Journal of Integrated Care
Practical evidence for service improvement

Number 2
97 Editorial boards
98 Editorial
100 Integrating health and care in the 21st century workforce
Matt Aiello and Julian D. Mellor
111 Exploring an integrated palliative care model for older people: an integrative review
Marina Raco, Teresa Burdett and Vanessa Heaslip
123 Co-designing integrated care for high-needs clients: the Help Team for school-aged children
Tuula Tuominen, Mari Harju, Erja Oksman and Anneli Hujala
131 Roles and responsibilities in integrated care for dementia
David Robertshaw and Ainslea Cross
141 A critical evaluation of integrated care: a case study of the supported discharge service
Rachel Louise Ware
153 HealthPathways implementation on type 2 diabetes: a programmatic evaluation
(HIT2 evaluation)
Josephine S.F. Chow, Veronica Eugenia Gonzalez-Arce, Chun Wah Michael Tam, Ben Neville and Alan McDougall
163 Conceptualizing "project resiliency": a qualitative study exploring the implementation of coordinated care within a context of system change
Laura M. Holdsworth
173 Integrated care for community dwelling older Australians
Jennifer Mann, Sue Devine and Robyn McDermott

www.emeraldinsight.com/loi/jica
EDITORIAL BOARD

Mike Attwood
Trustee – Sue Ryder and Associate – Centre for Innovation in Health Management, Leeds University, UK
Rob Baggott
De Montfort University, UK
Derek Birrell
University of Ulster, UK
Gemma Carey
University of New South Wales Canberra, Australia
Michael Clark
London School of Economics, UK
Michelle Cornes
Kings College London, UK
Simon Duffy
The Centre for Welfare Reform, UK
Amanda Edwards
Social Care Institution for Excellence, UK
Jon Glasby
University of Birmingham, UK
Stewart Greenwell
Health and Social Care Specialist Consultant, UK
Richard Humphries
The King’s Fund, UK
David J. Hunter
University of Durham, UK
Richard Kramer
Sense, UK
Jill Manthorpe
King’s College London, UK

Robin Miller
University of Birmingham, UK
Alison Petch
IRISS, UK
Joanne Travaglia
University of New South Wales, Australia
Helen Tucker
University of Warwick, UK

ADVISORY BOARD

Jenny Billings
University of Kent, UK
Diana Castro Sandoval
European Forum for Primary Care, The Netherlands
Robin Gauld
University of Otago, New Zealand
Anne Hendry
IFIC and University of West of Scotland, UK
Anne McGlade
Health and Social Care Board, Belfast, UK
Mirella Minkman
Vilans Research & Innovation and Tilburg University, The Netherlands
Henk Nies
Vilans and Vrije Universiteit, Amsterdam, The Netherlands
Rebecca Rosen
Nuffield Trust, UK
Does integrated care have a future?
At a recent conference celebrating the success of a European integrated care project, a colleague commented that what struck him most about integrated care is that there has been so little progress made for patients. Looking back over more than two decades of work in the field, the most remarkable aspect, he thought, was that most of the problems that services struggled with at the very inception of the discipline were still with us, issues around data sharing, governance and interprofessional learning.

That is not to say that integrated care has not made enormous advances and produced tangible improvements. Increased multi-professional collaboration counts as one of the biggest gains brought about by integrated care initiatives and it is now well evidenced. Yet, the wider picture is one of dogged resilience of health systems in the face of the continuous onslaught of policies advocating service integration of one type or another. Why is that the case? Are we running out of steam on the integration front?

When I started to work in learning disabilities in 2005, the doyen of Welsh learning disabilities research, David Felce, remarked to me that “learning disabilities have had it”. The English learning disabilities strategy “Valuing People” had been launched in 2001, following a sustained policy push on de-institutionalisation of people with intellectual disabilities. That, Felce believed, was “about it” for the next generation. Policy, he argued comes in waves, and by 2005, the field had had more than its quota of policy attention.

If policy attention comes in waves, then integrated care is very lucky indeed. It has been at the centre of policy making for almost two decades now in health and social care. In fact, it has never been quite out of favour, if you count “partnership work” in the 1990s and the shift to multi-disciplinary teams in mental health provision in the 1980s as precursors of integrated care initiatives.

However, a slow but steady change in the wider narrative of integrated care policy is palpable. Where it was all about overcoming professional fragmentation in the 1990s and early 2000s, integrated care is now about addressing rising healthcare costs. Integrated care has morphed from a mechanism to mitigate the effects of interprofessional boundaries to a vehicle of fiscal prudence.

The old motives may still be with us. Improved collaborative practices make for better patient care, no doubt. Yet today, the main impetus for integrated care is the spiralling cost of care, and integration at times appears to be a panacea for bringing healthcare budgets under control.

Whilst the sustained policy attention afforded to integrated care may give us reasons to be cheerful, it has also engendered a curious response by services and practitioners. Integrated care is rarely something that they do, out of conviction and enthusiasm. It is, more likely than not, something that is done to them, introduced top–down.

In fact, integration is often mandated by central or local government, as an answer to prayers for more efficient services and for better care outcomes. This lack of bottom–up activity in integrated care has reasons, and it has consequences. As for the reasons, integrated care is fiendishly difficult to design, implement and evaluate. Its impact is often unclear for years, with tangible results only showing after many years of upfront investment. Which raises the question, why would any service manager embark on such a complex service improvement programme?

A consequence may be that, by now, pretty much everything under the sun is called “integration”, leading to an inflation of claims, with little hard evidence to come by, and resulting in integration fatigue.
And then, there are the bad apples. Where acute hospital trusts “integrate” community trusts into their provision, integrated care initiatives may in fact be genuinely detrimental to patient care outcomes. Services that were previously provided in the community may be arrogated by hospitals with adverse consequences for patients. In effect, the power of large hospital trusts often remains one of the biggest obstacles to shifting hospital provision into community care. No doubt, there are other examples where what looks like laudable service integration turns out to be a victory of organisational control over patient needs.

So what is the future of integrated care? More policy initiatives? Or, perhaps we should ask another question: if David Felce was right and policy attention is a finite resource in a democratic society, what is the source of political capital for future integrated care initiatives?

We may glean an answer to this question is we change perspective. If integrated care has so far benefited from strong policy support, which produced mainly top–down initiatives, revitalising integration must start by (re)discovering its original purpose, the patient. At the heart, integrated care carries a commitment to person-centred services. Although rarely realised in practice, person-centredness is probably the most powerful tool to transform services if utilised appropriately in service reforms. Whilst it requires herculean efforts by professionals, it can bring about lasting change.

There are two mechanisms that are likely to push person-centredness at the forefront of healthcare provision, which in turn will make integrated care the main conduit for service improvements.

The first is that patients are increasingly in the driving seat of their own care. Several developments contribute to this: increased accessibility of medical knowledge through the internet (a blessing and a curse to many clinicians), the need for better self-management of conditions due to cost pressures and the continuing need for informal care in the health economy. These factors conspire to encourage patients to resist conventional, paternalistic approaches in health systems.

The second is the development of big data which enables healthcare services to analyse health populations to an unprecedented level of granularity, down to individual patient level. Actuarial modelling of local healthcare data can now reveal to service planners and commissioners who is likely to have a heart attack in the next three months, and design system responses to individual needs.

The predictive power of population health data will have two consequences. First, where it can be used, it will have to be used. Care planners have a duty of care and it would not be long until there will be an obligation to design preventative care packages on the back of predictive modelling.

The second is that care planning will shift from being disease specific, encompassing large populations to focussing at patient level. Service responses to anticipated healthcare needs will require holistic care plans involving community health, housing and social care interventions requiring a different magnitude of collaboration between service providers.

Integrated care will be a critical component of services when trying to design adequate responses to these challenges of big data and increased patient involvement. So, policy may come and go, but the larger trends in healthcare will make integrated care inevitable. Although integrated care initiatives will change their nature under the auspices of big data and patient-driven care, they will be with us for the foreseeable future. And we, researchers and practitioners alike, need to prepare for it.

Axel Kaehne
Integrating health and care in the 21st century workforce

Matt Aiello and Julian D. Mellor
NHS Health Education England, London, UK

Abstract
Purpose – The NHS needs to adapt as never before to maintain and plan for an integrated and sustainable multi-professional workforce, spanning all health and care sectors. This cannot happen without system leaders embracing workforce transformation at scale and enabling system-wide collaboration and support for multi-professional learning and role development. “By learning together, we learn how to work together”. The paper aims to discuss these issues.
Design/methodology/approach – The case studies included in this paper provide evidence of the ability of NHS systems to adopt integrated workforce models at scale. The case studies were chosen to demonstrate how system-wide change is possible, but still requires a partnership approach to innovation, strategic workforce planning and commissioner support for new models of care.
Findings – With partnership working between arm’s length bodies, commissioners, educators and workforce planners, the NHS is more than capable of generating a transformed workforce; a workforce able to continue providing safe, effective and joined-up person-centred care.
Research limitations/implications – The focus of this paper is integrated workforce development undertaken by Health Education England from 2017 to the date of drafting. The case studies within this paper relate to England only and are a cross-section chosen by the authors as a representative of Health Education England activity.
Practical implications – The NHS needs to find ways to use the wider health and care workforce to manage an ever-increasing and diverse patient population. Silo working, traditional models of workforce planning and commissioning no longer provide an appropriate response to increasing patient need and complexity.
Social implications – The evolution of the NHS into a joined-up, integrated health and social care workforce is essential to meet the aspirations of national policy and local workforce need – to centre care holistically on the needs of patients and populations and blur the boundaries between primary and secondary care; health and social care; physical and mental health.
Originality/value – This paper contains Health Education England project work and outcomes which are original and as yet unpublished.
Keywords Evidence-based practice, Multi-disciplinary teamwork, Whole systems, Health and social care, Integrated care, Joint commissioning
Paper type Viewpoint

1. Background
The term “integrated care” means nothing to most people, with at least 170 definitions for the term in the UK (HSCC, 2018). UK citizens are often unaware of the divides between health and social care services and are surprised when assumptions that the NHS is one joined-up organisation prove unfounded.

“Integrated” systems of health and care are dependent upon a joined-up multi-professional workforce, but challenges associated with spanning traditionally silo systems and commissioning models prevail, limiting true integration. However, it is a reality of today’s UK healthcare economy that health and care providers no longer have the luxury of working in isolation. Gaps are appearing in the clinical workforce across all systems on an ever-wider scale. Medical recruitment – especially in emergency medicine and general practice – is simply not training or recruiting sufficient doctors to support the needs of an increasingly ageing population, presenting with ever more complex health needs (NHS England, 2013). UK healthcare policy including the NHS Five Year Forward View and Next Steps reflect a system-wide recognition of this challenge (NHS England, 2017). Also recognised is the need to use multi-professional workforces across traditionally silo health and care providers in a more efficient and joined-up way. The NHS Five Year Forward View
emphasised the need for integrated out-of-hospital care based on general practice (multispecialty community providers), aligning general practice and hospital services (primary and acute care systems) and enabling a closer alignment of social and mental health services across hospital and community health settings (NHS England, 2014). The King’s Fund further underlined this position, suggesting that such ambitions would “[...] require a workforce that reflects the centrality of primary and community care and the need for more generalism [...] able to deliver increased coordination across organisational boundaries and address inequalities in treatment and outcomes across physical and mental health services” (Aldicott and The King’s Fund, 2015).

The combination of hospital workforce challenges stemming from avoidable admissions and unnecessary A&E attendance, alongside a shrinking GP workforce and challenges in the social care sector have led to an acceptance that admissions avoidance measures through alternative care pathways and integrated workforce models need to be implemented now, at scale, and through partnership working between traditionally silo or competitive providers (NHS England, 2013).

The rise of sustainability and transformation partnerships (STPs) and their evolution into Integrated Care Systems and Accountable Care Organisations formed the “real world” enabler for this approach, with Local Workforce Action Boards (LWABs) facilitating at-scale Workforce Transformation (NHS England, 2017).

Simply put, we need to find ways to use the wider health and care workforce to manage an ever-increasing and diverse patient population. Silo working, traditional models of workforce planning and commissioning no longer provide an appropriate response to patient need.

2. An integrated twenty-first century workforce

The evolution of the NHS into a joined-up, integrated health and social care workforce is essential, to meet the aspirations of national policy and local workforce need – to centre care holistically on the needs of patients and populations and blur the boundaries between primary and secondary care; health and social care; physical and mental health (Aldicott, 2015).

The evolution of the 44 national STPs into Integrated Care Systems presents an opportunity to influence the development of a workforce able to provide the kind of integrated care that local populations expect from a twenty-first century healthcare system (Aiello et al., 2014–2018). Outcomes from integrated workforce discussions have included the development of enhanced, “wide skilling” pathways for multi-professional teams, supported by national policy and investment (HSCC, 2018). For example, increasingly popular multi-professional rotational placement programmes (encompassing areas such as frailty, urgent care, cancer survivorship, and child health) are an example of local and national workforce transformation, supported by multi-organisation teams, guided by identified patient need and demonstrably supporting the career aspirations of the workforce (Dale et al., 2017). Portfolio careers and flexible working models are becoming increasingly desirable among clinicians including middle grade doctors, GPs, nursing and pharmacists – staff who no longer wish to be limited to traditional roles and training pathways and seek enhanced clinical and academic development (NHS Improvement, 2017). Through its Quadruple Aim, the NHS Five Year Forward View identified the need to improve the individual experience of care, the health of populations, reduce per capita cost of healthcare and improve the experience of providing care (NHS England, 2014).

Workforce planners across healthcare, social care, local authority and third sector providers are increasingly being encouraged to test the potential for deployment of new and enhanced roles beyond the traditional scope of practice, as part of new, cross-sector, multi-professional health and care teams. In 2017, NHS England expressed a strategic intent to connect all Urgent and Emergency Care (UEC) services; dissolving traditional boundaries...
between hospital and community services and supporting the free flow of information and expertise needed to enable the most appropriate and convenient standards of patient care (NHS England, 2017). “New Models of Care” provide an opportunity to maximise the potential for multi-skilled specialist generalist clinicians to overcome traditional silos in health and care, providing the basis for truly integrated patient care (Aiello et al., 2014–2018).

3. Challenges – why do citizens need an integrated workforce?
For people relying on health and social care, “integration” is about joining up the services they use and putting them as individuals at the centre of their own care. Services should be capable of sharing information, working collaboratively, supporting patients in the management of their own health and focusing on their personal priorities, goals and aspirations (HSCC, 2018). However, the UK Government recognised in 2018 that the NHS is in “survival mode.” With NHS providers struggling to recruit, train and retain staff and maintain standards in the face of national austerity measures and increasing public demand, the idea of innovatively developing service offers falls behind the need to survive.

Recognising this, the Commons Health and Social Care committee commented that long-term funding settlements and effective workforce strategies are essential not only to alleviate immediate pressures on services, but also to enable the transition to integrated models of health and care (HSCC, 2018). It should be noted that the use of investment can be as disruptive to workforce integration as having no investment at all. For example, the NHS Five Year Forward View proposed the delivery of national and local healthcare transformation within five priority workforce programmes: UEC, Primary Care, Integrated Care, Mental Health and Cancer (NHS England, 2014). However, one year on from the 2017 Next Steps on the Five Year Forward View, it appears as though investment flowing from these priority programmes may have unintentionally levered providers to align their workforce strategies in silos relative to this.

There is a clear risk from this of increasing the disconnect already extant between local and national health and care systems, opposing the Five Year Forward View recommendation for joined-up workforce development (NHS England, 2014). To enable truly integrated workforce transformation, NHS commissioners must be prepared to be flexible in the way that workforce development is commissioned and funded. Commissioners must avoid simply repeating traditional commissioning strategies and instead recognise and support work which is attached to a clearly identifiable commissioning priority, as well as integrated workforce models which may span several different commissioning budgets or investment plans. The Health and Social Care Committee accepted that there are examples of local areas which have made excellent strides forward in difficult circumstances, but stressed the need for a dedicated national financial and leadership support to enable the NHS to transform at pace. The committee commented that too often, workforce transformation plans are constrained by access to the upfront funding needed to make them effective (HSCC, 2018).

The challenge for the future NHS is how to take an undefined health and care system, complex in the extreme, and work in partnership to build a consistent national approach to integrated working; breaking through cultural, professional and strategic boundaries?

Taking a “top–down” approach would require partnership working by system leaders across NHS arm’s length bodies – leading by example and generating combined investment and integrated workforce programmes with a system-wide strategic fit. Conversely, a “ground up” approach would require the enabling of local health and care systems to work collaboratively on scalable transformation programmes, test of concept and pilot workforce development projects, with investment for evaluation to prove “real world” workforce impact and return on investment. A combination of both of these approaches may enable the translation of national policy and investment into actual “shop floor”
change, while capturing system-wide workforce best practice, to guide future national policy and investment. Both approaches require collective planning, system-wide leadership, partnership working, shared agendas and a breakdown of traditional barriers. Like it or not, the NHS needs to transform as a single system [...] as one NHS [...] but a single approach to system-wide transformation continues to elude and perhaps always will. The National Health Service may simply be too fragmented, too vast, too fluid, too reactive, to ever be able to achieve proactive, universal evolution, proportionate to patient demand.

But change is happening with examples including Pockets of transformation, partnership working across local systems, commissioners, regulators and system leaders working together to enable seamless transitions of health and care. Local integrated care models are being developed, delivered and evaluated, with evidence already pointing towards the need and potential for a joined-up workforce that can sustain and ensure the capability of frontline services (Aiello et al., 2014–2018). Integrated Care Systems are an established mechanism to support workforce transformation at the local level, but with local transformation varying significantly across the country and no evaluation has yet been undertaken to determine the potential for local ICS strategies to be adopted at scale. We maintain that, as a conceptual single UK Health and social care system, the NHS is capable of learning from and expanding pockets of good practice at scale, but the sheer size and complexity of the NHS often means that such opportunities are missed (Ettelt et al., 2015). To identify, support and transition innovation into system-wide “business as usual” requires a shift towards joined-up, partnership working. As system leaders, enabling this sea change has been recognised by the government as a priority (HSCC, 2018), but processes to translate this into actual “shop floor” change remain elusive.

The case studies included in this paper were chosen to demonstrate the capability of health and care systems to adopt integrated workforce models and evolve successfully tested concepts at scale. The case studies are a small cross-section of operational and strategic workforce transformation being undertaken at local, regional and national levels. This sample demonstrates that, with commissioner-supported working, NHS organisations are more than capable of working in partnership to generate a transformed workforce with the ability to provide safe, effective and joined-up patient-centred care in the twenty-first century.

4. Case studies – integrated workforce development
In 2015, NHS Health Education England (HEE) invested in a programme of workforce transformation to support the delivery of integrated care in the West Midlands (Figure 1). During the research and development phase, the programme team approached available literature, including an analysis of lessons learnt from UK and international models of integrated care (Aiello et al., 2014–2018). Literature searches established precedent and informed direction of the programme. The case studies below are a part of a set of resources that were subsequently produced for this programme and used in the Midlands and East region (http://learning.wm.hee.nhs.uk/integratedcare).

Resources include work undertaken in recognition of the important role of care coordination in delivering integrated care services, as well as the potential to adopt the “Making Every Contact Count” approach more widely and in different settings. A model Integrated Care Framework was developed by HEE, to assist workforce planners and commissioners in setting up new, or improving existing integrated teams (Figure 2) (http://learning.wm.hee.nhs.uk/node/901).

Case study 1: promoting integrated care in higher education
The Health Education England (2017) “investigation to understand and evaluate the best ways to educate for and promote integrated working across the health and care sectors”
The investigation focussed on how integrated working can be promoted and reinforced within higher education institution (HEI) curricula. This study, which covered both taught and placement programmes, was developed as a learning resource for HEIs, to support integrated working through undergraduate and postgraduate curricula.
The full report includes the identification of best practice across health and social care programmes; case studies from integrated care services and recommendations (for HEIs, HEE, Professional and Statutory Regulatory bodies and placement providers) on how to support integrated working.

Further work is now being undertaken with the Centre for the Advancement of Inter-Professional Education to implement these recommendations. (http://learning.wm.hee.nhs.uk/node/909).

Case study 2: achieving strategic fit – integrated system workforce planning
To address the challenges facing health and social care within the Birmingham and Solihull area, including the rising demand for services, financial pressures and workforce issues, HEE and Skills for Health agreed that a more coordinated approach to providing care and support was needed. In partnership with Skills for Health, HEE produced a forward-looking strategic report covering a five-year period. Scenario planning was used to highlight key demographic changes and workforce challenges likely to impact on services, alongside predicted cultural, technological, and political changes. This resulted in a series of workforce development options for health and social care. Using a six-step process, partners were encouraged to think in new ways about their own organisational and workforce challenges within the wider political and social context. Participants shared best practice in areas such as talent management and leadership development – ideas that could be adopted and scaled across the wider system. One of the key learning points form this work was the observation that workforce development sessions at strategic, as well as operational level, were most effective when they involved a broad mix of people, all with different views and backgrounds.

Key to the success of the process was a sustained investment of time and energy in discussing and formulating the strategy with partners. Crucially in Birmingham and Solihull, there was representation from across health and social care, education providers and the voluntary sector. It was important to secure commitment from the right people early in the development process and set realistic timeframes for delivery. The benefits and outcomes of the process in Birmingham and Solihull included recommendations that integrated seamlessly into the STP submission. The recommendations helped to articulate the workforce priorities linked to the broader service transformation objectives. The process has since informed emerging work-streams within the LWAB[1]. Those leading the LWAB see this as a repeatable exercise to support the ongoing shaping of the STP workforce strategy, through refinement of the action plan and continued testing against different scenarios.

Case study 3: promoting integrated working
Development of managers. In 2017, Health Education England-West Midlands presented findings from a qualitative evaluation of research into a development programme for health and care sector managers. The three-day programme was aimed at a cross-section of managers in health and social care; including NHS Trusts, local authorities, private and voluntary sector providers and commissioning organisations. All participants were involved in the delivery of integrated care within a specific locality. Cohorts could also include other public sector and community sector leads and offered an opportunity to explore and develop delegates’ potential as system leaders. The programme featured a group Action Learning Set, which supported and empowered the group to work across boundaries and to demonstrate impact through collaborative working on a Service Improvement Project.

A key feature of the programme is the contribution from community organisations including Community Navigation Services, who share their insight and experiences of receiving care and support services.
Future sessions will be delivered as place-based initiatives to support local priorities, as defined by STPs and LWABs. Apprenticeships. “Scoping integrated apprenticeships in Health and Social Care” (2017) was developed as a “best practice” learning resource for organisations and partnerships with an interest in developing Integrated Apprenticeships. The report, commissioned by HEE and produced by Skills for Care (working with Skills for Health), includes an overview of current apprenticeships that provide rotational placement opportunities, “good practice” case studies from successful projects and guidance on overcoming system barriers.

This collaborative work has continued with Skills for Health and Skills for Care across HEE Midlands and East, including test sites in Birmingham and Solihull, Shropshire and Lincolnshire.

While there are ambitions for future “Trailblazer” apprenticeships that are genuinely integrated, the main focus currently is on how to maximise the opportunities for rotational placements across health and care settings (Figure 3).

Rotational programmes. Doctors, nurses, paramedics and allied health professionals are engaged in a quiet revolution of role and skills enhancement. As well as enhanced – wide-skilled – clinicians, new “generalist” roles such as physician associates, medical assistants and nursing associates are being developed and integrated within multi-professional clinical teams. The demand for adaptable clinicians within multi-professional teams spanning traditional primary and secondary care settings has never been greater or more varied (The Health Education England, 2017). Generalist practitioners are needed in traditional office-based family practice, as out-of-hours acute practitioners, as clinical practitioners working within intermediate care teams, or specialising in the care and rehabilitation of an increasingly frail population, in addition to the delivery of timely and effective community healthcare.

Enhanced and emerging clinical roles will, it is hoped, ensure that patients and populations experience their health and care as close as possible to where they live.

