Integration of health and social care
A review of literature and models
Implications for Scotland

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*The views expressed in this report do not necessarily reflect the views of the RCN.*
Summary

This exploration of integrated health and social care reviews the literature on models of integration from six European countries and New Zealand, assesses the factors which help or hinder integration and considers the implications for Scotland.

An unequivocal message from the literature is that there is no single, agreed definition of integrated care. Integration can take place at a number of levels: team, service or organisation. It can apply to a small number of specialist services or to the full range of health and social care services. The body of information on integration is extensive but contains surprisingly little evidence of improved outcomes for patients. Most measures of the success of integration concentrate on criteria such as admissions to hospital, reduced waiting times or service responsiveness and infer benefits to service users. However, robust evidence of the impact on health outcomes is lacking.

There are a large number of different models of integration. Some are based on multi-disciplinary team working and networks. Others involve structural reform to create single, integrated organisations. Two recent examples of structural integration are the TioHundra municipal company in Sweden (Norrtälje) and the Care Trusts Plus in England.

Factors helping or hindering integrated working fall into three categories:

- Organisational issues
  - Vision and culture
  - Unified budgets or structures
  - Communication and IT
- Professional issues
  - Status and stereotypes
  - Patient focus
  - Training and education
- Policy and legal issues
  - Policy environment
  - Legislation
  - Employment contracts, terms and conditions.

Scotland already has experience in integrating health and social care services through joint future bodies, community health (and care) partnerships and managed clinical/care networks. A track record of joint working is a marker for success in integration so this previous experience bodes well. However, integration is not a quick or cheap option so if the drivers for integration are a need to reduce costs and ease pressure on secondary care, it may fail.
**Introduction**

Closer links between the NHS and social care have been part of the policy landscape in the UK for many years. The Griffiths Report on care in the community in the late 1980s highlighted the need for health and local authorities to work together and the subsequent NHS and Community Care Act 1990 gave local authorities lead responsibility for planning and co-ordinating community care services.

After devolution, partnership and joint working became a common thread in Scottish Government policy documents. In 1999, the then Scottish Executive established the Joint Future Group to identify ways in which existing policies on joint working could be more effective (Scottish Executive, 2000). Since then, joint or partnership working between NHS boards and local authorities has featured prominently as a policy driver.

The Community Care and Health (Scotland) Act 2002 paved the way for more formal joint working by allowing NHS boards and local authorities to establish joint management and financial arrangements for community care services. Initially limited to services for the elderly, these ‘joint future bodies’ covered all types of community care services from 2004 (NHS Confederation, 2004).

The same year, the NHS Reform (Scotland) Act 2004, compelled NHS boards to establish Community Health Partnerships (CHPs). Formed as committees or sub-committees of NHS boards, these partnerships aim to link primary and specialist services, health and social care, leading to greater integration of services.

In practice, the CHPs that emerged were diverse and the scope and nature of integration varied between partnerships (Cook *et al*, 2007). More recently, Scottish Government policy has sought to strengthen CHPs’ role in integrating services by increasing the resources delegated to them from NHS boards and by giving them greater freedom to make decisions (Scottish Government, 2007).

CHPs continue to evolve and show considerable variation in structure and purpose. However, a review of CHPs’ progress and achievements (Watt, Ibe and McLelland, 2010) suggests that while CHPs have improved joint working, further improvement could come from better alignment of: health and local authority priorities, budgeting cycles, target outcomes and accountability.

Against this backdrop, the Scottish Labour Party announced, at its annual conference in October 2010, plans to establish a National Care Service (NCS) during the lifetime of the next Scottish Parliament. This NCS will sit within the NHS with the aim of “bringing together health and social care so that no one falls through the gaps – one organisation, one budget and one focus - on the person needing care” (Baillie, 2010).

To add to RCN Scotland’s understanding of health and social care integration, the College commissioned a short project to review the literature on integration in a number of other countries and consider the facilitating factors and barriers. This report sets out the findings of the review and considers the implications for Scotland.
The literature review was carried out between mid-November 2010 and early January 2011. Searches were conducted in the CINHAL, Ovid, EMBASE and Cochrane Library databases to identify descriptions, studies or evaluations of models of integrated care in seven countries: Denmark, England, Finland, New Zealand, Northern Ireland, Norway and Sweden.

The search included peer-reviewed, academic publications, grey literature such as policy documents and reports from government departments or non-departmental public bodies (NDPBs), and articles from the professional nursing, medical and social services press. Searches were conducted online using the NHS Scotland Knowledge Network and the RCN e-library and complemented by conventional internet searches using Google and Yahoo. In addition, the reference lists of the most relevant papers were hand searched for additional publications not identified in the database searches.

The search was limited to English language academic literature and other documents either wholly in English or with English summaries.
Defining integrated care

The drivers for greater integration of health and social care are common to many countries: an increasingly elderly population, higher demand for care, for example because more people are living with long term conditions, the need to develop more responsive, patient-centred services, workforce pressures and reduced or static funding (Pieper and Vaarama, 2005).

However, the evidence base for integrated care remains weak. The literatures shows that one reason for this is the varied aims for integration, different contexts and dissimilar patient groups so that comparisons and generalisations are difficult. A further reason is that patient outcomes of integrated care are not easily measured.

Many definitions of integrated care exist. The phrase ‘integrated care’ has a variety of meanings, conveying different things depending on context, organisation and professional group. One group of researchers (Armitage et al, 2009) found around 175 definitions and concepts in a literature review of the field. Most definitions describe bringing together inputs, delivery, management and the organisation of services in such a way as to improve access, quality, user satisfaction and efficiency (Kodner and Spreeuwemberg, 2002).

The term ‘integrated care’ is used to refer to:

- Health and social services delivered by a single organisation
- Joint delivery of health and social services by more than one organisation
- Links between primary and secondary health care
- Joining care at different levels within a single sector eg mental health services
- Joining prevention and treatment services.

Integration can mean that services are jointly commissioned and/or funded, delivered by multi-disciplinary teams in which team members are employed by more than one organisation, or delivered by multi-disciplinary teams in which members are employed by the same organisation.

Kodner and Spreeuwemberg propose two approaches to defining integrated care, patient-centric or organisational. Patient-centric integrated care is concerned with aligning funding, management and organisational issues by cutting across multiple services, providers and settings to deliver the best quality of care, quality of life, patient satisfaction and efficiency possible. By contrast, organisational integration is largely structural or hierarchical, driven by corporate systems and processes designed to achieve efficiency.

Integration takes place in a number of ways. Kodner and Spreeuwemberg (2002) describe a continuum from co-operation between entirely separate organisations through the co-ordination of services in multi-disciplinary networks (eg managed clinical networks) to fully integrated services with pooled funding, joint planning and management, and multi-disciplinary teams. They identify a number of strategies and approaches which foster integration (Figure 1).
**Figure 1: Integration strategies and approaches**

**Funding:**
- Pooling funds (at various levels)
- Prepaid capitation (at various levels)

**Administrative:**
- Consolidation/decentralisation of responsibilities/functions
- Inter-sectoral planning
- Needs assessment/allocation chain
- Joint purchasing or commissioning

**Organizational:**
- Co-location of services
- Discharge and transfer agreements
- Inter-agency planning and/or budgeting
- Service affiliation or contracting
- Jointly managed programs or services
- Strategic alliances or care networks
- Consolidation, common ownership or merger

**Service delivery:**
- Joint training
- Centralised information, referral and intake
- Case/care management
- Multi-disciplinary/interdisciplinary teamwork
- Around-the-clock (on-call) coverage
- Integrated information systems

**Clinical:**
- Standard diagnostic criteria
- Uniform, comprehensive assessment procedures
- Joint care planning
- Shared clinical record(s)
- Continuous patient monitoring
- Common decision support tools (i.e. practice guidelines and protocols)
- Regular patient/family contact and continuing support.

