Integrating Services for Older People:
A resource book for managers

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Edited by Henk Nies and Philip C Berman

EHMA
European Health Management Association

CARMEN is the acronym for the Care and Management of Services for Older People in Europe Network. This thematic network has been supported by the European Commission's 'Quality of Life and Management of Human Resources' programme, which is part of DG Research's fifth framework programme.

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Cover illustration: 'The ancient sick wards' by Jan Beerblock (c. 1778). The picture hangs in the Memling Museum, which used to be St John's Hospital – one of the oldest surviving Medieval hospitals in Europe. In Medieval times, the hospital was also a hotel and a pharmacy – an early example of integrated care. Reproduced with kind permission of Stedelijke Musea, Bruges.

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Foreword

HENK NIES AND PHILIP C BERMAN

This resource book addresses the issue of integrated care for older people with long-term, complex, multiple needs. The sustainable provision of appropriate care to older people is a challenge for the next decades that all EU member states are facing. There are three main reasons for this challenge: demographic changes, cost containment and empowerment.

- **Demographic changes** The unprecedented high proportion of older people in society, especially older people living as single-person households, will cause increasing demands for care and services. One the one hand, the number of older people in need of care will rise while, on the other, the supply of carers is at risk because of an ageing population. There is also an increasing need to use the potential and competencies of older people for an active and positive contribution to society.
- **Cost containment** The tendency towards rising public expenditures on health and social care, and the fact that the future of pensions is at stake, call for cost containment in public expenditure. Financial sustainability of the social protection systems is an issue of current debate among all national and European Union governments.
- **Empowerment** Older people and their carers are becoming increasingly empowered. They demand the care and services to which they are entitled, and they demand choice and care that is attuned to their needs. They also call for full accountability of services. The relationship between professionals and clients becomes increasingly subject to jurisdiction, and clients are claiming their legal rights. The era of compliant citizens is in its final stage.

Integrated care provides *one* answer to these challenges – not *the* answer. This type of care promises to tackle the problems of older people with long-term, complex and multiple needs. People in this group require a different approach to care delivery: a tailored package of care and services covering multiple domains of life, as well as an attitude of care providers that pays attention to their preferences and responsibilities. They are relatively often faced with complex problems in the physical, mental and social domain. Timely detection, appropriate assessment, treatment and care can – at least partly – avert or ameliorate the negative outcomes on health and well being.

Providing appropriate packages of care and services at the appropriate time and place contributes to people's well being in their old age, in spite of frailty and disabilities. Moreover, having autonomy and responsibility contributes to their quality of life. So integrated care deals with meeting the complex and multiple needs of older people, and with empowering them to live their own lives. It is important that we realise this, while at the same time recognising that not all older people are the same.

Care providers and professionals should not generalise and stereotype older people. For example, the majority of older people prefer to remain at home for as long as possible, and to have a large degree of self-direction. Others simply do not. In the interaction between the professional and the older person, these preferences have to be communicated. This interaction is the core of care, even if the partnership between the older person and the professional is somewhat unequal. Caring is a discipline of human relations, and the key to integrated care is to ensure that these relationships function at their optimum.

It is a challenge to care providers (managers and professionals alike) and policy makers to deliver such care. There are many obstacles in our current care and service delivery systems, as well as in our traditional management styles. This resource book provides insights and tools to assist managers in establishing well-integrated services where they are appropriate. It also contains practice examples, suggestions for further reading, and web links. It is a first step into establishing a body of knowledge on a Europe-wide level on integrated care for older people.

Definitions and terminology

Integrated care

By ‘integrated care’, we refer to a well-planned and well-organised set of services and care processes, targeted at the multi-dimensional needs/problems of an individual client, or a category of persons with similar needs/problems. This concept is developed further in this resource book. For now, it is sufficient to say that integrated care for older people should be built up by elements of acute health care, long-term (health) care, social care, housing, and services such as transport and meals. It should also address empowerment of older persons, to enable them to live their lives as independently as possible.

Older people

In this resource book, we use the terms ‘older people’ or ‘clients’ to refer to older people with complex, multiple needs. We do not intend to stereotype older persons as needy people, or people who always have a ‘clientist’ relationship with professionals or informal carers – we simply use these terms to enable readability.

Implementing the concept

Although the concept of integrated care is increasingly gaining attention, implementing it seems to be complex. Policy structures, legislation and funding are not suited to this type of care. Organisations are based on specific division of labour and tasks, and professionals are trained under a system that rewards specialisation and fragmentation. Nevertheless, older people, their carers and society expect services to provide the right care, at the right time, in the right place. So the challenge of integrated care has to be taken up, and this process has already started.

While working on the issue of integrated care over the past three years, we have learned that various strategies, mechanisms and tools exist, and are actually applied. Examples of supportive policy measures exist too. However, a systematic collection and description of instruments and measures has yet to be started.

The body of knowledge on integrated care is at its very beginning. Research and policy development within the field are addressed in the *International Journal of Integrated Care*, but this resource book is the first cross-national step towards providing a sound professional basis in the area of management of this type of care within the context of European care systems.

How was the resource book developed?

This book was developed by the Care and Management of Services for Older People in Europe Network (CARMEN). This is a thematic network that operates under the auspices of the European Health Management Association (EHMA). It is supported by the European Commission's 'Quality of Life and Management of Human Resources' programme. It is made up of 40 organisations from 11 European countries. These member organisations represent a wide range of stakeholders, including representatives of service users, carers, primary care providers, acute hospitals, care homes, social care providers, purchasers, researchers, consultants and some other members.

The first task of the CARMEN members was to explore the welfare systems and regional and local systems of care provision in European Union member states. They then studied the interfaces between primary care and secondary care (in other words, between home and hospital), between primary care and residential care (home and care homes) and between residential care and secondary care (care homes and hospitals).

Next, they analysed integration at three levels: client level, organisation or network level, and policy level. They based their analyses on literature reviews, a members' questionnaire, vignettes, structured analyses of good practice, input from external experts, and discussions among CARMEN members. One group worked on quality management and evaluation. The network also developed a website, as a means for internal and, at a later stage, external communication, and as a portal to relevant links.

This publication was developed as a result of this knowledge and experience. The topics were established and discussed in subgroups and plenary sessions, and members and managers (as non-members of CARMEN) critically reviewed drafts, both in meetings and by email or through the website. The network plans to develop and update the resource book on a regular basis. This will involve adding new chapters and examples, and organising meetings to refine the knowledge presented here. The network also welcomes any organisations interested in localising the resource book so that it applies to the situation in their country (*see* Geographical spread of content, p 15).

Who should use the book?

The resource book is primarily designed for managers of care-providing organisations, and for managers and officials responsible for commissioning long-term care for older people. The resource book addresses the main concepts, questions and considerations that a manager needs at strategic and tactical level. It provides an overview rather than a detailed account, because it aims to support managers in taking the right decisions while giving direction in developing and implementing services, mechanisms and instruments. More detailed information, and information on more operational issues, are available in the form of references to other publications, web links and case studies.

How to use the book

This resource can be read from cover to cover, but is also designed to be dipped into and out of according to the reader's priorities. It is written in a condensed style, to enable you to quickly grasp the issues. Each chapter is written to a similar format, with some or all of the following headings:

- definitions
- objectives and intended outcomes
- models and approaches
- the implementation process
- staff
- monitoring and evaluation
- barriers that need to be overcome
- support factors
- references, further reading and web links.

Case studies and practice examples are also provided, and each chapter ends with a 'key points' section summarising the main topics addressed in the chapter.

The book is available in hard copy and has also been adapted for the web, available via www.ehma.org. This means that readers can download, photocopy and distribute the resource book, or parts of it, as often as they like. It is not prohibited – on the contrary, we welcome and encourage it. Additional specific background information, such as practice examples and web links, is available at the EHMA website (www.ehma.org).

Topics covered

This resource book is the very first step towards establishing a body of knowledge on integrated care for older people. In this first edition of the book we have covered a selection of particularly topical themes. CARMEN and EHMA intend to form a special interest group to refine and update it, and add new case studies and web links. The network also hopes to include sections on key topics, such as finances and capacity management, when sufficient resources become available.

For information on integrated care and policy development, *see Policy Framework for Integrated Care For Older People* published alongside this resource book. This framework can be used at national level, covering basic considerations and policy requirements that have been determined as important in the CARMEN meetings and analyses.

In its present form, the resource book addresses integration activities that managers can influence, and mechanisms and instruments that they can apply. The basic elements of integrated care are dealt with in chapters 2–7:

- well-integrated organisational structures (Chapter 2)
- a willingness to give older people and their carers a real voice and partnership responsibility in the delivery professional care (Chapter 3)
- well-established needs assessment procedures and instruments and clear and easy access procedures to the professional care system (Chapter 4)

- well-developed care pathways (Chapter 5)
- case management in cases with complex packages of care (Chapter 6)
- multi-professional teams around the client (Chapter 7).

These basic elements of integrated care require a number of factors to enable them to work effectively. These are covered in chapters 8–10:

- a workforce that is quantitatively and qualitatively equipped for their task (Chapter 8)
- an organisational culture in and between the participating organisations that is client-centred, sensitive to collaboration and eager to be innovative (Chapter 9)
- leadership that supports this organisational culture and gives direction to the strategic and operational processes involved (Chapter 10).

Finally, the processes involved should be supported by the following factors, examined in chapters 11–13:

- strategic planning (Chapter 11)
- information management (Chapter 12)
- quality management (Chapter 13).

Two further issues are also of importance at this stage: financial management and capacity management. We are hoping to address these in a later edition of the resource book.

Geographical spread of content

At a general level, the resource book is applicable throughout Europe. However, at national level, adaptations may be necessary. The EU countries have different welfare regimes, and the dynamics within each country are partly determined by its policy system. For these reasons, we encourage any national organisations that have participated in CARMEN to adapt this resource book to fit their respective national context, and to publish the results on the EHMA website.

Welfare regimes in Europe

The socio-political literature makes a number of different classifications of welfare regime. Within the European Union, the following main types can be distinguished:

- **The 'Beveridge' or Anglo-Saxon system** – public provision and 'single payer' financing from taxes, in which the payer (for example, the health authority, local authority or district) is responsible for managing the services provided. Payer and purchaser may be synonymous terms if the government (in a broader sense) is the source of payment
- **The 'Bismarck' or central European system** – a variety of 'quasi-public' payers and corporatist arrangements with the state, social insurance-funded and controlled by legal private organisations, such as sickness funds and commercial insurers. 'Public' money is used for most care or services. There is a purchaser–provider split
- **'Mediterranean' or southern European systems** – a mixed system with some elements of a national health insurance and others from a social insurance model, and traditionally with a strong element of family responsibility and a less-developed public long-term care sector

- **‘Eastern European’ or developing former socialistic systems** – a strong tradition (and expectation) of state provision. At present, resources are scarce and the role of the state has changed.

Precisely how services should be integrated depends partly on which system they sit within. However, the general mechanisms and instruments are very similar across the member states.

How to get involved

This resource book is intended as a dynamic and developing source of information and support for managers and policy makers responsible for delivering services for older people. We welcome comments and constructive criticism, and especially examples of good practice that illustrate the issues explored in the book, and would be delighted to hear of any ideas and suggestions that contribute to our work. CARMEN is a network of people who share a passion for enhancing the quality of care for older people through better-integrated services. If you would like to contribute to its growth and the development of ideas, visit the EHMA website at: www.ehma.org.

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Dr Jan Coolen, who was at the Netherlands Institute for Care and Welfare (NIZW), and who is now at Zorgverzekeraars Nederland, was Scientific Director of the CARMEN project during the first sixteen months. It was largely his vision that formed the basis of the project proposal and the work of the project partners in those initial months. We are all greatly indebted to him for his contributions.

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Finally the authors and editors would like to thank the members of the CARMEN network who have laboured over a three-year period, first to understand the differing approaches across Europe, then to learn from each other, and finally to distil their learning into the ideas contained in this resource book. The journey that we have shared has been exciting, illuminating and occasionally frustrating, but certainly of great value to all of us. From these small efforts, we can build a Europe in which people value the benefits of different approaches and perspectives – a Europe that will prize the contributions of its older citizens to the common good – and a Europe that will care for its older people with gratitude and generosity. (For details of all CARMEN members, *see* CARMEN participants, p 213.)

Chapter 1
Integrated care: concepts and background

HENK NIES

Case study: Mrs Costa-Alvarez

Mrs Costa-Alvarez is a 78-year-old widow who suffers from dementia. She lives in an apartment on the third floor in a moderate-sized city. She emigrated from her native country with her husband in the early 1960s, and they raised three children, one of whom lives abroad. The others live on the other side of the country, 300 km away.

Two of her children visit her monthly and phone her every week. The son who lives abroad visits her a couple of times a year. Mrs Costa speaks only her native tongue with any confidence and fluency. She hardly has contact with neighbours. She receives a minimum old age pension because she did not have a formal job and has not lived all her life in the same country.

A couple of years ago, she started to become forgetful. When she had a mild stroke, the GP sent her to the hospital for observation. After some days she was discharged and sent home, although she remained rather confused.

At present, she has some difficulties moving around the house because she has arthritis. As a result of the stroke she still has difficulty performing refined locomotive tasks. In her view, she more or less manages to do the housework by herself. She has been losing weight for some time, and the children are concerned about whether she cooks properly for herself. They are also worried because she usually does not rise before noon. The children disagree whether professional help is required. Mrs Costa herself rejects all offers of professional assistance.

The situation described above demonstrates the rationale for integrated care for older people. It could be taking place anywhere in the European Union, and would be dealt with differently in each country. Moreover, within different countries and families, there would be a range of different responses to this case. One thing, however, is clear: Mrs Costa needs an integrated approach that combines:
- needs assessment and diagnostics
- medical treatment
- psychosocial interventions
- assistance in personal care, household tasks and establishing meaningful activities and relationships
- aids and adaptations in her house (possibly).

The first step is to establish a relationship with Mrs Costa that opens the door to professional assistance, in combination with informal care by the family and possibly neighbours and volunteers. All this has to be co-ordinated to fit with the contents and timing of the interventions. The interventions have to be based on converging principles of all those who are involved, strengthening each other's input. Moreover, the interventions have to be applied at times that are most suited to the needs of Mrs Costa and to principles of logistics.

Although different organisations, professions and agencies in the EU countries work within different legislative and financial contexts, and different expectations exist with respect of the roles of families, the need for managing integration is universal.

The case of Mrs Costa is one example of how integrated care can help older people. Complex problems and frailty in old age may evolve gradually, or may occur rapidly after an acute illness or crisis. Typically, they will interact and intensify each other, affecting all domains of life. These problems need to be dealt with systematically and coherently, and integrated care aims to do just that. It also has a preventive element – especially concerning risk reduction for those who are in vulnerable states.

Definitions

'Integration' has many meanings and interpretations (Kodner and Spreeuwenberg 2002). Here, we define integrated care as a well planned and well organised set of services and care processes, targeted at the multi-dimensional needs/problems of an individual client, or a category of persons with similar needs/problems. We specifically concentrate on integration issues around older persons with complex, multiple needs, focusing on cross-organisational integration of services. Tasks and services also have to be integrated within organisations, but that type of integration is a more common management task, while integration across organisations and services is a relatively new issue for the long-term care sector.

Integrated care can be conceived as client- or consumer-driven care (Kodner 2003). As such, it is not very different from developments in industry, agriculture, commercial services, or other public sectors such as education, town and country planning, youth care or public transport. In all these sectors, supply-driven management systems are gradually being replaced by integrated, demand-driven systems. These systems are developed because of client demand, but also because they are cost effective and efficient, as well as offering employees more job satisfaction (van der Aa and Konijn 2001, Goodwin *et al* 2003).

Integrated and linked services can serve all these objectives, and the various services can fit together well in a range of areas, including care for older people. What is more, service users are demanding integrated services. In a time of increasing demands and decreasing resources, it is obvious and politically compelling that health services should work closely with community and social care services to fulfil their objectives. Finally, for care workers, integration provides new perspectives in career and professional development.

The focus for managers

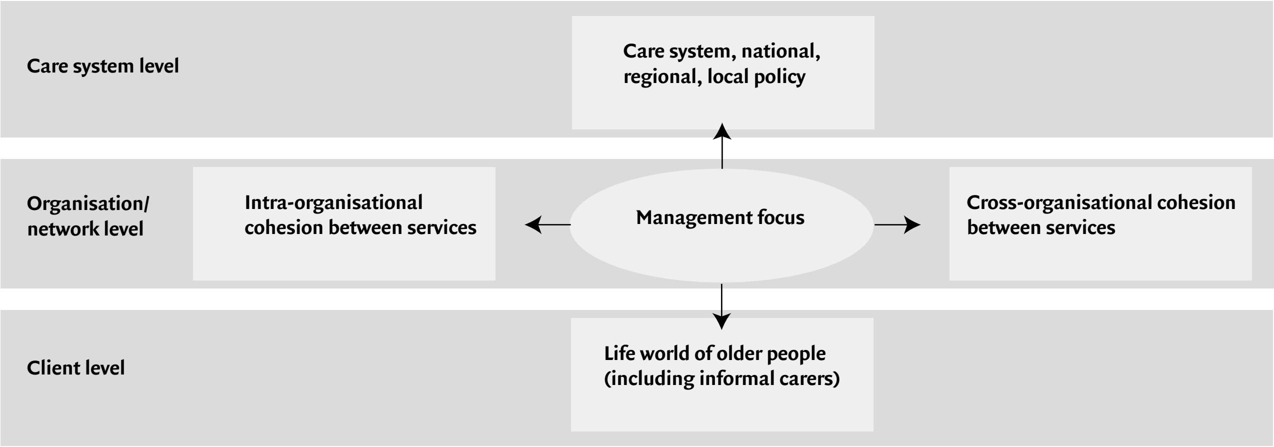
Integrated care is not an outcome, but a means to achieve optimum performance at service level – in this case, for older people. This shift from supply-driven to demand-driven care requires new management styles and skills. Managers are faced with multiple focuses and loyalties while integrating and connecting services around the client. Their challenge is to organise and secure care and service provision so that it:

- supports the ‘life world’ of clients
- combines tasks of professionals, informal carers and volunteers
- connects and combines services within organisations
- co-ordinates services delivered by different providers
- interconnects with the specific framework or care system.

The challenges in establishing integrated care are as follows:

- **Supporting the ‘life world’ of clients** – A client’s ‘life world’ includes their personal background within their social and physical environment. Supporting this includes helping clients experience their essential personal identity and meaning of life. These objectives, taking into account the client’s personal competencies and resources, and acknowledging and respecting their personal history, are essential whatever their needs.
- **Combining tasks of professionals, informal carers and volunteers** – This involves adequately assigning all necessary tasks to services or professionals, in a well-balanced dialogue with clients and/or informal carers. It may also include agreeing on new qualifications that new staff will need to have, as well as additional contracts and positions.
- **Connecting and combining services within organisations** – This requires co-ordinating, co-operating, and using information and technology to structure the workflow between services.
- **Co-ordinating services delivered by different providers** – Standards, information systems, criteria of evaluation, and orientations towards the client have to be linked or adjusted to each other, across the various social and health care organisations.
- **Interconnecting with the specific framework or care system** – It is important to work within the context of the system in which the services have to be delivered, such as the financing system, legal regulations or standards for good quality care. This means that managers of integrated services need to work at three levels:
  - **the client level** – the life world of older people
  - **the organisation and network level** – their own organisation and its connections with other organisations
  - **the care system level** – society and, more specifically, the existing and future policy framework (care system level).

Fig 1: Management focus in integrated care



The managers' orientations towards the fields shown in the four boxes in Fig 1 require them to have multiple loyalties, responsibilities and accountabilities, which they have to balance out. Having to deal with these four fields, which may reflect contrasting or contradicting commitments, can cause ambiguities, and dealing with these ambiguities is one of the most challenging tasks that managers have to deal with (Carrier 2002).

Aims of integration

Checklist: Objectives for the client

The client is the main beneficiary of integrated care. From their point of view, integrated care works best if it is run in the following way:

- ✔ The services are organised around the service user in response to his or her needs, and, if possible anticipating and preventing care needs.
- ✔ The services cover the full range of needs responding to the client's personal preferences and responsibilities.
- ✔ The interest of carers is an interest in its own right – they have their own rights, and their well being and quality of life must be taken into consideration, as well as the needs of the person they are caring for.
- ✔ The possible and desirable roles and contributions of the clients, and of their carers, are regarded as a vital element of care provision.
- ✔ Clients and, if desired, carers have choice and control in service delivery, with due observance of their entitlement.
- ✔ The services are accessible in all respects:
  - physical, for example, by replacing stairs with ramps
  - geographical, by making sure services are within reasonable distance of users
  - psychosocial, by ensuring that they do not stigmatise service users
  - financial, by making them affordable
  - informative, by providing clear guidance about options and entitlement.
- ✔ Clients should experience seamless continuity while receiving the services. Ideally, they should not notice the boundaries between services and organisations.
- ✔ Packages of care are designed and delivered in a dialogue between users, carers and providers, who are all considered 'partners in care'.
- ✔ A full professional assessment of the needs of the service user, and of their carers, is seen as the first step in drawing up a package of care.

For more information on this process, *see* Kodner and Spreeuwenberg (2002) and Carrier (2002).

Checklist: Objectives for the organisation

In line with these requirements, the objectives and intended outcomes for the organisation can be understood as:

- ✔ **to enhance quality of care**, quality of life, user satisfaction and system efficiency cutting across multiple services, providers and settings
- ✔ **to improve services** in relation to access, quality (user satisfaction and outcomes, system and process quality) and financial sustainability – including efficiency, public expenditure, common good (Commission of the European Communities 2003)
- ✔ **to link and co-ordinate** the various aspects of care across different professions, services, organisations and systems
- ✔ **to bring together** elements of acute and short-term health care, long-term care, social care, housing, and services such as transport, meals, odd jobs, garden maintenance, and leisure and education activities
- ✔ **to strengthen** the voice of older people with complex, multiple needs to enable them to live their lives according to their personal preferences and objectives.

These principles, drawn from Gröne and Garcia-Barbero (2002), Kodner and Spreeuwenberg (2002), and Commission of the European Communities (2003), are attractive at first sight. Indeed, one hardly can oppose them. It is easy to adopt them verbally and continue with day-to-day work without changing working routines and division of tasks. However, to improve everyday practice, these principles need to be tested and translated in operational terms, by asking 'How can we bring this particular principle into practice?' and 'How can we change our practice to further this principle?'. In other words, managers should not consider the principles to have been embraced simply because they have been verbally adopted. That is too easy.

Matching service users with forms of integration

So far, integrated care appears to be an attractive option. However, it is not a solution to every problem. Whether integration is meaningful – and if it is, what level of integration is most suitable – depends on the client's characteristics and conditions. In this respect, the stability and the severity of the client's condition are crucial (Leutz 1999).

Client characteristics and conditions can be related to a frequently used typology of degree or intensity of connections between services or organisations developed by Leutz (1999). He distinguishes three levels of integration:

- linkage
- co-ordination in networks
- full integration.

These are explained in detail below:

Linkage

This level operates within the setting of the existing services. By and large, it accepts the existing division of labour in the care system, and complies with eligibility criteria for the separate services. At this level, integration implies adequate referrals to guide older people to the right place at the right time in the system, as well as good communication between the professionals involved, to promote continuity of care when the person goes from service to service. Providers understand who is responsible for payments for each type of service, and costs and responsibilities are not shifted.

Co-ordination in networks

This level arises in settings where regulating agencies and service organisations seek new balances in care provision, re-definitions of core tasks, client flows, and eligibility criteria. This level is more structured than the linkage level, but it still operates largely through the separate structures of existing systems. It aims to:

- co-ordinate benefits or coverage and use of services
- share clinical information in a planned manner
- manage transitions between settings
- assign primary responsibility for co-ordinating care.

Co-ordination identifies points of friction, confusion, or discontinuity between systems, and establishes structures and processes to address these problems.

Full integration

This level aims to develop comprehensive care programmes or care packages attuned to the needs of specific client groups. It is connected with recently developed methods of care management. It creates new programmes or units that pool the resources of multiple systems, define new benefits and use common records. The integrated services are directly and specifically managed through one-to-one management, with no layers in between – only some type of joint governance above them. Full integration may include specialised types of intervention, 'fast-track' access to them, and close co-operation between knowledgeable professionals. The most pressing issues at this level are defining the target group, assembling the necessary services and allocating appropriate resources.

The characteristics and conditions of each client have different implications for the optimum level of integration, and for managing operations, as illustrated in Table 1, below.

Table 1: Levels of integration

Client's needs	Linkage	Co-ordination	Full integration
Severity	Mild-to-moderate	Moderate-to-severe	Moderate-to-severe
Stability	Stable	Stable	Unstable
Duration	Short-to-long term	Short-to-long term	Long-term-to-terminal
Urgency	Routine or non-urgent	Mostly routine	Frequent, urgent
Scope of services	Narrow-to-moderate	Moderate-to-broad	Broad
Self-direction	Self-directed or strong informal	Varied levels of self-direction	May accommodate weak self-direction or informal

Adapted from Leutz (1999)

Table 2: Operational implications

Operational implications	Linkage	Co-ordination	Full integration
Case management	—	Case managers and linkage staff	Teams or case managers manage all care
Transitions and service delivery	Refer and follow up	Smooth transitions between settings, coverage and responsibility	Control or directly provide care in all settings
Information	Ask whether it is needed Provide when requested	Define and provide items or reports routinely in both directions	Use common record as part of daily joint practice and management
Finance	Understand who pays for each service	Decide who pays for what in specific cases, and in general guidelines	Pool funds to purchase from both side and new services
Benefits	Follow eligibility and coverage rules	Manage benefits to maximise efficiency and coverage	Merge benefits Change and redefine eligibility

Adapted from Leutz (1999)

Table 2 demonstrates that levels of integration need to be chosen very carefully. Integration has its advantages, but it also requires investment, implies new boundaries and, as mentioned earlier, it does not solve every problem.

Laws of integration

- You can integrate all of the services for some of the people, some of the services for all of the people, but you can't integrate all of the services for all of the people.
- Integration costs before it pays.
- Your integration is my fragmentation.
- You can't integrate a square peg and a round hole.
- The one who integrates calls the tune.

Source: Leutz 1999

Dimensions of continuity of care

In developing well-linked, co-ordinated or fully integrated services, continuity is the key priority (Haggerty *et al* 2003). The design of the services and the care pathways along which the services are provided needs to take into account that integration is a dynamic process. It changes over time and needs regular monitoring and adaptations. Both the content and timing must have continuity. Two dimensions of continuity are always at stake – the simultaneous and the sequential:

- **The simultaneous dimension** – The provision of multiple services has to be coherent in its contents and its logistics. For instance, Mrs Costa-Alvarez, featured earlier in this chapter, may need a multiple package of care and services. This package must be fitted into a daily rhythm or programme. All the professionals involved should work according to consistent principles, so as not to make her even more confused and depressed. The involvement of her children should also be in line with these same principles. In this context, one can speak of 'simultaneous' linking, co-ordination or integration of services during the entire process.

- **The sequential dimension** – Care and services have to follow the needs of the user over time, but the stages of progression must appear seamless. For instance, after a stroke, appropriate and timely diagnosis and treatment is required. Then the user will need a rehabilitation programme of aftercare or – in the case of a long-term residual state – long-term care, so sequential linking, co-ordination or integration is required. The chain of care has to fit to achieve continuity in contents and actual delivery over time (Åhgren 2003).

To safeguard eligibility and funding of service provision, the stages in the care process have to be connected to the relevant processes of control or administration. From the initial presentation of a problem through the stages of referral, needs assessment, and eligibility testing, the care packages have to fit care delivery smoothly. All concerned – from those responsible for care provision to the clients, carers, purchasers and governments – need to be accountable at each stage.

The task for managers is to achieve continuity on each of the three levels on which they have to focus – that of the client, that of organisations and networks, and that of the care system.

Services to be integrated

To orchestrate integrated care, a set of services needs to be linked, co-ordinated or integrated. These services are delivered by various professionals and/or providers who may work in various sectors. When linking or co-ordination is required, traditional services may be sufficient. In most EU countries these services already exist, but under different names or meanings, and they may function in different sectors and different policy frameworks. To mention the most relevant, more or less 'traditional' services:

- **short-term health care** – general practitioners, physiotherapy, occupational therapy, rehabilitation centre, outreach inter-disciplinary team (interventions and co-ordination), palliative home care team, hospitals
- **long-term care** – district nursing, personal care workers, home helps, day hospital or day care, sheltered housing and communal living, care homes (including nursing homes and residential homes), psychiatric hospitals
- **social care** – social work, support groups, sitting services, education, leisure activities, peer advisers, housekeepers, carer support centres, day care or day centres, community centres
- **housing** – regular housing, adapted or special design housing, 'smart' houses (technologically advanced housing), sheltered housing, venues for community centres
- **supportive services** – transport, leisure, education, domestic support, odd jobs, financial assistance
- **aids** – walking aids, hearing and visual devices, communication technology, ergonomic adaptations in houses or household appliances, alarm systems
- **health promotion and maintenance** – preventive home visits, keep-fit exercises, regular check ups, self-help groups, friendship courses.

Checklist: Choosing services

✔ Check which elements of integrated care are accessible for your organisation for collaboration, either by linking, co-ordination or full integration.

✔ Find out whether coherence of and access to these services is a problem for clients. Do the present services and integration mechanisms provide a real solution to the most prominent problems with which your clients are confronted?

Innovative services

Especially when full integration is required, new, innovative services are required. By definition, these services do not fit into the traditional classifications, nor do they fit the traditional roles, pathways and responsibilities.

Case study: Mrs Costa-Alvarez (continued)

Mrs Costa rejected all kinds of traditional professional assistance. One option that she may have preferred was a local 'Alzheimer café', which she could have attended with one of her children. Alzheimer cafés offer education and support, informal advice and consultation by professionals and fellow sufferers, in a relaxed atmosphere. Service users are encouraged to attend a series of ten monthly meetings. The content of each meeting is agreed in advance, but it generally covers the course of dementia.

The café concept is based on a fixed structure of five half-hour sessions:

- *arrival and introduction*
- *information*
- *live music*
- *group discussion*
- *rounding off.*

The information sessions generally take the form of interviews with patients, family and experts, in front of the group, led by the discussion leader. The information and peer advice offered by this service can provide clients and carers with some insight into the condition. It can also give them practical information and reduce their reluctance to seek professional support. Alzheimer cafés are currently available in Australia, Belgium, Germany, Greece, the Netherlands, the United Kingdom and the United States (Miesen and Jones 2002).

Another option might have been a small-scale housing project for people with dementia, attuned to Mrs Costa's minority ethnic group, providing housing, personal care, supervision and company in a homely atmosphere.

The role of service users and non-professional carers

The majority of care is provided by informal carers, such as next of kin and neighbours, often at irregular hours, and volunteers can also be important in care provision. However, professional care providers do not always acknowledge the contribution of these groups, and they are seldom regarded as partners in the system. Instead, they are considered as an 'overflow reservoir' when other elements of the system fail or are unavailable. Informal carers, such as spouses and children should be legally entitled to be relieved of their responsibilities when caring is long term and becomes a burden. However, they should also be entitled to provide care if they want to do so and are able.

The specific role and contribution of volunteers differs between countries as a result of different cultural values and roles of the statutory and private sectors. The voluntary sector – and, in particular, its volunteers – has a specific, intrinsic value for those who receive their service, as well as for those who provide it. There is much potential for informal carers and volunteers to be used in a positive way to benefit the clients involved, not least through the special relationships that is often formed between service users and volunteers.

Barriers to integration

Despite the desirability of integrated care, incorporating it into day-to-day practice is not necessarily easy. Neither the care delivery system nor the professional systems is based on principles of integrating services. On the contrary, many have been fragmented as a result of specialisation and task differentiation.

The main obstacles for implementing integrated care are deeply rooted in the prevailing organisational and policy systems (*see also* Leichsenring and Alaszewski 2004). The CARMEN network has analysed the various systems in EU member states, as well as day-to-day management challenges. From this analysis it appears that managers in these countries face many of the same obstacles:

- **Insufficient public funding to provide sufficient services** – These shortages may result in waiting lists, which hamper adequate referrals and care provision. Integration and smoothly running systems with appropriate capacity management are hard to implement.
- **Non-corresponding funding and legislative systems** – Different services may be governed by different authorities or organisations with incompatible regimes.
- **Unequal access** – The counteracting mechanisms of means testing and co-payments may influence people's access to long-term care in opposite directions, as do specific eligibility criteria for social care between local authorities and/or regions.
- **Unbalanced systems** – Changes in one part of the system, such as budget cuts or rationing, may not be compensated for in other parts of the system.
- **Complexity of the system** – Multiple stakeholders may have different roles, tasks, interests and power positions. Barriers to synchronising processes between the sectors and agencies involved include factors such as the social, economic and political context, local circumstances, different legislation and funding streams, and procedural and structural arrangements at different system levels.
- **Responsibility** – In most systems, no one within the professional, managerial and administrative system has overall responsibility for integrated provision of care and services, nor for outcomes. This is a barrier to decision-making.

- **Interface problems** – Frictions in collaboration between organisations and professionals usually reflect the fragmentation of the various systems involved. Frictions between professionals may hamper collaboration because of differences in their professional cultures and views.
- **Supply driven systems** – In spite of the ideology of consumer- or client-driven policies and systems, day-to-day practice is still predominantly determined by current supply and by providers' interests.
- **Human resources** – Staff shortages, shortcomings in quality of staff and, conversely, over-qualified staff may hamper the implementation of integrated care. The new system requires new types of professionals and collaborative teams (such as case managers and peer advisers) that cut across services.
- **Non-corresponding cultures** – There are significant differences between the social and health care sectors, in areas such as qualifications, ways of working and systems.
- **Quality management** – Social services lack quality systems and policies more often than is the case in the health services. Quality definitions sometimes conflict between parties, so they are often not agreed upon. Integrated care management is almost totally missing definitions or criteria relating to quality control. Those that do exist fail to pay attention to consumer control, client choice and well-informed clients. Quality of life is little planned, monitored and evaluated, and so are the interactions of care professionals with clients' relatives and informal carers.
- **Integration becoming an end in itself** – Integrating services can only be welcomed, as long as integration does not become a way of solving other system problems while failing to meet clients' needs.

In spite of these obstacles, various examples have shown that they are not insurmountable. Sometimes, the obstacles are used merely as an excuse for non-collaboration. Managers have to deal with these issues to achieve integration, implementing interventions at client, organisation or network and care system levels. Various processes, mechanisms and instruments have proven to be valuable. There is some consensus about the usefulness of some, but much of the evidence still has to be provided.

This resource book addresses a number of possible management interventions. However, not all interventions can be extensively addressed here. Policy measures are also necessary to further integrated care. As such, they may be regarded as prerequisites or supports for integration. CARMEN has separately published a booklet on policy development with regard to integrated care by national governments (Banks 2004).

The implementation process

When an organisation's members decide that their clients would benefit from integrated care, that they can manage the context, and that they share the core principles, the next question is how to take up the process of integration.

In strategic and innovation management, there are a number of distinct phases in the process of working towards implementation. At each phase, there are specific tasks that need to be accomplished. To ensure that they have completed all the necessary tasks, managers can ask themselves a series of questions (outlined below). Their answers will determine what tasks the organisation need to carry out.

In theory, each phase should result in a 'go' or 'no go' decision. In practice, separate phases and decisions are often not explicit. Nevertheless, the phases outlined below (based on Nies and Können 1996) may help give some direction to the decision process.

Phase 1: Deliberation – 'Is integrated care an option for us?'

- Why should we think of providing integrated care?
- For which target groups?
- With whom?
- What type of integration might be most suitable?
- Which options exist for collaboration?

Phase 2: Exploration – 'How should we set about the process?'

- When are we going to negotiate, and with whom?
- How do we take up the negotiations?
- How should we communicate (internally and externally)?
- Should we work towards a letter of intent?
- Which codes of conduct should we agree with our partner?
- How can we give older people and/or their representatives a significant say?

Phase 3: Practicalities – 'How should we design integrated care?'

- How can we develop a mission and a view on the future provision of care and services?
- What types of functions and capacity should be subject to future collaboration on integrated care?
- How can we test feasibility and possible consequences of integrated care and collaboration?
- Which juridical arrangements should be taken?
- Which organisational structure is most suitable?
- How can we create support for the ideas?
- How are personnel affected by our services?
- What role can client and staff participation play in the integrated organisation?
- What will be the consequence of integration for our current documentation system, quality system and financial system?
- What is the order of the investments we have to make in the long run?
- How should we plan the actions that we have to undertake?
- How can we monitor process and progress?

Phase 4: Implementation – 'How do we get integrated care to work?'

- How should we design the project organisation to prepare the implementation?
- How should we choose the project leader, and what are the conditions for optimum functioning?
- How will we manage the collaborative process?
- How can we monitor progress of the preparations?
- What are the aids and obstacles in the implementation?
- How can we recognise resistance, and how should we deal with it?

Phase 5: Evaluation – 'How do we decide whether we should continue?'

- Are clients and their carers better off?
- Are the members of staff better off?
- Are we achieving our objectives?
- Are we proceeding within the time schedule that was set?
- Are the unforeseen effects outnumbering the foreseen effects?
- Is the cost–benefit balance what we expected it to be?

Ethical issues

The ethical issues relating to integrated care of older people relate to the tension between empowerment and the client's individual rights on the one hand, and the rules and regulations of the 'system' on the other (Defever 2002). Managers need to make addressing ethical issues a priority. The ethical issues that may face a manager working in this area include:

- empowerment
- freedom of choice
- patient privacy
- risk management
- prioritisation of the target group.

