health is considered as both a global public good (Lamy and Phua, 2012) and a necessary focus for international policy development (Brown and Moon, 2012).

4. Policy transfer in global healthcare and health policy, and in integrated care

As a concept, policy transfer has been particularly important for global healthcare and health policy. Its global occurrence has been evident in several healthcare areas, such as in tuberculosis control (Bissell et al., 2011; Colvin et al., 2015; Ogden et al., 2003), gender mainstreaming and healthcare (Kuhlmann and Annandale, 2012; Payne, 2014), malaria and HIV/AIDS treatment (Ngoasong, 2011; Parkhurst et al., 2015) and childhood illness management (Bennett et al., 2015). Increasingly, and given the globally shared experiences, such as the rapid ageing of the world’s population (WHO, 2014a), the growing global burden
of chronic diseases (WHO, 2014b), increasing global healthcare costs (Chan, 2010) and fragmented systems of care, countries have begun engaging in policy transfer in regard to integrated care as an approach to managing some of these issues as cost-effectively as possible (Fabbricotti, 2003; Viktoria Stein et al., 2013).

In integrated care development, the policy shift at the global level towards care integration is evident in the policy articulations and initiatives in many developed countries. A literature search made across countries that enacted policies to support the pursuit of integrated care development, showed that the UK, for example, has seen integrated care policy and practice being rolled-out over recent decades in all four of its constituents. In England, the enactment of The Health Act 1999, The Health and Social Care Act 2001, The Health and Social Care Act 2012, Care Act 2014, as well as the introduction of Sustainability and Transformation Plans is testaments to its ongoing determination to mainstream integrated care into its health and social care policy and practice (Hammond et al., 2017; Legislation.gov.uk, 2014).

Similar policy shifts have also been seen in Canada. For example, in 2001, the Romanow Commission recommended that the Canadian healthcare system evolve from a system in which a multitude of participants work in silos and focus primarily on managing illness, to one where they work collaboratively (Romanow, 2002). The Respecting and Health Services and Social Services Act 2003 in Quebec (2006) sought to establish an integrated health and social services organisation, to bring the entities closer to the general public, in order to facilitate the transition process through care pathways. However, there is also a need to take into account differences in jurisdictions and how they might differ in the development of integrated care. The Australian National Health and Hospitals Reform Committee also strongly recommended a focus on access and equity, vertical and horizontal service integration and the development of an agile and sustainable health system with a focus on primary healthcare (Connor et al., 2016).

In New Zealand, integrated care pilots have been implemented since the late 1990s in different service areas (Canterbury District Health Board, 2013). The more recent Integrated Family Health Centres 2010; Better, Sooner, More Convenient Healthcare in the Community 2011; and the Statement of Intent 2012/2013 to 2014/2015, and the Integrated Performance and Incentive Framework of 2014, reflect its government’s strategic goals and policy decisions towards healthcare reform that facilitates integrated care (Ashton, 2015; Letford and Ashton, 2010; Ministry of Health, 2011, 2012). Healthcare reform in the USA, through the implementation of the Patient Protection and Affordable Care Act 2010, for example, seeks to provide “a comprehensive, integrated health insurance reform programme for those who are eligible to enrol”; indeed, one of its key features is the aim to integrate primary health, behavioural health and related services (Kuramoto, 2014, p. 44). Similar shifts have also been seen in Sweden since the 1990s, where there have been efforts to integrate healthcare focused on the integration of intra-organisational processes (Ahgren and Axelsson, 2011; Anthony et al., 1989), and now on the development of chains of care in the health and social care settings (Ahgren, 2003; Ahgren and Axelsson, 2011). Policy shifts towards integrated care are also evident in other countries, such as Finland, Austria, Spain and the Netherlands (Mur-Veeman et al., 2008).

While the above evidences the presence of policy transfer across countries, it is less clear how the actual mechanisms and roles of policy transfer, and necessarily policy translation occur in the development of integrated care. For example, it is unclear how policy ideas on integrated care get transferred and thereby translated in the process. What is transferred, who does the transfer, where the idea is from, and what the facilitators and constraints in the transfer process are, are unknown. It is also less clear how varying understanding of integrated care, across space, time and contexts, and by the various stakeholders influence the translation of the policy. These considerations are important as they could determine
what gets transferred, by whom and who benefits and losses in the process. With more than
70 terms and phrases, and about 175 definitions and concepts in relation to integration, there
is also a need to be clearer in terms of the definition of integrated care by which the policy is
being transferred and translated in the process.

It would be crucial therefore to explore how varying understanding of integrated care
and differences in context can influence its development in a way that is coherent,
meaningful and important to a context, which can be defined by its culture, political
structure, economics and other technical factors. Understanding the role of contextual
influences and differences when comparing federal and provincial policies would be
crucial in the policy translation of integrated care.

The dearth of studies in this regard underscores the need for more case and comparative
case studies at national and jurisdictional levels. It would mean exploring what factors
influence the development of integrated care through the lenses of policy transfer and
translation, and can be used to explain the differing development of integrated care across
jurisdictions. This also points to the relevance of policy transfer and policy translation to
studying integrated care development.

5. Conclusion
As countries explore and learn from one another on integrated care approaches, it is essential
to be cognizant of the influences of policy transfer and the factors to be considered in the
policy transfer and policy translation process. Policy transfer and policy translation offer a
lens through which to explore integrated care development by identifying the multi-site and
multi-scalar networks at work, accounting for differences in contextual features and by
making explicit the complexity of various processes when policy ideas travel across space and
time, which are crucial to integrated care development. One of the main challenges in the
current literature is the lack of research studies exploring and articulating the actual
mechanisms or illustration of how transfer and translation have occurred globally. While this
paper highlights the presence of ongoing policy transfer in integrated care, as evinced by the
mushrooming of integrated care policies across jurisdictions, it underscores the need for more
research in this regard to explore the actual mechanism of policy transfer and translation of
integrated care. This paper offers policy transfer and policy translation as augmenting lenses,
and an alternative framework, to explore integrated care development.

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Creating a community driven bioethics network

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Abstract

Purpose – The South West Health Ethics Network (SWHEN) was created to bring together health care providers from a variety of health care settings across a geographical region. SWHEN’s mission was to connect health professionals who have an interest in ethical issues. SWHEN’s target participants are people with an interest in this field regardless of the individual’s capacity within an ethics profession. While other ethics networks exist, few of these expand beyond a narrow scope of ethics professionals (clinical ethicists). The preliminary vision in bringing together this group was to create a regional collaborative to educate, share lessons and begin to create a common approach to ethics issues in our region. Ethics networks increase collaboration and the exchange of resources, information and ideas among clinical ethicists. As a result, they address many of the ethical dilemmas faced in integrated care and facilitate the success of these systems in providing coordinated patient care. The paper aims to discuss these issues.

Design/methodology/approach – A Delphi consensus building approach was conducted to determine goals and priorities of the network.

Findings – Several priorities and counter priorities were discussed. In the end, the network was stifled by three major challenges: resource sharing, balance of network priorities and individual needs, and leadership.

Originality/value – While the journey to creating a sustainable network is long and complex, it is still worth the struggles. Network members remained connected through e-platforms, and the meetings have increased our region’s cohesiveness around ethics. We remain cautiously optimistic of SWHENs future and acknowledge that our initial plan may have shifted but our achievements are still meaningful and worthwhile.

Keywords Ethics, Integrated care, Network

Paper type Research paper

Background

The health care system has continuously faced added pressure due to increased demand for access to health care services and an aging population (World Health Organization, 2015; Varkey et al., 2006). These added pressures necessitate a holistic, patient-centered health care system, focused on people, not diseases, to empower patients to be their own advocate for themselves (Nurjono et al., 2018). In response to this need, integrated care has been proposed as a better approach to care, fostering a comprehensive, collaborative, person-centered health care system (Roberts et al., 2018).

Integrated care involves coordinating care for patients provided by multiple health care practitioners across the system and even into our sectors of care (e.g. social services). Practitioners involved in integrated care include various professionals including: doctors, nurses, social workers, psychologists and specialists (Reamer, 2018). This type of health care provides centralized access to preventative and curative services for patients at various levels and supports access to care suited to their needs (Mittinty et al., 2018). At the center of any integrated care discussion is the patient perspective and a consideration of context, unique to patient care, care providers and allied health professionals, policy maker, manager, regulator, evaluator and community perspectives also have a role to play in this holistic approach (Shaw et al., 2011).
Supporters of integrated care assert that it allows for continuity in care between providers and as a byproduct prevents patients from experiencing fragmented care and falling through gaps (Mittinty et al., 2018). Additionally, integrated care models address sociodemographic disparities, produce higher quality of life and improve health outcomes (Williamson et al., 2017). The benefits of integrated care have been shown to extend beyond the patient as well, improving the efficiency of the health care system (Shaw et al., 2011) and decreasing costs (Mittinty et al., 2018). While integrated care has the potential to improve patient care and overall health system well-being, there are a variety of ethical issues, though not unique to an integrated care approach, that require further consideration to fully understand their potential implications. These include informed consent, privacy and confidentiality, and professional boundaries (Reamer, 2018). These ethical issues can be difficult in a traditional care context; integrated care broadens the scope of providers, making challenging issues more complex.

Ethical issues in health care are prevalent and often increase in complexity and frequency when resources are constrained (Hofmann, 2011). While most health professional training programs offer training in ethics, once in the workplace these learned skills are often insufficient or difficult to apply. Typically, large multi-faceted hospitals employ one ethicist and smaller hospitals either share an ethics service or contract to private ethics professionals. Hospital ethicists face numerous challenges and maintain varying levels of responsibilities, while trying to ensure that patient and staff needs are met. To work well, ethics within organizations needs a cohort of interconnected professionals who work together to deal with the changing health care system and the challenges that accompany it. There is also a lack of guidelines regarding best practices for ethics, and a lack of peer support for ethicists to consult for second opinions and oversight (Macrae, 2005).

The South West Health Ethics Network (SWHEN) was created to meet the needs of health care facilities (e.g. hospitals and long-term care homes) aiming to meet new legislative and accreditation requirements which made stronger use of ethics (Government of Ontario, 2015). SWHEN also aimed to meet the needs of staff (care providers and administrators), who were struggling with everyday ethical issues with little to no organizational support. The network is inclusive to non-ethics professionals including academia, trainees and health care providers from a variety of settings with or without a formal role in ethics. The preliminary vision in bringing together this group was to create a regional collaborative to educate, share lessons and begin to create a common approach to ethics issues in a geographic region. While other ethics networks exist, few of them expand beyond a narrow scope of ethics professionals (clinical ethicists), and there were no support structures for ethics in our area.

In Ontario, Local Health Integration Networks (LHINs) are responsible for the planning, funding and integration of local health services (Ontario Ministry of Health and Long-Term Care, 2017). One of the main functions of a LHIN is to engage health professionals and their organizations to determine the health care priorities of the community and then to plan, integrate and fund the resources required to meet those needs. The mission of LHINs is to build a health system that demonstrates the values of equity, access and quality that consumers can rely on (South West Local Health Integration Network, n.d.). SWHEN, being a network of different health professionals, situated in the South West LHIN, is built on similar goals to collaborate around equity, access and quality using their professional perspective.

Education and sharing information is crucial to an effective network (Paina et al., 2013). Quality collaboration within a network can lead to many benefits for individuals, organizations and more broadly the health systems. Collaboration is a common means of developing educational material across multiple disciplines and often can support the needs of a dynamic and complex climate, such as that of health care (Alpay and Littleton, 2001). Interprofessional collaboration, when done effectively, can improve patient outcomes and result in better service delivery. Interprofessional education supports health care providers
who work on complex problems to effectively problem solving in critical situations. Interprofessional education is most successful when participants understand their own and others’ roles (Meads et al., 2008). Reviews have also found that interventions related to improving interprofessional collaboration had the potential to generally improve patient outcomes and also improve professional practice (Olson and Bialocerkowski, 2014). SWHEN aimed to provide both interprofessional collaboration and opportunities for interprofessional education.

Networks

Networks in health care are becoming increasingly popular as evidence grows to support the importance of collaboration in research and partnerships (Nieuwboer et al., 2017). Networks support collaboration and the exchange of resources, information and ideas. Knowledge can be spread more efficiently using an effective network structure. Research networks often make use of knowledge brokers, who are responsible for promoting learning and facilitation of information exchange (Wales and Boyle, 2015). Networks also allow information sharing which in turn can help support collaborative problem solving (Agreli et al., 2017).

Networks have the potential to improve health care delivery and coordination between practitioners. The impact of network is strengthened if they are situated within integrated care systems (Willis et al., 2015). Our study found that coordinating networks within primary care facilitated better meeting of patient needs and goals (such as reducing avoidable hospitalizations) (Popolin et al., 2016). By establishing a system of networks, such as LHINs and SWHEN, using a more integrated care system approach, our hope was to provide a foundation for a more coordinated approach across the system and higher quality of care as a result.

A survey to evaluate the structure and function of bioethics networks across the USA found that networks were organized either into stand-alone organizations or under existing organizational structures that support ethics education in the hospital (Fausett et al., 2016). These networks operate in defined regional, state or community areas to foster communication across multiple perspectives with an aim to solve complex health care issues. Many ethics initiatives are framed under a quality lens (Christopher, 2001). Ethics professionals can often bridge a gap in discussion and decision making from what ought to be done to what can (or arguably should) be done (Brummett and Ostertag, 2017). Ethics networks are often suited to take on quality development in institutional reform because of their role in understanding multiple dimensions of and perspectives on quality and health care. They can be well suited to support an integrated care approach, based on the similarities between the foundational tenets of each area.

Creating SWHEN

The SWHEN was created to bring together health care professionals who have an interest in and concern for ethics, but for whom ethics is not necessarily their domain of specialty. The principal goal of SWHEN was to create a regional collaborative that facilitates education and lesson sharing amongst its members in an integrated whole system approach. The mission of the network was to develop a common framework for navigating health-related ethics issues in southwestern Ontario (“Mission of SWHEN”). SWHEN’s vision has seven principles that guide network activities and decision making (“Vision of SWHEN”).

Mission of SWHEN:

To be a proactive agent of systemic change in enhancing the quality of care delivered by the full spectrum of health care providers in the South West LHIN – through a commitment to ethics and shared learning.
Vision of SWHEN:

1. develop a common framework for navigating health-related ethics issues in Southwestern Ontario;
2. enhance collaboration and partnerships through a “functioning collaborative” between and across sectors in our health system;
3. facilitate resource sharing by strengthening communication networks amongst providers through meetings and the HealthChat website;
4. educate health professionals through a collaborative network of lesson sharing;
5. develop a knowledge base through traditional academic approaches (journals, conferences) and through user-driven methods (Listservs, town hall and policy briefs);
6. identify thematic issues by applying critical thinking to real-life case studies and developing solutions going forward; and
7. increase awareness about research opportunities put forth by and for SWHEN members.

On December 11, 2014, SWHEN held its inaugural meeting with 23 participants representing 13 local health care organizations. The high level of interest shown was interpreted as an indication of the strong interest in and need for a network like SWHEN. At the first meeting, the network discussed precipitating events, a draft terms of reference, the network’s integrated research component and resource sharing. From this meeting, a steering committee (SC) was formed (n = 5). SC members worked to plan SWHEN events, finalize a terms of reference and plan the direction of the network. Since the inaugural meeting, three network meetings have occurred (June 2015, November 2015 and April 2016). Each meeting follows the same general pattern: sharing of priority issues to inform the network work plan, discussion around the research component and education/case discussion. Themes of meetings have included: physician assisted death, falls and violence in long-term care and quality improvement approaches to prevent ethical errors in transfers between care settings. Each meeting theme was chosen based on member interest and perceived need, informed by a Delphi process to set SWHEN priorities and direction. At the end of each meeting, we collected feedback on the meeting content and its usefulness.

Determining priorities: methods

SWHEN was also created with a goal to meet the needs of the broader community. To assess this, a thorough evaluation plan was developed. The evaluation plan had two objectives: to examine the effectiveness of the network to meet community needs and to implement feedback and adapt the structure to ensure a strong and useful network. Changes were made to the original evaluation protocol based on feedback and discussion from the first SWHEN meeting and SC meeting. The evaluation plan was modified to focus on the second objective and to gather feedback around members’ perceived needs. A Delphi process was initiated, as a way to establish a consensus on the directions and priorities of SWHEN.

Delphi is a qualitative tool used to develop consensus and assess agreement on a specific issue or topic (Hsu and Sanford, 2007). In a Delphi process, questionnaire results are assessed and amalgamated through an iterative process. This method facilitates communication between individuals to create a group solution in the face of complex, multi-faceted problems (Adler and Ziglio, 1996).

Approval for the Delphi project was granted by the Western University Research Ethics Board (Protocol No. 106406). In total, three rounds of Delphi were conducted. The Delphi contained items which inquired about respondents’ professional roles and the nature of their organizations (Part 1), the relevance and meaning of certain work/priorities for SWHEN (Part 2),
and respondents’ ideas about future directions and priorities for SWHEN (Part 3). Round 1 of the Delphi was administered at the second SWHEN meeting (June 2015). It was completed by participants at the end of the in-person meeting. Those who were unable to attend the meeting in person could complete an electronic version. Information from Round 1 Delphi was incorporated into the survey for Round 2. The same was done between Rounds 2 and 3. Round 2 happened in November 2015. Round 3 occurred in April 2016.

Results
In total, 16 people completed Round 1 of Delphi. In all, 17 participants completed Round 2, and 22 participants completed Round 3. As expected, the majority of participants (80 percent) in each round worked in hospitals and long-term care with the remaining coming from public health, academia and primary care. Over half of participants (86 percent) said their organization had a formal ethics committee in place. Most said they had access to a clinical ethicist. Participants were asked to rate their workplace in terms of ethical infrastructure/systems and practice. In all, 42 percent stated that their workplace was “probably just achieving accreditation standards,” while 5 percent believed they were exceeding accreditation standards.

Network priorities
Education was the number one priority for all participants. Participants were interested in learning different ways of working through problems, and in sharing educational resources amongst the network. Case studies were felt to be essential to improving education. Analysis of open-ended responses revealed that case studies are vital to aid in ethical discussion and to help identify the ethical issues.

Support with consultation was ranked second most important, followed by collaboration and networking. The participants felt that coming together and bringing their own area of expertise would improve sharing. E-mail was chosen to be the most useful mode of communication for future planning of meetings.

Counter priorities and future directions
In Part 3 of the Delphi, participants were asked if there were any areas seen as counter priorities and if there are future areas of research that they foresee becoming important priorities. The major counter priority identified was identifying the network as a consultation service. This may have been a result of our initial discussions around the goals of SWHEN, and ensuring participants knew consultation service was not a part of the network.

There were also concerns around challenges to information sharing. While sharing resources was seen as a top priority, participants were acutely aware of the challenges associated with sharing organization policies and other documents, such as privacy. Another counter priority was SWHEN focusing on a single sector (i.e. hospital) focus. Participants strongly believed discussions should be integrated and cross sector and should focus on how challenges in one area of health care can impact other areas.

The major future area of research that was seen as a priority was medical assistance in dying. Changing laws for euthanasia is something that nearly all participants deemed important to discuss and report on. Some other responses included issues around capacity in decision making, responsive behaviors and proactive patient/family involvement in ethical decision making.

As a new and evolving network, participants were pleased to have SWHEN as a forum to meet and share as well as the enthusiasm about the network. There was unanimous agreement that the membership of the network should be broad and inclusive of multiple
settings and sectors. Ensuring SWHEN was accessible to the entire region was important to all participants, which meant thinking about having meetings accessible via web technology or moving location of the meeting around our region.

Meeting effectiveness
In order to gain an understanding of the participant’s impression of the information provided and topics discussed, surveys were completed at the end of SWHEN meetings in November 2015 and April 2016. The survey asked about content and structure as well as usefulness of content. In both meetings, the majority of the participants strongly agreed or agreed (88 percent in November and 96 percent in April) that the content of the session was useful and relevant. The majority of participants strongly agreed or agreed (88 percent in November and 100 percent in April) that the session increased their awareness of a perspective outside their own roles. Additionally, the majority strongly agreed or agreed (88 percent in November and 82 percent in April) that they would use the skills and knowledge learned in the meetings in their workplace.

Discussion
Joint education of concerned professionals, collective decision making and developing trust are all essential to deriving benefits of collaboration for health care providers (San Martín-Rodríguez et al., 2005). The goal of SWHEN is to not only realize the benefits of a collaborative and integrative sharing space for health care professionals, but also to benefit patients by actively developing regional strategies to decrease preventable adverse events. Across the region (i.e. the LHIN) there is an appetite for a more integrative approach to care and broad support of integrative approaches.

The enthusiasm and perceived need for a network like SWHEN was apparent from our first meeting. The conversation that occurred during the meeting, supporting the formation of SWHEN, echoed what has been said in literature regarding issues within integrated care system as a result of the lack of an ethics network. Further exploration (i.e. the Delphi) supported this need, and encouraged network planners (i.e. SC) to continue with efforts.

Despite initial success and interest in SWHEN, there have been several challenges in building the network. These include: resource sharing, balance of network priorities and individual needs, and leadership. These challenges are not necessarily unique to our network; others have reported similar challenges (Van der Veken et al., 2017).