*From Kodner and Spreeuwenberg (2002)*

Leutz (2005) takes a similar approach but describes only three forms of integration: linkage, co-ordination and full integration. Other definitions (Ramsay, Fulop and Edwards, 2009, Reed et al 2005, and Glendinning, 2003) concern the level at which integration takes place, for example:
- Vertical – integrating care at different levels, for example community, primary care, secondary care
- Horizontal – care at each level is delivered by multi-disciplinary teams
- Service – all care for a defined population or patient group is integrated

A large number of definitions and descriptions therefore complicate the debate about integrated care. In their 2009 literature review of integrated care, Armitage et al comment, “this diversity of terminology is overwhelming”. A broad range of descriptive terms further complicates the picture. These include: seamless care, care or case management, multi-agency care, care networks, co-ordinated care and transmural care. While there may be some differences in the way in which care under these headings is organised or delivered, they all share the common theme of joint or collaborative working with the aim of delivering a higher quality, patient-centred service while reducing demand on acute services and improving efficiency.

Van Raak et al (2003) sum up the debate about what integration means by concentrating on the patients’ perspective. They comment: “The essence of integrated care is that individuals received the care services they are in need of when and where they need them. It is care which appears seamless to the service recipients and devoid of overlaps or gaps to service commissioner and providers. It is required when the services of separate agencies and individual professionals do not cover all the demands of the multiple-problem service users.”
Models

Much of the literature on integrated care comes from the UK (England in particular), the US and Canada. Many publications identified during the literature search concerned integration within the healthcare system rather than between health and social care. A complicating factor is the diversity of national health and social care systems. In some settings, primary or local health organisations include social care while in others they deliver medical and nursing care but exclude social care. Much of the literature reviewed was unclear about precisely which professional groups were involved in multi-disciplinary teams. As a result, examples of integration were excluded unless it was clear that they brought together health and social care.

The models described below are drawn from six countries in Europe and in New Zealand, all with something in common with Scotland, for example: geography, size, population or culture.

Denmark
Denmark has a population of approximately 5.5 million. Its universal health service is funded mainly through taxation and access is free at the point of use with the exception of dental care, physiotherapy and some medicines. National level institutions are responsible for the overall framework, co-ordination and supervision of services while management and planning are devolved to regions and municipalities all of which have democratically elected assemblies. The regions are responsible for primary and secondary medical services while the municipalities are responsible for social services, care of the elderly and services for people with long term conditions or disabilities. Legislation requires the regions and municipalities to co-operate with each other (Strandberg-Larsen et al, 2007).

Discharge management
Some hospitals have established multi-disciplinary teams to provide post-discharge follow-up care at home or in the community, for example to elderly patients. Teams include primary and secondary health care professionals and social workers and have the twin aims of reducing readmissions and offering care/treatment at home (Lloyd and Wait, 2006). An example of this approach in the municipality of Søllørd is a nurse-led discharge management scheme. According to the Providing Integrated Health and Social Care for Older People (PROCARE) study of nine European countries (Billings and Leichsenring (eds), 2005) the services available through the scheme include: nursing home places, supported accommodation, day care, intermediate care and rehabilitation, 24-hour domestic care (personal care and home nursing), meals on wheels, and anticipatory care.

Skævinge
The rural municipality of Skævinge adopted an integrated health and social care service in the mid-1980s, one of the first to do so (Stuart and Weinrich, 2001). Services are provided from the Bauneparken Health Centre, which also has supported accommodation for elderly residents unable to continue living in their own homes. The scheme employs 136 people from 13 different professional groups and provides a single entry point to health and social care services. The PROCARE study describes improvements in the well-being of elderly people in Skævinge following the start of the new approach. Expenditure on services
decreased despite an increase in the elderly population, an outcome presumed to result from the preventive focus of the scheme. There is no waiting list for supported living apartments in the Bauneparken Health Centre, no delayed discharge and the use of intermediate care has reduced hospital admissions by 30 to 40 per cent (Billings and Leichsenring, 2005).

**Acute rooms**
Another approach involves setting up ‘acute rooms’ offering an alternative to hospital admission for elderly patients with an acute condition but who do not need specialist treatment. Acute rooms are located in nursing homes or social care units in local communities. Local GPs are responsible for the rooms and they co-ordinate referral and treatment with secondary care, social care and the emergency services. (Colmorton et al as cited in Lloyd and Wait, 2006).

**ENGLAND**
Integration of health and social care has been on the agenda for England for a number of years and partnership working has been consistent feature of recent Government policy. The result has been a range of different approaches and pilot projects, from the location of social workers in GP surgeries to the integration of adult health and social services in a single organisation (Lyon, Miller and Pine, 2006). The experience of the US Health Maintenance Organisation Kaiser Permanente, where the role of commissioner/insurer combines with the direct provision of hospital and community-based care, has had a significant impact. Three projects to adapt learning from Kaiser were established in Northumbria, Birmingham and Solihull, and Torbay beginning in 2000 (Ham, 2010).

More recently, the publication by the Department of Health in 2008 of the *High Quality Care for All: NHS Next Stage Review Final Report* led to the establishment of 16 care trusts (Ham, 2010) including two ‘care trusts plus’. Care trusts are partnerships between the NHS and the local council in which local authorities delegate some social care functions to the care trust. The features of care trusts are (Ramsay et al, 2009):

- Pooled budgets (where the partners contribute to a common budget)
- Lead commissioning (where one partner commissions services provided by both partners)
- Integrated provision (where a single organisation provides both health and social care services).

Care trusts remain within the NHS structure and councils retain ultimate accountability for the delegated services (Department of Health, 2002a and 2002b). The two care trusts plus (North East Lincolnshire and Blackburn with Darwen) take the care trust principle a stage further and involve the transfer of services from the NHS to local authority or vice versa and also the transfer or secondment of staff.¹

¹ The precise difference between a care trust and a care trust plus is unclear. The distinction here is based on an interpretation of the Department of Health’s background briefings on care trusts, care trust governance guidelines and descriptions of the two existing care trusts plus.
North East Lincolnshire Care Trust Plus
The Care Trust Plus formed in September 2007 with the transfer of services between North East Lincolnshire Council and North East Lincolnshire Primary Care Trust (PCT). The new organisation is responsible for commissioning and providing all adult health and social care for the area. At the same time, a children’s trust was created to commission health and social care and provide community services, and a joint NHS/local authority public health function was formed, hosted by the Council.

A review of the arrangements detailed a number of changes (Audit Commission, 2009):
- Adult social care was transferred from the council to the care trust plus and included the TUPE transfer of 677 staff (519 whole time equivalents (WTE)).
- The Public Health Directorate transferred to the Council under the management of a jointly appointed Director of Public Health. Sixty five public health staff (56 WTE) were seconded to the council.
- All children’s services transferred to the council with the secondment of 117 staff (85 WTE).

The benefits attributed to the new arrangements by the care trust plus and the council include:
- Integrated teams
- An integrated equipment store
- Closer working relationships between staff.

The Audit Commission review identified several anecdotal improvements. For example:
- Better attendance at multi-agency meetings
- Improved working between health and education staff
- Public health is now a corporate priority for the council
- Multi-agency teams work together to improve public access. These include a homelessness team and health trainers.
- Health impact assessments are now part of the council’s regeneration strategy
- Improved access to information, particularly on children’s services.

However, the Commission criticised the new arrangements for not being sufficiently clear about the expected benefits and outcomes for service users. The review comments: “Early self-assessment reviews and evaluations of the partnership were not sufficiently focused on service-user outcomes...Without having clear, planned service-user outcomes and benefits, and evaluating these, partners cannot be confident that their arrangements are successful or delivering required improvements in value for money.”

The terms and conditions of staff transferred under TUPE regulations (transfer of undertakings (protection of employment)) from the council to the new trust were harmonised. However, staff seconded from the NHS to the council were unclear about their position. They were unsure about the basis of their secondment and the impact on pension continuity. In addition, they did not know who to contact to resolve problems and felt transition arrangements were inadequate.
At the time of the Audit Commission report, a number of issues remained to be resolved. These included:

- Bringing together two incompatible IT systems so that staff could share information
- Creating a single, case-record management system
- Integrating performance management arrangements and financial reporting
- Updating governance arrangements to reduce their dependence on pre-existing relationships between individual officers.

**Torbay Care Trust**

Torbay Care Trust was created in 2005 when the area’s existing primary care trust (PCT) and adult social services combined. The trust serves a population of around 145,000 with a higher than average proportion of over 75s. The rising prevalence of long-term conditions, including dementia, was a major factor in the decision to form the care trust (Hickey, 2008).