These issues are discussed in detail below.

- **Empowerment** – If the older person makes a choice about a service that appears to be 'unsuitable', from a professional's viewpoint, this can cause a great moral and ethical dilemma, which needs to be managed sensitively and appropriately. Managers need to support their staff in dealing with these situations.

- **Freedom of choice** – As opposed to consensus-based care pathways, freedom of choice can be idealistic and often not cost-effective. If a patient chooses a care pathway that results in an increase in public expenditure, the chances are that freedom of choice is actually not part of the equation at all, and may lead to shortages of care provision to other clients. It is up to the manager to ensure that the options available are realistic and appropriate at all times. There is a similar situation in the case of conflicting interests between clients and their informal carers. Whose interest should take priority: the client who wishes to remain at home, or their spouse who has been caring for them and is close to collapse?

- **Patient privacy** – The limitations of privacy are challenged by the issue of client information flows. In other words, can all the client's information be forwarded to the relevant partners in the system without obtaining client consent at every single step? It is important to note that client consent at an early stage may not be valid for the entire process of care provision.

- **Risk management** – This becomes an issue when considering who is responsible for the risks involved in care provision: the client (assuming he or she is well-informed), or the care providers with joint responsibilities.

- **Prioritisation of the target group** – The notion of risk can be taken a step further when we look at the prioritisation of the target group for integrated care services. Does the current 'system' of home care facilities, for example, tend to give preference to those recently discharged from hospital (because of the high costs of hospital admission), as opposed to those who have been living at home but are no longer able to cope? If this is so, is this primarily how to balance costs versus risks?

These and other questions are part of the reality of integrated care and the ethical and moral issues with which managers are confronted every day. These issues require careful deliberation before and during the implementation process. Discussions in this topic often reflect different professional and organisational norms and cultures, but they are absolutely necessary. There are no 'right' or 'wrong' answers to the ethical dilemmas of integrated care, and Mrs Costa will not be helped by general answers. However, general principles may be helpful to provide her, in her individual circumstances, with the care that meets her individual needs. This is what integrated care is all about.

Key points

- **Integrated care is not an outcome but a means to achieve optimum performance at service level. It is about effective and efficient targeting of services to the needs or problems of individual or categories of older people with similar needs.**
- **Integrated care has the ambition to meet the needs of older people with long-standing multiple problems. However, it is not the one solution for all problems. Effective types of structures and strategies of integration depend on the type of integration problem involved and the phase of the process of developing integrated care.**
- **Management interventions can be directed to different levels of care provision: the individual client, care organisations and networks, and the interaction with the care system.**
- **Integration may focus on two main dimensions: sequential and simultaneous. These have to be connected to relevant processes of control or administration.**
- **The input of carers and volunteers is often overlooked but it is essential to integrated care.**
- **There are real barriers to integrated care. However, they are often also used as an excuse for non-collaboration. In that case, it is important to target the underlying resistance and measures to address this resistance.**

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Web links

www.ehma.org – The website of the European Health Management Association (EHMA). It contains information on CARMEN, with many of its documents and publications, as well as on other projects. It also gives an overview of EHMA's activities, members and various relevant web links.

www.ijic.org – The International Journal of Integrated Care is a peer-reviewed digital journal of scientific articles. The journal is practice-oriented and publishes on theory and research as well as projects and policy developments. It also hosts the International Network on Integrated Care.

www.integratedcarenetwork.gov.uk – The website of the Integrated Care Network in the United Kingdom aims to help frontline organisations to deliver integrated care. The content is organisted around seven key themes: integration, organisation, policy, research, inclusion, performance and evaluation, and governance. It provides an overview of activities, publications, guidelines and a discussion area.

www.euro.centre.org/procare – The Procare project focuses on a new contept of integrated health and social care for older people. It does this through comparing and evaluating different modes of care delivery in EU member states. The website provides national reports as well as general papers and a number of useful web links.

Chapter 2
Integrated organisational structures

RICHARD PIEPER

The introduction to this resource book explains how integrated care can be analysed on three levels: the client level, the organisation and network level, and the care system level. In this chapter, we discuss arrangements in integrated care that are located on the second of these levels.

The term ‘integrated organisational structures’ refers to organisations, relations between organisations, and networks. This chapter relates especially closely to issues of quality management, information management, leadership, cultural change, and strategic planning, dealt with in other chapters of the resource book.

Integrated care particularly focuses on relations *between* organisations, since problems with integration typically arise in fragmented care systems with insufficient co-ordination between care providers (as stated in the introduction). But integrated care can also be provided *within* integrated organisations – in other words, solutions ‘under one roof’ of a larger organisation – so the chapter also examines this option.

There are no simple solutions for integrated care on this level. So the reader is invited to consider some basic concepts, models and strategies that should provide guidance in the search for practical arrangements.

Definitions

The term ‘integrated structures’ combines two concepts: structures and integration.

Structures

The word ‘structures’ refers to the more or less stable arrangements of co-ordination and co-operation within, or between, organisations or agencies. These might include hierarchies, contracts, regulations, agreements, pooled budgets, and technological infrastructures.

Depending on the intensity and quality of the integrating relations, it is possible to distinguish between:

- **integrated organisations** which organise their functions under one hierarchy of management or ‘under one roof’
- **integrated networks** which include arrangements or contracts between essentially independent partners.

The term ‘integrated structures’ refers to both types of integration. There are also ‘mixed cases’, which combine integrated organisations and integrated networks, since arrangements in social and health care systems are relatively complex.

Integration

The word 'integrated' describes a characteristic of these structures or processes. It implies that actors (members) and activities (functions) are relatively:

- highly connected
- interdependent
- functioning to achieve common goals.

'Integration' always implies the inclusion of certain actors and activities and the exclusion of others – in other words, it makes a distinction between the system and the environment.

Integrated structures

Integrated structures of care are well-balanced or fair, and well-organised or 'optimised' arrangements, that will promote and support seamless care or integrated care.

- **Well-balanced relationships** This concept implies some relevant differences of values, interests, or goals that result in costs, risks, and potential conflict and that call for negotiation, compromise and trust. The parties involved basically accept the arrangement, because it respects their vital interests – in other words, the balanced arrangements reflect some principle of fairness.
- **Well-organised relationships** This concept incorporates connectedness, co-ordination, co-operation and coherence of activities, on the basis of some consensus or authority (hierarchy). The arrangement organises the available means in the best conceivable flow of work and information to achieve the goals.

The distinction between these types of relations is fundamental, but they should not be confronted as representing different, incompatible, 'cultures' (for example, the social model as opposed to the medical model, or discursive co-ordination versus systemic rationality – *see* Dahme and Wohlfahrt 2000), but should be reconciled in practical solutions.

It is important to note that the 'optimal' solution in the eyes of one partner may well not seem fair, or even optimal, in the eyes of another.

Goals and intended outcomes

Integrated structures are a means to an end. They are designed as a result of an integration strategy being put in place. It should be evident from the principles of fairness and optimising (*see* 'Integrated structures', above) that strategies of integration can be dominated by certain interests:

- Organisations may want to extend their influence on partners.
- Network members may try to increase their share of the benefits.
- External agencies may want to increase their leverage on the organisation or network.

Such interests are not inherently bad, and may in fact result in some improvements to the way that care is integrated. However, they may be unbalanced. They may also provoke resistance, which can arise when the state or an organisation attempts to reorganise existing care systems to function more optimally for their own benefit. Politicians and administrations will claim to integrate for the common good, but in practice the goals tend to be more partial following, for instance, an overriding goal of cost containment. In another common situation, they might impose supposedly successful models of integration from other fields on to social and health care – where they may or may not be helpful (*see* Goodwin *et al* 2003).

So the basic goals and strategies have always to be negotiated with, and within, the care system to be accepted and implemented effectively.

Integrated structures are designed to enable common goals to be realised more effectively. From a user-oriented or client-centred perspective (which is taken throughout this resource book), the basic goals to be promoted by integrated structures are:

- quality of life of clients
- equity or social justice
- financial sustainability
- access to services for all, when and where needed.

These goals have to be translated into specific 'things to do' and 'outcomes to be realised'. Since the situation in national, regional or local care systems differs widely (for example, compare the NHS reform in the UK with the adaptation of the Scandinavian model to changing needs, the introduction of personal care budgets in the Netherlands or the development of care centres in Greece), there is not one set of outcomes that will indicate the achievement of more integration and better performance.

In practice, it is crucial to have a relative improvement – relative, that is, to the concrete situation and the resources at hand. But it is also important that there is an explicit agreement on a limited set of concrete and observable outcomes. This is essential for establishing a consensus about 'being on the right track' towards integrated care in the organisation.

Checklist: Attaining goals

✔ When you discuss goals with partners, be prepared to talk about concrete, achievable and achieved outcomes.

✔ Select only a few goals at a time (such as those in the box below) and set clear priorities.

✔ Set goals and agree how you will know when they have been achieved.

✔ Implement a procedure for regularly evaluating and reconsidering the goals.

The benefits of integrated working

Integrated working can make a difference at a number of levels, some of which can be thought of as pressure points within the health and social care system – for example, within older people's services the benefits might include:

- more holistic screening and assessment processes
- better co-ordinated hospital admission and discharge
- better co-ordinated intermediate, rehabilitative, long-term and continuing care.

Integration processes that help organisations deliver these outcomes include:

- improved communication between agencies delivering the service, professionals, service users and carers
- increased management efficiency by removing barriers between agencies
- clear leadership and clear accountability
- multi-agency and multi-professional teams working towards the same goal
- a simplified system of decision making

- a single system that is better understood by users, practitioners and managers
- one point of referral with a one-step process for assessing a person's health and social needs
- one combined approach to the care planning process
- one complaints procedure
- more co-ordinated packages of care
- one common budget that is accessible to health and social care staff alike.

Source: Peck *et al* (2000)

Models and approaches

When looking at models of integration, one can find a wealth of initiatives, projects, innovations, re-organisations and other experimental arrangements in the field of integrated care.

The first lesson to note is that there are no models that can be transferred readily to other contexts, but that there are some basic organisational principles or strategies of designing for more integration, and there are also solutions adapted to sometimes very specific local situations. In trying to identify relevant options, one may distinguish models of integration by their degree or intensity of integration – in other words, the extent to which the partners connect their activities by linkages, co-ordination or contract (*see* Leutz 1999). In fact, the degree of integration does not tell us very much about the character of the relationships. Organisation theory reminds us that the principles underlying these connections can be different in important ways.

The second lesson, therefore, is that the usual classifications that order models of integration on a continuum (with 'no integration' at one end and 'full integration' on the other) are not very helpful. There is not just one solution for every problem of integration, and sometimes a closer look may reveal that less, rather than more, integration is the answer. Typically, different strategies of integration and networking are called for in different problem situations.

Managers of integrated social and health care need to realise the complexities of this area and have to learn the 'management of dualities' (Pettigrew and Fenton 2000). Managers of innovations must pursue more or less mutually exclusive goals in theory, and must reconcile them in practice, in a fair and optimising way. And in practice, we find very different strategies and arrangements establishing reliable relations with partners in the care system (*see* Smith Ring and van de Ven 1992, Hudson 2003, Williamson 1985, Walsh 1995, Woods 2002).

Four basic models

Looking for relevant 'dualities', we first consider the two options on which relations can be based:

- trust versus contract
- accountability to some 'higher' authority versus no accountability.

The first option – trust versus contract – seems relatively straightforward, although contracts certainly can be more or less formal and binding, and can also require trust. In the second option, the reference to some higher authority means that the transactions are determined more or less by a shared commitment to goals or values, and entail some way of being accountable to some controlling third party, as will become clearer below.

Combining these options, we can identify four models of integration between agencies or organisations in care systems:
- markets
- hierarchy or integration by joining an organisation
- co-orientation networks
- co-operative networks.

These are explained below.

The market model

This model regulates the usual business relations between partners. Market models are valued for their openness, flexibility, innovativeness and optimal allocation of resources. However, they tend to be ineffective in providing collective goods such as public health or prevention, in realising social justice, or in protecting underprivileged persons, such as those who are poor, frail or elderly. Their focus on individual interests of care providers is often in conflict with care integration for the benefit of the clients.

These business relations rely primarily on contracts rather than trust. They do not expect a shared higher authority or to share values with the partners, although contracts are backed up by a legal and sanctioning system. Examples of market relations can be found in purchaser–provider models in the Netherlands, Germany and the UK, which typically emphasise the role of the client as a consumer (Kodner 2003).

The hierarchy model, or integration by joining an organisation

In this model, care provision of an organisation is established 'under one roof'. The organisation may also be a state organisation if the state or municipality provides integrated services. Hierarchies have the advantage of being able to establish an effective management and bind their members (employees) by contracts to the pursuit of their goals (in this case, the goals of integrated care). They do not have to rely on trust since they exercise control under a clear 'higher authority' defined by the goals of the enterprise.

Hierarchic models play an ambiguous role in care systems. On the one hand, we find that larger organisations and mergers are promoted to achieve more integration – especially in rather fragmented market systems. For instance, the discussion on managed care in the United States and on care trusts in the UK demonstrates such hopes for more efficiency and quality by integrated organisations with strong elements of hierarchy (*see* Goodwin *et al* 2003 and Wernet 1999). In some situations, such as in Germany or Austria, new larger organisations are expected to bridge and break up existing barriers between traditional parts of the care system – in other words, between the health and social care systems (*see* Pelikan *et al* 1998, Schaeffer 1998). On the other hand, we find criticisms of hierarchical structures, because they are considered to imply too high a degree of centralised power and bureaucracy (for a Finnish example, *see* Sinkkonen and Jaatinen 2003).

The co-orientation network model

This model establishes a preferred and stable relationship allowing for an integration of exchanges and activities on an operative level based on 'recurrent contracting' (*see* Smith Ring and van de Ven 1992). Here, 'co-orientation' means that people or agencies are clearly orienting their activities to partners in a network, but that the relations may not be very strong, and membership in the network may be changing relatively easily. Between partners in the care system, this implies the development of durable relationships on the basis of recurrent co-ordinated transactions – for example, the co-ordination between hospital and community care to provide a 'seamless' discharge management. This co-ordination may be considered a necessary first step or a key towards (more) integrated care.

Important networks in the care system that would come under the category of 'co-orientation networks' include the wider network of community care – especially networks of social work, and the informal care network or the 'life world' of the client. Another important case is the situation in less professionalised care systems, such as in the southern Mediterranean, or in new Eastern European care systems, where informal support and fragmented care systems are still prevalent (for a Spanish example, *see* Rico *et al* 2003).

Co-orientation networks are based on trust, although some relations may not require high levels of commitment. This is because the relations do not typically involve a formal reference to higher values and are not subjected to controlled accountability. Partners essentially keep their independence.

The co-operative network model

This model of co-operation, also known as 'relational contracting' (*see* Smith Ring and van de Ven 1992) involves some agreement on basic values and a strong reliance on trust. Co-operative networks tend to be the preferred option in the realm of integrated care. They might even be considered an essential element of the philosophy of integrated care. However, the precise characteristics of this 'culture of trust and co-operation' vary widely between different countries and different professional sectors, so the conditions for co-operative networks vary.

In central European care systems, such as the Netherlands, Germany and Austria, the 'third sector' of not-for-profit organisations and voluntary associations plays a systematic role in care provision. There has also developed a rather strong tradition of non-profit non-governmental organisations (NGOs) in the care sector and of their co-operation with the state or municipalities. These traditions are still very influential and provide a basis for trust and shared value commitments for the 'common good', although in recent years the co-operation has been structured increasingly on market principles (Dahme and Wohlfahrt 2000, Schaeffer 1998).

In modern, market-oriented societies, co-operative networks typically need support from the 'higher authorities' of the state, region or municipality to command sufficient influence and legitimacy. Both types of networks can be looked at as 'integrated networks' in the terminology suggested here. The main choices – in this perspective – are then between markets, hierarchies, and networks. The choice between markets and hierarchies, on the one hand, and types of integrated networks, on the other, will depend on how far the local or regional 'culture of trust' supports co-orientation and co-operation.

Integration and coping with risk and openness

The four models described above can be further characterised by strategies of coping with, or sharing risks, overleaf. Basically, strategies can be distinguished based on trust, power, knowledge or exchanges (of money, goods and services). The strategies can be combined with the basic models to form the options in Table 3 (*see also* Smith Ring and van de Ven 1992).

Considering care systems, each of the four models favours very different options:

- **The markets model** imposes no restrictions on membership. It involves conceptualising risks as belonging to certain individuals, putting a price on risks, and then creating insurance services. This is a frequent solution also to health risks as long as the clients can enter such a market as competent and resourceful consumers and if providers see a profit.
- **The hierarchies model** enables organisations to cope by using power, control and closure. This model is typically preferred if the various provider parties have to share high risks involving pooled budgets and large investments into common infrastructures. This means that detailed contracts and controls are to guarantee the transactions, rather than mutual trust.
- **The co-orientation networks model** tends to be effective when the risks for all parties – providers and clients – are low and when trust can develop on an operative level during recurrent transactions or everyday practices. Co-orientation aims at improving transactions so, in this model, knowledge and insight about the meaning and the mutual benefits of co-ordination are important. But such networks will avoid risky innovations.
- **Co-operative networks** are called for in high-risk situations for providers, where commitment and trust between partners at a strategic level must also be high. Such 'strategic alliances' typically involve membership restrictions, long-term co-operation, and rules for the sharing of the risks. Co-operative networks tend also to rely strongly on knowledge and professionalism as a means to reduce risks, by raising competence and the quality of performance.

It is important to note that reliance on knowledge is ambivalent in two ways. First, knowledge is power and it can be used by managers and professionals to pursue an 'optimising' of processes in their specific interests. But then, a reliance on knowledge creates an openness towards 'knowledge communities' (institutions of education and research), which accounts for the innovative potential and an orientation toward evidence-based quality standards. Typically, co-operative networks have some research or higher education institution among their membership because relying on knowledge can mediate between interests and provide for better solutions.

Second, as the term 'professional culture' indicates, the knowledge of a profession consists not only of 'evidence-based' scientific knowledge but also of visions, paradigms, unquestioned concepts and procedures, practical experiences, and even disciplinary folklore. Such a culture may, in fact, be a 'closed' sub-culture or an enclave, and the sub-cultural knowledge can create considerable barriers to integration across boundaries (*see* Goodwin *et al* 2003). The prime example in integrated care is the split between the cultures of medical care and social care.

Table 3: Models of integration and coping strategies – options in structuring integration

Basic models of integration	**Markets** or individualistic contracting	**Hierarchy** or integrated organisations	**Co-orientation networks** or weakly connected networks	**Co-operative networks** or strongly connected networks
Risk-coping strategies				
Power	Decentralised power, moderate accountability by contracts	Centralised power, high accountability	Decentralised (low) power, low accountability	Low central power based on consensus, high accountability to shared goals
Exchange	Unrestricted flow of decentralised exchanges based on prices and competition	Restricted flow of goods and services based on central goals and controlling	Open flow of goods and services based on recurrent contracting or 'norms of reciprocity'	Restricted flow of goods and services based on 'fair' agreements, sharing of benefits and risks
Trust	Low reliance on trust, balancing of individual interests, open membership	Low reliance on trust, dependence on loyalty, clearly defined membership	Reliance on trust, selective membership and relations with (low, moderate) commitments or risks	High reliance on trust on strategic level, commitments covering high risks, controlled membership
Knowledge	High reliance on innovation for competitive advantage	Low reliance on innovative knowledge, administration of confirmed knowledge	Moderate reliance on knowledge, domain-specific operative innovations, traditions of good practice	High reliance on knowledge, innovation, if shared culture 'open-scientific' rather than 'closed-ideological'

Partners in all model situations have to cope with risks and to decide with whom they want to share risks, and with whom they do not and in which way they accept responsibility and accountability. Partners will agree to regulations and make commitments that they consider necessary to achieve their goals, but they will also try to avoid levels of integration and hierarchy, which they consider unnecessarily restrictive and limiting of their choices. Integration is expected to limit risks and increase benefits, and this has to be reflected in the objectives and procedures of an integrated structure.

From the perspective of professionals, some problems might have to be solved by specialists in special institutions. This is also true from the perspective of the clients, who will consent to greater restrictions to their freedom of choice if the risks for their health are high. So they will favour the restrictions of institutional care in a hospital when they are vulnerable. But then, some openness and integration with other networks might be necessary for better care outcomes. For example, hospitals are undergoing considerable change under the impact of more client orientation – in other words, by allowing 'rooming in' (for example, allowing mothers of sick children to stay with them overnight) and 'reaching out' (for example, providing rehabilitation services at home, which benefits health care).

These reflections on risks highlight the importance of the clients and the nature of their problems:

- **Clients involving high risks** Clients with serious problems, high dependency or disability, and high risks for their future health condition typically also imply high risks for the provider (liabilities) and the employment of special knowledge and qualification, so they require a higher level of organisational integration and accountability. The organisation of acute hospitals is a typical case. Care providers will try either to avoid clients with high risks or to specialise in high-risk cases (for example, AIDS disease management), and develop corresponding systems of accountability and insurance against professional failures as well as against the economic risks of insolvent clients.
- **Clients involving low risks** Clients considered to involve relatively low risks, such as those needing home-help services, can do without enforced rules for accountability, lower professional qualification, and may be treated in care arrangements that are less hierarchically regulated. Family or neighbourhood support is a typical case.

The terms 'low risk' and 'lower qualification' are a matter of social and political definition. This also poses the more general problem of who has the right, and the responsibility, for deciding on which risks are considered high or low, who carries the risks, and who is accountable. The legal framework does not typically provide sufficient guidance. Some health risks (such as accidents) or social risks (such as unemployment) may be very high, but they may or may not be adequately recognised by support systems, insurances, or society at large. Care providers have to cope with the fact that the term 'low risk' usually refers to circumstances that can be treated by someone with a lower professional qualification, offering lower prestige, and the fact that their roles can often be substituted by informal care – the characteristic situation of not-for-profit organisations in social and health care. This fact tends to make the coverage of 'low risks' under-financed and unattractive for the services.

Including family relations in integrated care creates special challenges, since they are a special network embedded in community networks or life worlds, and supporting both types of client. Family relations are not chosen to cope with risks (whether one chooses to use them or not), but they are a resource nevertheless because their traditional values predispose members to see carrying burdens and high risks as a matter of fate, love or solidarity. But these family traditions are changing. In modern society, while these relationships are strong in some cases or local cultures, in others they are not. Family relations may also form a sub-cultural enclave, which creates barriers to co-operating with the care system, as with some religious traditions the oppose medical treatments.

Integrating services for both types of clients, or for clients with changing levels of problem severity over their care paths, can be expected to produce difficult integration problems and to require great flexibility in service provision. This is especially the case when the distribution of risks and responsibilities is seen to be unjust, and the effectiveness of the accountability system is questioned. The issues of accountability and control can be raised by:

- the provider, following their own individual or professional interests
- clients and their informal carers, to assure the responsibility of the care system and the quality of performances
- financing systems, to control their costs
- courts or society, to protect collective goods – for example, public safety or data protection (*see also* Woods 2002).

So the choice of a model of integration should be guided by the types and levels of risks and responsibilities that have to be distributed or shared, and by the accountability procedures required.

Stakeholders and strategies

In integrated organisations and networks, different partners and professions with a range of interests co-ordinate their activities and co-operate for the common goal of integrated care. 'Stakeholders' are actors or agencies who have an interest in the goals, processes and outcomes of integrated care, and who can significantly influence the available alternatives and the outcome of interventions.

Stakeholders are also potential partners in a concerted initiative for integration. Important stakeholders in integrated care typically include:

- **service users or clients** for whose benefit the care system operates
- **managers** who have to create integrated structures and are responsible for the organisation of services and interventions
- **professionals**, who contribute relevant services and are responsible for the quality of care
- **owners and board members** of provider organisations, who set the basic goals for management
- **quality control agencies**, which check on legal and quality features (including courts)
- **financing agencies**, who provide vital resources
- **politicians and administrators**, who decide on the frame conditions and the structure of the care system.

Additionally, it should be recognised that interests of stakeholders are represented by lobby associations on different levels.

Checklist: Stakeholder analysis – questions a manager should ask

✔ What are the focal care processes facing the problem of integration?
✔ Who are the relevant actors and agencies involved in the processes?
✔ Where is my position in the relation to relevant other stakeholders?
✔ Which stakeholders are potential allies and which are potential opponents?
✔ Which stakeholders should be considered partners in 'my system' and which should be considered part of the 'environment'?
✔ What are the relevant internal needs, goals, and interests of partners that have to be integrated and balanced within 'my system'?
✔ Are there 'third parties' available supporting the integration without (too many) own interests?
✔ What are the relevant external interests and conditions set by stakeholders in the 'environment'?

For a helpful manager's checklist', see the appendix in van Raak et al (2003).

The service user as a stakeholder may play four different roles:

- **Client** – In relation to formal care, the service user is a client who is largely dependent on the professional services. This role relates to quality of care and client involvement.
- **Customer** – In relation to the care provider, the service user is a customer. This role relates to user choice – in other words, the freedom to select from alternative providers.
- **Citizen** – In relation to the political framework of the care system, the user is a citizen with rights. This role relates to the user's 'voice' – in other words, his or her influence relating to participation and advocacy.
- **Self-provider** – In relation to the formal care system, the user can – or must – rely on the care capacities of his or her own life world. For this role, the qualification and availability of these resources depending on their social environment are important.

A strategy for care integration must start with a thorough analysis of the local and regional stakeholders in the social and health care system, to identify potential initiators, supporters and opponents of integration. Depending on the influence and position of the initiators, they can choose a stakeholder strategy:

- **Top-down strategies** may be best in some situations in which integrated care is developed from the basis of a strong stakeholder, such as a regional hospital or a municipal health centre. They may also be effective in breaking up established interests and bridging fragmentation of professional cultures.

- **Bottom-up strategies** may be appropriate in other situations initiating the formation of a network of providers, such as a network of GPs and social services by NGOs. They are especially effective when a wide scope of partners and interests can be joined under some overriding and specific concern, as in cancer or AIDS disease management.

- **Mixed strategies** are also possible. Indeed, the introduction of markets in purchaser–provider models, or of internal markets in public provision, can be interpreted as 'mixed strategies'. The new financing structure may be imposed top-down, but new structures of provision may have to be negotiated bottom-up. An example of this is the introduction of care insurance in Germany, with its options for integrated models. The differences between private and public provision are diminishing as new public management introduces basic principles of competition, decentralised budgets, efficiency, and quality management into public organisations (*see* Dahme and Wohlfahrt 2000, Walsh 1995).

All strategies have to face the fact that integration requires and creates a new centre of influence or power. This holds whether an existing organisation is expanded, the internal governance structure of a network has to be developed, or existing networks are to be influenced or managed more effectively from outside (in other words, by the state). Resistance by stakeholders is the 'natural' reaction.

The external management of networks is an especially demanding task since it has to manoeuvre between the strategies for organisations and for networks (*see* pp 44–48). Members of an integrated network tend to perceive this management of networks as management by an external stakeholder (*see* Goodwin *et al* 2003). Therefore, 'management of trust' is essential.

To decide on which model is appropriate, it is necessary to analyse the local structure of stakeholders to identify supporters of integrated care, and to set incentives to encourage professionals to co-operate.

The implementation process

The philosophy of integrated care especially favours co-operative networks, as explained earlier. But summarising the lessons from a decade of health care reform in Europe, one analysis reaches an ambiguous conclusion:

- On the one hand, there are strong pressures towards hierarchical structures of accountability to support political accountability, and ‘sticks’ outnumber ‘carrots’ as incentives, as economic rewards are increasingly difficult to finance.

- On the other hand, incremental strategies ‘from the ground up’ driven by experience and evidence rather grand blueprints or the pulling of big policy levers seem to be called for (*see* Naylor *et al* (2001), cited in Woods 2002).

It is therefore necessary to experiment with the design of integrated organisations, as well as with integrated networks, to find the appropriate mix that fits the local circumstances.

Strategies for designing integrated organisations

Designing integrated organisations is typically top-down. A kind of strategic alliance with an agreement on central goals and values is negotiated at the start, and the partners consolidate this into an integrated organisation ‘under one roof’. The process of the design itself will follow a strategy applying the principle of optimising.

Integrated care organisations can use different strategies to develop (*see* Pelikan 1998), including:

- adapting an existing organisation (for example, a hospital expanding its social services for discharge into more comprehensive extra-mural social services)
- outsourcing or contracting out additional services, constituting binding partnerships
- setting up mergers or fusions with organisations that provide complementary services
- forming a managed care organisation on the basis of existing provider organisations
- creating new types of integrated care centres.

Typically, the resulting integrated organisation is internally structured into relatively independent units specialising in different types of services (such as social, health or rehabilitation services). So the distinction between an integrated organisation and an integrated network is not clear cut in practice. The important elements of integrated organisations are integrated management, pooled budgets, and the degree to which contracts between partners are exclusive.

The focus in the design of integrated organisations is on containing costs and achieving quality through improved co-ordination and integration of services. Concepts of managed care typically try to achieve both these goals, although they are frequently seen as opposing objectives, but this is not necessarily the case. In fact, integrating services to enhance care quality often does increase costs for the extra effort, although in the long run it may reduce them. So, cost containment in one given area may be a prerequisite to free up sufficient resources for innovative integration. In addition, placing the organisation in a stronger position in negotiations with financing agencies (such as the state or insurance companies) may be a goal.

A managed care strategy should combine knowledge and technologies, the economies of scale of larger organisations, lower transaction cost, the pooling of budgets, common infrastructures, and research and development capacities to organise integrated care 'under one roof'. It is basically a strategy of optimising, so that different interests are balanced within the organisation through hierarchies and contracts.

Reviews of managed care and care trusts provide experiences with integrating partners (*see* Wernet 1999, James and Miles 2002, Bailyn and Miller 2001). In view of these experiences, the following design rules are suggested as checklist for practice. These rules should be observed beyond the management strategies applicable to any viable enterprise.

Checklist: Design rules for integrated organisations of care

- ✓ **Goals and policy guidelines** Establish policy guidelines respecting the basic values of integrated care which include principles of care quality and cost containment (sustainability), but also of solidarity, social justice and access for all. The success of integrated care depends on the trust of clients in the care relationship. Be aware that the exclusion of certain clients and their needs has to be justified by effective inclusion of these clients into complementary services, otherwise the principles of integrated care are violated and the legitimacy of the care system as a whole is in question.
- ✓ **Governance** Establish strong leadership and a clear management structure to support co-operative partnerships between very different professional and organisational interests and cultures in the field of social and health care (or even beyond, in areas such as housing or social work).
- ✓ **Costs, benefits and risks** Establish consensual and transparent regulations concerning the common budget, performance contracting, risk sharing, standard protocols of treatment, capitation and accountability, to guarantee a fair distribution of costs and benefits. This is especially important because there will be different cultures of dealing with questions of how, and indeed whether, to treat or charge, raising issues about concepts such as altruism, carer self-exploitation and professional ethics.
- ✓ **Infrastructure and technologies** Decentralise the service structures to optimise access. Implement advanced and innovative technologies for information, communication and transport, to achieve the combined goals of integration, cost containment and care quality.
- ✓ **Professional culture and staff qualification** Establish incentives to co-operate within the organisation and across boundaries, provide education and training and provide incentives for staff, by structuring careers in such a way that co-operation is rewarded. Establish training and education programmes. Integrated care intrinsically requires higher levels of qualification.
- ✓ **Organisations, boundaries and interfaces** Create effective and fair gatekeeping and discharge strategies and agencies (for example, case management). Integrated organisations develop necessarily clear boundaries between themselves, on the one hand, and external services and the community, on the other. These have to be handled by special procedures to assure seamless care across boundaries.

- ✔ **Quality assurance** Establish effective, transparent regulations for quality assurance and external audits. The public concerns of social justice and cost containment, and the vulnerability of integrated care service users, warrant effective external control of due processes, care quality and accountability.
- ✔ **Client orientation** Clarify and make transparent the relationships between the organisation and the clients, and the boundary between the organisation and the life world of the client and their broader community. Establish a respect for their dignity and privacy including ways of protecting their data. Note that hierarchical institutions tend to encroach on the life worlds of individuals.

A special emphasis should be placed on the final point in the checklist: client orientation. The client's personal, informal support network – as well as their wider community – are no more than co-orientation networks, in the terminology introduced above. So the interface and interrelations between the organisation and the life world of the client become a very difficult problem for integrated organisations following an essentially different 'logic' based on hierarchy and contracts, while the 'logic' of informal support is based on trust and norms or reciprocity. The problem is reflected in the differences between social and health care, since to be effective in its mission social care typically has to develop more 'open', trust-oriented structures and advocacy roles on behalf of the client.

Strategies for designing integrated networks

Integrated networks can be designed top-down or bottom-up. The strategy essentially has to develop more effective structures of governance between partners. As stated above, managing networks from the outside is especially difficult, since the external agent has to exercise influence without an accepted position within the network. Special qualities of the manager as a negotiator and 'boundary spanner' (*see* Goodwin *et al* 2003) are decisive for success.

Integrated networks essentially consist of fair, balanced and well-organised arrangements, regulations, contracts between organisations or agencies on the basis of negotiations on central values and policies, leadership and decision-making, and the co-ordination and co-operation of care activities, and the evaluation and sharing of costs, benefits and risks.

Networking is an 'art', rather than a science or a technology with guaranteed success. The basic process is one of communicating and negotiating with other people. In obvious win–win situations in which everybody gains by co-operation, forming an organisation or network is either not necessary or not difficult, and requires only a clear contract to avoid conflict over the gains. In other words, the market usually takes care of it.

Integrated networks are knit together by implicit and explicit contracts, but they depend essentially on trust. In practice, negotiating typically starts because attempts to solve the problems through the pursuit of individual interest by all partners (market model) and statutory regulations (hierarchy model) have not produced solutions. Professional expertise and insight alone cannot produce the solutions either, because typically integrated care depends on knowledge from a range of different disciplines and practical spheres and accepting other people's knowledge requires considerable trust.

In this situation, altruistic motivations or higher values are called for, to convey legitimacy to the initiative. Typically, voluntary or non-profit organisations are founded to establish a forum for discussion of the common cause and to address the problem. This is one reason why NGOs play an important role in many countries, and why integrated networks usually consist of a 'welfare mix' of statutory or state, private or market and NGO organisations. The rules detailed in the checklist below may be applied to design or improve networks.

Checklist: Design rules for integrated networks

✔ **Goals and policy guidelines** Establish a common vision that can help to identify members and clients with the network and promote trust. As in integrated organisations, the policy guidelines should respect the basic principles of integrated care, including care quality, cost containment (sustainability), solidarity, social justice, and access for all. Be aware that if you exclude certain clients, or clients with certain needs, you need to justify this by effectively including these clients into complementary services, otherwise the principles of integrated care are violated and the legitimacy of the care system as a whole is in question.

✔ **Governance** Establish clear procedures for common decision-making, and reach an agreement on strategies for conflict management, typically involving a third party to mediate negotiations. Decisions, commitments and investments should be made explicit and documented to support 'hands-tying' commitments. Focus on goals, values, knowledge ('software') and delegate tasks, technologies, productions, services ('hardware') to the level of partners (in other words, avoid interference with the work processes and technologies of the partners directly). Accept initial leadership, but safeguard against later domination of the network.

✔ **Costs, benefits and risks** Establish consensual and transparent regulations concerning the costs, benefits, performance contributions, risk sharing, standard protocols of treatment and accountability, to guarantee a fair distribution. This holds especially true because different organisations have different cultures of dealing with how, and whether, to treat or charge, raising issues about concepts such as altruism, carer self-exploitation and professional ethics.

✔ **Infrastructure and technologies** Set up the necessary infrastructures and ICT to ensure that all partners have access to information and other resources, and can effectively co-operate in the network. Make sure that the clients have equal access to the services provided in the network and that their voice is heard.

✔ **Professional culture and staff qualification** Establish incentives for potential members to co-operate in the network and to work across organisational boundaries. Provide education and training, and encourage staff to get involved in co-operative activities, by offering corresponding career opportunities. Also offer staff opportunities to learn about the professional culture and practices of partner organisations, such as common workshops, visits and exchanges.

✔ **Network boundaries** Establish transparent and clear rules for membership. Pay special attention to the criteria and procedures for new members. Decisions about inclusion or exclusion are vital to the network identity and to the members' willingness to invest. Be sure to include firm supporters of integrated care first (do not include everybody), and integrate new partners as they feel ready to accept established network policies.

- ✔ **Quality assurance** Establish clear criteria of quality performance for each network member. Create procedures for the development and proliferation of new standards and guidelines. Make use of opportunities for peer review, benchmarking and constructive criticism in an open network. Accept and evaluate, as a form of quality assurance, the feedback from service users and their choices between services of network members or choices of services from outside the network.
- ✔ **Client orientation** Use the opportunities of an open network to co-operate with clients and informal carers, and to co-produce integrated care, but respect the dignity and privacy of clients, including methods of data protection.

Again, a special emphasis should be placed on the final point in the checklist – client orientation. Co-operation in integrated networks typically develops in a situation of open community networks that have close relationships with the life world of clients. These networks are a valuable resource, but they can present difficulties in strategies emphasising a more managerial culture and professionalism in the pursuit of quality in integrated care. Telling examples of this problem can also be found in other fields of social policy, such as in networks on crime, disorder and drug prevention. (For examples, although with a somewhat different analytical framework, *see* Goodwin *et al* 2003.)