The emergence of new models of care and closer inter-agency service delivery are creating new development opportunities to wide-skill the multi-professional clinical workforce (Hughes et al., 2017). The need to develop generalist practitioners with the ability to lead and change services across health sectors and professional groups is driving this wide-skilling approach. Since 2014, enhanced training programmes termed fellowships, preceptorships and internships have been developed to address this service need. Co-funded by provider and
educational organisations, these rotational programmes respond to the growing needs of service for “generalist specialist” clinicians and recognise that the current workforce are now embracing varied portfolio opportunities, rather than joining and working in the same care setting throughout their career (Dale et al., 2017). There is no standard definition for the terms “Fellowship,” “Internship” or “preceptorship” in this context, but common traits can be extracted from each of the current national portfolio of programmes (Table I), undertaken by GPs, middle-grade doctors, foundation doctors (F2), Pharmacists, Paramedics, Nurses and Physician Associates (The Health Education England, 2017).

5. Promoting integrated working: summary
Evidence from established (GP, nurse) and pilot (Paramedic, Physician Associate) programmes suggest that rotational models can assist recruitment to and retention within a range of clinical professions. Rotational placement models benefit from a level of adaptability over and above that of traditional education programmes and deployment strategies and may be offered at a range of academic and professional levels; often with the benefit of staged entry and exit points (Dale et al., 2017).

Evaluations across the various pilot and commissioned programmes demonstrate both workforce impact and potential to attract clinicians to regions experiencing challenges with recruitment and retention (Cottrell et al., 2018).

National discussions are taking place across provider organisations, regulating bodies, NHS arm’s length bodies and education providers; the aim being to consider the potential and workforce need for a national, multi-professional rotational programme and delivery framework (Aiello et al., 2014–2018).

6. Discussion
Strategies and processes alone are not sufficient to drive the degree of change we are seeking […] the NHS should focus on tackling the behaviours and cultures in the system that stand in the way. (NHS England, 2009)

It is recognised that workforce transformation initiatives exist in abundance, but require collaborative working from the outset to transition from innovation into core business.

<table>
<thead>
<tr>
<th>Rotational programme aims</th>
<th>Potential learning outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>To explore ways in which the skills and experience of the clinician can be enhanced within the wider healthcare economy</td>
<td>To develop innovative ideas/share best practice of meeting and supporting national and local policy requirement and workforce need</td>
</tr>
<tr>
<td>To develop ways in which the clinician can apply enhanced clinical, service improvement and leadership skills to support the development of alternative, community-based care pathways</td>
<td>Embedding clinical practice while continuing development – enhancing local contribution, confidence and competence in clinical practice</td>
</tr>
<tr>
<td>To raise clinician interest in undertaking and developing hybrid primary, community and secondary care “interface” roles – recruitment and retention and career development opportunities</td>
<td>To develop enhanced skills in management of complexity and co-morbidity</td>
</tr>
<tr>
<td>To support and follow the national policy drive for integration of primary, secondary and social care</td>
<td>To understand and develop new pathways of care, including use of digital technology solutions</td>
</tr>
<tr>
<td>To develop a recruitment strategy which satisfies both the career aspirations of the clinician and identified workforce need of the employing organisation/s</td>
<td>To successfully complete an accredited education programme or undertake educational support relevant to the programme outcomes</td>
</tr>
<tr>
<td></td>
<td>To demonstrate increased understanding and clinical skills in managing a wider patient population, competence in critical appraisal of evidence and ability to formulate and implement care according to good practice</td>
</tr>
</tbody>
</table>

Table I. Rotational programme aims and outcomes (suggested)
While LWABs, STPs and Integrated Care Systems were set up to enable workforce transformation, an increasingly stretched and under-resourced system will naturally overlook innovation in favour of maintaining day-to-day operations. Investing in and driving innovation and workforce transformation may be seen by traditionalist system leaders as a luxury, rather than a necessary mechanism to futureproof our NHS. System transformation teams should be supported in giving equal resource to the delivery of both core business and innovation. Both approaches require very different implementation strategies, resource and investment, but should be considered equally important and complementary parts of any wide-scale system change strategy (Ettelt et al., 2015).

The case studies in this report are presented as a representative cross-section of local and regional innovation and transformative working. From these and other national examples, it is possible to draw out common factors and key messages; predominantly, the need to plan for a multi-professional workforce using competency-based (rather than traditional role-based) approaches to integrated workforce planning. Moving beyond silo and organisation-specific workforce development will require cross-system collaboration and partner working. The case studies in this report evidence that UK health and care systems are more than capable of evolving approaches to workforce development now, without radical infrastructure redesign or formal integration of organisations. However, transformation at scale requires a collective shift both at strategic and operational levels. From the strategic perspective, we must avoid commissioning and investment models which create silos; instead encouraging flexibility in the way that workforce development is commissioned and funded.

Change cannot just come from a “top–down” or “bottom–up” redesign but from both directions simultaneously – for example: developing strategies to capture good practice and evidence from “shop floor” innovation, to inform policy and investment planning; identifying areas of workforce development or patient need which require policy support; using informed policy development, driven by identified workforce and patient need, to support new or revised commissioning and investment models.

Furthermore, a balance needs to be struck between investment both in core business and innovative pilot work. There must be a collective recognition that innovation and collaboration are crucial to future service delivery and should not be set aside when austerity closes. The workforce can only evolve if commissioners, planners and policy makers are able to capture the evidence arising from innovation and use it to guide future direction. A lack of support for pilot development and a lack of robust evaluation data can adversely impact on the transition of concepts into core business, resulting in unnecessary cost to the public purse, wasted workforce time and organisations being less inclined to support future innovation or test of concept projects (Hendy et al., 2012). STPs, LWABs and emerging Integrated Care Systems are ideally placed as the vehicles to drive this change. Through these groups, regional and national transformation programmes can be developed to enable partnership working, allowing traditionally isolated health and care systems to identify, support and transition integrated workforce models system-wide.

It is contended that collective action that connects local innovation and best practice within consistent national frameworks is required, if we are to meet the aspiration of a multi-professional, health and care workforce across local systems. Such action requires a joined-up, transformational approach at both strategic and operational levels from workforce planners and commissioners, if we are to achieve truly integrated healthcare at scale.

7. Conclusion
It seems logical to assert that if we work to a common cause, we are enabled to work together as a joined-up, integrated team. If we take every opportunity to learn together, then we will learn how to work together.
Give us something to do that we can only do together and we will join up because we have to […] Because we cannot achieve our goals alone. We learn how to work together through delivering real change and the challenge then will become not whether we should work together, but why we should not.

The case studies in this paper demonstrate the art of the possible, emerging best practice, opportunities for inter-professional learning and evidence that the NHS is more than capable of generating integrated workforce models at scale. However, it is up to us as system leaders to recognise that we can and do deliver an integrated workforce and to enable that transformation through a shared vision, partnership working and the breakdown of silo approaches.

Note
1. Local Workforce Action Boards are a collective group of stakeholders who support their STP locally on all workforce issues – strategic, HR, education and training. Each LWAB is jointly chaired by an NHS organisation chief executive and HEE leader from that locality.

References
Further reading


Corresponding author

Matt Aiello can be contacted at: matthew.aiello@hee.nhs.uk
Exploring an integrated palliative care model for older people: an integrative review

Marina Raco, Teresa Burdett and Vanessa Heaslip
Department of Nursing and Clinical Sciences, Bournemouth University, Bournemouth, UK

Abstract

Purpose – Due to an international ageing population, global health organisations have recognised the challenges arising from fragmented interaction between health and social sectors in the end of life care. The purpose of this paper is to explore the existing literature on integrative palliative care services for older people.

Design/methodology/approach – An integrative review was conducted using the Preferred Reporting Items for Systematic reviews and Meta-Analyses. Papers included in the review focused upon integrated care within palliative care systems (January 2007–2017). A certain number of papers were excluded when the review focused on individuals younger than 65, not written in English and not being focused on integrated palliative care.

Findings – Nine studies fitted the inclusion criteria and three themes were identified: person-centred care, co-ordination of care, and education and training. The review identifies that integrated palliative care requires co-ordinated techniques that focus upon the quality of life, individual needs and awareness of vulnerability rather than fixation on inevitable mortality.

Research limitations/implications – The emerging presence of the need for integrated palliative care requires further research in order to develop coherent models of integrated palliative care which can be incorporated into practice.

Originality/value – This review identified themes relevant to the emerging issues in the global health sector of end of life care. The literature suggests that the optimised use of an integrated care approach to a palliative model of care is required and in need of further investigation.

Keywords Multidisciplinary teamwork, Integrated care, Older people, Palliative care, Co-ordinated care, Person-centred care

Paper type Literature review

Introduction

Due to a 40 per cent increase in the proportion of individuals aged 65 and older, there are increasing public health concerns regarding an ageing population (Jin et al., 2015), prompting the World Health Organisation (WHO) to declare the phenomenon as a demographic milestone (WHO, 2017). The prevalence of chronic health conditions increases with age (Piazza et al., 2007), and multi-morbidity is more common among older people provoking the need for palliative care (White et al., 2016). Chouvarda et al. (2015) propose that this demographic shift brings about new healthcare needs of older people transitioning into end of life care. This has been recognised by the WHO (2017) who argues that a more suitable health policy is required; the one which addresses socio-economic needs relating to a higher demand for end of life care.

There are multiple definitions of what constitutes palliative care, for the purpose of this paper, palliative care is defined as “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illnesses” (WHO, 2017). The unpredictable journey towards the end of one’s life can lead to endless hospital admissions and overlap in the management of palliative care (Main et al., 2006). Pizzo et al. (2014) highlight that specialists in palliative care are trained to provide patients and their loved ones with emotional support when they are making decisions, encouraging transparency of information between health disciplines. In contrast, Carson et al. (2016)
argue that there is a lack of co-ordination in decision-making and care goals which creates failed expectations for both health professionals and patients in palliative care. Research by The King’s Fund (2015) signifies that communication is a key issue in care co-ordination and the development of outcomes for older people receiving palliative care services. These barriers in palliative care articulate a need for an integrated care approach improving co-ordination, communication, and fragmentation currently residing in end of life care.

Leutz (1999, p. 1) envisioned that the outcome of integrated services “could address cross-system care problems, including poor co-ordination […] and frustration for users in accessing services”. Integrated care has evolved into systems of care which features integration at multiple levels: clinical, professional, organisational, and systematic (Valentijn et al., 2015). At the heart of these perspectives is that integrated care can offer solutions to fragmented health and social care (Stange, 2009). Busetto (2016) argues that integrated care is the most promising solution for improving the quality of care for older patients experiencing palliative care. By encompassing an integrated care approach to palliative care, it can improve the standards of healthcare through the improvement of co-ordination of care between health disciplines (De Stampa et al., 2013). The WHO Report on Palliative Care (2011) calls for the development of an integrated palliative model of care that will link healthcare professionals from health and social segments of care, rather than further fragment them (Ling et al., 2010). To achieve this, there is a need to understand the barriers and challenges to an integrated palliative model of care.

Methods
The aim of the review was to understand the literature surrounding an integrated palliative model of care. An integrative review methodology was chosen as it enables the inclusion of both empirical and non-empirical literature (Whittemore and Knafl, 2005).

Search strategy
The Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) checklist (Liberati et al., 2009) framed the searching and reporting of the review, whilst an adapted version of the PICO Framework (Bettany-Saltikov, 2012) was used to identify search terms (Table I). Inclusion criteria included papers published in English between January 2007 and 2017, while papers were excluded if they focused upon individuals younger than 65 and not focused on integrated, palliative care (Table II). MySearch Bournemouth University’s version of the EBSCO Discovery Service tool was used to search multiple databases including CINAHL, MEDLINE, PubMed, and Cochrane Review.

Screening and selection
The original search (Figure 1) identified 190 hits which were reduced to 115 following the removal of duplicates. Following this, there was a two-stage screening process: at the first stage, titles and abstracts were reviewed alongside the inclusion and exclusion criteria.

<table>
<thead>
<tr>
<th>Population</th>
<th>Intervention</th>
<th>Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older people</td>
<td>Integrated care</td>
<td>Palliative care</td>
</tr>
<tr>
<td>Elderly</td>
<td>Co-ordinated care</td>
<td>End of life care</td>
</tr>
<tr>
<td>Seniors</td>
<td>Multi-disciplinary</td>
<td>Eol</td>
</tr>
<tr>
<td>65+</td>
<td>Integrated health</td>
<td>End-of-life</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>Integrated palliative care</td>
<td>Terminal care</td>
</tr>
<tr>
<td>65 or older</td>
<td></td>
<td>Dying</td>
</tr>
<tr>
<td>Older adults</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table I. Search terms
At this stage, 74 papers were excluded. The remaining 41 papers were then read in full in the second stage and a further 32 were excluded at this stage. Reasons for exclusion included unmet age criteria, secondary focus (i.e. integrated care, palliative care, education, or technological advancement), conference/poster abstracts, and proposed frameworks. This resulted in nine articles which met the criteria for inclusion in the review (Table II).

The quality of the research was also reviewed at this stage using Critical Appraisal Tools Programme (2017). A synthesis was performed by compiling and categorising the data using thematic groups for the identification of interests and central concepts related to the topic. The three themes identified in this review included: person-centred care, co-ordination of care, and education and training.

**Results**

**Study characteristics**

Of the nine articles included, four of them were reviews (McCormick, 2012; Burns and Nair, 2014; Duffy *et al.*, 2011; Chan *et al.*, 2016), six were empirical studies including qualitative research (Phillips *et al.*, 2008; Ho *et al.*, 2016) and mixed-methods research (Bergman *et al.*, 2014; Hanratty *et al.*, 2014; Marshall *et al.*, 2011). The review included papers from diverse geographical regions, significant to a global outlook on integrated palliative care, including the UK (*n* = 4), the USA (*n* = 2), New Zealand (*n* = 1), Australia (*n* = 1), and China (*n* = 1).

**Person-centred care**

The importance of taking a person-centred care approach in integrated palliative care was highlighted in seven of the nine papers (Hanratty *et al.*, 2014; Marshall *et al.*, 2011; Phillips *et al.*, 2008; Bergman *et al.*, 2014; Ho *et al.*, 2016; Duffy *et al.*, 2011; Chan *et al.*, 2016). In an integrated palliative care clinic in the USA (Bergman *et al.*, 2014), participants revealed that the quality of care was improved due to an enhanced patient–provider relationship developed from a better understanding of individual needs and by identifying the patient as a whole (Ho *et al.*, 2016). The importance of the needs of the individual in a palliative care setting was evident in five papers in the review (Hanratty *et al.*, 2014; Phillips *et al.*, 2008; Bergman *et al.*, 2014; Duffy *et al.*, 2011; Chan *et al.*, 2016). Focus groups in both New Zealand and China identified that collectively sharing empathy, compassion, and devotion through integrated care helped unify actions between all stakeholders in an end of life care setting (Marshall *et al.*, 2011; Ho *et al.*, 2016). Yet, reviews by Duffy *et al.* (2011) and Chan *et al.* (2016) identified that the different aims of multiple parties involved made it more challenging to address the individual patient’s needs in a coordinated, organised manner.

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older people aged 65 and older</td>
<td>Patients under the age 65</td>
</tr>
<tr>
<td>Patients designated to palliative or end of life care</td>
<td>Patients not designated to palliative or end of life care</td>
</tr>
<tr>
<td>Evidence of merging integrated care into palliative or end of life care pathway</td>
<td>Research that does not include evidence of using an integrated care approach</td>
</tr>
<tr>
<td>English language</td>
<td>Integrated care exclusively</td>
</tr>
<tr>
<td>Publication date January 2007–2017</td>
<td>Palliative or end of life care exclusively used</td>
</tr>
<tr>
<td>Published peer review papers</td>
<td>Any other speciality primary focus</td>
</tr>
<tr>
<td>Non-English language</td>
<td>Grey literature or not published in a peer-reviewed journal</td>
</tr>
</tbody>
</table>

Table II. Inclusion and exclusion criteria
Co-ordination of care

All nine articles identified a component of coordinated care as a major factor in the development of an integrated palliative care approach. Four out of the nine papers focused on the use of some form of multidisciplinary team as a means of positive assistance in palliative care (Phillips et al., 2008; Bergman et al., 2014; McCormick, 2012; Burns and Nair, 2014). Additionally, multidisciplinary teams in Australia found it effective to regularly meet to discuss the patients and their health status (Phillips et al., 2008). In contrast, Hanratty et al. (2014) identified that a single point of contact referred to as a “transition” coach (i.e. nurse leader or clinical manager), facilitated the co-ordination through multi-faceted care levels. The importance of an organised relationship between healthcare professionals within

Figure 1. PRISMA 2009 flow diagram
<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Aims and objectives</th>
<th>Methodology</th>
<th>Findings</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bergman et al.</td>
<td>Community-partnered collaboration to build an integrated palliative care clinic: the view from urology</td>
<td>To ascertain clinical views about the quality of care delivered and avenues for improvement in the integrated palliative care clinic</td>
<td>Qualitative semi-structured interviews were undertaken with 18 clinicians. Analysis based upon grounded theory</td>
<td>Four themes: Clinicians felt it was feasible and appropriate to address pain and comfort issues within a surgical clinic. When incorporating pain and comfort issues perceived quality of care was improved and patients were happier. Offering a palliative care consultation to patients did not require an undue amount of time. Patients viewed the terminology of the “integrated” clinic to be a misnomer and offered opportunities for the clinical organisation.</td>
<td>Small, single site study</td>
</tr>
<tr>
<td>Burns and Nair</td>
<td>New horizons in care home medicine</td>
<td>To outline recent updates on clinically relevant topics and describes service models which may improve care in care homes for older people</td>
<td>Review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chan, et al.</td>
<td>End-of-life care pathways for improving outcomes in caring for the dying</td>
<td>To assess the effects of EOL pathways compared with usual care (no pathway) or with care (no pathway) or with care guided by another EOL pathway across all healthcare settings</td>
<td>Systematic review of 3,028 papers</td>
<td>Primary outcome of the review: no evidence of clinical, physical, psychological or emotional effectiveness of end of life care pathways</td>
<td></td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Aims and objectives</th>
<th>Methodology</th>
<th>Findings</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duffy et al.</td>
<td>The Liverpool care pathway: does it improve the quality of dying?</td>
<td>To examine the evidence in relation to the LCP as a tool to improve PC for dying patients and their families in non-specialised PC practices</td>
<td>Review</td>
<td>The complexity of patients care needs at the end of their lives is vast and complex yet not all professional staff see the value of integrated care pathways. Limited evidence to suggest the Liverpool care pathways improve end of life care</td>
<td>Process of analysis not made explicit</td>
</tr>
<tr>
<td>Hanratty et al.</td>
<td>Transition at the end of life for older adults- patient, carer and professional perspectives: a mixed-methods study</td>
<td>To understand the experiences, influences and consequences of transitions between settings for older adults at the end of life</td>
<td>30 participants aged over 75 Mixed methods including interviews with older adults, interviews and questionnaire with bereaved carers, interviews care commissioners and providers, analysis of hospital episode statistics and mortality data (2001-2010)</td>
<td>Transition across care setting in last year of life was common Patients/carers experiences of transitions of EOL were of disjointed Lack of information for carer who tended to have the coordination role Good relationships between different professional sectors was recognised as important Out of hours services and care homes were identified by many as contributors to unnecessary transitions</td>
<td></td>
</tr>
<tr>
<td>Ho et al.</td>
<td>Dignified palliative long-term care: an interpretive systematic framework of end-of-life integrated care pathway for terminally ill Chinese older adults</td>
<td>To identify the interplaying dynamics, mechanisms and systematic factors that underscore the implementation practice of EOL-ICP in Chinese context of Hong Kong</td>
<td>30 stakeholders in 4 focus groups Inductive and deductive thematic analysis. NVivo software was used to manage the data</td>
<td>10 themes were organised into three categories Regulatory Empowerment (interdisciplinary teamwork, resource allocation, culture building, collaborative policy making) Family-centred care (continuity of care, family care conference, partnership in care) Collective compassion (devotion in care, empathic understanding, compassionate actions)</td>
<td>Small single site study</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Aims and objectives</th>
<th>Methodology</th>
<th>Findings</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marshall et al.</td>
<td>Staff perceptions of end-of-life care in aged residential care: a New Zealand approach</td>
<td>Sought ARC staff perceptions of EOL care obtained to inform LCP intro and evaluation</td>
<td>Survey of 195 staff working in residential care. In total, 32% response rate. Questionnaire consisted of Likert and open text questions. Analysis included thematic and descriptive statistics.</td>
<td>Six themes identified: naturalness of dying; character of care; care relationships; emotional response; knowledge; and organisational environment. Key recommendations focused on the following groups: Workforce, Research, Education, Policy. Conclusion was there were tremendous opportunities for collaboration to foster solutions to the challenges faced in care of serious ill older adults.</td>
<td>Single site study with limited response rate</td>
</tr>
<tr>
<td>McCormick</td>
<td>Report of the Geriatrics- Hospice and Palliative Med work group: American Geriatrics Society and American Academy of Hospice and Palliative medicine leadership collaboration</td>
<td>To identify areas of potential synergy between two specialities and to design a plan for exploring and developing these areas of common interest</td>
<td>Report on the Hartford Summit meeting between American Geriatric Society and the American Academy of Hospice and Palliative Medicine Leadership Collaboration.</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Phillips et al.</td>
<td>Multi-faceted palliative care intervention: aged care nurses’ and care assistants’ perceptions and experiences</td>
<td>To describe residential aged care nurses and nurses’ assistants’ perceptions of a multi-faceted palliative care intervention to identify potential areas to be addressed during subsequent action research phases</td>
<td>28 aged care nurses and assistants. Focus groups and thematic analysis</td>
<td>Four themes: Targeted education makes a difference; Team approach is valued; Clinical assessment tools are helpful. Using right language is essential.</td>
<td>Small, single site study</td>
</tr>
</tbody>
</table>
health and social segments of palliative care was heightened by numerous papers (Hanratty et al., 2014; Marshall et al., 2011; Ho et al., 2016; McCormick, 2012; Duffy et al., 2011). According to Ho et al. (2016), this relationship led to coordinated care through effective communication, inter-professional management between all organisations and parties involved in end of life care. While communication is shown as an integral part of integrated palliative care, it can occur in several diverse ways including regular updates and newsletters (Ho et al., 2016) and briefings between all members involved in care (McCormick, 2012).

**Education and training**

Seven studies highlighted a lack of general knowledge in palliative care (Marshall et al., 2011; Phillips et al., 2008; Bergman et al., 2014; Ho et al., 2016; McCormick, 2012; Duffy et al., 2011; Chan et al., 2016). Induction into palliative care was identified as not being delivered adequately to patients (Chan et al., 2016) or staff (Bergman et al., 2014; McCormick, 2012). In addition, the quality of the education that was offered to the health professionals did not reflect the depth that is required for palliative care (Ho et al., 2016; McCormick, 2012; Duffy et al., 2011). When integrated care was introduced as a concept to enhance palliative care, education and training resulted in a positive impact as Marshall et al. (2011) identified staff had higher confidence in preventing inappropriate transfer during end of life care. Focus groups in Australia identified that providing quality palliative care education to multi-faceted care teams prompted a collaborative integrated care approach (Phillips et al., 2008), while reviews of integrated palliative care pathways revealed that staff development and staff education in palliative care had resulted in the global needs of the patients in the palliative phase being addressed (Bergman et al., 2014; McCormick, 2012; Duffy et al., 2011; Chan et al., 2016).

**Discussion**

Eight out of the nine studies and reviews were conducted from 2011 onwards (Hanratty et al., 2014; Marshall et al., 2011; McCormick, 2012; Burns and Nair, 2014; Bergman et al., 2014; Ho et al., 2016; Duffy et al., 2011; Chan et al., 2016), implying that research in this field is emerging. As identified, integrated palliative care is an embryonic field of practice, as such there are limited published peer-reviewed papers in this emerging field. In addition, as this review focussed upon published peer review literature, we recognise that there may be other reports and grey literature in this field which were not included in this review.