Services are organised in five integrated teams each serving a geographical area covering around 25,000 people and aligned with general practices. A sixth team is responsible for specialist services, for example for people with learning disabilities, and covers the entire trust area (Hickey, 2008).

Integrated team members all work from the same location, have a single manager and use a single assessment process. Teams meet frequently, often daily, and focus on identifying the needs of the most vulnerable people in their locality and then managing their care in partnership with the individual’s GP. Referral processes have been simplified (Ham, 2010).

Each team has a health and social care co-ordinator who deals with referrals and acts as the single point of contact for the team. Co-ordinators provide the link between service users and team members, arranging care and support as necessary. Care Co-ordinators do not need to be professionally qualified and Ham (2010) describes them as “in many ways the most fundamental innovation in Torbay”.

Health and social care budgets are pooled and the trust operates with fully integrated, electronic care records so that teams can commission the care people need regardless of whether it is a health or social service. Although Torbay is a care trust, rather than a care trust plus, Hickey (2008) reports that “social care service staff have been assimilated into the NHS pay structure, a huge and complicated task”.  

Torbay Care Trust has invested in intermediate care in order to reduce inappropriate admissions. One community hospital has changed from a traditional convalescent facility into an intermediate care service by developing the role of nurses, occupational therapists and physiotherapists, and establishing closer links with the local acute hospital’s geriatric team (Ham, 2010).

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2 Based on the Department of Health guidance on care trust governance, care trusts do not directly employ social services staff. See note 1.
The trust has also created a discharge management scheme that aims to discharge patients when there is pressure on beds and reduce lengths of stay. The discharge scheme is part of a broader integrated care project for older people, which also includes:

- Anticipatory care to support people at home for as long as possible
- Acute care
- Ensuring people regain their independence as soon as possible after a hospital stay or crisis
- Palliative care.

**FINLAND**

Finland is a country of approximately 5.3 million people. Health care is delivered by a combination of services; a public service funded through local taxation, state funding and fees paid by service users, a private service and an occupational service. Most health care is provided by the public service which is delivered by the country’s 415 municipalities. Municipalities are legally obliged to deliver primary health services, including public health, through primary health centres. Twenty hospital districts, each of which has one or more acute hospitals, organise and deliver specialist health care. Municipalities must belong to a hospital district and contribute to the cost of specialist care for their populations but they do not provide this level of care directly (Vuorenkoski, Mladovsky and Mossialos, 2008).

Improving collaboration between different health and social care providers has been an important goal for several years but Finland’s long tradition of local self-government has led to extensive decentralisation and considerable variation in provision. Nevertheless, health and social care policy still aims for equal access and provision. That aim, combined with Finland’s geography, put a significant burden on the health care system and may explain the intensive development of IT applications for health and social care (Van Raak et al).

**Primary care health centres**

Initially established as a way of improving access to health care, Finland’s primary care health centres have developed a range of integrated services. They offer a variety of services: outpatient medical care, inpatient care (in effect, GP-run hospitals in some places), preventive services, dental care, maternity care, child health care, school health care, care for older people, family planning, physiotherapy and occupational health care. Facilities usually include X-ray, laboratory facilities, minor surgery and endoscopy, ECG and ultrasound, and the centre employ GPs, nurses, midwives, social workers, dentists, physiotherapists and psychologists (Vuorenkoski, Mladovsky and Mossialos, 2008).

Some health centres have focused on integrating health care services while others have included social care services. An example is ‘care at home’. Initially, nurses delivered only nursing care while home helps provided social support. Now, home helps undertake nursing tasks including wound care, medicines administration and diabetes care to provide the care at home service. (Kokko, 2009).

An example of the care at home service in Helsinki was the Old Age Care Programme. In addition to ‘normal’ home care, the programme included intensive home care to replace hospital or institutional care and speed up hospital discharge. The scheme involved multi-
disciplinary teams of physicians, nurses, social workers and home help advisors, all with specialist geriatric expertise (Valvanne, 2005). An interim evaluation of the project suggested patient satisfaction increased, but overall, Valvanne reports that results from the project were mixed. Possible reasons are:

- A top down approach coupled with lack of effective leadership
- Contradictory local health policy
- Failure of the intensive home care programme because care professionals did not see the merit in having two levels of service
- Professional boundaries remained despite multi-disciplinary working.

**Leading groups**

Leading groups allow the integration of strategic management of health and social care services. Managers from different divisions or services meet to plan delivery, transfer knowledge and share information. Groups can also include private and voluntary sector providers. There is considerable variation between groups, which can operate on either an official or an informal basis. An example of a leading group is the SAS-group. The group’s focus is to identify the patient’s needs, assess what services are appropriate and then deliver the appropriate service. (See the problem, Assess services needs, Suitable placement) (Niskanen, 2002).

**Service circles/teamwork**

Multi-disciplinary team working has received much attention in Finland. Team members organise tasks so that colleagues from health and social care can work jointly with each other and with patients. The service circle is one version of Finland’s teamwork model. For example, a team looking after a sick child will have members from primary care, specialised health care, social care, and from the voluntary sector. Each member of the circle is aware of the child’s needs and what role the other partners play in delivering the most appropriate service (Niskanen, 2002).

**NEW ZEALAND**

New Zealand’s health service is funded mainly through general taxation and is based on an integrated model of funding, planning and provision (French, Old and Healy, 2001). Twenty one district health boards either provide services directly or commission and fund them from other organisations. District health boards are responsible for hospital, community and primary services as well as social services such as home and residential care for the elderly. In practice, district health boards can find secondary care priorities overwhelming primary and social care. As a result, New Zealand is reviewing its funding mechanisms, performance frameworks and incentives in search of a better balance (Ham et al, 2008).

**Chronic care management model**

The chronic care model of disease management was developed in the US. This approach brings together community resources, patient self-management, decision support systems for professional staff, the redesign of services and clinical information systems. It involves anticipatory care, organising interventions into systems of care, sharing information, and using reminders to prompt guideline-based care.
Multi-disciplinary, practice-based teams are at the core of the model, which sees the health system as a component part of a wider community care approach. Monitoring and evaluation of outcomes also play an important role. An example is the Co-ordination of Services for the Elderly (COSE) project in Christchurch in which a key worker is assigned to several general practices but works independently, identifying resources and opportunities for each person in need of care. The key worker conducts a comprehensive assessment and liaises with GPs, practice nurses, community services and informal networks to recognise and respond rapidly to changes in patients’ circumstances (Parsons, 2006).

**NORTHERN IRELAND**

Health and social services in Northern Ireland are delivered to its population of around 1.8 million through a two-tier structure. A single health and social services board commissions services, mainly from the five territorial trusts. The trusts manage and administer hospitals, health centres, residential homes, and day centres, and provide health and social care services to the community. A sixth trust is responsible for the Ambulance Service (Northern Ireland Statistics and Research Agency (NISRA) 2011, and Department of Health, Social Services and Public Safety, 2011).

For each area of the province, then, a single organisation is responsible for the delivery of both health and social care. A number of benefits are suggested in the literature (Heenan and Birrell (2006) and Challis et al (2006)). For example:

- The ‘one-stop shop’ approach means people have access to services through a single contact.
- People can move easily through levels of care.
- Community care to support hospital discharge is improved.
- Multi-professional working leads to a more needs-led, ‘person-centred’ service.

However, there is little objective evidence of these benefits. Indeed, Heenan and Birrell cite the independent review of health and social care services, published in 2005 by Professor John Appleby, which concluded the success of integrated care varied across trusts and there was little collaboration between them.

The advantage of the structurally integrated system in Northern Ireland seems to be that a single employer with one source of funding, a single set of goals and one organisational vision is likely to avoid many of the problems of fragmentation described elsewhere (Heenan and Birrell, 2006).