Some additional rules or strategies are important in practical networking. These are detailed in the following checklist.

Checklist: Additional strategic rules

- ✔ Remember that trust is based on past practice or iteration and habits, so establish regular and reliable contacts and procedures (meetings).
- ✔ Build up and safeguard the reputation of the network because symbolic capital is vital for the identity and for the attractiveness perceived from inside or outside of the network.
- ✔ Use the resources of a common history, such as religion, cultural or regional traditions, ethnicity or political party affiliation, to establish a common identity.
- ✔ Use local or regional criteria for membership, if possible. Territory can connect people even if they are from different social groups, and can also exclude others for a neutral, less controversial reason than social differences.
- ✔ Respect individual identity and minority groups among the partners by setting explicit rules. Some services might not be used frequently or involve only small groups, which usually will reduce their influence in the network.
- ✔ Be aware of the effects of exclusion as well as those of inclusion. Exclusion is necessary to focus membership, but it can create strong opposition.
- ✔ Accept initial costs and make them explicit. Be clear about the fact that creating a network will imply initial costs, even if the later benefits are high.
- ✔ Use knowledge as a resource whenever possible because knowledge is a source of power for the network, which can be shared. Objective or evidence-based procedures and standards are helpful for settling differences of opinion among members.
- ✔ Finally, be aware of the productive functions of competition and conflict. Do not integrate too much!

Staff

Three types of role in organisations and networks are vital for the success of integrated care: entrepreneurs, stakeholders, and care professionals. Unfortunately, in most systems the clients do not (yet) have an influential role.

Entrepreneurs

All literature on the success and failure of integration initiatives testifies to the fact that successful initiatives depend on individuals who identify with the goals, and invest their capacities, skills, influence and enthusiasm in the project. If these people stop being involved (or are dismissed), the project will seriously suffer or fail. This positive influence does not usually come from one single person but from a dedicated team that unifies vital functions, such as leadership, expertise, public relations, network integration and established influential connections. Innovation depends on entrepreneurs, and on their recognition, respect and support from partners inside and outside the initiative.

Stakeholders

Entrepreneurs fit into the stakeholder category, but there are also other actors and agencies that have to be supportive, qualified and resourceful. An initiative cannot usually select these actors, but has to accept them as given. But across the care system at large, it is vital that entrepreneurs find stakeholders in all fields, and on all levels, who are willing and competent to support and co-operate. In practically every project report that has a more personal tone, there are phrases such as ‘If it had not been for that particular person in that agency (whether a ministry, administration, political party or labour union board), this would not have happened’. Integration depends on a culture of support for integration.

Care professionals

Comparisons of integrated care in Europe (Jarvelin 2002, Mur-Veeman *et al* 2003) reveal that relatively similar problems of care integration can be found in all the countries. This phenomenon can be explained by the fact that, to some extent, the problems and solutions are produced by the care system itself – especially by the professionals in Europe, who share a relatively similar education and play a decisive role as stakeholders in the social and health care system.

So, strategies and structures that are designed to set incentives for professionals to co-operate and support integrated care are crucial to the success of care integration. These strategies include:

- emphasising the value of care quality and integrated care
- quality assurance, peer reviews, benchmarking and audits
- education of staff and rewards for co-operative activities in professional careers
- independent assessment of needs
- case management and disease management
- client education, empowerment and choice.

Barriers

There are many factors that might pose barriers to initiatives of integrated care. Frequently these are rooted in the history and structure of the specific care system or region, so there are no more general barriers than there are general solutions. Each situation has to be analysed in its own right. Thus, in this section we emphasise only some important aspects already referred to in the 'design rules' checklists (pp 44–48).

One great barrier is the lack of a culture of trust that provides accepted values, regulations, organisational models and procedures for co-operation. Past conflicts in the local setting can build up this barrier and they have to be addressed and raised to common awareness.

Another barrier that is very influential – for instance, in the relationships between the social system and the health care system – is that of differences of professional culture and discipline, which hinder dialogue and understanding across the divide and make a constructive discussion about goals and means difficult.

Deeply ingrained in each country's welfare system are more structural barriers resulting from the legal frameworks and incentive systems that promote the pursuit of individual interests and property rights at the expense of incentives for co-operation and collective benefits. These barriers are often difficult to overcome because the regulations typically cannot be changed by partners looking for more co-operation at the local level.

Supports

Most of the important factors supporting (or hindering) initiatives for integration have been mentioned in the design rules, so in this section we emphasise a few points again. The initiatives and interventions for integrated care should be embedded in a national programme for 'integrated services for older people' – which is, in fact, the title of a public programme and policy in the United Kingdom (*see* Audit Commission 2002). The development of integrated care in organisations and networks has to be supported by cultural, social and political changes throughout the social and health care system to provide a favourable ground for local or regional projects. Trust is an important feature that has to be based on widely accepted attitudes in favour of integration.

Especially for integrated networks, support must be available from experts, third-party agencies and financing programmes, which can provide guidance in network formation, mediate in case of problems and conflict, and provide financial resources, especially to overcome initial barriers. There also here needs to be guidance resulting from practical experiences. This type of support, with additional material, references and links and other useful resources including a report on projects in eight European cities (Goumans and Tamsma 2003) can be found on the EHMA website (*see* Web links, p 53).

Two factors are considered of special importance:

- awareness of the problem of integration in a care system shared by all partners
- awareness of the interdependence of the partners and their actions and solutions (*see also* Audit Commission 2002.)

Another factor that deserves emphasis here, although it is dealt with in Chapter 12, is acceptance and implementation of modern information systems and technologies. Many, if not most, expectations of increased integration arise because in an information and knowledge society, there are simply more opportunities for integration. Without the corresponding technologies, such expectations must be frustrated (*see also* Dykes and Wheeler 1997).

It is also of great importance that projects and initiatives exchange their experiences and learn from each other. Integrated structures have to be communicating and learning structures. This is what the CARMEN network and this resource book are all about (*see also* Vaarama, Pieper eds 2004). However, when it comes to co-operation and networking, each local and regional situation is different. There are some principles and rules, such as those provided here, but there are no ready-made models. Integration models cannot be transposed to different contexts as easily as some of the other models in this resource book because they cannot be implemented within the relatively well-defined setting of the care process itself. They essentially reach out to other fields and partners. There is only one answer: find partners and start learning by doing!

Conclusion

Integrating organisations and networks is an art. There are no simple recipes and there is no substitute for learning and experience in practice. This holds also for basic choices between 'top-down' and 'bottom-up' strategies, or between integrating under one roof of an organisation or integrating partners in a network. But in an open society, the search for – and experimentation with – arrangements improving co-operation in integrated care is not only a demanding challenge, but also a rewarding opportunity. In an information society, we not only have rising expectations of co-ordination and integration – we also have more effective and efficient means of communication. And in an ageing society, we have to find innovative and sustainable solutions for a rising demand. Integrated care is a means to an end – not an end in itself. We should not lose sight of the central goal of improving the life quality for everyone involved, from the frail older people with needs for integrated care to those who care, both inside and outside the professional system.

Key points

- **Trust, negotiation and commitment are essential. Integrated care depends on a culture of trust and co-operation.**
- **Integration is not simply an issue of well-organised co-ordination in a fragmented system – it requires negotiation between principles of optimising and finding a balance between diverging interests (principle of fairness).**
- **Integrated care can be achieved by markets, within an integrated organisation, by a co-ordination network, or by a co-operation network. Designing these basic model and strategies of power, exchange, trust and knowledge has to be combined in a way that is adapted to concrete circumstances.**
- **The choice of the strategy will have to consider, on the one hand, the risks and responsibilities involved for clients and providers and the need for accountability in the care system, and on the other, the preferences of clients for support at home, client choice and flexible combination of services from diverse providers, and the integration of informal care.**

- **Guidance for the design of organisations and networks of integrated care should include a checklist of eight important issues:**
  - **establishing common goals and policy guidelines**
  - **agreeing on governance regulations and decision-making**
  - **setting transparent rules for sharing risks and benefits**
  - **implementing adequate infrastructures and IT**
  - **ensuring staff qualification and developing a co-operative professional culture**
  - **clarifying organisational and network boundaries and membership issues**
  - **establishing criteria for performance quality and procedures for quality assurance**
  - **focusing on client orientation, client empowerment and co-operation with the larger community.**

- **More integration is not always the solution. Be aware of the productive functions of competition and conflict, and the dangers of integration, such as centralisation of power, exclusion, diffusion of responsibility, and encroaching on the life world of the client.**

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Web links

www.ehma.org – The European Health Management Association, which managed the CARMEN network, the group that produced this resource book. CARMEN publications and other materials can be found via the EHMA website or by emailing info@ehma.org.

www.integratedcarenetwork.gov.uk – UK government website providing a forum and guidance for researchers and practitioners of integrated care.

Chapter 3
Involvement, empowerment and advocacy

JAN REED

Any manager working in integrated care for older people will be aware of the current moves to involve older people in service and care planning and empower them so that they can make their voices heard and acted on in debates. Some of their performance indicators or organisational policies may require them to set up systems for consultation or advocacy. Alternatively, they may find that they need to do this to address problems with service user satisfaction, the efficiency of resource use, or the systems of care delivery, for example. They may need to know and demonstrate that their service is meeting the needs of older people in a way that is acceptable to them and valued by them.

Working in an integrated care system, however, makes developing the user voice more complicated. Managers need to develop systems that address the views of individual older people and groups or organisations of older people, and they need to be able to do this so that the discussion relates to the whole system of care, not just their service. This is because the experiences of older people are of the whole system, and their evaluations will reflect this. They might not distinguish between different services or organisations. Involvement in integrated care, therefore, is more complex than being involved in shaping a single service with well-defined boundaries.

This chapter outlines some of the debates about empowerment and provides short descriptions of some of the strategies that managers may want to try, both for individual and group involvement and empowerment of older people.

Definitions

The concept of 'empowerment' has been developed against a background of authoritarian services that have not listened to service users, and indeed have developed systems of decision making that have excluded them, both as individuals and as groups. 'Empowerment' means correcting this imbalance by changing systems and structures and providing support for service users so that they do have real power in the services they use. This may take several forms. Advocacy is one specific form, where an advocate speaks up for individuals or groups, and puts their case or expresses opinions on their behalf. As such, it falls short of empowerment, as it still means that the service user is dependant on the availability and skill of the advocacy provision, but in some circumstances it may be the most useful approach.

Sometimes the terms 'involvement', 'empowerment' and 'advocacy' are used interchangeably, as if they were the same thing. While there is some overlap, we use the following definitions in this chapter:

- **Involvement –** the extent to which older people have a role in shaping services. This may be quite minimal – for example, only being consulted, or on the other hand they may take a major part in making decisions about services or their own care.
- **Empowerment –** the process by which older people are given the support and resources that they need to become involved in care. This may involve providing information or material resources (such as transport and communication aids) or it may be simply about building confidence to participate.
- **Advocacy –** a specific strategy to support involvement. A person or team of people is given the responsibility to find out what older people want, and to present this to service providers. This is usually on an individual basis, but can be to represent groups, and can be a formal role or be an informal development.

Objectives and intended outcomes

As integrated services have developed, there has been a move away from thinking about service users as passive recipients of care who do not challenge the assumptions that professionals make about what they need. One of the features of state or charity-run services has been that service users are expected to be grateful for what they receive, and are not considered to have the necessary knowledge or understanding to question what is provided – still less, to play an active part in shaping these services.

This ethos is now changing. As private-sector companies become more involved in providing services, they bring with them ideas about customer choice that have also affected the thinking of other providers. As people become more aware of the way in which they pay for services – either through taxation, insurance or by direct payments – they become more likely to see themselves as consumers, and therefore as people who should have a say in what is provided. Consumerism is not the only driver for change, however. Increasing challenges to the expertise of professionals and policy makers, coupled with a movement to make services more democratic and accountable, have also led to calls for service users to be more involved in the way that services are run.

Service user involvement, therefore, is an aim of services and systems that subscribe to the values of democracy and consumerism. It is a broad term that covers many other ideas and concepts, but essentially it is about making service users part of the decisions made by service providers. As part of the move towards involvement, we may also need to consider the concept of empowerment, and the particular strategy of advocacy.

The outcomes for services are:

- that services have an effective system for listening to, and acting on, users' views, and involving them in decision-making
- that these systems operate on both an individual and a group level
- that these systems are adequately supported and managed.

Checklist: Forming priorities

✔ Consider whether the voice of older people is heard effectively so that your service is really responsive to their needs.

✔ If not, consider whether you should be doing more to:
  - involve older people

  - empower older people
  - provide advocacy for older people.
- ✔ Finally, consider whether one of these should have priority over the others.

Models and approaches

As Barker, Bullen and de Ville (1999) say, 'There is no right way of involving the public. The choice of methods should be matched to circumstances in which it takes place.' This section looks at the various different models that have been identified in services. These can be represented as a continuum of empowerment:

provider control ——— partnership ——— user control

The main dimension of the continuum is power. At the left-hand end, the power is all with the service provider, while at the right-hand end the power is all with the service user. Often, however, it is difficult to tell one from the other. Sometimes what may look like a partnership is really tokenism, where older people are included in processes so that the organisation looks as though it is involving them, but in fact they are not really listened to. Managers need to move towards the middle of the continuum, to a partnership position. This position ensures that involvement is effective and meaningful, and avoids the development of user-controlled services, which may give rise to the problems outlined (*see overleaf*).

Provider control

At the provider-control end of the continuum, services users may be invited to sit on committees, or given evaluation questionnaires, or asked about their preferences, but there is little effort to do more than collect their views, and there is no commitment to do this effectively, or to act on these views. Evaluation questionnaires that are given out may be poorly designed or difficult to complete, and there is no system for collecting them or analysing them. Similarly, people may be asked about their preferences for care, but there is no system for responding to these opinions or wishes.

These tokenistic models are most likely to operate in organisations that have been given empowerment targets to meet but in which the change in thinking that is required for empowerment has not taken place. An example would be where a committee has to have one member who is a service user member, so it invites someone to join but chooses them from a small pool of familiar people that it feels are supportive rather than critical of the service.

Tokenism does little to achieve real user empowerment, merely serving to give the appearance of meeting externally imposed requirements. It can be a precursor to real changes in thinking, as service providers become accustomed to involving service users, but it can also be an excuse for not doing more.

Partnership

Partnership sits near the middle of the continuum, representing a position where power is shared more equally between service providers and service users. This requires efficient processes of communication and discussion to ensure that users are sufficiently well-informed to participate in discussions without feeling that they are at a disadvantage because they do not understand key issues. These may include information about service agendas and goals, policy directives, and service resources and expenditure.

Partnership also requires changes in organisational structure so that service users become part of the decision-making procedures and have responsibilities and duties towards improving services, rather than simply commenting on services and having no responsibility to promote improvements. Sharing responsibilities should also be accompanied by shared rewards and recognition. There are, however, problems in negotiating payment for user input. If the service provider pays the service user, this can cause problems with their benefit entitlements – but also, perhaps more importantly, the service user may lose their independence from the service provider and feel unable to be critical.

User control

At the user-control end of the continuum, service users have most, if not all, the power – for example, by setting up their own services. Complete user control is difficult to establish within existing service structures because of the legal regulations on accountability, which normally specify some form of professional skills or knowledge as a basis for practice.

Because of these constraints, complete user control is usually only possible if users set up their own, non-professional services. These services may meet needs that service users feel are not met by established services, but they may not have the benefit of professional knowledge and expertise. They may also have problems in accessing stable funding sources. Most typically, they are voluntary agencies or charities and are dependant on donations, which fluctuate according to the popularity of their cause.

User-controlled services may pose a healthy challenge to established services, but if they remain completely separate, they may cause a number of problems for older people. They may duplicate provision, complicate care delivery, and compete for resources. So where user-controlled services exist, it is important to find ways of working constructively with them.

Checklist: Assessing your situation

Ask the following questions:

- ✔ Is user involvement in your service based on provider control, partnership, or service user control?
- ✔ Are you willing to move towards more user empowerment, or is this unrealistic?
- ✔ Are you prepared to take the risks inherent in user empowerment?
- ✔ Can you afford not to take these risks?

The implementation process

Chapter 11 identifies some ways of ensuring that older people are involved in planning. Empowering individual older people may be best done through individual advocacy services, keyworker systems and good quality information and communication about their options. These strategies should form a fundamental part of quality assurance processes in services but can become extremely complex when working across services – it is difficult to find a source of information that is comprehensive and up-to-date. Before service users can be informed, providers have to develop knowledge and understanding of the 'whole system'. (This point is also reflected in Chapter 9, alongside a discussion of how to facilitate 'thinking across the system' in staff.)

To design a strategy for empowering older people who use services across the system, the following questions need to be asked:

- Is the aim to empower individuals or groups of older people?
- Is the issue specific or general?
- What support is needed?

Is the aim to empower individuals or groups of older people?

Empowering individual older people requires a one-to-one approach in many cases, with an identified advocate who can inform people about their options and help them choose a course of action. This role may also involve supporting older people in disputes with service providers, so it may be better to identify an advocate who is independent of the service. In any case, they must have comprehensive knowledge and the opportunities to update this knowledge, as well as communication skills, and the time and skills to provide people with counselling when necessary.

If the aim is to empower groups of older people (a 'user population'), then the first step is to define the groups. If the groups are made up of people with particular needs, make sure strategies are tailored for them, bearing in mind the problems that they may have. Ask questions about how to approach and identify potential members. Use proactive recruitment to help access those who are more frail or reluctant to participate to avoid a situation where groups are represented only by the fit and articulate. Consider how the older people's involvement can be supported in terms of transport, facilities, and help with costs or payments.

Is the issue specific or general?

If the aim is to tackle a specific organisational issue, then setting up systems for involvement can be time-limited, with clear aims. A specific focus also provides clear indicators for recruitment from service users or interest groups. Those known to have experience or knowledge of the issue are obvious choices.

If the aim is more general – to include service users on quality assurance committees, for example – give more thought to identifying appropriate people to invite. Just because someone is older does not mean that they have an interest in the issue at hand. It is important to consider skills and experience, bearing in mind that choosing people who are already familiar may exclude others with contributions to make. Make the basis for the invitation clear to everyone – in other words, what contribution or representation is expected. Succession planning is also important – if this person stopped being involved, who would be asked to replace them?

Systems and instruments

Various instruments can be used to facilitate user involvement at both an individual and a collective level. These include strategies to:

- empower and involve groups of older people
- empower individuals.

Group strategies

The following strategies have been used to empower and involve groups of older people:

- forums
- user panels
- consultation
- user groups
- user-led services
- campaigning and direct action.

Each of these is described in detail below.

Forums

In the context of older people's issues, these tend to be local groups, set up to debate and campaign on local issues, with a membership drawn from older people's groups and individuals. Membership often depends on availability and energy, so they tend to exclude older people who are frailer or less mobile. They can be supported by local services, which may donate office facilities or meeting space. They are independent of services, and are wide-ranging in their interests, so their activities may not be directly relevant to service development.

User panels

This kind of group is more focused than a forum, and sets its own agenda to address a particular issue. User panels may invite people along to provide information, or canvass wider user views and experiences through questionnaires and other tools. Participants enjoy being involved, but unless their reports are acted on, they can feel frustrated. These panels need a wide-ranging membership and clear terms of reference to maintain credibility.

Consultation

Here, agencies carry out specific exercises to canvass user opinions about specific issues. This can be through surveys, public meetings and focus groups. In addition, developments in information technology have increased the possible consultation mechanisms. However, views have to be collected through a user-friendly process to maximise responses. The process may be managed by a researcher commissioned to carry out the consultation exercise, but the findings are limited to the specific issue in question.

User groups

These are made up of people who use services, and who experience similar problems and have similar needs. They may have national or international links, and so can draw on a wide range of information and experience. They are often formally constituted, with structures and systems for consultation, and are relatively stable. They can therefore offer representatives as members of committees or user forums.

User-led services

In this instance, user groups set up their own services to provide an alternative to existing services, fill gaps in services or complement existing services. They are managed, and sometimes staffed, by service users, and are usually non-profit making. They may rely on grants or fundraising activities, and so are often vulnerable to changes in funding priorities. They meet the needs and preferences of service users, as they themselves have identified their activities. They can play an important role in integrated services.

Campaigning and direct action

This involves older people getting together around a particular issue and campaigning about it. Examples include campaigns for better pensions or equal access to services. Traditional methods have included marches and petitions, but recent technological innovations have led to more high-tech campaigns, such as emailing politicians. Campaigns can be very effective around specific issues, but are difficult to sustain over time and across issues, although longer-term, broader campaigns can develop from initial movements.

Practice example: Involving older people in planning services

This exercise was initiated in Noord-Brabant, the Netherlands. It aims to involve elderly people by developing local policy. The idea is to try and stimulate as many older people as possible to think together about their future, and about how they like to live in their home and neighbourhood. They can do this by answering questions such as:

- What do we need to keep on living (independently)...
  ... in our own homes?
  ... in our own neighbourhood?
  ... in our municipality?
- What kind of services do we think we will need (care/welfare/housing, and so on)?
- What local policy is needed?

Older people and their organisations are responsible for taking the initiative to organise the project, because they are often aware of which services they currently need, and which they are likely to need in the future. Local authorities and provinces need to collaborate, perhaps working alongside a welfare organisation, to offer support such as finance, advice, additional capacity and other services.

The project takes one-and-a-half years to complete and costs around 17,500 euros, 50 per cent of which is paid by the local authority. This model is being rolled out across five other provinces, with a total of 46 projects. Some have already finished and the main conclusion was that this simple method really works. For example, in the village of Berkel-Enschot, positive outcomes of the project included:

- more houses/apartments for older people being built
- a welfare organisation deciding to contract some elderly advisers
- more activities for lonely older persons being organised.

For more information about this project, go to the PON website (see Web links, p 66).

Individual strategies

In addition to the strategies outlined above, there are also some other approaches that can be used to empower older people in shaping their own individual care. These include:

- advocacy and information services
- keyworker or care manager systems
- person-centred care planning
- direct payment schemes.

Each of these is described in detail below:

Advocacy and information services

Services can be set up to inform and advocate of behalf of older people using services. ‘Advocacy’ may form part of the role description of staff providing services, but staff can feel some conflict between advocacy and their role in the organisation – particularly if there are disputes. For this reason, an independent advocate role is sometimes the better option. It can be supported and funded by provider organisations, or by independent bodies such as voluntary agencies.

Co-ordinating advocacy and information is very important in integrated care, as it ensures consistency across agencies. There are some debates about when an advocacy service should become involved. If advocacy only starts when there is a dispute or a problem and difficulties have already begun, this is in many ways too late. However, routine advocate support may be expensive and beyond the means of individual services. In the Netherlands, a system has developed in which older people have ‘advisers’, and this has been well evaluated. Services elsewhere could consider setting up a similar advisory or advocacy service across agencies as part of their process of integration.

Keyworker or care manager systems

One approach that may overlap with advocacy systems is to develop a system in which the older person has a named individual who is responsible for assessing their needs, planning their care, delivering their care and monitoring its delivery. Someone who oversees care may be called a ‘care manager’, and someone who directly gives care may be called a ‘keyworker’ or ‘named carer’, depending on the country and system. Over time, a relationship between this person and the older person develops, which allows trust to be built up and communication to be effective. Where keyworkers have some control over resources, they can plan care and allocate resources with full negotiation and discussion with the older person. Where they do not hold budgets, they can act as advocates on behalf of the older person.

Keyworker and care management systems need to be set up so that the relationship is sustained over time, and so that staff are aware of their responsibilities and have the skills to carry them out. This has implications for training and staff development, and also for the way in which work is organised within the agency. Staff must be able to maintain relationships, which means having a stable role and clear client responsibilities. They also need the skills to develop and manage relationships with clients, and the knowledge of resources and systems that will enable them to co-ordinate care effectively.

Person-centred care planning

Another way in which older people can be empowered is by having an effective care-planning approach that actively requires them to express their views and wishes. Many care-planning systems are written and carried out for the benefit of service providers, and choice is limited by the systems that have already been set up – for example, someone may get help going to bed only within the hours that have already been decided on for this service to be available. A strongly user-focused care planning system starts off identifying the older person’s preferences and needs, as they define them, and then looks to see how these can be met.

As with the keyworker approach described above, person-centred care planning requires staff with time and skills to do this, and recording systems that make the process of discussion clear. Care plans need to be negotiated carefully, with dialogue with the older person and, where appropriate, their significant family and friends. In integrated care systems, these may need to be extended across the system, to make sure everyone knows the aims of the care. This may raise ethical issues about the confidentiality of information, and practical issues of record design and accessibility.

Direct payment schemes

One strategy currently being developed under various names is that of direct payments. Here, instead of services being decided upon by providers, the individual older person is given a budget or sum of money, which they can spend on the care and services that they decide that they need. This may mean that they buy services that are not provided by main agencies, or in ways that are not provided by traditional services, such as transport to social events that take place late at night. In some systems, the care may be provided by friends or family, in which case the money can go to them.

Direct payments potentially allow people to develop a care package themselves that will meet their needs and preferences better than existing provision. There are, however, some potential problems. First, individual solutions may not engage with service development, and individual strategies may not be incorporated into service development. Second, there may be issues of quality management – in other words that older people may not get high quality services, and may feel unable to complain or change them (especially if they are provided by friends and family). Third, the process of choosing services and managing them may be difficult for some older people, and so they may need some support.

Practice example: The daily living plan

For an older person moving into a care home, one of the greatest fears is that they will have a very different lifestyle to the one that they would like. Part of this fear comes from a lack of knowledge about care homes, which makes it difficult for them to imagine what life be like living in one. In addition, care home staff have found that when they first move in, older people are often too anxious 'not to be a trouble' to state their preferences and make requests.

The Centre for Care of Older People at the University of Northumbria and Newcastle City Hospitals Trust devised a 'daily living plan' for older people moving from hospital to a care home. The older person completed the plan with a member of the hospital staff (usually a nurse who had got to know them). This involved the nurse helping the older person to think about their preferred routines and habit – for example, what hobbies they had, and whether they liked to spend time alone. The hospital could then send the plan to the care home with the older person, so that the staff there could see what sort of lifestyle was preferred.

The plan was very popular with care home staff. The hospital staff also found it worthwhile, if time-consuming, and it made them think about aspects of life in care homes that they had not considered previously. The older people enjoyed the process, on the whole, although some were overwhelmed by the number of forms to fill.

> The daily living plan was extremely successful and, with careful monitoring, could be adapted to use in other circumstances – for example, as a general review of lifestyle and support.
>
> *For more information on the daily living plan, email the author at:*
> jan.reed@unn.ac.uk

Staff

The strategies and tools outlined earlier in this chapter indicate some of the staff development requirements of an integrated system that facilitates older people to have their say. Training must be available to develop interpersonal skills, including clear communication and negotiation strategies. In addition, staff need up-to-date information about the whole system of care, including what other agencies can provide and how these services can be accessed.

The new roles and practices involved in empowering older people may be very challenging to those accustomed to traditional ways of working, so staff may need support from managers and colleagues to sustain changes. Some strategies can be found in Chapter 9, but these may range from informal support networks and interest groups to more formal systems – for example, recruiting people who have appropriate attitudes and experience, or implementing appraisal and monitoring procedures that identify empowerment as a key performance indicator.

Barriers

There are a number of potential barriers to empowering older people using services. The one that is most frequently raised is that of resource limitations. This may include financial resources, such as equipment and building modifications to make access to meetings possible. Supporting older people in making choices also involves staff time – a valuable resource that is often in short supply in organisations trying to make a limited budget stretch.

Financial resources can also include human resources – having a skilled and experienced workforce. Perhaps the most difficult workforce-related barrier, however, is attitudinal – that is, where that staff do not have positive attitudes towards the empowerment of older people. For example, they may have a general, ageist attitude that sees older people as less capable of involvement, or less deserving of empowerment. Negative attitudes may also arise from the workplace culture, where service users are seen as objects to be ‘processed’ as quickly as possible in order to meet organisational performance indicators. People who hold this view strongly may see empowering older people as a waste of time.

Supports

Communication and information are vital, as mentioned earlier, and facilities, access issues, resources and staffing also need to be considered. In addition, consider the following:

Checklist

- ✔ Arrange meetings at convenient times in accessible places, with adequate facilities and staff to support the activity.
- ✔ Make sure questionnaires and letters are easy to read and to respond to.
- ✔ Identify staff to co-ordinate the activity, and make sure they have the necessary time and resources – this can be a useful mechanism to ensure that problems are avoided and involvement maximised.
- ✔ Consider whether you want to empower individuals or groups of older people.
- ✔ Think about whether there is a specific issue to be addressed or whether you want to ensure that older people's voices are in general better heard, and in the latter case, consider how to choose the best people to represent older people.

Conclusion

Involvement is an ongoing process that requires cultural change within organisations, and across the whole system of integrated care services. Involvement can help ensure that services are meaningful and useful, and that they are integrated. Users are well-placed to identify problems and gaps, and if they are involved they can make constructive suggestions for improvement, rather than resorting to complaints procedures, to make their voices heard.

The benefits to the whole system of integrated care can be huge, but developments in individual services may take time to spread across the system, and early days may be difficult as some services involve older people more than others. This, however, is part of the process of whole-system change, and is not a reason for not doing it.

Key points

- **Empowering older people to become involved in service development is a complex process.**
- **If the empowerment process is not adequately supported, it will result in tokenism or, as older people become frustrated, in user-controlled alternatives to existing services.**
- **Support includes providing information and good communication, to enable older people to have meaningful involvement.**
- **Involving older people means not only listening to them but acting on what they say.**
- **Care must be taken to involve a range of older people – not just those who are fit and articulate.**
- **Empowering older people also involves a change in thinking on the part of service providers, and engaging with the ethical debates and values that underpin involvement.**

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Web links

http://independent.livjm.ac.uk/healthforall – an internationally recognised structure that enables those working to improve the health of local communities and apply 'health for all principles' to meet and share information, research and experiences.

www.communitiesforhealth.net/health-activist/index.html – provides information about training health activists, including outlines of what skills are needed, and available training initiatives.
www.healthvoice-uk.net – a Health Voice Network website set up to enable more people to have more of a say in planning and improving services that affect their health.

www.healthyliving.org.uk/links.htm – the website of the Healthy LIVING Project, which works to bring people and groups developing healthy living initiatives together through information and communication technology.

www.ponbrabant.nl – Website of PON Institute for Advice, Research and Development in the province of North Brabant, the Netherlands. This organisation works in the fields of health and social care, housing and welfare, work and employment, education, culture, sports, and social environment. The site provides facts and figures and information about its projects and activities. It is in Dutch.

Chapter 4
Needs assessment

GUNNAR LJUNGGREN

The needs assessment process is perhaps the single most important part of optimising care for the older person in integrated care. The challenge for managers is to ensure that the client-centred assessment takes place within a 'whole system' that delivers the right assessment at the right time. This process should not be seen simply as a matter of data collection but also as a starting point for making priorities and optimising the resources – and thus the care – from the client's various care providers. The information arising from the needs assessment will be the basis for organising the chain of care and managing the system.

To the client, the needs assessment is the grounds by which he or she is seen as an individual and can interact with the service provider and the funding agency, and can thus discuss and influence the care. To the manager, the needs assessment is a more objective tool with which he or she can balance the resources to the summarised needs of clients. On a systemic level, the needs assessment provides information that enables authorities to scrutinise costs of care in comparison to other costs in society, and make priorities.

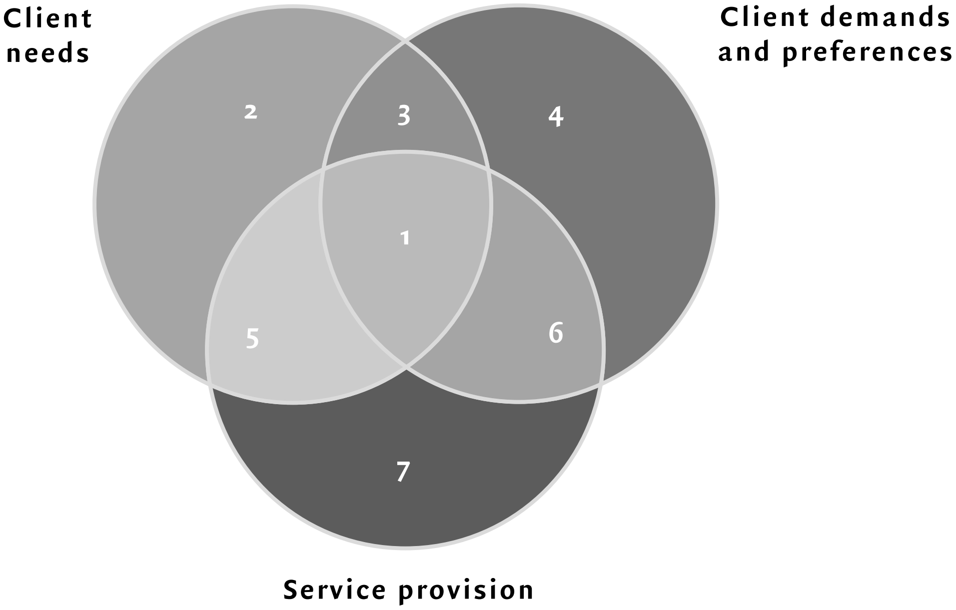
It can be tempting to make a rough estimate of what a client might need, but it pays off to try to obtain a more holistic view (including functional deficiencies that need to be supported by various services, and strengths that could be a base for further rehabilitation to support client autonomy). This view can enable data to be gathered through one process to be used for all levels of decision-making: from the care given via management of staff and resources to national monitoring, or even international research. A comprehensive assessment covers many domains, the most important ranging from health care, physical and social function, psychological and spiritual needs to environmental and economical needs, as well as the preferences of the client and informal carers.

It is beyond the scope of this resource book to go too deeply into the philosophical concepts of client 'need'. However, managers must nevertheless consider that there is always someone defining the need. It may be the client and the family, the integrated team, the single assessor among the health and social service professionals or the purchaser. Alternatively, the need may be defined by government. One way or another, whoever defines them or however they are defined, this is the opportunity for the manager to influence the team members and division of labour, to balance the available resources to the assessed needs and client demands.

When managing the care needs in relation to services provided, the manager has to consider all of the following perspectives:
- client needs
- client demands and preferences
- service provision.

These perspectives are shown in Fig 2, below.

Fig 2: Three perspectives to consider in care management



Key

1 **Care that is needed, demanded and well produced (which should be – and usually is – the largest part)**
2 **Care that is needed but not demanded nor provided (for example, from patients with dementia or psychiatric illness, or who are chronically ill or have language problems)**
3 **Care that is both needed and demanded but not provided (due to budget restraints or long waiting lists)**
4 **Care that is demanded but not needed nor provided (for example, if a client or insurance company requests x-rays or investigations that are required for reasons that are not evidence-based. These may need to be provided outside public funding)**
5 **Care that is needed and provided but not demanded (including preventive measures such as influenza vaccinations, or screening for functional decline)**
6 **Care that is demanded and provided but not needed (for example, over-diagnosis, or activities performed 'to be on the safe side', either from the client's view or the professional view or both. Examples include clients receiving help with cooking or transport even if they do not need it, 'to be on the safe side', or relatives requesting tube-feeding for a dying dementia patient, which is considered ethically questionable in most countries)**
7 **Care that is provided but is neither needed nor demanded (such as services that are already provided by others, informal care that covers needs that are also met by publicly funded agencies, or ineffective methods in diagnostics or treatment). Home helpers and others carry out many activities due to tradition, despite there being no evidence of their benefits.**

Source: Adapted from unpublished material from Stockholm County Council

The prevailing attitude in many countries is that there is a need for a comprehensive process that is more structured and standardised, to establish the basis on which the service packages are planned. This type of process makes it more difficult to overlook client needs that are important, or not immediately evident, which could decrease their quality of life in the future.

Definitions

A 'needs assessment' is a process of establishing the needs of a service user. It may trigger a package of services. The assessment may be carried out at various stages, so it can serve several goals, and it falls into three main types:

- **assessment for eligibility for services** to determine eligibility for service and funding for someone who is not yet into service delivery
- **simple needs assessment** to establish early on the most appropriate care plan, care pathway and package of care for a client who has recently entered the service delivery system, to determine the diversity of their needs, if they are not too complex
- **comprehensive needs assessment** to establish a full care plan for a client with complex needs, but also to evaluate the appropriateness of the service provided, and see whether it is necessary to add, withdraw or in other ways make changes in the service packages (*see also* Monitoring and evaluation, p 77).

The first option, an eligibility assessment, is the least resource consuming of the three, and may be the initial step in a care episode. If the client's needs do not seem to be too complex, a simple needs assessment (the second option) could be added to the eligibility process. For example, if an older person needs help with cooking or laundry, and no family or friends are available, the decision to provide meal services or washing services does not need a full needs assessment. The third option of a full evaluation is more costly but is needed in integrated care for people with complex needs, to organise, provide and manage their care from different agencies or professionals.

Objectives and intended outcomes

The overall objective of the needs assessment is to obtain a picture of the client's needs that balances their requests for services with an objective analysis of their needs (in the light of limited public funding), and spending decisions. This process involves ethical decisions, drawing on concepts such as equity, integrity, and autonomy.

The needs assessment is intended to support clinicians in planning care for individuals, and to support service planners to ensure that service developments are matched to greatest need as far as possible, and to prioritise between different needs (*see* Achterberg *et al* 1999, Aminzadeh and Dalziel 2002, Challis and Hughes 2002, Hawes *et al* 1997). Depending on the reason for the needs assessment, as outlined in the previous section, more direct objectives can be identified.