Although qualitative data were collected, the data from the individuals themselves were limited. This is in part a response due to the ethical considerations of the vulnerability of the patient going through end of life care and their family which contributes to the challenging nature of research in this field (Aoun and Kristjanson, 2005).

The results of this integrative review indicate that while implementing an integrated palliative model of care into practice is on the horizon, there is still a way to go to progress this. Seeing that there is a global phenomenon of an ageing across the world increases the need for integrated palliative care. For older people, death is inevitable and not feared (Lloyd-Williams et al., 2007); however, it is the quality of life through care that is a concern (Wetle et al., 2005). Small (2007) formulates a “too little, too much” approach in the care of older people with dementia as the individuals are frequently transitioned through different care settings or the level of care needed was simply not sufficient or person centred.

The significance of a person-centred care approach was highlighted as a key aspect in this review. Older people are identified as a frail population due to an increased risk for adverse health outcomes (Fried et al., 2001) and when requiring end of life care as their degree of frailty increases (Boockvar and Meier, 2006). In recent years, there has been a shift towards “at-homeness” in end of life care, where the individuals feel like they are at home irrespective of the setting (Saarnio et al., 2016).
Coulter et al. (2013) argue that health organisations require care co-ordination between professionals across sectors and this review identified that tailored multidisciplinary teams are at the heart of an integrated palliative model of care. The benefits to the patients of teams being organised to provide an integrated palliative model of care have been identified in a number of studies including Bergman et al. (2014) and Burns and Nair (2014). The formation of these tailored multidisciplinary teams assisting the transition from situational to end of life care has been apparent throughout the last couple decades. Thiel et al. (2013) identified thriving multidisciplinary teams in the form of community resource teams and esteem teams, as well as, teams led through a single point of contact. Though consisting of different names and structures, the overall aim of these multidisciplinary teams were similar in that they were constructed with multiple levels of management and coordinated services within a partnership framework.

As mentioned earlier, Patel and Masi (2015) identified the lack in progressive training and quality education in palliative care. While there are palliative care specialists, it is important that all staff working in these areas feel they have the education they need in order to provide high levels of quality care (Harris et al., 2016). By increasing palliative care training across all disciplines, it can open awareness to the public and allows healthcare professionals to communicate to patients and family members about end of life care and practice. Communication has been acknowledged by Olsen et al. (2010) and as an attractive skill added by an integrated palliative model of care, although the sensitivity of the subject makes it hard for professionals to convey the need for palliative care. There have been successful training exercises that utilise interactive theatre to enhance patient–provider communication and improve the promotion of inter-professional education (Pastor et al., 2016), which is one of the essential foundations of any effective healthcare plan (Arnold and Boggs, 2015). Continuous engagement through constant updates and feedback developed by interdisciplinary relationships proves to engage effective communication levels (Cunniffe et al., 2016), which can be used to create a joint holistic integrated palliative model of care.

**Conclusion**

This integrative review has identified that an integrated palliative model of care could facilitate the delivery of person-centred care to older people who are dying in a variety of different settings. Integrated palliative care is clearly an area of increasing interest, and as a result concepts of integrated care are ever-changing. However, there is currently very little published research in this area and more work is needed to identify particular models of care and the impact of these on patients and their families. Nevertheless, this review has identified that provision of coordinated care, through integrated multidisciplinary teams, enhances communication and inter-professional relationships all of which can lead to a better quality of care.

**References**


**Further reading**


**About the authors**

Marina Raco is currently based in the USA after completing her MSc Degree in Public Health at Bournemouth University.

Dr Teresa Burdett is Senior Lecturer in Integrated Care and is Professional lead for Inter-professional Education at Bournemouth University. As a treble, trained adult and Mental Health Registered Nurse and Health Visitor, her research interests include integrated care, interprofessionalism, workforce development, person-centred care, the impact on the individual of their care and hearing the voice of the individual. She is passionate about improving care for the individual and focuses on this whether in a clinical, teaching or research capacity. Dr Teresa Burdett is the corresponding author and can be contacted at: tburdett@bournemouth.ac.uk

Dr Vanessa Heaslip is Principal Academic and Deputy Head of Research in the Department of Nursing and Clinical Science at Bournemouth University. As a Registered Nurse, her research interests are in the field of vulnerability and vulnerable groups in society whose voices are not traditionally heard in the academic and professional discourse. In particular, she is interested in marginalised communities who experience inequity of opportunity in accessing healthcare services and education.
Co-designing integrated care for high-needs clients: the Help Team for school-aged children

Tuula Tuominen
Pikassos – The Centre of Excellence on Social Welfare in the Regions of Kanta-Häme, Pirkanmaa and Satakunta, Tampere, Finland
Mari Harju
City of Tampere, Tampere, Finland
Erja Oksman
Päijät-Häme Welfare Group, Lahti, Finland, and
Anneli Hujala
Department of Health and Social Management, University of Eastern Finland, Kuopio, Finland

Abstract

Purpose – The purpose of this paper is to describe a Finnish pilot project aiming to support high-needs clients in their everyday lives by developing an integrated care approach based on the multi-sectoral collaboration of care professionals. The Help Team for school-aged children will be described as an example of the integrative practices developed on the project.

Design/methodology/approach – Altogether 250 professionals from primary and secondary health care and social care and from the education sector were designated to collaborate in 37 local, multi-sectoral teams, aiming to develop integrated care practices for high-needs clients. Teamwork was supported by coaches and project seminars, the Breakthrough method and other LEAN methods. The project was evaluated internally by means of a survey and interviews with the participants.

Findings – As a result of the project, all 37 teams developed a specific collaboration model for their selected target group comprising different kinds of high-needs clients.

Research limitations/implications – The sustainability of the outcomes of the project depends on how managers and decision-makers are committed to applying the collaboration models in future.

Practical implications – Many of the collaboration models developed in the project will be implemented in practice in a wider area.

Social implications – The project highlighted the need to pay attention to the problems of people with multiple care needs and the challenges they pose for integrated care.

Originality/value – The project was based on the client-centered development work done by frontline professionals. Due to the high level of involvement of the professionals themselves, the project proved highly instructive for them. It is extremely important to engage frontline level professionals in development work and support them in collaborating beyond the traditional “silos”.

Keywords Integrated health and social care, Multi-disciplinary teamwork, Health and social care, High-needs clients

Paper type Case study

1. Introduction

Is everyday life with your school-aged child a never-ending conflict? Is your junior stuck at the computer? Do you quarrel about when your child should come home? Are you worried about the company your child keeps? Are there problems with school? Have you lost the contact to discuss with your child? Are you worried about the way your child spends his/her time?[1]

Like many countries in Europe, Finland is struggling with the sustainability of its health and social care systems. A forthcoming extensive national-level reform, which is expected to take place in 2021, aims at the total integration of health and social care (Regional Government, 2017).
The reform will also include legal provisions on freedom of choice. The reform aspires to serve the public better and more equally and, at the same time, to curb rising costs.

One of the most challenging groups in integration reforms is high-needs clients requiring both health and social care services from several care providers (Hujala et al., 2017; Kulksni et al., 2017). These are also the people who incur a considerable part of total costs of care. In the public discussion, these people are often referred to as patients with multiple complex problems, high-cost clients, frequent users or even heavy users. In this paper, we prefer the term high-needs clients. These may be people with multiple chronic diseases, and also people who need support from social care in order to manage in their everyday lives – such as the school-aged children and their families addressed in this paper.

The current fragmented, disease-based health and social care systems do not meet the needs of high-needs clients (Goodwin, 2015; Rijken et al., 2017). Co-operation among primary care, specialized care and social care is very often inadequate and nobody is responsible for co-ordinating these “silos.” High-needs clients are a target group who stand to gain considerably from integrated care. In addition, integration of care is likely to result in considerable cost savings due, for example, to avoiding unnecessary and overlapping care.

Integrated care takes place at different levels in society (Valentijn et al., 2013, 2015). Structural and administrative macro-level solutions are essential but not sufficient prerequisites for the successful integration of health and social care. The principles of shared responsibility and seamless collaboration must be implemented in practice at organizational, professional and client levels. In addition, the normative (e.g. differing values) and functional dimensions of integration have to be taken into account. Top-down orientation with no real involvement of lower-level actors may become an obstacle to the successful implementation of integrated care.

In the Finnish reform of health and social care mentioned above, the integration of health and social care will be accomplished at all levels. The provision of health and social care services will be transferred from 300 municipalities to 18 counties. Even now some of these have integrated all public health and social care services at the regional county level, so that primary care health, specialized health care and social care are under one administration and budget. The aim is that this system level integration will lead to integrated and coordinated care pathways also at organizational, professional and client levels. The structural reform will indeed form a basis for integrated care, but the changes nevertheless will need to be implemented at the practical level by frontline professionals through multi-professional collaboration.

The Better Everyday Life (BEL) project (Oksman, 2017) was one of the pilot projects of the forthcoming reform, aiming to implement the principles of the reform in practice through involving frontline professionals to develop integrated care at the practical level. This reflection paper draws on the experiences of professionals who participated in the BEL project. The specific focus of the paper is to describe one of the services developed in the project, The Help Team for school-aged children and their families. The paper aims to share the understanding that emerged during the project about the importance of involving frontline professionals in developing ways to implement integrated care in practice:

Everyday life with your school-aged child can be challenging. Answers and solutions are difficult to find. You don’t always even know where to seek help. You are not alone with these thoughts. The Help Team offers help for day-to-day problems.

2. Design of the BEL project
The aim of the BEL project was to support high-needs clients in everyday life by developing a person-centered, integrated care approach based on multi-sectoral collaboration among frontline professionals. The target group was clients needing both health and social care
services – and sometimes also support from other sectors (e.g. employment or education services). These clients can also be described as “shared clients” between health care and social care. The BEL project was a pilot project for Finland’s national reform aiming to complete the integration of health and social care.

The project was evaluated internally by means of a survey targeted at project participants and by conducting interviews among them. This evaluation was conducted in conjunction with the research project Successful Integration of Social and Health Care of the University of Eastern Finland.

The frontline professionals on the project developed integrated care for high-needs clients. Altogether 250 professionals (nurses, doctors, social workers, therapists, teachers, etc.) from primary care, secondary care, social care and the education sector were recruited to collaborate in 37 local, multi-sectoral teams. The participants were professionals already working in the field, but the multi-sectoral teams were established specifically for the purposes of this project. The members of the teams were selected by the local health and local care authorities in the municipalities who were participating the BEL project.

The goal of the BEL teams was to develop multi-sectoral collaboration models to cater for high-needs patients. Each team consisted of representatives of different care sectors. Each team focused on a specific client group, which was also chosen by each local health and social care authority. Client groups were, for example, families with children having multiple needs, young people with mental and/or drug problems, older people frequently requiring acute care, unemployed people and rehabilitation patients.

The work of the teams was supported by project seminars, in which the Breakthrough Collaboration model and PDSA-cycle (Plan – Do – Study – Act) were applied (Series and Kilo, 1998; The Breakthrough Series, 2003). The seminars formed a forum where local teams could meet teams from other geographical areas and the participants had an opportunity to compare experiences and learn from other teams. Those seminars lasted two days and there were held three times, so that about 80 people were attending each seminar set. After every seminar, the teams were given assignments to be done at their regular work, related to the development of services for their target group. They were also asked to take clients to their meetings and give them an opportunity to participate and tell the professionals what they really need in services. So-called experts by experience (expert patients) also attended one Breakthrough seminar, where the teams practiced doing the shared social and health care plan for these clients. After this practice, the clients gave feedback to the professionals and the whole seminar group discussed challenges related to doing the plan for clients, in particular what should be taken into consideration from the client’s point of view.

Meanwhile, the teams worked on their own according to the PDSA-cycle, doing their assignments related to the aims of the project (see Box 1), supported by the project coaches as facilitators. Other LEAN methods (Bhat et al., 2013) were also applied. Fish bone analysis was used for assessing the pitfalls and root causes of current care pathways for high-needs clients. A special focus of this analysis was on revealing factors that impede multi-sectoral and multi-professional collaboration. The Lean Lego Exercise (see e.g. Conger and Miller, 2014)

---

Box 1. Key aims of the BEL project

- To develop ways to identify clients who would mostly benefit from multi-sectoral collaboration of care professionals
- To develop and test a shared social and health care plan for clients
- To develop concrete patient-centered collaboration models which bring together diverse professionals needed in caring for high-needs clients

---
was used to demonstrate the benefits of collaboration. The main goal of the Lego Exercise was to illustrate how extra value is produced for clients and to demonstrate how “waste” can be avoided by, for example, balancing the work load of individual workers.

Theoretically, the development work drew on the extended Chronic Care Model (Barr et al., 2003). The project advocated explicitly client-centered orientation by according vocabulary: word client was used instead of the health-oriented word patient, high-need replaced the system-oriented term high cost. Client groups needing integrated care was addressed by using the term shared clients, which emphasized to care professionals that nobody can take care of these patients alone; shared responsibility and collaboration over traditional boundaries is needed.

3. Results of the project
All 37 BEL teams developed a collaboration model specifically intended to meet the needs of their respective target groups. The models varied, but the main common elements were the following: principles and tools to identify shared clients, a shared health and social care plan for clients and description of how multi-professional collaboration should be organized, including a named contact person for each client.

One concrete example of the collaboration models developed in the project is the Help Team, a service for school-aged children and their families. The target group of the Help Team service was school children aged 7–16 and their families from one school in Tampere, a Finnish city of about 220,000 inhabitants. The BEL team who developed this service consisted of representatives from the education sector, primary care, specialized care and social care: a school welfare officer, a school nurse, a school doctor, a social worker for families with children, a youth psychiatrist, a psychiatric nurse for adults' specialized care and a dental hygienist. The team members were appointed by the local health and social care managers.

The Help Team is an easily accessible service for children with multiple needs, resulting in better co-ordination of care based on collaboration among experts from the health, psychiatric, social and education sectors. It offers help for the everyday challenges faced by families with school-aged children. The main idea is to gather a multi-disciplinary team of professionals to help both the child and the family.

The specific aims for the Help Team service were:

- to create a multi-professional collaboration model to support school-aged children and their families in order to identify and prevent problems at an early stage;
- to find tools for support and to allocate and deploy them in a timely, flexible and effective manner; and
- to reduce overlapping work by professionals and avoid children and their families being shunted from one professional to another.

After jointly outlining the model for the service, the Help Team notified all pupils at the school and their parents using the electronic messaging service used for everyday communication between school and home. All Help Team members cleared certain shared times in their diaries for the next half year to be able to respond to the anticipated demand for the Help Team service. Any pupil or parent experiencing family problems could contact the Help Team, which also accepted contacts from school social workers, school nurses or any other professional feeling concern about certain pupils. After eliciting information on the problems, the Help Team contacted the pupil’s family. If the family agreed, a team meeting was arranged with the family. In each case, the Help Team consisted of the relevant professionals depending on the needs of the pupil and the family.
The working model of the team is described in Box 2:

1. Contacting the Help Team
   A client (school-aged child and/or family) contacts the school nurse or some other professional (teacher and school doctor) about the problems, then the client is referred to the Help Team. In addition to families, any professional with concerns about a pupil can contact the Help Team to initiate the helping process

2. Agreeing on how to proceed
   The Help Team agrees with the client on how to proceed (timetable, who will be involved on the client’s side, which professionals need to participate). A background information form and an official form for information sharing are sent for the client to complete

3. Meeting with the Help Team
   The client is invited to meet the Help Team as agreed in phase 2 above. A plan on how to proceed is drawn up together with the client and professionals (determining the goal, what needs to be done in practice, plans for follow-up). A contact person for the client is chosen according to the client’s wishes

4. Follow-up
   Follow-up meetings (1-2) are arranged if needed to assess the client’s situation

5. Closing the case in the Help Team
   The client (child and/or family) has received speedy help and support from the relevant directions. If necessary, the client will be assigned a personal support worker. Client feedback is requested

4. Contribution of the project

The most important aim of the BEL project was to provide client-centered, integrated services so as to offer high-needs clients a complementary, flexible and continuous service package. The aim was thereby to improve the clients’ experiences of managing their everyday lives and improve their quality of life.

In the Help Team service, in particular, it was deemed important that families should get help quickly and easily without having to meet several professionals separately. In this model, it was also important that professionals specialized in both working with adults and those familiar with working with children were available in the Help Team. This combination was one of the key elements, because too often the services for children do not pay attention to the potential problems of the family as a whole.

The feedback from the users at the end of the project was summarized by the team members as follows:

The feedback from the parents regarding the team meetings has always been positive. The parents felt that they gained new perspectives on their problems and also concrete help. The parents also found it useful that the team is multi-professional. They felt that their problems were given a hearing. The clients of the Help Team included pupils of all the ages. In addition to the original members of the Help Team, depending on the case, other relevant professionals such as the school principal and a school psychologist attended the team meetings with clients.

Another key area of the Better Everyday Life project concerned the work of health and social care professionals: the aim was to strengthen professionals’ collaboration, communication and know-how in order to cater for of high-needs clients and to provide a holistic, client-centered service. At the end of the project, the Help Team members reflected on their success as follows:

All of us [team members] felt that this way of working was extremely good. Most of us usually work alone, so doing things together and having a multi-professional team around to ponder the same problem was highly motivating. Not to mention the advantage of being able to consult or
contact colleagues from different sectors now that we know each other. Our managers have encouraged this collaboration model, so the meetings of the Help Team will continue once a month. So far the team's clients have mostly been referred by the school nurse, but the goal is that in future more parents would learn to contact us […] It has been easy to find clients and it really seems that there is a demand for this kind of service.

As on all projects, the sustainability of the development work accomplished by professionals during the project depends on the commitment of managers and their willingness to facilitate the implementation of the collaboration model in practice, as part of the organizations’ everyday work. Currently, it is planned to implement the collaboration model in several schools in Tampere region. In addition, at national level, it shows a way to proceed for other regions: the Help Team service is being used as an example of the national level LAPE project. LAPE is a key program of the Finnish Government aiming to develop client-centered services for children and their families.

5. Learning points
As the example of the Help Team shows, the BEL project was “an eye-opener” for care professionals from diverse points of view. The most important learning points from care professionals’ perspective can be summarized as follows:

- Professionals’ understanding of high-needs clients and their needs increased. High-needs people are not a group of similar cases but comprise diverse sub-groups and individuals with different kinds of demanding life situations. Each group and sometimes even each individual client needs tailored care pathways and services.

- Working together with colleagues from different sectors is the most effective way to meet the needs of high-needs clients.

- Earlier these professionals were not familiar with each other and the work carried out in other sectors and organizations. During the project, they realized that they were working with the very same clients, but separately, each in their own “silos.”

- The common aim of the collaboration emerged through concrete collaboration on real client cases. Concrete client cases helped professionals to understand that these clients really benefit from co-produced holistic, client-centered services.

- Multi-professional and inter-organizational collaboration helped them to understand in practice the meaning of trust and respect: appreciation of expertise other than one’s own. It became evident that no individual professional can cope alone with high-needs clients.

- Collaboration moreover helped the professionals to understand at first hand the benefits of collaboration: doing things together shares the burden caused by a complex situation and people with multiple difficult problems, because not only the clients but also the professionals get help and support from others.

- In addition to collaboration among professionals, commitment and support on the part of management were deemed extremely important.

- Small-scale pilots within a broader project, focusing on a specified group of high-needs people by each multi-sectoral team made the idea of integrated more concrete.

- The best way to understand why integrated care is needed and how it can be implemented is “learning by doing.”

6. Conclusions
The lessons learnt from the BEL project give some useful guidance for implementing the Finnish reform of health and social care. The project addressed probably the most important
target group of integrated care, people with multiple needs and the ways in which multi-professional and inter-organizational collaboration among professionals can help to provide better and more sustainable care for these people. Integrated care implemented through collaboration beyond the traditional sectoral boundaries is necessary in order to improve the care of shared high-needs clients and to avoid costs caused by inappropriate and overlapping services.

It is noteworthy that with some high-needs people integration of health and services is not enough; the education sector is often needed as a partner in providing integrated care for families; and the employment sector may need to be included when developing services for working-aged people with multiple problems.

Changes in macro-level administrational and funding structures form the basis for an extensive national level reform. However, successful implementation depends on how well the changes are adopted and implemented at organizational, professional and client levels. The ultimate reform will be carried out by frontline professionals; the very same people who are already working in care organizations. This means that the structural and administrative reform must be achieved and scaled to the level of people and their everyday life.

What mattered most in the BEL project was that the frontline professionals themselves were involved in the actual development work of integrated care. Working together with clients beyond professional and organizational boundaries rendered the common objective, the client’s best interests, more concrete. The professionals saw more clearly how each of them could contribute toward a holistic view of the person with multiple problems.

Integration at the client interface requires a huge amount of work from professionals. Professionals need to sit at the same table and try to find a shared understanding and a common language, learn to trust other professionals. This can be achieved by doing things concretely together at the level of professionals’ everyday work. The extra work needed for creating new ways of working must be appreciated by management: the commitment of and support from management is key to leading the implementation of integrated care.

In addition, involving clients in the development work from the very beginning is important. Listening to the voices of clients is a prerequisite for the successful integration of health and social care, hence it is crucial to include the service users and expert patients when developing something new.

To sum up, it is extremely important to engage frontline level professionals in the development work and encourage them to collaborate in concrete ways beyond the traditional “silos.” This was expressed by one of the BEL project participants as follows: “For goodness sake give us time to develop our own work! There will be no development if there is no time to think.”

Note
1. Italic text citations are from the advertisement of the Help Team.

References


Corresponding author
Anneli Hujala can be contacted at: anneli.hujala@uef.fi

For instructions on how to order reprints of this article, please visit our website:
www.emeraldgrouppublishing.com/licensing/reprints.htm
Or contact us for further details: permissions@emeraldinsight.com
Roles and responsibilities in integrated care for dementia

David Robertshaw
School of Nursing and Professional Practice, University of Derby, Derby, UK, and
Ainslea Cross
UDOL, University of Derby, Derby, UK

Abstract

Purpose – Effective integrated healthcare systems require capable, trained workforces with leadership, shared governance and co-ordination. The purpose of this paper is to characterise roles and responsibilities in relation to integrated care from the perspective of massive open online course (MOOC) participants.

Design/methodology/approach – MOOC discussion board posts were analysed using framework analysis consisting of transcription, familiarisation, coding, developing an analytical framework and application of the framework.

Findings – Boundaries and key issues surrounding roles and responsibilities were highlighted and participants suggested a number of enablers which could enhance integrated care in addition to barriers to consider and overcome.

Originality/value – Enablers included introduction of shared communication and IT systems to support continuity of care. Awareness and understanding of dementia was seen as crucial to promote person-centred care and care planning. The roles of education and experience were highlighted. Barriers preventing effective roles and suitable responsibility include funding, role conflicts, time constraints and time-consuming paperwork.

Keywords Dementia, Integrated care, MOOC, Online learning

Paper type Research paper

Introduction

People living with dementia require significant ongoing support and care from individuals and teams who work across a wide range of services and organisations (Miranda-Castillo et al., 2010). There has been an increasing pressure in the UK since the Health and Social Care Act of 2012 for health and social care services to restructure and integrate. Health and social care transformation has been driven by the challenge to deliver over £22 bn cost savings in efficiency measures by 2020/2021 (Dunn et al., 2016). Increased pressure, restructuring and efficiency measures, alongside the rising cost of care, have placed increasing pressure on healthcare providers to ensure that their services are fit for not just current care demands, but also those in the future. Health and social care organisations are facing financial deficits, worsening referral waiting times and increased demand for health and social care services (The King’s Fund, 2017). These challenges compound the issues of providing adequate numbers of staff to implement effective care.