**NORWAY**

Health care in Norway is organised in a three-tier structure. Overall responsibility for health policy, legislation, public health and performance management of the health care system lies with central government. Hospital services are the responsibility of five regional health authorities, while primary care, health promotion, care of the elderly and services for the physically or mentally disabled are the responsibility of the 434 municipalities. The system is primary funded through taxation (national and local), including a national insurance scheme. The service is a universal one, aiming for equality of access and providing care regardless of location or ability to pay (Johnsen, 2006).
**Helsehus**

A heslehus (health-house) is a form of intermediate care providing medical care, assessment and rehabilitation in a nursing home setting. Patients may be discharged from hospital to the health house before returning home. In a collection of examples of best practice, the OECD describes the Søbstad Helsehus in Trondheim as offering “better and cheaper services”. Patients spend on average 18 days in the health house (Hanssen, 2008) which employs more medical staff than usual for a nursing home resulting in better outcomes for patients compared to others receiving more conventional care; re-admission rates were almost halved and mortality rates after one year fell from 31 per cent to eight per cent (OECD, 2010).

After six months at the Søbstad unit, 25 per cent of patients were able to live independent lives, compared with only 10 percent of those treated in hospital. In addition, the cost of care at Søbstad was significantly lower. “This and similar findings suggest the potential efficiency gains that could stem from better care co-ordination, for example at the interface between hospital and community health-services,” notes the OECD.

**The Co-ordination reform**

The 2010 White Paper ‘The Co-ordination Reform’ outlines proposals to “provide proper treatment, at the right place and right time”. The reform will address three main challenges in the Norwegian health system: patients’ need for better co-ordination of health services; the inadequacy of disease-prevention initiatives; and the need to respond to demographic changes.

The Co-ordination Reform proposes a system of binding legal agreements between the centrally-run, specialist hospital services and municipal-run, primary health and social services (Norwegian Ministry of Health and Care Services, 2009). The reform aims to reduce and prevent illness and limit loss of function. It is expected to concentrate resources on municipalities and improve inter-professional collaboration between health and social care agencies (Hanssen, 2008).

Other aims are:

- A single point of contact in the municipalities for patients
- Increasing the role of municipalities in prevention and early intervention without jeopardising care services for long term conditions
- The transfer of care delivery from hospitals to municipalities
- Systematic involvement for service users
- Greater investment in services in the municipalities for priority groups
- Increasing the amount of time GPs give to the public health service
- Improvements to IT infrastructure to support ‘electronic co-ordination’.

The reform also proposes to alter the funding system to give incentives to municipalities to change how care is delivered. This would mean municipalities sharing responsibility with regional health authorities for funding specialist hospital care and paying for the care of
patients ready for discharge even if they remain in hospital (Norwegian Ministry of Health and Care Services, 2009).

The reforms are due to be implemented from 2012 onwards and a number of issues remain to be resolved:

- How should funds flow between regional health authorities and municipalities?
- What are the risks of the proposed co-funding arrangements particularly to smaller municipalities?
- What share of the total funding should each partner assume?

**Sweden**

The integration of health and social care has been a priority for Sweden since the early 1990s. The health system is highly decentralised and organised at three levels: state, county and municipality. Primary and secondary care is funded and delivered at county level. Municipalities are responsible for nursing and residential homes as well as home care and other social services. Funding is through taxation (Adamiak and Karlberg, 2003).

During the 1990s, the municipalities assumed responsibility for care of the elderly, and services were ‘de-medicalised’. The number of beds in county council hospitals reduced significantly after 1992 and few geriatric care beds remain. The social care services provided by the municipalities now look after people with more complex needs and recruiting suitably skilled nursing and social care staff is a challenge (Glenngård *et al.*, 2005).

**Local Care**

Introduced by the majority of Swedish county councils, Local Care is defined as a family and community orientated primary care system supported by an “adaptable hospital service”. County councils and municipalities deliver the service jointly.

Local Care is mainly concerned with long-term conditions, family and child health and care of the elderly. The aim is to respond to the needs of local populations, which means that Local Care services vary between locations. Organisational integration is uncommon and collaborative networks are the norm. This might be seen as an extension to the Chains of Care model described below which seeks to use networks to integrate different levels of health care (Åhgren, 2007).

**Chains of Care**

Chains of care are condition-specific, care pathways, similar to managed clinical networks (MCNs) that include all clinical work even if it is delivered by different providers. Chains of care involve co-ordinating multi-disciplinary care based on clinical guidelines. Chains of care may have a manager responsible for organising activities, resources and finance. The two largest Swedish county councils have each developed more than 50 chains of care (Åhgren, 2003).

**Norrtälje**

A structurally and financially integrated health and social care organisation established in 2006, the Norrtälje model is the first of its kind in Sweden. Planning, financing and organisation is based on three groups: birth to 18 years, 19 – 64 years and over 65s. The
model involved new contracts for employees, new financial and reporting systems, shared patient information and electronic medical record systems, co-ordinated patient pathways for stroke, a re-organisation of care of the elderly, and home care services.

Before the formation of the new organisation, Stockholm county council funded and delivered primary and secondary care services in the Norrtäle area. All staff, including physicians, were employees of the county council with the exception of two independent GPs. At the same time, the Norrtäle municipality funded and provided long-term care for the elderly, care for the physically disabled and those with long-term mental illness. The municipality’s services included nursing home care, school health, childcare, environmental health and other social services (Øvretveit, Hansson and Brommels, 2010).

The key driver of the reform was the threat of closure at Norrtäle’s hospital. The process began with extensive consultation with local people and 15 different trade unions. Guarantees were given about the protection of pay and conditions so that no employee would lose because of the changes (Øvretveit, Hansson and Brommels, 2010). The result was a municipal company, TioHundra, jointly owned by the Norrtäle Municipality and Stockholm County Council, to deliver health and social care services, along with a joint political governance board to commission services for the people of Norrtäle. Both are public organisations (CEMR, 2006).

The governance board comprises 12 elected members, six from the municipality and six from Stockholm County Council and includes employee representation (CEEP, 2007). As ‘owner’ of the TioHundra municipal company, the board can appoint or dismiss the TioHundra chief executive. A third organisation was created to deal with collecting payments from the various funding sources, paying providers and carrying out the political board’s policies. The three organisations together are known as the “Norrtäle Integrated Organisation” or Norrtäle model.

During the initial stages of the reform, clinical staff had little involvement but a programme of clinical improvement did begin later and in 2009 further structural and organisation changes were made to improve the co-ordination of care (Øvretveit, Hansson and Brommels, 2010).

Among the changes are:

- From 2009, management, financing and information for all TioHundra services are organised according to care groups rather than functionals or professions. The care groups are: 0–17; 18–65; over 65, with further divisions into sub-care groups for each.
- Individual care planning, focusing on preventive care
- Co-ordinated patient pathway for stroke patients for their entire care episode.

After two years both management and trade unions argue that care services have improved considerably in efficiency. Inpatient psychiatric care has declined. Fewer people are admitted to hospital. Costs have not increased. A report from the Council of European Municipalities and Regions (CEMR, 2006) concludes: “Although more time will be needed to see how efficiency and quality will develop over a longer period of time, all indications so far
are positive. Not all issues have been resolved and management and trade unions are working to resolve problems around working time and shift patterns”.

Esther project
This was a multi-disciplinary project set up by Jönköping County Council involving GPs, nurses, social workers and secondary care clinicians in improving patient flow through the care system by co-ordinating the different elements of care and enhancing communication between care providers. The project sought to align capacity with demand and to strengthen co-ordination and communication among providers. Examples of changes made included a redesigned intake and transfer process across the continuum of care, team-based telephone consultation, integrated documentation and communication processes and an explicit strategy to educate patients in self-management skills (Baker et al, 2008). Reported outcomes were fewer hospital admissions, reduced lengths of stay and shorter waiting lists (Weatherly et al, 2010).

The project was named “Esther” after a symbolic 88 year-old woman living alone with multiple chronic care needs and followed a chronic disease management model. Hospital staff, municipality staff, and primary care staff considered Esther’s needs and wants over time, rather than as discrete episodes, in order to identify improvements (Institute for Healthcare Improvement, 2010). Torbay took a similar approach when ‘Mrs Smith’ helped shape the vision for the new care trust.