Assessment for eligibility for services

The needs assessment for eligibility of services may be performed to:

- put measures in place to safeguard equal access
- prevent unnecessary access to care
- monitor the development of demand, to provide information for strategic planners.

Today, most EU countries have a legislation on this type of assessment, to assure a more just access to services within each member state.

Simple needs assessment

A simple (short) needs assessment may be performed to suggest a care plan delivery for people with few needs, where only a few service packages will be considered. In some cases, this simple approach is adequate. For example, when only a few services are considered, such as shopping, cooking or transport services, a simple needs assessment will enable service providers to find out whether the client is satisfied with the quality, and to detect whether a rearrangement is necessary. It can also enable management to make sure their services are producing the desired results. This assessment can also enable screening into more heavy care.

Comprehensive needs assessment

Where clients have more comprehensive needs, professionals and informal carers are presented with more challenges. Here, the needs assessment provides a structure for collecting the information from all parties involved, where this 'global' information is used for all as a basis for visualising the needs for integration of services and shared responsibilities.

The more comprehensive needs assessment is carried out to:

- establish care plans, service packages and needs for integrated care for persons with complex needs
- control and develop quality of care later in the care process
- evaluate outcomes, such as resource consumption and caregiver stress.

The purpose of this type of needs assessment is to obtain a view of the client's needs that is fuller than that of the eligibility assessment. The reason for this is that a broader assessment might highlight new needs that have not been dealt with earlier. At first glimpse, this may lead to higher resource consumption, but evidence shows that identifying and handling needs earlier on improves the quality of care and quality of life. It also enables service providers to prioritise their activities better.

For the manager of integrated care, a needs assessment at this level provides a reliable summary description of the area or agency workload to request and allocate resources more appropriately. They can use this information to help intertwine the services that are delivered by several participants in the care of the older person. This information also enables providers to meet their legal requirements to provide authorities with information about their work.

Assessment as part of service evaluation

A needs assessment may be carried out as part of an evaluation of the services given. If this is a standardised and comprehensive procedure, this could solve various problems.

The existing services may not meet the client's needs for a number of reasons. For example, if they are based on historical factors, they may be obsolete or out of line with the client's current needs. Without re-evaluation of services, historical inequalities or errors may be perpetuated. Another possibility is that the services may be too demand-led. In this case, only those who ask for the services receive them, and only the most urgent needs are met. This prevents service users from obtaining early information about the client's physical, cognitive or social decline that may enable them to put preventative measures in place. Another problem is that needs that are obvious at a first glance may not always be the ones to cover first.

Risks such as these are more easily prevented if service providers carry out a more structured needs assessment, based on more global knowledge of the service user's needs and declining functions with increasing age. If a client is suffering from incontinence, a simple solution would be to prescribe the use of diapers rather than making a thorough investigation of the cause of the incontinence. This risk is evident if the staff believes incontinence is a natural part of being old – as with loss of memory, appetite or thirst, and these misconceptions can be a hotbed for ageism and stereotypic views of elderly people. But by requesting a more thorough picture of the client needs and analysing the educational needs of the staff, the providers can clarify which problems are simply due to ageing and which require treatment. In some cases this may also enable preventative treatment in certain conditions, if they are discovered sufficiently early.

Assessment outcomes

Nevertheless, a needs assessment will not resolve all issues – indeed, it may even give rise to new questions, such as:

- How does one deal with a situation where there is a conflict between client needs and client demands and preferences?
- How should one link present service activities to the needs assessment?
- How can one include risk management to the assessment process?

To deal with a discrepancy between client needs and preferences, it is important to involve the client and his or her relatives in the care planning process. This situation should also be dealt with in the team discussions, to ensure a true balance between different interests. With a fuller picture of the client needs, we can more easily make priorities and remodel different services, if we consider them based on clients' unmet or over-met needs.

Furthermore, if the assessment is carried out comprehensively, this increases the likelihood of discovering risk areas and preventing risks such as psychiatric conditions (often disguised by the client or relatives), violence between spouses (often not reported), and environmental risks (carpets and electrical cables to stumble on, lack of heating or air conditioning).

Checklist: Assessment outcomes

- ✔ **Sharing information** Make sure purchasers, service providers, service users and their carers share information about their clients' functional deficiencies and remaining strengths, to develop a deeper understanding of the service users and their needs, and to make everyone, including the clients and their relatives, part of the process.
- ✔ **Carers' needs** Consider whether you plan to screen for the informal carers' needs.
- ✔ **Care planning** Do you encourage your staff to work according to evidence-based standards? Do you communicate the care plan, and its intended outcomes to all parties in the integrated care?
- ✔ **Resource planning** Make sure that the tasks performed and resources used are selected by a thorough analysis of the needs and wishes of the client.

The importance of needs assessment

The care provider uses the comprehensive needs assessment to obtain a better picture of the client, and can use this to provide a more professional care plan, alongside the other members of the care providing team. This is more easily done if the assessment is carried out by professionals who are involved in the actual care delivery. They can also work with the client to balance different needs over time and to help prevent physical and social decline. As a result, the service providers will have better self-esteem in their employment, and will have a better sense of their professional development.

A full assessment also provides the client with a better view of the types of preventative measures than the assessor, or care provider, can offer. Evidence shows that multi-disciplinary groups are preferable to single-discipline approaches in needs assessment (Fleming *et al* 1995), even if they are still uncommon (Morris *et al* 1997). However, the multi-dimensional approach has also been addressed as cumbersome and time-consuming (Applegate *et al* 1990).

On the management level, a standardised assessment also allows one to aggregate functional and needs data from the individual to the population served. Managers who do not use the suggested models and techniques referenced later, will have a much more difficult task to defend the resource allocation of their organisations. Neither can they adjust the competence and educational level of the team around the client.

Models and approaches

Most European countries have some legal prerequisites on how and when to carry out the eligibility needs assessment, but few support the use of a comprehensive assessment process. Instead, this is the responsibility of the professional care givers working with the client. Governments do not wish to be too closely involved in more thorough assessment processes because of the often prevailing division of responsibility, where the government has the responsibility of surveillance while the local authorities have the role of implementing and executing assessment and care delivery. So the legal frameworks are designed only to help the funding agencies and care providers offer social and health care support, based on equity, allowing for the client's integrity and supporting their autonomy. However, there is no common, European-wide model for establishing the access and financing of services to older people.

In some countries, such as the Netherlands, eligibility to long-term care or home-care services is assessed by actors independent from those involved in care provision and funding, based on standardised procedures and instruments. In most of the Nordic countries, eligibility assessment is carried out by funding and/or care providing agencies, either together or separately. A few governments, such as that of the United Kingdom, are already requesting a needs assessment that combines social and health care needs in the same process.

These models can work at a range of levels. They can provide everything from a simple screening of needs by a single assessor to a comprehensive, multi-professional team assessment. They can be performed as a basis for eligibility alone, or can provide a holistic view of the client's needs for thorough care planning, including risk management. They can be based on primarily medical information or on a multi-dimensional basis. They can be performed in one step or in multi-stage phases. They can also provide information on quality issues, client preferences, and evaluation and follow-up.

In several countries, there are now practical suggestions on how to go about the assessment process. In the United Kingdom, there is the 'single assessment process', which also suggests instruments to use (*see* Department of Health, Web links, p 81). In the Netherlands, there are now detailed eligibility criteria and forms. However, many consider these to be expensive and bureaucratic. The New Zealand government specifies when to carry out the assessment, at which levels, for which client groups, and with which instruments (*see* NZGG, Web links, p 81). For some national initiatives on the use of standardised assessment data on older people, see the articles on Canada, Iceland, Italy, and the United Kingdom on the Milbank website (*see* Web links, p 81).

The implementation process

The first question to ask is what systems need to be in place. In many countries, much effort has been made at the national level to agree on how a person with minimal to extensive needs, in one or several domains, can be supported through public funding, by balancing existing resources and interacting with informal carers, volunteers and NGOs. This requires comprehensive information on both needs and services. In integrated care, however, less emphasis has been focused on this area to date. During the implementation process it is important to relate to and discuss at the managerial level, as well as in the team, the following issues:

Action points: Choosing systems

✔ **Access to care assessment** Ask:
  - Who triggers the needs assessment?
  - What is society's decision on what should be covered by public funding?
  - Who pays for the assessment?

✔ **Information sharing** To avoid duplication of work, once the information is collected, it should be available to everyone involved in the client's care, as long as the information is necessary and the client does not object.

✔ **Monitoring care** The care plan should be open to all involved in the caring process, in order to allow early intervention if things seem to go wrong, and to support with more resources when needed.

✔ **Complaints and appeals** These must be taken seriously. This calls for objective measures to be used and scrutinised by everyone involved in the client's care, as well as by clients themselves. In some countries, such as Germany, the agency or funding body have appeal options. In many municipalities of other countries, such as Sweden, there is a special ombudsman available to take care of complaints.

Systems and instruments

This section looks at the assessment instruments that are available, and the reasons for using methodologically developed instruments. During the past 15–20 years, there has been much clinical research on the methodological issues of needs assessment (Applegate *et al* 1990, Fletcher 1998, Morris *et al* 1997). It has addressed questions such as:

- How does one obtain reliable and valid information?
- How can one include the clients and their carers in the process?
- How should one balance the need of in-depth information with the issues of time consumption and costs?
- How can one use the information about the work that is carried out to meet the managers' and government's requirements for monitoring, evaluation and research?

Based on this, there is little reason to use instruments or techniques that are not described in the literature. Using such instruments often produces better care (involving the client and informal carers as part of the process) and better data to use for management and surveillance at local, regional and national level.

Content and criteria of an assessment

A needs assessment is a procedure that involves one or several skilled professionals holding person-centred conversations with older people and their carers to identify problems, and to provide cost-effective services when appropriate. This process is facilitated by the use of validated and reliable instruments and scales to determine in a multi-dimensional way the client's needs and preferences that require support. Using standardised and structured instruments and scales also simplify comparisons between agencies, regions and nations.

An integrated needs assessment is the preferred option when several funding bodies or providers have to deliver care to an individual and therefore need to consider the benefits of using the results of the comprehensive assessment to optimise the resources used, whoever carries out the services or provides the care. This calls for a discussion – or at least, a common policy – on how to look at needs from different angles, so as to optimise the resources.

Integrated needs assessments may produce a number of challenges for the integrated care manager, such as:

- How should the client's needs be measured?
- If there are different traditions within the collaborating organisations, how should the integrated care team deal with this?
- If several people are involved in the assessment, who should have overall responsibility?
- Who is responsible for collating the information gathered, analysing the educational needs of staff and making a summary of all the agency's needs?
- How long and detailed should the assessment be?
- Should it be carried out in several steps, or 'once and for all'? How do we arrive from the assessment to a professional care plan?

These questions do not have simple answers but must be discussed at the local level, between managers, and also between the team members and different professionals. Attempting to answer them is a large part of the learning process when developing structures for integrated care.

Irrespective on how the assessment process is outlined, only one part of the procedure is to use instruments – the main part of the assessment should always be made up of broad dialogue between client and carers.

Domains of needs

The next issue is which domains of needs should be addressed in the assessment. The comprehensive picture of client needs related to human functioning tends to fall into the following domains:

- health care needs (physical function, polypharmacy, nutrition, medical conditions)
- social needs (living arrangements, family involvement, social networks and activities, cultural needs)
- mental health and function (mood, cognitive function, emotional well being)
- environmental needs (housing or carers)
- psychological needs
- spiritual needs
- economical needs
- preferences of client and informal carers.

Ideally, a needs assessment will cover all these domains, which means taking behavioural, social, medical and psychological functions into consideration, as well as the social and physical context, such as availability, strengths, preferences of informal care, housing conditions, transportation needs and household needs. Even if a client's needs change over time, it is important to keep in mind this dynamic approach of needs.

The assessment needs to be comprehensive and accurate, and there are several instruments that enable organisations to fulfil the required criteria (*see* The implementation process, p 73). However, it is also a process that takes place within the context of the time and circumstances in which it is carried out, so it must not to be seen as a static 'solution'.

It is also important to consider the balance between the resources used to carry out the assessment and the information gathered. Using information that is already available from other sources is usually very important, and this will be more readily available in the future as more information technologies continue to develop. Clients are rarely concerned about which payer or provider gathers the information, but they do prefer not to have to provide it several times over.

To guarantee the quality of the information gathered during the needs assessment, the process should be followed by care interventions documented in the care plan. (Indeed, organisations should collect only information that calls for some kind of action or service provision.) The interventions identified may include responsibilities or requirements for the client, the client-support system or the physical environment. The service provider can then establish the care plan, even if this is not the same organisation that carried out the assessment. The crucial thing is that the information is shared between all parties, while taking into account the individual's right to privacy.

The World Health Organization's *International Classification of Functioning, Disabilities and Health* (World Health Organization 2001) covers broad areas of functioning, and provides listings of domains that can be included in the needs assessment process. These are not a model for the assessment procedure in themselves, and require other instruments to be used to decide which criteria to use (*see the list below*). Furthermore, it is important to carry out 'cross-walks' (comparisons of item concepts and descriptions of functional levels) between instruments that have already been tested and those that have been recently developed and not yet tested. Using this approach saves resources in the long run and sometimes helps organisations to discard instruments earlier in use.

Checklist: Criteria for assessment tools

Make sure the instrument:

✔ has good validity (detects what it is supposed to measure)
✔ has good sensitivity (detects most cases of need)
✔ has good 'inter-rater' reliability – gives the same results whoever uses it
✔ has been systematically standardised and developed, including testing
✔ is comprehensive, and covers all domains identified as significant for the needs of older persons
✔ allows for comments on the form
✔ enables adaptations for different cultural and ethnic groups
✔ is practical to administer
✔ is supported by database development for monitoring and evaluation

- ✔ enables inclusion of data from various agencies and providers
- ✔ provides information that can be used for care planning and monitoring at the client level, as well as for managerial and national purposes, thus avoiding different, parallel data collections.

An optimal managerial instrument should help the staff provide professional care planning, by supporting the client's integrity and autonomy while at the same time providing evidence-based information about the manager's units, as well as information that can be used at the national and international level, to enable reliable comparisons between units, regions and nations.

One useful instrument is the Resident Assessment Instrument (RAI). This instrument fulfils many of the criteria above, providing a structured, standardised assessment that triggers and supports care-planning activities for the individual, while also providing information for the manager. It exists in about 20 languages and is used in more than 30 countries. Another instrument mentioned in the recent literature and with its own website is EasyCARE Version 2004. This instrument is a compilation of several scientific scales but is not directly linked to the care planning process. (For details of both these instruments, *see* Web links, p 81)

Finally, it must be remembered that no instrument, however good, provides a complete answer to the needs of an older person. Clinical intuition and experience are also very important, and for this reason continuing education for the assessors is crucial. This education may be highly formalised or less so, but it must consist of information being shared between different professionals and participation in team conferences on care planning. *See also* Staff, below.

Staff

It is important to have a clear policy on which staff members are involved in the assessment, and how they will be trained and supported. If an assessment procedure is new to an organisation, it is not always easy to implement, particularly in integrated care, since many different professional and cultural aspects have to be taken into consideration. When developing a needs assessment for integrated care, the team must decide who will be primarily responsible and who will co-ordinate the information gathering – particularly if the care is divided between different budgets.

This is one of the most difficult aspects of integrated care. However, it is certainly not impossible as long as:

- a decision is made as to whether the assessment will be carried out by one professional assessor or a team of different professionals
- a process is in place for gathering information from different sources or teams, and sharing it between them
- the organisations involved take a flexible, and 'learning organisation' approach.

Whether they work alone or in a multi-professional team, the assessors need suitable tools, training in how to use them, and a broad view of what a client might need (Landi *et al* 2001). The training materials that are available within the various off-the-shelf assessment instruments provide good instructions on how to perform reliable assessments (*see* References and further reading, p 80).

The task of training the assessors in integrated care has both positive and negative sides. There may be negative inter-professional reactions to the content and level of the assessment but, on the other hand, the strength of an integrated team is that it has various competencies readily available that can lead to a broader training option than in other organisations. This is also a help since clinical judgement alone may not be sufficiently accurate to discriminate between those who have needs and those who do not.

Finally, by providing adequate training and supporting the use of a comprehensive needs assessment, the manager will enable staff to have more direct interaction with the client. This can free up more of the manager's time for strategic planning, rather than supporting the day-to-day activities.

Monitoring and evaluation

An assessment process in integrated care that has been newly implemented has to be monitored and evaluated in various ways, and a number of questions must be raised about diverse issues such as clinical and caring outcomes, cost-effectiveness, client satisfaction and staff satisfaction. Managers need to consider:
- Do we cover changes in needs on a population basis?
- Should we perform population surveys to get an answer to this?
- Can we be better in benchmarking support, making available to the agencies involved comparative data or information?
- How should we evaluate our needs assessment process?
- What do our waiting lists look like?
- What is the profile of our care givers?
- Are the service needs of our clients met by our staff skill-mix?
- What is our client satisfaction?

To answer these questions, managers need to collaborate with other actors on the local, regional or national level. These could include research or survey institutes to create client surveys or epidemiological studies, or software companies that could provide computerised support to the managers.

The final test of the needs assessment is whether it enables the client's situation to improve. Here, we must consider the long-term and short-term effects of the care planning, based on the assessment process. However, in integrated care as well as in more traditionally organised care, there is a lack of knowledge on the outcomes of care, and more research in this area is needed.

Barriers

Unfortunately, but not unexpectedly, there are a number of barriers to the needs assessment process in integrated care. It is not always easy to bridge the different concepts of needs, balance social and health care needs, and promote the idea of a strong interaction between most sections in a multi-dimensional approach to care needs.

If the assessment is performed by someone outside the integrated team, this could be a barrier to care planning. So someone needs to act as a guide, to help the client through the system. This could be carried out by one of the team members, acting as contact person.

Another obstacle is professional narrow-mindedness – the idea that 'others should not bother with my client or patient'. This negative attitude could also live longer if double, or even triple assessments on the same client, using different assessment instruments and different main concepts, are allowed. This prevents the integration care and the needs assessment alike. This problem can be exacerbated if there is more emphasis on the services provided than on the needs that trigger those services. This often prevails more in the areas or domains where well-accepted instruments or scales are lacking. There is an ongoing need for more instruments that focus on clients' social, existential and spiritual needs rather than on the medical and functional aspects of their lives.

A further barrier relates to legislation. Within one country there may be different laws calling for different approaches, and different budgets responsible for different needs. In many countries, social care is supported by the family, and support is available from society only if no family is available. In most countries, on the other hand, health care tends to be state-funded.

A further legislative barrier is that of privacy. Some countries have data protection laws that prevent different organisations having access to information held by other organisations. However, if the client does not object, this is usually simple to solve by obtaining the client's permission.

Finally, even if the clients agree to their information being shared, if there is a lack of infrastructure to enable this to take place, this will be a barrier too. This could be the case if there are different computerised record systems that do not communicate with each other, or the level of complexity, if computerisation varies between different players. The flow of information may be hindered not only between the same levels of care, but also between different levels. A lack of integration between decision-making bodies that address people's different needs can also hinder the process of using the needs assessment as a base for integrated care, and thus providing services in a cost-effective way, based on equity.

Supports

Needs assessments should be covered by legislation specifying when, and how, an assessment should be performed. Legislation supporting eligibility assessments already exists in many countries, but not in all. A comprehensive needs assessment can also support informal and voluntary carers by looking at issues such as what type of care is needed, and how it should be provided. However, no information should be gathered that does not influence the individual user's care.

Needs assessment is relevant only when clients ask for it, or if they request care and services that can be delivered only after assessment. Where the client is unable to make the request themselves, their carer or a professional may make it on his or her behalf. However, unless there is a risk of the client causing danger to their environment and he or she is not willing to co-operate, a consent is always required. Further, the client's privacy should be safeguarded. There should also be an opportunity for the client to challenge a decision and/or to complain about the procedure or the assessor to an independent body. However, this also calls for the use of common instruments. Beyond the legal support, the best support to needs assessment in the integrated care environment is professional open-mindedness within the team.

Conclusion

The main goal of needs assessment is to provide cost-effective, high-quality care that is client-centred and client-acknowledged. However, it also enables better evaluation of total resource use in relation to aggregated care needs of an area or a region. The technologies around the needs assessment process are, as a whole, relatively new to care providers, but today, the tools are there, and they can be used by the integrated care manager if they are implemented with care. By so doing, the three competing perspectives of client needs, client demands and preferences, and services provided will soon overlap, making better use of available resources.

Key points

- **In integrated care, the needs assessment process should be a starting point for optimising the resources from different care providers around the client.**
- **A comprehensive, structured and standardised assessment process makes it more difficult to overlook needs that are important or not immediately evident.**
- **For integrated care managers, a needs assessment provides a reliable summary description of the area or agency workload and can minimise the risk of ageism.**
- **Sharing information about physical functions and strengths of the client between the purchaser, providers, client and informal carers provides a deeper understanding of the client and his or her needs, and makes everyone part of the care process.**
- **While eligibility needs assessment is often legally mandated, a comprehensive assessment is the professional responsibility of the care givers working with the client.**
- **Through the comprehensive needs assessment, the client is assured of a more objective needs picture that can be more reliably funded. The more you know about the client, the better the priorities of services.**
- **To guarantee quality, the needs assessment process should be followed by interventions documented in the care plan – a process facilitated by using validated and reliable instruments and scales, which also simplify comparisons between agencies, regions and nations.**
- **The assessment should always be made up of a broad dialogue between client and carers. Only one part of the procedure involves using instruments.**
- **Ideally, needs assessment covers all domains of human functioning, which means taking behavioural, social, medical and psychological functions into consideration.**
- **A comprehensive needs assessment can also support informal and voluntary carers by looking at issues such as what type of care is needed, and how it should be provided.**

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Web links

www.cms.hhs.gov/medicaid/mds20 – website of the US government agency, Centers for Medicare and Medicaid Services. The link takes you directly to more information on the legally mandated assessment strategies.

www.dh.gov.uk – website of the UK Department of Health. For detailed information on the single assessment process, go to the policy and guidance section, within the health and social care topics, and select 'social care'.

www.interrai.org – website of the Resident Assessment Instrument (RAI).

www.milbank.org/reports/interrai – website of Milbank foundation. Under 'reports', go to the online version on Implementing the Resident Assessment Instrument: case studies of policymaking for long-term care in eight countries.

www.nzgg.org.nz – website of New Zealand Guidelines Group. For information on the assessment process, look under 'gerontology' within the 'guidelines/publications' section.

www.sheffield.ac.uk/sisa/easycare – website of the assessment instrument EasyCARE.

Chapter 5
Care pathways

TIZIANO VECCHIATO

Continuity of care is particularly relevant for people who are unable to be self-sufficient, those who are terminally ill, older people suffering from dementia, stroke patients, and others with severe care needs at home. Care pathways are integrated care strategies that offer a means of achieving better integration among practitioners, community-based services, and other health and social care services. They can contribute to better continuity of care, whether simultaneously (where the services are all delivered at the one time) or sequentially (where they are delivered within a distinct period). *See* Chapter 1.

Care pathways have primarily been developed in the acute care sector. However, they may also be a promising instrument for long-term care and social care, by providing professional and organisational solutions tailored to the problems of those who need integrated long-term care, and those who move from cure to care. Care pathways are need-related at the group level, and are helpful in finding the best ways to match needs with services at the individual level, as well as in managing chains of care. They should not be seen as a 'cookbook' for healthcare – with prescriptive, step-by-step instructions – but rather as a set of appropriate, evidence-based activities and interventions for a specific user group.

Care pathways are instruments that can reduce improper access to hospital emergency services, inappropriate admissions and unplanned discharges. So, to a great extent, they can help avoid unmotivated and undesirable interruptions of care, which can damage people in need and be a waste of resources. Wasted resources are particularly common in situations where different professionals intervene without consulting each other, creating unnecessary and costly overlaps and confusion.

Care pathways can be a helpful instrument for managers committed to:
- optimising continuity of care
- being clear about responsibilities and resources
- involving the person and their family or carers in the care process.

Practice example: Stroke

The Italian health and social care system is reducing the potential damage to people in need through its approach to stroke care. In Italy, there are more than 130,000 new strokes each year. All things being equal, this number will rise to more than 170,000 by 2008, because of the ageing population. In the case of stroke, prompt hospitalisation is recommended. Optimal care can be provided by a stroke unit or a hospital with a dedicated team, equipped with appropriate instruments and connected to a rehabilitation service. This method of acute stroke management has been proven to reduce mortality and residual disability and to increase the rate of patient discharge.

Source: SPREAD (2003) (*See* Web links, p 100)

Definitions

A care pathway is an integrated strategy of care for a specific user group based on guidelines and evidence, where available. It determines locally agreed, multi-disciplinary practice (*see* National Pathways Association and Integrated Care Pathway Users Scotland, Web links, p 100) and outlines the optimal sequencing and timing of interventions (McQueen and Milloy 2001).

A prerequisite for care pathways is chain management. This concept reflects a strategy of:
- managing care pathways
- guaranteeing continuity of care
- safeguarding best quality of care
- ensuring the appropriate use of resources (considering that there are different responsibilities involved)
- managing the provision of care.

Guidelines often underlie care pathways. Guidelines are commonly defined as indicators of a course of action that should be followed, or of what future policy will be – however, in fact, these concepts are complementary. Guidelines are primarily the responsibility of professionals, while chain management of managers and care pathways are a joint effort.

Checklist: Key characteristics of care pathways

✔ **Validity** Interventions should produce the expected results
✔ **Reliability** All professionals involved should be able to interpret and apply the interventions in the same way
✔ **Specificity** The particular client population should be clearly defined and tasks, sequences, timescales and disciplines should be well described
✔ **A systematic approach** Interventions should follow an agreed, standardised process
✔ **Clarity** Interventions should be easily understood by clients and professionals
✔ **Flexibility** Expected variations should be clearly defined
✔ **Stakeholder participatio**n Clients and professionals should be fully engaged from the onset
✔ **Reviewability** The date for and process of review should be stated
✔ **Measurability** Variances for planned care are to be noted and analysed
✔ **Adjustability** Plan and practice should be amenable to adjustment following evaluating or auditing
✔ **Predictability** An indication of clients' expected conditions over time should be available

Sources: McQueen and Milloy (2001); Integrated Care Pathway Users Scotland (*see* Web links, p 100)

An integrated care pathway is not a substitute for professional judgement. When monitoring the way in which care pathways are applied, there should be some variance measured. This variance is necessary to individualise interventions to each client, based on his or her specific needs or idiosyncrasies. Variance may also be a consequence of organisational factors or different performance of the professionals involved.

Objectives and intended outcomes

Care pathways serve multiple goals for all the stakeholders involved, such as clients, carers and managers in the health and social sector, public and private service providers, voluntary organisations and non-government organisations (McQueen and Milloy 2001; Integrated Care Pathway Users Scotland, *see* Web links, p 100).

Care pathways serve the needs of clients through:
- better approaches and practices, based on empirical evidence on outcomes, such as health, activities of daily living (ADL), mobility, quality of life, well being, cost-effectiveness, quality of life and respect for the person and their rights
- continuity of care to ensure quality of life for the carers, providing added value to informal care
- standards of care and expenditures becoming explicit to clients and their carers
- increased client involvement
- clarity about what benefits and risks can be expected
- improved communication.

Care pathways serve the needs of professionals and managers through:
- standards of care and expenditures becoming explicit, justifying professional activities and the means that are required
- care advances being incorporated into daily practice
- better quality of care and quality of life for the client and her/his family, which may add to professional satisfaction
- support to staff in daily decision-making
- enhanced collaboration and decision-making
- involvement of all professionals and managers in improving care
- effective use of resources
- well-defined roles, responsibilities and actions to be taken that are amenable to education and training
- easier audit by variance-tracking instruments, which monitor whether interventions have been carried out
- better understanding of the needs of clients and their carers, as well as shortcomings of the systems (or the care pathway) by analysing variations in practice.

Models and approaches

As mentioned earlier, care pathways have primarily been developed in acute health care and address sequential linking, co-ordination or integration. In long-term care, only a few examples of this type of care pathway exist (such as in stroke and palliative care), and many of the 'key characteristics' (noted opposite) are still far from being met. However, in some countries, public and private bodies have to take research and implementation into account when putting together appropriate solutions based on a good balance between cost and effect. These solutions relate to the client's progress from hospitalisation to residential and family care. In the meantime, the term 'care package' is regarded as more appropriate in some countries, because the specific care plan is drawn up according to the requirements of each situational need.

Practice example: Stroke care pathways

The Dutch Heart Foundation has developed a model for a stroke service, as well as a workbook for those who want to develop such a service. The process is described in three phases:

1. **Acute phase** Acute diagnostics are required and the treatment has to be initiated.
2. **Rehabilitation phase** The main objective of this phase is to prevent and reduce the chance of impairments and disabilities.
3. **Chronic phase** The onset of this phase is identified when it becomes clear what will be the remaining impairments and disabilities.

In each phase, specific services have a role in achieving the objectives of the particular phase.

At present, 69 stroke services exist across the Netherlands. In each stroke service, at least one hospital and a nursing home participate. In three-quarters of cases, a rehabilitation centre participates too, nearly always alongside the home care organisation and, in 73 per cent of cases, the general practitioner.

Sources: Carlier *et al* (1999), Verschoor *et al* (2004)

Practice example: Dementia pathways

The Kingshill Research Centre in the United Kingdom developed an integrated care pathway for dementia. It consists of five stages:

1. recognition
2. assessment
3. management
4. review
5. coping with change.

Each stage includes the evidence available for that part of the care process, and a flowchart identifying best practice. Each stage also includes examples of essential paperwork, audit and education.

Source: Naidoo and Bullock (2001)

Another model of using care pathways is to consider the responsibilities at local or regional levels. A single entry point, as well as distinct roles of general practitioners, social workers, and other professionals who may have a role as gatekeeper to the system, are prerequisites to guide people through the system (*see* Fig 3 opposite).

Fig 3 is a model for the sequence of multiple decisions that are to be made along three lines throughout the decision-making process. The left-hand column relates to the healthcare decision process. The right-hand column represents the social care decision process. The middle column represents the integrated care line. This can start as an integrated process from the beginning, or it can be suggested or promoted by the client's general practitioner or social worker, as soon as they understand that the complex needs requires integrated care.

Fig 3: Common access as a premise for different care pathways
Access to services and care paths at local/regional level

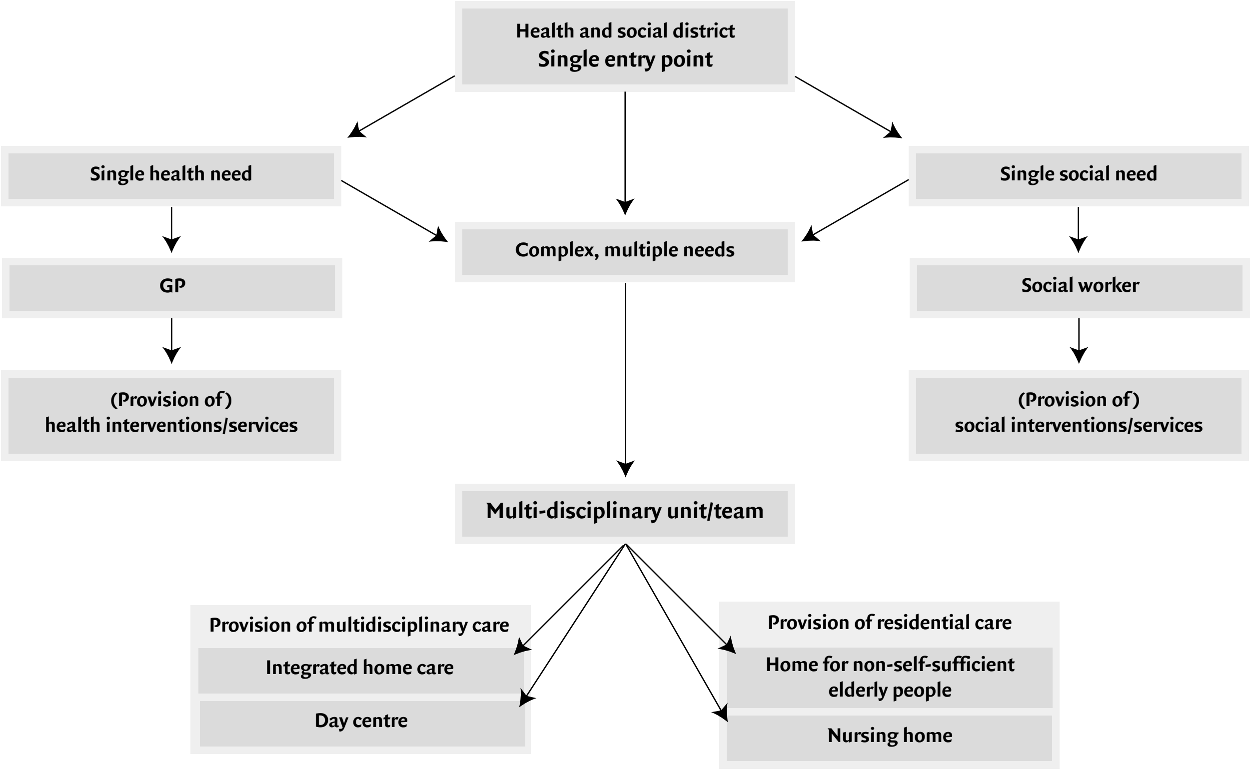
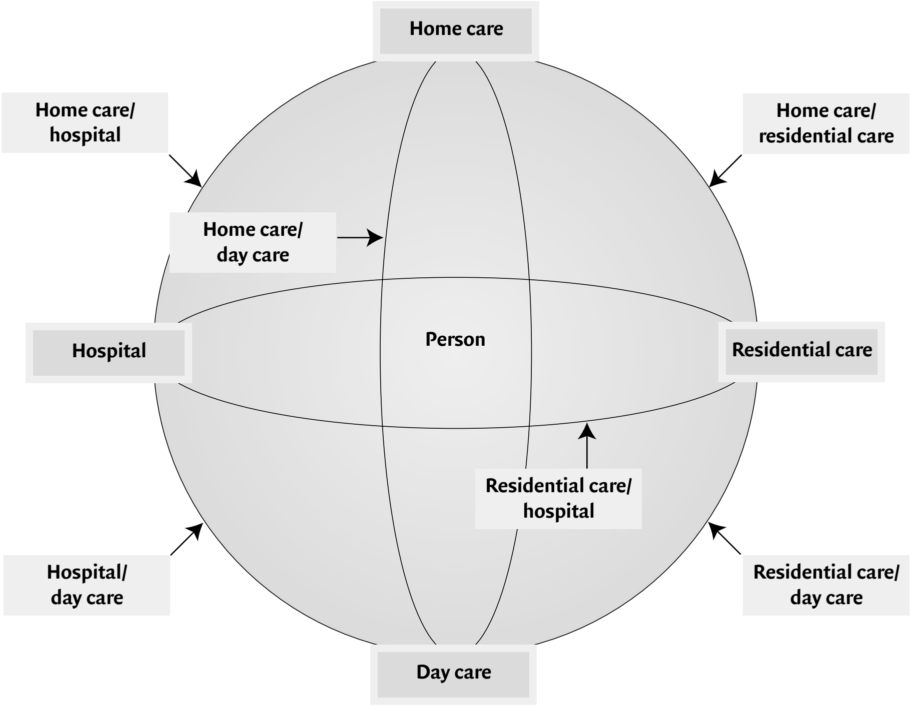


Fig 3 outlines three different ways in which the care system can be accessed. It starts from the point that the client enters the system, moves on to the integrated needs assessment, which is used to find out what can and should be done, and finally shows actual service delivery. The client's needs must be fully considered, and the care that is provided should be comprehensive. Care providers and authorities have to be explicit about which steps they will follow.

Each older person will follow a different pathway and move among different providers, according to the nature and the development of their needs. However, the preferred situation is for the care providers to move towards the client. Whether this is possible depends on the system: how far professional care in the community is developed, and how far institutional services go in providing outreach activities.

It is important to think in terms of location and interfaces. 'Location' refers to the place and setting in which the care plan is implemented (such as the home or hospital) and 'interface' refers to the collaboration and links between the places and settings in which the care plan is delivered. Fig 4, overleaf, is designed to aid thinking in terms of both these dimensions.

Fig 4: Integrated care pathways map



In Fig 4, the term 'day care' includes formal and informal services, such as day centres and outpatient care. The map identifies at least six critical areas for better defining need-related pathways. Each one is different because of the location in which the care is offered and because of the nature of its interfaces. The way in which these locations and interfaces are connected – by means of a care pathway – depends on the characteristics of the particular need group or user group, as well as the welfare system in which the system is operating.

If a manager is committed to organising solutions for people moving through different options of care – for example, from more intensive to long-term care – their options should be flexible and based on personalised solutions.

The implementation process

Integrated care pathways can be developed by following a series of steps, outlined in the checklist below, adapted from McQueen and Milloy (2001), Integrated Care Pathway Users Scotland (2003), Zander (2002):

Checklist: Steps to an integrated care pathway

✔ Step 1: Raise awareness and gain commitment for your endeavour.
✔ Step 2: Define the population for whom the care pathway is designed to fit.
✔ Step 3: Review the evidence.
✔ Step 4: Collect data.
✔ Step 5: Review current practice.
✔ Step 6: Identify key indicators.
✔ Step 7: Design an integrated care pathway.

- ✔ Step 8: Determine the tools.
- ✔ Step 9: Review and revise the draft.
- ✔ Step 10: Develop a client version of the pathway.
- ✔ Step 11: Implement the care pathway.