Resource sharing
A key aspect of integrated care’s potential to deliver specialized and superior care is providing continuity in care between the various providers combined with shared resources to accomplish this (Williamson et al., 2017). A SWHEN website was created, supported on the healthchat.ca platform. Healthchat is “an online community for health care professionals to communicate and collaborate” (HealthChat, n.d.). On this platform SWHEN members could upload and share relevant documents as well as be notified of upcoming meetings and resources. Healthchat provides the tools to increase collaboration through an accessible and cost-free format, decreasing potential barriers to access. Resource sharing is a method that can improve communication among providers and allow for improved integrated care. Resource sharing only works when the sharing is done by the entire group. Our Delphi showed some members were concerned with sharing resources outside their own organization due to organizational procedures and confidentiality. Even though Healthchat is a closed group (i.e. not open to the public), it has been difficult to get members actively using the platform. Financial resources were also a barrier to network sustainability. Without an integrative structure, a backbone on which
to build SWHEN was missing. SWHEN by design did not fit into existing funding structures of the organizations involved, which made accessing resources difficult.

**Balance of network priorities and individual needs**

Educational meetings can improve professional practice and health outcomes for patients (Forsetlund et al., 2009). Integrated care literature has demonstrated that peer-to-peer education of health care practitioners can improve critical thinking and problem solving, and facilitate improved patient care (Meads et al., 2008). SWHEN meetings utilized interactive peer-to-peer methods to engage participants and included real-life cases to apply critical thinking through active learning and learner engagement. Cases were brought to meetings by network members. Needs shift and it is difficult to set educational objectives for such a diverse membership. Whereas some members come with clinical ethical experience, others lack a basic understanding of key ethics concepts and theories. To address this challenge, we tried to start meetings with a “lay of the land” on various ethical discussions. It became clear during meetings that the diversity in knowledge level was a barrier to some discussions. It is important for network members to have an opportunity to learn from one another as well as work to shift the broader conversation to support system integration for ethics within the region.

**Leadership**

Active and supportive leadership and the importance of a champion to set the stage for effective networks are well known (Shediac-Rizkallah and Bone, 1998). An effective network champion can increase the number of advocates promoting an idea and can increase the speed and extensiveness of learning (Nevis et al., 2000). Although the majority of members expressed enthusiasm toward participating in the network, the extent to which members were willing to involve themselves was unclear. While a SC was assembled to help guide the goals and objectives of the network, sustainability of the SC was a challenge. The SC was ultimately accountable to the network by reporting, confirming and establishing research priorities; however, the original intent was for the network to be active in planning and identifying activities and not rely solely on the work of the SC. After two years, this was not happening. The majority of the work fell to a small number of members; this was neither effective nor sustainable and was counter to the vision of a self-sustaining network. This lack of member participation in planning was further challenged by the lack of dedicated resources. Meeting space was often easy to access, but added benefits (such as refreshments or parking) were not always available. Further, given the size of our region, holding meetings centrally excluded interested participants who lived/worked far way.

**Sustainability**

Despite a plan for shared accountability among SC members, meetings were often planned by the same one or two members. This left the network with insufficient momentum to continue planning events. Ultimately, contributing members were volunteering their time for the benefit of the community; in the context of dwindling resources and near constant change at regional and governmental levels, the funding, time and energy of the network depleted. The initial plan and strategy for expanding the network (e.g. online forum) were insufficiently embedded to survive without structured in-person meetings.

Meeting locations were problematic in two ways. First, the geographic region for the network is very large, limiting access for some interested parties to a multi-hour drive, or teleconferenced participation. Despite attempts to increase access (e.g. allowing attendance
via teleconference (Ontario Telemedicine Network), interaction proved to be very challenging and often did not meet the needs of online participants. Second, the cost associated with attending a meeting at a central/larger institution (e.g. refreshments and parking) added a cost to participation that was difficult to sustain.

While there were network members who could have taken over responsibility for SC activities, most willing participants lacked content expertise and were reluctant to take on a leadership role. There were only two identified ethicists participating in the network, making content expertise difficult to sustain.

SWHEN today exists as an informal contact list, an electronic group that occasionally serves to answer questions members might have, similar to a List-Serv. A new Provincial Government and potential regionalization priorities outside of ethics are likely to be the driving force behind future re-establishment of a regional ethics network. Until there is a mandate within one or more of the individual organizations to maintain such a network, it is unlikely that SWHEN will be re-established in a form similar to what had previously been attempted.

Future directions
The demand for this type of ethics network continues to grow, yet support from administration and supporting agencies is limited. It is difficult to keep the network afloat without dedicated support. The stage is set for change considering potential implications from Ontario’s new Patient’s First legislation (Legislative Assembly of Ontario, 2016), and there is an opportunity for leadership in community-driven regional ethics programs such as this one.

The formation of SWHEN has demonstrated not only a need but also a demand by practitioners for improved integrated approaches to complex care system needs. This study identified various challenges that should be considered as systems work to integrate. The challenges and successes of SWHEN can inform future similar networks and contribute to improvements in integrated care.

Following a recent change in Provincial Government, and leadership changes in regional institutions, there is an opportunity for the re-establishment of SWHEN under the auspices of broader regionalization of health care strategies. In order to re-establish a network similar to SWHEN in our region (or arguably in any region), three facilitators are needed. First, formal accountability for management of an ethics network is required. Second, a co-created regional ethics vision, aligned with new regional and provincial mandates, is necessary. Third, dedicated funding to support network function would be an asset.

Conclusion
In essence, SWHEN is a collaborative and integrated effort, created for health care professionals who are not necessarily ethics specialists, but share a common interest in ethics. The network’s mission to provide a united collaborative that supports learning and sharing of ideas among interested individuals remains important and relevant. SWHEN’s goals align with those of integrated care systems and networks; to improve access, quality and continuity of services by linking health and social services and decreasing fragmentation (Valentijn et al., 2013). Network meetings met participant expectations to educate and to work toward a common framework for navigating health-related ethics issues in our region. The goal of the Delphi process was to reach consensus on both the education and research goals of SWHEN. Results support the need for continual growth of the network; however, barriers around resource sharing, balancing priorities and leadership have made network sustainability a challenge. After three years, SWHEN exists as an informed network, but remains hopeful of a role to support health care providers in the region; SWHEN was created with a collaborative mindset. Through SWHEN’s efforts,
members became united in a goal toward sustainable and integrated ethics services (Valentijn et al., 2015).

While our journey to creating a sustainable network was long and complex, we believe it was worth the challenge, and that evaluation of networks such as these should be done and shared (Willis et al., 2012). Comprehensive and coordinated services for patients and integration need to occur via networks across the system and between various the health and social systems (Valentijn et al., 2013). Network members remain connected through e-platforms; the meetings increased our region’s awareness and cohesiveness around ethics.

We remain cautiously optimistic of SWHEN’s future and acknowledge that our initial plan may have shifted but our achievements are still meaningful and worthwhile.

References
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Impact of continuity of care on quality of life in patients with chronic obstructive pulmonary disease
A quasi-experimental study

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Abstract

Purpose – Patients with chronic obstructive pulmonary disease (COPD) suffer many physical disabilities which cause many problems in their life. These patients really need to have continuity of care based on cooperation between patient, the family and their care givers in order to achieve an integration of care. The purpose of this paper is to assess the impact of continuous care on quality of life of patients with COPD.

Design/methodology/approach – A before-after quasi-experimental study was carried out with 72 patients with COPD at Beheshti educational hospital of Hamadan University of Medical Sciences. The patients who met inclusion criteria were randomly allocated into an intervention group (n = 36) and a control group (n = 36). The patients completed the St George's Respiratory Questionnaire before and after their care. The intervention comprised continuous care with orientation and sensitization sessions (2 weeks), control and evaluation sessions (45 days) for intervention group and with routine care in the control group. Data were analyzed with SPSS, descriptive and inferential statistics were conducted to measure differences between intervention and control group.

Findings – Continuity of care improved significantly the quality of life of COPD patients in general, and in the symptoms, activity and impact domains (P = 0.001). In contrast, routine care did not improve quality of life for patients in general, and in the symptoms, activity and impact domains (P = 0.05).

Originality/value – Continuity of care has a positive impact on quality of life for COPD patients. Health care system should utilize continuity of care models as an overall plan for patients with COPD. Moreover, managers of health care system could reduce burden of chronic diseases by employing continuity of care models in planning patient care.

Keywords Integrated care, Quality of life, Continuity of care, Chronic obstructive pulmonary disease

Paper type Research paper

Introduction

Chronic obstructive pulmonary disease (COPD) or emphysema is associated with air retardation and bronchitis along with inflammatory process of lung tissue and an irreversible obstruction of the airways and alveoli (Coventry and Hind, 2007; Baraniak and Sheffield, 2011). The prevalence
of this disease in adults over 40 years old is reported to be around 10 percent worldwide (Pommer et al., 2012; Gardiner et al., 2010) and is currently the fourth leading cause of death in the world and according to the predictions by 2030 will be the third leading cause of death in the world (Smith et al., 2014). In the last available statistics for Iran, in 2000 the number of people with COPD in the age group of 15–49 years per 100,000 people was 105 and in the age group of 50 years and older, it has been reported 1,057 per 100,000 people (Zakerimoghadam et al., 2011).

COPD is associated with chronic cough symptoms, increased sputum and shortness of breath which are often associated with disturbances such as heart failure, osteoporosis, muscle weakness, cognitive impairment, fatigue and severe depression (Tselebis et al., 2011; Efraimsson et al., 2009). Several factors such as genetic background, long-term exposure to smoke, the amount of tobacco consumption, air pollution and upper respiratory tract infections are involved in the development of this chronic and progressive disease (Bhavani et al., 2015). The goal of treatment in chronic pulmonary obstruction is symptom relief, increased function and improved quality of life for patients (Vögele and Von Leupoldt, 2008; Hananiaa et al., 2005). The negative effects of disabling symptoms, limitations and decreased functional abilities in various aspects of their lives (Yawn and Wollan, 2008) have a significant impact on their quality of life (Hynninen et al., 2005).

In 1920, Pigou introduced the term “quality of life” and discussed the necessity of governments to support patients of low socio-economic standing and conceptualized any lack of support as an issue of national capital (Uebele and Myers, 2008). Quality of life has been expressed in different ways, such as feeling good, having a satisfactory health status, and having hope. From the point of view of the World Health Organization, quality of life is defined as the individual’s thoughts about his or her living conditions according to the culture and value system of his environment and the relation of this perception with their goals, expectations, standards and priorities in the life (Fairclough, 2010). Chronic patients, and especially COPD patients, place a high burden on any community and health care system (Borzou et al., 2014). In many studies, poor quality of life in patients with COPD has been reported with increased dyspnea, physical impairment, anxiety and depression, recurrent episodes of recurrence, and affects a poor prognosis for hospital admission and death (Ahmed et al., 2016; Bikmoradi et al., 2014; Bikmoradi et al., 2017).

Fragmented delivery of care is a significant problem for health care systems given demands for efficiency, patients’ satisfaction, quality of care and accessibility (Gröne and Garcia-Barbero, 2002). Integrated care appears to be essential for health care systems and may assist in overcoming professional fragmentation within and between care providers, patients and social care (Gröne and Garcia-Barbero, 2002; Kodner and Spreeuwenberg, 2002). Gröne and Garcia-Barbero (2002) defined integrated care as “a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion”. It could be an erroneous belief if care providers try to establish continuity care hoping it leads to improvement of quality of care and patients’ satisfaction (Tang et al., 2015) considering its complexities (Kaehne, 2016, 2017) and considerable requirements (Gulliford et al., 2006). Continuity of care relates conceptually to patient satisfaction with both the interpersonal aspects of care and the coordination of their care which may come together to enhance the patient centeredness of care (Gulliford et al., 2006).

Continuity of care as a model of care in chronic coronary conditions and its effect on quality of life was investigated in Iran (Khodaveisi et al., 2017). The model operates on four levels: acquaintance, sensitization, control and evaluation of patient’s perceptions as an important factor in the health process, requiring effective communication and interaction with the nurse and health professionals (Hashemi et al., 2015). Nurses act as key connecting links between hospital care and therapeutic services by identifying patients’ needs and problems. They sensitize the patients for an acceptance of routine behaviors related to health, treatment and care. Moreover, they try to maintain, improve and promote the patients’ health (Khodaveisi et al., 2012).
The effect of this continuity of care model on chronic heart, renal, psychological and endocrine diseases has been studied in many studies in Iran and elsewhere (Khodaveisi et al., 2012; SadeghiSherme et al., 2009; Baker et al., 2007). However, the effect of the continuity of care model on quality of life in COPD in Iran has not been studied sufficiently (Paap et al., 2016). Therefore, the aim of this study was to determine the effect of continuity of care on the quality of life of patients with COPD.

Method
A quasi-experimental study was conducted with measurements taken before and after from 72 patients with COPD at an intervention and a control group at Behesht educational hospital of Hamadan University of Medical Sciences at 2015. Based on the study of SadeghiSherme et al. (2009) counting $\alpha$ of 0.05 and $\beta$ of 90 percent, the required sample size was estimated to be 34 in each group. Anticipating 15 percent attrition, the required number of patients in each group was set at 40.

The data collection tool comprised two sections including a demographic profile and the St George’s Respiratory Questionnaire for COPD (SGRQ-C) patients, a 40-item version (Paap et al., 2016). Demographic characteristics included age, sex, marital status, occupation, income, education level, history of disease and duration of disease onset. The SGRQ-C assesses three domains: symptoms, activity and impact. The symptoms domain consists of 8 questions (frequency of respiratory symptoms and perception of the patient from respiratory problems), the activity domain contains 5 questions (daily physical activity disorders) and the impact domain has 27 questions (the range of psychosocial disorders associated with disease). The score of each domain is defined by the sum of the scores in that domain and the total score of the questionnaire is defined so that "0" indicates complete health and any increase in its score indicate a lower quality of life.

The standard SGRQ-C was evaluated in terms of reliability in studies conducted in other countries. The Cronbach’s $\alpha$ coefficient for this questionnaire was 72, 89 and 89 percent, and the total quality of life mean score was 94 percent (Paap et al., 2016). In an Iranian study, this standardization tool and Cronbach’s $\alpha$ were calculated for the domains of symptoms (78 percent), activity (93 percent), effect (93 percent) and total quality of life (93 percent) (FallahTafti et al., 2009).

Patients with obstructive pulmonary disease were identified and after obtaining written informed consent, 80 patients were selected through an access sampling method based on inclusion criteria. Following the application of inclusion criteria, eligible patients were assigned to one of the intervention and control group randomly. Inclusion criteria included having a diagnosis of chronic or chronic pulmonary obstructive disease by a specialist physician, a minimum of physical and sufficient cognitive ability in order to meet participation requirements such as taking part in educational sessions and completing a questionnaire. They also had to live in Hamadan City to facilitate study participation. Exclusion criteria were the occurrence of any new disease and admission to hospital and the impossibility of continuing to participate in the study for any other reason (Figure 1).

Before performing follow-up care for included patients, SGRQ-C quality of life questionnaire was completed by patients in both intervention and control groups. Since most of the patients were illiterate, the questionnaires were completed by the researchers’ assistants. Then, included patients in the follow-up care group received an educational package. The educational package (including educational pamphlets, dietary pamphlets and pharmacological care items) contained explanations about the nature of emphysema and bronchitis, their symptoms, the complications of the disease, the importance of preventing and controlling them, the importance of considering diet and medication and their related limitations and necessity of designing a physical activity plan, as well as the
importance of controlling stress and how to use coping strategies to address emotional stress. The importance of using respiratory exercises, the proper use of respiratory care, the importance of regular visits of the physician, adherence to medication orders, the need to attend to health and the abandonment of habits that are detrimental to health were also mentioned. In addition, the importance of behaviors that led to continuity of care, health and control of complications of the disease were outlined in the package.

Follow-up care was performed on the intervention group for two months whilst the control group received routine care. In the intervention group, patients and their families were invited by telephone for orientation in a classroom in the Lung Department of Beheshti Educational Hospital and informed about the implementation of the continuity of care model. The intervention was conducted based on the follow-up care model of four stages of awareness, sensitization, control and evaluation. In the briefing phase, sessions of 30–15 min in the presence of the patient and at least one family member were described and continued to be monitored. The expectations of patients and family members were documented. During these sessions, the need to maintain a close relationship with the researcher was emphasized. In the sensitization stage, the patients in the intervention group were divided into five groups of eight, and for each group, four sessions were held (session time was approximately 1 h and, if needed, individual training was provided).

At the first session, the educational package was presented to the patients or one of the family members and also delivered as a booklet and an educational CD. During the second to fourth sessions in each group, the researcher outlined the training topics presented in the package and the patients explained their experiences and questions on the topics. Patients were referred to a lung specialist if the patient’s problems were beyond the scope and expertise of the researcher.

In the control phase, follow-up care was conducted through following up and counseling in accordance with patient’s care needs and continued for one and a half months using telephone, face-to-face or SMS services. At this stage, the aim was to examine progress of
Results

After attrition, 36 in each group completed the study and all data were included in the final analysis (Figure 1). Most of the patients (51.4 percent) were males, married (83.3 percent), illiterate (48.6 percent), had a fixed income (58.3 percent) and had a history of the disease between one and five years (47.2 percent). Most of the women (48.6 percent) were housewives. The mean age of the subjects in the intervention group was 63.47 ± 12.57 and in the control group was 64.42 ± 16.41 (Table I).

In the intervention group, the quality of life mean score was 81.15 ± 16.36 in the domain of symptoms which decreased to 62.38 ± 14.17 after the intervention. Statistical test showed that there was a significant increase of patients’ quality of life before and after the intervention because a decreasing of mean score indicates higher quality of life (p = 0.001). In contrast, in the control group, the quality of life mean score was 77.04 ± 23.51 in the domain of symptoms which increased to 87.30 ± 9.20 after the intervention period. Statistical test showed a significant reduction of patients’ quality of life between before and after measures (p = 0.004).

In the intervention group, the quality of life mean score was 78.38 ± 10.81 in the domain of activity which decreased to 50.03 ± 7.32 after the intervention. Statistical test showed a significant increase in patients’ quality of life after the intervention in the domain of activity (p = 0.001). In contrast, in the control group, the quality of life mean score was 77.38 ± 15.22 in the domain of activity which means it decreased to 74.40 ± 10.76 after the intervention. Statistical test did not showed a significant increase in patients’ quality of life whilst there was no statistically significant change in patients’ quality of life in the domain of activity after the intervention (p = 0.365).

In the intervention group, the quality of life mean score was 72.25 ± 14.43 in the domain of impact decreased to 38.48 ± 14.37 after intervention. The statistical test showed a significant increase in patients’ quality of life in the domain of impact following the intervention (p = 0.001). In contrast, in the control group, the quality of life mean score was 67.05 ± 19.03 in the domain of impact which increased to 70.25 ± 10.24 after the intervention. Statistical test did not showed any significant difference between patients’ quality of life, while there was only a slight decrease in patients’ quality of life in the domain of impact between before and after the intervention indicating that there was a reduced quality of life for patients which was not statistically significant (p = 0.293).

As for the total quality of life score, for the intervention group, the quality of life mean score was 75.10 ± 11.59 which decreased to 45.69 ± 10.53 after intervention. Statistical test showed that there was a statistically significant increase of patients' quality of life between before and after the intervention (P = 0.001). In contrast, in the control group, the total quality of life mean score was 71.97 ± 16.35 which increased to 74.93 ± 7.38 after intervention. Statistical tests did not showed a significant difference between patients’ quality of life in total before and after the intervention (P = 0.256) (Table II).

Discussion

Our results show that continuity of care and care management with the support of a care team provides a better result than the current systems employed by educational and therapeutic centers and potentially could reduce costs of follow-up care (Khatiban et al., 2015;
A consistent follow-up process is likely to be effective in the rehabilitation of COPD patients (Griffiths et al., 2000). Based on the findings of the present study, the change of quality of life mean score in patients with COPD in the intervention group before and after the intervention was statistically significant (Jones et al., 2011). The quality of life means score of patients in the intervention group before the intervention was 75.10 ± 11.59 which reduced to 45.69 ± 10.53 after the intervention (Bourbeau et al., 2003). The present study is therefore consistent with the quality of life scores obtained in other studies (Jones et al., 2011; Heidarzadeh et al., 2010).

In a study on health care self-management education for 85 patients with COPD in Canada and in Quebec, there was no significant difference in the quality of life scores, although life expectancy was slightly improved from 55.7 ± 15.7 to 54.1 ± 16.6.
(Bourbeau et al., 2003). Also, in a study in 2010 in European Health Care Centers with 1,817 patients, their quality of life was 44.7 ± 19.4, indicating the norm of quality of life mean score for COPD in these centers (Jones et al., 2011) which is similar to the present study. Although the quality of life of COPD patients in Iran is much lower, it is reasonable to argue that it may be improved through a continuity of care model. Thus, local health care systems should modify their care plans for chronic patients, and develop new systems for follow-up care models in practice based on continuity of care (Table III).

According to the findings of this study, the quality of life mean score of patients with COPD was significantly different in the symptom domain in the intervention group before and after the intervention. In other studies, the normal level of quality of life was between 39.2 and 50.1 (Jones et al., 2011). In the present study, the quality of life mean scores of patients was 81.15 ± 16.36 before the study, and 62.38 ± 14.17 in the intervention group in line with a normal range of quality of life after intervention.