**GENERAL MODELS OF INTEGRATION**

Care/case management

Care and case management or disease management are general models of integration developed in the US. Care management applies to the integration of health services while case management includes social care and can extend to employment and educational needs. Case management is used in the US, Australia, Canada and Finland among other countries. England introduced case management as The Care Programme Approach (CPA) in 1991 as a way to improve the co-ordination of care for people with severe mental illness. Although some studies have found benefits including improved quality of life, reduced readmission to hospital, visits to casualty departments and lower costs, others have not and CPA has not been widely adopted in England (Simpson, Miller and Bowers, 2003).

Attempts to evaluate case management models are complicated by lack of clarity about definitions and the presence of a number of overlapping models. Reported outcomes differ between studies depending on the case management model and study methodology. Despite these difficulties, some common aspects of effective case management emerge (Simpson, Miller & Bowers, 2003):

- Good relationships between patients and care teams, especially case managers
- Effective leadership of the care team
- Training for case managers and regular supervision
- A range of interventions with flexibility to adapt according to changing needs
- Most contact taking place at home or in the community
- 24 hour or extended access to care team members.
A review of care co-ordination by Hofmarcher, Oxley and Rusticelli for the OECD (2007) examined experience with case management in a number of countries including New Zealand, The Netherlands, Sweden and Denmark (Norway employs a similar disease management approach). It concluded that while countries are experimenting extensively with better ways of co-ordinating care, there has been little detailed evaluation of the programmes. A number of benefits, in terms of patient outcomes, are assumed. For example, disease or case management should support the implementation of clinical guidelines, reduce re-admission rates, lead to better patient education, and improve monitoring and co-ordination across providers. But the evidence is weak.

The transition from one sector or level of care to another should also be easier with case management. Most of the limited evidence on this approach comes from the US where the focus is on process improvements and cost-efficiency rather than patient outcomes.

Overall, the OECD review concluded there is some evidence that case management improves the quality of care but no firm data to demonstrate cost benefits (Hofmarcher, Oxley, and Rusticelli, 2007).

**Chronic care model/disease management**

Adapted from models developed in the US (including Kaiser Permanente), the chronic care and disease management models hinge on multi-disciplinary team work. They include supported self-care for people whose conditions are stable, anticipatory care and case management for those with complex needs. New Zealand has adopted the chronic care model in its national long-term conditions strategy (Holloway et al, 2007, Gibbs and Taylor, 2008).
Measurement and evaluation

Evaluations of integrated care concentrate on its impact on process or inputs, for example admissions to hospitals, outpatient visits, rather than on outcomes for patients and service users. At least part of the reason for this is the lack of a precise definition of integrated care. Most definitions are similar, involving multi-disciplinary teams, continuity of care and cost-effectiveness, but a key difference is whether integrated care means integration within the health service or integration between the health service and other agencies, notably social care.

This level of complexity makes comparison between integration projects difficult. The literature on measuring integrated care is also diverse, revealing a large array of concepts and methods (Strandberg-Larsen and Krasnik, 2009).

Evaluation can concentrate on the process of integration itself or the result of integration on service delivery. Armitage et al (2009) found a limited number of measurement tools to assess the integration process and little research on the outcome of integration. Of the tools they identified, the most commonly used was the balanced scorecard, an organisational performance management tool developed by Kaplan and Norton. The balanced scorecard is a technique for assessing a project, business or system in a holistic way to determine what improvements need to be made to achieve the agreed aims or vision for the organisation.

Many authors comment on the lack of concrete evidence of the impact of integrated care on outcomes for patients. As Armitage et al (2009) note, most studies focus on perceived or assumed benefits rather than confirmed outcomes. Studies that do report real benefits, yield conflicting results. The European PROCARE study, for example (Billings and Leichsenring, 2005), reported both positive and negative results. Among the results achieved were:

- Reduced cost per patient visit
- Improved financial performance
- Reduced admissions
- Reduced length of hospital stay
- Development of shared cultures
- Flatter management structures
- Increasing workload
- Difficulties retaining staff
- Increased inter-agency cooperation
- Fewer A&E visits
- Greater dependency on community services.

In conclusion, Armitage et al express concern about the paucity of evidence of the impact of integrated care given the high expectations that most countries have placed on it. Maslin-Prothero and Bennion (2010) found in their literature review some evidence of improvements in clinical outcome but this was limited to one measure in one care group.
They do note, however, other benefits for both service users and staff are highlighted in the literature. These include:

- Increased job satisfaction
- More team working
- Shared cultures
- Improved communication
- More responsive services
- Shorter waits between referral and assessment
- Better relationships between service users and home care workers.
Barriers and success factors

Much is already known about the factors determining effective integrated care and collaborative working but there remains a gulf between theoretical understanding and practical delivery. Several factors are important to successful integration (Stuart and Weinrich, 2001, Simpson, Miller and Bowers, 2003) including:

- Shared values
- Co-ordination of services
- Collaboration between disciplines
- Consistent rules and policies at organisational level.

Barriers include concerns about professional status. The medical model of care may dominate in integrated organisations and some medical staff may be reluctant to work in a multi-agency setting. Other barriers centre on organisational boundaries, for example communication/IT systems, funding arrangements and employment issues such as training and career progression (Coxon, 2005, Heenan and Birrell, 2006).

However, robust and consistent information about the precise reasons for the success or failure of individual integrated care projects is often hard to identify. Generalisations are difficult as examples of integrated care may not be directly comparable. In addition, many descriptions of integrated care programmes or pilots do not specify which care services are integrated, nor do they necessarily discuss why they achieved the results they did.

Van Raak et al (2003) note the complexity of integration which involves interorganisational and inter-professional relationships across sectors, across service areas (health, social care, housing, transport, education), across levels of government and across different models of governance. Other factors are also involved: legislation, funding streams, organisational arrangements, competition, power struggles and differences in the goals and interests of service providers. Overall, these authors conclude: “Not surprisingly, the evidence suggests that in many cases integration is disjointed and limited.” (Van Raak et al, 2003).

Nevertheless, based on the evidence available a number of factors help or hinder integrated working.

Common themes

Vision and culture

Common goals and a shared vision seem to be crucial to the success of integrated care, whatever the model. One reason for the perceived failure of the Care Programme Approach to mental illness in England is that the lack of a shared vision undermines interdisciplinary working (Simpson, Miller and Bowers, 2003).

Differences in organisational culture between health and social services are well documented. In Northern Ireland, for example, health and social care trusts have established professional forums to deal with problems arising from cultural differences. Forums focus on issues of professional development, training and governance. They also provide peer support and information on good practice and research. In one study, staff
described these as ‘essential’, ‘fundamental’ and ‘prerequisites’ to the success of integrated working (Heenan and Birrell, 2006).

Elsewhere, a literature review by Cameron and Lart (2003) highlighted the importance to successful joint working of clear, realistic and achievable aims and objectives, understood and accepted by all partners. Differences in organisational processes, priorities or planning cycles are also a factor and can create a climate for conflict rather than co-operation.

**Pooled resources/unified structures**
Experience from Northern Ireland suggests a single source of funding, used to deliver integrated care according to a care programme approach, is a significant success factor. In separate organisations, funding earmarked for either health or social care cannot easily be redirected from one service to the other as managers cannot commit resources from budgets they do not control (Heenan and Birrell, 2006). Elsewhere, Leutz (2005) notes that overcoming financial differences is the biggest challenge.

However, where a single budget exists, the dominance of the medical model of care (and the medical profession) is a potential barrier. Heenan and Birrell (2006) observe that money can sometimes be diverted from community-based services in Northern Ireland to support hospital services as acute care takes priority. New Zealand has encountered a similar problems (Ham et al, 2008).

Sweden also has a model of structural integration in Norrtälje in which a single organisation administers a combined health and social care budget to purchase services from a second, integrated provider of health and social care services (Øvretveit, Hansson and Brommels, 2010). The result has been a flatter management structure, and greater integration of primary, secondary and tertiary care with social care (CEEP, 2007).

More generally, Sweden’s experience of pooled budgets succeeded in improving interdisciplinary working although negative attitudes towards other professions took some time to decrease (Hultberg et al, 2005). Pooling budgets reveals areas of duplication which means changing roles, skill mix and ways of working. In their review of experience in England and Sweden, Hultberg et al identify a number of potential solutions:

- Second staff from one organisation to the other.
- Bring staff together under a single management structure but retain separate employers.
- Transfer all staff to a single employer.