Each of these steps is described in detail in the following section:

Step 1: Raise awareness and gain commitment for your endeavour

This includes raising the idea, convincing participants, setting the boundaries, choosing the site, planning the activities, appointing the team and its roles, and clarifying the involvement of clients and carers.

Step 2: Define the population for whom the care pathway is designed to fit

The population can be defined in terms of three factors: problems that are most prominent, diagnoses, and location. This definition determines to a large degree the character of the pathway that is to be developed – whether it is clinically oriented, disease oriented, oriented on well being, oriented on carers' needs, and so on.

Step 3: Review the evidence.

Assess the information to ensure that it is relevant to your specific circumstances and to the specific population. The choice of the population will also influence to what extent evidence can be found. Summarise the evidence and make it available to the team members. Make sure that standards are agreed upon. Evidence that is scientifically sound is often not available in the fields of long-term care and social care. Where this is the case, it may helpful to distinguish various levels of evidence, from sound scientific research to consensus among peers.

Step 4: Collect data

The data illustrate current practice and establish a baseline for future evaluation of the pathway's impact. Only collect data on the particular client group or population and, where possible, include economic and organisational data.

Step 5: Review current practice

This practice can be recorded in a flow chart – a graph depicting the order of steps in a particular process. Record all improvement ideas while drawing this chart. This so-called 'process mapping' should not go too much into detail. *For further guidance, see* NHS Modernisation Agency (2003).

Step 6: Identify key indicators

Key indicators are milestones against which one can measure a client's progress along a care pathway. These indicators should be based on evidence with respect to the stages where the clients should be in their care. Indicators:

- should be seen as alerts when the activity has reached a certain target
- are points of reference for evaluation
- can be used to examine trends
- challenge organisations to provide better care
- are to be used to provide information at aggregate level.

Step 7: Design an integrated care pathway

Based on the current process analysis, the pathway should be modified and supported by the team and organisation involved, as well as by the clients and carers. Where decisions are unclear, rules should be established, so that policies are put in place for every eventuality. The pathway needs to be constructed as a multi-disciplinary plan and record of care that includes all key information, so make sure all the relevant and required documentation and records are taken into consideration. The basic idea of a care pathway is illustrated in Fig 5 (*see* p 91), which presents a global map of the decision-making process, together with its rationale. It shows how different pathologies (in this case, stroke) can have similar decisional processes that lead to the drawing up of personalised care pathways.

Step 8: Determine the tools

There are two types of tools available. The first is 'content tools', which add precision and depth, and enable analysis of inclusion and exclusion criteria, clinical outcome progressions, critical indicators, guidelines, algorithms, decision rules (*see* Step 7), protocols and practice support information. The second type is the 'action tools' connected to the contents of the care pathway, such as assessments, progress notes about variance, client and family educational materials, and forms (Zander 2002).

Step 9: Review and revise the draft

When the draft is developed, review the representatives of all relevant disciplines and professions, as well as clients and carers. The basis of this review should be the evidence on which the pathways are based. Pilot the care pathway, whenever possible.

Step 10: Develop a client version of the pathway

This enables you to involve clients, to be explicit about the match between your services and their expectations, and to answer some of the common questions that they undoubtedly will have. It is important to use plain language and communicate clearly. It is also helpful to test the care pathway among professionals for completeness and clarity to those who were not involved in developing the care pathway.

Step 11: Implement the care pathway

Agree a timescale. Remove all previous documentation, agree the dates for reviewing the care pathway, and allocate enough time for instruction, training and support.

Practice example: Guidelines for stroke prevention and treatment

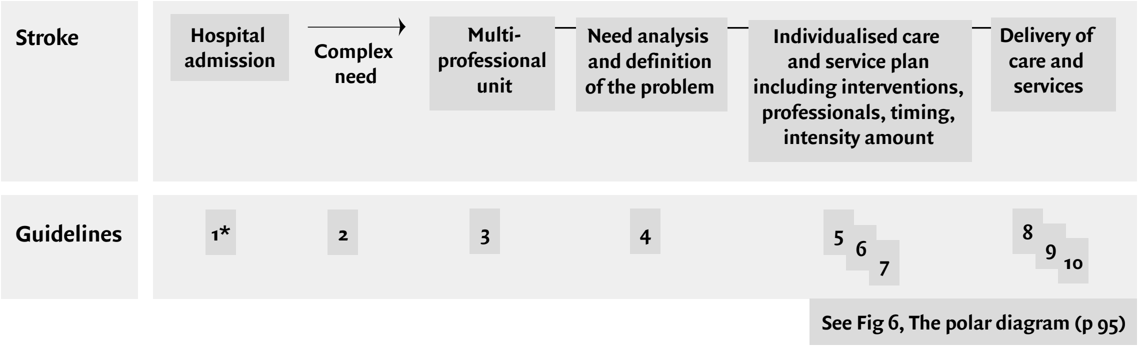
The Italian guidelines for stroke prevention and treatment are evidence-based, and may constitute the key elements of a stroke care pathway (synthesis, selection and adaptation of the Stroke Prevention and Educational Awareness Diffusion guidelines (SPREAD 2003, *see* Web links p 100). They highlight the fact that scientific knowledge can be shared at an international level and simultaneously adapted to the particular context, situation (welfare and delivery system) and specific country, where they can be put into operation.

The list below shows recommendations for care after a stroke. Each recommendation relates to the point of the corresponding number in Fig 5 below.

1. Consider a series of parameters such as clinical stability, residual independence, cognitive features, fatigability, and family support, when choosing the rehabilitation setting – from inpatient services (hospital, long-term care institution) to outpatient services (providing ambulatory services for people living at home).
2. A careful clinical assessment and evaluation of risk, and long-term health care targets including control of co-morbidities, prevention of recurrence, definition of prognosis, and enhancement of functional recovery.
3. A multi-disciplinary team to pursue optimal strategies for diagnosis, prevention and recovery.
4. A clinical estimate (needed for planning the client's rehabilitation project) based on patient evaluation according to their clinical status, social aspects, motor and cognitive impairments, mood and behavioural features, communication ability, family assistance, and independence.
5. A rehabilitation process that follows a precise individual plan, designed by a competent medical specialist as a part of a more general management project, which carefully defines the setting and a series of multi-disciplinary interventions, actively including the family physician.
6. The four main steps needed to enable the client to cope with residual disability are: developing abilities useful for daily life management; training based on key instructions and increasingly difficult tasks; progressive increase in self-confidence; and autonomous performance of rehabilitative activities at home.
7. When planning a rehabilitation project, the patient's needs must be taken into account in relation to disease characteristics, future perspectives, domiciliary services, modifications to living spaces, psychiatric management, and involvement in work and social activities.
8. Thorough counselling is needed for patients and their relatives, to explain the causes of stroke and rehabilitative expectations, and to enhance their collaboration.
9. Comprehensive carer training is needed, to guarantee proper rehabilitative support.
10. Encourage patients to resume previous activities of daily living, as soon as they are clinically stable, helping them with compensatory strategies if necessary.

Source: SPREAD (2003). (*See* Web links, p 100.)

Fig 5: General pathways for stroke and Alzheimer's care



* Numbers relate to corresponding points in Practice example: Guidelines for stroke prevention and treatment, pp 90–91

Involving clients, family and carers

There are a number of advantages to the client and their family and carers playing an active role. It enables them to assess how far the care pathway meets their needs and preferences, and to simply learn from experience how better to manage their condition, identify the 'key person' who they can rely on, and share an informed contract on the care pathway. The contract should include the client's name and details, the service provided, details of the agreed goals, actions, timeframe, expected outcomes, and commitments. It should provide space for signatures of both parties and the date.

Involving the client's family or carers in developing a care pathway, and in the care pathway itself, is very important. Consider their roles in sharing decisions, allocating responsibilities and resources, and in managing care pathways themselves. This can be better understood in terms of particular examples, such as older people with cognitive deficits who live with relatives acting as carers, and suffer from the stress that goes hand-in-hand with care-giving. Helping carers by involving them in strategies to overcome their stress can, in the long run, be fundamental in providing better assistance for the older person who is being cared for.

Staff

Care pathways are about continuity of care. It is useful to distinguish between three types of continuity:

- **information continuity** using information about past events and personal circumstances to ensure that current care is appropriate for each individual
- **management continuity** a consistent and coherent approach to managing a health condition that is responsive to a patient's changing needs
- **relational continuity** an ongoing therapeutic relationship between a patient and one or more providers.

(Haggerty *et al* 2003)

To ensure information continuity, care staff should take part in developing and implementing care pathways. However, specialists in information flows, records and monitoring instruments also need to be involved. Management continuity requires those involved in integrated care to have special competencies, as well as a coherent view on care and the care pathway that is relevant to the particular client. Relational continuity also requires continuity of staff, and this needs to be deliberately planned, taking into account work and salary conditions, and other issues such as motivation of staff and in-service training.

The case or care manager plays an important role in assuring quality and effectiveness in the integrated care processes, and in working according to care pathways. By assessing, planning, intervening and evaluating, they provide a continuous process of matching care with the changing needs of the client. They also provide problem-solving and decision-making support to their professional colleagues (Zander 2002). Because health and social care professionals are so crucial to the implementation of a care pathway, they too need to be actively involved in the development. All the staff involved need to have some expertise in monitoring systems, and in all the necessary administrative activities, so that they can monitor the care pathways. These administrative activities would include completing particular forms that address needs evaluation, ADLs, and environmental factors.

Monitoring and evaluation

Monitoring is an essential part of working with care pathways because it provides a constant review of the pathways of the clinical choices and their impact on the use of resources.

To monitor and evaluate the process and effectiveness of the pathways, it is necessary to have practical instruments that identify the total needs of the person, before and after the intervention. In other words, 'evaluation' is a comparison that enables differences and changes to be measured at the different stages of the care plan.

So it is important to use validated measurement instruments that compare the changing situation over time – both within one pathway, and between one pathway and another. This means that managers must be aware of using output indicators, which measure process performance (such as delivery index or cost), and outcome indicators, which measure the benefits to the client in all the different domains (such as body functions and structures, activities and participation, environmental and personal factors).

Checklist: Criteria for defining output indicators

The manager needs to ensure the following elements are in place:

- ✔ **Service accessibility** Roles of professionals as an opportunity or an obstacle, opening hours, need related/multiple access, waiting list
- ✔ **Information** Orientation and, if necessary, support for matching need and appropriate services – in particular, for frail older people
- ✔ **A comprehensive approach** Integrated need evaluation, definition and management of the individualised plan
- ✔ **Continuity of care** Within each single service, between services, and in particular between public and private services
- ✔ **Network** Dimensions and variety of care options
- ✔ **Overall management** Overseeing all the pathways in the network
- ✔ **Personalised care** Care and services that are tailored for each client and their carers.

There are two main methods for improving outcome evaluation: managing absolute outcomes and managing relative outcomes (Vecchiato 2002). The absolute outcome option measures the state of a person referring to different parameters over time (for example, organic, functional or cognitive parameters). It is useful to link the seriousness of the need to a specific care intensity, which can then be guaranteed in the care pathway. The relative outcome option measures the differences between the client's health and life conditions before and after the intervention. The greater the relative outcome, the more effective the impact of the care pathway.

Checklist: Criteria for defining outcome indicators

The manager needs to ensure the following elements are in place:

- ✔ **Specific need-related outcomes** These are identified by the various domains, such as body functions and structures, activities and participation, environmental factors and personal factors
- ✔ **Everyday life-oriented outcomes** These are identified in terms of the benefits in the life-space which includes the home/personal environment for the client and their family or carers.

The greatest challenge is to develop a set of outcome indicators that reflects a comprehensive assessment of the person with a complex need pattern. These indicators need to give an overall picture of the relevant domains of individual functioning, and to put the objectives of the intervention into operation, so they need to be monitored, and interventions and objectives may be adapted or altered.

A comprehensive solution for integrated need evaluation

The comprehensive geriatric assessment has become synonymous with geriatric practice. This assessment includes an evaluation of the older person's physical and mental health and functional and social status. The polar scheme is a new method conceived by the author together with a multi-disciplinary team (Vergani *et al* 2004), to represent the client's condition, through the so-called 'polar diagram' (*see* Fig 6).

The polar diagram is consistent with the international classification of functioning and health (World Health Organization 2001), and shows the subject's scores on the evaluation scales (arranged radially inside the circular area) during the care pathway at different times. The outer edges of the figure denote the optimum condition. This enables gaps between the optimum condition and the actual recorded scores to be easily identified. This tool can be used to monitor the condition of the client, and to evaluate the changes in the outcomes. The clinical dimension refers to scientific evidence for supporting appropriate decisions. The organisational contents of guidelines refers to the solutions for sharing the decisions, the responsibilities in delivering the care process, and the resources for reaching expected outcomes.

The polar scheme consists of a circle divided into three sectors. Each sector represents the principal domains covered by the comprehensive geriatric assessment:

- the cognitive and behavioural domain (structures and cognitive functions)
- the physical and functional domain (body functions and activities)
- the socio-environmental domain (environmental and interpersonal factors).

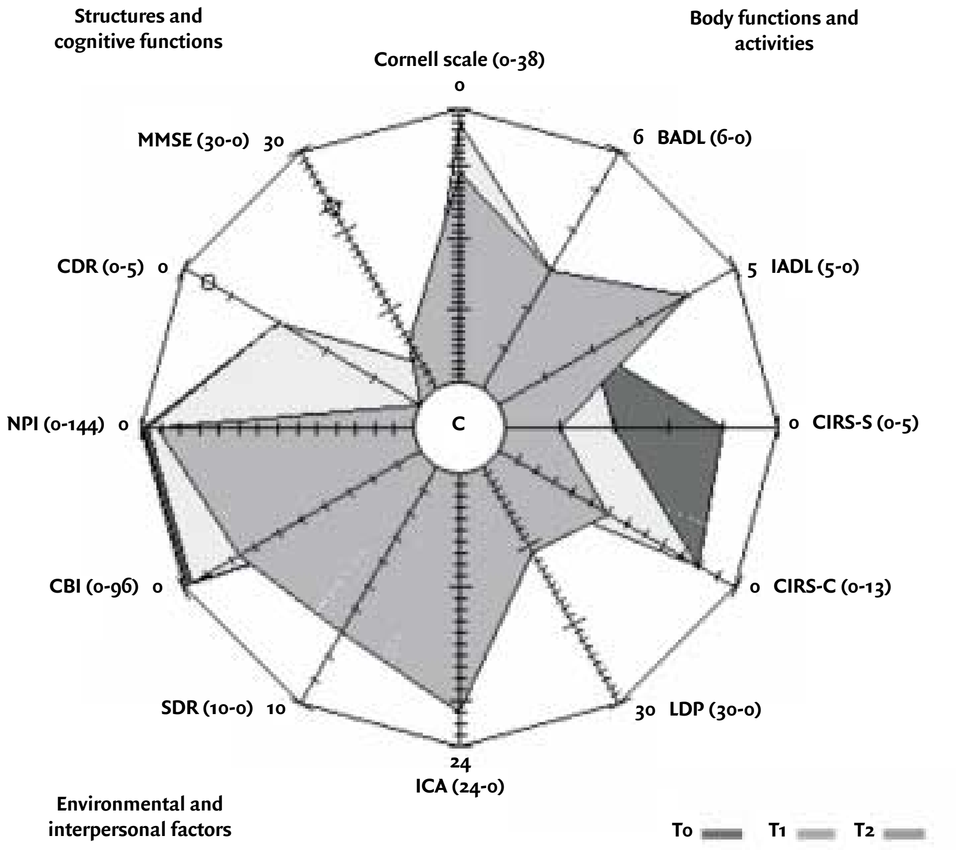
Within each domain are 'rays' by which the scales are rated. These may vary, depending on the person under investigation. The outer part of the circle shows the individual's condition at their best. The centre shows their condition at its worst. In brackets, each scale is described with its minimum and maximum value.

The cognitive and behaviour domain includes the mini mental state examination (MMSE), the clinical dementia rating (CDR) scale, the neuropsychiatric inventory (NPI) and the Cornell scale. The physical and functional domain includes the activities of daily living (ADL) scale, the instrumental activities of daily living (IADL) scale, and the cumulative illness rating scale (CIRS), both for severity and co-morbidity. The socio-environmental domain considers the caregiver burden inventory (CBI), the responsibility scale (SDR), the index of care coverage (ICA), and the level of protection in life space (LDP).

The different shaded sections of the diagram indicate different measurements in time. The shades of the scales indicate the three observational and measurement areas for evaluating outcomes:

- structures and cognitive functions
- body functions and activities
- environmental and interpersonal factors.

Fig 6: The polar diagram



Source: Vergani *et al* (2004)

Key
Cornell scale – scale for depression and dementia
BADL – basic activities daily living
IADL – instrumental activities daily living
CIRS-S – severity cumulative illness rating scale
CIRS-C – co-morbidity cumulative illness rating scale
LDP – level of protection in the life space (livello di protezione nello spazio di vita)
ICA – index of care coverage (indice copertura assistenziale)
SDR – responsibility scale (scala di responsabilizzazione)
CBI – caregiver burden inventory
NPI – neuropsychiatric inventory
CDR – clinical dementia rating scale
MMSE – mini-mental state examination

The different values represented in the polar diagram can facilitate the integrated evaluation and choices of professionals involved in the care pathway together with the client and his or her carers. These evaluation tools are described in use in the practice example below.

Case study: Maria

Maria is a 73-year-old woman. She is retired (she used to work in a factory) and she came to the attention of the health service in October 2001. During the past two years she has experienced memory problems and behavioural changes, resulting in loss of autonomy in her daily life (CIRS severity: 2.6/5; CIRS co-morbidity: 5/13; MMSE: 14/30; Cornell scale: 19/38; NPI: 69/144).

Maria has serious problems with mobility that lead to falls and accidents and she cannot eat without help (CDR: 3/5; SOB: 15/30; ADL: 1/6; IADL: 0/8).

Following a clinical examination, Maria is diagnosed with severe vascular dementia (according to the NINDS-AIREN criteria) and is prescribed medication to treat her associated behavioural problems. Maria lives at home with her daughter, who works full-time during the day (ICA: 15/24).

She is also supported by an informal network of people. Neighbours help with meals and therapies, but for most of the day she is alone at home. This is a worry for her daughter, whose working performance and relationships have been affected (CBI: 65/96). Maria's low income does not allow for private home assistance or temporary admittance to a nursing home, and social services are not aware of her case. Her daughter feels strongly that her mother should stay at home with her.

Social services are contacted to evaluate the family's income and investigate the possibility of home care support. They arrange for her to receive home help.

By January 2002, Maria shows an improvement in her attention capacity (MMSE 17/30). Her behaviour has also improved (Cornell scale: 13/38). Her daughter reports a reduction in the number of confused episodes and psychological and neurological anxiety, and Maria is sleeping throughout the night (NPI: 27/144).

Aspects of Maria's disability persist, but there are improvements in eating unassisted, due to socialisation interventions (ADL: 2/6; IADL: 0/8). Her mobility problems remain, but she has not had any falls since the process started and there have been improvements in her daily living activities and environmental factors (CIRS severity: 2.6/5; CIRS co-morbidity: 5/13; CDR: 3/5; SOB: 15/30). Her daughter expresses an improvement in her quality of life too (CBI: 56/96). The therapy remains unchanged.

By July 2002, Maria makes more progress (MMSE: 19/30; Cornell scale: 6/38). Her behavioural changes have disappeared (NPI: 14/144), although her loss of autonomy remains (ADL: 2/6, IADL: 0/8, CDR: 3/5; CIRS severity: 2.6/5; CIRS co-morbidity: 5/13). The daughter feels less stressed (CBI: 37/96). As a result of comprehensive integrated care combining medical, pharmacological, nursing and social support, Maria's situation has vastly improved. This particular treatment is considered complete and will be replaced with a new care plan.

Barriers

There are a number of common barriers to implementing care pathways in integrated care. These include:

- the composition of intervention or services within each pathway being determined more by available services than by people's needs
- the lack of integration between the different projects and the missions or aims of the providers
- the variety of service providers that could be involved in a specific care pathway
- a shortage of scientific evidence about pathway-related outcomes
- the lack of validated guidelines for better defining the mix of care and its continuity
- a lack of understanding by staff, patients and carers of the need to share a common responsibility in defining and implementing the pathway
- cultural barriers
- mechanistic thinking about care pathways and how to apply them.

Supports

There are a number of supports or strategies that facilitate the creation of care pathways in integrated care. If health and social care services take into account the different organisational configuration of services, this can make a big difference in reducing inequalities. For this reason, access rules to different care pathways (for example, based on means testing) should be considered and revised and/or improved for a better personalised care. Highlighting the costs of the decisions may be helpful in prioritising interventions.

Above all, the integrated needs evaluation is the key to appropriate care. However, this must be followed by the definition of expected results, which must be measurable in technical terms, and the client and their family or carers must be able to understand it. It is important to discuss with them the benefits and drawbacks of the possible interventions.

Outcome evaluation is essential for recognising which results are due to the interventions provided, by comparing the situation before and after intervention. Outcome measures consider the benefits and improvements and the well being of the client and their family or carers.

At the level of professional processes, managing integration requires protocols ('how to do it'), adequate assessment procedures and instruments, inter-professional communication, referral systems, and delivery systems, including co-ordination of activities carried out by different services providers, transfer routines and monitoring routines.

At the organisational level, there need to be agreements on collaboration (for example, regulation, financing, division of tasks and responsibilities), as well as definition of care packages, planning of adequate levels of service capacity (for example, places in rehabilitation units) and human resources management.

At the policy level, a balanced system of services (including regulation and financing) needs to be in place. For example, a reduction of long-term stay in hospitals will require extra capacity of community services.

Finally, an holistic approach to organisational thinking is essential:

> *Management thinking has viewed the organisation as a machine and believed that considering parts in isolation, specifying changes in detail, battling resistance to change, and reducing variation will lead to better performance. In contrast, complexity thinking suggests that relationships between parts are more important than the parts themselves, that minimum specifications yield more creativity than detailed plans. Treating organisations as complex adaptive systems allows a new and more productive management style to emerge in health care.*
> (Plsek and Wilson 2001).

Conclusion

This chapter has aimed to highlight the managerial and professional duties needed to transform the recognition of needs together with the available resources into personalised care pathways. It has led the reader through the decision-making process, including:
- existing models and guidelines
- possible strategies, objectives and outcomes
- ways of evaluating the quality and cost of the care plan.

Care pathways can offer a solution that allows us to look at the person as a focal point within a map. Within that map are managerial and professional figures and carers, who are committed to reaching good outcomes at a reasonable cost, continuity of care and – most important of all – the overall well being of the patient and their carers.

Key points

- **Care pathways are integrated strategies of care for a specific user group based on guidelines and evidence. They determine locally agreed, multi-disciplinary practice and the ideal sequence and timing of interventions.**
- **A prerequisite for care pathways is chain management, which reflects a strategy of managing care pathways, guaranteeing continuity of care, safeguarding best quality of care, appropriate use of resources and managing the provision of care.**
- **Clients and their families or carers should play an active role in developing the care pathway, and in the care pathway itself.**
- **Care staff should take part in developing and implementing care pathways, to ensure information continuity, but specialists in information flows, records and monitoring instruments should also be involved.**
- **The case or care manager plays an important role in assuring quality and effectiveness in the integrated care processes, and in working according to care pathways.**

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Web links

www.icpus.ukprofessionals.com/ICPs.html – website of the Integrated Care Pathway Users Scotland.

www.spread.it – website of the Stroke Prevention and Educational Awareness Diffusion Collaboration (SPREAD), with Italian guidelines for stroke prevention.

www.the-npa.org.uk – website of the National Pathways Association, a network of professionals interested in developing, sharing and promoting the use of care pathways.

Chapter 6
Case management

Penny Banks

This chapter is concerned with the integration of care at the individual level, where services are co-ordinated in response to the assessed needs of an older person and their carer. It describes different models of case management, with lessons from research, and provides key steps in introducing case management, including the skills and knowledge base of staff taking on the role of case manager.

Definitions

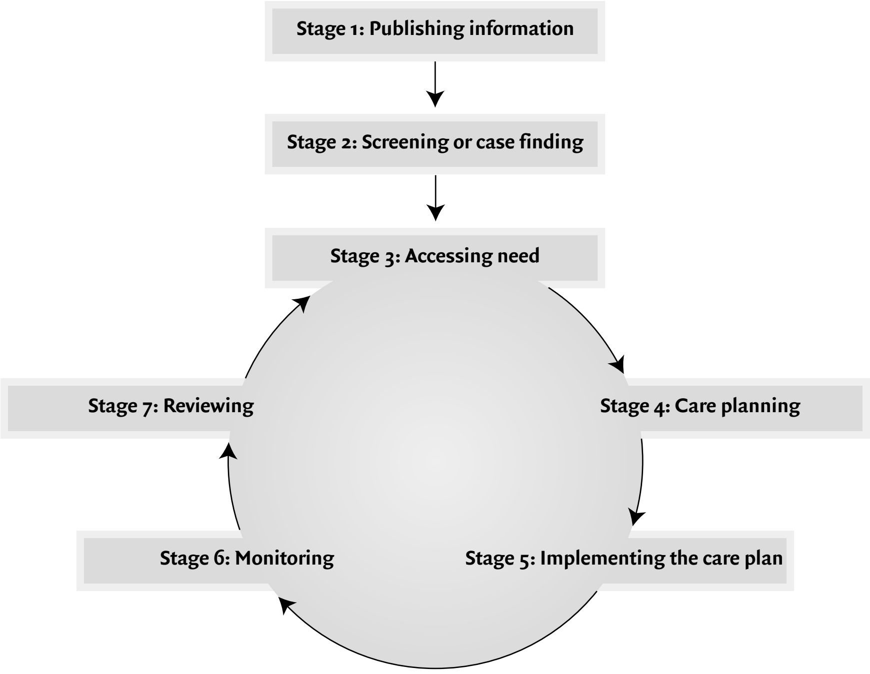
The processes of case management, as ways of achieving more integrated and co-ordinated services, have been defined and re-defined over a number of years. The terms 'care management' and 'case management' have often been used interchangeably, so for consistency, the term 'case management' is used throughout this chapter.

There is no universally accepted definition – particularly where there has been concern that the term 'case' is derogatory – but there is some consensus about the main components of case management (Hudson 1993). These are:
- screening or case finding
- assessment
- care planning
- implementation
- monitoring
- reassessment or review.

Challis (1999) describes case management itself as:
- a specific job
- a task within an existing job role within a single agency
- a job or task within a joint heath and social work structure
- an organisational process.

In this section, we define case management as 'the process of planning, co-ordinating, managing and reviewing the care of an individual to ensure that it meets that individual's assessed needs' (Department of Health 2000).

Fig 7: The case management process



Source: Department of Health (1991)

* Stages 1 and 2 are included in some models, such as this one.

Objectives and intended outcomes

Why consider case management?

Co-ordinating services or care packages in response to the assessed needs of older people and their carers is a core part of delivering integrated, person-centred care. Good, comprehensive assessment and care planning – undertaken in a way that properly engages with the older person and their carer, and involves them in decisions about their care plan – is crucial in ensuring that the most appropriate services are provided.

Co-ordinating these processes and services can avoid unnecessary duplication and promote good continuity of care. This promotes older people's independence by preventing a deterioration in their health and home situation, and by managing crises, as Challis describes: 'The impact of services upon well-being is much greater when those services are planned and co-ordinated in an integrated fashion' (Challis *et al* 2002).

So the aim of case management is to tailor services to the individual older person in order to improve the quality of their life, taking into account the wishes and needs of their carer – be they a partner, relative or friend.

Organisations will be considering the potential of case management to offer a cost-effective and efficient way of co-ordinating services so that older people receive:

- what they need (across service boundaries)
- when they need it (continuum of care).

The challenge for case management is that it takes place at the level of service provision at which needs and resources, scarcity and choice have to be balanced. 'Care management is no panacea but rather a mechanism which, if effectively implemented, can offer one way to manage the tension between social objectives and economic constraints in long-term care services' (Challis 2003).

Models and approaches

There are many different approaches and models of case management that provide pointers for success and highlight tensions to be addressed – particularly between needs-led and resource-led approaches (for example, *see* Beardshaw and Towell 1990). This section lists the different models that have been classified in numerous ways. These are summarised in Table 3, p 40.

The intensive case management model

In this model, case managers co-ordinate services for older people with severe and complex needs, undertaking all of the functions described in Fig 7 opposite, aiming to tailor services to the needs of individuals across time and place of service utilisation. These case managers may be employed by a single agency (either a provider or purchasing organisation) or by inter-agency arrangements, with or without a budget to commission or co-ordinate services.

Practice example: Intensive case management

In Castlefields Health Centre, Runcorn, case managers for older people are based in a general practice targeting specific groups of older people who are at high risk of hospital admission or making heavy use of services. The case managers undertake an individual needs assessment, working with the older person to:

- focus on their views about how they would like to see their life improve
- identify problems
- plan interventions
- organise support
- monitor and evaluate outcomes.

Another aspect of the integrated service is close working between a practice-based social worker and a nominated district nurse. Results indicate:

- reduced admissions to hospital
- reduced bed occupancy
- closer working between health and social care
- a more responsive service
- closer working within the primary care team
- improved primary–secondary interface
- easier access to services for patients and carers.

Source: Carrier (2002)

Practice example: Hospital discharge

In Finland, case managers have been used to eliminate hospital discharge problems and have worked with specific groups of older people to organise services and treatment in hospital before discharge as well as co-ordinating services in people's own homes for a fixed period of time.

Source: Ala-Nikkola and Valokivi (1997)

Practice example: Working with people with dementia

A study in Finland shows that where nurse case managers worked with older people with dementia, the older people's placement in long-term residential care was deferred – particularly for those patients with complex and severe problems. This intervention also had long-term effects on caregivers, and helped them to return to a normal life.

Findings also indicate that the nurse case manager must work in close collaboration not only with the social and health care system, but also with a physician, such as a general practitioner, who knows the patient. The nurse case manager requires problem-solving abilities, initiative and a high capacity for responsible and independent work.

Source: Eloniemi-Sulkava (2002)

The shared core tasks model

In this model, there are organisational procedures in place to make sure that discrete tasks of assessment, individual care planning and regular reviews are carried out for older people. In other words, these tasks may be carried out by more than one person.

Practice example: Shared core tasks

In England in the early 1990s, some local authorities with responsibility for social services focused on the discrete stages of case management when implementing case management arrangements. In 1994, a study showed a trend towards an administrative form of case management characterised by a lack of continuity of staff involvement in the tasks of case management. It was becoming a process that was applied to all service users rather than being targeted on more complex cases.

Commentators suggest that it is important to discriminate between 'intensive case management' (where there are designated care managers for those with complex needs) and more effective organisational procedures where core tasks of assessment, care planning and regular reviews are effectively carried out for all service users.

Source: Challis (1999)

The joint agency model

Here, case management is supported by a multi-disciplinary team, with workers drawn from different agencies. One of the team acts as a case manager or keyworker.

Practice example: Joint agency model

In two regions of Belgium, services practise a clinical nursing case management model for geriatric patients and their families. Each patient and family carer is provided with an individual package of care, designed and implemented in a multi-disciplinary context. The aims are:

- to prevent admission (or readmission) to acute hospitals and institutionalisation in long-term care facilities
- to maintain or enhance patients' health status and level of functioning
- to make sure services are co-ordinated and are appropriate to the needs of the client and carer.

In this model, case management focuses on achieving clinical outcomes, and fiscal management plays no role – or a limited one. The services delivered for each individual are based on their individual assessment. A comprehensive array of services is co-ordinated, and the family is offered support and education, as well as skills training and medication and symptom management. Services are provided through a multi-disciplinary team, which includes the case manager, nurses, physicians and social workers. Collaboration with psychiatrists, other physicians and hospitals is also an important component of this clinical case management model (*see* Tombeur 2002).

Source: Borgermans *et al* (1998)

The brokerage model

In this model, case managers are employed by an independent agency in a way that is similar to service brokerage. Here, case managers can be powerful advocates but may have weaker leverage within the service systems. They may primarily provide advice and information.

Practice example: Brokerage model

In central Finland, a local caregiver association has employed a worker to tailor support for families, particularly for the time at which caregiving begins, or when changes take place in the family situation. This has included working with the carer and the older person being supported, to identify their needs, provide information and help them access suitable services. Network or case meetings have been organised between the carers, older person and service providers to establish suitable care packages. Carer group meetings have also been set up, and are felt to provide valuable peer support.

Source: Mornings Project Caregiver Association, Jyvasseudun Omaishoitajatry. Email: eija.luomaa@omaishoitajat.inet.fi

Older person co-ordinating their own care

This is not strictly a 'model' but it has been included because it offers control by older people. It involves introducing some form of direct payment or personal care budget as an alternative to service provision being arranged by another body. It offers the option for older people (or their carers) to be their own 'care co-ordinators' and to buy in services that meet their needs.

Practice example: Older people co-ordinating care

In the Netherlands, since 2003, older people who are entitled to home care can ask for a cash payment rather than care in kind. 'Advisers of older people' are available to help them with the administration and provide information about the supply system so the older people can arrange their own care packages. These advisers, some of whom are older volunteers, aim to empower older people to keep their autonomy by providing information, advice and assistance for those older people preferring to self-manage.

Source: van Dam and Begemann (2004)

The case management agency model

Here, a case management agency (of the type often used in social insurance schemes) contracts the services included in the client's care plan. The agency will control costs by selectively contracting with providers.

Table 4: Case management models

Model	Advantages	Disadvantages
Intensive care management	Holistic approach to needs. Targeted at people with complex needs	Success is dependent on strength of inter-agency, inter-professional arrangements. Single agency models may restrict access to wider services and resources
Shared core tasks model	Allows for key tasks of care management – assessment, care planning and review – to be built into organisational procedures for large number of service users with less severe needs	Lack of continuity of staff for individual service users and less appropriate for older people with complex needs
Joint agency model/key worker model	Good access to multi-disciplinary services	Nominated key worker may have difficulty balancing that role with their own professional input or service delivery
Independent brokerage model	Strong advocates for older person and carers	Likely to lack influence in service system
Older person or carer co-ordinates care using direct payments	Older person able to control and choose own package of services	Support may be needed for older people who prefer to self-manage

Other approaches to co-ordinating care

Disease management, chronic illness management and integrated care pathways are other models of managing care, which seek to improve the co-ordination of services and clinical interventions. These models are based on anticipated clinical practice for a client group that shares a particular diagnosis or set of problems. The models provide a multi-disciplinary template of the plan of care, based on guidelines and evidence. These forms of managed care are primarily about promoting consistency in care for one particular health problem or chronic disease.

In some countries, case managers are employed to work with people with chronic disease to improve patient education and self-management, and to liaise between primary and secondary health professionals. However, many older people have multiple health problems with a range of inter-related needs that require integrated services beyond the health system.

Model evaluations: Ten things to remember

Evaluation of different models of case management has highlighted the following points:

- No single model of case management will suit all levels of need or service user group (Beardshaw and Towell 1990).

- It is necessary to differentiate between those older people with complex needs, who may be best supported by designated case managers (providing intensive case management) and other older people with less severe needs, who may best be supported through more effective organisational procedures for assessment, individual care plans and regular reviews. So these components of case management may be carried out by different workers (Challis 1999).
- There is evidence that supporting older people with a flexible intensive case management service that controls substantial levels of resource can significantly reduce the probability of admission to residential and nursing home care (Challis *et al* 2002).
- While targeting case management leads to improvements in welfare, the evidence suggests that there is little overall saving in cost (Challis 1999).
- Case management systems that work on a single-agency basis and lack access to appropriate expertise in assessment are unlikely to be fully effective – particularly for people with complex needs (Challis *et al* 2002).
- Appropriate legitimacy and mechanisms need to be developed to give case managers influence in the services network (Beardshaw and Towell 1990).
- Where budgets are devolved to allow case managers to purchase care, there is a danger that these managers may become 'gatekeepers' (Hudson 1993).
- It is important to make sure there are appropriate local services and flexible support options to co-ordinate the services and care. Some models of case management have a specific remit to develop new services in response to assessed need (Beardshaw and Towell 1990).
- Good training, supervision, quality assurance, information, planning and commissioning systems are required to support any case management arrangements (Hudson 1993).
- Continuity of involvement of the same case manager with the service user is significant in terms of quality outcomes for the older person (Challis 1999).

The implementation process

Implementing a case management model involves a series of activities. These can be broken down into the following steps:

Step 1: Agree aims and arrangements

To plan the introduction of a case management system, it is important to agree:

- objectives
- which model to adopt, taking into account evidence about different models (*see* Table 3, p 40)
- who will be eligible or targeted for case management
- funding and budgetary responsibilities
- the system of accountability.

For example, if a joint agency model is chosen, discussions between health and social care agencies may consider:

- whether this case management system will be targeted at older people with complex needs to improve the quality of their life and prevent unnecessary hospital or residential care admissions

- which agency will lead or whether this will be a jointly managed case management service
- which resources will be attached or can be accessed by case managers.

Agreement will be needed about the potential for pooling or aligning budgets from the two agencies, the level of devolved budgetary responsibility and the system of accountability.

Step 2: Clarify the case manager's roles and responsibilities

The roles and responsibilities of the case manager will need to be clarified, including those relating to assessment. This will include clarifying who takes on the different tasks of the case management process and whether the case manager is a distinct and separate role or whether this will be in addition to a professional role.