<table>
<thead>
<tr>
<th>Interventions group (n = 36)</th>
<th>Control group (n = 36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of life/its domains</td>
<td>Before</td>
</tr>
<tr>
<td>Sign domain</td>
<td>81.15 ± 16.36</td>
</tr>
<tr>
<td>Activity domain</td>
<td>78.38 ± 10.81</td>
</tr>
<tr>
<td>Effect domain</td>
<td>72.25 ± 14.43</td>
</tr>
<tr>
<td>Quality of life</td>
<td>75.10 ± 11.59</td>
</tr>
</tbody>
</table>

Table II. Comparison of quality of life and its domains mean scores in patients with chronic obstructive pulmonary disease before and after continuous care and routine care in intervention and control groups.

<table>
<thead>
<tr>
<th>Quality of life/its domains</th>
<th>Intervention group (n = 36)</th>
<th>Control group (n = 36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>After</td>
<td>Before</td>
<td>Statistical results</td>
</tr>
<tr>
<td>Sign domain</td>
<td>62.38 ± 14.17</td>
<td>87.30 ± 9.20</td>
</tr>
<tr>
<td>Activity domain</td>
<td>50.03 ± 7.32</td>
<td>74.40 ± 10.76</td>
</tr>
<tr>
<td>Effect domain</td>
<td>38.48 ± 14.37</td>
<td>70.25 ± 10.24</td>
</tr>
<tr>
<td>Quality of life</td>
<td>45.69 ± 10.53</td>
<td>74.93 ± 7.38</td>
</tr>
</tbody>
</table>
In other studies, the quality of life mean score of patients with COPD was significantly different in the domain of activity in the intervention group before and after the intervention, with the normal level of quality of life at around 39.2–50.1 (Jones et al., 2011). In the present study, the quality of life mean score of patients in the field of activity before study was 78.38 ± 10.8, which after the intervention reached 50.03 ± 7.32 indicating a normal range of quality of life. In this study, patients had relatively high scores in the domain of activity in the quality of life, which indicated a lower than normal quality of life judged by the standards in another study which the quality of life mean scores in the activity domain was reported as 41.47 ± 11.78 (Ahmed et al., 2016). However, the results of this study were consistent with the results of other studies in this domain (Weldam et al., 2014). Physical weakness and feelings of disability are often due to disabling coughs as reflected in studies that have shown a lack of quality of life scores (Paap et al., 2014).

We found that the mean scores of quality of life in patients with COPD in the field of effect in the intervention group before and after the intervention were statistically significant and aligns with other studies (Jones et al., 2011). In this study, the quality of life mean score of patients in the impact domain before the study was 72.25 ± 14.43, which reached 38.48 ± 14.37 after the intervention and demonstrated a normal range of quality of life. The results of this study were consistent with the results of similar studies, in which quality of life is clearly impacted by the disease (Cvaleiro-Saraiva, 2015). We would argue that patient outcome evaluations should not be based solely on pulmonary function tests, but should include measuring quality of life because most aspects of daily life are affected by the severity of the disease and by the presence of social, economic or occupational factors.

Our study showed that follow-up care may have a significant impact on the quality of care and can make the management of the disease more efficient by simplifying a complex process (Bikmoradi et al., 2016). Psychological assessment and psychiatric counseling are very important in improving symptoms, the quality of life, and initiating early diagnosis and treatment of symptoms. It can also contribute to better understanding and improved communication of problems preventing a worsening of the condition and impact on quality of life (Khatiban et al., 2015). The study has certain limitation. Our study has had a small sample size (72) and a relatively short (two months) period of intervention and follows up. This may impact on the generalizability of its findings and its replicability in other contexts.

Conclusion
Continuity of care has a positive impact on improving the quality of life of patients with COPD. Care should not be limited to the hospital environment. Continuity of care takes place at home with the help of the patient and their family. Also, the design and implementation of continuity of care delivery systems and nursing education systems are essential for establishing effective follow-up care. Follow-up care in the health care system can be very effective in the care and treatment of patients with COPD if implemented correctly.

Acknowledgments
Compliance with ethical standards: author AB declares that he has no conflict of interest. Author AJ declares that she has no conflict of interest. Author MS declares that he has no conflict of interest. Author MA declares that he has no conflict of interest. Author FD declares that he has no conflict of interest. Author GR declares that he has no conflict of interest. This study was funded by Hamadan University of Medical Sciences (Grant and Ethical Approval No. P/16351/240). All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Informed consent was obtained from all individual participants included in the study.
The authors would like to thank the vice-chancellor of education and the vice-chancellor of research and technology at the Hamadan University of Medical Sciences, who approved and founded this study. The authors would also like to thank all the staffs of the lung department of Beheshti Educational Hospital of Hamadan city who helped in conducting this study. This paper was a part of master's thesis in medical surgical nursing, approved by Research and Ethical Committee of Hamadan University of Medical Sciences with "P/16/35/1/240 dated 30.06.2015."

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Further reading


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Reducing emergency department visits among older adults
A demonstration project evaluation of a low-intensity integrated care model

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Abstract
Purpose – There is mixed evidence regarding the efficacy of low-intensity integrated care interventions in reducing the use of emergency services and costs of care. The purpose of this paper is to examine the effects of a low-intensity intervention formulated for older adults and delivered in an urban medical center serving low-income individuals.
Design/methodology/approach – The intervention included an initial evaluation of stress, psychiatric symptomatology and health habits; potential referrals for lifestyle management and psychiatric treatment; and training for physicians about the impact of lifestyle change in older adults. Participants included older adults (at or above 50 years of age) seen as outpatients in an urban medical center serving a low-income community (n = 945). Participants were entered into the intervention at any point during this two-year period. Mixed models analyses examined all visits for all enrolled individuals over a two-year period, comparing visits before the individual received the initial intervention evaluation to those received after this evaluation. Outcomes included total health care costs incurred, average cost per visit, and emergency department (ED) usage within the facility.
Findings – The intervention was associated with reduced likelihood of emergency department use and reduced costs per visit following the intervention. These effects were seen across all participants.
Research limitations/implications – Limitations of the study include the lack of control group.
Practical implications – This program is easy to disseminate and could improve the quality of care and costs.
Originality/value – This study is among the few available to document a decrease in medical costs, as well as decreased ED utilization following a low-intensity integrated care intervention.
Keywords Health and Well-being, Integrated care, Medical costs, Emergency department, Low-intensity intervention
Paper type Research paper
Introduction

Emergency department (ED) visits in the elderly are common. In 2010, 51 percent of all hospital visits by patients aged 65 or older in the USA were to the ED (Albert et al., 2013). Persons 65 or older account for up to a quarter of all ED visits (Samaras et al., 2010). ED visits and medical costs overall are also more common for those with undermanaged chronic medical conditions, including hypertension and diabetes (Lehnert et al., 2011). These conditions and their combination are highly prevalent among older adults (Ward, 2013). ED use and greater medical costs overall are also more common for those with co-morbid mental disorders, including depression, a condition common among older adults (Egede, 2007; Volkert et al., 2013). Better management of the medical and mental health needs of older individuals is a pressing public health problem given the rapid expansion of the aging population (DeNavas-Walt et al., 2013).

Integrated care has been proposed as a solution for addressing the medical costs attributed to undermanaged or preventable health conditions (Ouwens et al., 2005; Gröne and Garcia-Barbero, 2001). A position paper from the World Health Organization suggested the following definition of integrated care, “bringing together of inputs, delivery, management and organization of services as a means of improving access, quality of care, user satisfaction and efficiency” (Gröne and Garcia-Barbero, 2001). Although no definitive definition of integrated care exists, common components of integrated geriatric care include multidisciplinary care teams, targeted assessment, patient education, case management, and specialized education for the health providers (Ouwens et al., 2005).

Several authors have proposed different conceptual frameworks to describe the structure of integrated care (Leutz, 1999; Poitras et al., 2018). Many of these frameworks center around ideas well summarized by Ploch and Klazinga (2002) and others (Valentijn et al., 2013; Kodner, 2009) suggesting that integrated care efforts can be seen at three levels across a linked continuum: the micro-level (clinician), meso-level (organizational), and the macro-level (system). Integrated care can reflect both horizontal (e.g. routine basic health care incorporating lifestyle and behavioral health components) and vertical (e.g. referral to specialist) integration (Ploch and Klazinga, 2002).

Integrated care models vary in the type, intensity, and duration of service delivery (McCusker and Verdon, 2006). High-intensity interventions offer intensive evaluation plus ongoing treatment, including comprehensive interventions delivered in the context of inpatient evaluation and referral services, monthly or more frequent scheduled visits in the outpatient care setting or through outpatient psychotherapy combined with health education, among other approaches (McCusker and Verdon, 2006; Smith et al., 2012). Lower intensity interventions for older populations have included comprehensive geriatric evaluations intended to detect common medical and mental health difficulties facing geriatric patients (e.g. poor nutrition, alcohol abuse, mood, cognitive status, unmet psychosocial needs) combined with referrals to other providers without extended follow-up provided by the evaluation site (McCusker and Verdon, 2006; Ellis et al., 2011; Conroy et al., 2013). Other approaches for those with chronic conditions include collaborative care involving the integration of mental health and medical approaches (Bogner and de Vries, 2008; Katon et al., 2010; Bijl et al., 2004; Coventry et al., 2015).

The bulk of published studies on integrated care describe interventions targeted to individuals who require ongoing care, including patients with chronic conditions and/or older adults (Smith et al., 2012; Ellis et al., 2011; Martinez-González et al., 2014). These are often overlapping populations as multimorbidity is highly prevalent among older adults (Boyd et al., 2008). A recent meta-review (i.e. review of reviews) of integrated care programs for those with chronic conditions indicated integrated programs representing both high- and low-intensity approaches were effective in reducing mortality, hospital admissions and re-admissions, and adherence to care, although the effects varied somewhat depending on
the condition (Martínez-González et al., 2014). Reviews of comprehensive geriatric assessment have also found positive effects for outcomes including decreased mortality and health deterioration, as well as hospital admissions (Ellis et al., 2011). However, the findings suggest that effects are seen only for comprehensive multidisciplinary geriatric interventions conducted in dedicated wards within the hospital setting. Less intensive interventions, including mobile consultation units assigned to selected patients, were not effective in decreasing mortality and preventing medical decline (Ellis et al., 2011). A review of integrated care programs for older adults with two or more chronic conditions indicated that the majority of high- and low-intensity integrated care programs which involved elements of multidisciplinary care management and referral or intensification of care showed success in achieving specific health outcomes including lowering blood pressure and HbA1C levels (Smith et al., 2012).

Lower intensity programs, including those implementing collaborative care models, also have yielded some success in terms of patient health outcomes. Studies have reported low-intensity interventions were effective in increasing medication adherence and reducing hospitalizations (Bogner and de Vries, 2008; Bijl et al., 2004; Casas et al., 2006). Specifically, there is evidence that mental health screening in routine primary care is effective in reducing costs and self-reported symptomology, as well as improving functionality in patients with co-morbid depression (Bogner and de Vries, 2008; Bijl et al., 2004). However, although both low- and high-intensity approaches are promising in terms of improving adherence, satisfaction, and a range of health outcomes, researchers have noted that the quality of the research on patient-related outcomes remains limited and additional evaluation is needed (Smith et al., 2012; Martínez-González et al., 2014; Hopman et al., 2016).

There is mixed and generally insufficient evidence to support the hypothesis that high-intensity interventions, with greater financial and personnel resources, reduce medical costs overall or consistently do so more than low-intensity interventions. Specifically, although there are positive findings (Coventry et al., 2015; Casas et al., 2006; Vedel and Khanassov, 2015), reviews to date suggest that integrated care programs do not have well-documented effects on total costs of care (Martínez-González et al., 2014; Peikes et al., 2009). The meta-reviews indicate that substantial improvements to the quality of the research are needed to obtain a clearer picture of the effects of either high- or low-intensity interventions on costs (Martínez-González et al., 2014; Hopman et al., 2016).

Similarly, to date, the evidence on the effects of both high- and low-intensity integrated interventions on ED use are mixed (McCusker and Verdon, 2006). Reviews suggest that integrated care programs which recruited patients from the outpatient setting, had ongoing contact with patients, and/or used multidisciplinary care teams were associated with reductions in ED use (McCusker and Verdon, 2006). Reviews on transitional care programs for hospitalized patients with congestive heart failure indicate that high-intensity transitional care programs, involving both home visits and follow-up by telephone and clinic visits were more effective in reducing ED use than were low-intensity programs involving only clinic appointments (Vedel and Khanassov, 2015). Overall, the evaluation of the effects of integrated care programs on ED use is made more complicated by the variations in methodology. Studies used reporting periods ranging from 30 days to 2 years, and this lack of consistency in the reporting time frame contributes to the difficulty in assessing changes in ED use (McCusker and Verdon, 2006).

In summary, there is still limited evidence that low-intensity interventions can produce reductions in ED use or overall cost savings in older populations, including those with multiple chronic conditions. However, given that low-intensity interventions use fewer resources, it is valuable to determine if they can be associated with reductions in overall cost and ED use.
The Flushing Hospital Medical Center (FHMC) Integrated Care Program

This Integrated Care Program incorporated many of the elements of successful integrated care programs: grant funding, a close-knit multidisciplinary care team, and questionnaires assessing common geriatric health issues (e.g., alcohol use, depression) (Thornicroft and Tansella, 2004). The program was designed to avoid significantly increasing the burden of responsibility on primary care providers. Grant funding permitted the resources to be more easily available and quickly distributed. The team of physicians collaborating on the project was small, likely improving communication. A specific population (age ≥ 65) was initially targeted, but shortly after initiating the program the funders and medical team modified the protocol to include individuals 50 years of age and older. Chronic diseases with significant effects on aging are often present by 50, and earlier intervention may prevent morbidity from these diseases. Evidenced-based methods (e.g., the use of validated screening tools) for coordinating care were used.

The integrated care model implemented in this study most resembled a linkage model (Leutz, 1999). A linkage model is consistent with care as usual, but includes a framework in which general practitioners provide additional screening (horizontal integration) and seek out specialized care and services when appropriate (vertical integration). This framework integrates both the clinician (micro-level) and the organization (meso-level) to provide the intervention. The responsibilities of the physician for the intervention visit were increased. Physicians were asked to make verbal recommendations for behavior change and to interpret and discuss various screening measures.

The intervention consisted of an extended, 45-minute ambulatory care visit integrated into routine medical care visits with a primary care physician and supplemented with contact with a social worker or psychiatric nurse as necessary. Prior to the office visit, the patient was provided brief screening measures for depression, anxiety, alcohol abuse, and cognitive status. The patient and provider later discussed personalized lifestyle modification behaviors and related issues (e.g., diet, exercise, social support, pursuit of health goals), medications were reviewed, and educational brochures provided. Additional low-intensity behavioral health care interventions were provided at the time of the visit by a social worker or a psychiatric nurse.

The intervention approach was consistent with values-based capitated care rules (Porter, 2010). Specifically, there was no billing for the behavioral health services, and the interventions were not tied to CPT billing codes. This permitted the services to be delivered independent of the fee-for-service rules. Funds were provided by the NYS Office of Mental Health. New York State received a Centers for Medicare & Medicaid Services (CMS) waiver of $8.5 bn to distribute throughout the state with aim of reducing unnecessary admissions by 25 percent.

Study rationale

This study is an analysis of the effects of the FHMC low-intensity integrated care program for older adults which had been delivered in a community health setting. These are retrospective analyses conducted after the initial phases of the program were completed. The aim was to test the hypothesis that integrating mental health services into routine primary care practice visits would reduce costs and ED visits among low-income, older adults (> 50 years of age) seen in a community-based primary care medical center. The second aim was to determine if the effects of the program differed for patients diagnosed with two chronic health conditions (hypertension and Type II diabetes), both of which are amenable to lifestyle intervention. Prior studies indicate that integrated programs have been implemented with some success in older patients with hypertension and diabetes (Hopman et al., 2016).

As this is a retrospective analysis of a demonstration project, there was no formal control group. All patients over 50 years of age were eligible to participate. Therefore, we present results on those who participated in the program and provide comparison data on those who did not.
Method

Procedure. The study was archival. Medical account records were obtained from a major metropolitan hospital in Queens County New York. The integrated care model was implemented into routine ambulatory care for all patients 50 years of age and older. Participants were recruited into the intervention at the time of medical appointment. This analysis is confined to patients ≥50 years of age and older with medical account records available for the years 2008–2009. Medical account records were available for 1,286 individuals, with a total of 26,536 records.

Analyses reflect data from participants who were entered into the intervention at any point during this two-year period. The intervention was deployed with 73.5 percent (945/1,286) of all the patients for whom medical billing records were available over the two-year period. As per the standard hospital policy, patient records were recorded by administrative and clinical staff at each hospital and entered into a secure database. These records were analyzed by the research team who were recruited in 2014 after the initial project was complete. Analyses were completed as an initial project for a newly formed collaboration between a university psychology department and the hospital for the purposes of strengthening the research capabilities of the medical center.

Participants. Participants were regarded as having participated in the intervention if they had a minimum of one visit with the intervention team and completed a PHQ-9 Depression Screening Survey on at least one visit. A total of 945 individuals, 50 years of age and older, had contact with the team, but only 920 completed at least one PHQ-9. Therefore, the analytic sample for evaluating the pre-to post-intervention effects (i.e. the intervention sample) consisted of 920 patients. The sample which did not have any contact with the intervention team, and therefore did not receive the intervention included 341 patients. Socio-demographic and diagnostic information about the samples are presented in Table I.

The Flushing Hospital Medical Center Integrated Care Program. The goal of the FHMC Integrated Care Program was to provide psychiatric care in the context of the primary medical appointment. Referral for psychiatric consultation was available if necessary, and hospitalization services were immediately available if required. All participating patients completed all evaluation questionnaires for a portion of an outpatient visit to the hospital, regardless of whether they were subsequently referred for additional psychiatric care. For those who received the intervention, care as usual was

<table>
<thead>
<tr>
<th>Variables</th>
<th>Intervention sample (n = 920)</th>
<th>No-intervention sample (n = 341)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of medical billing records</td>
<td>22,973</td>
<td>3,271</td>
</tr>
<tr>
<td>Mean age (SD)</td>
<td>64.15 years (SD = 10.56)</td>
<td>59.77 years (SD = 9.28)**</td>
</tr>
<tr>
<td>Men</td>
<td>346 (37.61%)</td>
<td>134 (39.41%)</td>
</tr>
<tr>
<td>Women</td>
<td>574 (62.39%)</td>
<td>206 (60.59%)</td>
</tr>
<tr>
<td>Present for any visit</td>
<td>587 (63.80%)</td>
<td>118 (34.60%)***</td>
</tr>
<tr>
<td>Present for any visit</td>
<td>80 (8.70%)</td>
<td>15 (4.40%)**</td>
</tr>
<tr>
<td>Present at any visit</td>
<td>283 (30.76%)</td>
<td>35 (10.26%)***</td>
</tr>
<tr>
<td>Medicaid of any type</td>
<td>467(50.76%)</td>
<td>149 (43.70%)*</td>
</tr>
<tr>
<td>Medicare of any type</td>
<td>303 (32.93%)</td>
<td>69 (20.23%)***</td>
</tr>
<tr>
<td>Self-pay</td>
<td>74 (8.05%)</td>
<td>75 (21.99%)***</td>
</tr>
<tr>
<td>Total charges across all patients and visit days in two-year evaluation period</td>
<td>$21,364.88 (34,461.44)</td>
<td>15,469.86 (31,415.98)**</td>
</tr>
<tr>
<td>Percent of patients who made an ED visit across the two-year period</td>
<td>402 (43.7%)</td>
<td>153 (44.87%)</td>
</tr>
</tbody>
</table>

Notes: Comparisons between intervention and no-intervention samples. *p < 0.05; **p < 0.01

Table I. Socio-demographic and diagnostic differences between intervention and no-intervention samples

Reducing ED visits among older adults
provided along with an extended primary care contact (with visit length of about 45 min). The aim was to provide the intervention with minimal interference in the primary medical appointment.

In the waiting room, a behavioral health clinician (i.e. a social worker) administered psychiatric screening tools for major depression (PHQ-9), generalized anxiety disorder (GAD-7), alcohol use (CAGE), and cognitive status (Clock Drawing). These measures were scored immediately and patients were referred to the primary care practitioner (PCP) and a psychiatric nurse practitioner (PNP). Formal cutoff scores were not used with the screening tools, instead symptoms were discussed even if the level of symptoms did not meet criteria for a formal diagnosis. The evaluation data were used by the PCP for discussion with the patient during the primary care visit to reinforce health promotion, to communicate mental health information, and to prescribe medication as needed. At the same time, the PNP immediately evaluated the need for follow-up and referral for psychiatric care and worked with the PCP and the patient to develop a psychiatric treatment plan, as necessary. The PNP was able to start psychopharmacotherapy in conjunction with the PCP as needed. Mental health and lifestyle modification interventions could be initiated in the waiting room, and if necessary for privacy, patients, and behavioral health clinicians moved to an exam room. If warranted, the PNP could arrange for additional office visits between regular primary care appointments, if more intensive monitoring (short of hospitalization) was needed. If the patient was determined to be suicidal, an immediate psychiatric consultation was obtained to determine the need for psychiatric hospitalization. In addition to the evaluation and referral services, this intervention included components such the provision of referrals to other medical specialty clinics and case-by-case recommendations for healthy lifestyle behavior and counseling to improve self-control. Patients could also be referred to Tai Chi classes held frequently on the medical center premises.