The challenges of integrating different professional groups fall broadly into two categories: ‘soft’ issues such as culture, training and attitudes, and ‘hard’ issues like employment terms and conditions. Hultberg et al (2005) report that soft issues could be dealt with through joint training sessions and other approaches to building commitment to the new partnership. In contrast, the harder human resource issues could be very difficult to resolve; for example, negotiations with central government to transfer staff between local government and NHS employment without losing pension entitlements.
Norway’s Co-ordination Reform in 2009 recognises the challenges arising from different sources of funding and from the flow of funds between municipalities, where primary and social care are delivered, and regional health authority hospitals. The Norwegian Government (Norwegian Ministry of Health and Care Services, 2009) is now wrestling with several issues including:

- How much funding should be shared?
- What are the risks of pooling budgets?
- How these risks can be reduced?

An OECD review of the case management approach to integrating care concluded that pooling resources and/or colocating services were important (Hofmarcher, 2007). However, evidence from Northern Ireland suggests integrated structures are more focused on integrating management systems than the delivery of care to patients. In a comparison of integration in old age psychiatry services in England and Northern Ireland, Reilly et al (2003) found that while management arrangements were integrated, there was less evidence of integration in assessment, referral and medical screening. They noted also that even where management structures were integrated, problems arose if budgets remained separate. The authors conclude that integrated structures and are not enough in themselves to secure integrated service delivery.

**Inter-professional collaboration/status**

A recurring theme is the importance of inter-professional collaboration and professional status. A feature of Northern Ireland’s approach is to draw care programme leaders from any of the disciplines involved. The aim is to make sure all professions have equal influence and respect, and the approach seems to be effective for some disciplines, for example, social workers and nurses (Heenan and Birrell, 2006).

However, the position of medical staff is less clear. There is a suggestion from the Care Programme Approach in England that lack of commitment by medical staff was a key barrier to its success (Simpson, Miller and Bowers, 2003). A number of studies in Cameron and Lart’s literature review (2003) identified difficulties in collaborations with GPs. These were often thought to reflect GPs’ lack of understanding of others’ roles, notably social work. The same review found that social workers based in primary care lacked credibility with colleagues working from traditional settings.

Elsewhere good inter-professional collaboration is associated with success as measured by lower hospital admission rates, fewer GP visits and improved patient function in studies of people with long-term conditions (Reed et al, 2005).

However, the PROCARE project (a pan-European study of integration in nine countries including Finland, Denmark and the UK) concluded that getting doctors involved was the main barrier. Where good integration was achieved, it was a major contributor to success but was equally likely to reduce the involvement of non-medical staff. The PROCARE study also concluded more generally that the perceived lower status of social care staff compared to healthcare staff created significant difficulties in developing integrated systems (Coxon, 2005).
Coxon, Clausen and Argoud (2005) note that professional barriers are one of the five recognised barriers to integrated working identified by Wistow and Hardy (1991). They cite several studies which conclude that professional cultures create barriers to integration as a result of differences in training, values and ideas of good practice. Sharing office space and client groups makes integrated working easier while barriers between teams, and factors in the external environment that hinder the development of good relationships, make integrated working more difficult.

The impact of greater integration on professional boundaries is a well-recognised concern with some taking the view that integration will fail if it threatens professional status and identity. (Heenan and Birrell, 2006). The TioHundra (Norrtalje) project also encountered barriers created by professional boundaries and fears over the loss of professional autonomy (Øvretveit, Hansson and Brommels, 2010), while the OECD review of case management found that outcomes from a care programme approach were better when clinical staff worked in multi-disciplinary teams with social care staff (Hofmarcher, Oxley and Rusticelli, 2007). In addition, a US study of multi-disciplinary teams involving doctors, nurses and social workers in the community concluded that this approach reduced admissions and maintained patients’ health (Sommers et al, 2000).

In a review of the literature on integrated working, Maslin-Prothero and Bennion (2010) indentify a number of barriers related to inter-professional collaboration including a lack of understanding and clarity about others’ roles. They also report that confusion about management roles and responsibilities can result in conflict while imbalances in power and poor communication were also obstacles. A number of studies in their review found the ambivalence of some medical staff to be a barrier to integration in cross-agency working.

Overall, factors that support inter-professional working and overcome status issues are:

- Co-location
- A single line management arrangement
- Shared training
- Stable employment conditions
- Good liaison
- Flexible working arrangements

Communication and IT

Having robust information systems for rapid communication between sectors/organisations and within teams is repeatedly cited as an important success criteria. Cameron and Lart’s 2003 literature review found that good communication “is the bedrock of successful interagency working”. Examples of how communication can be improved include: holding patient records electronically (Hofmarcher, Oxley and Rusticelli, 2007) and using ‘one-stop’ information gathering from shared assessments (Reed et al, 2005).

Communication between professionals and service users is clearly also important, although in most cases it is uncertain how successful projects overcame communication challenges. In one example from Sweden barriers to information sharing were removed simply by
asking people if information could be shared between participating staff or by involving service users in meetings with staff (Hultberg et al., 2005).

Good communication seems to contribute in a number of ways. Howarth, Holland and Grant (2006) cite its role in the management of collaborative working and in the ability of teams to work together successfully. Conversely, communication difficulties arise from complex or inappropriate documentation, poor record keeping, incompatible IT systems and differences in referral arrangements (Cameron and Lart, 2003).

The need to integrate IT systems between health and social care organisations is also a recurring theme. A pilot, IT-integration project in Finland created a regional IT network to support health and social care comprising a database, portal and protected email system. The purpose of the Makropilotti project was to integrate records from primary, secondary and tertiary care, social services and the Finnish national social insurance provider because the absence of accurate, updated information was a fundamental problem with integrating care. Service users were issued with credit card-sized ID cards which acted as a key allowing care professionals and social services staff to access or record data (Niskanen, 2002).

The sharing of information between sectors needed new legislation and the project suffered delays and technical problems. Nevertheless, the health and social care staff involved were clear that such an integrated IT system was vital. An early evaluation of the project suggested that it was encouraging collaboration across municipal boundaries and had led to the development of IT-based service-chain models (Sinkkonen and Jaatinen, 2003).

However, the project encountered some common barriers. Sinkkonen and Jaatinen comment that lack of support for the pilot was evident, particularly on the part of management, and differences in professional, organisational and working cultures between health and social services were a factor. They also note that an external evaluation of the pilot concluded Makropilotti relied too heavily on gathering, storing and using data without sufficient emphasis on organisational change, including structural change if necessary.

Patient-focus

The literature confirms the importance of patient focus (Armitage et al., 2009) and suggests it contributes in two distinct ways. Firstly, evidence from the care programme approach indicates that focusing on patients at highest risk leads to better outcomes (Hofmarcher, Oxley and Rusticelli, 2007). Secondly, for staff working in an integrated structure, focusing on improving patient care helps to overcome professional boundaries (Heenan and Birrell, 2006).

Focusing on patient pathways to map journeys of care could be one way of increasing the focus on patient care and Fulop, Mowlen and Edwards (2006) suggest this sort of approach is more likely to succeed than the transfer of functions between organisations. However, integrating care round specific, single conditions could have drawbacks for people with co-morbidities and ultimately reinforce barriers at the interface between condition-specific services. In a review of the evidence on integration for the NHS Confederation, Fulop, Mowlen and Edwards (2006) conclude that integrating round pathways of care is an attractive option but urge caution with models of disease management that ‘carve out’ a
particular condition such as diabetes because of a risk of fragmenting care and losing the benefits that come from co-ordination.

In Finland, Kokko (2009) reports a common perception that small, rural primary care health centres performed better than larger, urban centres and suggests this is because staff in rural centres know their patients better and that co-ordination and continuity are more likely to be part of their daily practice.

**Employment issues and training**

The Norrtälje project in Sweden has reported some problems with employment issues including working time and shift patterns. Details are sketchy and these remain to be solved (CEMR, 2006).