Integrated care is an approach which integrates services for the benefit of patients, efficiencies and value from health delivery systems (Shaw et al., 2011). Successful international integrated healthcare systems exhibit effective leadership, clear and strong communication, shared governance between organisations and care navigation roles who assist in breaking down barriers and facilitating collaborative working (Royal College of Nursing, 2014). Care navigation is a process or intervention, rather than a specific role and all staff should be involved (Health Education England, 2017). Sustainability and transformation plans (STPs), a response to improve health and care, have led to “area” plans with focussed resources and services in particular places, rather than the organisations in which care is delivered (NHS, 2016); a development which will require flexible working across boundaries (Alderwick et al., 2016) and may promote integrated care for dementia.
Effective integrated care for dementia represents a significant priority, and this need will only rise as “baby boomers” approach older age and develop diseases, including dementia (Forbes and Neufeld, 2008). Integrated dementia care pathways are already in development and being implemented with positive effect (Timmons et al., 2017). Minkman et al. (2009) argue that the factors for successful integrated care include expert knowledge, strong provider networks and inter-organisational co-operation. This approach may undervalue the contribution of individual people who perform various roles and have responsibilities in relation to integrated dementia care.

This paper presents a major research theme emerging from a framework analysis study of integrated care from the perspective of participants of a massive open online course (MOOC) on dementia. The aim of this study was to explore experiences of integrated care from the perspective of carers, people living with dementia, healthcare professionals and researchers. A major theme emerging from this analysis is related to the roles and responsibilities people performed or undertook in relation to integrated care for dementia, rather than the specific professional or non-professional role they inhabit. This theme is reported here.

Methods

Design

This study reports the views of MOOC participants’ perspectives on the roles and responsibilities of staff involved in delivering integrated care for dementia in a variety of contexts. Robertshaw and Cross (2017), in the wider study, identified the general views and experiences of integrated care for dementia from the perspective of carers and families of people with dementia, healthcare professionals and researchers. Data were analysed using framework analysis of MOOC participants’ discussion board contributions to an activity on integrated care. The study utilised a MOOC on dementia which was available to learners in 2015, 2016 and 2017. The course had 3,058 learners from a diverse range of backgrounds, countries and professions. MOOCs are becoming an established methodology for crowd sourcing ideas to social issues (Robertshaw and Cross, 2016). The course was open to the general public and did not have any entry criteria. It included both accessible easily-understood information as well as technical information about dementia, and was intended to be a transformational intervention to change participants’ perceptions and attitudes about dementia. Participants studied a unit of learning on understanding integrated care and its importance in relation to dementia. Participants were then asked to reflect on their own definitions of integrated care, as well as its strengths and limitations from their experiences.

Participants

Discussion boards prevent the determination of exact demographic data of activity participants, however MOOC participants overall were mostly female (83 per cent) and there was a variation in the levels of previous study with 57 per cent of participants who had previously completed at least a two-year university course. Participants represented an international sample, with a large proportion of participants from Western Europe (45 per cent). There were 3,058 learners from a wide variety of professions and backgrounds.

Data collection

This study was designed to be compliant with the British Psychological Society Code (2017) for Internet Mediated Research. Ethics approval was granted by the University of Derby Online Learning’s ethics committee. All MOOC participants were contacted via e-mail with information on the aims and purpose of the study and contact details should a participant wish to withdraw their forum responses from analysis. All data were downloaded in a
spreadsheet and analysed by both researchers (AK and DR) using the framework analysis. Participant comments are quoted directly without modification or editing for spelling and grammar, other than removal of identifying information.

Data analysis
Framework analysis (Ritchie and Spencer, 1994) was used to identify themes and patterns in the data, and a framework chart was created for this purpose. Framework analysis has the capability of systematically organising and analysing participants’ views and experiences from interview data. It is used for analysis in policy and service development research. The development of a “framework” allows users to examine themes and inconsistencies in opinion between participants. This benefitted the exploration inconsistencies or contrasting experiences between carers/families and health care professionals. Framework analysis (adapted from Ritchie and Spencer, 1994) consisted of five key stages listed as below:

(1) Stages 1 and 2: transcription and familiarisation which involved the analysis of 847 discussion board posts exported to Microsoft Excel.
(2) Stage 3: coding which involved defining and refining the thematic framework.
(3) Stage 4: developing an analytical framework involving development of codes, comparing them and applying them.
(4) Stage 5: applying the analytical framework: subsequent transcripts were indexed using the categories and codes according to Robertshaw and Cross (2017).

Results
A major theme emerging from the data set was the importance of roles and responsibilities in relation to integrated care for dementia and this theme is explored here through sub-themes and their associated quotes. As per the framework analysis, surrounding discussions are included in these results. Quotes included here are indicative of responses and are attributed to individual professional roles, gender and location to protect anonymity. They are unaltered from their original written comments, which is why some quotes include spelling and grammar errors.

Discussion board participants recognised that a collaborative and inter-disciplinary approach to working was needed for effective integrated dementia care. However, this collaborative and inter-disciplinary approach alone was not considered to be adequate to achieve integrated dementia care. Participants stated that delivering effective integrated dementia care requires deploying holistic principles of care into practice, ensuring a holistic approach and collective responsibility. Person-centred and holistic care was mentioned throughout.

This theme was separated into six sub-themes (listed below), and each theme’s results are presented here.

Themes relating to roles and responsibilities identified from analysis:
(1) consistency and continuity of care;
(2) hierarchy;
(3) leadership and co-ordination;
(4) the need for advocacy within integrated care;
(5) boundary conflict and responsibility within integrated care; and
(6) need for dementia training and upskilling.

Consistency and continuity of care
Participants discussed the role of services within the context of integrated care, including dementia cafes, memory clinics and reminiscence groups and the functions these
Participants argued that in all these services people with dementia receive person-centred support from a range of professionals and carers. There was a concern that some of the functions these services performed were duplicated. Integrated care was thought by participants to prevent duplication and improve the allocation of resources whilst also providing consistent care:

Integrated care should prevent duplication of services, inadequate service provision, cessation of services and reduce costs. The outcome should be delivery of ongoing high quality patient centred care (Layperson, female, UK).

Participants saw information as providing power to its holder, however, seeking, identifying and using patient information was suggested as a challenge. Participants believed there was a need for the re-assessment of patients throughout their journey with dementia, but this had to be balanced against patient frustration when being asked the same questions repeatedly by different service providers. Getting the right information at the time from the right person was seen as difficult due to personal barriers and resistance to share information:

The difficulty lies in getting the information, and staff accepting what they are told. Many people are reluctant to admit to some health conditions, especially those with a stigma attached. Depending on who is available to corroborate information, we don’t always get an accurate picture (Medical student, female, UK).

Participants identified tools to manage and enhance information consistency and continuity of care. One example of these tools was “This is Me”, a tool to provide information about a person with dementia’s needs, wishes and preferences that was designed to enhance choice, personalisation and individualised care and in widespread effective use in dementia care (Alzheimer’s Society, 2017):

I use tools such as a “this is me” form, which aids the individuals to gain empowerment to state what they would like for the present and the future (Psychologist working in an MDT learning disabilities team, female, Greece).

The use of technology by various care providers was seen as a way to enhance consistency of care, to ensure care records are up to date and accurately represent the person’s needs and record episodes of care. Integrated care record systems were highlighted as a way to enhance consistency in addition to ensuring that records are safely stored. In this way different professionals can read each other’s notes and comments to enhance care:

I do believe that in a technological age we should be looking at integrating the different medical records systems in some way, though that sparks new rows as to whose system is the best and should be adopted by others! (Community Psychiatric Nurse Assistant, female (location unknown)).

Where staff did not have access to patient records they resorted to alternative means for information transfer. This was perceived as being difficult due to geographical dislocation and disconnection between staff. Integrated electronic care records were posited as an answer to enhance care consistency, leading to shared responsibility by various roles:

I do not have access to my patients record in primary care, or on hospital admission or social and voluntary care, therefore it all relies upon telephone calls. This is difficult when people are busy, work different hours, are out and about and just miss each other. For integrated care to truly work, we either all sit together in the same building or we have computer systems that link together (Lead Mental Health Nurse, female, UK).

Dislocation and disconnection in rural areas for people living with dementia were particularly noted by participants in Australia where staff work across very large areas. Participants felt technology provides a potential solution for enhancing integrated dementia care:

Limitations of this would be that it is difficult to find times when all health professionals needed would be available at once or the same day. This would result in multiple trips to hospitals, which
in Australia can be very troublesome as some people need to travel 1,000’s of KM’s from remote areas and communities to receive specialised and allied health input. These people often miss out or health professionals in remote areas learn to incorporate aspects from other professions into their practice to accommodate this (Registered Nurse, female, Australia).

Continuity of communication was considered to be important, facilitated by using a variety of technologies such as integrated care record systems. These ensure an overview of the whole patient journey. Computer systems that do not communicate with each other were a concern, which caused perceived delays in treatment:

Integration of care, especially between mental health authorities and social services, is frequently “not joined up”, with different computer systems that don’t ‘talk’ to each other and problems in accessing care packages. This can cause clients spending longer than necessary, e.g. in hospital awaiting discharge, which deskill clients with dementia, making return to home more likely to fail (Community Support Worker, female, UK).

New ways of working to promote consistency in care delivery were discussed, in particular the care navigator role. Care navigation is an essential component of delivering integrated person-centred care and these functions exist to help people chart a course with purpose and direction (Health Education England, 2017). Participants seemed to use the word care co-ordinator and care navigator interchangeably:

“I work as a Care Co-ordinator and care co-ordination would be much simpler if all services used one patient record. Currently, there are GP practices, Community staff (District Nurses, Community Matron’s, Therapists), Mental Health staff; Social Services staff all using different systems and that doesn’t include when the patient goes to A&E or sees a Consultant – it will never be integrated until there is ONE patient record (Layperson, female (location unknown)).

Hierarchy

Hierarchy, a common issue for businesses and large organisations, was a theme of discussion by participants. They shared their concerns about fear of changing health and social care services leading to inefficiencies in care delivery. They also were afraid of their own approach to care changing:

Sadly, in practice, many professionals fear having to change their own approach which often leads to any integration of services being nigh on impossible to achieve efficiently and effectively (Layperson, female, UK).

Participants thought hierarchies not only existed amongst people but also between organisations. They shared their experiences of different organisations and how they work together; many held the belief that these activities could be improved:

I work with a charity that provides social events for older people, many with early onset dementia, reducing isolation. Sometimes we come across safeguarding issues and my colleagues and I are often shocked at how difficult it is to communicate with all the different organisations that are supposed to be ‘caring’ for vulnerable individuals (Educator, female, UK).

Hierarchy exists not only between organisations, but also between health care and social care. Despite improvements to promote parity participants considered, this inequality to remain:

[…] integrated care can work well when the patient receives the best care but there still remains a vast divide with health and social care (Occupational Therapist, female, UK).

Some participants constructed their experiences of services as being managed and operating like businesses, rather than as a care service. Although many National Health Service (NHS) services are now privatised, most care homes in the UK are privately owned
and run as businesses. Participants shared their experiences of this tension and the adverse effects of commercialised healthcare:

I also feel with dementia, integrated care is needed as the majority of care homes is run as business. this is one of the main causes of the quality of life of the patient being overlooked in my opinion and in my experience having seen this hierarchy division working in practice (Day Centre worker, female, UK).

Leadership and co-ordination

Participants recognised the need for new roles and functions such as the care coordinator and care navigation, which could provide valuable leadership and co-ordination. Whilst it was recognised that the creation of new roles would entail substantial training needs, the roles were important for the facilitation of an effective part of integrated care for dementia. The care navigator role is embedded in the integrated care model, and promotes partnership working to promote optimum healthcare outcomes (McMurray and Clendon, 2015):

Each service user should be appointed a care coordinator: an intermedia tort who could liaise between service users and service providers. The weaknesses is that is requires case managers, who may not be available or who are not qualified. I have witnessed the latter, which means, needs go unmet. Positives are that time should be reduced, good communication networks so that repetition is reduced. Negatives are that, sometimes, the person’s main need is not met as they are being case managed by a different discipline. Not all social workers understand nursing issues and vice versa (Daughter of a person living with dementia, location unknown).

Some participants noted barriers that prevented interprofessional and collaborative working such as time constraints, lack of funding and awareness. They felt there was a need to have time for case discussion and meetings with other professionals. Conversely, short visits or disconnected working was identified as having a negative impact:

However from experience most none private health and social care professionals have such big case loads that taking time to meet other people including the patient is often very difficult. Supporting people however integrated a team may be by providing care in short 15 minute visits by many different carers cannot be beneficial to the patient or the families (Professional Dementia Carer, female, UK).

The need for advocacy within integrated care

Participant discussed the importance of social care and its advocacy role, which was considered to be often forgotten or at least underfunded. Participants believed there could be rapid improvement in the NHS if social workers were employed in a wider range of care environments, which could improve access to and awareness of social care services. They highlighted the importance of social workers and social care in general to support integrated care for dementia:

I think that patient experience would be hugely improved if the NHS employed social workers and each team could access one with ease. Despite health and social care trying to sing from the same hymn sheet in reality the structures and processes in place really do make this very difficult— (Occupational Therapist, female, UK).

Boundary conflict and responsibility within integrated care

Participants shared their experiences of working in complex teams with diverse ranges of roles. Each role has its own ontology, area of responsibility and focus. When bringing teams together there can be blurred boundaries and where overlap exists there can be risk of inaction or failure to recognise issues as they “fall through the cracks”. These factors can lead to boundary conflict; however, participants generally found working in teams as a rewarding process despite these challenges:

I work as part of a community team consisting of a GP, Community Matron, District Nurse Team, Mental Health Community Worker and CPN, Social Care Worker, Local Area Coordinator and a
Care Coordinator. As a team we can discuss the whole patient care. It also enables all the different agencies involved in a patients care to communicate with each other on a regular basis. It can be difficult to get all these health/social care professionals together at the same time, but we have all found it a worthwhile and productive process (Care Coordinator, female, UK).

Need for dementia training and upskilling
Participants believed integrated care was contingent upon appropriately trained people being present and available at the right time. This was in addition to an understanding of the specific roles such as occupational therapists and physiotherapists who work alongside other staff. Some participants believed there was an overwhelming medical focus, and that alternative perspectives were not always considered. Despite this, there was a desire for a “joined up” (integrated) approach with individuals working as part of teams able to discuss the patient’s care as a whole. There was also a sense of doing something worthwhile, which could prevent burnout and reduce stress.

Some participants compared dementia care with other professional roles; noting this particular area presents unique challenges. They reported that some staff may be unaware of the professionalism and time management requirements for their roles. Staff entering new roles are required to complete induction and competency packages, including the Care Certificate (Skills for Care, 2017), which may mitigate this lack of skills:

Dementia care is challenging itself and people thinks this is a mental issues and often subtle their needs and feelings. Most of them are unaware of treating in good manners. In fact, many caring homes are aware of dementia but lacking staff with limited time management strategies and struggling to manage their daily routine only leaving behind their mental, emotional feelings (Geriatric Care Worker, female, location unknown).

Discussion
The aim of this study was to explore the experiences of integrated care from the perspective of carers, people living with dementia, healthcare professionals and researchers. A major theme emerging from this analysis was related to the roles and responsibilities people performed or undertook in relation to integrated care for dementia, rather than the specific professional or non-professional role they inhabit. This study has, therefore, provided additional understanding of the roles and responsibilities people perform in relation to integrated care.

MOOC participants desired a tailored, person-centred, holistic and inter-disciplinary approach to care complementing rather than restricting professional roles. Care co-ordination was seen as a challenge. However, implementation of dedicated coordinator roles was seen to lead to a diffusion of responsibility, consistency and trust, with managed boundary conflicts. Care navigation and co-ordination can improve patient journeys and promote independence (McMurray and Cooper, 2017). Participants questioned which professional roles should be involved and how these facilitate shared ideas; a care coordinator could prevent separation and ensure the involvement of relevant individuals around the person requiring care. They could prevent the duplication of effort and rationalise resources by ensuring care is provided when it is needed.

Perceived enablers included introduction of shared communication and information technology (IT) systems to support continuity of care and consistent record keeping to facilitate the integration and co-operation of roles. These IT systems were thought to be challenging as there are many systems which are not interoperable. Records held on these systems should be accessible and useable by all. Until such time as this is possible, it may be more practical to have patient-held records which have been shown to prevent carer strain and allow patients to maintain a locus of control (Simpson et al., 2006). There is a recent increase in the use of IT systems, particularly telemedicine (Munro et al., 2014; Vahia et al., 2014; Weiner et al., 2011) which may enable integrated dementia care.
Minkman et al. (2009) saw inter-organisational working and technology as promotional factors for integrated dementia care, which correlate with these findings. Awareness and understanding of dementia were seen as crucial to promote person-centred care and care planning. The role of education was consistently highlighted, in addition to experience.

Perceived barriers preventing effective roles and suitable responsibility include funding, role conflicts, time constraints and time-consuming paperwork. These barriers could lead to care fragmentation. Communication continuity was particularly seen as a challenge due to time constraints. Participants argued that funding constraints are a result of the division of health and social care, therefore, as organisations integrate funding may become more available. Concerns about conflicts and overlaps of roles were shared; these could prevent direct responsibility for individuals leading to failures in recognising and dealing with problems. Healthcare professionals historically are not in favour of change (Melnyk et al., 2012) yet they have a primary role as a leader and change agent and have the greatest potential to promote better care (Wall, 2013).

This course has demonstrated that MOOCs and online learning can be a useful platform to gain insights into perspectives of roles and responsibilities. It is known that learning in this type of environment with people from other backgrounds and roles is beneficial (Hallin et al., 2011), and the course was designed with an emotional thread throughout which Helmich et al. (2011) report is important for learning. Service users were involved in the development of the MOOC and participants were able to directly observe their experiences which further promote learning (Morgan and Jones, 2009).

This work has some important limitations which must be acknowledged. This study used MOOCs to crowd source the data. MOOCs use online fora, and this method of data collection can result in groupthink, whereby conversations and comments can be influenced by other members of the group, preventing authentic discussion (Tsikerdekis, 2013). However, online fora are places where participants can be honest and open about their responses without fear of retribution due to the anonymity afforded in this space. The data were analysed by two researchers with different professional backgrounds. This increased the level of confidence in the thematic analysis; however, each research may have brought their own bias when reading and coding comments. This may have resulted in bias during the allocation of themes. Respondents were from a large number of countries. Whilst this brought diversity in discussion, it often prevent direct comparison and discussion about integrated care for dementia as societies and communities were not directly comparable, due to differences in health and social care systems.

**Conclusion**

This paper has explored participants’ perceptions of roles and responsibilities in relation to integrated dementia care from the perspective of MOOC participants. They believed that effective integrated care for dementia not only relies upon a well-designed system, but also the individuals who work and operate within it who must be adequately prepared resourced and funded to do their roles. The current financial climate and uncertain future of care services means this is unlikely to be resolved soon, despite dementia now being a leading cause of death (Office for National Statistics, 2016). It is recommended that all organisations consider developing care navigation and co-ordinator roles and functions; they develop interoperable IT systems with electronic records and that all staff involved in dementia care access education and training to promote skills and knowledge development. Knowledge and understanding of the roles and responsibilities of people and organisations need to be embedded into future professional programmes to give professionals of the future an awareness of their potential, although it is often difficult to define what these roles and responsibilities should be. Further research is recommended to understand the factors and successful activities which “work” to promote integrated dementia care so that these can be effectively implemented.
Implications for practice

- Care co-ordination and care navigation are important functions but are not currently fully embedded in all integrated care systems. These roles could improve approaches to joined-up care.
- Shared care records facilitate interprofessional working and collaboration and should be considered for implementation. These shared care records could be enabled with technology and electronic solutions.
- Further research is recommended to understand the factors and successful activities which “work” to promote integrated dementia care so that these can be effectively implemented.
- Knowledge and understanding of the roles and responsibilities of people and organisations – and their functions in the provision of integrated health and social care – needs to be embedded into pre-registration professional programmes.
- MOOCs, although they have limitations, may be a useful method of conducting social research in health and social care by “crowd sourcing” solutions to deliver effective integrated dementia care.

References


Alzheimer’s Society (2017), *This is Me*, Alzheimer’s Society, London.


Further reading
A critical evaluation of integrated care: a case study of the supported discharge service

Rachel Louise Ware
Ripon Community Care Team, Harrogate and District NHS Foundation Trust, Ripon, UK

Abstract

Purpose – The purpose of this paper is to evaluate the Supported Discharge Service as a case study of integrated care. The paper will critically evaluate integrated care with regard to patient outcomes, patient satisfaction and cost and productivity.

Design/methodology/approach – A retrospective mixed methods case study design was adopted utilising patient satisfaction questionnaires, therapy outcome measure and a performance dashboard to measure improvements in patient satisfaction, patient outcomes and cost and productivity.

Findings – Measured improvements were observed in the integrated discharge process and analysis of the findings demonstrated a statistically significant improvement in patient outcomes, high levels of patient satisfaction and improved productivity subsequently leading to financial savings.

Research limitations/implications – Due to convenience sampling, the small sample size and a short time frame when analysing patient outcomes, the generalisability of results is limited. Despite this, with integrated care being polymorphous the findings can be utilised to develop theoretical principles to make assertions about integration (Wikfeldt, 1993).

Originality/value – This paper draws on the importance of integration as the principal driver of reform within the healthcare system. Even though on a small scale, the case study provides evidence to support the use of integration to improve patient outcomes, patient satisfaction and financial savings.

Keywords Integration, Cost, Patient satisfaction, Integrated care, Hospital discharge, Patient outcome

Introduction

The National Health Service (NHS) is faced with major challenges in meeting the needs of an ageing population, as well as using resources more efficiently (Ham et al., 2011). Older people account for 62 per cent of total bed days spent in hospital and there is a long-standing issue with unnecessary delays to discharge which has been estimated as a gross annual cost of £820m (National Audit Office, 2016). In 2015 1.15m bed days were lost to reported delayed transfers of care (DTOC) and one of the main reasons was patients awaiting a package of care (POC) to support them in their own home (National Audit Office, 2017). Increased length of stay (LOS) can cause considerable distress, increase the risk of infection, depression, loss of independence and reduced muscle strength (Department of Health, 2010; Kings Fund, 2018; National Audit Office, 2016; Young, 2014). Keeping older people in hospital longer than necessary is an additional and avoidable pressure on the financial sustainability of the NHS (National Audit Office, 2016).

The complexity of needs arising from the nature of multiple chronic conditions, in combination with increasing frailty in old age, requires the development of systems that synergise a range of health and social care professionals to meet those needs (Nolte and McKee, 2008). However, service delivery has developed in ways that have tended to fragment care, both within and between sectors (Glasby et al., 2006). These include structural and financial barriers, distinct organisational and professional cultures and differences in terms of...
governance and accountability (Glasby et al., 2006). This fragmentation negatively affects the provision of care and support for older people with complex health needs (Spoorenberg et al., 2013). Failure to integrate services along the care continuum may result in suboptimal outcomes, such as potentially preventable hospitalisation, high levels of DTOC or service duplication, causing an adverse economic impact and a negative effect on the quality of care (Goodwin et al., 2012; Nolte and Pitchforth, 2014; Vogeli et al., 2007).

Integrated care is a concept that has been widely used in different health systems and a review of the literature established 175 different definitions and concepts (Armitage et al., 2009). While terms such as integrated care, coordinated care, collaborative care, joined up care and case management differ conceptually, the boundaries between them often remain unclear and therefore there is a general absence of a sound analytical framework through which to examine the processes of integration (Kodner, 2009; Kodner and Spreeuwenberg, 2002). The current challenge is to be specific about what integrated care looks like in different settings and how integration can achieve its aims within the NHS (World Health Organization, 2008). To undertake a critical evaluation of integrated care the definition used by the Nuffield Trust will be utilised: “Integrated care is an organising principle for care delivery that aims to improve patient care and experience through improved coordination” (Shaw et al., 2011). The diverse definition emulates the concept, as there are a variety of methods, models and processes that can be utilised to implement integrated care, thus integration in healthcare is not likely to follow a single path (NHS England, 2014).