Measures
Records for each individual patient visit were obtained for every service. Records included information about the patient’s sex and age, date of service, date of discharge, primary diagnosis, the unit rendering services, charges operational costs, direct costs, indirect costs, insurance provider, and age and gender. The emergency department was listed as one of the nursing units.

Costs of care. On any given visit day, patients could visit multiple nursing units as they accessed different types of medical services. Consequently, the medical billing records could have one or more entries for each patient on each visit day, with each entry reflecting a visit to a different unit. Each visit was assigned a charge. Therefore, to calculate total charges per visit day, all charges were summed across all visits made on that visit day. The billing record procedures assign all charges for visits lasting multiple days (i.e. inpatient admissions) to the first visit day on which the patient was admitted to the hospital.

ED use. Patients were regarded as having used ED services on a visit day if any of the visits on that day occurred in the ED. Each visit day was scored “1” if one or more visits on the visit day were made to the ED or “0” if no visits on that visit day were made to the ED.

Principal diagnosis. The targeted diagnoses included hypertension, Type II diabetes, and depression. Patients were regarded as having essential hypertension (HTN), Type II diabetes, or depression if they attended any visit for which the medical code assigned to the principal diagnosis on the account record belonged to the ICD-9 category for the respective disease or disorder (e.g. HTN = 401); Type II diabetes (250 codes), depression (311, 309, 304 or 296)).
**Analytic plan**

Preliminary analyses were conducted using ANOVA or $\chi^2$ tests to provide descriptive socio-demographic and diagnostic information for the intervention and no-intervention sample, as well as information on total charges and emergency department visits for the sample as a whole, the intervention sample only, and for the intervention sample members with chronic conditions. These analyses also examined the differences between the intervention vs no intervention samples. To test the effects of the intervention, all visits occurring prior to the patient’s first visit with the treatment team were considered pre-intervention visits, and all visits occurring on or after the first visit were considered post-intervention visits. Multi-level regression analyses conducted with Proc Mixed (SAS 9.4) tested the main effects of time (i.e. pre- vs post-intervention) on charges per visit using Proc Mixed (SAS 9.4). Multi-level logistic regression analyses conducted with Proc Glimmix (SAS 9.4) tested the main effect of time on the likelihood that any given visit day included a visit to the ED. In these analyses, time was treated as a random effect, and the Satterthwaite approximation to calculate the effective degrees of freedom was employed. These analyses are robust to missing values and permit evaluation of effects, even when participants vary in the numbers of visits to the hospital before and after the initiation of the intervention (Littell *et al.*, 1996). To determine if the effects of the intervention were also seen for patients with chronic conditions and for those who were 65 years of age and older, the multi-level modeling analyses of the effects of time were repeated for each of these smaller subsamples.

**Results**

**Descriptive data on the intervention and no-intervention groups.** As shown in Table I, both samples included more women than men, and there were no differences between the samples in the ratio of men to women ($p < 0.56$). Both groups included individuals who were 50 years of age or older.

Data on race/ethnicity were available only for the intervention sample, as the data were collected as a part of the diagnostic interview. As it is consistent with the population served by FHMC, the intervention sample was largely comprised of ethnic/racial minority group members and individuals with low incomes. The majority of the intervention sample included individuals who were Hispanic (48.53 percent), Asian (24.10 percent), or black (13.25 percent). There was a smaller group of white individuals (12.92 percent). The vast majority of both groups used Medicaid or Medicare to pay for services.

**Comparisons between intervention and no-intervention samples.** These analyses revealed that the intervention sample was comprised of individuals who were older and more likely to have one or more chronic conditions, and were more likely to rely on government-funded insurance. Specifically, the average age of participants in the intervention sample was significantly higher than the average age of those in the no-intervention sample ($F(1,1259) = 45.52$). $\chi^2$ analyses revealed that in comparison to the participants in the no-intervention sample, those in the intervention sample were more likely to use Medicare ($\chi^2(1) = 19.29$, $p < 0.001$) and Medicaid ($\chi^2(1) = 4.97$, $p < 0.03$). Participants in the no-intervention sample were more likely to self-pay than those in the intervention sample ($\chi^2(1) = 46.47$, $p < 0.001$). In contrast to the no-intervention group, the intervention group included a significantly greater percentage of patients with hypertension ($\chi^2(1) = 86.05$, $p < 0.001$), diabetes ($\chi^2(1) = 55.42$, $p < 0.001$), and depression ($\chi^2(1) = 6.59$, $p < 0.02$).

**Medical costs across the sample.** For each participant, all charges were summed across the two-year period. Across the sample, the average of all charges summed across the two-year period was $19,742.65 (SD = 33,676.52, range = $315–358,842.00). Patients in the intervention sample accumulated significantly higher charges ($21,364.88 (SD = 34,461.44)
over the two-year period in comparison to the no-intervention sample ($15,469.86, SD = $31,415.98; F(1,1259) = 7.63, p < 0.01).

A total of 566 (44.01 percent) of the full sample made at least one ED visit in the two-year period. There were no significant differences between the intervention (n = 402, 43.7 percent) and no-intervention (n = 153, 44.87 percent) samples in the percentage of patients who made ED visits.

Costs of care and use of ED for those with and without chronic conditions. Within the intervention sample, we examined the costs accumulated by those with and without chronic conditions. As shown in Table II, the overall total costs were higher for those with no chronic conditions; however, the costs per visit were lower. Specifically, costs over the two-year period were compared for those who had two chronic conditions (hypertension and diabetes) vs only one of the conditions or neither condition. Comparisons among the three groups were significant (F(2, 917) = 6.93, p < 0.001). Post hoc analyses with Bonferroni corrections revealed that total costs were higher for those who had both hypertension and diabetes than they were for those who had neither of the conditions. However, multi-level modeling analyses revealed that costs per visit day were lower for those with two chronic conditions than for those with one or no chronic conditions (F(3,415) = 181.19, p < 0.001). Similarly, multi-level logistic regression analyses revealed that any given medical visit was less likely to be an ED visit for those with two chronic conditions vs one or no chronic conditions (F(3,896.4) = 909.98, p < 0.001).

Intervention intensity. Of the 920 participants in the intervention analytic sample almost a quarter (n = 208, 22.61 percent) received only one intervention-related visit. A total of 75.65 percent (n = 696) of the sample had five or fewer visits in total, and about 8 percent (n = 80) were seen for ten or more sessions.

The proportion of non-emergency visits which involved contact with the intervention staff varied from 1 to 100 percent of total visits across patients. The average patient was contacted by the behavioral health clinician during 37.2 percent (SD = 29.1 percent) of non-emergency visits in 2008 and 2009.

Intervention effects: pre-post differences in costs of care and ED visits. To test intervention effects, multi-level modeling was used to assess the main effects of time (pre-intervention vs post-intervention) on charges per visit and ED use. As displayed in Table III, mixed models regression analyses with time treated as a random effect revealed the average cost per visit was significantly higher before the intervention was implemented compared to after F(2,1285) = 129.60, p < 0.001). These effects were also seen when the sample was restricted to those who were diagnosed with two chronic conditions (F(2,103) = 33.10, p < 0.001), and when the sample was restricted to those 65 years of age or older (F(2, 243) = 106.85, p < 0.001).

Patients with two chronic conditions: hypertension and diabetes in intervention condition (n = 212) Patients with one chronic condition, either hypertension or diabetes (n = 446) Patients with neither chronic condition (n = 262)

<table>
<thead>
<tr>
<th></th>
<th>Patients with two chronic conditions: hypertension and diabetes in intervention condition (n = 212)</th>
<th>Patients with one chronic condition, either hypertension or diabetes (n = 446)</th>
<th>Patients with neither chronic condition (n = 262)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sum of all charges across</td>
<td>26,476.42</td>
<td>22,575.97</td>
<td>15,167.20</td>
</tr>
<tr>
<td>two-year period (SD = 36,098.87)</td>
<td></td>
<td>(SD = 33,861.11)</td>
<td>(SD = 3,330.62)</td>
</tr>
<tr>
<td>Sum of costs per visit day (SE = 71.68)</td>
<td></td>
<td>1,004.37</td>
<td>1,633.83</td>
</tr>
<tr>
<td>Estimate of likelihood visit = ED visit (SE = 0.12)</td>
<td></td>
<td>(SE = 0.09)</td>
<td>(SE = 0.12)</td>
</tr>
</tbody>
</table>

Notes: Post hoc tests of differences among groups. Differences between estimates with different superscripts (a vs b vs c) are significant at p < 0.01.
Multi-level logistic regression analyses revealed a main effect of time on ED use, with visits made before the intervention more likely to involve the emergency department than visits made after the intervention ($F(2,715.4) = 1,332.30, p < 0.001$). The estimates generated from the analyses translate into a reduction in ED use from 5.66 percent of visits to 3.01 percent of visits. These effects were also seen when the sample was restricted to patients with two chronic conditions, with estimates indicating a reduction in ED use from 2.75 percent of visits to 2.46 percent of visits ($n = F(2,174.3) = 554.86, p < 0.001$). The effects were also seen when analyses included those 65 years of age and older ($n = 429: F(2,1082) = 702.86, p < 0.001$).

The estimated correlation of the random effects for the analysis of ED visits across the full intervention sample was 0.71. This estimate indicates that patients who had relatively high ED use before the intervention tended to also have relatively high ED use in comparison to others after the intervention; however, the overall frequency of ED use declined significantly after the intervention.

**Discussion**

This study was a retrospective analysis of the effects of a low-intensity integrated care intervention formulated for older adults and delivered in an urban medical center serving low-income individuals. The intervention included an initial evaluation of stress, psychiatric symptomatology and health habits, potential referrals for lifestyle management and psychiatric treatment, as well as training for physicians to enable them to provide more information about lifestyle change for older adults. The findings suggest the intervention was associated with reduced costs per visit and reduced likelihood of emergency department use. The effects of the intervention were seen across the Intervention sample, as well as when the sample was restricted to those with two or more chronic health conditions, or those who were over 65 years of age. The findings suggest that relatively high users of the ED remain relatively high users, but their overall levels of usage can be reduced.

The program has shown evidence of sustainability. The intervention was initiated in 2007. External funding from OMH was ceased in 2012. However, the program remains in effect. The hospital was awarded an Integrated Care License that required the continuation of the project, and necessitated that the hospital provide behavioral health staff. In addition, The Delivery System Reform Incentive Payment provided incentives to screen patients for depression and provide relevant treatment planning, strategies which were consistent with the Integrated Care Program. Similar services are now provided in the OB-GYN and pediatric clinics, adding a lifespan approach to this Integrated Care Model.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full intervention sample, n = 920</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costs per visit day</td>
<td>1,986.77 (SE = 202.14)</td>
<td>941.97* (SE = 65.58)</td>
</tr>
<tr>
<td>ED use</td>
<td>−2.81 (SE = 0.09)</td>
<td>−3.47* (SE = 0.07)</td>
</tr>
<tr>
<td><strong>Intervention sample, participants with both hypertension and Type II diabetes, n = 212</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costs per visit day</td>
<td>826.91 (SE = 102.85)</td>
<td>810.59* (SE = 122.96)</td>
</tr>
<tr>
<td>ED use</td>
<td>−3.57 (SE = 0.17)</td>
<td>−3.68* (SE = 0.12)</td>
</tr>
<tr>
<td><strong>Intervention sample, participants 65 years of age and older, n = 429</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costs per visit day</td>
<td>2,230.21 (SE = 299.40)</td>
<td>997.61* (SE = 76.45)</td>
</tr>
<tr>
<td>ED use</td>
<td>−2.23 (SE = 0.13)</td>
<td>−3.61* (SE = 0.098)</td>
</tr>
</tbody>
</table>

**Note:** Comparisons between pre- and post-intervention estimates at $p < 0.01$.
This study is among the very few available that document a decrease in the average medical costs per visit, as well as decreased ED utilization following a low-intensity integrated care intervention. Past integrated care studies with similar sample demographics have generally only found improvements in health-related behaviors and other objective health outcomes (e.g., blood pressure, glucose levels). Our findings may reflect the large sample size (i.e. larger than the samples used in most individual integrated care interventions), and our patients were followed across a protracted two-year span. The use of mixed modeling analyses permitting examination of every visit may also have served as an improvement over prior studies.

The essential finding of this study was that an extended outpatient visit that included targeted assessment using self-report measures, lifestyle recommendations, and referrals to appropriate specialty departments resulted in cost savings and decreased ED utilization. One study of the cost efficiency of psychotherapy sessions suggest that in patients with clinically significant levels of psychological distress, a single session of therapy produced a reliable decrease in self-reported symptoms for 88 percent of patients, while 12 sessions decreased symptoms for 62 percent of patients (Barkham et al., 2006). From the standpoint of an outpatient medical care model, it is conceivable that dedicating additional time, even within a single appointment, to discuss individualized patient issues may be beneficial. These discussions may allow the patient to re-assess their health and wellness and initiate positive lifestyle or behavioral changes that otherwise would have been unrecognized or avoided.

The intervention effects seen in this study are not a function of targeting healthier patients. In fact, the opposite appears to be the case. The individuals who did not participate in the intervention were generally younger and more likely to pay for their own care. They had lower overall costs of care, possibly because they were less likely to be diagnosed with any of the chronic health conditions examined. Members of this sample may have had more limited contacts with the medical system, both because they needed less care and they were attempting to reduce expenses. As a consequence, they were less likely to be recruited for the program, since participants were recruited during their medical visits. To enable integrative care visits for primary prevention for this younger and potentially healthier population, more intensive outreach efforts may be needed.

Limitations
There are a number of important limitations to this analysis. This program was conducted to improve service delivery and not to test hypotheses about the effects of integrated care. Analyses were performed after the initial phases of the program were completed. Consequently, there was no formal control group, making it difficult to determine if the effects can be attributed to the intervention vs other factors which may have operated simultaneously. In future pragmatic evaluations of medical center-based programs, it may be preferable to use a stepped-wedge design to permit greater insights into causality. We relied on medical billing records for patient diagnoses. Additional confirmatory data from EHR and other sources would improve the ability to confirm diagnoses and outcomes (Wei et al., 2015). As patients could have varying numbers of visits before and after the intervention, we did not examine total charges. Our definition of patients with chronic conditions is limited to those with co-morbid Type II diabetes and hypertension, and although this combination of conditions is common, it does not reflect all definitions of multiple morbidities (Boyd et al., 2008). Further, participants varied in the degree to which they participated in treatment, with some receiving more extensive services, and the overall sample size is insufficient to determine the effects of any particular component of the intervention. The sample included largely low-income urban individuals who were the
members of racial and ethnic minority groups. It is unclear if these effects will generalize to other regions or samples.

However, despite these limitations, the data are encouraging. They suggest that low-intensity integrated care interventions may provide an important addition to standard medical care, with benefits for utilization and cost. Even minimal mental health evaluation and intervention offered in the context of primary care visits may improve health and health care utilization. Integrating mental health professionals into the medical appointment may reduce the barriers to evaluating one's own mental and physical health and accessing needed resources. The findings support further research on low-intensity collaborative care interventions which combine mental and physical health interventions.

References


Further reading


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Inter-agency adult support and protection practice

A realistic evaluation with police, health and social care professionals

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Abstract

Purpose – Collaborative inter-agency working is of paramount importance for the public protection agenda worldwide. The purpose of this paper is to disseminate the findings from a research study on the inter-agency working within adult support and protection (ASP) roles in the police, health and social care.

Design/methodology/approach – This realistic evaluation study with two inter-related phases was funded by the Scottish Institute for Policing Research. This paper reports on Phase 1 which identified existing gaps in the implementation of effective inter-agency practice by reviewing the "state of play" in inter-agency collaboration between the police and health and social care professionals. In total, 13 focus groups comprising representatives from Police Scotland (n = 52), Social Care (n = 31) and Health (n = 18), engaged in single profession and mixed profession groups addressing issues including referral and information exchange.

Findings – On analysing context-mechanism-outcome (CMO), gaps in joint working were identified and attributed to the professionals’ own understanding of inter-agency working and the expectations of partner agencies. It recommended the need for further research and inter-agency training on public protection.

Research limitations/implications – This unique Scottish study successfully identified the inter-agency practices of health, social services and police. By means of a modified realistic evaluation approach, it provides an in-depth understanding of the challenges that professionals face on a day-to-day basis when safeguarding adults and informed strategic recommendations to overcome the barriers to good practices in organisational working. The methods used to determine CMO could benefit other researchers to develop studies exploring the complexities of multi-causal effects of cross-boundary working. The use of the same case study in each focus group helped to neutralise bias. However, the voluntary nature of participation could have resulted in biased perceptions. The limited numbers of health professionals may have resulted in less representation of health sector views.

Practical implications – This paper reports on a Scottish study that focused on the coordinated and integrated practices amongst the police, health and social services’ professionals who support and protect adult members of society at risk of harm and has implications for their practice.

Social implications – Whilst the focus of this study has been on ASP, the conclusions and recommendations are transferable to public protection issues in many other contexts.

Originality/value – Studies on the joint-working practices amongst police and health and social services’ professionals who support and protect adult members of society at risk of harm are uncommon. This study investigated professionals’ perceptions of gaps and concerns pertaining to integrated working by means of a realistic evaluation approach. It recommended the need for further research and inter-agency training on public protection.

Keywords Integrated health and social care, Partnership working, Community care, Multi-disciplinary teamwork, Inter-agency police health and social care adult support and protection

Paper type Research paper
Introduction
Collaborative inter-agency working is of paramount importance for public protection worldwide. This paper reports on a Scottish study that focused on the coordinated and integrated practices amongst the police, health and social services professionals who support and protect adult members of society at risk of harm. It investigated perceptions of gaps and concerns in inter-agency working using a realistic evaluation approach (Pawson and Tilley, 1997).

Previous studies have called for integrated working but there is a paucity of research examining integrated practice (Parker et al., 2017; Higgins et al., 2016; MacKay et al., 2011; Petch, 2008). Parker et al. (2017) conducted a scoping review of the international literature and found 13 models of inter-agency collaborative care for mental health-related interactions between the police and mental health and emergency care services. They acknowledged the need for further research that focused on the key elements of integrated care which include information sharing, joint decision making and coordinated intervention. This study focuses on such practises that cross organisational boundaries.

The Scottish context
In Scotland, The Adults with Incapacity (Scotland) Act (2000), the Mental Health (Care and Treatment) (Scotland) Act 2003 and the 2007 Adult Support and Protection (ASP) Act introduced significant changes in the support offered to adults considered to be at risk of harm Scottish Government (2003). In ASP legislation, an adult is defined as 16 years and above and “at risk” adults may include those with “disability, mental disorder, illness or physical or mental infirmity and are more vulnerable to being harmed than adults who are not so affected”.

The ASP Act provides measures to identify, support and protect those individuals who are at risk of harm, whether as a result of their own or someone else’s conduct. It clarified the roles and responsibilities of those involved in ASP and by adopting codes of practice professionals complied with the legislation (Scottish Government, 2014). To define “at risk” the ASP Act introduced the “3 point test”. This identified if people were unable to safeguard well-being, property, etc.; that they were at risk of harm; and that the effect of their disability meant that they are at a greater degree of vulnerability. There is recognition within the legislation that a multi-agency approach is required.

Multi-agency and cross-boundary working
It is a challenging undertaking for any professional to practise effective collaborative working given the complex knowledge and skills needed to create effective channels of communication. There is an assumption that professionals working within health and social care integration alongside police colleagues know how to work collaboratively. Discerning the mechanisms to achieve joint working remains difficult (Stevens, 2013; Police Scotland, 2016). However, there is evidence of effectiveness when adopting multi-agency practices. For example, in their consideration of violent crimes in two policing areas in England, Higgins et al. (2016) found partnership working to be effective and resulted in a reduction of crime.

A key challenge for ASP is empowering “at risk” adults and also respecting their liberties, balancing the need for professional interventions, when they are perceived as making choices which put them at risk of harm.

The ASP Act (Scottish Government, 2007) provides clarity and balance between an individual’s right to freedom of choice and the risk of harm. Working collaboratively in ASP requires formulating professional judgements, understanding definitions and thresholds and often working in environments without a “culture of co-operation” (DOH, 2010). Such difficulties can restrict communication and information sharing, particularly with sensitive personal data owing to varying ethical practices.
There are no specific UK figures available on information sharing for adult protection; however, Cambridge et al. (2010), investigating 6,100 adult protection referrals in two local authorities in England, found a dramatic increase in police referrals from 20 per cent in 1998 to 40 per cent in 2005, whilst health referrals remained static at 21 per cent. Reasons for these differences required further investigation but could potentially relate to ASP policy and legislation changes during this time. In total, 84 per cent of all referrals in the study led to investigation with significant joint working in 10 per cent of referrals. The report on the effectiveness of adult protection arrangements across Scotland (Care Inspectorate Scotland, 2014) failed to identify figures for information sharing.

This current study was therefore deemed important in addressing ASP practices in Scotland and enhancing the information required to promote exemplary joint working for safeguarding adults.

Aim of study
The aim of this study was to investigate the inter-agency practice of police and health and social care professionals in Scotland in relation to ASP.

The research questions were as follows
Phase 1: to identify existing gaps in the implementation of effective inter-agency practice by reviewing the “state of play” in inter-agency collaboration between the police and health and social care professionals; education and training needs in relation to key ASP issues; and information sharing.