An advantage claimed for Northern Ireland’s integrated system is that all health and social care staff have the same employer so reducing variation in management practice or terms and conditions. However, training is cited as a potential barrier. While service planning and delivery is integrated, core professional training remains separate. Some consider this the key barrier because training reinforces issues of professional status and identity (Heenan and Birrell, 2006).

In their literature review of educational needs for integrated care, Howarth, Holland and Grant (2006), highlight the challenge staff face in adapting to a plethora of new roles as they begin to deliver an integrated service. Uncertainty about their own role in an integrated team and a low awareness of what other roles involve are both barriers to effective team working. The potential for ‘role blurring’ is a widespread problem regularly raised in the literature.

Howarth, Holland and Grant go on to suggest that professional education plays an important part in influencing team success and report calls by some writers for a move to inter-professional education to replace single-discipline learning.

Staff training to increase knowledge of the condition and support relationship development with patients and carers supports integration (Hofmarcher, Oxley and Rusticelli, 2007). Finland has introduced a new, multi-professional training scheme for nurses. Nurses completing the training scheme are equipped to perform some medical procedures, social care and home-help tasks as well as work in their own area of expertise (Niskanen). Closer to home, a review of integrated working in Scotland found evidence that joint training was considered central to building a shared culture (Stewart, Petch and Curtice, 2003). Cross-agency secondments also helped to prepare people from different agencies and professional backgrounds for integrated working and to appreciate other people’s roles and perspectives.

Contractual issues play a role and there is some evidence that item-of-service GP contracts may hinder integration (Hofmarcher, Oxley and Rusticelli, 2007). For some staff, issues of short-term contracts, pension arrangements, pay protection and uncertainty about career structure are a concern. Coxon (2005) reports that professionally qualified staff in integrated services risked finding themselves in flat organisations where the only opportunities for promotion would mean leaving the team or project. She concludes: “The
relatively small size of integrated organisations contributes to improved multi-professional working but at the same time limits the careers of those who work in them.”

**Legislation and policy**

Much of the commentary on integrated care highlights the importance of a legislative and policy framework that consistently supports and encourages integration. A key barrier is time. Successful integration takes time and a short-term approach to policy making is likely to lessen the chances of successful integration (Reed et al, 2005).

In Denmark, legislation was passed in 1988 preventing further building of nursing homes and requiring the conversion of the remaining nursing homes to single-occupancy rooms. As a result, the number of elderly people in institutional care fell. The Danish authorities also took care to avoid perverse financial incentives that would otherwise promote institutional care and these acted as a further incentive to develop community-based care services (Stuart and Weinrich, (2010). Other legislation requires hospitals and local authorities to have contracts covering discharge arrangements (including fines for local authorities if discharge is delayed because home/community services are not in place) and to conduct two home assessment visits a year to elderly patients regardless of their health status (Leichsenring, 2004).

The Finnish experience with primary health care centres also highlights the importance of consistent legislation and policy-making. Following legislation to allow more local control of health centres some services, such as long-term care, substance abuse and rehabilitation, were reduced as they were ‘less popular’ with local decision-makers (Kokko, 2009).

In models with a mix of public, private and voluntary sector providers where the aim is to increase choice for service users, competing policy agendas are common. In these situations, co-ordination becomes even more complex and equitable access may be difficult (Lloyd and Wait, 2006).

**SUMMARY OF FACTORS**

Removing organisational barriers is a key factor but it cannot achieve integrated working in the absence of meaningful professional collaboration between and within disciplines.

**Enablers**

- Supportive legislative/policy environment
- Combined health and social care organisations
- Pooled resources
- Co-location
- Single employer for health and social care staff
- Up-to-date, accessible patient information
- Robust IT which allow different sectors/organisations to communicate easily
- Meaningful inter-professional collaboration

**Barriers**

- Inconsistent or rapidly changing policies/legislation
- Organisational cultures
- Inter-professional rivalries
- Medical dominance
- Item-of-service GP contracts
- Separate IT systems that do not ‘speak’ to each other
- Diverse management arrangements
- Separate budgets
- Segregated training
Implications for Scotland

Scotland shares many of the goals of the integrated health and social care models detailed in the literature and the challenges of implementing integrated care are broadly similar in different countries and projects. However, direct comparisons are difficult. There are several reasons for this. Chief among them is the diversity of integration models, policy drivers and environments to which many commentators refer. Descriptions of integrated care generally do not relate them to a theoretical model which makes it hard to draw conclusions about their applicability in other settings. The language of integration is rather unclear so that it is not always apparent precisely what any given model involves. Evaluation tends to focus on processes rather than outcomes from the patients’ perspective.

However, the literature highlights a number of general themes which should influence thinking about applying models from elsewhere in Scotland.

Among these is the impact of the global recession. This could tip health and care systems towards greater integration or it could have the opposite effect. Greater integration may flow from local services concluding that working together more effectively is the only way to make the best use of scarce resources. In contrast, reduced budgets may cause organisations and professional interests to retreat from integration in order to protect their share of scare funding (Glasby, 2010).

General issues

Policy and practice

A key theme is the importance of a consistent legislative and policy framework to support and encourage integration. Integration has been part of the policy debate in Scotland for more than 10 years. During this time, Scottish policy has encouraged, or required, local authorities and the NHS to share information and resources and work together in partnerships, although the forms of joint working adopted are many and varied (Cook et al, 2007).

This consistency in the policy landscape should be an enabler of new forms of integration based on learning from elsewhere. However, experience from projects in Europe and the UK suggests there is a gap between the policy rhetoric and practical implementation (Jarrett et al, 2009) which is compounded by the lack of clarity about what integration actually means, overly bureaucratic governance arrangements, limited resources, inadequate leadership, professional and institutional barriers and protracted decision-making processes (Williams and Sullivan, 2010).

This means that while integration is consistently promoted from the top, health and social care organisations are rather left to their own devices to know how to put it into practice. In Williams and Sullivan’s exploration of collaborative working, they describe a perception that collaborative working is an additional responsibility, demanding time and resources that could otherwise be devoted to core activities. This, together with the threat of restructuring, is unsettling and distracting for staff.
Motivation

A clear message from the literature on integration in the UK and elsewhere is that it takes time and is not a cheap option. Indeed, integration may cost money rather than save it in the short term and can also be costly in terms of staff time and energy. Weatherly et al (2010) report that the cost of integration can be substantial with high set-up costs needing significant initial investment. Organisations must support continuing costs and link to cost-saving programmes elsewhere in the organisation if integration is to be sustainable.

Time is also an important factor. New services take time to become more stable systems of care and cost-savings might only be evident in the longer term, although robust evidence on improved outcomes even in the longer term is lacking (Weatherly et al, 2010).

For these reasons, the best motivation for embarking on an integration project is to improve outcomes for patients rather than as a way to relieve pressure on the acute sector or to contain costs. Some commentators have expressed concern that the pursuit of integrated care is being driven by the search for cost efficiencies and reduced pressure on acute services rather than better patient care (Cook et al, 2007). In the current climate, this could be an important issue for Scotland. Budget pressures and reduced staff numbers raise the possibility that integration will be seen as a way to cope with these. Any subsequent improvements in patient care will be a beneficial consequence rather than the primary motivation.

Staff motivation is also important. If individual nurses, doctors, and social workers think the purpose of integration is to save money or to re-organise care to cover for redundant colleagues, they are far less likely to support the new approach. It is evident that a key success factor is the willingness of staff groups to work together in the interests of patient care. Therefore, in the absence of this motivation, concerns about professional status and identity are likely to hinder progress.

The evidence

The benefits of integrated care are usually assumed but the evidence is weak in terms of outcomes for service users. Stewart and her colleagues (Stewart et al, 2003) report earlier work which highlights the potential tension between measurable short-term benefits and evidence of longer-term gains. Most evaluation has concentrated on short-term process measures such as reduced admissions to hospital or increases in the use of community services rather than changes in individuals’ health status (Weatherly et al, 2010).

There is also some evidence that efforts to integrate health and social care services can be detrimental. Some researchers have found that cultural differences deepen, inter-professional gaps widen and staff become pre-occupied by changes within their own organisations to the exclusion of external links (Hiscock and Pearson (1999), cited in Stewart et al, 2003).