Over three decades government policies have highlighted the importance of integrated care and promoted its application to meet the needs of the ageing population and enable people with complex needs to live healthy and independent lives (Goodwin et al., 2012; Shaw et al., 2011). The importance of integration was recognised in the final report of the NHS next stage review as it set out a vision to provide seamless care, developed around patients and delivered by integrated teams across services (Department of Health, 2008). The Five Year Forward View highlighted the need to take decisive steps to break down barriers in care in order to provide financial sustainability, however, the Department of Health does not propose how services should integrate, as organisations can choose to integrate in different ways to ensure the needs of the local population is met (National Audit Office, 2017; NHS England, 2014).

There is emerging evidence of the benefits of integration within the NHS such as improving access to care, managing demand and reducing DTOC, however, the Department of Health has not yet tested integration on a large scale (Ham and de Silva, 2009; National Audit Office, 2017). Various smaller integration studies have documented the clinical effectiveness of integrated care demonstrating improvements in patient outcomes such as quality of life (QOL), well-being and coping with activities of daily living (Huang and Liang, 2005; Lin et al., 2005). A study evaluating proactive integrated care for patients suffering from chronic obstructive pulmonary disease found it significantly improved QOL compared to the control group. However, a relatively small number of patients were enrolled in the study, increasing the chance of Type 1 error (Koff et al., 2009). Conversely, an overview of systematic reviews assessing the effectiveness of integrated care on QOL for patients with chronic conditions suggested that the effectiveness varied (Flanagan et al., 2017). Although numerous reviews reported statistically significant positive findings, this significant improvement was often only seen on a single domain of a multi-component QOL scale (Flanagan et al., 2017). In general, multi-component, condition-specific interventions were more likely to lead to positive patient outcomes (Flanagan et al., 2017). Furthermore, most of the reviews utilised focused on patients with a single chronic illness. It is therefore questionable whether the results can be generalised to patients with multimorbidities as they often face unique challenges when navigating health and social services and their QOL can be further compromised whilst facing these additional challenges (Flanagan et al., 2017).
Integration aims to overcome organisational, professional, legal and regulatory boundaries, to ensure that patients receive the most cost-effective care, when and where they need it (National Audit Office, 2017). However, assessing the cost effectiveness of integration is hampered by the diversity of approaches within the polymorphous field of integration, resulting in a scarcity of robust evidence (Cameron et al., 2015; Nolte and Pitchforth, 2014). Nonetheless, international examples of successful integration provide valuable learning opportunities that demonstrate how integration has shifted care out of the hospital and into the community setting resulting in a reduced strain on acute hospitals, reductions in waiting times and fewer acute medical admissions (Timmins and Ham, 2013). However, the health and social care systems are significantly different to the NHS and to date there is no evidence to show that international models can be readily replicated in the UK (Timmins and Ham, 2013).

LOS is used by researchers as an important indicator of successful discharge planning, as reducing a patient’s LOS can release capacity for the service, establish cost savings and improve quality of care (Paton et al., 2014; Vingerhoeds et al., 2010). It has been estimated that a reduction in LOS of between two and six days per patient can save the NHS £15.5 to £46.5m a year (National Audit Office, 2000). A Cochrane review studied interprofessional collaboration and suggested it can improve healthcare processes and outcomes such as reducing LOS (Zwarenstein et al., 2009). However, it is difficult to provide a precise figure on the cost saving due to significant variation in marginal bed day costs between specialities (Offord et al., 2017).

Methodology

Design
A retrospective mixed methods case study was utilised to provide a detailed and intensive analysis. Yin (2003) states that a case study design should be utilised to consider contextual conditions relevant to the phenomenon in question. Like many areas in healthcare, integration is complex and a mixed methods approach is an innovative method to address these complexities and deepen the understanding of integrated care (Tariq and Woodman, 2013).

Case study
Recent reports for a Foundation Trust in the North of England identified that since the beginning of 2016 the acute hospital has experienced a sustained period of high admission rates and a high bed occupancy compared to the previous year. Local evidence shows that the acute hospital failed to achieve the national 3.5 per cent DTOC standard and that 60 per cent of inpatients have a LOS longer than seven days. “Every Hour Matters” week in April 2016 identified that patients care was often delayed whilst waiting for therapy assessments or for commencement of a POC to support them at home. Operational Pressures Escalation Level 4 (OPEL) was reached due to the community teams’ inability to deliver comprehensive care for patients being discharged resulting in higher levels of DTOC. A community services review in 2014 highlighted that the community teams involved in supporting patient discharges from the hospital worked in parallel and not as an integrated service.

The Supported Discharge Service (SDS) is a pilot that was introduced in July 2016 as an integration initiative to improve patient flow and bed management across the acute bed base. The service was modelled on the national Discharge To Assess initiative; providing opportunities for allied health professionals (AHPs) to deliver an integrated approach to discharging patients home (Offord et al., 2017). The discharge to assess initiative is where patients who are clinically optimised and do not require an acute hospital bed but may still require care services are provided with short term, funded support to be discharged to their own home. No one model will deliver Discharge To Assess but the essential design principles
that underpin the model can be utilised to shape services. These include the default pathway of supporting patients home, free at the point of delivery, safety and a prompt assessment, with rapid access to care and support that is time limited (Offord et al., 2017).

The aim of the SDS was to reduce occupied bed days for the cohort of patients over the age of 65 by supporting patients in returning to their normal place of residence as soon as medically fit. The service was run over seven days and consists of physiotherapists, occupational therapists and multidisciplinary assistants undertaking environmental and functional assessments in the patients’ home environment, as well as provision of equipment, rehabilitation and support until their POC could commence. Referrals were taken from all wards at the Foundation Trust, following the criteria for inclusion and exclusion illustrated in Table I.

Initially to increase the referral rate and promote professional cultural change the SDS would visit each ward and regularly review the long stay list to prompt discussion about discharge plans. This would aid staff to highlight appropriate patients for the service and challenge professionals to take positive risks. Daily huddles would be held with SDS, discharge liaison team, therapy frailty team and social services to discuss potential patients. Once a patient was referred a therapist would complete a holistic assessment on the ward ensuring a safe and timely discharge. Areas of assessment included formal and informal support, mobility, skin assessments, medication management and equipment. The therapist would liaise with family, carers and ward to ensure transport and access to the property. Once home the patients would receive support up to 72 h or until the POC could commence.

Data collection methods
Integrated care can be assessed as successful if it contributes to improved patient care outcomes; improved care experiences and delivery of a cost-effective service (Goodwin and Smith, 2011). Therefore, qualitative and quantitative data were collected and the evaluation process included: therapy outcome measure (TOM) to analyse patient outcomes; patient satisfaction questionnaires and a performance dashboard to evaluate the cost and productivity of the SDS. Convenience sampling was utilised and all patients that were referred to the SDS and met the inclusion criteria, as illustrated in Table I, were included. TOM and patient satisfaction questionnaires were collected over a two-week time frame during February 2018. The time frame was short due to time constraints. To determine an accurate cost analysis of the SDS the data from the performance dashboard was analysed over 33 weeks.

Instruments and data analysis
Therapy outcome measure. TOM allows professionals to monitor changes over time and describe the relative abilities and problems of a patient in the four domains of impairment, activity, participation and well-being, in line with the International Classification of Functioning, Disability and Health (Enderby and John, 2015; World Health Organization, 2007). TOM has been rigorously tested for reliability and clinical validity and it is easily

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 years +</td>
<td>Not medically fit</td>
</tr>
<tr>
<td>Medically fit/Community ready</td>
<td>Acutely confused</td>
</tr>
<tr>
<td>Admission to a ward</td>
<td>Pain not adequately controlled</td>
</tr>
<tr>
<td>A rehabilitation requirement</td>
<td>Patients who have experienced new stroke</td>
</tr>
<tr>
<td>Has capacity or a formal capacity assessment/best interest decision</td>
<td></td>
</tr>
<tr>
<td>Patient agrees to a level of risk identified to be able to return home</td>
<td></td>
</tr>
<tr>
<td>A start date for the POC</td>
<td></td>
</tr>
</tbody>
</table>

Table I. SDS inclusion and exclusion criteria
administered allowing good compliance (Enderby and John, 2015). The TOM was completed by the AHP on initial assessment and on discharge. The quantitative data collected were analysed using SPSS Statistics 24; each domain was analysed separately by the non-parametric Wilcoxon Signed Rank Test to identify differences and magnitude of difference between pre- and post-intervention scores.

**Patient satisfaction questionnaires.** The satisfaction questionnaires were formulated as part of the pilot study to gain the patient’s perspective on the integrated discharge process and provided qualitative data on the quality of care from a patients’ perspective (Youssef et al., 2017). The patients were asked two open questions: what went well with their hospital discharge and what the team could improve on? These questions were selected to prompt patients to discuss and explore what aspects of their discharge have increased their satisfaction. The satisfaction questionnaires were provided to patients on the hospital ward and collected on the last visit from the service. The satisfaction questionnaires could be completed by patients, relatives or their carers. Given the heterogeneity of patient experiences a deductive thematic analysis method was utilised for the satisfaction questionnaires and themes were generated in relation to the definition of integrated care (Youssef et al., 2017). The themes generated were patient outcomes, patient satisfaction and coordination of services.

**Performance dashboard.** A performance dashboard was created to report key measures such as referral and discharge date, reason for referral and estimated bed days saved. Bed days saved was estimated for each patient after discussion with the multidisciplinary team to determine how many overnight stays the service has potentially prevented. Bed days saved was recorded to the nearest whole number and the data allowed assumptions to be drawn with regards to the cost and the productivity of the SDS. The data on the performance dashboard was analysed by calculating the average number of daily discharges and bed days saved and estimations were calculated with regards to potential cost savings. Statistical methods also included descriptive statistics.

**Ethical considerations**
Ethical approval was granted by the York St John University module research ethics committee, reference number 140119365-MID183-Ware&Boyes and permission to conduct the study was granted by the Foundation Trust Clinical Effectiveness Department. The five ethical considerations of minimising the risk of harm, obtaining informed consent, protecting anonymity and confidentiality, avoiding deceptive practises and providing the right to withdraw, were adhered to. Informed consent was gained from each patient referred to the service along with consent to share information on the IT systems. Participants had the right to withdraw from the case study at any time and patients who declined intervention from the SDS were offered the conventional discharge planning process. Confidentiality was ensured and data from the performance dashboard, questionnaires and the TOM was anonymised and stored to comply with the rules from the Foundation Trust Clinical Effectiveness Department.

**Findings**
Over the two-week time frame there were 35 referrals and all were deemed suitable for the service using the service inclusion and exclusion criteria. The sample included 19 females and 16 males with the majority of patients aged between 81 and 85 years and the main reason for admission was a mechanical fall.

A Wilcoxon Signed Rank Test revealed a statistically significant improvement from assessment to discharge in all domains of the TOM and Cohen (1988) considers the effect size demonstrated as medium. These results are illustrated in Table II.
In total, 18 patient satisfaction questionnaires were analysed with a response rate of 51 per cent, which is below the 80 per cent rate that most researchers suggest as being adequate (Cummings et al., 2001). The low response rate could be attributed to the short exposure that patients had with the service and with the financial costs of providing a stamped addressed envelope which was not a viable option.

Table III illustrates the themes as determined by the definition of integrated care and the indicative quotes deducted from the responses of the patient satisfaction questionnaires.

The SDS pilot has managed 532 referrals with an average of 1.7 discharges per day. It is estimated that the service has saved on an average 2.3 bed days per patient resulting in a total of 975 bed days saved overall, which is in excess of 100 bed days per month. With an approximate price of £250 per patient bed day, this equates to a potential saving of £243,750.

Discussion
The case study has presented measured improvements in the discharge process, demonstrating improvements in patient outcomes, high levels of patient satisfaction and cost savings. Even though the polymorphous nature of integrated care hampers systematic understanding, successful application and meaningful evaluations, the SDS has provided promising results for the utilisation of integrated care within the NHS (Cameron et al., 2015; Kodner, 2009).

Patient outcomes
Within the case study the TOM data demonstrated that each domain (impairment, activity, participation and well-being) significantly improved from assessment to discharge, demonstrating an improvement in patient outcomes following the SDS. However, whether these improvements are sustained over a long period after the intervention is questionable as Rudd et al. (1997) found that at a one year follow up for patients that received an integrated early discharge scheme, there was no significant difference with clinical outcomes when compared to conventional discharge planning. This was further supported by Flanagan et al. (2017) as the QOL improvements made within the first 12 months following an integrated intervention were not evident from 18 months onwards. However, due to different instruments used to measure patient outcomes it is difficult to compare results (Deyo et al., 1998).

<table>
<thead>
<tr>
<th>Theme</th>
<th>Indicative quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient satisfaction</td>
<td>“assessment was comprehensive and has proved invaluable”</td>
</tr>
<tr>
<td></td>
<td>discharge was “painless compared to anguish caused” from a previous discharge</td>
</tr>
<tr>
<td></td>
<td>“made a big difference and we wouldn’t have managed”</td>
</tr>
<tr>
<td>Patient Outcomes</td>
<td>“back to her own home where she wants to be”</td>
</tr>
<tr>
<td></td>
<td>“got me home quicker”</td>
</tr>
<tr>
<td>Coordination of services</td>
<td>cared for from “A&amp;E to fracture clinic and discharge”</td>
</tr>
<tr>
<td></td>
<td>“catered for our every need”</td>
</tr>
</tbody>
</table>

Table II.
Wilcoxon signed rank test and effect size of TOM

<table>
<thead>
<tr>
<th></th>
<th>Mean (SD)</th>
<th>Discharge</th>
<th>Z</th>
<th>p</th>
<th>r (Cohen’s d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairment (n = 35)</td>
<td>2.8 (1.1)</td>
<td>3.6 (0.6)</td>
<td>-3.787</td>
<td>&lt; 0.001</td>
<td>0.5 (1.15)</td>
</tr>
<tr>
<td>Activity (n = 35)</td>
<td>3.1 (1.0)</td>
<td>3.8 (0.7)</td>
<td>-3.819</td>
<td>&lt; 0.001</td>
<td>0.5 (1.15)</td>
</tr>
<tr>
<td>Participation (n = 35)</td>
<td>3.1 (1.0)</td>
<td>3.6 (0.9)</td>
<td>-4.146</td>
<td>&lt; 0.001</td>
<td>0.5 (1.15)</td>
</tr>
<tr>
<td>Well-being (n = 35)</td>
<td>3.6 (1.1)</td>
<td>4.3 (0.5)</td>
<td>-3.745</td>
<td>&lt; 0.001</td>
<td>0.4 (0.87)</td>
</tr>
</tbody>
</table>
To provide robust evidence within the area of integrated care and patient outcomes, there needs to be standardisation of assessment tools to measure QOL. This is of particular importance as Ramsey et al. (2009) highlighted the need for development of standardised markers within integrated care. Achieving integrated care requires the patient’s perspective as the organising principle of service delivery, therefore an individualised subjective measure would allow for the variances in patient perspectives (Higginson and Carr, 2001). However, use is limited by difficulties in administering and scoring which limits comparisons on a larger scale (Higginson and Carr, 2001; Shaw et al., 2011). Similarly, disease-specific QOL scores cannot be compared with those of the general population and with integration not always disease specific this measure would not be appropriate (Goodwin et al., 2012). The case study highlighted the impact that integrated care can have on a patient’s social and emotional well-being, as well as their physical health and therefore the outcome measure needs to be valid within each of these domains (Planagan et al., 2017). Both, the Short Form Health Survey and the TOM are valid, reliable and feasible measures that are responsive to social, mental and physical changes and are widely used in research and clinical practice (Ware and Gandek, 1998; Enderby and John, 2015). Furthermore, they can be used with carers which will provide further evidence to support the overall effectiveness of integrated care (Argimon et al., 2004; Cameron et al., 2015). However, there is no single or best tool to measure QOL, therefore further exploration into combining an individualised subjective measure with a short standardised measure and developing statistical methods, so data from the individualised outcomes can be analysed, would be beneficial (Higginson and Carr, 2001; Lin et al., 2010).

Patient satisfaction
The high levels of satisfaction expressed in the patient questionnaires may be attributable to improved communication between patient and health professionals but also between different members of the multidisciplinary team as effective communication underpins collaboration (Payne et al., 2002). Potentially sharing of information resulted in improved capacity and a reduction in duplication as on several occasions when SDS was supporting patients awaiting a POC the number of calls the patient required was reduced prior to social services taking over. Furthermore, the daily meetings improved communication between health and social care professionals which potentially led to referrals being allocated and seen earlier, enabling seamless movement of patients across the care levels with the intended improvement of patient flow. This was acknowledged in the patient satisfaction questionnaires as a patient reported that they were cared for throughout the hospital experience from “A&E to fracture clinic and discharge”.

The SDS also placed the patient at the centre of the discharge process. This promotion of personal involvement provided them with ownership, which has been shown to lead to higher levels of satisfaction as they are no longer passive in the process and are involved in decisions about their care (Haddock, 1994; Connolly, 1991). However, an emerging theme within the satisfaction questionnaires was carer satisfaction. The NICE guidelines state that families and carers can play a significant role in aiding the discharge process as they can provide additional information about the patient’s needs and circumstances which may reduce the likelihood of readmission (NICE, 2016). A carer reported that they felt “isolated, worried, not knowing what was to happen” and that the SDS should “talk to the carer, so they feel part of the process”. Grimmer et al. (2000) reported that carers rated the quality of conventional discharge planning much lower than the patient, indicating that their needs were often not met. Therefore, greater importance needs to be placed on involving the carer within the integrated discharge process, when applicable, by asking of their concerns, informing them of arrangements and offering them support or signposting.
The patient satisfaction questionnaire analysis has decisively demonstrated that patients need to be at the heart of any integrated care intervention; addressing what aspects of care are meaningful to them will help ensure that integrated care models are effectively implemented and supported to build effective healthcare systems (Hasardzhiev et al., 2016; Mastellos et al., 2014). Integrated care has the potential to improve patient experience by increasing patient involvement in decision making, enhancing the relationship between patient and AHP and strengthening collaborative working (Mastellos et al., 2014). Considering that integrated care needs time to establish successful structures and deliver anticipated benefits, patient and carer satisfaction questionnaires need to be monitored over a long period to capture their effect on experience and quality of care (Mastellos et al., 2014).

**Cost and productivity**
The SDS was instigated by AHPs transforming current service delivery therefore requiring no extra financial support for its implementation. Research has shown that there is regularly inadequate funding designated for integration initiatives and when funding is available it is often only for the short term therefore hindering the opportunities for integration (Regan et al., 2008; National Audit Office, 2017).

The National Audit Office (2017) state that whilst there are positive examples of integration at a local level there are no evaluations of initiatives that provide systematic, sustainable reductions in cost of care and concluded that reductions in activity do not necessarily translate into savings unless whole wards or units can be decommissioned. From commencement of the SDS, it has saved the annual accumulation of 4.5 beds, and even though these beds have not been decommissioned the Foundation Trust has been able to use them more efficiently. This can potentially result in a reduction in the need for escalation beds and avoid the need for capital investment in new inpatient wards and associated workforce costs therefore, demonstrating a cost-effective service. Future opportunities to evaluate whether the SDS has had an effect on the OPEL framework and DTOC to underpin the true cost effectiveness would be beneficial. These measures are used nationally and are highly suitable as integration aims to address fragmentation and therefore a reduction in DTOC can demonstrate seamless and integrated care between an acute and community setting. However the effect on DTOC and OPEL will be difficult to attribute solely to the success of integration, due to the confounding factors involved, but a rigorous study design with randomisation and extended time frame can reduced confounding factors (Bench et al., 2013).

**Limitations**
The main limitation of the case study was generalisability. Due to convenience sampling, the small sample size and a short time frame when analysing patient outcomes, the transferability of results is limited. Despite this, with integrated care being polymorphous the findings can be utilised to develop theoretical principles to make assertions about integration (Wikfeldt, 1993).

**Conclusion**
There is no single model of integrated care that is suited to all contexts and settings and there is an urgent need for large scale, robust and high-quality evidence to inform decisions about how to develop integrated care (NHS England, 2014; Shaw et al., 2011). Progress with integration has, to date, been slower than expected as it is a challenging concept to implement, manage and evaluate (Kodner, 2009; National Audit Office, 2017). Financial pressures are increasing and it is not clear whether integrated care is the answer. Even though on a small scale, the SDS pilot has shown promising improvements in patient outcomes, patient
satisfaction and also productivity and cost savings. As a physiotherapist within the SDS pilot I was able to see improvements in joint working arrangements and to substantiate these improvements future research comprising of interviews with therapists involved would be fitting. Overall, a number of lessons have been learnt for future integration initiatives. These include the need for a foundation level change management approach, ensuring that the patient and carer are at the heart of the process and the importance of evaluation evidence and standardised measures to support future recommendations. Utilising the transformative capabilities of the AHPs provided a flexible, adaptive service that was striving for success. The plans are to expand the SDS to enable more patients to benefit from the integrated service and the challenge of how to refine and embed the SDS will continue but with the understanding it has had a positive effect on patients.

References


National Audit Office (2016), Discharging Older Patients from Hospital, National Audit Office, London.


Further reading


Corresponding author

Rachel Louise Ware can be contacted at: raylou84@hotmail.com
HealthPathways implementation on type 2 diabetes
A programmatic evaluation (HIT2 evaluation)

Josephine S.F. Chow
Clinical Innovation and Business Unit,
South Western Sydney Local Health District, Liverpool, Australia, and
Veronica Eugenia Gonzalez-Arce, Chun Wah Michael Tam,
Ben Neville and Alan McDougall
South Western Sydney Local Health District, Liverpool, Australia

Abstract

Purpose – The purpose of this paper is to appraise the development, implementation and acceptance of HealthPathways (HP), specifically in Type 2 Diabetes Mellitus (T2DM), at different levels of the health system in a large metropolitan Local Health District in Australia.

Design/methodology/approach – This study used a programmatic approach and mixed methods including literature reviews, site visits, semi-structured interviews of stakeholders and General Practitioners (GPs), and surveys (GPs and patients) to better understand the development, implementation and acceptance of T2DM pathways.

Findings – Results from this study indicate that 63 percent (n=37) of all survey respondents use HP and nearly half (47 percent) use HP in caring for a patient with diabetes. More than 80 percent of the health professionals found HP a useful tool, which has improved the quality of care, keeps them informed and supports diagnostics process. The use of website has led to an improvement in referral quality (69 percent), has assisted in the provision of more healthcare in the community (87 percent) and made their job easier. Thematic analysis from stakeholder interviews (n=12) emphasizes the importance of established collaborations and the need for standardized tools with common priorities and transparency in processes.

Practical implications – This study has provided insight into the details of delivery of integrated healthcare using HP. It provides a preliminary analysis of the lessons learnt for the implementation of HP.

Originality/value – The results of this study will be ideally placed to inform future policy amendments in the area of integrated healthcare as well as serving as a guide on implementing HP in the future.

Keywords Community care, Integrated pathways, Chronic care, Integrated care

Paper type Research paper

Introduction

HealthPathways (HP) is a web-based resource for delivering information to General Practitioners (GPs), though other health practitioners within the primary care team (e.g. practice nurses) may use and have access to them (Gray et al., 2017). It supports integration by bringing together general practice and hospital-based clinicians to develop agreed local pathways that best fit the local context. HP includes information on areas of referral for secondary care, and is not proposed as an automated or structured decision support tool or to describe the management of a condition within the hospital (McGeoch, Sycamore, Shand, Simcock, 2015; McGeoch, Anderson, Gibson, Gullery, Kerr and Shand, 2015; McGeoch, McGeoch and Shand, 2015). The pathways are intended for use as a guide only and are not intended to replace clinical decision making (Gray et al., 2017; South West Sydney Local Health District, 2008/2018).