There will also need to be agreement about the appropriate size of caseload for the case manager, allowing time to plan individual care packages and programmes, establish rapport with user and carer and undertake reviews. There is evidence of a decreasing capacity to perform follow-up, monitoring and review as caseload size increases (Challis 2003).

Step 3: Put older people and carers at the centre

As a priority, it is important to ensure the older person and their carer are at the centre of this new process, by, for example:
- agreeing care plans with the older person and their carer
- providing information to users and carers to help them make informed choices about services
- ensuring access to advocacy if there is a danger that the case manager is acting as a 'gatekeeper' to services.

Step 4: Liase with other organisations

All other organisations involved in the service system that will be in contact with, or affected by, the new case management process need to be involved in discussions to clarify how this will relate to their work and services. This will include agreeing shared protocols and procedures – for example, in making and accepting referrals, confidentiality over information sharing and managing emergencies.

Step 5: Develop information and communication systems

Good information systems are essential to support the case management process. They must be able to:
- provide information to older people and their carers about the case management process
- provide information to service users on services and their eligibility criteria, health conditions and self-management
- provide information to case managers on service costs and eligibility for services
- communicate with other agencies contributing to the care plan
- offer shared or common recording systems
- record unmet needs to feed into planning processes.

Checklist: Introducing case management

✔ Consider targeting older people with complex problems.
✔ Put older people and carers at the centre of the process.
✔ Agree aims and arrangements for the new system.
✔ Clarify roles and responsibilities of case manager.
✔ Ensure training and induction for case managers.
✔ Liaise with other organisations and professionals in the service system.
✔ Develop information and communication systems.

Staff

Staff from a range of professional backgrounds may be suited to taking on the role of case manager but will need the following skills and knowledge base:

- the ability to listen and work with older people and their carers rather than making plans on their behalf, and the ability to establish rapport and trust
- the ability not to be confined by their own professional role, and to take a holistic approach
- technical skills in assessment and knowing when more specialist input is needed
- interpersonal and communication skills to work with others
- good team and collaborative working skills
- a close working knowledge of the needs of the client group and local service and community resources (including eligibility criteria for access to these services)
- experience of working across a range of agencies and an understanding of their role
- the ability to manage budgets and an understanding of relevant financial issues.

Other staff in the service system will need to know about the role and responsibilities of case managers, so good communication and trust need to be developed between different professionals and the case manager. Any fears about losing responsibilities must also be addressed.

Monitoring and evaluation

At an individual level:

- Obtain direct feedback from older people and carers about whether the objectives of the agreed care plan are met (for example, by commissioning an independent body to carry out interviews, or through comment cards, telephone interviews and focus groups).
- Use a regular review process as part of the case management cycle (*see* Fig 7, p 102) to check delivery of outcomes for the older person and their carer.
- Audit samples of case files at regular intervals to monitor case management practice and review the match between care plans and service delivery.
- Monitor the quality of process from the perspective of older people and their carers.

At system level, the first task is to set up monitoring systems and joint evaluation processes across agencies to answer:

- whether the case management service or process is meeting the specified objectives – for example, how many older people have increased their independence or achieved a better quality of life?
- whether the service is effectively targeted, and whether this is fair and equitable

- whether it has changed service use in a positive way – for example, preventing unnecessary hospital admissions
- whether this is a cost-effective process.

The second task is to make sure any unmet needs are being systematically collated and fed into planning and decision-making bodies.

Barriers

The first potential barrier is the danger of a case manager being more heavily influenced by their employing organisation than by the preferences of older people – particularly where case managers are part of the services that need to be co-ordinated, or where case management is seen primarily as a form of budgetary control and a way of restricting access to the service system.

A further barrier is that case management, with its overhead costs of the case manager, may tend to increase costs for those with less severe needs. Difficulties can also arise where service boundaries are not co-terminous, and case managers have little influence in wider networks.

Finally, limitations can arise if staff acting as case managers are unable to think outside of their usual professional role and do not think about holistic needs and flexible, imaginative, co-ordinated service solutions.

Supports

The success of any model of case management depends on local and national factors that ensure the provision of sufficient appropriate services to co-ordinate, as well as organisational and professional support for those undertaking the role of case manager. These factors include:

- a good mix or 'menu' of local services
- national policy and financial incentives
- joint training across professions and organisations
- excellent communication and shared information systems.

These factors are addressed in full below.

- **A good mix or 'menu' of local services** – This will help tailor services to meet the needs of the older person and their carer. So service planning, commissioning and managing the market play an important role in supporting case management arrangements. Here, commissioning involves:
  - strategic planning of services, based on an understanding of local needs and supply of services
  - applying resources to achieve strategic goals
  - reviewing progress to meet any changing needs.

- **National policy and financial incentives** – These need to promote partnership working and joint strategic planning between health, housing, social care and community agencies, supporting the integration of services at both strategic and operational levels (*see* Banks 2004).

- **Joint training across professions and organisations** – This must involve users and carers and develop the skills and understanding of the case managers and professionals with whom they liaise.
- **Excellent communication and shared information systems** – These are key supports to care management systems.

Key points

- **There are many different models of case management for co-ordinating services for individuals. Their merits and effectiveness depend on a number of factors, including:**
  - **the target group chosen**
  - **clarity of objectives**
  - **supporting organisational infrastructure**
  - **budgetary control**
  - **relationships with other organisations in the service system**
  - **availability of a range of local services.**
- **Evidence suggests that it may be important to target case management for those older people with complex needs, and to adopt a model that works beyond a single agency and that can control substantial levels of resources.**
- **There are dangers that services may be co-ordinated to meet budgetary or service providers' requirements rather than the preferences of older people. As a priority, it is vital to support ways of putting the older person and carer at the centre through, for example:**
  - **needs-led assessments**
  - **regular reviews**
  - **systematic monitoring**
  - **access to advocacy for older people and their carers.**
- **The role of case manager calls for a range of skills and knowledge, whether this is a job carried out separately or is a task as part of another professional role. It is important to provide staff taking on this role with training and support.**
- **Any effective case management system must be underpinned with strategic service planning and commissioning, involving agencies from across the entire local services system, to ensure an appropriate and connected range of services.**

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Chapter 7
Integrated teams

Judy Triantafillou

The central pivot of integrated care for older people is the care provided by a team of service providers through integrated processes that overcome professional and organisational barriers. Workers of various professional backgrounds, and in different organisations, have to form collaborative teams in order to provide a full array of services that are integrated to meet the needs of older people.

Much of this care may be already provided by the older people's family members and friends, so family and other informal carers are closely involved in the work of the integrated team – both as co-providers of care and as clients with their own needs. The issues of family carers' training and needs for support are addressed in chapters 5 and 6.

Integrated teams aim to address the gaps in care for older people with complex health and social care needs that can occur between traditional services. They achieve this by offering a comprehensive and seamless care service designed to organise the way the required services are provided around the needs of the older person and the informal family care network, rather than trying to fit the clients' needs into an existing, set service system.

Definitions

Integrated teams are groups of multi-disciplinary and inter-organisational health and social care professionals, working together as a distinct team to provide services to support the various individual needs of non-self-sufficient older people and their family carers. Service provision is based on comprehensive needs assessment (*see* Chapter 4), and the team is defined by its agreement on common tasks and outcomes, which are designated by management, with clear roles and duties.

The clients of integrated teams are defined as older people and their family carers with complex health and/or social care needs.

Objectives and intended outcomes

From a management perspective, the integration of the team occurs at different levels:

- **the core team of hands-on care providers** – usually consisting of a permanent group of professional workers from different health and social care sectors

- **the intermediate level** – the team management, within the existing health and social care systems, which co-ordinates and collaborates with other related sectors, such as housing, transport and education
- **the higher level** – responsible for integrating the work of the team with local or national policy development and its overall implementation.

From the perspectives of the clients, professional care-providers (staff) and managers of the organisation, the objectives of integrated teamwork are as follows:

The clients' objectives

For clients, the main objective of integrated care teams is to provide satisfactory, consultation-based solutions to their short- and long-term health and social care needs that cannot be addressed through the regular single-service system.

The staff's objectives

For staff, the intended outcome of working as an integrated team is to provide effective and efficient health and social care to older people, aimed at improving their quality of life through:

- multi-professional, functionally integrated teamwork
- acting as a specialist support, teaching and advisory resource on older people to general primary care workers and teams
- linking and collaborating with other sectors and groups working with older people, such as service users, carers and volunteers.

Objectives for managers and the organisation

Here, the main objective and outcome of integrated teamwork is to provide and evaluate health and social care to improve the lives of the older people for whom they are managerially responsible. This care must be financially viable, equitable, effective and appropriate.

Managers in the regular, non-integrated care pathway often ask 'Why should I as a manager introduce integrated teams?'. A key answer is the issue of acute hospital beds being 'blocked' because there is no suitable community care into which to discharge older patients. By introducing integrated community care teams, managers can reduce the length of stay for older patients, thus reducing the cost of expensive and inappropriate hospital care while improving patient well being by providing care at home. It is a major challenge to integrated teams to prove their worth in this way, through appropriate evaluation methods (*see* Monitoring and Evaluation, p 122).

Practice example: Government policy

In 1992, the Swedish government's Adel policy reform aimed to integrate all public care for older people under the authority of the municipalities, strengthening the social service culture and de-medicalising care, while simultaneously providing the municipalities with a strong financial incentive to offer home-based care for hospital patients on discharge. Between 1992 and 1996, the number of hospital beds has been halved and the average stay in hospital has dropped from 11 to 7 days, with a more pronounced decline in geriatric hospitals and clinical wards from 52 to 22 days in 1996. Most of the patients who are now cared for at home are older people.

Source: Theobald (2003)

Models and approaches

Many different models of integrated teams have been developed in response to specific needs and areas. They share the common characteristics identified in Definitions (*see* p 113), being composed of multi-disciplinary and inter-organisational health and social care professionals working together as a distinct team, the composition of which depends on the designated service target group.

Examples of different integrated team approaches include:
- specialist multi-professional integrated care teams
- general multi-professional community home care teams
- specific disease-based integrated care teams
- community centres for older people providing health and social care services.

These approaches are discussed in detail below.

Specialist multi-professional integrated care teams

These teams are based in the community, and operate at the interface between primary and secondary care, to assess and intervene and/or treat older people with complex health and social care problems.

Practice example: Co-ordinating home and hospital services

The 'specialist integrated programme of home care with home-support teams' (ESAD) is based in Madrid's primary health care sector and aims to co-ordinate home and hospital services for older people, by setting up home care teams in three of the city's health areas, and to provide support for primary care. Each core team consists of:
- two doctors with experience in geriatric and primary care
- two nurses with experience in diagnostic and therapeutic techniques, needs assessment and planning of home care, as well as the ability to promote health education in basic and specific care to patients and caregivers
- a nurse assistant
- an administrative assistant
- a part-time social worker.

Integration takes place between the team members and the family carers, and between primary (home) and secondary (hospital) health care levels, as well as with the social service sector, using a shared electronic record system (*see* Supports, p 125).

The positive results of evaluation of the project have included:
- more rational use of resources
- a reduction in hospital and emergency admissions
- support in home care, co-ordination and training for traditional primary care teams
- improved quality of life for patients and caregivers.

Source: Sanchez del Corral (2002)

Practice example: Hospital and health board collaboration

In Ireland, Home First is a collaborative project for home care between a hospital and an area health board (regional body with responsibility for planning, administration and implementation of health services). The project was initiated by the primary care sector, and its aim is to enable older people to return home, and remain there, after hospitalisation.

The project involves the hospital and the health board working together to provide individualised packages of home care to older people whose care needs would otherwise have necessitated institutional care. The team uses comprehensive assessments to draw up a care plan, which is then implemented by the care organiser. Integration takes place between the primary and secondary health care sectors, and with the social service sector.

Source: O'Cleirrigh (2002)

Practice example: Rapid response teams

Organisations such as Community Care, in Cumbria, UK, are implementing 'rapid response teams' – integrated teams designed to prevent admission to hospital or residential homes. The team provides a 'fast-track' needs assessment and implementation process in the patient's own home, working collaboratively and integratively with existing services. The teams are made up of nurses and social workers, but they may be housed in different locations, so integration is 'virtual', which can lead to communication problems.

Source: Alaszewski *et al* (2003)

General multi-professional community home care teams

These teams provide home help and personal care on a regular basis to dependent older people in their local community.

Practice example: Home care service teams

A programme of 400 'help at home' home care service teams has been developed throughout Greece. Each team consists of a social worker, a nurse and a home help, and the programme aims to provide care at home for dependent older people. Priority is given to those living alone and without the means to pay for private help, although in some areas the programme has recently been extended to relieve family carers (predominantly women) from the burden of full-time care, enabling them to enter the labour market.

These teams work in close association with the local primary health care services and local 'KAPI' community centres (*see* Practice example: The KAPI network opposite). This means that the integration of care services takes place both within the team and at the local authority level at the interface between primary health and social home care. It also exists within the broader context of national policy, which aims to maintain older people's autonomy by supporting them in their home environment.

Source: Amira *et al* (2002)

Specific disease-based integrated care teams

These teams are set up to address the multiple problems of care for patients (mainly, but not exclusively, older people) with a specific disease diagnosis (such as Alzheimer's, diabetes, stroke, or hip fracture). In the two practice examples that follow, nurses have taken on new roles in promoting integrated care services for older people between hospital and home.

Practice example: Diabetes care

A nurse specialist-led diabetes care project in the Netherlands was set up to improve diabetes care. The specialist nurses were appointed to act as liaison co-ordinators between the hospital and primary care services, as well as central care providers to the (mainly older) patients and their families. Key stakeholders include the hospital, the home care agency and GPs. A project director and project co-ordinator were also appointed. The co-ordinator carries out daily managerial activities, such as organising meetings, writing the minutes, and answering questions from caregivers. A working group of caregivers and patient representatives from the regional diabetes union developed a multi-disciplinary protocol for the project.

The summary report states: 'The development of the project, from experimental phase and performance until the establishment of the integrated care model as a form of regular care, took six years. This demonstrates that success in integrated care development... requires patience, understanding and negotiating competencies, but also a strong vision, clear goals and constant guidance of the participants in the desired direction; in short, much depends on the change management in charge.'

Sources: Mur-Veeman *et al* (2001), Eijkelberg *et al* (2001)

Practice example: Individualised care packages

In a nursing case management project in Belgium for geriatric patients and their families, each patient, as well as the family caregiver involved, was given an individualised package of care, designed and implemented in a multi-disciplinary context. The project aims to prevent premature institutionalisation of older patients with mental health problems. The total care process is co-ordinated and organised by a nurse case manager who also carries out clinical interventions towards the patients and their families. This type of case management is another way of enhancing nurses' professionalism by encouraging them to acquire specialised knowledge and autonomy within the integrated team.

Source: Tombeur (2002)

Community centres for older people

Local community centres for older people are well situated to act as co-ordinating and implementing bodies for integrated care service provision. The range of services provided includes preventive physical and mental health programmes and primary health and social care, together with recreational programmes, aimed at promoting social participation and well being among older people in the area.

Practice example: The KAPI network

The Greek Open Care Community Centres for Older People (KAPI) constitute a pan-Hellenic network of more than 370 centres taking an innovative approach to integrating health and social care for older people in the community. The centres are run by local authorities and represent the main axis of service provision in Greece specifically for older people. They aim to promote and maintain autonomy and well being in the elderly population in general by providing primary health services, including health promotion and disease prevention programmes, together with social care services and recreational facilities. Participation in the KAPI activities is by membership, and the members elect representatives to serve on the management committee, which also has a staff representative.

The integrated team of the KAPI usually consists of a core staff of social worker, health visitor or registered nurse, home care worker, doctor, physiotherapist, occupational therapist or ergotherapist and other associated specialists and volunteers as required. Many of the KAPI centres now also provide 'help at home' services to older people with greater needs, thus extending their collaboration and integration with other local services and bodies (*see above*).

Source: Triantafillou (2002)

The implementation process

A manager faced with the task of implementing an integrated team of professionals to provide care to dependent older people and their family carers needs to ask:

- What is the strategic background for the establishment of the team?
- What sort of integrated team do I need to solve the problems identified?
- How can project management structures be organised?
- What are the basic steps in the assessment and care process?
- What systems do I need to support the working processes of the integrated team?

These questions are examined in detail below.

What is the strategic background for the establishment of the team?

Supporting factors are:

- a national or local policy commitment to provide an integrated care service, backed by designated resources (budget and staff) funded over a set time period
- a client-centred approach
- an examination and identification of the main issues in the provision of care for older people in the area, by each agency or sector involved in the team – for example, primary health care, social services, voluntary agencies, or the local authority
- practical experience, knowledge and skills in forming and sustaining integrated teams.

What sort of integrated team do I need to solve the problems identified?

A multi-professional, integrated health and social care team may include a broad mix of staff, working on a full- or part-time basis, depending on the team's objectives and the allocated resources. However, the core team will usually include:

- a primary care doctor
- a nurse
- a social worker
- a home care worker
- administrative and other support staff
- managers.

This core team may be supplemented or expanded, according to need, with:

- a community geriatrician
- a health visitor
- a physiotherapist or physical therapist
- a home help or domestic worker
- a personal care worker
- an occupational therapist or ergotherapist
- a speech therapist
- a psychologist
- a chiropodist
- family carers
- volunteers
- workers in associated sectors, such as transport or housing advisers
- laboratory and technical staff
- information technology specialists
- support staff, including secretarial and office workers, and cleaners.

How can project management structures be organised?

The actual composition of the team depends largely on the type and objective of the integrated care programme and the allocated funding (For examples, *see* Models and approaches, p 115). When planning organisational structures, the manager needs to identify:

- the mission of the team
- what financial, material and human resources are available
- work processes that can be planned, such as care packages or evaluation and monitoring systems
- how the team can be managed most effectively, clarifying roles, authority and leadership, and sustainability.

When organising project management structures and running an integrated team, the managers may also find the following strategies and steps useful:

- the appointment of team members on a full or part-time basis, with clear contractual obligations and rights
- an agreement between team members on the main aims of the service and the priorities and relative responsibilities in service provision, based on available funding
- a strategy for disseminating information on which services the integrated team provides within the community served
- a practical management strategy for the functional autonomy of the team and communication – both among the members within the team, and between the team and its manager. This must take into account the possible conflicting allegiances of the team members to the integrated team and to their own professional sectors.

The assessment and care process

Whatever the objectives and composition of the integrated care team, the client and the team members will take certain common steps in the assessment and care process:

Step 1: Identify the older person's complex needs and refer them
The team is approached either directly, by the older person and/or their carers, or indirectly, via the health or social service currently responsible for them.

Step 2: Assess suitability for care by the integrated team
The professional who is contacted makes an initial evaluation of the case and decides whether the team can accept it, depending on whether the circumstances fit the criteria for acceptance into the programme, and on the capacity of the programme.

Step 3: Carry out an integrated needs assessment
The team makes an integrated assessment of the older person's needs, with the participation of any family carers and other responsible health and social care service providers.

Step 4: Draw up a care plan
A care or case manager is allocated, and they draw up a care plan that meets the main needs identified during the assessment process. They identify specific objectives, which are agreed on by all concerned.

Step 5: Implement and monitor the care plan
The team provides the required health and/or social care interventions, together with a system of monitoring, evaluation and feedback on progress.

Step 6: Evaluate the care plan
If the evaluation and monitoring process indicates that no progress is being achieved, or that the situation is deteriorating, then there will need to be a re-assessment and new care plan drawn up.

Step 7: Provide continuous care or close the case
Either the team continues to provide care for as long as required or, in the case of specialist integrated teams when the objectives have been achieved, withdraws, and the regular service sector and the family carers continue the client's care.

Systems and instruments

The manager will need the following systems to support the working process of the team:

- **a standard referral system** that is known and available to all local organisations and services working with older people
- **a multi-professional assessment team**, with each member of the team taking referrals in rotation and using a common comprehensive assessment instrument
- **frequent and regular team meetings** for exchange of information and feedback. The client and the family carer should be invited to participate at regular intervals
- **a weekly 'critical incident' review** to improve listening skills and identify and discuss common problems, such as conflicts between older clients, their relatives and professional care providers regarding acceptable risks and needs

- **a budget** that is discussed and agreed on by the team manager and at least one staff representative. When the budget is funded by several different sectors, conflicts may often arise in relation to agreement on priorities
- **a clear and easy system of client access to the process**, including the need for a 'gatekeeper' who is usually the designated contact professional for the integrated team. The gatekeeper function is undertaken preferably by a health or social care professional, working either as a member of the integrated team itself or within the mainstream system, depending on the national or local structure of health and social care provision
- **a shared records system based on IT** This factor is crucial to the effective functioning of integrated teams. Patient shared and patient held records, based on IT, have made a major contribution to the success of the work of integrated teams, and help involve the patient and family carer in all discussions and decisions about care. Additionally, the implementation of IT systems has already simplified and sped up many administrative processes including availability of services, throughput and financial management of integrated teams.

Practice example: Sharing electronic records

In Madrid, the ESAD Home Care teams use a shared information system based on information technology, with three copies of the patient's electronic record held by the hospital, the integrated care team and the patient and family carer, to facilitate communication and collaboration between all participants in the care process (*see* Models and approaches, p 115).

Source: Sanchez del Corral (2002)

Practice example: Making the most of technology

In western Finland, the Satakunta Macro pilot project is an extensive national project involved in developing seamless care and service chains with the optimal use of information and communications technology (ICT). In the city of Pori, which has a population of 76,000, a specific sub-project on elderly care concluded: 'General lessons from the project are that national [governmental] co-ordination, special legislation and funding are enablers [of integrated care], and that ICT is indispensable.'

Source: Hanninen, cited in Huijbers (2002)

Staff

The main staffing issues that relate to integrated ways of working are concerned with staff competencies and qualifications, support and training, and leadership.

Staff competencies and qualifications

These factors vary according to the different professional requirements that are set at local and national levels. At the international level, one major issue is the recognition of equivalent professional qualifications between European Union member states. Although this issue has been well addressed for the standard health care professions, there is less agreement on training and recognition of 'new' caring professionals such as personal care and home care workers.

Support and training

Specific training for the staff of integrated care teams involves:

- basic and continuing multi-professional gerontology training
- practical experience in teamworking, with on-the-job support and training
- training programmes on teamwork building and role skills
- transfer of experience to other co-professionals working with older people in the local area and in the wider field
- training family carers in caring techniques. Family carers have noted this as being of major importance in supporting them and improving their ability to care. *See* Triantafillou and Mestheneos (1994), Mestheneos and Triantafillou (1993).

For more information on support and training, *see* WHO Europe (2001) – a comprehensive programme of training and continuing education for community-based health care providers working with older people.

Leadership

In multi-disciplinary teamwork, one major difficulty is deciding who should lead the team. This issue is best approached with a management policy of equity between all team members, based on respect for the unique contribution to the team's work of all the professionals involved. In this way, traditional professional hierarchies and rivalries may be abandoned in favour of a more egalitarian system based on the practical realities of the team's working conditions and terms of employment.

In the Greek KAPI centres, for example, often the only member of staff employed on a full-time basis will be the social worker or health visitor. In this case, these professionals would have a natural priority as team leaders, while in situations where there are a number of full-time professionals, the manager might prefer a rotation of each team member in turn as the leader. As discussed in Chapter 10, the team leader needs to have the ability to communicate with and co-ordinate a variety of disciplines, and to work between different agencies.

Monitoring and evaluation

To enable the manager to evaluate the effectiveness and efficiency of the work of the integrated team, information needs to be collected regularly and routinely. The figures must relate to clearly identified criteria, and will be used to assess for performance management and for evaluation by the client. This means that the staff need to continuously monitor their own work, and there needs to be a clear system for the older person and the main family carer to participate in, and give their opinions on, the care process.

A main problem is that, despite generally positive feedback from clients of integrated care teams, there is a lack of objective measures of success. These need to be addressed in terms of:

- clinical effectiveness
- effectiveness of social interventions
- cost effectiveness
- client/user satisfaction
- increased job satisfaction of care providers.

These factors are discussed in detail below.

Clinical effectiveness

Measurable changes in specific aspects of a client's health status (health outcomes) can be monitored using standardised scales or instrument, such as:

- the Katz scale (Katz *et al* 1963) and Barthel index (Mahoney and Barthel 1965) for measuring functional ability
- the mini-mental state, or 'MMS', for assessing cognitive function (Folstein *et al* 1975)
- the geriatric depression scale (GDS) (Sheikh *et al* 1991) and the WHO-Qol Bref (WHO 1996) for measuring psychological state, well being and quality of life.

The routine use of these instruments, during the initial comprehensive assessment and subsequently at intervals during the monitoring and evaluation process, can provide invaluable information on the client's progress. However, relating improvements or relapses to specific interventions in practice is more difficult, since this usually requires specific research protocols to eliminate confounding variables. Nevertheless, the routine monitoring of relevant outcome indicators is increasingly an obligation of all integrated teams aiming to justify their existence. Additionally, the use of a standardised measure of carer well being, such as the COPE index (McKee *et al* 2003), could further improve the assessment and monitoring process.

Effectiveness of social interventions

Unlike the standardised ways of measuring the effectiveness of clinical interventions, it is more difficult to evaluate improvements in well being and quality of life that result from the social interventions of the integrated team. This is because the multi-focused approach of many social interventions makes scientific evaluation of their effects more complex, but also because even measured improvements or decreases in older people's well being may be due to factors in their lives other than the efforts of the team.

Cost effectiveness

A crucial factor in promoting the work of integrated teams is the overall costs of running the service. While these may be higher – at least initially – than traditional methods of service provision, if the integrated team can be demonstrated to be more effective in terms of outcomes for the client and family, this may justify the extra costs. Ideally, integrated teams should be more economical to run while also resulting in better client outcomes than traditional services.

Client/user satisfaction

The opinions of the older people and their carers using the services of an integrated team must be routinely monitored as a part of the feedback process for staff, managers and administrators of the service. It may also be possible to compare this data with that of traditional care service users.

Increased job satisfaction of care providers

There is documented evidence that the promotion of 'team working' leads to improved professional well being and increased performance of staff working in primary care teams (Borrill 2000). However, so far, similar evidence from the staff of integrated teams is lacking.

Having to arrange for the large amounts of data needed to measure all these parameters to be routinely and systematically collected can be a major burden for care providers. Some may argue that the time this takes could be better spent on patient or client care, or simply in strengthening the relationship between client and caregiver. However, it is vital for the manager to negotiate with staff and agree on a feasible plan for monitoring and evaluating outcomes from the care provided by the integrated team, as this is an essential contribution to an evidence-based evaluation of their work.

Practice example: Assessing performance

A study in Wiltshire, UK, found that the integrated teams examined did not score better on any of the measures of clinical effectiveness and user satisfaction than traditional care services, and indeed appeared more expensive to run. However, service users were more likely to refer themselves than they did before, and were assessed more quickly than in the regular service sector. Most of the older people were not interested in the way in which services were organised and delivered, but in the quality of the service they received, and the quality of the relationship with service providers was of utmost importance.

The negative findings could be attributed to the fact that:
- the projects had not yet fully integrated
- better IT systems were required to measure effectiveness
- measuring user satisfaction needs to be incorporated routinely into evaluation processes
- in evaluating any service, the instruments needs to be developed in line with the specific service offered and with clear objectives.

Source: Brown (2002)

Barriers

The main barriers to integrated teamwork are:
- a failure to invest in IT
- overcoming traditional hierarchies
- establishing roles
- resource allocation
- team–managerial relationships
- unforeseen outcomes.

These are explained in detail below.

- **The failure to invest in IT** – As a basic prerequisite for successful inter-sectorial and inter-professional record keeping and communication, this issue is a major delaying factor in the promotion of integrated systems of health and social care. In a study aimed at evaluating the effectiveness of integrated teams compared to the regular service system, the inability to measure the effectiveness of the integrated team's service provision may have been linked to inadequate IT systems (Brown 2002).

- **Overcoming traditional hierarchies** – In practice, the main initial problem to integrated teamwork is in 'extracting' the team members from their individual, professional group – in other words, overcoming the traditional professional hierarchies in the health and care professions. This process involves a willingness to learn from other team members and to transmit knowledge between staff, as well as developing trust between them.

- **Establishing roles** – On the other hand, another major problem is that integrated teams are a separate category that is 'neither fish nor fowl'. They fall between the two main areas of health and social care provision, and are in danger of being supported by neither.
- **Resource allocation** – Following on from the issue of establishing roles, if separate finance is allocated to the integrated care team, its members are more likely to be viewed positively by existing field workers. Otherwise, they may be viewed by other workers as a threat, by 'stealing' scarce resources from health or social care budgets.
- **Team–managerial relationships** – There is a need for frequent and clear communication between managers and the team personnel, so all decisions must be discussed beforehand, and agreement reached as far as possible on both sides. It is a good idea to nominate a member of staff to represent the team's views to the manager directly in charge. In line with the collaborative framework, this task can be allocated to each team member on a rotating basis. From the managerial point of view, time spent intelligently promoting good relations with the staff and motivating them to operate as a team will reap benefits in terms of their overall productivity and job satisfaction (Goleman 1995).
- **Unforeseen outcomes** – Referral of clients from the regular service sector to the team for specific problems, such as managing incontinence, can lead to other unmet needs being identified, and a build up of waiting lists. Cases need to be constantly reviewed, and successfully managed patients or clients referred back to their main primary care providers, where appropriate, to keep the caseload at a manageable level. This means that the process of comprehensive assessment, diagnosis of problems, formulation of intervention strategies, implementation of measures and review of outcomes needs to be conscientiously applied (*see* The implementation process, p 118).

Supports

The main factors that support a move towards integrated teamwork fall into the categories of policy and practice.

Policy

A supportive local or national policy on integrated care for older people is an important pre-requisite for success in implementing a service for older people, based on integrated teams.

Practice example: Policy framework

The UK's National Service Framework for Older People (Department of Health 2001) gives priority to integrated provision of services in community health and social care. Its Standard Two, person-centred care, states:

> National Health Service and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.

The current implementation of this policy line is assessed in the PROCARE report (Leichsenring and Alaszewski 2004), which documents the practical problems of carrying out and acting on integrated needs assessments at the local level, using the experience of a number of UK primary care trusts.

Many other countries, including Finland, Germany and Sweden, have also developed policies for the care of older people that are supportive of integrated teams, and these are examined further in the CARMEN policy framework document (Banks 2004).

Practice

Crossing organisational barriers is a pre-requisite for the function of such multi-disciplinary teams. In practice, this necessitates a major change of perspective on the parts of care providers and managers alike. If the regular care sector has a positive and supportive attitude to the integrated team, this can be a major factor in the successful functioning of such a project. To achieve this, the integrated team must demonstrate its ability to solve complex care problems, showing that it is an asset to the regular health and social care sector, rather than a threat.

Separate or independent funding for the integrated team may reduce the perceived threat of financial or staff cutbacks in the regular care system, but may also make it more vulnerable to cutbacks because the work of the team is not seen as an 'essential service'.

The management body needs to positively promote the existence and role of the integrated team among all the related organisations and agencies. This is of major importance in establishing the team's credibility and usefulness locally. The following supportive factors can also contribute to the effective work of an integrated team:

- shared records
- a willingness to work flexibly
- small teams
- 'lowering' professional roles
- accepting different ideas of leadership
- exchange of staff between organisations
- demonstrating the effectiveness of the integrated team.

These factors are explained below.

- **Shared records** – With a smooth flow of information, this is a key requirement for the successful operation of integrated teams. An accessible and accurate information system has to be developed before the team starts to function. The main areas that need to be addressed are:
    - accessibility
    - integration
    - practical implementation of initiating and maintaining an up-to-date record
    - accuracy
    - clearly defined responsibilities among the team members
    - involvement of the client and carers in record-keeping
    - ethical issues relating to shared information, such as confidentiality.
- **A willingness to work flexibly** – This includes a willingness to work across professional boundaries, with mutual support (including training in developing skills in working with other professionals and in teamwork).
- **Having a small team** – This helps by making communication and delineation of responsibilities easier. It is also more acceptable to clients and their family carers in terms of trust and the formation of more satisfactory client/staff relationships.

- **'Lowering' professional roles** – This enables all team members to accept each other as equal co-professionals, with less emphasis on hierarchical power structures than in other fields of health and social care.
- **Accepting different ideas of leadership** – This seems to be more important than who leads the team, and the choice needs to vary according to the problem. This involves identifying each specific problem and allocating for responsibility accordingly, so that the different team members are 'leading' on certain aspects of each case.
- **Exchange of staff between organisations** – This can facilitate mutual understanding.
- **Demonstrating effectiveness** – It is also very important to demonstrate the effectiveness of the integrated team interventions, both to users and to other primary care teams (*see* Monitoring and evaluation, p 122).

Key points

- **The main aim of an integrated team is to provide good care to older people in need, for whom the quality of the relationship with the care providers is of prime importance.**
- **Family carers play a unique role in the care process, both as co-providers of care and also as clients with their own needs.**
- **Supporting factors for the successful implementation of integrated teams include national or local governmental co-ordination, special legislation and funding. However, the use of information technology is indispensable.**
- **Routine monitoring and evaluation of outcomes from the care provided by integrated teams is an essential component of evidence-based, cost-benefit evaluation of their work.**

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Chapter 8
Workforce

NICOLINE TAMSMA AND SWANEHILDE KOOIJ

To improve integrated care for older people, it is important to have the right number of staff with the appropriate knowledge, skills and motivation to deliver services with expertise, empathy and efficiency. New or different professional roles, competencies, values and attitudes may have to replace the more traditional ones, as they do not necessarily fit the requirements for integrated care service provision. Working across professions and organisations, and taking on a client-centred perspective, are only two of the challenges that need to be met. New structures or organisations may have to be set up, new partnerships created or old collaborative arrangements reframed.

Delivering this change puts the whole workforce to the test, in terms of knowledge, flexibility and attitudes. This requires commitment throughout organisations, from senior management to frontline staff. Managers need to facilitate changes, support and motivate their staff, and forge new partnerships with other organisations, as well as with service users. They face this challenge against a demographic backdrop of an increasingly larger and diverse older population coupled with a diminishing influx of young people into the labour market. The same demographic trend also puts an extra strain on the public and private finance available to deliver the appropriate services.

This chapter looks at the key building blocks for human resources that need to be in place to manage and deliver integrated care. It provides pragmatic examples and tools, and aims to help managers take a further step towards building an appropriate and sustainable workforce.

Definitions

The overall picture of the human resources that contribute to the provision of care for older people has many facets. It may include professionals, lay people, volunteers, paid employees, friends and family, and workers from the so-called ‘black market’, which may also include illegal immigrants. In order to arrive at truly integrated care provision, communication and collaboration with all these formal, informal and unofficial ‘care resources’ is important, particularly in countries where substantial gaps exist in the regular services available or where direct payments enable clients to buy their own care packages.

While acknowledging the reality of the diversity of human resources in the care domain, this chapter focuses on the formal workforce domain only. Here, the term ‘workforce’ includes all staff employed by care-providing organisations and agencies, but particularly those employees actually involved in care delivery, as opposed to technical, financial and administrative staff.

The role of informal carers is certainly recognised as being very important, but for the purpose of this chapter they are not considered to make up part of the workforce. However, the scope of the chapter does include professional support for carers.

Objectives and intended outcomes

Integrated care provision is very much a service of people, for people – a service reliant on human resources. No matter what financial means, modern buildings, or state-of-the art equipment your organisation may have available, it is your workforce that can make service delivery take place, and will indeed make it take place, provided there are sufficient supportive conditions in place. It is your staff who do the actual caring, engaging with older people and their carers, and who deliver your services at the frontline. Last, but not least, it is also your frontline staff that function as your primary eyes and ears – receiving and transmitting first-hand feedback on the quality and efficiency of local service provision, and functioning at the heart of your 'learning organisation'.

The very fact that your workforce is functioning within an integrated setting may present some specific concerns to your staff. They may be working under management from several different organisations, or may have to take their lead from a manager who is not formally employed by their own organisation. They may find that their colleagues from other agencies do not have equivalent qualifications and yet are being given similar, or even more senior, responsibilities. Wages and benefits packages may differ across organisations, as can professional standards and work cultures. In addition, staff may be asked to uproot from the location they are working from and to settle into a team with new colleagues.

Of course, the same coin also presents a more positive side. Bringing together different types of services and professions, integrated care arrangements present more opportunities for horizontal staff mobility. It also has high potential as a creative environment for professional growth and cross-sectoral learning.

A well-managed and supported workforce will be beneficial for clients, but also for managers. For managers, important outcomes will include:
- increased efficiency
- more opportunity to implement complex innovations
- improved communication flows
- more horizontal mobility of staff.

For staff, benefits will include:
- a clearer sense of their role and how it fits in the bigger picture of care provision
- greater confidence and the ability to deliver better levels of care
- more enjoyment from working in multi-professional teams
- less work pressure, due to more efficient sharing of the workload within and across organisations.

Models and approaches

To achieve the outcomes described above, and to deliver high-quality, efficient integrated care, staff and management alike need to shed their more traditional mindsets and acquire new skills and knowledge. Integration of services often implies that boundaries between provider organisations will become increasingly blurred. For this reason, sharing workforce-support mechanisms – including training – across organisations may be not only appropriate but also could be instrumental in advancing teambuilding.

There are, of course, many different ways to support and train staff, or to identify new roles and embed them in the whole system of service provision. Your preferred approach may depend on the type of organisational integration you want to achieve. This may vary from a 'linkage' model to co-ordination of services, through to full integration, or even a merger (Leutz 1999). Integrated arrangements may take many forms, as do problems challenging the process of integration. The same holds true for integrated teams. All these issues will reflect on the training needs within your own organisation as well as those of your partner organisations.