Phase 2: to identify interprofessional and inter-agency training resources with key performance indicators (KPIs) to enable subsequent evaluation and monitoring of practice for all professionals involved in ASP.

Study design
A qualitative study, using an adapted “realistic evaluation approach” (Pawson and Tilley, 1997), was designed to evaluate inter-agency practices. A steering group of experts from across Scotland guided the project team. The steering group members are included in the acknowledgements. The study was funded by the Scottish Institute for Policing Research (SIPR) and included two phases.

This paper focuses on the findings from Phase 1 of this study.

Figure 1 provides an overview of the study design used to generate “context-mechanism-outcome (CMO)” configurations (Pawson and Tilley, 1997). The configurations identified: for whom it worked, in what way and why it worked or not.
For example:

(1) collaborative practices were working for health, social care and police professionals in some urban locations and most rural locations;

(2) the ways in which it worked related to good communication practices across organisational boundaries; and

(3) collaborative practice was achieved because when they worked in small cohesive teams and had built up trust and respect for each other over some time.

Representative numbers of professionals from each of the disciplines responsible for ASP were invited to participate in focus groups, via the different ASP committees and the Health Boards and Police Command Areas across Scotland. Figure 2 highlights the police divisions within the three command areas (14 divisions) from which the sample groups were drawn. The study focused on professionals and their descriptions and experiences of the services. We acknowledge the distinctions in terminology between “social services” and “social care”. Our study included both social workers and other professionals working in social care. The terms are used synonymously in this paper.

The corresponding areas for Local Authorities and Health Boards were matched according to the associated police division (see Figure 1). There was no direct correlation and a potential problem in communication and information sharing when boundaries do not co-align was identified.

Focus groups with single disciplines (i.e. police only, health only or social care only) and mixed were conducted. Ethical approval was granted by the Ethics Committee at Robert Gordon University.

Focus groups
The focus groups were audio recorded and facilitated by different team members. The schedule introduced the realistic outcome questions, i.e. for whom it worked, in what way and why it worked or not. All focus groups included a simulated case study developed from anonymised “real case” histories. The purpose of this case study was to ensure that the discussions could be focused and deeper insights into the participants’ thinking and decision-making practices were consistently evaluated. From a research perspective, this strengthened the reliability of the theoretical points made during focus group discussions and validated their professional practice (Table I).

Findings
In total, 13 focus groups, involving 101 participants, were recorded and transcribed verbatim. Framework analysis (Ritchie et al., 2013) was used to identify categories, themes and sub-themes. Eight key themes, as highlighted in Table II, were identified.

The key themes from Table II are discussed individually:

(1) Information sharing included discussions on two main topics. First, the development of an “at risk persons” database for all professions was identified as an important step for improved practice. Second, participants identified challenges with information sharing across different professions that was exacerbated by the need to protect confidentiality. Police and social work reported frustration at healthcare professionals’ reluctance to share information.

(2) “Relationships” highlighted that “team working” and “information sharing” are greatly improved when organisations are co-located and/or informal relationships are established resulting in greater collaborative working and the development of trust for information sharing.
(3) People and processes identified both positive and negative influences for working practices. If protocols and processes were “unfit for purpose” then this was a demotivating factor for collaborative working. In contrast, where processes were working well and professionals felt included, the system motivated collaborative working. The three-point test for identifying if an adult is vulnerable in Scotland
(Scottish Government, 2007) was criticised by more than half of the participants. Perceived police over-reporting of persons who may not “fit” the test resulted in some social workers reporting less scrutiny of police reports. Conversely, when more than one agency was involved in a case there was a perceived reliance on the police to submit the report, when all agencies should have submitted their own concerns.

(4) “Lessons from child protection” related to the established and effective practices that already exist for child protection cases. Participants noted that there were no confidentiality and information sharing issues in child protection cases. This was perceived as positive and recommended as an aspiration for ASP.

(5) “Environment” related to the lack of places of safety for at risk adults to recover from an acute episode. The closure of safe environments such as hospital wards has led to some individuals being inappropriately “locked up” in police cells.

<table>
<thead>
<tr>
<th>Breakdown by area</th>
<th>Total number of participants</th>
<th>Police</th>
<th>Health</th>
<th>Social care</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>47</td>
<td>18</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>East</td>
<td>28</td>
<td>19</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>West</td>
<td>26</td>
<td>15</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Totals</td>
<td>101</td>
<td>52</td>
<td>18</td>
<td>31</td>
</tr>
</tbody>
</table>

**Table I.** Total participant numbers by area and profession

<table>
<thead>
<tr>
<th>Theme</th>
<th>Quotation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information sharing</td>
<td>Respondent PO3FG1 (Police): “[…] there is a well-established format within the police to pass on information to our partner agencies […] but it doesn’t always flow back to us in a way that we would want it […]”</td>
</tr>
<tr>
<td>2. Relationships</td>
<td>PO1FG1 (Police): “when we had a social care worker dedicated in our office […] it worked really well, we were finding out all the information we had on the family”</td>
</tr>
<tr>
<td>3. People and processes</td>
<td>SW4FG2 (social work): “We actually had one (case) recently and it was someone that didn’t meet the 3 point test, but round the table the consultant Psychiatrists and people are saying ‘he’s a likely candidate to kill himself’ and the Police are going ‘well do something about it’ what? Do you know and it’s that bit they don’t (do) because they’re so risk averse […]”</td>
</tr>
<tr>
<td>4. Lessons from child protection</td>
<td>SC1FG2 (social care): “I think child protection’s probably gone through that process, it’s well established now what everyone’s responsibilities are (known) whereas I think in adult protection you can almost see people dragging their heels at times, you know very reluctant to become a part of the process”</td>
</tr>
<tr>
<td>5. Environment</td>
<td>SW2FG3 (social work): “To be fair to health we shouldn’t be taking hospital beds with people that are under the influence either and I mean I don’t think it should be a cell either”</td>
</tr>
<tr>
<td>6. Implementation of the Adult Support and protection Act</td>
<td>SC4FG3 (social care): “You had a child at risk, you wrote that report and you got your order and that child was removed. To remove adults, despite (the Act), it’s like what you were saying there about this person’s very chaotic (lifestyle) they are in some people’s eyes choosing to be this way you know, if they have capacity”</td>
</tr>
<tr>
<td>7. Regional variations</td>
<td>SC2FG4 (social care): “I think working […] with the police is really positive and we’ve got quite a good relationship with the referral unit works […]”</td>
</tr>
<tr>
<td>8. The rights of an individual</td>
<td>HC4FG7 (health): “There is the consideration around is this a ‘vulnerable adult’ or is this an ‘adult at risk’ and do we also need to be thinking about then referring them on to social work for instance or you know you were asking about what happens if you can’t get social work in the middle of the night, very often we would use our police colleagues in a crisis situation where we felt there was an immediate risk to the person”</td>
</tr>
</tbody>
</table>

**Table II.** Key themes from focus groups
Implementation of The ASP Act (2007) stipulates local authority social work departments’ responsibilities as the coordinators for inter-agency working practices. However, participants felt that this Act had not fully met the needs of the people it was intended to support and protect. This has led to some challenging decision making by professionals.

Regional variations were obvious throughout the focus groups. Remote and rural areas had developed more cohesive team arrangements and practised cross-boundary working. Urban locations tended to report fragmented team working and a lack of understanding which often resulted in a lack of information sharing.

The rights of the individual were perceived differently amongst participants. Debates centred on the rights of the individual to adopt a “risky” lifestyle choice and the need for professionals to “protect and support”.

The case study discussion at the end of each focus group provided valuable insights into participants’ thinking and decision-making processes. The narratives were analysed verbatim using framework analysis (Ritchie et al., 2013). Table III highlights the disparity noted amongst professionals when discussing the case study. The references made to the stages of action by different professionals for the case presented, demonstrated strengths and weaknesses in inter-agency working. In some focus groups, there was greater agreement as to what the decisions and actions of each profession would be and how they

<table>
<thead>
<tr>
<th>Topic</th>
<th>Social work</th>
<th>Police</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workload</td>
<td>Workload; lack of resources; paperwork overload; co-location facilitates immediate communication</td>
<td>Not being able to walk away; left to pick up the pieces</td>
<td>A&amp;E too busy to do referral; expectation that police will refer; few referrals from community; liaison psychiatry overload; IT systems not compatible between agencies</td>
</tr>
<tr>
<td>Case study assessment</td>
<td>Consent issues; friends and neighbours often make the initial referrals</td>
<td>Sexual offences; issues of alcoholism and mental health; issues of engagement</td>
<td>Challenges around co-morbidity of alcohol and mental health</td>
</tr>
<tr>
<td>The Act and Assessment of capacity</td>
<td>Skilled in identifying how people “Fit the Act”; not only agreed ambiguity of the Act but also agreed ASP good piece of legislation; capacity in case study; problems associated with use of banning orders</td>
<td>Challenges of the 3-point test; understanding that Police are not able to make medical assessment</td>
<td>Capacity fluctuating; questioned if there is a need for reporting if person is a frequent attendee, i.e. suicide attempts</td>
</tr>
<tr>
<td>Roles and responsibilities</td>
<td>Key role for the hospitals especially in terms of mental health assessment; issues around place of safety</td>
<td>Responsibility to investigate criminality</td>
<td>Lack of trust in assessment between partners; not understanding that others are depending on health assessment</td>
</tr>
<tr>
<td>Decisions</td>
<td>Emphasis on adult support with the case study not adult protection</td>
<td>Interprofessional case conference but often it can be a uniprofessional decision</td>
<td>Acknowledged the difficulties of getting someone admitted to hospital, especially psychiatric units</td>
</tr>
<tr>
<td>Education and training</td>
<td>Recommended joint investigation training</td>
<td>Officers may not know the criteria; agreed police should be trained in ASP with other professionals</td>
<td>ASP training is unprofessional; NHS Education Scotland (NES) project used in training</td>
</tr>
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</table>

Table III.
Topics raised during case study discussion
would also work collaboratively sharing information and often conducting joint investigations. In some focus groups, there was greater disparity in the expectation of other professionals and inconsistencies in decision making. Focus group data led to the development of CMO analysis.

**Context-mechanism-outcome**

Table IV highlights the CMO analysis of the multi-factorial processes involved to illuminate the findings. This analysis allows an exploration of the multiplicity of factors that impact on ASP practices. The Pawson and Tilley (1997) model has been adapted as follows: The context were facts related to the status quo and on most occasions reflected what was not working. The mechanisms were enablers (i.e. the policies, processes and innovative approaches) that facilitate the safeguarding of vulnerable adults. The outcome was the stipulated sequels that arose if the context was sustained and the mechanism enabled improvement. By linking this to the three questions (i.e. “for whom it works”, “in what way” and “why it works”), a strategy for improved future practice was recommended.

**CMO 1: geographical location**

Further analysis identified gaps in inter-agency working relating to geographical location. Many urban teams reported larger caseloads and fewer resources to deal with issues other

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanism</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural location</td>
<td>Informal communication strategies and cross-boundary working</td>
<td>Positive for joint working</td>
</tr>
<tr>
<td>Urban</td>
<td>Formal communication strategies, less cohesive teams</td>
<td>Not satisfactory for joint working</td>
</tr>
<tr>
<td>Urban-specialised</td>
<td>Formal and Informal communication strategies, cohesive teams</td>
<td>Positive for joint working</td>
</tr>
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</table>

**CMO 2: environment**

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanism</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital location</td>
<td>Decision making by A&amp;E health professionals; mental health professionals</td>
<td>Not always satisfactory for vulnerable adults</td>
</tr>
<tr>
<td>Police cell/custody suite</td>
<td>Decision making by police professionals, after trying healthcare referral</td>
<td>Not satisfactory for vulnerable adults</td>
</tr>
</tbody>
</table>

**CMO 3: capacity**

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanism</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diminished capacity</td>
<td>Police assessment</td>
<td>Not always satisfactory for vulnerable adults</td>
</tr>
<tr>
<td>Diminished capacity</td>
<td>Health assessment</td>
<td>Positive outcomes for vulnerable adults</td>
</tr>
<tr>
<td>Diminished capacity-reзнexising fluctuating capacity</td>
<td>Joint investigation and assessment with police, social work and healthcare professionals</td>
<td>Positive outcomes for safeguarding vulnerable adults</td>
</tr>
</tbody>
</table>

**CMO 4: referrals**

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanism</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals from health professionals</td>
<td>Not seen as a priority for healthcare</td>
<td>Minimal referrals – safeguarding adults compromised</td>
</tr>
<tr>
<td>Referrals from Police</td>
<td>High priority creates overload for social workers</td>
<td>Large numbers of referrals not always actioned – risks for safeguarding adults</td>
</tr>
<tr>
<td>Referrals from social work</td>
<td>High priority for high risk cases – respect for the rights of individuals to undertake risky lifestyle choices</td>
<td>Less numbers of referrals – risks for safeguarding adults</td>
</tr>
</tbody>
</table>

**Table IV.**

CMO analysis
than “protection”. Rural areas and specialised teams within urban areas worked more cohesively adopting formal and informal communication strategies. The lack of places of safety for at risk clients was perceived as a gap in resource provision that had not been there previously.

CMO 2: environment
The context here is environment and related to a place of safety and the mechanisms related to the decision-making processes leading to positive or negative outcomes for vulnerable adults. The difficulties with the definitions of mental “capacity” were noted by all professionals. The police perceived that they are not the recognised profession to make a “diagnosis” in relation to capacity or to assess risk. However, they reported being “left” to make these judgements when medical colleagues were unable, or unavailable, to assess capacity and social work colleagues were unable to locate legislation upon which they could intervene. The Police have to deal with these situations without adequate support for diagnosis and safe location from health services.

CMO 3: capacity
Here, the context relates to clients with capacity issues and the mechanisms rely on appropriate assessment leading to positive or negative outcomes. The initial referral and shared decision-making processes were hindered in some areas due to unavailability or lack of involvement of some professionals, and more than half of the health staff were identified as falling into this category. One aspect that widened this gap was the lack of compatibility and interoperability for transferring information.

CMO 4: referrals
The mechanisms denote the professional differences in terms of the number and value of referrals and the outcomes relate to safeguarding. Police professionals described consistent referral practices with most vulnerable adults being referred to social services. Social care workers described practices that prioritised police referrals into those that were high priority only, as they did not feel they had the resource capacity to manage them all. Health professionals described very low referrals to either police or social services. The outcomes, therefore, demonstrated that safeguarding of adults could potentially be compromised by these differences in professional practices with potential risks to adults in need of support and protection.

Discussion
The findings identified barriers and also ways of overcoming the barriers. The following aspects are highlighted for discussion.

Place of safety
There were many references from participants acknowledging the importance of a place of safety for vulnerable people and these were seen as hospital based or social service provision and as a last resort police cells. Findings indicated that police professionals often accompanied adults into A&E services and contacted mental health organisations. They not only reported wasting time “babysitting” clients in A&E for up to 4–5 h whilst waiting for medical colleagues to conduct assessments, but also spoke of “not being able to walk away” due to the vulnerability of the client. The closure of statutory provisions of places of safety and the policy of “deinstitutionalization” have led to increased police contact with those at risk of harm and particularly those with acute mental illness. Police officers argued that their training in dealing with these vulnerable clients was minimal, concurring with other
researchers (Herrington and Pope, 2013; Laing et al., 2009). Participants in our study spoke of working around systems and processes, crossing boundaries and coined the term, “boundary spanners” to explain how they overcame barriers to protect and safeguard. Some police participants identified health colleagues with whom they had forged good relationships and who were able to provide timely advice when official channels of communication had failed. However, barriers to communication were also noted when there was a perceived “no answer” from social services for out-of-hours calls.

Assessing capacity
Whilst the assessment of capacity has been made easier by the introduction of the criterion based tests (UK Government, 2005; Scottish Government, 2007), the implementation of these tests requires a degree of mental health awareness from skilled health professionals. If they were unavailable police officers perceived that they were compelled to make decisions that did not always lead to the best outcomes for the adult at risk.

Partnership working for “joint assessment” was apparent in some areas with social work and police working together. Improvements within the 2016 vision for Police Scotland (2016) acknowledged that all professions need training whilst also recognising that police officers cannot and should not take on the roles of social workers and community psychiatric nurses for assessing capacity.

Interprofessional differences
The notion of recognising professional differences within partnership and collaborative working is an important skill. It relies on cohesive team working, mutual trust and respect for each professions’ knowledge and expertise (Hammick et al., 2009). This study found this to be true with recognition of role differentiation to provide the best outcomes for vulnerable adults and their families. Hall (2005) described this as different professionals finding similarities when seeing something together and yet identifying very different things. The case study discussion during the focus groups confirmed this.

Professional differences affected judgements and decision making. Police professionals were found to be most “risk averse”, social workers the least and health professionals somewhere in between. There was an awareness from social work professionals to “live and let live”, recognising the rights of individuals to live “risky” lives. On the other hand, police professionals preferred to make a decision on life choices, implying “better” outcomes for the adult and other members of the public. Participants spoke of challenging debates at case conferences on this issue.

Information sharing
Information sharing is an area affected by professional allegiances and was most apparent from the health professions. Data revealed that General Practitioners (GPs) were especially reluctant to share information to police and social work professionals based on the need to adhere to data protection and protect the special “privileges” of the doctor–patient relationship. Social workers were perceived as acting as “boundary spanners” to access information. GPs were not perceived as having any concerns about the doctor–patient relationship in situations, where discussions pertained to child protection issues. Participants advocated that professions should learn the lessons from child protection. However, these two aspects of protection are not comparable and information sharing within the context of child protection occurs more readily because the child is deemed unable to give consent. The challenge in ASP is one of the capacities, where the adult is deemed capable so can refuse consent to information sharing.
Informal information sharing was deemed to be more reliable than formal information sharing, concurring with previous work (Cotter, 2015; Cambridge et al., 2010; Petch, 2008). ASP data on information sharing and Care Inspectorate Scotland’s (2014) report also concur with this study’s findings (2013–2014). Police officers, who had reported and documented concerns, were disappointed when these were subsequently deemed low priority for social services. The call for comprehensive audit arrangements that provide leadership and direction for ASP continues to be identified in the literature (Care Inspectorate Scotland, 2014), despite the codes of practice demanding audit information since 2009.

Joint working – “rural and urban split”
From the study, it appears that most rural teams worked cohesively and were able to cross boundaries easier than some urban teams. There were exceptions to this, however, when urban teams were more specialised, focusing on specific areas (e.g. domestic abuse) close working relationships had developed.

When teams were more opportunistic in composition because of location or size, it was difficult to develop good relationships and the data revealed concerns regarding the achievement of quality standards for safeguarding adults. Cambridge et al. (2010) described “territorial variations” between two English local authorities. They concluded that this portrayed the national picture for England and called for the development of KPIs in ASP. From the findings of this study, parallels can be attributed to the Scottish picture and Phase 2 of this study developed KPIs for ASP.

Strengths and limitations
This unique Scottish study successfully identified the inter-agency practices of health, social services and police. By means of a modified realistic evaluation approach, it provides an in-depth understanding of the challenges that professionals face on a day-to-day basis when safeguarding adults and informed strategic recommendations to overcome the barriers to good practices in organisational working. The methods used to determine CMO could benefit other researchers to develop studies exploring the complexities of multi-causal effects of cross-boundary working.

The use of the same case study in each focus group helped to neutralise bias. However, the voluntary nature of participation could have resulted in biased perceptions. The limited numbers of health professionals may have resulted in the less representation of health sector views.

It is important to acknowledge that this research was conducted during the introduction of Police Scotland in April 2013, when eight police forces were merged. Practices may have changed since the data collection period. In particular, there has been the re-structuring of public protection units to include “Risk and Concern Management Hubs” in each Division. These hubs are responsible for collating and assessing “concern reports” on adults at risk, child protection, hate crime and domestic abuse incidents. The hubs focus on improving Police Scotland’s approach to well-being concerns with the identification of opportunities for early intervention and prevention through strong partnership working. The strategy for the next 10 years not only provides a clear vision for change but also identifies vulnerabilities in policing (Police Scotland, 2016).

Conclusion
This qualitative study has investigated the inter-agency ASP practices of police, health and social care professionals in Scotland. It provided information on ASP that concurred with the few studies and reports available (Cambridge et al., 2010; Care Inspectorate Scotland, 2014), but the need for further research and updating of current reports were recognised.
It was unique in identifying gaps in the working practices of ASP professionals that can be attributed to their own understanding of inter-agency working and the expectations of partner agencies.

Participants referred more to the generic term “Public protection” widening the remit of the study.

Processes were practiced differently in different areas and professional differences in decision making also resulted. Debates centred on the rights of the individual to adopt a “risky” lifestyle choice and the need for professionals to “protect and support”.

This was of particular significance for reporting and referral, where all agencies involved in a case are expected to submit a report providing a clear understanding of the inter-agency perspectives. The development of an at risk persons’ database that all professions could access was identified as an important step for improved practice and is work in progress.

Recommendations from this study include the need to strengthen information sharing and improve interdisciplinary education and training. This would potentially result in improved collaborative decision making, closing some of the gaps in practice. Further longitudinal research studies and incidence related audit trails are recommended to assist in the evaluation of practitioners’ skills in the changing world of public protection.

Whilst the focus of this study has been on ASP, the conclusions and recommendations are transferable to public protection issues in many other contexts.