Implementation of the Australian HP program is supported by the New Zealand-based technical communications company, Streamliners Ltd. HP evolved in 2008 as part of changes toward an integrated healthcare system in the Canterbury region of New Zealand (HealthConsult Pty Ltd, 2016a, b), where it has shown to have contributed to the delivery of...
more care in the community by developing primary and community services that supported
people to take greater responsibility for their health and ensured patients were treated by
the correct person, thereby reducing demand on secondary and specialist resources. It has
been associated with an improvement in referral quality, more equitable referral triage and
more transparent management of demand for secondary care (McGeoch, Sycamore, Shand,
Simcock, 2015; McGeoch, Anderson, Gibson, Gullery, Kerr and Shand, 2015; McGeoch,
McGeoch and Shand, 2015). In Canterbury (McGeoch, Sycamore, Shand, Simcock, 2015),
the use of HP for clinical guidance on skin cancers has increased steadily, reducing waiting
times – from 11–12 months to 3–4 months – and patients getting treated generally within
one week, reporting an increased access to care on a more equitable basis and reduced
waiting times and number of visits to hospital. Within Australia, some impacts include:
referral quality improvement, process redesign leading to improved access to specialist care
and reduction in the patient wait time (Gray et al., 2017; McDonald, 2013).

The HP development process has demonstrated positive impact on relationships between
key stakeholders as a result from effective collaboration (McDonald, 2016; Mansfield et al.,
2016; Holland et al., 2017), improving awareness of each other’s processes; trust and respect;
icomunication; and stronger relationships between organizations such as Medicare Locals
(now Primary Health Networks (PHNs)) and Local Health Districts (LHDs) (McDonald, 2013).
The LHDs have been delegated with the administration and governance of the State’s public
healthcare services managing all aspects of hospital and health service delivery for their local
region, whereas the PHNs are established by the Commonwealth Government to increase the
efficiency and effectiveness of medical services for patients by working directly with GPs,
other primary healthcare providers, secondary care providers and hospitals to facilitate
improved outcomes for patients (Director-General, NSW Department of Health, 2011).

In 2014, New South Wales (NSW) Health implemented an integrated care program,
followed by the NSW Integrated Care Evaluation Framework (NSW Ministry of Health,
2015) to demonstrate and support transforming how care is delivered in NSW to improve
health outcomes for patients and reduce costs deriving from inappropriate and fragmented
care, across hospital and primary care services by:

• focusing on organizing care to meet the needs of targeted patients and their carers,
rather than organizing services around provider structures;

• designing better connected models of healthcare to leverage available service
providers to meet the needs of our smaller rural communities;

• improving the flow of information between hospitals, specialists, community and
primary care healthcare providers;

• developing new ways of working across State government agencies and with
Commonwealth funded programs to deliver better outcomes for identified
communities; and

• providing greater access to out-of-hospital community-based care, to ensure patients
receive care in the right place for them.

HP is now being implemented at 22 sites across Australia, 9 regions in New Zealand and 1 in
the UK (HealthPathways Community, Canterbury District Health Board and Streamliners
NZ, 2016). It has been identified that a national “rollout” of the program would not be
appropriate and that HP must be initiated and implemented at the regional level in order for
the process to be effective (Australian Medicare Local Alliance, 2014). Therefore, this study
will appraise the development, implementation and acceptance of HP, specifically in Type 2
Diabetes Mellitus (T2DM) at different levels of the health system in a large metropolitan
LHD in NSW, Australia.
Methods
This study used a mixed-method approach for the programmatic evaluation of T2DM pathways implementation. Both qualitative and quantitative data were collected for the better understanding of their implications and applications. Although this study aims for the overall evaluation of the HP implementation, the in-depth analysis and scope of the qualitative data will be released as a separate evaluation paper. Data from semi-structured interviews of GPs; semi-structured interviews of stakeholders (i.e. staff across organizations who have been involved in the management and governance of the pathways); GPs online survey; anonymous paper survey of patients attending diabetes clinics; working groups and program meeting documents; and web server utilization data were collected and analyzed to create the overall results.

Participants
This study was conducted in a number of general practices and diabetes clinics across a large metropolitan LHD in NSW, Australia. Participants were sampled purposively, and included stakeholders, clinicians and patients from the study LHD area; and GPs on the PHN’s database for initial general survey and semi-structured interviews. Patients were invited to complete anonymous questionnaires at each diabetes clinic across the LHD.

Recruitment and data collection
For GP participants, an initial online survey was distributed to registered GPs and general practices across the target LHD (estimate of 930 GPs/400 practices on PHN’s database in February 2017). This survey included questions on perceptions, expectations and feedback on general usage of HP as well as some demographics and practice characteristics. The survey questions were based on the previous New Zealand evaluation to provide consistency and point of comparison across sites; however, other questions were adapted to the specific purpose of T2DM evaluation and as a method for voluntary recruitment for the follow-up semi-structured interview. This survey was composed of 27 single and compound questions (including multiple choice and Likert scales) to assess: awareness of HP; basic demographics about the GP and the practice (i.e. age range, current position, years in practice and number of sessions per week, other GPs or services within practice, influx of DM patients, computer skills and internet accessibility); use of other web-based clinical decision-making resources (before and after the release of HP); use of HP in treating their diabetes patients; overall feedback on practicality, usage, acceptability and quality of information of the HP; and recommendations for improvement or troubleshooting. As well as if there were any specific reasons why the low/lack of use of HP.

GPs who indicated in the initial survey that they were willing to be contacted by a research team member, and who fulfilled certain criteria (influx of patients with Diabetes Mellitus, familiarity with HP and use of diabetes pathways for patient management), were invited to participate in an individual semi-structured interview to discuss their insights, suggestions and acceptability of the pathways. Those GPs, who were interviewed, were offered financial reimbursement equivalent to their clinical time and capped to 1 h per interviewee.

For patient participants, an anonymous paper survey (ten items) was available at reception areas of the diabetes clinics for them to complete whilst waiting at the clinics. Participation was strictly voluntary.

For the other stakeholders, an invitation for a semi-structured interview was sent out to all of those participants who were identified across partnering organizations, given their involvement in the governance and day-to-day management of the HP program. Participants were sampled purposively, and included stakeholders, clinicians and patients from the study LHD area; and GPs on the PHN’s database for initial general survey and semi-structured interviews.
Other data gathered included HP working group and meeting documents related to the implementation of the Diabetes HP (comprising implementation plan, operational meeting notes and e-mail correspondences). Google analytics data for the total number of sessions on HP for the period July 2015 to February 2018 were extracted to examine the pattern of utilization of HP, frequency, specific pathway take-up and other distributional features of the usage patterns.

Analysis
Quantitative data from the questionnaires, and from the Google analytics data of the HP website, were analyzed descriptively using Microsoft Excel and IBM Statistical Package for the Social Sciences, Version 20.

Semi-structured interviews were digitally recorded and transcribed. Interviews were progressively analyzed using a thematic analysis approach within QSR NVivo software. For qualitative analysis, the comments were grouped into broad themes with initial codes generated directly from the participant’s words (in vivo). These codes were abstracted further to identify concepts and categories to generate final themes. In addition, a framework analysis of data from the HP working group and the meeting documents were undertaken against the NSW Integrated Care Evaluation Framework (NSW Ministry of Health, 2015).

Ethical considerations
Ethical approval for this study was granted by the South Western Sydney Local Health District Human Research Ethics Committee (HREC Reference No. LNR/15/LPOOL/587).

Results
Demographics
In total, 54 percent (n = 31) of all GPs survey respondents (n = 57, response rate of 7 percent) were male, predominantly from the 55 to 64 years age group (Figure 1), with a mean of 22.6 years (SD: 14.7) of experience in general practice. Most of the respondents were senior GPs who considered themselves as confident users of computer technology with better than basic skills and had full access to internet.

Mean age of the anonymous patient survey (n = 41) attending diabetes clinics was 55 years (SD: 18.84), with T2DM being the main diagnose (80 percent). Most of the patients have been attending the diabetes clinic for years (mean: 5.62, SD: 7.57) and half of them are on insulin.

![Figure 1. GP survey age demographics](image-url)
Online GPs survey data (n = 57)
Results show that 86 percent (n = 49) of respondents were aware of HP. However, 63 percent (n = 36) of them used HP, with a pattern of use of 37 percent (n = 21) on a daily or weekly basis and 28 percent use it only a couple times a year. Nearly half (47 percent, n = 16) of those who use it used HP in caring for a patient with diabetes.

To evaluate HP’s development, implementation and acceptance at different levels of health systems, the survey questions and responses were categorized on the basis of its effectiveness: navigation, ease of use, service design, personal experience and patient management with respect to referrals and triage, along with reasons for not using HP.

GPs’ response to effectiveness of HP in caring for patients with diabetes (n = 16):

(1) HP as a site to navigate and obtain information
In all, 94 percent (n = 15) of the respondents agreed that information on HP is of high quality and guidance provided is of practical use. In total, 81 percent (n = 13) of them found HP an effective search function and helpful in knowing the criteria for availability of publicly funded patient care.

(2) Ease of use
In all, 75 percent (n = 12) of health professionals found HP clear and easy to understand and use in daily practice.

(3) Improvement in the service design as a result of the pathways implementation
GPs agreed that HP has assisted in the provision of more healthcare in the community (87 percent, n = 14) and made their job easier (81 percent). It has improved the quality of care (87 percent) and supports diagnostics process (87 percent). It has also increased the number of patient information leaflets or website links they can provide their patients (75 percent).

(4) Personal experience
Nearly half (44 percent, n = 7) of GPs felt that their relationship with patients had improved since using HP. Similarly, respondents (37 percent) considered their working relationship with hospital clinicians had improved since the introduction of HP.

(5) Patient management
In total, 69 percent (n = 11) of GPs reported that HP enables them to manage patients they would have previously referred and half of them found it encouraged them to offer private referral options.

Overall, more than 60 percent (n = 34) of the health professionals are using HP in the management of their patient. They found HP useful tool which keeps them informed (42 percent). They reported that it helps streamline processes, especially for local area relevant information and advice about public clinic referrals, i.e. criteria and investigations prior to referral (17 percent). They mentioned that they would refer HP to other colleagues, as professionals will always welcome addition support.

When GPs were asked for feedback or reasons why they did not use HP, the results highlighted that HP as a tool was not frequently within GPs’ minds. As demonstrated in Figure 2, 52 percent (n = 11) GPs reported that they forget using HP website, 9 percent (n = 2) mentioned that they do not know how to use it and 5 percent (n = 1) said they cannot access the website (error message or restricted access). In all, 33 percent (n = 7) had very limited time to access an online system during consultations, 24 percent (n = 5) felt that many and better health information is available on other more reliable websites. In total, 5 percent (n = 1) were unsure about the content and how it will add to the consultation/management of their patients.
Diabetes patient care experience ($n = 41$)

The mean wait time to get an appointment at diabetes clinic from the time they were referred by doctors was 54.32 days. Most of them visited the diabetes clinic once (19 percent) or twice (37 percent) in the past 6 months, 19 percent ($n = 8$) attended emergency department and 17 percent ($n = 7$) were hospitalized in the past 12 months.

Data were also compared on diabetes patient care experience across three sites which included appointment wait times, emergency attendance or hospitalization in past 12 months, duration patient had been attending diabetes clinic and frequency of visits to diabetes clinic in past 6 months. It was observed that out of three sites, Site 2 had the highest frequency of visits to the diabetes clinic in past 6 months, attended most for emergency department and were hospitalized the most (Figure 3).

Maximum waiting time of 108.46 days was observed in Site 3. Mean frequency of visits to diabetes clinics within 12 months was of 3.9 and duration of attending diabetes clinic of 7.1 years in Site 2, which was highest as compared to other two sites. In all, 80 percent of the respondents from Site 1 did not attend emergency department or were hospitalized for issues directly related to diabetes in past 12 months.

Google analytics data

Google analytics data showed a total number of 160,695 page views of which 7 percent were to access Diabetes HP (Figure 4). Of all Diabetes HP views, gestational diabetes (GD) (9 percent) was the most commonly viewed page followed by newly diagnosed T2DM (9 percent), non-urgent diabetes specialist referrals (6 percent), diabetes continuing care (5 percent) and screening/detection of diabetes and pre-diabetes (5 percent).

Semi-structured interviews

A total of 16 interviews were conducted with GPs ($n = 4$) and stakeholders ($n = 12$) (i.e. general managers, chief executive officers, service managers and project managers). The qualitative evaluation identified four core themes that promote the integration of care in SWS through utilizing HP: engagement, transparency, sustainability and accountability. First, engagement refers to how different members at organizational and individual levels of the healthcare system actively create and maintain collaborative partnerships to implement and maintain HP. Transparency describes how communication and information affect the provision of health services; sustainability refers to factors...
promoting the ongoing and efficient delivery of health services; and accountability describes how relationships created between people and organizations affect the provision of health services. The full scope and in-depth analysis of the qualitative data for this study will be released as a separate evaluation paper.

Diabetes was established as the model for HP development because of the many different services providing care for diabetes patients, and the recognition of the prior work done by working parties to establish guidelines and referral paths for these patients. Some of the stakeholders interviewed were allied health professionals, who care for diabetes patients; these stakeholders were included in the initial working parties and subsequent design of...
Diabetes HP. One of the stakeholders determined the examination of how care is delivered for diabetes as follows:

[A] great opportunity […] given the many changes around medication, a lot of changes around clinical practice and guidelines.

Another stakeholder working as a diabetes nurse educator, who when asked if printing HP material would assist in a consultation, remarks:

No. We don’t. We've got our own; we go through the Australian Diabetes Council resources. We also have […] depends on the age group. We’ve got different resources to suit them. Not just the age group, the ethnicity, if someone’s bilingual, we would go look for a printout in their own language because people like to read in their own language. So, yeah, so we would find the more suitable [one] for that patient.

Communication issues were perceived to be central to how HP might promote the engagement of patients and their carers in the management of chronic disease, and therefore contribute to the deployment of HP.

Discussion

Survey/analytics

This study appraises the development, implementation and acceptance of HP (specifically in T2DM) at different levels in a large metropolitan LHD in Australia. By using a mixed-methods approach, it allowed the collective analysis of different data and improves the consistency of the observations.

While the specific aim of this study is to investigate HP related to T2DM, many of the participants appeared to reflect on HP more broadly rather than focusing solely on T2DM.

Based on the Google analytics data (Figure 3), this suggests the pattern of Diabetes HP usage as compared to the whole website and clearly identifies an increase in the utilization of website over the years. More so, it also identifies the linear progression of the views for the DM pathways, of which, GD was the most commonly viewed (9 percent), followed by newly diagnosed T2DM (9 percent), and non-urgent diabetes specialist referrals (6 percent). Insulin pump breakdown and troubleshooting were the least viewed (0.5 percent), followed by Diabetes Case Conference (0.5 percent) and HbA1c Conversion Chart (0.7 percent).

Interviews

Interviews revealed how communication and information affect the provision of health services as a consequence of implementing the HP program, which is associated with the identified theme of transparency.

Engagement, trust and understanding within partnerships have also been reviewed as key elements for the implementation of the HP. Organizational aims and values become transparent and aligned with the implementation of HP, which is perceived as “proof” of the viability of relationships between different healthcare sectors.

Shared governance of HP by the PHN and the LHD has facilitated this process, but it has also led to an identified problem about the unclear reporting accountabilities across organizations of people contracted to an individual organization. This resulted in miscommunication and misallocation of resources, which subsequently affected the prioritization of the project. HP development entailed identifying which and how services are provided within the LHD and across sectors. For HP to be effective this must be delineated as one part of the referral process inside the program; not doing so may hinder the effective utilization of HP. The indicators required to assess the success of HP beyond being a “work in progress” are unclear, when considering the many different responses
focused on this question. Nevertheless, if one examines the effectiveness of HP in facilitating a transparent means of communication and accessible information for its users, it currently appears to have succeeded on these counts.

Limitations
Limitations of this study included that the study only covered one LHD but not a wider distribution of population. Therefore, it does not provide evidence for national and international generalizability. The study design was dependent on volunteer participation for two arms of the study: GPs surveys and interviews, requiring vast dynamic engagement (need for incentives); and access to diabetes clinics for “passive” recruitment of participants. Despite a number of strategies for engaging the GPs, the uptake of the GP interview has been a challenge for the research team. The challenge of adequate sample size and purposive sample characteristic has significant impact on the results for this study. Moreover, the study focus was on T2DM, which resulted on low numbers for GPs online survey uptake and translated into even lower numbers of possible participants for the semi-structured interviews. This study only provides a process evaluation.

One of the background aims of this study was to identify and develop research questions based on the study experience. This study provides a process evaluation for an integrated care initiative within our region. This evaluation includes information on development and project implementation. Further longitudinal large studies on utilization rate impact on integration in the diabetes field would be useful to investigate and explore the health outcomes and impact of HP with the community. Broader scope for evaluation of multiple HP is important to identify the best ways of ensuring sustainability and uptake of the program, identify outcomes related to the effect on patient care and provide lessons for other regional health service interventions.

The results of this study will be ideally placed to inform future policy amendments in the area of integrated healthcare, as well as serving as a guide on implementing HP in the future, its sustainability and how it aligns with the NSW Integrated Care Strategy.

Conclusions
A mixed-methods evaluation of the development, implementation and acceptance of the HP project supports that HP appears to have been successful on the counts of facilitating the integration of patient care across different healthcare sectors.

This study has provided insight into the details of delivery of integrated healthcare using HP. It provides a preliminary analysis of the lessons learnt for the implementation of HP in a metropolitan region in Australia. While suggestive of being useful to communicate between acute and primary healthcare, further analysis and research is required to demonstrate that this is a useful tool in improving management of chronic conditions. This study has also served to increase understanding of the practical issues for implementation of Diabetes HP working with patients, GPs and other healthcare providers. Future projects should be targeted to appropriate patient cohorts and include other chronic health conditions.

References


Corresponding author
Josephine S.F. Chow can be contacted at: josephine.chow@health.nsw.gov.au

For instructions on how to order reprints of this article, please visit our website:
www.emeraldgrouppublishing.com/licensing/reprints.htm
Or contact us for further details: permissions@emeraldinsight.com
Conceptualizing “project resiliency”
A qualitative study exploring the implementation of coordinated care within a context of system change

Laura M. Holdsworth
Centre for Health Services Studies, University of Kent, Canterbury, UK and Department of Primary Care and Population Health, Stanford University, Stanford, California, USA

Abstract

Purpose – To meet the multidimensional needs of patients, health services are increasingly implementing complex programmes of care through partnerships between public, private and voluntary sector organisations. The purpose of this paper is to explore the implementation process of a complex, multi-innovative regional health and social care partnership to coordinate end-of-life care in the South East of England.

Design/methodology/approach – The study adopted a pragmatic, pluralist design using primarily qualitative methods including observations, interviews, focus group and document review. Implementation theory provided the research framework.

Findings – While progress was made towards greater collaboration in the provision of end-of-life care, regional coordination of care among the 13 partner organisations was not achieved as envisioned. Low engagement stemming from national health system changes delayed decision making and shifted partners’ priorities. Individual stakeholder interest and motivation carried the elements that were successful.

Practical implications – The external political and economic environment hindered the involvement of some of the partners and suggests that a concept of “project resiliency” is particularly important for complex, multi-organisational projects which are implemented over time and by multiple stakeholders from different sectors. Future research should look further at what contributes to project resiliency and whether it might be operationalized so that projects can develop resilient factors for success.

Originality/value – Project resiliency is a new concept that bridges a gap in understanding how time-limited multi-organisational projects function amid a changing environment.

Keywords Partnership working, Implementation research, Coordinated care, End-of-life care

Paper type Research paper

Background

Partnerships and collaborative working between health and social care services are an increasingly advocated approach to deliver more efficient and integrated patient-centred care amid tightening budgets (Lewis, 2001; DH, 2006). A partnership is defined as a local, voluntary coalition of independent health and social care providers with informal, non-authoritative relationships in which participation is based on consent and negotiation (Plochg et al., 2006; Hjern and Porter, 1981). Programmes delivered by partnerships are often complex, requiring multiple stakeholder engagement, organisational change and provider behaviour change. Effective partnerships and collaborative working depend on the successful relationships between stakeholders (Jackson, 2000; Connor and Kissen, 2010), yet little is known about how partnerships implement complex change programmes to coordinate or integrate care across organisations.

Implementation research is often focussed on the implementation of interventions in a single organisation. There is a dearth of evidence about how partnerships implement change
in health care across organisations. Implementation refers to the targeted use of planned strategies and adaptive activities to change and routinise new practices; it is a process, not an event (Fixsen et al., 2005). Partnerships introduce added complexity to the study of implementation because interorganisational working may compound the influence of political, social and economic factors; factors which are rarely explicitly investigated (McConnell et al., 2013). Understanding the implementation process is important to ensure that partnerships maximise resources and deliver interventions as intended.

Over the last decade national policy in England and Wales has targeted end-of-life care for quality improvement through coordination of services (DH, 2006, 2010). It is perceived that patients in the last few months of life, with incurable, irreversible illness (cancer, non-cancer or multifactorial) require access to a range of services which are poorly coordinated. In the UK, voluntary organisations such as hospices (usually with both inpatient and community outreach services) and hospital palliative care units are key providers of specialist palliative care to patients who are known to be in the last year of life, though many receive end-of-life care through their primary care provider and about a quarter use social care services (Georghiou et al., 2012). Family members provide much of the informal care support for patients who remain at home. Due to such a varied landscape of care provision, there are often, paradoxically, duplication of assessments and care delivery for professionals, yet also gaps in access to appropriate care for patients and family carers. There is an ongoing need for health and social care services to work together to deliver better outcomes for patients at the end of their lives and their caregivers with fewer resources.

Methods
This study aimed to explore the implementation process of a regional health and social care partnership project to coordinate end-of-life care. The study design was a prospective longitudinal and primarily qualitative mixed methods study using a naturalistic and pragmatic approach to inquiry to understand and interpret the process of implementation (Hammersley and Atkinson, 2007; Snape and Spencer, 2003).

Setting
The project covered an area in South East England with a population of 630,000 and characterised by average to high deprivation indices in coastal, urban and rural areas (Research & Evaluation, 2011). It included 13 health and social care organisations working as a partnership. The partnership was a voluntary, two-year arrangement in which organisations volunteered representatives to participate in various management and working groups with the aim of implementing consensually agreed changes. At the same time as this partnership project, the Health and Social Care Act (2012) was implemented across England which introduced extensive structural and financial changes to the health and social care system.

Conceptual framework
Implementation theory was used as the framework for the study, particularly drawing on the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2009). CFIR characterises five domains of implementation which were explored: innovation characteristics, individual characteristics, process, inner setting and outer setting. The domains are composed of 39 constructs and sub-constructs that are thought to influence implementation. CFIR is meta-theoretical in that it is a synthesis of theories, but does not depict the relationships between the constructs within the framework.
**Data collection methods**

Multiple qualitative methods were used over the two-year study period: participant observation, interviews, focus group and document review. A scoping exercise was undertaken at the start of the study to determine appropriate data sources, arrange access and refine tools for data collection (Hammersley and Atkinson, 2007). Data were collected continuously to capture the flow of the implementation process, key decisions and contextual factors. A template was created to ensure consistency across observations, and handwritten field notes were typed up in full (Miles and Huberman, 1994; Hammersley and Atkinson, 2007). Prior to each interview a topic guide was produced based on insights from previously collected data. Interviews followed a semi-structured, conversational approach. Interviews and the focus group were recorded and transcribed for analysis.

**Data analysis**

The analytic process was drawn from guidance by Miles and Huberman (1994) and the Framework approach to analysis described by Ritchie and Spencer (1994). NVivo 9 software was used for data management and analysis. The format and quality of the documents varied; documents with a narrative structure were treated like a transcript, whereas numeric documents were summarised into notes for coding. The steps in the content and thematic analysis process involved: familiarisation with the data, development of *a priori* codes and a coding structure derived from CFIR and implementation theory, deductive and inductive coding, and displaying data using a matrix for each of the data sets. Data from different sources and methods were triangulated using the matrices (Yin, 2009). Concepts were viewed as stronger if there was evidence for their existence within data sets (e.g. a theme identified in multiple interviews) and across data sets (e.g. a theme identified within interviews and observations). In addition to the content and thematic analysis, the documents were also analysed quantitatively to build a picture of functional project activities, such as tabulating the frequency of meetings and attendees.