Prior to the design and development of training, the organisations within an integrated care network will benefit from mapping all their training needs and developing a joint strategy for recruiting and training, or retraining (Audit Commission 2002). In addition, periodic review meetings need to be held to make sure that knowledge and skills are kept up to date and that they still adequately match the services needed.

In looking at the needs of the workforce with regard to training, the person-centred approach can be useful in integrated care networks. This approach takes the individual client as a starting point to identify and map what services and staff are needed, what new roles need to be developed, and what training is necessary. It encourages process-oriented thinking across traditional boundaries of the various service organisations involved (Schwartz *et al* 2000). The system-level approach is similar, but broadens the perspective to include the integrated family network. This approach looks at how treatment, care and support are provided to both client and informal carer. Thus, it perceives the carer as part of the integrated team – in other words, a 'colleague' of the professional staff involved. It also takes into account the carer's support needs in terms of care provision, as well as in a more personal respect (Tjadens and Pijl 2000).

The implementation process

In operational terms, supporting the human capital needed to deliver client-centred integrated care implies:

- building, managing and sustaining a highly motivated, well trained, flexible workforce
- incorporating new roles with shared vision, values and principles
- embracing a client-focused perspective
- the ability to work efficiently across sectors and professions.

The specific demands that this makes on management leadership are explored in more detail in Chapter 10.

Building a new vision

Seamless care delivery is often laid in the hands of interdisciplinary teams. However, the cultures of health care and social services are not very supportive of this kind of teamwork (*see* Chapter 7). When looking at implementing changes in these cultures, managers need to think about training, supervision, legal safeguards (accountability and responsibility for a procedure or activity), planning, and resources (Dargie *et al* 1999). For more information on working towards a joint vision and adopting client-centred attitudes, *see* Chapter 9.

However, as could be learned from transforming service provision and introducing integrated quality management in local services in Finland (Vaarama *et al* 2004, Valvanne 2002), changing vision and practice is a gradual and challenging process of learning, training and implementation. It requires the inclusion and acceptance of the staff at all levels within each organisation. Everybody's input should be valued in this process as shared vision is an anchor for change.

Developing new roles

As has been explained throughout this resource book, traditional professional roles and expertise do not necessarily fit the requirements for the provision of integrated care services. Because of this, integrated care has proved to be a very creative breeding ground for new professional roles. The work areas of many of these new professionals are described in more detail in other chapters. They include elderly or peer advisers, case managers, information managers, advocacy workers, needs assessment specialists, quality monitoring specialists, service planners and team managers. Three other examples – integrated services officers, service network co-ordinators and logistics service producers – are explained in detail below.

Integrated services officer

This type of professional role was developed within the context of sheltered housing for people with dementia. In this arrangement, one professional provides all the services needed to support the clients in living independently in their communal home. This includes support with activities of daily living and domestic activities such as cooking and cleaning, caring, social support, linking with and supporting relatives and friends, and logistic management. In making the shift from a more traditional approach to this type of integrated service, four key steps can be identified (Krijger *et al* 2002):

- from 'caring for' to 'supporting with', reaffirming a sense of normality of this living arrangement for both clients and professional
- from single-professionalism to multi-professionalism, sometimes involving more complex needs, and requiring a more perceptive and reflective attitude from the professional
- from task-oriented to integrated provision, requiring additional expertise and excellent communication skills
- from working within a more collective setting to providing tailor-made support to individuals, albeit within a communal living arrangement.

Service network co-ordinator

Local integrated care service networks need to be co-ordinated. A service network co-ordinator provides structure to the network, and manages its joint efforts. He or she enables the network and stimulates its participants to work towards achieving common goals or solving common problems. The co-ordinator also monitors process and progress. Expert knowledge, process skills, natural leadership qualities or available resources may all play a role in choosing an appropriate co-ordinator for the network. The co-ordinator also needs to be trusted by all parties. Democratic participation in appointing a co-ordinator is important as the network should be based on equality of partners (Goumans and Tamsma 2003).

Logistics service producer

While case managing care services is a fairly accepted phenomenon, older people may also need help in organising various domestic services to help out with activities of daily living such as shopping and cleaning.

Practice example: Logistic services

The city of Helsinki, Finland, initiated logistics services in 2002, in response to a client-satisfaction survey with regard to the city's care services. Recipients of Helsinki's home-care services were fairly positive about the quality of care overall, but they did come up with numerous suggestions for improvement. The most important ideas all had to do with the logistics of bridging the gap between demand and supply:

- being able to contact care staff in an easy way when they were needed
- continuity of staff making home visits
- clarity as to what service one could expect to be provided.

Source: Valvanne (2002)

Professional support for carers

On average, informal carers provide by far the most care to their family members, friends or loved ones. Carers may need support with many different aspects of their responsibilities, including easing of their workload, advocacy, information and advice, practical and instrumental support, financial support, emotional support, forms of respite, and/or the opportunity to participate in policy or practice-oriented inter-sectoral networks. Examples of support organisations for carers may be seen in many countries, including Ireland, in the national carers' association 'Caring for Carers', and Finland, with the Association of Care Giving Relatives and Friends. In addition, regular care-providing agencies or research and development organisations may run support and training programmes for carers (Banks and Cheeseman 1999).

Practice example: Training for carers

In Finland, the Association of Care Giving Relatives and Friends has developed a number of projects providing training for carers. The first provides training for peer group leaders for carer groups, in co-operation with 13 patient or other social sector associations. The scheme provides peer group activities to find new ways, and to promote old ways, of providing emotional support for family caregivers.

The second project trains volunteers and professionals to support carers in difficult situations and helps them to discover the best ways of offering this support. Two smaller projects focus on supporting carers before the care recipient moves into institutional care, and supporting carers of short-term patients.

Source: Autio (2002)

Mapping: capacity, skills and competencies needed

As a broad concept with regard to integrated care, 'capacity' is certainly not just about 'beds and buildings'. It can refer to a whole range of resources, such as finance, leadership, knowledge and skills. Capacity is required at qualitative and quantitative levels, and within different entities, including the whole system of services, organisations, personnel, and the individual receiving care. If capacity is 'the ability to carry out stated objectives' (Goodman *et al* 1998), then capacity building is the process or activity that improves this ability. It should also contribute to sustainable performance (LaFond *et al* 2002).

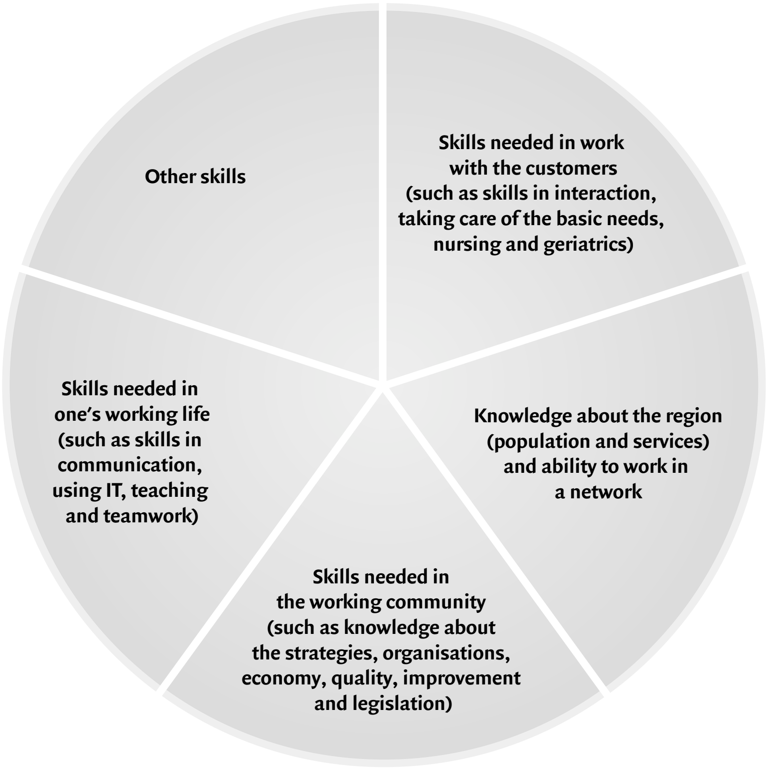
Mapping is the initial step in the design of capacity-building interventions: it provides the link between capacity and performance. The issue of mapping services is discussed in more detail in chapters 10 and 11. However, with regard to mapping skills and competencies of the workforce, management and staff both have a role to play.

Management should develop proposals and solutions in relation to the key workforce issues by:

- identifying and reviewing the key skills (*see* Fig 8 below), competencies and attitudes needed to deliver quality care, feeding into relevant pieces of work
- 'translating' the outcome of this review to all areas of the human resources field, such as education and training, recruitment and retention, and pay.

Fig 8 shows the main areas of quality requirements in home care. Staff should map their individual skills according to the quality requirements identified by the management. Development and training plans for individual staff, for teams, for the whole organisation, or for teams working across organisations can then be drawn up.

Fig 8: Skills mapping for an integrated service network



Source: Valvanne (2002)

In addition to more ‘technical’ professional competencies, staff members involved in delivering integrated care within the context of multi-disciplinary teams need to be responsible, communicative, able to perform an assessment, and able to work beyond professional boundaries and across a range of organisations. Other competencies that are particularly relevant here include communication and problem solving skills, and creativity.

Practice example: Competency mapping

The elderly adviser is one of many new professions developed to meet the demands of integrated care delivery. The Netherlands Institute for Care and Welfare developed a formal specification that included the following competencies:

- approaching, linking and contacting older people
- clarifying needs and problems as perceived by the older person (in other words, putting the older person in the centre and listening to them)
- identifying more structural problems in the system and putting them forward to those responsible for them
- providing adequate expertise to older people and professionals
- providing competencies to older people
- sustaining older people’s independence
- supporting non-paid carers and other volunteers
- sustaining quality of personal and professional growth
- contributing to further advancement of own service organisation.

Source: Lammersen and Phillipi (2003).

Recruitment

Managers across the European Union are currently facing the challenge of staff shortages. This is due to a variety of factors, including demographic trends. Across Europe, a range of approaches are being applied to tackle these shortages. These include running media campaigns aiming to improve the image of care work, recruiting from under-represented groups, and improving recruitment strategies, employment conditions and access to – and the level of – education and training.

Of course, recruiting professional staff will first and foremost focus on people who already have the required professional or vocational qualifications and/or can demonstrate recent work experience. However, without losing sight of the importance of regular professional standards and qualifications to deliver high-quality services, building the integrated teams that are needed to deliver integrated services can provide an excellent opportunity to recruit staff with supplementary skills and expertise. Flexible and creative people who are able to help a team ‘gel’ and to overlook old ‘demarcation lines’ could, of course, come from many backgrounds. For this reason, you may consider recruiting staff with less conventional qualifications.

Another creative way to draw in newcomers is to look for people who are very motivated – and, of course, suited for the job – but lack formal qualifications or recent work experience. People who have not been in paid employment for a long period of time – for example, through a history of unemployment, illness, caring or parenting – could be encouraged to re-enter vocational training if your organisation offers to accredit their prior learning as well as their organisational or caring skills learned in the domestic environment.

Practice example: Alternative recruitment strategies

In collaboration with local social benefits agencies, the Netherlands Institute of Care and Welfare set up 'Working and caring', a project to improve the competence of long-term unemployed women and, to reduce loneliness among older people. The scheme recruited women from deprived communities with a history of unemployment, and trained them in a group setting to reach out to, visit and support older people suffering from loneliness. This project contributed to the quality of life of the older people involved as well as increasing the self-esteem and employability of the trainees.

Source: Tenhaeff (2003)

As staff shortages increase, recruitment of staff from other countries may become a viable option. Freedom of movement of people, goods, capital and services is being promoted within the EU internal market, and legal arrangements regarding the mutual recognition of professional qualifications relevant to health care – such as doctors and general care nurses – will become more simplified through new European Community legislation (European Commission 2002). With the accession of ten new countries in 2004, the European Community has widened considerably, with many different implications for all involved (Irwin 2001, Albreht 2002, Zajac 2002).

Certain skills, such as language skills or familiarity with the professional culture in the host country, may influence the focus of international recruitment. The UK, for instance, predominantly looks to the Philippines, South Africa and Australia to help solve its staffing problems (Buchan 2002).

Whether recruiting from one's own country or from abroad, it is important to involve older people, or their staff representatives, in the recruitment process. This can either happen indirectly, by asking them to identify what is important to them in a professional care provider, or directly, at some point in the recruitment procedure itself.

Training

Across sectors and organisations, staff training programmes need to include a range of themes. The interaction, relationship and dialogue with the older person as a client should be the basis of the training. The same holds true for the awareness that working together with all key players in the care system (including the client and their informal carer) will lead to more efficient, better-quality care.

Acquiring a full understanding the concept of integrated care and its consequences for their own tasks, functions and competencies will help staff develop a shared vision. In addition, interdisciplinary learning enables working across professional and organisational boundaries: it should be a focus as well as an objective of the training programme. Developing a common language is an essential tool for integrated working. Finally, in team-building programmes, special emphasis should be put on communication between staff from different professional backgrounds, as well as between clients, carers and professionals.

Working in an interdisciplinary team often implies taking over tasks from other professionals – both horizontally as well as vertically – which means an extension of one's tasks. As a consequence, it might be wise to provide staff with some generic training during the first stage of the implementation period (Dargie *et al* 1999), or to set up a job-rotation programme to develop the necessary skills. Recognising that professional and organisational identities and boundaries may be persistent, managers are recommended to provide incentives, such as accreditation points or certificates, for staff taking part in training.

Across the European Union, countries are seeing their populations becoming increasingly diverse. As client-centredness and service delivery within older people's own living environments are key to integrated care provision, care needs to be provided in a culturally sensitive way. Thus training programmes should address issues related to diversity in terms of issues such as language, culture and lifestyle. In some European countries, specific services for black and minority ethnic communities have already been set up.

Education

The needs of the care system do not always match the output of the education system. Basic vocational training courses that directly prepare students for practical work are becoming less popular as many aspire to achieve grades in higher education. This puts pressure on the demand for staff providing domestic and hands-on care services. On the other hand, care providers may need more personnel with university-level education to keep up with the development of new methods of working, treatment, care and support. In Sweden, statutory care providers – in other words, representatives of local government – are now working with the education system to improve the match, by creating capacity in the university system for one-to-two-year training courses for assistant staff in health and social care for older people (Lofgren 2001).

Some problems in the development of inter-agency working are due to differences between staff in attitudes, background and professional language. In Finland, this is being addressed by the development of a basic level of education for those wanting to work in elderly care in either the health or the social sector. In the long run, any staff working at primary level should 'see and hear' their older clients in the same way and share a common language (Rissanen 2001).

Staff

Staffing issues are addressed throughout various chapters in this resource book. Without negating the relevance of specific technical expertise, such as integrated needs assessment, the overall message that emerges is the importance of 'soft' competencies, which rely heavily on social and emotional skills. Integrated care has very much to do with to attitudes, values, holistic approaches, interpersonal skills, the ability to work in teams and across organisations, and creativity. Integrated care is also about listening to clients, and teaming up with them and with their carers. It needs to be carried out by a learning organisation that embraces change and fosters open communication along horizontal lines.

All staff need to be involved in the shift towards client-centred integrated working and must perceive their contribution to be recognised and validated. Integrated working is well and truly a team effort: a process that needs to be 'owned' at all levels, within and across organisations. Encouraging bottom-up input into this process is essential but should not cover up the importance of middle-management involvement and senior management support and leadership.

Staffing for staffing issues

As this chapter is dedicated to building blocks for human resources, it is important to look at staff requirements for delivering the workforce agenda, in terms of support, training and developing new roles. Developing and sustaining integrated care services is not a quick fix or 'one off', but a continuous process that needs time, and benefits from periodic review. Setting aside adequate resources in terms of time, finances and people is essential and should be perceived as a long-term investment. Creating a special executive management portfolio may help to support the process and practice of integration, and to acknowledge its importance for the organisation as a whole.

Checklist: Developing a workforce

- ✔ Depending on how many staff you have, and on your financial resources, consider pooling budgets with partner agencies and jointly employing support staff to manage and deliver various aspects needed to develop an adequate workforce for integrated care.
- ✔ Use these staff to safeguard access to specialised training programmes, competency management and process evaluation.
- ✔ Employ joint competency support staff to enhance further working across organisations and developing a common language.

Integration entrepreneurs

Service integration and networking often need one or even several 'integration or social entrepreneurs' to make the whole integration process happen and to keep the ball rolling (Hudson 2003). They should have a strong commitment to change and will be skilled at mapping and developing policy networks, identifying where linkages are possible, and able to build coalitions and alliances.

They will have rather different tasks from those with conventional line-management functions within organisations. These will include:

- managing across and upwards
- influencing and motivating people over whom they have little control
- creating and assembling resources owned by others
- building trust between partners, keeping them committed to moving the wider agenda forward
- maintaining relationships and communication networks across agencies at a variety of levels.

(Hudson 2003)

Management

In facilitating and supporting their staff, managers need a variety of competencies (Audit Commission 2002, Adams 2003). These include:

- acting as a model for and supporter of partnership behaviour
- developing healthy relationships with peers across the system to build a leadership team
- supporting actions that benefit older people and the system as a whole
- creating an organisational culture in which whole-system working can flourish
- identifying 'win–win' solutions to shared difficulties
- agreeing and communicating consistent messages about the system's values, vision and priorities, in particular by placing older people at the centre
- valuing staff who work using a whole-system approach
- supporting innovation, celebrating success and learning from failure.

In a study to find out what types of behaviour among leaders may enhance innovative behaviour of co-workers, de Jong and den Hartog (2003) came up with a similar list of traits that were found to be effective:

- role-modelling
- provision vision
- consulting
- delegating
- supporting innovation
- rewarding.

They also found that excessive monitoring and target setting could impede innovation, as this could discourage staff from taking risks and may make them feel safer sticking to routines.

Barriers

Although they could substantially contribute to the development of integrated care (*see* Supports), national policies and jurisdiction may also function as substantial obstacles. They can inhibit services within and across sectors from certain forms of collaboration – for example, with regard to joint employment arrangements or pooling budgets. Formal national standards or requirements may also frustrate experiments with new professional roles or the more structural incorporation of these new professionals in your workforce.

A shortage of data about the population that the integrated team serves can also be a substantial hurdle, particularly to your planning abilities. Furthermore, data may be available or accessible only within the sector in which the team is working, which could lead to insufficient insight into the clients' living conditions, social and financial resources, or specific needs with regard to culture or language.

Supports

As far as management skills are concerned, getting things right in terms of workforce has much to do with good leadership and managing cultural change. National policies can be helpful or enabling in developing and supporting an integrated workforce. Particularly helpful are inter-sectoral policies that acknowledge the increasing demand for client-centred integrated care and make provision for this through:

- long-term planning for, and access to, appropriate vocational and university education and training courses and programmes that incorporate new competencies and professional roles that are crucial to integrated care
- stimulating and enabling long-term unemployed people to re-enter training and/or combine work with parenting, caring or educational activities.

Key points

To conclude, the following issues seem essential in building an appropriate and sustainable workforce and thus in supporting 'human capital' to deliver client-centred integrated care:

- **Allow for ample time to facilitate processes related to vision, attitude and skills building.**
- **Allocate specific human resources and executive management commitment to guide the process, map skills, and to build competencies.**
- **Shed traditional perspectives in translating client needs to staff requirements.**
- **Be creative in your recruitment: integrated care calls for some new technical competencies as well as many 'softer' skills.**
- **Do not be afraid to experiment with new professional roles.**
- **Form partnerships with other service providers, as well as with the education sector, the social care and employment sector, and businesses.**
- **'Use' national and EU policies wherever you can to the advantage of high-quality, accessible integrated care.**
- **Seek inspiration from colleagues in other countries, as they will have been trying to find solutions to similar challenges.**

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Chapter 9
Cultural change

Mia Defever

When two or more organisations, professions or teams from different backgrounds come together to provide needs-driven integrated care for older people, they have to work together in ways that are unfamiliar to them. If they come from different sectors, or if they have different histories or traditions, this is even more the case.

These innovative ways of collaborating, between systems and across organisations, can bring about an added value that equals more than the sum of the efforts of all organisations. To realise this surplus value, the parties involved have to cope with and overcome their multitude of differences in mutual perceptions, status, work styles, organisational affiliations, employment regimes and salaries, or in frames of reference. So in integrated care, the organisations and workers alike need to share each other's value patterns in order to provide a coherent care package.

This chapter outlines the issues and recommendations that managers need to consider when cultural change is introduced as a management instrument for developing needs-driven integrated care for older people.

Definitions

The term 'culture' refers to the value patterns of a society, a system or organisation, and to the attitudes of people and workers. 'Cultural change' is an intended process that supports the strategies of change in organisations. Cultural change may follow as a result of collaboration and innovation. In this chapter, cultural change is considered as a mechanism to support the development towards needs-driven integrated care for older people.

Practice example: Changing perspectives

A national charity in Belgium was funding a full-time care manager responsible for a team of 40 care workers supporting 160 older people in a semi-rural community. The charity developed a project of integrated care. This meant drawing together three separate agencies:

- the care manager and his 40 staff
- four GPs actively engaged in caring for older people
- the head of geriatric services at the local hospital.

- **The care manager** – The care workers worked in close collaboration with local GPs, but had no resources to further streamline their activities. They had close, long-term contact with their clients and were in permanent conflict with the local hospital about discharging older people. The manager believed that the team's work was essential to the well being of the older people in his region.

- **The GPs** – The GPs relied on the home care team, but as it lacked capacity the only solution for older people in acute need was often the emergency department at the local hospital. The GPs were convinced that they should play the key role in any newly developed integrated care team for older people because they believed that this was a core task of their role as physicians in the local community.

- **The head of geriatric services** – The head of geriatric services at the local hospital was often asked by his general manager to monitor his discharges more closely, and to reduce the number of 'bed blockers'. He was frustrated because his efforts to find proper, short-term accommodation for his discharged older patients were unsuccessful. Developing and managing hospital-based integrated care programmes was almost his personal mission, because he considered himself to be the only one with command of the required information, know-how and resources.

At the first meeting between these three agencies, each group was preoccupied with the urgency of their problems, blaming the other stakeholders for a lack of understanding and willingness to co-operate. There was no climate of respect for the diversity in attitudes, values and beliefs, and this was fuelled by inequity in their mutual status perceptions.

At the second meeting, the national charity called in an outside expert to facilitate. The three agencies organised an afternoon of activities such as role plays designed to help participants understand each other's perspectives. The integrated programme has now begun, and the three parties are no longer adversaries but have begun to understand the value in each other's contributions.
Source: Personal communication (2004)

Objectives and intended outcomes

Cultural change in integrated care is designed to bring about:

- a fundamental shift in the paradigms about care for older people among the people and organisations involved in the integrated care process – including staff, older people as clients, and their carers
- a perception among older people, their carers and staff in daily interactions of shifts towards person-centredness as a result of cultural change efforts
- a tangible reorientation in beliefs and attitudes towards the core values of integrated care
- a shared purpose and vision that puts older people at the centre
- deeply rooted and sustainable change, internalised by the different partners, operational at every level and in all parts of the system
- understanding, respect and sensitivity to cultural differences and mutual roles, for the work of each other between the different persons and agencies involved
- sustainable change, with the aspiration of reaching a cumulative and non-reversible change in attitudes, values and beliefs.

Sustainable cultural change

Since so many health and social service processes depend on the actions of people, sustainability comes down to winning the hearts and minds of all those involved. Cultural change becomes sustainable when new ways of working and improved outcomes become the norm, so that it becomes clear that the organisation has really evolved and is definitely not going back.

Models and approaches

Various models can be applied to guide the process of cultural change. Some, such as 'triple-loop learning', are more general and refer to organisational processes, fitting into what we can call the 'learning approach'. Others, such as 'client responsibility', refer specifically to the core values of integrated care. They fit into what could be called the 'client-comes-first approach'. These models are not mutually exclusive. For example, triple-loop learning is an approach to guiding cultural change throughout an organisation, while client-centredness introduces the values of integrated care.

These two models – the learning approach and the client-comes-first approach – are discussed in full below. We then look at a number of other instruments that are helpful in implementing the cultural change process.

The learning approach

Managers who want to support and initiate cultural change in their organisation need to understand the strategy of a learning organisation and to consider learning as a core activity. In that respect, this activity goes beyond superficial learning – a barrier to sustainable change. Learning organisations consider their environments to be a rich source of opportunities. They are familiar with the perceptions of the different stakeholders, and are focused on a deep understanding of their clients' needs (Davies and Nutley 2000).

Becoming a learning organisation is not always easy. Learning organisations need to learn how to learn. This is expressed by the concept of triple-loop learning, which makes a distinction between three levels of learning:

- **Single-loop learning** involves detecting and correcting errors with a simple feedback mechanism, such as an audit that compares practice with standards.
- **Double-loop learning** is a more sophisticated level of learning that affects the organisation's processes by questioning its objectives and the course of change. This level can lead to a redefinition of the organisation's goals and policies and even to structural changes.
- **Triple-loop learning**, also known as 'learning about learning', is usually an underdeveloped aspect of learning. Here, organisations learn about the contexts of their learning and develop the capacity to identify when and how they learn and when and how they do not, and to adapt accordingly. Successful learning organisations build on their experience of learning to develop and test new learning strategies (Argyris and Schön 1996).

Practice example: The triple-loop learning process

- **Single-loop learning** – A hospital examines its care of geriatric patients. Through a clinical audit, it finds various gaps between established standards and guidelines and actual practice. It holds meetings to discuss the guidelines, makes changes to working procedures, and enhances reporting and feedback on practice. These changes increase the proportion of patients receiving appropriate and timely care (that is, in compliance with the guidelines).

- **Double-loop learning** – As part of its geriatric care service review, the hospital interviews some patients at length. It emerges that the issues of most concern to older patients are continuity of care, convenience of access, quality of information, and the interpersonal aspects of the patient–professional interaction. To prioritise these issues, the hospital completely reconfigures its geriatric care to a team system led by nurses. The standards laid down in the guidelines are not abandoned, but are woven into a new pattern of interactions and values.

- **Triple-loop learning** – Despite the hospital's attempts, it finds that it is unable to reach its new objectives, so the hospital draws up a new programme. The factors that helped with the reconfiguration, and those that impeded it, are analysed and communicated within the organisation and among the different agencies – not through formal written reports, but via informal communications, temporary work placements and the development of teams working across services. Finally, the hospital is able to share with other services and agencies the lessons learned about learning to reconfigure.

Adapted from Davies and Nutley (2000)

The process outlined in the practice example above shows that the organisation understood the lessons from their learning in former phases. What started as a reorganisation of service (single) developed to including the perspectives of the client or customer (double). They finally understood (triple, or 'learning from learning') that a real reform could only take place beyond the traditional pathways by involving partners and collaboration from other sectors.

The client-comes-first approach

Client-comes-first models emphasise core values of integrated care. These include the patient-centred model and the client-responsibility model:

- **The patient-centred model** is a framework based on the beliefs and expectations of a patient. Health workers need to be able to identify the patient as a person, the relationship that exists between themselves and the person, and the expectations that each has about that relationship. To be operational in practice, person-centredness requires the values of the patient and care providers to be explicitly identified, alongside those values prevalent in the care environment (McCormack 2003).
- **The client-responsibility model** incorporates creatively engaging the client, assessing family needs, setting mutual goals, following the goal achievement process, and setting aftercare objectives. It includes issues such as confidentiality, shared medical decision-making and respect for patient autonomy. This model emphasises decision-making, taking into consideration the patient's goals and preferences for their care so that the patient and their non-paid carers negotiate the process of care decision-making taking into account the patient's values and perspectives (Pantilat *et al* 1999).

The implementation process

Cultural change can either occur as a result of careful planning, or it can emerge through programmes of integrated care, or through collaborative behaviour among services and institutions. In the first scenario, a planned cultural change programme in initiated by the managers, while in the latter, a reorientation in beliefs and attitudes and an understanding and respect for mutual roles comes about as a result of integrated care activities.

Practice example: Planned cultural change

The chief executive (CEO) of a network of health care institutions identifies cultural change as being crucial to the success of a major restructuring of its older people's services, since the attitudes and beliefs of the 'old guard' were considered to be constraining progress. The CEO is convinced that shared core values across an organisation can overcome the obstacles of restructuring towards integration.

In planning his cultural change programme, the CEO pays special attention to the traditionally embedded culture and subcultures of health service provision – particularly the ideas and beliefs surrounding authority, deference, status, discipline and blame. By delineating his objectives, he is able to reveal the irrational face of organisations and can create awareness about the taken-for-granted beliefs that determine behaviour and lead to resistance to change and innovation.

Adapted from Mahony (2000)

Implementing cultural change for integrated care based on the needs of older persons is a step-by-step process. Looking for an unambiguous set of common values would be an over-simplification – on the contrary, it is an evolution towards a deeply rooted change in vision and attitudes of workers on collaboration and integration of care. This process includes the following:

- team building and team development
- transparent, mutually agreed management lines, with the support of contractual clauses and codes of conduct
- staff appraisal systems linked to reform objectives, such as salaries and promotion rewarding front-line workers
- developing sustainability criteria
- external facilitation (especially in the starting phase)
- external monitoring by regulatory bodies and insurers
- developing joint protocols
- working together and systematic reflection.

Systems and instruments

This section provides three examples of instruments that can be helpful in implementing cultural change:

- vignettes, including older people's stories
- mentoring or leadership
- models that guide people through the process of change.

These three instruments are detailed below:

- **Vignettes, including older people's stories** – These can be used by managers as illustrative models to help survey the organisation and root out the obstacles to change. Vignettes are hypothetical or real-life stories that trigger the response to a set of questions, which in turn offer the possibility to evaluate systems, conditions, situations or changes. Vignettes can be particularly usefully applied when an explicit conceptual framework or methodology is lacking (Liaw *et al* 2003), and can be very useful for discussing professional values and organisational norms.
- **Mentoring and leadership** – Because managers sometimes overlook the need for leadership skills, it may be necessary to engage external mentors to teach them specific leadership skills, such as improved communication. Managers can sharpen their leadership skills by:
    - distinguishing between leadership and management
    - adopting a new mentoring model management style
    - evaluating the usefulness of new management techniques
    - understanding the connection between technology and leadership
    - looking for the solution beyond the problem, which means being seen and heard by other agencies and organisations (Kowalski and Campbell 2000).
- **Models that guide people through the process of change** – for example, the 'what's in it for me?' model. A 'what's in it for me?' analysis is a useful way to consider the different needs and attitudes of each of the key stakeholders in the change initiative (whether individuals or groups). The analysis should be carried out right at the beginning of the improvement initiative, before people have taken up 'positions', and can be revisited as often as required.

Table 5: What's in it for me?

Key people/group	What's in it for me?		What could the partners and stakeholders do to support or prevent the improvement initiative?	What can/should the manager do to reduce non-compliant activities and encourage and support compliant ones?
	Impact	Risk		
A	B	C	D	E

Adapted from NHS Modernisation Agency 2003a

Checklist: How to complete Table 5

✔ **Column A** – Identify people or groups by one of three types:
- those expected to be for the change
- those expected to be against it
- those expected to be neutral, or as yet undecided.

✔ **Columns B and C** – Record ideas and comments (both positive and negative) expressed by the individual or group on hearing about the change idea. Criteria could include:
- deep-held values and beliefs
- working relationships

  - salary
  - power
  - position.

The more criteria that are negatively affected by the change, the greater the resistance to change. Changes that negatively interfere with a person's power, status, position and identity will evoke the most resistance.

✓ **Column D** – List actions that individuals or groups could take to support or resist change initiatives. Consider whether they show:
  - commitment – want to make the change happen and will work to make it happen
  - apathy – neither in support nor in opposition to the change
  - non-compliance – do not accept that there are benefits and have nothing to lose by opposing the change.

✓ **Column E** – Indicate actions to take that will:
  - move non-compliant people to a position of neutrality, as it is very difficult to move them to a position of commitment quickly
  - detect and negate potential non-compliant activities
  - look for, build on and encourage any supporting behaviour.

Staff

The involvement of all staff is a major prerequisite for developing cultural change towards integrated care for older people. Special efforts will be needed in the first place to increase the awareness and sensitivity of the staff to the values and ideas of integrated care. The 'internalisation' by staff members of values and beliefs is critical. This means that the ideas of integrated care emerge among staff as obvious, and are perceived as being their personal values and belief.

It is important to take the following elements into consideration:
- an emphasis on innovation
- team development
- representation of all groups involved
- a bottom-up approach
- attention to the roles of volunteers and NGOs
- training of professionals
- empowering frontline staff
- special attention to middle-level management.

These factors are considered in detail below:

- **Emphasis on innovation** – Learning organisations are constantly searching for new ways of delivering services, so innovation and change are highly valued. A prerequisite for progress includes a tolerance for learning from failure, which in turn requires a culture that accepts the positive spin-offs from errors, rather than seeking to blame and scapegoat. This does not, however, imply a tolerance of routinely poor or mediocre performance from which no lessons are learned.

- **Team development** – As a team leader, the manager can convey the mission of integrated care in terms that are understandable and applicable to each organisation since, eventually, effective cultural change depends on its acceptance by all members of the integrated care team. The emphasis on team delivery of care reinforces the need for team learning. In this respect, team leaders and managers have to act as major change agents, and to operate as a living example.
- **Representation of all groups involved** – All stakeholders should be represented in steering committees, and in developing the integrated care team.
- **A bottom-up approach** – This approach must take into consideration the perceptions and attitudes of the client or family, and of ground workers involved in implementing the programme. Managers need to be aware of the danger of using cultural change as a top-down control mechanism to extend control and power (Mahony 2000).
- **Attention to the role of volunteers and NGOs** – This will involve identifying volunteers and being aware of their values and objectives. Managers must be conscious of the importance of the input of volunteers, and of the relevance of their beliefs (Rayner and Marshall 2003).
- **Training of professionals** – This activity deserves major attention, since training curricula of health professionals often do not include sharing information beyond their professional field. Special training efforts of the medical group are needed to convey the integrated care culture.
- **Empowering frontline staff** – Managers must be able to trust that subordinates will use wisely the time, space, and resources given to them through empowerment programmes, and will not indulge in opportunistic behaviour. Without trust, learning is a faltering process.
- **Special attention to middle-level management** – Accrediting middle-level managers in the integrated care team to re-affirm their commitment is important. Examples of accreditation might include formal appointments, command over budgets, and delegation of power and authority.

Monitoring and evaluation

A follow-up process, using validated instruments, is not helpful in this area because there are no instruments designed specifically to measure cultural change. Changes in attitudes, values and beliefs towards a deeply rooted common vision develop and evolve alongside the development, growth and implementation of integrated activities, so it is not possible to measure the ‘processes’ of the changes – only their outcomes.

This means that the evaluating process requires qualitative instruments, such as:
- **qualitative views** of service users and staff (how they perceive the collaboration in the integrated care team)
- **a definition** of the mission of integrated care, by each team member in his or her own terms
- **viewing complaints** by team members, older persons and their non-professional carers as indicators of reluctance to change, or wrong direction of the integrated care programme
- **an evaluation**, by a simple survey method, of client and staff satisfaction
- **a formal evaluation meeting** among staff members, offering each member the opportunity to voice the positive elements and those that need improvement

- **a permanent alertness** in the manager to the comments and recommendations voiced by the team members during informal gatherings and while working on the floor
- **an attention to rumours** spreading among outsiders about the integrated care developments.

Practice example: Establishing a multi-disciplinary team

In Newcastle upon Tyne, a multi-disciplinary team was established to assess frail older people within the community, and to provide training and support to primary care teams and care homes. The team consisted of a general practitioner, a community geriatrician, a community nurse, a physiotherapist, a social worker, an occupational therapist, a chiropodist, a community psychiatric nurse, and a speech and language therapist.

The team identified the following key steps as important in ensuring that it delivered a service that was valued by older people and their carers, and by frontline staff and key stakeholders in the locality:

- work with primary care teams, care homes and key local stakeholders to involve them in developing the vision for the team and the referral criteria
- initial team building to make sure the team functions effectively
- a single, shared record with one common assessment, completed on initial referrals by all members of the team, on rotation. This led to better joint working and increased respect and understanding for different roles
- a weekly critical incident review with open discussion of problems and complaints, using a model that looked at the learning arising from issues. One early result of this was a request for training in listening skills, so that staff paid more attention to the needs and concerns expressed by patients and their carers, as well as addressing the needs identified by professionals
- a care planning model that involved patients and carers in setting goals and objectives, and reviewed them before discharge
- a model relating to assessing, intervening and handing care back to patients, their carers and primary care teams and care homes, rather than building a continuing caseload.

Adapted from Drinkwater (2003)

Barriers

A number of obstacles need to be overcome before cultural change can take place:

- **short termism ('target culture')** – the attitude that integrated programmes are less important because the results are not noticeable in the short term
- **intolerance of ambiguity** – the goals and objectives of integrated care programmes are less clear and tangible in comparison with clinical care programmes, leading to intolerance for a certain level of vagueness
- **inflexible funding** – funding is mostly allocated by type of service or system, rather than for innovative programmes. Traditional or vested interest groups perceive adequate funding for programmes through different segments as 'waste' or 'overlap'. At times, limited resources are used as an excuse for inappropriate funding
- **professional cultures** – despite cultural pluralism, the values of the dominant groups tend to prevail, with dominance by the traditional powerful groups based on their professional status or on their positions in the hierarchy and by dominance of the medical profession

- **the prevailing cultural climate** – a poor understanding of the aims and instruments necessary to achieve integration with the prevailing belief that one's own system and the traditional mechanisms are superior
- **resistance to change** – a reluctance to engage in unfamiliar structures and pathways and in programmes that may disrupt the daily activities. The fear of one's vested interests, such as power and income, being challenged
- **the mismatch between macro- and micro-levels** – especially between the developments in society at macro level and the aspirations of the client or family at micro level to be entitled to services. Due to the shrinking social safety-net in European welfare states, a considerable group of older people and/or their families are not covered for care spending, and are unable to make payments themselves. Integrated care team members need to become acquainted with the shifts in values, structures and beliefs around ageing and care provision in the society at large
- **the focus in funding on high-tech, acute care provision** – this often means neglecting long-term care. Lip service is paid to the aims of integrated care for older persons, but attention and resources are devoted to glamorous medical technology. This means promoting care for frail older persons while embracing a high profit acute care industry.