Acknowledgement
The following people are acknowledged for their valuable contribution to this research project: all the ASP professionals in Scotland who participated in the focus groups: project team member; Inga Heyman Lecturer, Edinburgh Napier University, Edinburgh; steering group: Paul Comely, National Adult Protection Coordinator, at the time of the project: WithScotland www.withscotland.org, Albert Donald, Convenor of Adult Protection Committees, Grampian, Detective Superintendent Martin Dunn, Specialist Crime Division, Police Scotland, National lead for Adult Protection, James Ferguson, Consultant Surgeon in Emergency Medicine, NHS Grampian National Clinical Lead for ‘The Scottish Centre for Telehealth and Telecare’ (SCTT), John Myles, Independent Chair Adult Protection Committee, Fife, Kenny O’Brien, Adult Protection Unit Co-ordinator, Aberdeen City Council, Dr Rebecca Riddell, Locum General Practitioner, Lead for Clinical Communication Division of Medical and Dental Education, University of Aberdeen; support staff: Midj Falconer, Research Fellow, Alison Reddish, Research Assistant.

References


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Abstract

Purpose – The purpose of this paper is to report on the findings of the first stage of a project seeking to evaluate and overcome inter-professional barriers between health and social care staff within a single, co-located, integrated community team. The project seeks to answer the following questions: first, Do inter-professional barriers to integrated working exist between health and social care staff at the interface of care delivery? Second, If inter-professional barriers exist, can joint health and social care assessments help to overcome them? The paper develops the current evidence base through findings from a staff questionnaire and the initial findings of a pilot study of joint health and social care assessments aimed at overcoming inter-professional barriers to integration.

Design/methodology/approach – The first stage of the project involved running an anonymous, online questionnaire with health and social care staff within a single, co-located community adult health and social care team. The questionnaire aimed to explore staffs’ perceptions of inter-professional collaboration when assessing the health and care needs of service users with a high degree of complexity of need. The second element of the study presents the initial findings of a small pilot of joint health and social care assessments. A second staff survey was used in order to provide a “before and after” comparative analysis and to demonstrate the effect of joint assessments on staffs’ perceptions of inter-professional collaboration at the interface of care delivery.

Findings – Health and social care staff value joint working as a means of improving quality of care. However, they also felt that inter-professional collaboration did not occur routinely due to organisational limitations. Staff members who participated in the pilot of joint assessments believed that this collaborative approach improved their understanding of other professional roles, was an effective means of enabling others to understand their own roles and helped to better identify the health and care needs of the most complex service users on their caseloads. Initial findings suggest that joint assessments may be a practical means of overcoming inter-professional barriers related to a lack of communication and lack of understanding of job roles.

Practical implications – The questionnaires highlighted the need for integration strategies that are aimed at facilitating collaborative working between staff of different professions, in order to achieve the aims of integration, such as a reduction in duplication of work and hand-offs between services.

Originality/value – To date, few studies have explored either staff perceptions of collaborative working or the effectiveness of joint assessments as a means of overcoming inter-professional barriers. This paper adds new data to an important area of integration that legislators and researchers increasingly agree requires more focus. Although the findings are limited due to the small scale of the initial pilot, they provide interesting and original data that will provide insight into future workforce integration strategies.

Keywords Integration, Integrated health and social care, Health and social care, Integrated care

Paper type Case study

Introduction

Integration of health and social care is a key national priority in England in response to an aging population with increasingly complex health and social care needs (NICE, 2015). The changing demographic has contributed to health inequalities which are described in the policy document “NHS Five Year Forward View” (NHS England, 2013). Governing bodies agree that integration of health and care is one way of reducing such inequalities
(Bardsley et al., 2013; Imison and Bohmer, 2013; National Audit Office, 2017). So far, numerous integration strategies have been implemented and evaluated across the English health and social care system (LGA, 2016). However, the evidence that integration strategies are having the desired impact on health inequalities remains stubbornly elusive (Cameron et al., 2014; Mackie and Darvill, 2016).

Central to the entire discipline of integration is the design of community services around the needs of local populations (NHS England, 2013). Experts and service users have collaborated under the banner of “National Voices” in order to understand what good quality care should look like. (National Voices, Think Local Act Personal, 2013). They concluded that NHS and social care staff must collaborate together in order to deliver individualised care in a way which reduces duplication and hand-offs between services.

A number of researchers have examined the relationship between organisational integration strategies and collaborative working. Thomas (2015) argues that integration at organisational level, although essential, does not automatically lead to professionals working collaboratively at the interface of care delivery. Despite this, the integration agenda has focussed largely on delivering structural or process integration whilst ignoring the front line (Heenan and Birrell, 2009; Thomas, 2015). Where front line solutions are reported, they widely involve new boundary spanning roles (Gilburt, 2016; Nasir et al., 2013; Bianchi et al., 2012), co-location (RAND Europe, Ernst and Young, 2012) and single assessment processes (Department of Health, 2012b).

Boundary spanning roles, such as care co-ordinators and case managers, have been associated with significant reductions in unplanned hospital admissions (Alshabanat et al., 2017; Huntley et al., 2016), reduced referral times and improved information sharing (Thistlethwaite, 2011). However, others report that they can lead to entrenched “professional protectionism” (Christmas and Millward, 2011) and professional “Turf wars” (Nasir et al., 2013).

The co-location of health and social care teams has seen a resurgence more recently as the integration agenda has gained momentum (RAND Europe, Ernst and Young, 2012). In a systematic review of the literature, Mackie and Darvill (2016) identified that co-location of staff during the development of integrated teams was widely viewed as essential for different professions to develop collaborative working relationships. Further studies have linked co-location to improved communication and a greater understanding of job roles (Lees et al., 2017). However, co-location alone does not necessarily result in measurable improvements in collaborative working across professional boundaries (Taylor, 2012; SCIE, 2017).

Latterly, joint assessments and care plans have been given priority within government guidance on integration and have been used by regulators as a measure of quality (SCIE, 2017; NHS Confederation, 2016). The expectation is that a collaborative approach to patient assessment will reduce duplication of effort and bureaucracy, leading to conservation of resources and improved service user experience (NHS England, 2013). On the other hand, uncoordinated assessments are said to lead to delay in care provision, multiple uncoordinated visits from health and social care staff, unsafe transfers through the care system, unnecessary emergency admissions, a lack of information for people on how to manage their long-term conditions and failure to meet a person’s wishes at the end of life (NHS England, 2013).

Early evaluation of the implementation of the Single Assessment Process within English organisations concluded that the scheme had not led to the initial objectives of a systematic, standardised approach to assessment and care planning (Abendstern et al., 2011). Furthermore, research also suggests that organisational implementation of single assessment processes does not automatically lead to their use in practice by the workforce (Huxley et al., 2008). In a recent review, the Care Quality Commission found that more frequently than not, practitioners were not using single assessment tools and were not routinely sharing key information, missing opportunities for timely intervention (CQC, 2016).
Although the evidence of the impact of integration strategies on patient outcomes is difficult to find, most would argue that this does not mean that health and care staff are not willing to work together to deliver the best possible care for service users. The issue of inter-professional barriers, such as a lack of trust and understanding of each other’s roles, is increasingly recognised as an area of concern which needs to be addressed in order to achieve the aims of integration (Nasir et al., 2013; Mangan et al., 2015; Lees et al., 2017). The government has argued for moving beyond stumbling blocks to making integration happen whilst exploring the barriers that undoubtedly exist (Department of Health, 2012a).

This paper reports on the initial findings of an evaluation of staff perceptions of inter-professional barriers to integration within a co-located, health and social care team in a single locality in the North West of England. The primary aim of the study was to gain an insight into inter-professional barriers to integrated working by capturing staff’s perceptions. Additionally, a small pilot of joint health and social care assessments was evaluated to establish the effect on inter-professional barriers.

**Approach**

A cross-sectional questionnaire design was adopted to assess health and social care staffs’ perceptions of collaborative working within the co-located team. First, a literature review was undertaken to identify common themes of barriers to integrated working. Differences in professional values, insufficient communication, insufficient resources and a lack of trust and understanding of job roles were most frequently cited. Themes from the literature informed the design of two sets of anonymised questionnaires, consisting of ten questions each, which were a mixture of Likert scales, sliding scales and multiple-choice questions.

The first questionnaire was sent to all health and social care staff within the co-located, integrated team. The purpose of which was to evaluate the first project aim which was as follows:

1. Do inter-professional barriers to integrated working exist between health and social care staff at the interface of care delivery?

   The intention was to establish a baseline from which to measure the effect of joint health and social care assessments on staff perceptions of inter-professional barriers to integration. Measuring a baseline makes it possible to demonstrate when change has had a positive impact (Wheeler, 2003).

   The second questionnaire was sent only to those staff who participated in a pilot of joint health and social care assessments. The purpose was to evaluate the second project aim which was as follows.

2. If barriers do exist, do joint health and social care assessments help to overcome them?

**Results**

*Do inter-professional barriers to integrated working exist between health and social care staff at the interface of care delivery?*

The initial survey was sent to a total of 38 staff, 29 of whom responded (76 per cent). In total, 22 of this number answered all 10 questions. In order to frame the narrative of the questionnaire, respondents were asked to read the following statement and consider how service users with complex needs are assessed by their team:

> If I have complex health and care needs, the NHS and social care work together to assess my care needs and agree a single plan to cover all aspects of my care. (National Voices, 2013)

If I have complex health and care needs, the NHS and social care work together to assess my care needs and agree a single plan to cover all aspects of my care. (National Voices, 2013)

Respondents were asked to indicate whether they believed that NHS and social care staff members work together to assess the care needs and agree a single plan of care for service users with complex health and care needs. This was important to establish because
it mirrors the National Voices definition of good quality care (National Voices, 2013). The majority of those who responded to this question (17 from a total of 22) did not believe that health and social services usually worked together in this way. A subsequent question developed this concept further by asking respondents how often they carry out joint assessments for newly referred service users. The findings from both questions correlate and are consistent with those of other studies which found that a joint approach to assessment and care planning was rarely adopted within organisations (NAO, 2017).

Respondents were then asked to indicate if their own assessments were comprehensive enough to identify all aspects of service users’ health and care needs. This question was designed to give insight into staffs’ perceptions of the value of joint working. Both academics and governing bodies tend to agree on the importance of integrated working as a means of ensuring that services are delivered efficiently, with fewer hand-offs (Cameron et al., 2014; Murphy et al., 2017; NAO, 2017) and that patients have a smoother transition through the care system (NHS England, 2013). In contrast, the majority of respondents (16 out of 22) believed that their individual assessments were usually or always comprehensive enough to identify all health and care needs.

The following two questions asked staff to rate on a scale of one to ten, how easy it was and also how comfortable they felt approaching other professionals when care planning. The intention was to differentiate between organisational and personal barriers to integrated working as described in the literature (Berglung et al., 2015; SCIE, 2017). A comparison of the results revealed a clear difference. Although respondents generally reported a high level of confidence, they did not always find the process of collaboration easy. The findings corroborate the research which suggests that organisational barriers, such as separate records and a lack of resources, stifle collaboration at the interface of care delivery (Laugesen and France, 2014; National Coalition for Integrated Care and Support, 2013).

The penultimate question sought to establish if respondents valued joint assessments as a means to improving quality of care. Researchers have previously asked this of service users (Taylor, 2006; National Voices, 2013; Trivedi et al., 2013; NHS Confederation, 2016). However, no research has been found that seeks staffs’ opinions. In contrast to perceptions of the comprehensive nature of their own assessments, respondents all either agreed or strongly agreed that joint assessments would improve quality of care (n = 23). This corresponds to service users’ opinions from research and suggests that joint assessments are highly valued by both staff and service users (Trivedi et al., 2013; Cameron et al., 2014).

The final question of the initial survey presented a list of ten potential barriers to integration which were derived from a synthesis of the literature. Respondents were asked to rank the top three biggest challenges to integration within their organisation. Interestingly, the following four options were selected by a clear majority of respondents:

1. insufficient communication/information sharing (n = 13);
2. cultural or philosophical differences between different professions, e.g., different professional values and/or approaches to assessment of need and care delivery (health and social care) (n = 12);
3. insufficient resources/funding (n = 13); and
4. lack of confidence/trust between professions (n = 11).

Communication, cultural differences and trust are frequently cited as both barriers and potential beneficiaries of integration strategies (Department of Health, 2012a; Nasir et al., 2013).

The initial survey demonstrated that barrier to inter-professional working were limiting opportunities for staff to collaborate at the interface of care delivery. A small-scale pilot of joint assessments was then carried out and participating staff completed a second questionnaire designed to answer the second project aim.
If barriers do exist, do joint health and social care assessments help to overcome them?

The joint assessment pilot was carried out as a PDSA cycle. The first cycle involved the evaluation of five joint assessments carried out in the homes of people with complex health and social care needs. Current caseloads and new referrals were purposively analysed to identify complex patients. Purposive selection from existing caseloads answered one of the concerns of key stakeholders identified in the planning stage, which was to avoid the generation of new referrals into services that were already under pressure. The initial data is limited and should be interpreted with caution due to sample size. However, interesting observations have already begun to emerge and will inform further PDSA cycles.

Respondents to the second questionnaire all agreed that joint assessments would improve collaborative working between health and social care workers. Additionally, four of the five respondents indicated that joint assessments were better than single assessments in identifying all health and care needs for people with a high level of dependency. This reinforces the notion that staff value joint assessments as a means of facilitating integration and improving quality.

The next section of the questionnaire focussed on how staff understood the job roles of others. Much of the literature that evaluates barriers suggests that a lack of understanding of job roles leads to a lack of trust and poor communication between professions (Erens et al., 2015; Gilburt, 2016; NAO, 2017). All respondents felt that other professionals had a better understanding of their role after the intervention. Furthermore, the majority of respondents (four out of five) indicated that they gained a better understanding of others’ roles.

The subsequent questions were intended to measure the effect of joint assessments compared to baseline measurements establish in the first questionnaire. Respondents indicated that the intervention had a positive effect on their level of comfort and ease of collaboration. Respondents also strongly supported the notion that joint assessment would improve quality of care.

The initial findings indicate that the joint health and social care assessments could be an effective strategy to overcome some of the stated barriers to integrated working.

Discussion

Previous research has found that nurses and social workers do not routinely work together to share information (Taylor, 2012). This can result in a lack of understanding of each other’s roles, which can lead to mistrust and poor communication (Mangan et al., 2015). Co-location has been found to mitigate this to a certain degree (SCIE, 2017). However, effective processes do not generally exist that facilitate joint working at the interface of care delivery (NAO, 2017). Lack of processes can lead to workers retrofitting into old, familiar “silos”, resulting in fragmented care delivered in multiple settings (National Coalition for Integrated Care and Support, 2013). In a national review of joint health and social care assessments in the UK, Abendstern et al. (2011) found a high level of resistance from workers towards their use, even within co-located, integrated teams. This lack of co-ordination can result in delays in referrals (Thistlethwaite, 2011), duplication of effort and service users often having to explain their story more than once (National Voices, 2013). Service users are at risk of feeling that professionals are not working together and that services are inefficient and uncoordinated (NAO, 2017).

The initial findings of this study are consistent with the research which suggests that organisational integration strategies are not routinely leading to improved collaboration at the interface of care delivery. Health and social care staff felt that they were not routinely working together to agree a single plan of care for service users. On the other hand, staff generally perceived that their assessments were comprehensive enough to establish all of the health and care needs of patients with a high degree of need. There are several possible explanations for staff holding this view. A greater proportion of those who responded in this way had job roles that may be described as boundary spanning, such as active case managers and advanced nurse practitioners. Boundary spanning roles work across
different services and sectors and act as a single point of contact for service users (Nasir et al., 2013). This cross-sector working may lead staff to perceive that they have achieved the level of expert practitioner in both health and social care (Benner, 1982). However, in an evaluation of such roles, Gilburt (2016) suggested that the capacity to deliver truly integrated care was limited by the fact that they were founded in a single profession and, therefore, were not truly boundary spanning.

The fact that staff believed their assessments captured all aspects of health and care need has further implications around inter-professional barriers. Where staff opinions have been examined in the literature, social workers sometimes believe that their job roles are misunderstood by health staff (Nasir et al., 2013; Mangan et al., 2015; Lees et al., 2017). Respondents may think that they are identifying all aspects of health and care need but may not fully understand what they do not know. Furthermore, anecdotal evidence that has emerged from this project indicates that the holistic nature of health care assessments is sometimes misunderstood by social care staff. Therefore, there seems to be a degree of misunderstanding from both professions.

Another important finding of the initial survey was that staff did not always find it easy to collaborate across professional boundaries, despite feeling confident in their ability to do so. Therefore, it is conceivable that there is a need to evaluate processes that could make it easier for co-located staff to work together collaboratively.

The findings of the second questionnaire correlate to the research findings based on service users’ perceptions. Health and social care staff who participated in joint assessments valued them as a means to improve quality of care. Initial findings also indicate that inter-professional barriers, such as lack of trust, understanding of job roles and poor communication may be overcome through joint assessments.

Limitations
Although the initial findings add new data to an important and largely overlooked aspect of health and social care integration, the use of surveys can introduce bias where questions are set to measure respondents’ perceptions (Bardsley et al., 2013). Further bias may result from the measurement of barriers and the assumption that barriers do exist. In order to mitigate this, a literature review was carried out to establish key themes regarding collaboration of health and social care at the interface of care delivery. Additionally, questions were designed to avoid the use of negative language, such as “barriers”.

Of the many evaluations of integration pilots in the literature, few are comparative in design or offer a “before and after” analysis, which limits studies ability to demonstrate the success of an intervention (Cameron et al., 2014). The pilot study in this paper did compare staff perceptions of integrated working before and after joint assessments were carried out. However, the anonymisation of the initial survey prevented a direct comparison of how the intervention affected individual staff’s perceptions.

Further limitations relate to the small scale of the initial pilot within a single co-located team. However, the findings do add to the argument that integration strategies should focus more on solutions aimed at the interface of care delivery. Results of the PDSA cycle suggest that joint health and social care assessments can help to improve communication and understanding of job roles across professional boundaries. Therefore, the assessment process could reasonably be a practical focus for an integration strategy aimed at improving inter-professional collaboration.

Despite limitations, initial findings are encouraging and add impetus for future development and sustainability. Additional, PDSA cycles are required to evaluate joint assessments and improve data quality. Expanding the pilot to other co-located teams within the organisation will require further stakeholder engagement. This would also increase the trustworthiness of results by delegating project lead responsibilities to others. A natural progression of this work would be to analyse service users’ experiences of joint assessments.
Cameron et al. (2014) argue that evaluations of integration strategies should focus on patient outcomes. Informal recordings from this pilot have supported the research which suggests that service users’ value joint assessment and experience more efficient and effective care as a result. Recording case studies with ethical approval could prove to be a rich source of data that may add to this area of incomplete research.

Conclusion
Integration of health and social care is a major political priority aimed at reducing cost and health inequalities within aging populations. Despite the implementation of a wealth of integration strategies, the hoped for improvements in cost and outcomes remain stubbornly elusive. This pilot study has demonstrated that staff members are not routinely collaborating at the interface of care delivery, despite being co-located. Staff identified that insufficient information sharing, different professional values and approaches to assessment, insufficient resources and a lack of trust or understanding between different professions were the biggest challenges to integration within their organisation.

A growing consensus is emerging which suggests that integration strategies should focus more on solutions to inter-professional barriers. The findings of this study suggest that joint health and social care assessments could provide a practical opportunity for inter-professional collaboration at the interface of care delivery, which could achieve the universal desire of truly co-ordinated care designed for the future health and well-being needs of our changing population.

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Further reading


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Perception of integrated practice in home care services
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Abstract
Purpose – As a result of demographic changes, older people are increasingly living at home, with multi-morbidity and complex care needs. This calls for enhanced integration of homecare nursing and social services. The purpose of this paper is to describe the clinical collaboration, scope and impact of integration from the perspective of staff in a setting identified as fully integrated.

Design/methodology/approach – In this qualitative study, data consisted of interviews with managers and care workers in social services and homecare nursing (n = 14) in daily clinical collaboration, followed by five focus group discussions (n = 28). Data were analysed using framework analysis.

Findings – Although the homecare services studied were ostensibly fully integrated, the study showed that the process of integration was incomplete. Interdisciplinary coordination between nursing and social services team managers was described as strong and efficient, but weaknesses were identified in collaboration between care workers. They lacked acquaintance with one another, opportunities for communication and knowledge of the contribution of members of other teams. They felt unclear about their own role in coordinated teamwork and lacked a shared vision.

Originality/value – This paper's originality lies in the model of integrated care studied and its focus on actual care practices. The findings highlight that integration does not automatically permeate between different levels of service. Time and space must be allowed for conversations between health and social service teams to promote integration.

Keywords Integrated health and social care, Qualitative method, Nursing, Home care

Paper type Research paper

Introduction
Demographic changes leading to an increase in the number of older people with multi-morbidity and complex care needs demand new ways of organising services, specifically effective coordination between multi-skilled workforces. The implementation of integrated care programmes takes diverse forms at different levels, with either public or private providers, and with varying performance (Jolanki et al., 2017). The integration of health and social homecare services for older people, in order to strengthen and develop such services, has been the focus of policy-makers in recent years (Exworthy et al., 2017; Jolanki et al., 2017; Kodner, 2009b; Valentijn et al., 2013; Vondeling, 2004). Effective interdisciplinary integration of nursing and social homecare services enables older people to remain in their own homes, even those suffering from more severe health conditions, resulting in fewer visits to emergency departments (Cameron et al., 2014; Goodwin et al., 2012; Kuluški et al., 2017), improved coordination of care, fewer hospital bed days and reduced use of nursing homes (Thistlethwaite, 2011).