**Results**

In total, 16 observational sessions totalling approximately 25 h were carried out in a variety of settings: 11 meetings, 4 navigation centre visits and 1 training session. In total, 17 interviews were carried out with: the project manager (4 longitudinal interviews), hospice director (3 longitudinal interviews) and stakeholders (10 at the end of the project) representing five work groups, the hospice, primary care commissioning, ambulance, hospital and community health trust perspectives. Four care navigators who worked different shifts participated in the focus group. A total of 112 documents were collected from project archives and as they were disseminated throughout the project (e.g. meeting minutes, audits, communications) and analysed.

The following sections describe the key influences on the implementation process: how the project was structured, engagement and participation by stakeholders, task interconnectedness, competing priorities and unanticipated benefits of partnership working.

**Project structure, aims and implementation strategies**

The project ran from March 2012 to March 2014 to address the aims of the National End-of-life Care Programme. The aims of the project were to improve the end-of-life experience of patients, reduce inpatient admissions to hospital for dying patients and reduce service duplication. The project was designed as a partnership led by the local voluntary hospice and included: primary care leaders representing 88 GP practices, a foundation hospital trust with three acute treatment hospitals, a community health trust, ambulance trust, an NHS and social care partnership trust, social care services and a variety of voluntary sector organisations, such as Admiral Nurses.
The project structure for developing and implementing a coordinated approach to care, shown in Figure 1, included a three-tiered hierarchy in which all partners were invited to participate: an executive board for strategic decision making, a project management group to oversee task progress and work stream groups allocated task-based activities. Participants in the groups included leaders from various levels within each organisation, including some with frontline responsibilities. The key work of the project involved: establishing a 24-h navigation centre operated by hospice-trained lay call handlers to navigate patients and professionals to appropriate support; implementation of an electronic palliative care coordination system (EPaCCS) which is a shared electronic patient record incorporating patient wishes; and numerous work groups to address regional gaps in care including: improving pharmacy access, developing an integrated patient pathway for end-of-life care, communication, patient engagement and workforce training and education. There were a number of explicit and implicit strategies for implementing the project that included: inclusion of all partners in the hierarchical project management structure, hiring a project manager and data analyst, dividing project activities among multiple working groups, monitoring project progress through a series of audits and evaluation and communication through face-to-face meetings and electronic material.

The influence of partner engagement and participation on decision making

Engaging stakeholders from all organisations equally across the three management tiers, and dispersing tasks across the groups was expected to be a key strategy for generating change in the region. However, irregular attendance at meetings and low stakeholder engagement meant that this strategy did not have the intended affect as non-participation meant many of the groups could not make decisions that required agreement from all partners:

This group has struggled with attendance in this time of intense change and agreeing work that was needed. (Document M12Q4-01)

Low engagement was attributed primarily to issues arising from the extensive structural changes in the NHS as a result of the Health and Social Care Act (2012) that came into force on 1 April 2013 in the middle of the project. Briefly summarised, the key changes in the Act 2012 involved shifting commissioning power from Primary Care Trusts (PCTs) to
GP consortiums (Clinical Commissioning Groups (CCGs)) and financially linking health care providers to local authorities to integrate health and social care provision. Changes in commissioning and funding introduced great uncertainty for project partners, especially those in primary and social care:

There was a lot of change and flux in the system at the time, particularly with the transfer of the PCTs to the CCGs and I think [the county council] were also undergoing quite a significant reorganisation at the time so I think that actually affected the level of engagement from key people which is why the overall project I don’t think got delivered in the way that was envisaged. (Stakeholder 02)

Task interconnectedness and implementation
Project work was divided among multiple work streams focussed on addressing known gaps in the provision of end-of-life care, such as improving access to medication out of hours and facilitating rapid discharge home from hospital. Project tasks which were independent of the other groups were more likely to be implemented, such as the navigation centre which was wholly implemented by the hospice:

I think there is an element of we have total control over [the navigation centre], we were having that site with us so we were able to manage the whole thing as we saw fit and have control over it. (Stakeholder 05)

Though work was divided, there was some overlap between the issues addressed in each group, such as discharge home from hospital on a Sunday (patient pathway) would likely require a prescription to be filled be a pharmacy. Thus, tasks that were dependent on the outputs of the other groups created a cyclical process of development and implementation, and were not successfully implemented:

[...] the other work streams weren’t as far ahead as us and therefore [our output] just fell at that last hurdle really. (Stakeholder 04)

The hierarchical management structure was meant to lead to decision making that would resolve such issues as they arose, but as described, low engagement due to conflicting priorities meant that key decisions were delayed or unmade, and thus there were no outputs to be implemented across the partnership.

Competing priorities and perception of need
The partnership included a wide array of professions (administrators, doctors, nurses, specialists, therapists, social workers) from various organisations (NHS primary, secondary and tertiary care, voluntary organisations, local authority). Stakeholders viewed the need to adopt the innovations and changes proposed in the project (navigation centre, EPaCCS, outputs from work streams) differently and their views were influenced by the nature of their work, whether the innovation met their needs and what else was available. The EPaCCS software was adopted by the hospice, but had limited adoption by GP practices after the first year of the project (24 of 88 practices). Many GPs were already using a different electronic system to track end-of-life patients and objected to using two systems. Additionally, GPs engaged with end-of-life patients relatively infrequently and so saw little advantage in using the EPaCCS over the existing software. In contrast, the ambulance service found the content of the EPaCCS and introduction of the navigation centre to be useful in filling an information gap for responding to patient calls and was thus advantageous to their work. These differing views partly stemmed from different professional traditions:

Well I think it’s different varieties of work in parts and paramedics are quite process orientated so if they’ve got a process they use it, and it’s drilled into them to use their processes within their training and their support [...] but they are not autonomous practitioners; nurses and doctors are. (Stakeholder 05)
Partners’ individual interests, either due to tradition, organisational pressures or as a result of personal experience influenced their involvement in the partnership. One of the stakeholders who was active throughout the project had a strong personal interest in the subject matter which motivated him to participate:

[…] at that time my brother was at his end-of-life so it helped me understand and try and relate some of the problems I was experiencing as well, so I really, if it’s the right word, I really found the project of benefit. (Stakeholder 08)

While personal motivation facilitated active engagement by some stakeholders, this was not the case for everyone and there were different interpretations of what it meant to be partner. Some stakeholders felt they were accountable for the outcomes of the project in their respective organisations which was a facilitating view, while others felt that it was more voluntary and participated because they were interested, which was both a barrier and facilitator because though they were interested, they did not feel pressured to achieve the aims. Engagement in the project also depended on whether stakeholders felt that the project was going to help them achieve their priorities within their job or deliver outcomes that were of direct relevance to their organisation’s goals. For example, the ambulance service used the navigation centre regularly as a means to access information quickly and was keen on the project achieving its aims because end-of-life care was a time-consuming aspect of their work, whereas the hospital had other competing priorities that took precedence:

[…] it feels to me as though the work we were doing was something that we thought would be a good thing to do, so we should go and do it, and sometimes those things slip behind you know the 4 hour target in A&E and hitting the 18 weeks target and those kind of things. (Stakeholder 07)

Likewise, GP stakeholders prioritised establishing the CCGs:

Members of the work stream are being approached to participate in these various CCG groups so their time is being stretched and the CCGs are taking priority. (Observation P12Q4-07)

Ultimately, there were different visions for how to achieve regional coordination of care which related to the diversity of the partnership and made reaching consensus difficult:

[…] there wasn’t really I would say a unilateral agreement of where we all wanted to go with it. (Stakeholder 09)

Unanticipated benefits of partnership working

While the expected, measurable outcomes of the project (e.g. work stream tasks) were perhaps limited due to low engagement, there were other outcomes with less tangible effect that could be attributed to the project implementation process and collaborative working. First, there was a greater awareness among stakeholders about the role of others in providing end-of-life care. One stakeholder described how he knew little about the hospice prior to the project:

[…] the hospice is a lot bigger than I thought it was. I thought it was “two man and a dog” but it’s like 300 people and they have more beds than I thought so they have quite a lot of stuff that they want to analyse every week. (Stakeholder 07)

Subsequently, this led to closer working between the two organisations in helping to analyse data which was relevant to both partners. Improved willingness to work together was also evident from the care navigators’ experience in dealing with the out-of-hours service:

I think there were a bit of obstacles put up at the start but now it’s “oh hello, the Hospice, oh what can we do?” and that’s really improved an awful lot. (Navigator Focus Group)
The partnership working which occurred as part of the project spurred on some unplanned activities related to the project’s goals. For example, during the project period the hospice developed the role of their in-house social worker to become a trusted assessor to work with the local authority which was seen to be a consequence of more integrated working. Also, the hospice and hospital trust had begun looking at ways that they could work closer together through shared posts or job swaps to move towards better coordination and integration between the two organisations. Instead of implementing innovations across all partner organisations to coordinate care, towards the end of the project, focus shifted towards implementing relevant changes on a smaller scale in those organisations that were willing or able to adopt.

**Discussion**

This study demonstrates the complex nature of trying to implement a regional approach to coordinated care through a large multi-organisational, multi-professional voluntary partnership during a period of significant system-wide change. The collective local experience among the partners established the need for improving end-of-life care through better coordination, hence the initial buy-in to launch the project, but priorities for achieving coordination shifted over time. The project was an example of a movement in health and social care in which implementation is driven by policy and commissioning imperatives, rather than a scientific evidence base, as there is no good evidence for advocating one model of care (Higginson and Gysels, 2004). A substantial body of literature on collaborative working indicates that success requires alignment of motivation, capacity, capability and conceptualising success (Williams and Sullivan, 2010), yet within the context of system-wide transformation, these features of success were difficult to align given the different priorities among a diverse range of partners. These individual and organisational characteristics and priorities variously facilitated and prevented participation in the partnership. However, such implementation influences are often conceptualised as either a facilitator or a barrier, but less often existing on a continuum reflecting change over time (Chambers et al., 2013). This study demonstrates that there is nuance across such issues – one’s barrier may be another’s facilitator. Across a diverse partnership such as this, there is likely to be great variability in how issues are perceived, particularly when the basis for adoption is soft. Reconciling different perspectives and priorities through negotiation is a feature of partnership working, which implies a less rational and more adaptive approach to implementation, yet the large and diverse partnership seemed to hinder this negotiation as engagement was unequal.

Outer setting, specifically the system-wide changes from the Health and Social Care Act (2012), was a major influence on the success of the project, yet is often poorly understood as a mediator of change (Dopson et al., 2008). This study demonstrated how influential the wider political and regional context (macro level) can be on professionals and their actions (micro level). The health and social care restructuring and subsequent uncertainty appeared to lead to a lack of openness to innovate among those stakeholders and organisations most heavily affected (primary and social care). Some stakeholders were more concerned with their role in the new landscape and therefore the project lost a number of influential people, especially from primary care. This study confirms that threats to job security stemming from organisational and system change is a barrier to implementation (Devlin et al., 2015; Jackson, 2000) and suggests that implementing multi-organisational projects is not advisable during national health care reform.

**Project resiliency**

The picture of implementation and project work across the partnership was one of mixed success and suggests that projects need strategies to cope with external threats to progress. A similar study of the implementation of a national digital health system which took place at the same time as this study found similar effects on organisations and individuals; the externally imposed NHS changes impacted the internal organisational working and the
fear of role redundancy as a consequence restricted stakeholder engagement (Devlin et al., 2015). The authors concluded that there was a “need for resilience in the face of challenging socio-political and economic factors in the external environment” (p. 5); however, it is not specified how such resilience would be achieved. Resilience can be viewed as “a process that leads to adaptation and superior outcomes” (Brodsky et al., 2011). How to operationalise resilience is still debatable (Pangallo et al., 2015; McManus et al., 2008), but at a project level will perhaps combine features of both personal and organisational resilience; that is, a positive outlook, awareness of dependency on other parties, anticipation of possible threats and slack resources (Vogus and Sutcliffe, 2007; McManus et al., 2008). Many of these features relate to the role of leaders in both modelling behaviour and anticipatory planning (Aarons et al., 2014). In this study, resilience seemed to relate to stakeholder interests (individual characteristics), adaptability and separation of the innovations which could be individually adopted by organisations or individuals (innovation characteristics), and multiple diverse implementation strategies, rather than relying on a singular approach to implementation.

Resiliency within the implementation process is similar to the concept of adaptability, but whereas adaptation is more often considered as a feature of the innovation itself (Damschroder et al., 2009; Durlak and DuPre, 2008; Rogers, 2003), project resiliency is aligned more to the human aspects of implementation and describes the agility of the people to adapt project resources and re-orientate implementation strategies to effectively deal with barriers and threats stemming from the outer setting. This suggests that it is not situated at just an individual, project or organisational level, but rather reflects an ongoing reciprocal process between all three layers. This back and forth relationship is likely to be relevant in partnership project implementation in which there is movement between the project and organisation via stakeholders. Fundamentally, individual resilience is likely foundational to project resilience in the same way that it is essential for organisational resilience (Brodsky et al., 2011). Indeed, individual leaders at various organisational levels are influential in setting the climate for implementation and can either facilitate or block change efforts through their conscious or unconscious actions (Aarons et al., 2014). Thus, carefully selecting a leader(s) for organisational representation in partnership projects is likely crucial to the success of the project. Such resiliency or flexibility in the face of contextual challenges which almost always present during the implementation process does not seem to appear as a construct in implementation frameworks (e.g. Damschroder et al., 2009; Greenhalgh et al., 2004), but rather likely reflects the interaction of a number of constructs. The concept of resilience in project or programme work may gain more traction in future as partnership working at scale becomes increasingly common (DH, 2006, 2010; HM Government, 2012).

**Limitations**

The design of this study aimed to capture key points of decision making and progress reporting that could be captured by one researcher. The study only captured project level data and not data on how the project was taken up within the partner organisations, except for the feedback which was given by the stakeholders. It might have been useful to track the progress of the project through each of the organisations to gain insight into how it was prioritised and resourced, particularly given the changes from the Act (2012). By only capturing project level data, there is little first-hand data regarding GPs, out-of-hours care and social care, particularly the latter two as they did not engage with the project. Any data regarding their involvement were provided secondhand by those engaged in the project.

**Conclusions**

This study found that establishing coordinated care through a regional partnership approach is messy and depends heavily on partners’ capacity to participate, which reflects individual
and organisational interests and priorities. Unintentionally, this study demonstrated the impact of national, system-level change on a multi-organisational partnership project, which brought the concept of resiliency to project implementation and suggests that as an internal attribute it may be a useful construct for exploring how interventions and implementers interact and adapt to external project threats. Future studies might look at whether the concept of resiliency can better explain the relationships between approaches to implementation and contextual influences, and how projects can develop resiliency to ensure success.

References


About the author
Laura M. Holdsworth is Qualitative Health Services Researcher with particular interest in understanding the patient experience of health services in order to improve the implementation and delivery of services. Her content areas of focus have been in palliative, end-of-life, long term and integrated care. She uses a range of methods in my work including interviews, focus groups, ethnography, participant observation, document review, survey and literature reviews. She also enjoys engaging with patients as partners in the research process, from research question formulation through to dissemination. Laura M. Holdsworth can be contacted at: l.holdsworth@stanford.edu
Integrated care for community dwelling older Australians

Jennifer Mann, Sue Devine and Robyn McDermott
Division of Tropical Health and Medicine, James Cook University, Townsville, Australia

Abstract

Purpose – Integrated care is gaining popularity in Australian public policy as an acceptable means to address the needs of the unwell aged. The purpose of this paper is to investigate contemporary models of integrated care for community dwelling older persons in Australia and discuss how public policy has been interpreted at the service delivery level to improve the quality of care for the older person.

Design/methodology/approach – A scoping review was conducted for peer-reviewed and grey literature on integrated care for the older person in Australia. Publications from 2007 to present that described community-based enablement models were included.

Findings – Care co-ordination is popular in assisting the older person to bridge the gap between existing, disparate health and social care services. The role of primary care is respected but communication with the general practitioner and introduction of new roles into an existing system is challenging. Older persons value the role of the care co-ordinator and while robust model evaluation is rare, there is evidence of integrated care reducing emergency department presentations and stabilising quality of life of participants. Technology is an underutilised facilitator of integration in Australia. Innovative funding solutions and a long-term commitment to health system redesign is required for integrated care to extend beyond care co-ordination.

Originality/value – This scoping review summarises the contemporary evidence base for integrated care for the community dwelling older person in Australia and proposes the barriers and enablers for consideration of implementation of any such model within this health system.

Keywords Chronic care, Health and social care, Integrated care, Primary care, Aged care, Older person

Paper type Literature review

Background

Integrated models of care are fundamental to Australia’s capacity to respond to the challenges emerging from an ageing population and rise in chronic disease (AIHW, 2014; NHHRC, 2009). Present methods of health and aged care delivery are unsustainable against this backdrop of demographic and epidemiological change (Tieman et al., 2007). The economic burden created from the needs of the unwell-aged demands a fiscally responsible approach for the alignment of health and aged care services while improving client outcomes. Fragmentation of care is the by-product of health and aged care systems under pressure (Amelung et al., 2017). Australia can boast universal access to medical, hospital and social care via a mix of public and private health service provision, yet disconnection between health and aged care services, difficulty with access and extended wait times are evident (Swierssen and Duckett, 2016; NHHRC, 2009; Strivens et al., 2016; Foster et al., 2017).

Cognitive and physical impairment, chronic disease and multi-morbidity demand timely, co-ordinated care to prevent complications that are costly to the health system and life-threatening for the older person (World Health Organization, 2015; De Carvalho et al., 2017). For many older persons, the need to access multiple medical specialists demands navigation of a complex and often disconnected web of health services (Strivens et al., 2016). Decrease in function associated with ill health and ageing requires access to the supports necessary to assist the older person to remain living at home. Defined by Leutz (1999, p. 77) as “[…] the search to connect the health care system (acute, primary medical, and skilled) with other human service systems (e.g. long-term care, education, vocational and housing services) in order to improve outcomes (clinical, satisfaction, and efficiency)”, integrated care brings these commonly fragmented services together for the provision of comprehensive,
quality care, to prevent avoidable hospitalisation and assist the older person to remain at home for longer. With its roots embedded in early models of primary health care, integrated care is a suitable means to mobilise and extend primary practice for a holistic, strengths-based approach to the delivery of health and social supports for the older person (Valentifin et al., 2013; Tieman et al., 2007; Davy et al., 2016).

Integrated care for the older person has an established history, internationally (deCarvalho et al., 2017; Philip et al., 2013; Wodchis et al., 2015). Evaluation of international models of integrated care suggests that the most effective community-based integrated strategies for the older person include a community extension to multidisciplinary sub-acute care, care co-ordination, shared data systems and primary–secondary care collaboration (deCarvalho et al., 2017; Philip et al., 2013; Wodchis et al., 2015). The Canadian Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA) model is a programme of integrated care for the older person that creates a service delivery network through co-ordination of existing health and social services under a central organisation, resulting in client empowerment and improved satisfaction with care (Stewart et al., 2013). In New Zealand, the Te Whiringa Ora model of integrated care is a community-based multidisciplinary team with case management that places the client and their family at the centre of their health plan and broker health and social supports from partner providers (Wodchis et al., 2015). Te Whiringa Ora has shown improved access to care and a reduction in hospital admissions and length of stay (Wodchis et al., 2015).

Integrated care as a policy directive is not new to Australia (Nicholson et al., 2014). The Council for Australian Governments agreement for co-ordinated, patient-centred health care was released in 1995 (Australian Productivity Commission, 2017). More recently, the Australian Government’s Living Longer, Living Better national aged care reform provided impetus for integrated health and social care solutions to deliver a fairer, more sustainable and consistent system for older Australians (NSW Agency for Clinical Innovation, 2014). However, translation of integrated care from a policy objective to the practice setting has proved challenging in Australia. The Australian Productivity Commission (2017) lists discordant funding objectives, incompatible information systems and poor professional linkages as obstacles to integration. The first round of Australian Coordinated Care Trials of the late 1990s experienced many of these barriers. Described as “ambitious” in design yet “disappointing” in capacity to show benefit to participants, the Australian Coordinated Care Trials were the first large-scale, national attempt at bridging the gap between various levels of health care via a care co-ordinator and fund pooling (Commonwealth Department of Health and Ageing, 2003a; Esterman and Ben-Tovim, 2002). However, brief project timeframes, rigid interventions and limitations in evaluation design compromised the capacity for the programme to produce or measure benefit to participants or the health system (Esterman and Ben-Tovim, 2002; Commonwealth Department of Health and Ageing, 2003b).

To clearly describe how the integrated care landscape for older persons in Australia has developed over the past decade, this scoping review explored innovative models of care for the community dwelling older person that translate public integrated care policy objectives to quality, service delivery at the community level. The aim of this scoping review was to identify and discuss contemporary Australian models of integrated care that target the needs of community dwelling older person. In alignment with current policy focus for integrated care, community-based enablement models were the focus of this scoping review.

Methodology
This literature review is scoping in design. A search for peer-reviewed articles was completed on the Cochrane, PubMed, Scopus and Informit databases. A search for grey literature was conducted on Australian State and Federal Government websites. Reference lists were reviewed to identify possible additional titles.
Search terms
The following keywords were searched: integrated/integrate/integration, co-ordinate/co-ordination/co-ordinator, multidisciplinary, elderly, older person, geriatric, frail, hospital avoidance and community. Keywords were searched as Boolean phrases and used to inform and explore MeSH terms. Results were limited to Australia, and to publications from 2007 to 2018.

Inclusion and exclusion criteria
To ensure consistency with Australian aged care and health policy that is considerate of the lower life expectancy for Aboriginal and Torres Strait Islander peoples, an older person was defined in this study as a non-Indigenous person aged 65 years and older and/or Aboriginal and Torres Strait Islander person over 50 years of age. Publications from 2007 were included in the review to capture all contemporary Australian models implemented within the past decade. Included models provided community-based care. Articles were excluded that investigated models of integrated care for older persons in residential care, which were hospital based or centred on palliation.

Review strategy
Peer-reviewed publications were screened for inclusion by title, abstract and full text. Two researchers independently reviewed search results at the stage of title review. One researcher reviewed the abstracts against inclusion and exclusion criteria. Any publications that were not clearly for inclusion or exclusion were reviewed by a second researcher.

Synthesis/Analysis
For this review, the level of integration macro, meso, micro (as defined in Table I) was used to delineate and describe the integrating features of the various models.

The methods of co-ordinating care, alignment of health and aged care services, and collaboration with primary care were examined. Data were extracted that described: outcome measures; economic viability; and barriers and enablers to implementation (Bardsley et al., 2013). As the focus of this scoping review was on the design features of the integrated models, the strength of study design was not evaluated.

Results
In total, 248 publications were identified through the described search strategy. The PRISMA flow diagram (Figure 1) outlines the process of refinement that resulted in 11 papers meeting eligibility criteria for review. Of the included papers, five were peer-reviewed publications and 6 were items within the grey literature (Table II).

<table>
<thead>
<tr>
<th>Level</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macro</td>
<td>The level at which providers seek to deliver integrated care to the populations that they serve</td>
</tr>
<tr>
<td>Meso</td>
<td>The level at which providers seek to deliver integrated care for a particular care group or populations with the same disease or conditions, through the redesign of care pathways and other approaches</td>
</tr>
<tr>
<td>Micro</td>
<td>The level at which providers seek to deliver integrated care for individual service users and their cares through care co-ordination, care planning or use of technology and other approaches</td>
</tr>
</tbody>
</table>

Source: Adapted from Curry and Ham (2010, p. 7)
Features of integration
Alignment of health and aged care services. Each of the models included in this review incorporated both health and aged care services in their approach to quality care for the older person. All but one model provided patient care initiated by a health service with strategies such as the Hospital Admission Risk Program’s (HARP) multidisciplinary team (Bird et al., 2007), HealthOne’s co-location of health services (McNab et al., 2013) and the nurse practitioner hospital in-reach role (Centre for Health Economics Research and Evaluation, 2017). A holistic approach to the needs of the older person was facilitated by engaging social supports and interventions from existing aged care services on an individual “as needs” basis supplementary to the direct health care provided from within the model. Alignment of health and social services in this way was universally considered the most efficient means of creating a comprehensive system of support for the individual that reoriented health care from preventable acute presentation through utilisation of community care, and assisted the older person to live at home for longer.