Caution is therefore needed along with a willingness to evaluate the longer-term impact of integration. This could mean investing scarce resources in a new model of care without expecting to reap the benefits in the short-term; a difficult proposition in the current financial climate.
Resourcing
Funding, and staffing, new models of care is a key consideration. While integration might remove duplication and reduce waste, it is clear from the literature that it is not a low cost option. Introducing new models might result in a period of ‘double-running’ so increasing costs rather than reducing them.

Applying other models in Scotland
Models of integration fall into three broad categories:

- Full structural integration
- Integrated networks
- Multi-disciplinary teams.

Structural integration
Models of structural integration from Northern Ireland and Sweden (Norrtalje) are typically ‘top-down’ with the focus on integrated budgets, governance and management arrangements. They are characterised by fully integrated financing, planning and service delivery.

In Scotland, this approach is familiar to some degree through the creation of joint future bodies and community health and care partnerships (CHCPs) though these do not represent full structural integration as the NHS boards and local authorities involved remain autonomous bodies.

The literature on integrated care suggests that full structural integration is unusual and is neither sufficient nor necessary for effective partnership between health and social care. Some authors argue the merit of using networks as the basis for integration rather than new organisational structures on the grounds that partnerships are nimbler and can respond better to changes in their local environments or the policy landscape (Weatherly et al., 2010).

The most pressing issue for the successful implementation of an integrated structure is how to realise the intended aims at the practical, service delivery level. Joining existing organisations or creating a new organisation from parts of others carries several risks:

- Adding layers of governance creates more bureaucracy, for example by expecting a new integrated body to be accountable to both health and social care organisations in its area.
- The starting point in the integration journey for some organisations can be self-interest as they seek to protect their own power, autonomy and budgets (Williams and Sullivan, 2010). For example, one partner may see it as an opportunity to ease pressure on its budgets by shifting responsibility for some service delivery to another. In addition, the nature and purpose of integration may be understood differently by the people involved.
- Re-organisations take time and energy, can be unsettling for staff and service users and may damage existing relationships.
Different professional interests may try to safeguard their own autonomy or responsibilities by resisting such change.

**Integrated networks**
These are looser integration models involving pooling or transfer of resources. They may also involve some formalisation of management and governance along with a manager or co-ordinator appointed jointly by the partners in the network. However, the focus of integration is on service delivery. Examples are chains of care in Sweden, leading groups in Finland and managed care networks in Scotland.

The success of networks depends on building up trust between the partners and individual professionals working together. At operational level, trust develops as professionals become accustomed to working together in day-to-day practice. To be successful, the partners in the network must share the same understanding of the network’s goals.

**Multi-disciplinary team models**
Many integrated care models centre on multi-disciplinary teams, particularly in mental health. This approach was the starting point for managed clinical networks in Scotland. Examples from elsewhere include the Esther project in Sweden, the chronic care and disease management models in New Zealand, the home/community models in Denmark, and primary health centres and teamwork in Finland.

This approach also includes co-location ‘placement schemes’ where a social worker, for example, is located in a GP practice or a hospital ante-natal clinic (Cameron and Lart, 2003). Here, argue the researchers, the importance of clearly identified roles and responsibilities is paramount. Such clarity helps to identify, and eliminate, overlaps or gaps and ensures staff know precisely what is expected of them.

**Hybrid models**
Some integrated care models have elements of more than one type. Torbay Care Trust in England, and the newly proposed arrangements in Highland fall into this category. Torbay Care Trust was formed when Torbay Primary Care Trust took over responsibility for adult social services in the area. All other social services, however, remain the responsibility of the local council. The proposal for Highland is similar with the NHS board taking the lead on adult social care while the council takes the lead on children’s services.

For the services that are combined in the care trust or NHS board, the integration is presumed to be full and structural. But because other care services remain the responsibility of another organisation, there will still be boundaries which may need to be negotiated. A possible danger in the Highland proposal is that one set of boundaries will simply replaced by another. Petch (2007) warns of the unintended consequences of integration. Multi-disciplinary teams and partnerships are “at the heart of much current organisational regrouping”, she notes, but at the same time previous links are being lost so that communication outside the team or network is weaker. She goes on to cite the example of local authorities where adult and children’s services may be separated (as in the Highland proposal) so introducing a new boundary to be negotiated where previously some communication, or at least awareness, existed.
IMPLICATIONS FOR SCOTLAND

Decisions about which are the most appropriate models for Scotland will depend on local circumstances and it will be important to balance flexibility with consistency in what is proposed and implemented under the National Care Service. However, a number of factors are particularly relevant.

- A shared history of joint working increases the likelihood of success (Cameron and Lart, 2003) so any model of integrated care is more likely to succeed in locations with a good track record eg Highland and Borders, and least likely to succeed in areas where there are/have been tensions between the NHS and local authority eg Glasgow.

- The dominance of the medical model of care; the influence of doctors on the success of integrated care emerges strongly from the literature. Doctors were crucial in establishing the first managed clinical networks but their continued support for models of integration that may give greater prominence to other disciplines eg nursing and social work, is less certain. The profession in Scotland has a strong voice and significant influence and will lobby hard to protect its interests in the new NCS.

- Re-organisation; local authorities are already moving to share services as a way of cutting costs, special NHS boards are likely to be reduced in number with additional responsibilities going to territorial boards. In addition, the general view among senior NHS managers is that the overall number of NHS boards should be reduced by around half or more (IHM Scotland 2010 conference, personal communication). This backdrop and the prospect of formal re-organisations following the Scottish Parliamentary election in May 2011, mean the climate for introducing new models of integrated care will be less favourable than one of greater organisational stability. The literature points to evidence that re-organisations and instability in both local authorities and the NHS reduce management support for projects and undermine trust between organisations (Cameron and Lart, 2003, and Ham, 2010).

- Financial climate; the current financial climate will place great pressure on boards from 2011 onwards and already staff numbers are reducing in some areas. Boards with major hospital building programmes eg Forth Valley and Glasgow will be under particular pressure. In such a climate, there must be a danger that integrated care will be seen as a way to reduce costs and take pressure off the acute sector rather than as a way to improve patient care. Introducing a new model of care is likely to need more staff not fewer and extra funding rather than less. The current climate in Scotland, therefore, could reduce the chances of new integrated models succeeding if they are introduced on a large scale.
**Conclusion**

The integrated care landscape is complex. There is an extensive body of literature on the topic but little consensus about what integrated care actually is or how it can best be delivered. One review estimated there are around 175 different definitions of integrated care and any assessment of the field is complicated by this lack of agreement.

Overall, the evidence for the effectiveness or otherwise of integrated approaches to delivering services is limited and tends to be subjective. A particularly significant factor is the weakness of the evidence for benefits to patients and service users in terms of health status. Many commentators note that integration is assumed to improve outcomes but most evaluations are concerned with costs, admission rates, lengths of hospital stay, waiting times and so on rather than reduced disease burden and improved function for patients. This is, at least in part, a result of the difficulties in measuring such outcomes when the focus of many integration projects is short-term.

A range of factors either help or hinder integration and joint working between health and social care staff, but the contribution of professional stereotypes and issues of status is significant. It seems clear that for any form of multi-disciplinary integration to be successful time and energy have to be devoted to helping the different professional groups understand each other’s roles, responsibilities and ways of working. Joint training and education can make an important contribution here as can having different professional groups work together from a shared location.

There is evidence both for and against structural models of integration, as there is for integration based on multi-disciplinary networks. A clear message from the literature is that a single solution is unlikely to be appropriate. Whatever model is adopted is likely to have barriers of some sort. Allowing integrating services some flexibility in the model they adopt should mean they can reflect their local circumstances, keep barriers to a minimum and retain an ability to respond to changes in the political or financial environment. However, there is a danger that such flexibility could introduce a degree of variation in service provision that might not be acceptable.

The detail of the proposed National Care Service remains unclear. What is apparent is that a clear description of precisely what it aims to achieve for service users is essential. These aims must be realistic and achievable. They must also recognise that integrating health and social care takes time and investment. Action to reduce professional stereotypes and remove barriers created by professional status concerns will be a major factor in the success of the National Care Service, whatever model it adopts.
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