Integrated homecare demands close collaboration, with clear goals and a shared vision among interdisciplinary professionals (Hebert et al., 2008; Kodner, 2006; van Dijk et al., 2016), but integrating different work cultures and procedures can be complex and challenging (Cameron et al., 2014; Kodner, 2009a). Insufficient flow of information and
understanding (Edgren, 2008; Tsasis et al., 2013; Valentijn, Ruwaard, Vrijhoef, de Bont, Arends and Bruijnzeels, 2015; Valentijn, Vrijhoef, Ruwaard, de Bont, Arends and Bruijnzeels, 2015), unclear definitions of work roles, responsibilities and expected outcomes may lessen the benefits of integration (Jolanki et al., 2017). Studies have found that collaboration is of utmost importance in an integrated service (Ahgren and Axelsson, 2005; Jolanki et al., 2017; Kodner, 2009b; Kulik et al., 2017; Valentijn, Ruwaard, Vrijhoef, de Bont, Arends and Bruijnzeels, 2015; Valentijn, Vrijhoef, Ruwaard, de Bont, Arends and Bruijnzeels, 2015). Teamwork with face-to-face interaction improves the flow of information and facilitates the sharing of tasks (Jolanki et al., 2017). Employees must have opportunities to get to know one another and take part in conversations or discussions to gain mutual understanding of their roles (Jelphs and Dickinson, 2008; Randström et al., 2014).

A multiplicity of definitions of integrated care and approaches is arguably a barrier to integration reforms (Hudson, 2012; Nolte and Pitchforth, 2014). Recent systematic reviews showed that successful integration projects are based on building trust within teams and strong leadership (Auschra, 2018; Kirst et al., 2017). Nevertheless, negative attitudes and cultural differences between professionals remain, such as inequalities that include the different use of terms and lack of a basis for information sharing (Pike and Mongan, 2014).

Most integration projects and research studies have primarily focused on the structural level, how frail older people can remain living in their own homes and how hospital admission can be prevented, or integration between primary and secondary healthcare (Kodner, 2006; Somme et al., 2007; Valentijn, Ruwaard, Vrijhoef, de Bont, Arends and Bruijnzeels, 2015; Valentijn, Vrijhoef, Ruwaard, de Bont, Arends and Bruijnzeels, 2015). There is, however, a lack of deeper understanding of collaboration between health and social care employees in an integrated homecare setting and thus a need for empirical research from the perspective of service users and employees (Hébert and Veil, 2004; Jolanki et al., 2017; Kirst et al., 2017). This qualitative study explored the benefits and barriers of collaboration as perceived by the employees of nursing and social services in a public community homecare service in Reykjavik, Iceland, a setting identified as fully integrated.

The homecare setting
In Iceland, healthcare services are financed and provided by the central government but social services are financed and organised by the municipalities. Homecare nursing services in Reykjavik, the capital, have undergone a number of structural changes since 2000. In 2002, all services were transferred from the community health centres to one united nurse-led homecare centre that served the whole city. Although this change allowed increased rationalisation and optimisation in the use of staff, it also meant that relations with GPs and community health centres were weakened. In 2008, a decision was made to integrate homecare nursing and the social services and create an independent, integrated homecare centre within the city’s municipal welfare services. Homecare nursing thus came under the operational management of the municipality or the Department of Welfare of the City of Reykjavik, though still financed by the state. Thereafter, a process of systematic integration of nursing and social homecare took place from 2009 until 2016, when homecare nursing and social services were described as fully integrated (Velferðarsvið Reykjavíkurborgar, 2012; Velferðarsvið Reykjavíkurborgar, 2016).

Although reference was made to Leutz’s theoretical model of integration, only some of his criteria were met (Leutz, 1999; Shaw et al., 2011). Services are located under one roof in a collective service centre. A single phone number is provided for homecare services and all requests for services are handled centrally by a team of nurses and social workers, who decide if the client is in need of nursing care, social services or both. The client’s information is
then sent to the relevant team manager, nurse and/or social worker, who will visit and assess the client at home, in cooperation with the family and decide on the need for homecare. The team manager’s role is to assess how team members are instructed and managed in providing clinical care. Integration takes the form of collaboration between nursing and social services and informal connections to other disciplines or specialists, such as doctors, physiotherapists, nutritionists and outpatient clinics, enabling the creation of a network of services and informal assistance around each patient (Bjornsdottir, 2018).

Although the homecare services are ostensibly fully integrated, they are divided into separate nursing and social service teams, though with much collaboration. A significant drawback for collaboration is the separate electronic systems, which are incompatible and do not interact. The nursing teams are typically composed of a registered nurse, who is a team leader, three to five certified nursing assistants and sometimes another nurse. The social service teams are composed of a team leader and various administrative, social and health service assistants and unskilled employees. The 24-hour service is operated by nursing teams and social care teams, situated at the municipal service centre for each neighbourhood, working in an interdisciplinary way and in close daily cooperation. Team managers for nursing care and social care share an office and are in direct contact everyday from 8 a.m. to 4 p.m. The focus of this study was the integration between homecare nursing and social services. It should be noted that homecare nursing is not formally integrated with GPs or other medical providers, although good relations exist in many cases.

**Aim and research question**

The aim of the study was to explore the impact of the integration of homecare nursing and social services in an ostensibly fully integrated work setting on the nature of the services. It was guided by the research question:

*RQ1. How do the homecare nursing and social services work together?*

**Method**

**Design**

The study was set up as a two-phased qualitative study (see Figure 1). Phase one yielded a broad view of the collaboration between nursing and social services. Interviews were conducted with employees from each work group in homecare, comprising team managers, registered nurses, social workers, nursing assistants and social/health service assistants. These interviews were subjected to content analysis before proceeding to the second phase. The second phase consisted of five focus group discussions, in which issues raised in the individual interviews were explored in greater depth. Of 100 employees in this homecare setting, 42 participated in the study ($n = 42$), a good representation of the workforce at that time.

Criteria for participation were a minimum of two years’ work experience in homecare, ability to speak Icelandic and interest in participating in the study.

Figure 1. Model of the study.
Data collection and analysis

The individual interviews were semi-structured. An interview guide was used, complemented by a critical incident exercise (CIE). The critical incident technique was developed by Dr John Flanagan in 1954 and aims to maximise the input of the interviewees by asking them to identify a critical incident in which they have engaged. Typically, respondents relate a story about an experience they have had and their thoughts about the experience (Butterfield et al., 2005). Key interview questions were: “What is your understanding of the meaning of integrated nursing and social service homecare?” “Could you tell me about your experience of a good/difficult collaboration in homecare?” and “What influence has this collaboration had on the care provided?” Finally, participants were asked how they perceived the future of integrated homecare and whether they thought it was developing in the right direction or should be done differently.

The individual interviews were subjected to qualitative content analysis (Elo et al., 2014; Graneheim and Lundman, 2004) and the findings were used to frame the questions for the five focus groups with interviewers from the same area of work ($n = 28$). The focus groups consisted of two groups of healthcare assistants ($n = 11$), two groups of social service employees ($n = 11$) and one group of team managers of nursing and social service teams ($n = 6$). The findings from the focus groups were subjected to thematic framework analysis (Lewis and Ritchie, 2003; Spencer et al., 2013). The first author took the lead in the analysis, but all authors read and analysed the interviews independently, followed by common meetings where the analysis continued collectively. The findings have been presented and discussed at a number of meetings among the workers, who have confirmed the understandings that developed from the analysis.

Results

Analysis of the individual interviews revealed somewhat contradictory opinions on the benefits of integration. Team managers saw integration as successful and highly beneficial for the flow and coordination of care. They observed how being located in the same office enhanced the flow of information and shared decision making. Interviews with team members in both the social and the nursing services revealed a more complicated and less robust situation. Although interviewees from both sides were satisfied with how their individual teams worked, they did not experience integration and collaboration between the work groups: they did not know one another, had no common meetings and no opportunities to participate in a shared dialogue with members from the other occupational groups. They even had different working hours, which meant that they did not meet informally at the workplace. Participants had limited knowledge of the assistance provided by members of the other profession and felt unclear about their own role in coordinated collaboration.

The findings are represented in four themes in Table I.

Benefits of integration

Team managers in both nursing and social services regarded close cooperation as highly beneficial and did not want to go back to the previous situation. Working in the same office led to increased communication in the form of informal connections and trust between the team managers.

As one team manager said:

I felt a positive change right away. It is extremely good to sit next to the team manager of the social service and get information. The flow of information has increased. Now we are both more into each other’s work and what needs to be done […]. (Nursing team manager)

Because of the closer connection, team managers saw an increase in the flow of tasks between nursing and social services in both directions. They were able to react
more quickly to changes in their patients’ situations and needs and adapt their provision accordingly.

Social service employees gave many accounts of increased responsibilities and a larger role in the care of elderly people, thanks to the back-up and support from nurses. For instance, everyday care was performed by the social service, with a weekly evaluation from nursing:

I think it is better in many ways […] people are getting more visits than before. And we are increasing their security. Sometimes we were leaving a person after a visit at 10 o’clock, feeling bad and knowing that no-one was coming again until 6 in the evening. Now they can have more visits if they need them. (Healthcare assistant)

Inadequate integration of interdisciplinary care workers: insecurity about boundaries and responsibilities

Despite these positive structural changes and obvious elements of integration, members of both teams complained of unclear work boundaries and responsibilities.

“We don’t know them”. Nursing and social homecare teams were found to operate as separate groups that never had an opportunity to meet. Their shifts did not even start and finish at the same time. There was a lack of formal meetings and little acquaintance with the members of other teams. As one employee of the social service said:

I can say unequivocally that collaboration does not exist at all; it’s just a big zero! Because we have never been introduced to each other. I have been working in social homecare for all of these years, and worked with this whole group of people, but still I couldn’t point out who is who, not even to save my own life.

A member of the nursing team echoed this view:

[…] and we are supposed to be working together! We don’t even know each other’s names! Our patients find it strange and confusing; they talk about it: “What, you don’t know her? Aren’t you working together?” (Healthcare assistant)
Employees said they felt tension in the atmosphere and in conversations between nursing and social service teams, which they thought was due to the insecurity of their positions and a lack of knowledge of each other’s roles and task boundaries. Both groups felt somehow that their territory was being invaded or even that the others were offloading their most difficult tasks on to them (noted by both nursing and social service participants).

“What is their role?” In each focus group, participants agreed that there were too many grey areas in provision and service, suggesting a need for sharper boundaries and clearer definitions of roles and responsibilities by coordinators and team managers, in order to ensure continuity of care:

I say we need more detailed job descriptions, which would lessen the friction. You know, “They only do this or this, and we always have to do some other tasks” [...] There’s this constant comparison! (Social service team manager)

This grey area [...] changes all the time. One day we are not allowed to do anything that is supposed to be done by the nurses and then another day we are told we have to do those tasks. There is such a lot of inconsistency. We need clearer boundaries. Of course situations can vary but then we need guidance and explanations about what to do, how and why. Not just be left to read it on the task schedule when there is no-one around. (Social service employee)

**Lack of interdisciplinary support**

Within each team, members found regular meetings provided them with good support. However, there was no conversation or support between the nursing and social service teams:

We need to be able to seek advice from nurses and nursing assistants about clients with complex needs. They have the special skills and knowledge needed for an appropriate approach. We need that guidance and training to be able to guarantee the quality of the service we deliver. Otherwise, how are we to know how to treat difficult individuals? (Social service employee)

**Willingness and opportunity**

Despite staff’s frustration with the lack of continuity and coordination of the work shared by the social and nursing services, participants were eager for more collaboration and understood the importance of integration for providing a better service and a stronger workforce:

There must be a lot to gain from increased collaboration. Because we are taking care of the same patients! (Social service employee)

There is a total lack of opportunities for us to talk to one another. I mean, this could work very well! If we got the time and space to talk about the patients we have in common, I believe that could change everything! They might be a bit defensive towards us [...]. (Healthcare assistant)

The healthcare assistants also remarked on the opportunity for empowering untrained staff by offering them more systematic support:

We need more courses for those unskilled employees – teach them more about things like infection control and how to behave in a client’s home, all those things that they need constantly to be reminded about. (Healthcare assistant)

We can teach and guide social service employees about many things, I mean, we have a lot of knowledge and we can share that with them. (Healthcare assistant)

When they’re new to the job, why not let them shadow us for a week or so? We can teach them and give them guidance – that could be very useful. (Healthcare assistant)

**Discussion**

The aim of this study was to explore the impact of the integration of homecare nursing and social services by exploring how the two services work together. As has been noted, there is
a lack of theoretically informed empirical work on the actual practice of integration (Valentijn, Ruwaard, Vrijhoef, de Bont, Arends and Bruijnzeels, 2015; Valentijn, Vrijhoef, Ruwaard, de Bont, Arends and Bruijnzeels, 2015; Hanley, 2016; Stokes et al., 2016). This study considered the practical implications of integration between nursing and social services from the employees' view. The results showed close and successful cooperation between the team leaders of the respective services, with a better flow of information, more flexibility in planning and a focus on the person-centred needs of each client, as has been noted in studies on the benefits of integration (Valentijn, Ruwaard, Vrijhoef, de Bont, Arends and Bruijnzeels, 2015; Valentijn, Vrijhoef, Ruwaard, de Bont, Arends and Bruijnzeels, 2015; Kodner, 2009a). On the other hand, employees from the respective services who provided the actual care in the clients' homes did not experience the benefits of integration. Therefore, it can be concluded that integration was only partial and limited to the managers and did not permeate all the layers and branches of homecare. Participants in focus groups were disappointed and did not understand the purpose and goals of integration. Other studies have found that clear and accessible information about the purpose and structure of integrated service strengthens interdisciplinary collaboration, since understanding the benefits of new ways of working increases employee participation and job satisfaction (van Dijk et al., 2016; Mackie and Darvill, 2016; Goodwin et al., 2014). Joining up systems that were not designed to be integrated is difficult and often results in their further drifting apart (Glasby, 2017). The present study’s informants pointed out the lack of joint meetings among employees from the health and social services. Such meetings should be mandatory rather than dependent on individual managers (Pearson and Watson, 2018). Giving space for reflection and discussion about integrated homecare provided to each client creates opportunities to develop common understandings between the two disciplines.

Thematic analysis of the focus group discussions revealed some problems in the implementation of integration. Insecurity and conflicts between nursing and social services can be traced to a lack of communication, understanding and trust, in addition to unclear roles, a lack of job descriptions and insufficient explanation about operating procedures. The systemic difference between nursing and social service teams observed in the present study has emerged in other studies (Pearson and Watson, 2018; Exworthy et al., 2017), indicating the need for organisational changes in terms of management and the structure of teamwork. Participants felt that the integration had reduced the duplication of tasks. However, better information and coordination were needed to improve efficiency and their ability to handle the complex and demanding tasks involved in homecare. To achieve a holistic integration, the gap between nursing and social service teams and their support systems needed to be bridged.

Nevertheless, all participants saw a bright future for an integrated service, which would benefit their clients and the service. According to Leutz (1999), common work procedures are a criterion for an integrated service and essential for clearly defining roles. Staff of both the nursing and social service homecare teams saw an opportunity for their professional growth in an integrated homecare system. That attitude and willingness to collaborate further can be used to make improvements to the service, with benefits to the community as a whole.

This study focused on the experiences and views of staff towards the benefits of integration of nursing and social services in a community setting, while the perspective of service users was not included. Researches focusing on integrated homecare from the perspective of service users are scarce. Much can be learned from this study about ways to enhance integration but for future researches it is important to turn the attention to the users and their carers.

Conclusion
In the environment studied, full integration of nursing and social service homecare will require attention to the lack of opportunities for staff members in different groups to meet and discuss the care they provide, enabling them to develop mutual understandings of each other roles.
Integration does not come about instantly simply by combining work groups under one roof with a single overall manager, but requires active leadership to set the direction for integration. Integration is an active process, wherein priority must be given to providing time and space to bring staff together for common reflection and information sharing. This will enhance knowledge of different work cultures and lead to the development of common vision for the services. It is recommended that future research focus on the impact of regular meetings between social service and nursing staff.

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System wide collaboration? Health and social care leaders’ perspectives on working across boundaries

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Abstract
Purpose – Structural integration is increasingly explored as a means of achieving efficiency gains alongside improved health outcomes. In 2015, three boroughs in London, England began working together to develop an Accountable Care Organisation for the 750,000 population they serve. The purpose of this paper is to understand the experiences of working across organisational and sectoral boundaries for the benefit of the population, including enablers and barriers encountered, the role of financial incentives and perspectives on Accountable Care Organisations.

Design/methodology/approach – A single site instrumental case study involving 35 semi-structured interviews using a topic guide, with key leaders and decision makers from the site and nationally, between April 2016 and August 2016.

Findings – There are differences in levels of autonomy and operational priorities between councils and the NHS. Existing financial mechanisms can be used to overcome sectoral boundaries, but require strong leadership to implement. There are challenges associated with primary care participating in integration, including reluctance for small organisations to adopt the risk associated with large scale programmes. Interviewees were aligned on espoused ambitions for the Accountable Care Organisation but not on whether one organisation was needed to deliver these in practice.

Research limitations/implications – Progressing the integration agenda requires consideration of the context of primary care and the core differences between health and government. Further, research into ACOs is required as they may not be required to deliver the anticipated integration and system outcomes. Understanding if there are specific population groups for whom cross-organisation and cross-sector working could have particular benefits would help to target efforts.

Originality/value – This paper highlights some of the challenges associated with cross-sector collaboration.

Keywords Integrated care, Integrated health and social care, Interagency working, Partnership working

Paper type Research paper

A growing, ageing population that are living longer with more complex care needs has reinforced the international call for integration across services. Coupled with the £22bn efficiency gap the National Health Service (NHS) in England needs to close by 2020 (NHS England, 2014), the current delivery model of services is unsustainable. Now more than ever organisations need to work together across professional, organisational and sectoral boundaries to drive quality and efficiency improvements in service delivery, although

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obstacles to collaborating across boundaries have been identified (Taylor-Robinson et al., 2012; Belling et al., 2011).

The 1997 NHS White Paper highlighted the importance of collaboration across health and social care, centred on the needs of the patient (Department of Health, 1997). The power of integration to address NHS efficiency challenges is centred on the wide variation in avoidable use of hospital care, although the formal evidence remains undeveloped. Whilst the Health and Social Care Act 2012 focused on extending competition and choice in the NHS alongside devolved decision making, implementation of the Act led to several amendments to explicitly promote integrated care. This included the creation of Health and Wellbeing Boards, creating conditions for collaboration at a local level for a defined geography and reinforcing the importance of local authority partnership. However, the new models of care for the integration of health providers (e.g. through Primary and Acute care Collaboratives and General Practice led Multi-Disciplinary Community Providers) risk oversight of the important role local authorities need to play in health and social care partnerships. Literature on integrated care stresses the importance of strong leadership for partnership working, as well as highlighting additional success factors including clinical leadership, IT infrastructure, the scale of change, and the presence of financial and budgetary opportunities to work across sectors and services.

Financial incentives have been identified as a key barrier to enabling organisations to work together, with the separate payment systems often giving conflicting incentives (Ahmed et al., 2015; Marshall et al., 2014). Examples of incentive schemes to promote quality improvement and efficiency savings across care organisations and sectors are increasing. International examples include implementing integrated care management alongside pooled budgets (Australia, Canada, USA), and structural integration alongside pooled budgets (Sweden) (Mason et al., 2014; Walshe et al., 2016). In England, these include: localities pooling budgets across pathways and population groups (NHS England, 2014); the Better Care Fund (BCF), which aims to accelerate integration of health and social care (HM Treasury, 2013) and provide implementation levers for Health and Wellbeing boards; recent policy changes to facilitate the devolution of budget accountability allowing pooled budgets on a larger scale (HM Treasury, 2014); and development of Integrated Care Systems – and Accountable Care Organisations to move budgetary control for multiple settings into one organisation (Ahmed et al., 2015; NHS England, 2017b). The latter sparked concern of privatisation of the NHS, similar to the critiques of competition the 2012 Act received, but legal challenges to date have failed (Torjesen, 2018).

In response to The London Proposition (Greater London Authority, 2015), which set out ambitions for further devolution to London in support of public service reform, the three boroughs of Barking and Dagenham, Havering and Redbridge began working together to develop an Accountable Care Organisation for the 750,000 population they serve. Overcoming conflicting organisation responsibilities and priorities, and funding of individual bodies, were key drivers for the new approach. Furthermore, the creation of Integrated Care Systems and Accountable Care Organisations has become a core component of the delivery of the NHS Five Year Forward View, which was published in 2014 and set out a shared view on how services would need to change, proposing seven new models of care (NHS England, 2014). A group of eight Integrated Care Systems were announced in June 2017 (NHS England, 2017a; British Medical Association, 2017). Integrated Care Systems have collective responsibility for the resources and health and well-being of a defined geographical population, whereas an Accountable Care Organisation also holds a single contract with a single organisation for the provision of health and care services for that population (British Medical Association, 2017).