In contrast, the Lungurra–Ngoora Aboriginal model of care described by LoGiudice et al. (2012) was focussed on the alignment of social supports to improve quality of life for the older person (amongst other population groups). In this community-led approach, pooled funding and centralised management of social supports facilitated patient-focussed aged care linkages as the primary objective of a holistic model that utilised social supports to facilitate improved client engagement with the health system.

<p>| JICA 27.2 |
|---|---|
| <strong>Figure 1.</strong> Summary of search results, PRISMA |
| Source: Moher et al. (2009) |
| <strong>Features of integration</strong> |
| Alignment of health and aged care services. Each of the models included in this review incorporated both health and aged care services in their approach to quality care for the older person. All but one model provided patient care initiated by a health service with strategies such as the Hospital Admission Risk Program’s (HARP) multidisciplinary team (Bird et al., 2007), HealthOne’s co-location of health services (McNab et al., 2013) and the nurse practitioner hospital in-reach role (Centre for Health Economics Research and Evaluation, 2017). A holistic approach to the needs of the older person was facilitated by engaging social supports and interventions from existing aged care services on an individual “as needs” basis supplementary to the direct health care provided from within the model. Alignment of health and social services in this way was universally considered the most efficient means of creating a comprehensive system of support for the individual that reoriented health care from preventable acute presentation through utilisation of community care, and assisted the older person to live at home for longer. In contrast, the Lungurra–Ngoora Aboriginal model of care described by LoGiudice et al. (2012) was focussed on the alignment of social supports to improve quality of life for the older person (amongst other population groups). In this community-led approach, pooled funding and centralised management of social supports facilitated patient-focussed aged care linkages as the primary objective of a holistic model that utilised social supports to facilitate improved client engagement with the health system. |</p>
<table>
<thead>
<tr>
<th>Author, date</th>
<th>Model features</th>
<th>Level of integration</th>
<th>Study purpose</th>
<th>Study design and sample size</th>
<th>Summary findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Government Department of Health and Ageing (2007)</td>
<td>Second round of co-ordinated care trials. Various designs. Coordinated Health Care Trial (CHC) focussed on community dwelling older persons and partnership between co-ordinator, GP and patient</td>
<td>Macro</td>
<td>To determine if co-ordinated care improved service delivery for patients and communities and identify features of success</td>
<td>Randomised controlled trial of 25 months duration. Total trial participants 1,108 in intervention group and 417 for control group</td>
<td>CHC: no significant change in health status of intervention group. No significant difference in quality of life between groups at 6 months. Care co-ordination model relatively expensive</td>
</tr>
<tr>
<td>Bentley et al. (2015)</td>
<td>Nurse Practitioner within a large GP practice. NP providing co-ordination and clinical care</td>
<td>Meso/Micro</td>
<td>To describe the implementation and challenges for the development of a Nurse Practitioner (NP) role within primary practice</td>
<td>Multi-method evaluation with no comparison group. 2 NPs and 168 clients included in the study</td>
<td>Challenges to implementation included professional relationships, access to facilities. Client consultations provided via home visit. Multi-mobility a characteristic of 74% of trial participants at recruitment</td>
</tr>
<tr>
<td>Bernoth et al. (2016)</td>
<td>Community service workers trained to provide care aimed at functional decline and quality of life</td>
<td>Micro</td>
<td>Explore the experience of community support workers in the provision of a multidisciplinary service aimed at addressing functional decline</td>
<td>Qualitative evaluation. 7 individual client interviews and 12 support workers in focus group</td>
<td>Themes identified: functionality/independence; prevention; confidence; connection; the approach; the care plan; the role of the CSWs. Clients experienced improved quality of life</td>
</tr>
<tr>
<td>Bird et al. (2007)</td>
<td>HARP: geriatrician and multidisciplinary team for comprehensive assessment and care co-ordination plus budget for provision of support services and equipment</td>
<td>Micro</td>
<td>To discuss the format and outcomes of a programme designed to connect health and social services: hospital and health service utilisation; stakeholder satisfaction; economic viability; process of implementation</td>
<td>Quasi-experimental pre–post design with 231 persons in 85 persons in comparator group</td>
<td>Statistically significant reduction in Emergency Department presentations and bed days of the intervention group. Costs savings to the health service of $2m. Model of care complimentary to existing services</td>
</tr>
<tr>
<td>Cameron et al. (2013)</td>
<td>Multidisciplinary team providing care coordination and allied health intervention</td>
<td>Micro</td>
<td>Evaluate the effectiveness of an interdisciplinary frailty intervention</td>
<td>Randomised controlled trial, total of 216 older frail participants</td>
<td>Statistically significant between group frailty score at 12 months. Mobility remained stable in the intervention group but declined substantially in the control group</td>
</tr>
</tbody>
</table>

Table II. Studies included in the review
<table>
<thead>
<tr>
<th>Author, date</th>
<th>Model features</th>
<th>Level of integration</th>
<th>Study purpose</th>
<th>Study design and sample size</th>
<th>Summary findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre for Health Economics Research and Evaluation (2017)</td>
<td>Care co-ordinators who assist in the development and facilitation of a client’s care plan (GP Management Plan) by liaising with and linking client’s to existing services. Budget for home modifications</td>
<td>Micro Pre-post design with no comparator group. Data available for 2,544 participants</td>
<td>To analyse change in referral pattern, expenditure allocation and effectiveness of a co-ordinated care programme</td>
<td>Statistically significant reduction in ED presentations. TCC strongly associated with reduction in patient acuity</td>
<td></td>
</tr>
<tr>
<td>Davey et al. (2015)</td>
<td>Variety of Nurse Practitioner models of care working within a primary practice, solo practitioners or government based. Co-ordination and clinical service provision</td>
<td>Meso/Micro Multi-method evaluation with no comparator group. No sample size provided</td>
<td>To assess the extent that Nurse Practitioner models of care improve access to care for elderly clients, facilitate growth in the NP workforce and are economically viable and sustainable</td>
<td>Model managers and NPs viewed the initiatives to be effective. Improved access to primary health care for older people. 30% of overall models did not continue because they were not financially viable. Clients satisfied with care provided by the NP</td>
<td></td>
</tr>
<tr>
<td>LoGiudice et al. (2012)</td>
<td>Fully integrated model with joint funding arrangement and common objectives created between health and social services. Care co-ordination</td>
<td>Meso Multi-methods study with no comparator group. 25 stakeholders interviewed. 22 programme participants</td>
<td>To describe the development and implementation of a model of health and social care in a remote Aboriginal community</td>
<td>Increase in client numbers and use of community services. Up-skilling of staff. Funding gaps identified. Agency partnerships formed. Complicated funding arrangements hindered the project. The need for services to relinquish or share roles challenging</td>
<td></td>
</tr>
<tr>
<td>Masso et al. (2015)</td>
<td>Various models. Three models targeted community dwelling older persons at risk of functional decline. Care co-ordination to link health and social supports</td>
<td>Meso Summative multi-method evaluation with no comparison group. Total of 2,734 programme participants. 69 stakeholder interviews</td>
<td>To evaluate the success in achieving the following: establish referral pathway; Improve access; reduce hospital admissions and length of stay; skilled and flexible aged care sector</td>
<td>Objectives met: improve access to complex health care services for aged care recipients; diversify the aged care sector to include more complex community and residential health care services for aged care recipients; establishment of effective referral pathways between aged care and health care service providers</td>
<td></td>
</tr>
<tr>
<td>Author, date</td>
<td>Model features</td>
<td>Level of integration</td>
<td>Study purpose</td>
<td>Study design and sample size</td>
<td>Summary findings</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>McNab et al.</td>
<td>Model centred on the role of the GP liaison nurse. Nurse assists client through the continuum of care by creating a care plan and arranging required services and facilitating communication between existing organisations</td>
<td>Meso</td>
<td>To evaluate the success of a programme designed to align primary health and community services: Hospital and health service utilisation, stakeholder satisfaction, economic viability, process of implementation</td>
<td>Multi-method evaluation with no comparison group</td>
<td>Reduction in ED presentations for the chronic aged and complex group. Clients felt supported experienced improvement in quality of life. Increase in referrals to allied health and decrease in referrals for nursing. GP satisfaction with the programme</td>
</tr>
<tr>
<td>McNamara et al.</td>
<td>Not applicable</td>
<td>na</td>
<td>Examine health care provider (HCP) experience of approaches to multi-morbidity management for community dwelling older persons</td>
<td>Qualitative study. Semi-structured interviews with 26 HCPs</td>
<td>Themes identified: incorporation of shared decision making and patient preferences; evidence base; patient prognosis; clinical feasibility of treatment plans; optimising therapies and health management plans; co-ordination of care system wide gaps in implementing a coordinated approach to the care of the older person with multi-morbidity</td>
</tr>
</tbody>
</table>

Table II. Integrated care
Collaboration with primary care. Each model of care included in this review incorporated primary care into their design with service delivery performed where primary care interfaced with either acute or secondary care provision. A general practitioner (GP) and care co-ordinator partnership was formed in many of these models with case conferencing utilised to facilitate joint decision making (Australian Government Department of Health and Ageing, 2007; Bentley et al., 2015; Centre for Health Economics Research and Evaluation, 2017; Davey et al., 2015; Masso et al., 2015; McNab et al., 2013; McNamara et al., 2017). The co-location of nurse practitioners within the GP practice produced a depth of integration with primary care not seen in other models; co-location was reported to enable timely case discussion and collaboration on joint care plans. The establishment of the GP liaison role in HealthOne was a targeted and beneficial means of increasing communication with primary care across the care continuum. Unique to the GP liaison role was the capacity to facilitate case conferencing with the primary care physician to inform inpatient care and assist with discharge planning (Bentley et al., 2015; Davey et al., 2015; McNab et al., 2013). Self-management, specialised aged care assessment and frailty interventions were utilised across several models to complement existing primary care services.

Care co-ordination. Service linkage and liaison were familiar strategies across all models of care, most often facilitated by a care co-ordinator who established an individualised care plan for the client and referred to external services to facilitate plan activities. The title of this co-ordinating position differed: general practice liaison nurse (McNab et al., 2013); care facilitator Bird et al. (2007); and service co-ordinator (Australian Government Department of Health and Ageing, 2007); however, the key duties of this position were described similarly between models to include client advocate, educator, co-ordinator and counsellor. A nurse filled the co-ordination role in many models (McNab et al., 2013; Bentley et al., 2015; Centre for Health Economics Research and Evaluation, 2017; Davey et al., 2015; Masso et al., 2015). HARP (Bird et al., 2007) employed multidisciplinary care facilitators of a variety of health professions who could refer to each other for specialist intervention.

The role of the co-ordinator was valued by stakeholders and participants as an essential component to integration:

And then the GP Liaison Nurses, their role, coming on board [was] instrumental in getting all this going. If they weren’t there, this wouldn’t have moved along. So, a very, very fundamental glue, if you will, between how community health does its business, and linking into general practice […] We perhaps hadn’t quite appreciated when you start out with these things that these were sort of the linchpins of the model in terms of how do you bring disparate parties together to keep them, to keep them working together. (Policy Maker, McNab et al., 2013, p. 61)

Programme outcomes

Client-level outcomes. Neither of the randomised controlled trials included in this study produced a significant statistical difference in emergency department (ED) presentations or quality of life between groups at the completion of the study period (Australian Government Department of Health and Ageing, 2007; Cameron et al., 2013). However, HARP, Brisbane North Team Care and HealthOne, each attributed improved access to timely health and social supports to a decrease in the number of ED presentations for intervention participants (Bird et al., 2007; Centre for Health Economics Research and Evaluation, 2017; McNab et al., 2013). The HARP described by Bird et al. (2007) also credited a decrease in acute hospital usage to an improved understanding of appropriate health service utilisation amongst participants.

An increase in quality of life for integrated care participants was identified in two model evaluations with participants of HealthOne and Bernoth’s Participatory Care Model.
reporting a decrease in health anxiety linked to the direct support provided by their GP liaison/community support worker (McNab et al., 2013; Bernoth et al., 2016). Qualitative findings highlight positive outcomes related to physical and psychological health:

I’m not so stress […] So yeah…they’ve done like a lot for me like if I didn’t have the help I wouldn’t have the grass done and the walker […]. (Mrs K. in McNab et al., 2013, p. 43)

And:

One particular client had [a] severe condition that limited his ability to walk or manage his personal hygiene […] he had not walked for many months and was unable to access his toilet or shower, and his mental state was very low […] however the project has enabled him to partake in valued activities such as fishing. (Allied Health Professional, LoGiudice et al., 2012)

Cost effectiveness. The Coordinated Care Trials, HARP and Nurse Practitioner models included economic evaluation, with mixed results (Australian Government Department of Health and Ageing, 2007; Bird et al., 2007; Davey et al., 2015). The HARP claimed a $2m saving to the health service achieved through a reduction in ED presentations and hospital admissions amongst HARP participants following the intervention, with success attributed to linkage to and use of community health and social services in place of reliance on acute hospital care (Bird et al., 2007). The National Evaluation of Nurse Practitioners reported that 30 per cent of models included in their evaluation did not continue as restricted revenue streams impacted negatively on financially viability (Davey et al., 2015). The National Evaluation of Coordinated Care Trials reported that inpatient costs for the intervention group were lower than the control in the late stages of the trial but that care co-ordination was determined to be “relatively expensive” (Australian Government Department of Health and Ageing, 2007).

Patient and provider satisfaction. Patient satisfaction was reported in the evaluation of three models (Bernoth et al., 2016; McNab et al., 2013; Davey et al., 2015) and stakeholder satisfaction in four evaluations (LoGiudice et al., 2012; Bernoth et al., 2016; McNab et al., 2013; Davey et al., 2015). Overall, findings from both groups were positive with the role of the care co-ordinators valued by both groups.

Care co-ordinators appreciated the benefits of applying a holistic patient-centred approach to care:

[…] I think we’ve become closer to our clients. They feel that we really care about how they are actually doing. (Community Support Worker in Bernoth et al., 2016, p. 433)

GPs were impressed with the capacity to have a pathway to access hospital-based information and valued the trust built with the care co-ordinator.

Clients felt supported, connected and listened to. Client’s felt relief in having a central point of contact for their needs:

If I could have [Mrs S’s GP] and the team down here [GPLN and Mount Druitt Community Health staff], I wouldn’t need anybody else [laughter]. There you go, that’s how, I am absolutely rapt in them. And if the government, and if that goes back to the government, if the government ever stops it, look out, I’ll be on your door step [laughter]. (Mrs S. in HealthOne Mt Druitt in McNab et al., 2013, p. 42)

Barriers and enablers to implementation

The process of implementation was discussed in many of the publications. Alignment of disparate services was discussed as a challenge:

The major impediment to improving connections between aged care and health care was the silos within which individual providers work […] These silos differ in so many ways – different goals, different philosophies of care, different sources of funding and different operational requirements. (Masso et al., 2015, p. 73)
And:

Working with the GP who has a slightly different way of working. Get a shared understanding of what each other does, and how those roles can complement each other, and that’s not an easy thing as you’re coming from very different places. And, you know, it’s just a lot of hard work to actually work that through to get that shared understanding. (Policy Maker in McNab et al., 2013, p. 67)

Introduction of a new model of care within and across existing services was often met with a reluctance to change, particularly for those models integrating at the meso level. The Lungurra–Ngoora programme in remote Western Australia (LoGiudice et al., 2012) sought to develop partnerships for integration through a strong shared governance framework. A steering committee and local action group involved in all aspects of model of care development could not overcome the uncomfortable experience of organisational change and related relinquishment of roles.

Conversely, evaluation of HealthOne (McNab et al., 2013) concluded that commitment of key partners and dedication to a changed way of working were essential to model implementation and sustainability. The inclusion of primary care in the early stages of model development was an enabling feature of HealthOne and the CHC. While the establishment of trust and respectful relationships took time, these models were situated to benefit all parties and common values were established:

[...] we determined at the outset that there were certain parameters within which we wanted this model to develop, and the absolute fundamentals [were] that it had to be a partnership between general practice and community health [...] (Policy Maker in McNab et al., 2013)

Discussion

The aim of this scoping review was to identify and discuss contemporary Australian models of integrated care for community dwelling older persons implemented within the past decade. Although the documented evidence of integrated models of care designed specifically for this client group within Australia was scarce, the 11 publications included in this review provide insight into the interpretation of public integrated care policy to improve care provision for the older person; each model unique to their community yet distinguished by their use of care co-ordination and collaboration with primary care.

The World Health Organization (2015) clearly outlines that comprehensive care for the older persons’ demands connection of health and social care. The combination of improved access to health services, the smoothing of transitions within health care and the co-ordination of aged care supports in the home have shown internationally to improve the quality of life of the older person, reduce acute hospital utilisation and keep the older person living at home for longer (Wodchis et al., 2015; Curry and Ham, 2010; Goodwin et al., 2014; Sendall et al., 2016). In Australia, the disparate funding arrangements of health and aged care services (acute and secondary care funded by the State, and primary care and aged care funded by the Commonwealth) remain influential in shaping methods of integration with minimal evidence to suggest that integration of health and social services beyond care co-ordination is possible. Many of the models of care included in this review utilise Commonwealth-funded services to impact State-funded hospital outcomes. This is discussed, not to discredit goals of improved quality of life and independent living, but to illustrate why silos of care continue and why the design of integrated models at the macro level are avoided.

Care co-ordination is widely considered to be an essential component in quality patient outcomes and is an appealing approach to integration in Australia, as it is internationally, as there is no need to address the structure of existing services, conflicting funding objectives can be avoided and there is little requirement to manage behavioural symptoms of change (Amelung et al., 2017; Goodwin et al., 2014; Suter et al., 2009;
Curry and Ham, 2010). For these reasons, care co-ordination remains popular as the driver of integration in Australia. However, care co-ordination on its own, particularly when based on a linkage model, does little to address the underlying reasons for service fragmentation (Goodwin, 2013). Care co-ordination provides the most vulnerable clients with an improved experience of the health system by bridging gaps and navigating complexities of the care continuum, but the gaps and complexity remain. As such, a disconnect between integrated care as a policy directive and the governmental structures required to embed integrated care into the Australian health and social care landscape is evident. Short-term project funding creates reliance on care co-ordination and avoidance of the complexities of service alignment, but results indicate that care co-ordination is expensive (particularly when undertaken by a nurse practitioner) and does not have a reliable revenue stream in the Australian health system to promote model sustainability (Masso et al., 2015; Davey et al., 2015; Australian Productivity Commission, 2017).

Primary care is valued as an essential element of integrated care for the older person yet engaging well in this space remains challenging. The GP, specifically, is vital to sustainable health outcomes for the older person (Amelung et al., 2017; Mitchell et al., 2015). The expressed difficulty in aligning integrated care interventions to the values of the GP appears at odds with this. A reluctance to participate in patient-focussed care is discussed by the Australian Productivity Commission (2017) as a barrier to integration, an obstacle that while not unique to Australia contrasts with health care models of those western countries that place value on the patient’s role as a co-contributor in their care (Australian Productivity Commission, 2017; Swierssen and Duckett, 2016; Topol, 2015). Engagement of the GP in early stages of model development and a commitment to relationship building, while difficult, are beneficial to implementation and programme acceptability.

Integrated, patient-focussed care is the right care, at the right place, at the right time. The first round of co-ordinated care trials emphasised the need to understand usual care as a pre-cursor to system redesign (Commonwealth Department of Health and Ageing, 2003c). A strength of many international models of integrated care is their capacity to respond to unique community needs, with family inclusion and community-led care evidence of this in practice within the Te Whiringa Ora model. Consistent with this New Zealand-based approach, community consultation is particularly important for strategies implemented for Aboriginal and Torres Strait Islander communities within Australia, as this approach fosters key community partnerships, can ensure cultural safety of the intervention and assists in broadening integration beyond a biomedical model to include spiritual and community well-being and the social determinants of health (Amelung et al., 2017; Davy et al., 2016; Smith et al., 2011). A one-size-fits-all approach to service delivery is rarely successful between and within communities. Triage, prioritisation and flexible service design were suggestions of the first round of Coordinated Care Trials, considered to be components of successful programming (Commonwealth Department of Health and Ageing, 2003c).

Electronic patient records, teleconferencing and other means of technological application are considered central to contemporary integration, to improve timely communication, avoid duplication of assessment and to improve access to care (Suter et al., 2009). The geographical spread of Australia’s population is motivation for technological innovation to facilitate integration but activities focussed on this were not described or explored by any of the models of care included in this review. The lack of focus on information management within integrated care models is not unique to Australia (Goodwin et al., 2014).

Limitations
This study was limited by the reporting mechanisms employed by the evaluations and the subsequent difficulty in drawing conclusive statements about those interventions that were the most successful. The summative nature of the Better Healthcare Connections, Second
Conclusion
The Australian health system is becoming increasingly interested in the concept of integrated care to facilitate sustainable, quality outcomes for an ageing population. Care co-ordination remains the most popular and acceptable means of supporting older persons with complex needs to manage the complexity of the current health system. Care co-ordination must align with primary care and support the work of the GP for the greatest success. Although popular, reliance on supernumerary models of care linkage does not address the underlying cause of fragmentation within the Australian health system and lacks the capacity to work with patients preventatively. Little evidence exists of the effectiveness of strategies that pursue integration through service redesign and the use of technological mechanisms for communication and service delivery is underutilised or unexplored. Historical barriers to integrated care permeate contemporary approaches and compromise the capacity for depth of integration to be achieved. With solid cross-sectoral partnerships and innovative funding arrangements future models of integrated care could push beyond care co-ordination for sustainable quality service provision that addresses the challenges of accessing the right care, at the right time, for older persons with complex needs.

References
Integrated care


NSW Agency for Clinical Innovation (2014), Building Partnerships: A Framework for Integrating Care for Older People with Complex Health Needs, NSW Agency for Clinical Innovation, Chatswood.


Further reading


Corresponding author
Jennifer Mann can be contacted at: jennifer.mann@my.jcu.edu.au

For instructions on how to order reprints of this article, please visit our website: www.emeraldgrouppublishing.com/licensing/reprints.htm
Or contact us for further details: permissions@emeraldinsight.com
Backfiles Collections

Preserving over 100 years of management research online

A lifetime investment for your institution, Emerald Backfiles will significantly enhance your library’s offering by providing access to over 125,000 articles from more than 260 journals dating back to 1898.

Visit emeraldinsight.com

Get Backfiles Collections for your library

Recommend Backfiles to your librarian today.
Find out more: emeraldpublishing.com/backfilescollections
Journal of Integrated Care

Practical evidence for service improvement

Number 2

97 Editorial boards

98 Editorial

100 Integrating health and care in the 21st century workforce
    Matt Aiello and Julian D. Mellor

111 Exploring an integrated palliative care model for older people: an integrative review
    Marina Raco, Teresa Burdett and Vanessa Heaslip

123 Co-designing integrated care for high-needs clients: the Help Team for school-aged children
    Tuula Tuominen, Mari Harju, Erja Oksman and Anneli Hujala

131 Roles and responsibilities in integrated care for dementia
    David Robertshaw and Ainslea Cross

141 A critical evaluation of integrated care: a case study of the supported discharge service
    Rachel Louise Ware

153 HealthPathways implementation on type 2 diabetes: a programmatic evaluation
    (HIT2 evaluation)
    Josephine S.F. Chow, Veronica Eugenia Gonzalez-Arce, Chun Wah Michael Tam, Ben Neville
    and Alan McDougall

163 Conceptualizing “project resiliency”: a qualitative study exploring the implementation
    of coordinated care within a context of system change
    Laura M. Holdsworth

173 Integrated care for community dwelling older Australians
    Jennifer Mann, Sue Devine and Robyn McDermott

www.emeraldinsight.com/loi/jica