The Barking and Dagenham, Havering and Redbridge Accountable Care Organisation aimed to remove commissioner-provider distinctions by taking ownership of, and applying new ways of contracting and distributing, the combined health and social care budget.
The partners had established working relationships at a system level through the Urgent Care Board, established in June 2013 as an Advisory Board to drive improvement in urgent care, the BHR System Resilience Group, in part triggered by the ongoing performance challenges in the local acute trust, and the Chief Executives’ Forum. In 2016, the governance structures were further refreshed creating the Integrated Care Coalition, chaired by a Local Authority Chief Executive and the forum through which the Accountable Care Organisation work evolved, to develop a joint approach to integrated care (commissioning and delivery) to build a sustainable health and social care system. The Integrated Care Coalition is an Advisory Board to oversee strategic change across health and social care, and replaces the previous Chief Executives’ Forum.

Key features of the Barking and Dagenham, Havering and Redbridge Accountable Care Organisation proposal include:

- Whole population coverage, 750,000 residents.
- Eight partnership organisations: three local Clinical Commissioning Groups (CCGs), three local authorities – London boroughs of Havering, Redbridge and Barking and Dagenham, an acute hospital provider Barking, Havering and Redbridge University Hospitals NHS Trust and the community and mental health provider North East London NHS Foundation Trust.
- Devolved budget of £1.2bn combining health budgets with adult social care and public health.
- Ambition to achieve improvements in population health outcomes alongside efficiency gains.
- Facilitate changes to service delivery and system wide investment to meet a forecast gap of £430m by 2018/2019. Underpinning this was a desire to reduce acute care expenditure and move activity into community settings.
- Increased focus on health promotion, prevention and community-based interventions to reduce reliance on acute care.

The development of an Accountable Care Organisation in Barking and Dagenham, Havering and Redbridge, a geography with existing strong leadership relationships, provided an opportunity to explore some of the questions arising from the literature on integration in more detail. In particular, how do the partnership work collaboratively across the full system of care? Are there settings for which integration remains a challenge? Are there specific challenges associated with integrating across sectors, in this case health and social care? Policy ambitions for integrated care described above have included the implementation of financial mechanisms to facilitate collaboration across health and social care. With financial incentives continuing to be widely acknowledged as a barrier to integration, what does this mean in practice? What is the difference between having the financial mechanisms to collaborate and the financial incentive? With growing policy attention on Accountable Care Organisations, is there alignment on the need for a structural solution to integration within a site that has existing strong leadership and a history of collaboration? Exploration of these questions will be of wider relevance to sites and national leaders aiming to progress integrated care, specifically understanding the ability to collaborate across sectors, the role of financial incentives and whether a structural solution is required.

Aim and research questions

This was a single instrumental case study (Crowe et al., 2011), involving semi-structured interviews with key leaders and decision makers across health and social care organisations.
in Barking and Dagenham, Havering and Redbridge, and national leaders between April 2016 and August 2016. National leaders were included to place Barking and Dagenham, Havering and Redbridge in wider context and compare insights from this case study with developments in other areas nationally. The interviews sort to understand:

- Experiences of working across organisational and sectoral boundaries for the benefit of the population, including enablers and barriers encountered.
- How system wide financial incentives influence working across organisational and sectoral boundaries.
- Aspirations for the Accountable Care Organisation, what it is hoped to achieve and how, and potential limitations.

Methodology
A single instrumental case study to explore the implementation of Accountable Care Organisations from the context of a local system. In-depth interviews were conducted with staff in senior leadership positions, who make operational and/or financial decisions for their organisation, in organisations that commission or deliver health and/or social care to the population. A combination of purposive sampling and snowball sampling was used (Liamputtong and Ezzy, 2009). Eligible participants were identified through documentary analysis and validated by key leaders in Barking and Dagenham, Havering and Redbridge. In addition, participants were asked to recommend colleagues to be interviewed.

Data collection
Of the 48 people invited to participate, 35 agreed to be interviewed; interviews lasted between 25 and 55 min (Table I).

Interviews followed a topic guide, using methods described by Britten (1995) and Patton (2002). The interviews explored respondents’ experiences of working across organisational and sectoral boundaries for the benefit of the population, including enablers and barriers encountered; their perspectives on the role system wide financial incentives play in facilitating or hindering multi-sectoral working; and their aspirations for the Accountable Care Organisation. Interviews were audio-recorded and transcribed, and primary data stored on a secure server. Data from the interviews were analysed using thematic content analysis (Boyatzis, 1998). Emerging concepts were identified, coded, refined and compared iteratively in order to extract robust themes from within and across interviews. This provided transparency on coding schemes and ensured study rigour with all themes being traced back to source quotes and set in the context of the interviewees wider responses.

Results
Four themes emerged from the thematic analysis with regard to the experience of and perspectives on working across organisational and sectoral boundaries:

- There are operational differences between councils and the NHS which could hinder multi-sectoral working.
- Financial mechanisms are in place to support cross-organisation working but organisations do not participate if doing so negatively impacts their financial or operational performance.
- Primary care is central to place-based working but the terms of participation need to recognise the different perspectives and scale of individual practices.
To make population health a priority requires overcoming short-term crisis management and finding ways to make long-term improvements. Each theme is described below. In addition, participants shared their perspectives on the emerging Accountable Care Organisation, and whether it could overcome some of the difficulties associated with multi-sectoral working identified in the themes above.

**Differences between councils and the NHS**

Participants described the challenge associated with the local democratic leadership of councils in contrast to the “command and control” NHS. The different governance and operational arrangements lead to different freedoms and behaviours. For example, the NHS has centrally driven policy and operational targets, whereas councils have locally set agendas:

> You get political pressures nationally for the NHS around what you must and must not do. At the same time you’ve got that democratic bit that plays in around the local authorities, or individual providers, and sometimes we need to be braver. I think you’ve always got one eye on what is the ask of you nationally for the NHS. Then what you look to do is try and reconcile or align those with the system asks (CCG).

Interviewees described differences between councils and the health system with regard to the concept of failure:

> [...] in local government service failure proceeds financial failure. Financial failure is the ultimate sin. In healthcare financial failure always proceeds service failure and service failure is the ultimate sin (Policy maker).

### Table I.

<table>
<thead>
<tr>
<th>Type of organisation</th>
<th>Role</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health provider (acute, mental health, community)</td>
<td>CEO</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Finance director</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Medical director</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Nurse director</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>9</td>
</tr>
<tr>
<td>Clinical commissioning group (CCG)</td>
<td>ACO lead</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>CEO</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Chief operating officer</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>GP chair</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>4</td>
</tr>
<tr>
<td>General practice</td>
<td>GP federation chair</td>
<td>4</td>
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<tr>
<td></td>
<td>GP</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>5</td>
</tr>
<tr>
<td>Local authority</td>
<td>CEO</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Director of adult social services</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Director of public health</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>9</td>
</tr>
<tr>
<td>Policy makers</td>
<td>CEO</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Director of public health</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>GP</td>
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<tr>
<td></td>
<td>Other</td>
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<td>8</td>
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<tr>
<td>Total</td>
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<td>35</td>
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</table>
The inability of NHS organisations to achieve annual financial balance was described by several local authority respondents as impacting their appetite for partnerships. The operational differences between councils and the health system were described with regard to the process of commissioning. Several interviewees described health service commissioning as “playing shop” with the financial risk never actually present:

Well because actually we’re not transferring any genuine risk, it’s all on the government’s risk. We bear […] we take […] we don’t change any of the public sector’s risks or responsibility. We move around who, within the bits of the public sector organisations, are directly accountable for that, but all of the money sits on the government, the Department of Health’s, balance sheet (Policy maker).

[…] an enormous amount of effort in the NHS goes in to playing shop. There’s some really talented people and if we freed some of these really talented people up to stop playing shops, writing contracts that aren’t worth the paper they are written on, to actually improve the service, we’d make progress (Local Authority).

One interviewee highlighted the importance of the different funding models, with social care subject to means testing and user charges, whereas NHS services are free at the point of delivery. Creating one organisation across health and social care could challenge these differences and change eligibility criteria for services for local populations.

Local partners manage the tensions described above through reliance on the strength of relationships. Local authorities referenced frustration at the differences with how NHS organisations are managed and regulated but an overriding commitment to overcoming tensions due to the importance of health services to the voting constituents.

In summary, the operational and regulatory differences between the health system and councils were seen by interviewees as a barrier to multi-sectoral working, inhibiting the collaboration of health services with council departments (including social care).

Financial mechanisms
Participants described financial mechanisms that are in place (e.g. section 75 agreements and pooled budgets) that allow organisations to work together across sectors:

[financial barriers are] a bit like PFI in relation to financial failure. It’s the convenient and publicly acceptable excuse for not doing things […]. So actually there is nothing, as I understand it at the moment, that would stop most local authorities and health bodies signing really comprehensive Section 75s agreements and pooling huge amounts of their money. Not to say it’s not difficult, it does have its own challenges and things but actually there’s a legislative vehicle there that’s been around for a long time (Policy maker).

However, local authority and commissioner participants highlighted that using these mechanisms requires strong leadership and relationships between individuals and organisations. Organisation priorities can often be in conflict with system wide priorities due to both statutory duties and financial accountability. When this happens, the default action is to act at an organisation level, ensuring you maintain financial and operational performance, not putting in place cross-organisation interventions even if the outcome is beneficial at a system level:

[…] you’ve got a number of sovereign organisations that are driven by tariffs, charges and contractual roles that don’t necessarily align with cross-sector working (Local Authority).

Site participants referenced specific examples of system wide initiatives, where organisations did not benefit but leadership enabled them to participate regardless. The most frequently referenced local initiative was the Joint Assessment and Discharge (JAD) service. The council invested in seven-day social worker presence in the hospital to accelerate discharge of patients and reduce length of stay. The investment in that instance
came from the council, with the benefit to health commissioners for reduced expenditure on acute services.

Emerging financial models to promote integration has not had wide spread traction, and commissioner and provider participants described minimal gain relative to the local and national effort that has gone into testing different contracting tools.

The BCF, a national pooled budget across councils and health announced in 2013 in order to shift resources into social care and community services from the NHS budget in England, was used by several participants as an example of a national facilitator for multi-sectoral working by providing new money to fund collaboration (Department of Health, 2017; HM Treasury, 2013). It was often referred to as a “tick box exercise” rather than a mechanism to change behaviours or incentives, and few thought it had achieved the ambitions of promoting health and social care collaboration.

There was consistency in the perspectives of site participants in the responses, and policy participants referenced and acknowledge the disconnect between some of the policy ambitions and how these have translated at a local delivery level.

In summary, the literature suggested that financial incentives in the system hinder multi-sectoral working. In contrast, interviewees described financial mechanisms that are in place to facilitate collaboration but the system incentives drive organisations to prioritise their own sustainability. Therefore, except for exceptional circumstances, cross-organisation collaboration will only happen when all participant organisations receive a benefit or at least no negative impacts.

**Primary care**

When asked for the examples of integration, Local Authority and health provider interviewees shared examples, where organisations had worked together to change how services were delivered. Examples included the development of the JAD team in the acute hospital, the creation of a joint health and social care service in one borough following the transfer of the social care team to an NHS organisation, and the Urgent Care Centre. By contrast, all GPs interviewed provided the examples of integration at a micro service level. For example, one described how changing how a community nurse worked improved support for sexual health. Another described the positive impact the ability to e-mail hospital colleagues had on working time efficiency and access to second and expert opinions.

Primary care interviewees, including those that chair CCGs, described the difference being a small business had on the ability to participate in system wide change, such as the emerging Accountable Care Organisation. They referenced the difference in budget size between large acute providers and single practices, and the financial risk associated with participating in some of the proposed changes to service provision. Whilst GP leaders were able to engage in conversations at a system level, the delivery implications reverted back to the perspectives of individual primary care practices and how to achieve action across the collective GP provider community:

[... “there have been times that we felt under pressure to provide something with a financial level of risk that we don’t feel is acceptable, and I think that does reflect the financial constraints and position of our Commissioners. So they’re obviously always trying to find a way of getting more efficiency and they want to transfer some of the financial risk to us. Which we obviously have to resist, because that’s the way the company works (GP).”

Interviewees also described the challenge of engaging with general practices given that the NHS centrally commissions primary care:

[...] there isn’t an ability of the local services to call primary care, or GPs as businessmen, to account, because their accountability isn’t local, it still really sits with NHS England. So unless there
is a real motivation amongst primary care to do that, rather than be businessmen, I think that’s problematic (Health provider).

In summary, primary care is a collection of small practices in contrast to the large scale of other health providers. Interviewees described how this impacts both the perspective of primary care providers, who focus on the micro delivery of care, and the ability of those providers to participate in large scale change, where financial risks are considerably larger than those that can be absorbed by small businesses.

Population health
Several of the interviewees acknowledged that short-term crisis management continues to dominate priorities and system activities, with little opportunity to step back and focus on longer-term interventions. This is further reinforced through the nature of a politically responsive system, with a three-year political cycle and ambition to make changes within that timeframe. Whilst delivering improvements in population health was the core motivation referenced by most interviewees for the development of the Accountable Care Organisation, the time horizon for impact was consistently acknowledged as a challenge for shifting attention and investment:

[...] public health cannot demonstrate that people will be dead in the street as a result of not doing things, so it always gets trumped by the need for people to take resources and fix the immediate crisis, of which there seems to be endless amounts (Policy maker).

Several local authority staff discussed the changes happening within their council, moving from support being accessed and managed at a department level to a more comprehensive service. This was in recognition of the number of high users that span departments and the opportunities to offer more holistic support when addressing their multiple needs together. This is similar to the transition in health services, moving from disease-based care to better manage people with multiple long-term conditions, and elderly populations by looking at their holistic health and care needs.

In summary, high cost hospital service users have dominated the focus of initiatives to achieve cost savings for the NHS. The interviewees described how the need for immediate, short-term, impact on closing the funding gap makes investment in upstream prevention with longer-term outcomes harder to action, even within an Accountable Care Organisation.

Perspectives on the Barking and Dagenham, Havering and Redbridge Accountable Care Organisation
There were consistent aspirations for the Barking and Dagenham, Havering and Redbridge Accountable Care Organisation, with interviewees describing ambitions for improving population health alongside creating a financially sustainable system. However, there was no consensus as to whether a single organisation was needed to achieve these ambitions or whether system alliances across the partners would suffice. Descriptions highlighted different perspectives on the definition of an Accountable Care Organisation, with some describing the Accountable Care Organisation as a mechanism to achieve collaboration, but with organisations maintaining individual sovereignty, whilst others described the need for one organisation, an Accountable Care Organisation, as essential to overcome the challenge of organisation self-interested behaviour. Irrespective, the majority of those interviewed did not think the Accountable Care Organisation would be able to capture the scale of savings required to be financially sustainable in either the short or medium terms. All interviewees described the financial implications of the Accountable Care Organisation as having an influence on their organisations participation in the Accountable Care Organisation, with the majority placing this as the biggest influencing factor. The second most frequently
referenced was the strength of leaders to deliver the Accountable Care Organisation, with some referencing the need for strong relationships between leaders and trust in one another. Further, influencing factors referenced included whether resources would be available to deliver the programme, the reputational impact of either participating or not participating and the importance of health services for the local population and, therefore, its importance to political leaders that councils participate.

Discussion
There were four principle findings with regard to working across organisation and sector boundaries. First, differences between councils and the NHS. It seems unlikely that the implementation of Integrated Care Systems and Accountable Care Organisations will be able to overcome them without making fundamental changes nationally. Creating one organisation across health and social care needs to acknowledge differences in funding, with means tested social care and tax funded health services. There are risks that boundaries between these categories could be obscured and eligibility criteria changed, in turn creating more services that are self-funded and potentially widening health inequalities (Sutaria et al., 2017). The Greater Manchester Devolution agreement (HM Treasury, 2014) changes the financial flows, but does not address the tension described by interviewees between a centrally run NHS and locally led council or change the incentives associated with maintaining organisational financial performance as a priority reinforced through regulation.

Second, financial mechanisms: across published literature, there is wide recognition that the structure of financial incentives across services does little to support cross-sector working and achieve policy ambitions of integration and shifting care out of the hospital setting (Marshall et al., 2014). The implementation of policy initiatives to create financial mechanisms to allow collaboration across health and social care is in part a recognition of the operational differences interviewees described across the two sectors. Furthermore, whilst it was acknowledged that financial incentives do not facilitate organisations to participate in cross-sector working, they were not perceived by interviewees as a barrier. Rather, the biggest challenge is having in place trusting relationships between leaders and strong leadership (Health Foundation, 2012) that is able to have the confidence to invest in system wide priorities even when they are in conflict with their own organisation’s priorities. Perspectives on what constitutes strong leadership in the evolving health and social care system are also changing, with a call for system leaders equipped to work across traditional system boundaries (Timmins and O’Neill, 2015; Maruthappu and Keogh, 2015).

Third, primary care: the reflections of interviewees were largely associated with primary care operating as a series of small business. Nationally, the landscape of primary care provision is changing. There are increasing examples of organisations that have enabled practices to work together in different formats, either under umbrella organisations, or as a larger organisation (Pettigrew et al., 2016; Miller, 2017). In the NHS in England, three-quarters of practices are now working collaboratively in larger scale organisations (Pettigrew et al., 2016). Madan suggests that working across groups of practices is required in order to be able to integrate with other providers (Madan et al., 2017), which may be a different primary care perspective than that shared by the interviewees. However, many of these collaborations are in place to achieve operational efficiency for practices and to implement electronic tools, such as electronic prescribing, new booking systems and appointment allocation. The interviews suggest that general practice is influenced by initiatives that impact their operational day to day. General practice input into strategic and system wide initiatives may still remain a challenge given the wide ranging perceptions across the general practice community. The tensions between GP leaders in commissioning organisations, and their role as providers remains. Recognising the operational reality of primary care may facilitate progress.
Finally, population health: the dominance of acute activity in health spend in the NHS continues despite decades of policy initiatives to move investment upstream (Appleby, 2013). In addition, following the move of public health into councils in 2013, projections suggest decreased expenditure on public health and decommissioning of several prevention services (e.g. smoking cessation and sexual health promotion). Population health was a term broadly used by interviewees. Recent research suggests that use and understanding of the term are wide ranging (Noble et al., 2014). The health of a population is influenced by a wide range of factors and the interactions between them. While healthcare services play an important role in keeping people healthy estimates suggest that wider social, economic and environmental factors play a greater role (Mcginnis et al., 2002). There is established evidence on the impact specific initiatives can have. However, the local information is not always readily available to present and contrast with shorter-term investment decisions and priorities. In addition, investment upstream, where benefits are realised over a long time horizon and potentially on another organisations balance sheet, requires overcoming the challenges associated with cost and benefit allocation.

The interviewees were from a wide set of roles, providing breadth of perspectives and opportunity for identifying alignment across different organisations – front line providers, system leaders and national policy makers. The recording and transcription of interviews facilitated a detailed analysis of the themes and provided clarity on the level of alignment across different interviewees, as well as providing quotes to support these findings. This reduced bias by ensuring that themes were not enforced but reflected outputs of the interviews. Interviews with national leaders were conducted to understand if perspectives were specific to the case study site or more generally present across England. The selection of a case study that included characteristics associated with successful integration was deliberate to understand if the policy ambition for structural solutions to integration was required. Whilst in-depth interviews were not conducted with participants of parallel programmes, such as Greater Manchester devolution, or with the four other boroughs who were delivering programmes in response to the London proposition, information about these programmes has been incorporated into the analysis. The interviews were conducted between April 2016 and August 2016, since then the policy environment has developed further. This includes the publication of Strategic Transformation Plans (NHS England, 2015), which for Barking and Dagenham, Havering and Redbridge includes four additional boroughs, the announcement of eight Integrated Care Systems across England (NHS England, 2017a) and the publication of the London announcement for Health and Care Devolution (Authority, 2015).

For organisation leaders across health and social care, these findings suggest that with an understanding of the impacts participating in system wide collaboration has on your own organisation, financial and operational, there may be mechanisms in place to allow participation, even when your organisation will be negatively impacted. The perceptions and perspectives of the primary care community are worth noting when developing approaches to move towards more place-based care, given the dominant role general practice has in the delivery system.

The implications of these findings for policy makers are important. With the continued ambitions for health and social care integration (Glasby, 2017), progress will require acknowledging the fundamental financial and operational differences described above in how the NHS and councils work. To achieve progress in population health, policies need to reflect the role all organisations can play in implementing change, as has been highlighted by the Health in All Policies framework, and find mechanisms to balance short-term operational priorities with longer-term outcomes.

Policy for integrated care may see an increase in the creation of Accountable Care Organisations. There was no consensus across interviewees as to whether creating a single
organisation would overcome the challenges described, namely the fundamental differences in leadership, funding and regulation between councils and the NHS. Future research would be beneficial to understand the contrasting approaches of Integrated Care Systems, Accountable Care Organisations and STPs, and their ability to increase cross-sector working between health and councils.

The financial position of the system was described by interviewees as motivation for participating in cross-sector working. Health and social care expenditure continues to be dominated by high cost acute services. Given the role wider social, economic and environmental factors play in achieving improvements in population health (Mcginnis et al., 2002), future research would be beneficial to understand if there are specific population groups for whom cross-sector working with health could particularly benefit. This will need to include analysis of costs of service utilisation in each setting of care in order to control for the dominance of acute costs.

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