Supports

Several factors are helpful in the development towards changing the vision and attitudes of team members of integrated care programmes. They include:

- **a clear demonstration of commitment** by key managers, as opinion leaders – especially in the phase of development (Gaunt 2000)
- **a culture that encourages risk taking** and gives scope for learning from mistakes
- **availability of information** that is appropriate and acceptable, about the aims and instruments of the integrated care project
- **financial incentives for innovation and risk taking** – incentives for individuals to give of their best and develop their competencies, and for groups to take risks. It is important to support the idea that risk-taking activities will be appreciated and valued, and in particular, to provide confidence that if someone makes a mistake, they will be supported and not rebuked
- **the policy climate** – consistent and clear policies that reflect the ideas and objectives of the integrated care approach (on national, regional and local levels as well as on the systems level) are a major prerogative. The integrated care ideology behind the regulatory framework should be visible
- **national awards** – as mechanisms of external pressure to praise efforts, promote their example, and provide continuity. Awards can be a major vehicle to keep successful programmes going, especially in periods of shifting national health care priorities.

Key points

In conclusion, the following elements emerge as being critical in initiating a process of cultural change, throughout the development of a needs-driven integrated care programme for older people:

- **The introduction, development and implementation of needs-driven integrated care will be viable only if they are supported by cultural change, which conveys the vision of integrated care.**
- **Cultural change gives rise to deeply rooted, internalised shifts in the values, beliefs and attitudes of all staff, clients and carers.**
- **A recognition and respect of mutual perspectives among stakeholders valuing interaction and inter-dependency of roles is essential.**
- **Key managers as opinion leaders need to engage openly in cultural change initiatives and support them with financial incentives that reward risk taking, innovation and engagement in non-familiar activities.**

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Chapter 10
Leadership

Jan Reed

Health and social care organisations providing services for older people are undergoing considerable change in the ways in which services are operating. These changes are being shaped by a range of different factors, including rises in the proportion of older people in the population, increasingly strong arguments for making services more effective, and moves towards the integration of services to avoid gaps and overlap. In this world, many have identified a need for organisations to have strong leadership, and to develop new visions and creative ways of delivering them.

However, many of the discussions and ideas about leadership are based on old ideas about leaders as dynamic, decisive, authoritarian and competitive. Although this model of leadership may have been appropriate in a world where services were in competition with each other for funding or for clients, in a world where the emphasis is on integration and working collaboratively, it has increasingly become irrelevant and unhelpful. It can fail to address the many challenges of leadership in integrated care, where loyalties may be tested as organisations find themselves collaborating and competing at the same time.

This chapter examines the different models of leadership more suited to working in integrated care. First, it discusses the difference between old and newer ideas and then it identifies what characteristics are needed for leadership in integrated care, and the systems needed to support it.

Definitions

Of the many different definitions of leadership, the one adopted here is ‘the articulation and effective communication of a viable vision’ (Strange and Mumford 2002). This definition has two components:

- developing a viable vision
- articulating and communicating that vision.

Objectives and intended outcomes

The objectives and intended outcomes of leadership can be explained in terms of the two components of the above definition.

Developing a viable vision

In developing integrated care, this vision may be radically different from previous ideas about how an organisation should go forward. If organisations have developed in an environment based on notions of competition, where there were few incentives to look at the whole system, then a vision that moves towards collaboration and integrated working will seem a difficult one to achieve. Leaders must therefore spend time working out the 'viability' of their vision – working out how it can be achieved, and what will help or hinder progress.

This definition encompasses the activities that a leader will take on to learn about and analyse the organisation and the challenges it faces, and the role that they have – to set direction, make decisions and motivate colleagues. Leadership in integrated care will involve all of these activities and roles, but will take place in a multi-agency context, where the analysis will encompass all relevant organisations, and the direction setting and decision-making will be done collaboratively.

Articulating and communicating that vision

The second element of the definition involves the relationship between the leader and the rest of their organisation. Articulating and communicating the vision effectively requires leaders to understand the language, concerns and perspectives of their colleagues. Their communication has to be carried out in a compelling way, to persuade people to work towards the same organisational goal, which may be particularly difficult if it is a radical departure from past practices.

The elements of visioning and articulating are distinctive aspects of the leadership role, which distinguish it from the management role. While the leadership role involves setting agendas and goals, the primary management role is to develop strategies for implementation (Caldwell 2003). This does not mean that managers cannot be creative and innovatory, but leaders are more likely to take on the broader agenda-setting responsibilities.

Models and approaches

Ideas about leadership have changed over the years as the contexts of leadership and the values and goals of societies have changed. Early historical examples of leaders have tended to be autocratic rulers who led their subjects to great military victories or economic successes. They displayed great conviction and determination during conflict with enemies, and enjoyed the unquestioning obedience of their loyal subjects.

So these leadership models are founded on the ideas of conflict and rule, with little attention paid to ideas of co-operation or democracy. As societies have become more complex – particularly with industrialisation and the growth of business – some traces of the military model are still evident, as organisations see themselves as fighting to win, and look for leaders who appear decisive and decided.

Personal and situational models

'Old' models were of the autocratic leader who would – through personal qualities alone – drive through change, with some more sophisticated models suggesting that situational factors could play a part. It was a question of the right person being in the right place at the right time, rather than simply a matter of finding the right person.

In an overview of theories of leadership, Horner (1997) identified a number of different approaches. One of the earliest approaches to defining leadership was to focus on the personal attributes of leaders. This was based on the idea that leaders were born, not made, but no clear traits emerged. Following this effort, another approach was tried, focusing on leaders' behaviour. Again, however, no clear characteristics were identified, partly because the research did not pay attention to context: successful behaviour depended on the leader's situation.

Contingency theories, which looked at traits, actions and contexts, were more sophisticated and served to make the complexity of leadership more apparent. In particular, one sort of leadership theory included the characteristics of those who were led – the followers. Eventually, these contingency theories led to attempts to develop decision-making tools that stated what leaders should do in different circumstances (Horner 1997).

Broader theories of leadership have focused on organisational culture and the management of change. Successful leaders understand the culture of the organisation and its change processes can set a strategic direction, communicating this direction and defining the vision and values of the organisation. Still more theories identify the ability to motivate staff, influence behaviour and set goals as key aspects of leadership.

Whole-system models

More recent thinking has extended this to a more inclusive model of leadership that takes a 'whole-system' approach, looking at the way in which the system supports, sustains and responds to leadership. This has led to models of leadership in which the direction and motivation of the system is based not only on the individual qualities of the leader, but also on how they enable the whole system to be supportive of innovation.

New models focus on organic leadership, which involves nurturing and growing rather than dictating. One of these is post-modernism. Post-modern ideas embrace ambiguity and challenge the idea that there is one right way to do things, so post-modern models of leadership question old ideas of leadership as having a simple cause-and-effect process.

New models of leadership have moved away from the 'heroic individual' idea to look at relationships and networks, and also to look at 'followership' – in other words, the way in which everyone in a system or organisation works together, towards a shared and mutually owned goal. These ideas are moving towards the idea of leadership as a team activity rather than the domain of one individual (Caldwell 2003).

The notion of collaboration extends within and across organisations. Instead of leaders thinking of their own organisation only in terms of its being in competition with others, whole-systems thinking and leadership places emphasis on effective leadership, which involves promoting the collaboration of organisations across the system, for the benefit of clients.

Transformational models

More recently, we have seen the development of theories of transformational leadership. These focus on definitions of leadership as involving creativity and personal development for the leaders and others. Some of this thinking is found in discussions on 'learning organisations', as an aid to effective working.

A ‘learning organisation’ is one in which there is a capacity to respond to changing contexts, which the organisational analysts Shelton and Darling (2003) argue cannot be done if an organisation relies on ‘the traditional mechanistic organisational paradigm’. These more recent ideas are of special relevance to leadership in integrated service development. Rather than assuming a competitive environment, they are more able to address issues of integration and collaboration, and in the emphasis on personal growth for all, they encompass issues of staff development and user involvement.

This reflects the argument (Wilderom 1991) that leadership in service provision organisations differs from that in industrial organisations, largely because in service organisations it involves direct interaction with service users to set goals and strategies. So leadership in service organisations is more complex, and requires sophisticated negotiation and consultation skills. Fig 9 shows one framework for leadership qualities that has been developed by the National Health Service in the UK.

Fig 9: Leadership qualities

Fig 9 was designed specifically to highlight the challenges for leadership in the process of modernisation – moving from the old structures to integrated services. The model suggests that effective leadership involves setting direction (involving a number of different activities and skills) and paying attention to the details and practicalities of delivering the service.

Included in the list of qualities necessary for delivering the service is ‘collaborative working’, which is particularly relevant to integrated care. Also included are the skills of ‘leading change through people' and 'empowering others', which again suggest a different approach to leadership, away from the 'heroic' individual model. This comes close to the 'empowering leadership' type identified by Pearce *et al* (2003), which involves the inclusion and development of everyone in a system or organisation, as opposed to the 'directive leadership type', which is more about giving instructions and commands.

Characteristics of leadership for integrated care

If we put together the characteristics of integrated care for older people discussed in this resource book, and then relate those to the features of leadership discussed above, we can identify the characteristics required for leadership in integrated care. These characteristics include an awareness and understanding of the complexity of integrated care, and the perspectives of all of the different stakeholders involved. In integrated care, the stakeholders include a range of staff with very different professional, educational and organisational backgrounds, and older people and their families, who will have different needs, preferences and experiences, as well as representatives of 'the system', such as government commissioners, inspectors and insurers.

In this complex world, then, leadership in integrated care services can raise many issues and problems. Each organisation in the system has its own history and goals, including meeting financial targets, legal responsibilities, and policy directives, so balancing these tensions requires a sound understanding of these issues, and the ability to develop strategies to meet these competing demands. This means that leadership to develop integrated services for older people requires the characteristics summarised in the box below:

Checklist: Characteristics of good leadership

Leadership in integrated care needs to:

✔ be person-centred (making the older person the centre of the service)
✔ be broad rather than narrow in its scope (including the wider system of provision and setting long-term rather than short-term goals)
✔ be inclusive of all members, partners and customers across the system of services
✔ take place at all levels of the system, from service delivery to service management
✔ negotiate shared visions and goals across the system
✔ have impact across the system
✔ be shared between key people across the system – 'leadership' is not just one person
✔ motivate staff in organisations to be reflective and committed followers of new collaborative goals.

Systems and instruments

Moving from old models of leadership to new ones involves change in the organisation's systems. While autocratic, combative leaders may have been supported by systems that maintained authority and discouraged challenge and debate, new leaders will need different systems. These are systems that will support good leaders, but they are also systems that good leaders should develop for the people that they work with.

To develop leadership for integrated care in an organisation, it is vital to promote or develop systems to support it. These include systems that:

- allow risk taking
- look at the long-term rather than the short term
- enable the recruitment of people with the skills to deliver and challenge
- favour incentive over punishment
- allow more space and support
- support open communication.

Each of these factors is discussed in detail below.

- **Systems that allow risk taking** – Leadership in integrated care involves trying out new ways of working and thinking – often without any guarantee that they will work – so systems need to be in place that will allow these new ways to be tried. It is not easy to develop these systems in a defensive climate of litigation, where individuals may be penalised for taking risks. Organisations need to look carefully at their liability and responsibilities, and negotiate these with legislative and policy-making bodies to avoid problems and misunderstandings.
- **Systems that look at the long term rather than the short term** – In integrated care, outcomes may be seen only after an older person has moved along their care pathway for some time, and across different organisations. Similarly, leaders' perspectives, if they are to be long term, must go beyond immediate political expediency, to address issues of integration, which is a complex and long-term process. This requires a long-term perspective to be adopted and made explicit by the organisation that employs the leader.
- **Systems that enable the recruitment of people with the skills to deliver and challenge** – These skills include open-mindedness, flexibility, creativity, and a commitment to integration. Appointing a leader requires the organisation to be clear about what it wants, and to understand the skills and abilities that will be required.

  Sometimes, organisations are aware of what is wrong with the organisation when they are recruiting a new leader, so they appoint a leader with the opposite characteristics to the previous one. However, often it is the new leader who actually clarifies what the organisation wants – because they are a leader, they are the one who has the clarity of vision. The organisation cannot expect a leader to simply maintain the status quo, or not make too many changes, but must support the leader in the developments that they lead, with robust methods of communicating with and supporting the leader.
- **Systems that favour incentive over punishment** – Identifying objectives, and identifying whether they have been met, is a vital process in rewarding leadership and encouraging the creative and adventurous thinking that is needed in developing integrated care. Systems that simply identify and punish mistakes do not promote innovative and creative thinking.
- **Systems that allow more space and support** – Rigidly restrictive systems do not support creative thinking and effective leadership, and some rethinking of resources and practices may be needed to facilitate innovation and fresh ideas. At the same time, there must be space for consolidation and reflection. Systems that demand constant change do not support the evaluation of leadership and development.

Most organisations are now in a process of constant change, and leaders are evaluated on their ability to manage this process of change while at the same time keeping their eye on the organisation's mission. If this activity is part of the necessary change and development in response to changing ideas and contexts then it is legitimate, but a system based on 'change for change's sake' wastes energy and does not allow leaders to consolidate and reflect.

- **Systems that support open communication** – Stakeholders need wide access to information, and to feel they can express their views freely. If leadership is to be effectively spread through an organisation, then everyone must be well informed and able to make their voices heard.

The implementation process

Strange and Mumford (2002) argue that vision comes either from a leader's personal values and standards (ideological vision) or from their understanding of social needs and change requirements (charismatic vision). The complexities of developing integrated care services suggest that both types of vision are needed, incorporating the ideological goals of developing a collaborative system in response to an understanding of the social context.

Implementing and managing integrated care involves responding to the growing understanding of the complexities of older people's needs by adopting a set of values that advocate collaborative and open working. As the understanding of older people and the social contexts in which they live grows, integrated care is ever more strongly supported as a way of delivering effective services that will meet their needs.

However, it does requires a set of ground rules or ethical codes on working collaboratively that need clear guidelines on working in an open and honest way, with a clear framework for 'fair play'. This would include organisations not actively engaging in activities that may damage each other, and identifying and discussing any potential conflicts.

Staff

All staff should have leadership responsibilities at all levels, and need to be able to work across organisational boundaries. This should not mean, however, that accountability for overall direction is shared uniformly. Within organisations, there are differences in power, responsibility and rewards, and these must be reflected in the expectations placed on different members of the organisation.

Staff need support and training in how to work collaboratively and in groups, but for this to happen there needs to be an atmosphere of honesty and trust. There are a number of different models of leadership education available (for an overview, *see* Moulton 2004). This involves clarifying accountability and enabling opportunities to learn from failure, and may need a willingness to relinquish power and control over some activities in order to develop the bigger picture.

There may be difficult balances to strike between the needs of service users and staff – these may be different or conflict. The effect on the service user should be the touchstone for development, and care must be taken to ensure that this has priority.

Attention must also be paid to ‘followership’ – the skills, abilities and needs of others in the organisation – and how it can be supported. Being able to follow effectively requires skills and abilities, but these are often dismissed or not acknowledged – everybody focuses on the leaders. The ability to put strategies into operation requires a grasp of basic principles, and some commitment to them, but good followership is different to uncritical obedience. As principles are put into practice, many difficulties or anomalies may arise, and followers need to be able to think critically about change, rather than just following orders.

Specialised courses in leadership are being developed and are increasingly available. They typically include strategic planning, service mapping, visioning, motivation and communication. However, they tend to be less didactic than traditional courses, and seek to build on experience and skills, often encouraging sharing of knowledge among leaders. Programmes such as this can actively foster the ethos of collaboration rather than competition, and so may promote integrated working.

Monitoring and evaluation

The traditional approaches to evaluating leadership mainly focused on setting performance targets and then measuring whether they were attained. Monitoring integrated services leadership, on the other hand, is more difficult because the interest is also in processes rather than only outcomes – and the outcomes are more complex.

An example might be a hospital that works alongside a day care centre to ensure that all their respective inputs are consistent. Evaluating both organisations’ records to make sure that they meet the needs of both organisations, and those of the clients, is more difficult than just measuring whether they meet the needs of one organisation. The evaluation might also need to include an assessment of the negotiation that led to the design and content of the records – whether everyone was consulted, and how effective these processes were. In integrated care, much depends on external factors and the action of other services, so the measure of the leader is in how effectively and creatively they respond to them.

Alternatively, measures of leadership can include:
- the extent to which goals are shared across the system or organisation
- the impact across the system, including user experiences and staff experiences.

These two options are explained below:

- **The extent to which goals are shared across the system or organisation** – If the organisation adopts a transformative model of leadership, the focus shifts from outcomes to processes of change. This may mean that instead of just looking at whether leaders have met tightly specified objectives (defined in terms of outcomes), the emphasis shifts to looking at whether the right processes for change have been developed. This recognises that meeting current or immediate goals is important, but that so is the capacity and ability to meet goals in the future. A process of sharing, negotiating and communicating goals will enhance this capacity.

- **The impact across the system, including user experiences and staff experiences** – Outcomes are still important, and identifying desired outcomes is an important part of goal-setting and motivating colleagues. The organisation should define these outcomes in observable terms so that it can monitor achievement, and define it through negotiation and discussion so that it is shared and fully understood.

  Evaluation of leadership must be 360 degrees – in other words, involving everyone in the organisation, whatever their level, and people in other organisations and service users. It needs to differentiate between the person and the system in which they work, and should not blame the leader for things that he or she has inherited or cannot control.

Barriers

Ensuring the continued development of leadership for integrated care depends not only on the policies and systems promoting it, but also the absence of those that discourage it. These can include:

- systems driven by cost-cutting rather than quality
- the enforcement of targets that are not person-centred or about integrating care
- a lack of training in new leadership
- a lack of opportunity for leaders to debate or disagree with central direction.

These factors are outlined below.

- **Systems driven by cost-cutting rather than quality** – This type of system does not encourage innovation and change. Initially, it can be resource-intensive, although in the longer term it may improve efficiency. A focus on short-term costs may limit changes to the extent that they have no impact. However, many leaders specifically use the crisis of cost-cutting as the perfect opportunity to change and be innovative, and it can force leaders to be far more creative and innovative than they would have been under other circumstances. If cost-cutting is the only measure of leadership, however, leaders will be reluctant to invest resources in change.

- **The enforcement of targets that are not person-centred or about integrating care** – Targets set by political or legislative bodies may owe more to these agendas than to a desire to improve services. The tension between external agendas and service agendas can prevent change and development as leaders are constrained in their vision-setting.

- **A lack of training in new leadership** – This problem requires skills and knowledge, as well as the ability and willingness to think differently. Developing these new ways of thinking requires time and support if new leadership is to be achieved.

- **A lack of opportunity for leaders to debate or disagree with central direction** – Where changes are determined centrally – say, by government – the opportunity for leaders to debate or disagree with central direction setting must be made clear. Where targets are set centrally, there must be a thoughtful and considered examination of why they have not been met, rather than a simplistic blaming process that encourages cover-ups and evasions.

Supports

There are a number of policy developments that have promoted the development of new leadership. These include:

- **service-user movements** that have encouraged leaders to put users at the heart of the service. This has focused attention away from internal power structures or inter-agency competition towards effects on service users and integrated working
- **policies that support risk taking** and have allowed leaders to be creative and set new directions. This has required political and legislative support in some cases, to give leaders the necessary safety to take risks with new ways of thinking and working
- **policies that have focused on processes of improvement** rather than inappropriate targets – avoiding the problem of 'hitting the target but missing the point'. The move towards integrated care has meant that leaders have to look at the bigger picture and not just think of their own organisations
- **training, support and networking opportunities** that have allowed leaders to share and develop ideas with their peers have encouraged the development of peer-group systems to facilitate new leadership practice.

The issues involved in promoting effective leadership for integrated care are related to those discussed in chapters 9 and 11. These developments require leadership that is inclusive, culturally intelligent, and aware of the differences between collaboration and competition. This form of leadership is necessary to manage integrated services through potential difficulties in early stages, and also to build robust relationships that can respond effectively to future change.

Key points

- **The 'old' notions of leadership as dynamic, decisive, authoritarian and competitive are not well suited to the integrated care environment.**
- **Leadership in the field of integrated care requires sophisticated skills of negotiation and consultation to enable collaborative direction-setting and decision-making with other stakeholders.**
- **Good leadership is not only about the individual qualities of the leader, but also about enabling the whole system to be supportive of innovation, an awareness and understanding of the complexity of integrated care, and the perspectives of all of the different stakeholders involved.**
- **Successful leaders understand the culture of the organisation, and can use the ways it changes to set a strategic direction, and define its vision and values.**
- **Equally important to leadership is 'followership' – the skills and abilities of others in the organisation enabling them to follow.**

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Chapter 11
Strategic planning

Penny Banks

The main activity that underpins integrated care for older people at the individual level is the co-ordination of services at a locality or a specialist network level. Essentially, this involves co-ordinating and managing activities between teams and different providers. This, in turn, needs to be supported by planning services for the whole older population in an area: the 'whole-system level' (Edwards and Miller 2003). This chapter is about planning across the whole system of local services, across different statutory, private and non-governmental sectors, to support the delivery of integrated care.

Understanding the connections between services and how different services impact on one other is crucial for meeting the complex and diverse needs of older people. This chapter describes some models and approaches to undertaking whole-systems planning and the key steps for planning and implementing change. Strategic planning is more likely to be effective in Beveridge-type national health systems than in the more Bismarckian and market-driven systems (*see* p 15), in which there is less top-down control. Nevertheless, the concepts in this chapter will provide valuable insights for such systems.

Definitions

Strategic planning is not concerned with the operational management of services. Instead, it is about key stakeholders from the statutory, non-governmental, private and community sectors working together to achieve a shared understanding of their local service system in order to redesign and improve the way it operates. This addresses the balance of services, the connections between health, social care, housing, transport and other community services, and the interdependence of services. Strategic planning takes local resources – including financial resources, supply and demand factors – into account, along with national policy, trends and other influences.

Although the context and drivers for planning are different in each country, the process of working together to understand how the local system operates is in itself important, and goes well beyond the production of plans on paper. This is not a static or one-off process but involves continual review, as plans are implemented and changes take place. Managing change and turning broad strategic plans into business plans will require a range of influencing skills and management approaches that are not covered in detail in this chapter.

Strategic planning seeks to achieve a balanced system of care that offers a comprehensive and co-ordinated range of services. These include services that:

- promote well being and health
- support people to live at home
- respond to a crisis or signs of need
- are able to assess needs and properly plan for those older people who may need acute care, residential care or extra-care housing.

This approach has been described as a ‘virtuous circle’ of services, where action in one part of the circle can have an impact at a different point – so, for example, prevention services to support older people to stay well at home, plus rehabilitation and other flexible services, can improve the working of the whole system of services, preventing unnecessary admissions to hospital or residential care (Carrier 2002).

Objectives and intended outcomes

The aim of strategic planning is to obtain a shared picture of the whole service system in order to plan and deliver capacity in the system, to offer older people choice, quality services and access to care – sometimes referred to as ‘the right services, at the right time, in the right place’.

Organisations and agencies seek as much control as possible over the way they operate. This enables them to be less crisis-driven, understand their interdependencies with other organisations, and to be clear about their contribution and what to expect from others. Integrated strategic planning also offers opportunities to focus resources on joint priorities.

Characteristics of whole-system working

- All stakeholders accept their interdependency and the fact that the action of any of them may have an impact on the whole system.
- There is agreement between the stakeholders as to the vision of services, priorities, roles and responsibilities, resources, risks and review mechanisms.
- Those using the system do not experience gaps or duplication in provision and services are responsive to their needs.
- Relationships and partnerships are enhanced.

Adapted from Department of Health (2003b)

Models and approaches

Various tools are available to support mapping and planning services at macro and micro levels. Some support widescale redesign of services over a geographical, local government or health area, while others support the redesign of services at an operational level, to improve processes and the experience of older people. This section primarily focuses on the strategic level and achieving a full spectrum of services that acknowledge their interdependency and how they fit together. (For more information on mapping services and patient journeys at operational levels, *see* Chapter 5.)

The following tools have been developed using experience from the field. They offer guidelines, checklists and examples of good practice for those aiming to develop more integrated approaches to planning:

- whole-systems mapping
- the ‘balance of care’ approach
- transactive planning/the whole municipality working together for older people
- whole-systems workshops
- the self-audit tool
- discharge planning and capacity planning
- processes for involving older people in mapping and planning.

The following brief descriptions of each of these tools illustrate the range of materials and approaches that have been published. No critique is offered, but the reader may wish to follow up the references provided at the end of each description for more detailed information.

Whole-systems mapping

This tool is for agencies working together to map services locally and provides a hypothetical service map, against which actual local services can be reviewed. It offers a list of questions to review the local system – for example, examining gaps in the services system, whether older people from all communities are able to access services, and where there are frequent ‘bottlenecks’ because of long waiting lists. It has been of particular use for people developing rehabilitation and intermediate care services in the United Kingdom (Stevenson and Spencer 2002).

The ‘balance of care’ approach

This approach takes the needs of older people as its starting point. Working with local stakeholders in workshops, it defines and populates a set of dependency groups. The resource consequences of different ways of providing care for these groups can be explored using a computer model. This enables volume, costs and types of services to be calculated, as well as indicating the potential impacts for the different organisations involved. (Forte *et al* 2002)

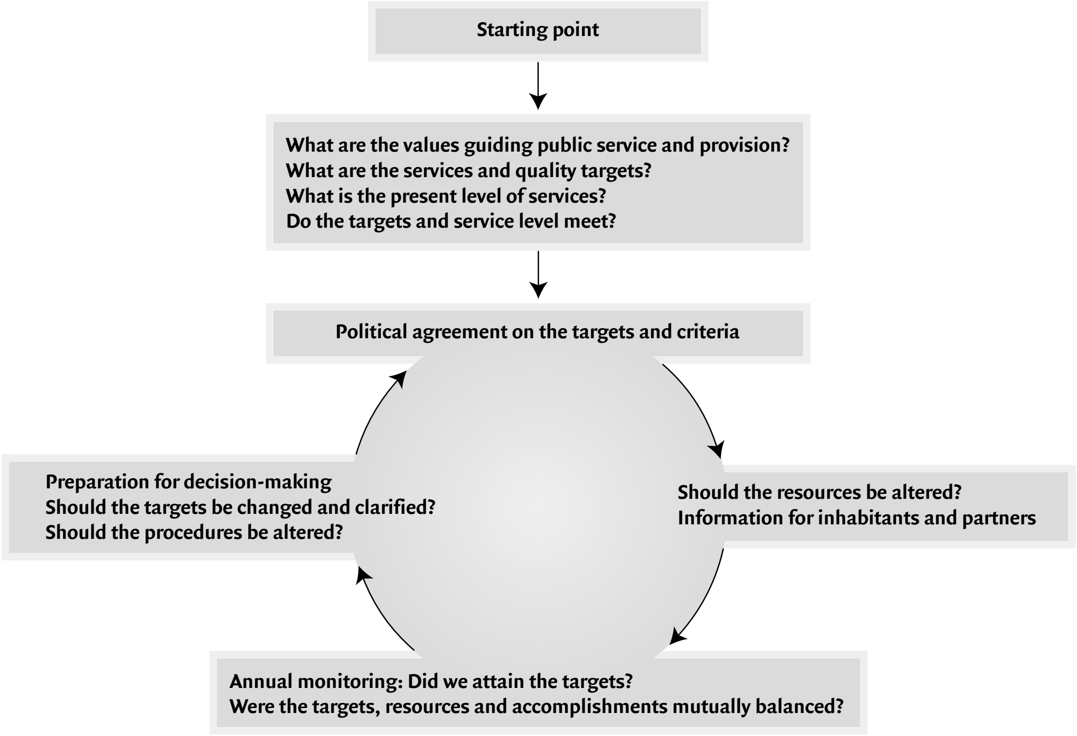
Transactive planning

Also known as ‘the whole municipality working together for older people’, this approach offers targets and action models for local authorities to support the development of their service structure. The models are based on local needs and resources, and are designed to promote participation of clients, relatives and other citizens in setting targets and assessing activities. The collaborative process of planning, monitoring and evaluating the strategy and service development programme is based on the model of the Danish Ministry of Social Affairs, shown in Fig 10 overleaf.

Whole-systems workshops

Whole-system events offer one way of engaging all the different stakeholders including older people and their carers. These are events to agree shared values and principles, to develop a common understanding of national policy and local circumstances, map existing services, match services to needs and begin to action plan for change.

Fig 10: Collaborative planning, monitoring and evaluation



Source: Vaarama *et al* (2001)

Practice example: Northumberland Health Action Zone

Day One began with everyone exploring the patterns of local services that have the potential to deliver or support rehabilitation. Older people brought a different perspective to this exercise, often suggesting rehabilitation opportunities unrecognised by professionals, such as tea dances, swimming clubs and exercise groups. The contribution of the professionals, on the other hand, was often restricted to naming services run or commissioned by the National Health Service or social services.

By identifying what existing services did well and what they did less well, the participants were able to move on to setting possible agendas for change. Thus, in almost every case, people recognised the need to integrate care, through closer partnership working across agency and professional boundaries. Older participants frequently emphasised the lack of rehabilitation opportunities in the community.

Day Two began by getting people to imagine how, in an ideal world, they would like to see rehabilitation opportunities improved in three years' time, using the ideas generated in earlier sessions. Various themes emerged, including objectives for systems and individuals, ideas for new services or reshaping existing ones, and changes in individual working practices. Groups of participants then selected a theme and developed an action plan for bringing about the desired changes.

Source: Stevenson and Spencer (2002)

The self-audit tool

A self-audit tool has been developed for managers in health, social care and independent sectors who have responsibilities for ensuring the delivery of a range of non-acute services for older people. The tool, in the form of a workbook, reinforces a whole-systems approach to change, and is designed to help multi-agency groups identify key steps. Questions are posed to managers from all the partner agencies covering the following topics:

- building partnerships (degree of trust, openness of communication)
- encouraging innovation
- maximising the use of resources
- understanding the market
- creating viable market conditions
- commissioning and contracting.

Department of Health (2003a)

Discharge planning and capacity planning

This resource book provides guidance for commissioners (who plan, secure and monitor services), practitioners and managers to improve discharge planning. It advocates a whole-system approach to tackling hospital discharge. The approach requires commissioners in primary care trusts (statutory bodies responsible for delivering health care to their local population) and local authorities (with responsibilities for social services and other community services) to work together with the independent sector and other stakeholders. It identifies three main areas where integrated whole-systems working underpins the discharge care pathway:

- capacity planning
- reviewing performance
- hospital discharge policies and inter-agency agreements.

With capacity planning, its aim is to make sure that current capacity is used to its best effect, and that capacity is increased, to avoid the need for hospital admission and to support earlier hospital discharge. Steps to achieve this include starting with a review of pressures in the local health and care system, and agreeing on specific action plans to develop a range of integrated community services, such as:

- intermediate care
- intensive home support
- support to family carers
- rapid response teams
- very sheltered housing.

(Department of Health 2003b)

Processes for involving older people in mapping and planning

There are a range of ways to involve older people and carers in planning processes, for example:

- **involving older people** as partners in whole-systems workshops (*see* Whole-systems workshops, p 169)
- **appointing older people** from organisations of older people as members of planning, partnership or network groups where these older people have good support and two-way communication with older people's networks and groups
- **engaging with older people's forums**, councils and networks on a regular basis, to debate the issues and where older people set the agenda

- **setting up panels** or special citizen juries where evidence is presented to older people and their views are heard
- **holding open, accessible information 'market days'** to disseminate information to older people and to provide opportunities for informal feedback
- **using photos taken by older people** themselves as a way of facilitating feedback on services from older people
- **conducting 'discovery interviews'** with older people and their carers so that practitioners and managers learn from the recent experiences of service users
- **engaging older people** to interview other older people in their own homes about their views
- **meeting with carer support groups** where carers have opportunities to give their views separately from the person supported.

Selecting an approach

The following points are drawn from research and experience in involving older people and carers:

- There are various methods for involving older people and their carers in mapping services and planning that go beyond traditional forms of representation on working groups.
- Some methods are more acceptable than others to different older people, so it is always important to offer a choice or find out their preference.
- Older people, including those who are frail or very dependent, are willing and able to be involved with appropriate support.
- It is important to distinguish between groups of older people who speak for themselves and those organisations which speak on behalf of particular service users. It may also be helpful to ensure there are not only older people taking part from local older people's organisations but also older people who have been invited as individual service users.
- To ensure engagement is productive rather than tokenistic, it is important (in addition to the other points noted) to clarify users' and carers' roles so that they, and other participants, are clear why they are being involved, what is expected of them and what they will contribute.
- The result of the involvement must be fed back to everyone taking part so people can see a clear link between their input and the eventual outcome.
- Skill, time, funding and commitment are needed if involvement is to be genuine, inclusive and ongoing.

The implementation process

After all the local stakeholders have agreed on the catchment population or boundaries for planning purposes, the ideal scenario is that all the stakeholders in the service system take the following four steps:

Step 1: Agree on shared values, principles and vision of the new system of services

Shared principles that are agreed by all the stakeholders are important for assessing any proposed changes. For example, does a new service address the needs of older people from all communities? Do services promote independence? It is also important to have a shared understanding of national policy, trends and other circumstances that might affect local services.

Step 2: Create a shared understanding of the service users' needs, and a 'map' of services

This includes understanding:

- the current and projected needs of older people and their carers
- what services are in place
- how services link to one another
- the current and likely future capacity of services
- where there are gaps or bottlenecks and problems in links between services
- who can access these services, and whether certain groups of older people are unable to use parts of the service system.

Step 3: Agree priorities for change

The challenge here is to achieve agreement or reach a compromise about priorities when partners have different objectives. Success depends upon a number of factors reflecting the strength of partnerships, the perceived benefits of working together, and power imbalances. The checklist below, and the later section on supporting factors, list a number of key issues that may be helpful for partnership working.

Step 4: Plan change to achieve reconfigured services

This involves identifying local resources (staffing, property and financial resources) and shortfalls, flexibility of resources and working out how these can be developed, reallocated or redeployed. It also requires all parties to agree a joint action plan that:

- clarifies the objectives
- identifies the stages and tasks to be done by whom and by when
- agrees milestones for each stage
- builds in a systematic review of the plan.

In practice, committing to plan together presents considerable challenges for the different players, given competing professional and organisational loyalties. Achieving change will also greatly depend on local decision-making and political processes.

Checklist: Achieving significant change

- ✓ Achieve commitment to whole-system planning as a prerequisite for better integrated care for older people.
- ✓ Make sure all stakeholders are involved, including older people, through inclusive processes such as whole-system workshops.
- ✓ Use qualitative information from all stakeholder perspectives, as well as objective data on supply and demand, making use of different models to support forecasts.

- ✓ Identify local and national drivers for change that will affect local services and care markets.
- ✓ Challenge current systems and practices and think 'outside of the box' to bring in innovatory ideas.
- ✓ Make sure that all players, from the top of organisations to the frontline, can see the benefits of working together, their interdependency and taking a whole-systems approach.
- ✓ Get all partners to sign up to shared risk-taking.

Staff

A cross-section of relevant staff at different levels within each organisation, and from across all the partner agencies, need to have input in describing and mapping the current system, as well as planning for change. This is important to understand how the system operates in practice, as well as to achieve ownership for change. Direct input from older people and carers is also crucial for understanding what happens in practice, and for supporting staff in focusing on outcomes for older people, rather than being constrained by professional or organisational ties.

To achieve change, senior executives need to provide encouragement for 'bottom-up' or operational-level solutions that can improve services in ways that benefit older people and their carers. They can play a key role in enabling these types of development to take place (or providing incentives) within an agreed framework or vision for services, and in accepting an element of risk-taking. All partner agencies need to agree on what identifies success when evaluating innovatory practice and services.

To realise strategic plans, it is best to appoint special staff who do not have other operational pressures to lead programmes of change or major service reconfigurations. These staff would need specific training in managing change.

Achieving change across a whole system of services may also be supported by identifying professionals, managers, practitioners, local politicians and others in different agencies who will promote and support whole-system approaches and reinforce the benefits on all sides, planning together and implementing change.

Monitoring and evaluation

All key stakeholders need to be involved in monitoring progress and must work together to agree on:

- an evaluation framework
- performance indicators of the system as a whole
- indicators or measures for individual services
- what information will be collected, and how
- who will routinely check performance using the agreed measures.

Any evaluation framework needs to reflect a range of perspectives and dimensions. These should include:

- the older person's and their carer's experience and satisfaction (quality of life)

- care outcomes
- processes
- cost-effectiveness.

These factors have been used, for example, in the 'balanced scorecard method' (Kaplan and Norton 1996).

Barriers

Strategic planning for integrated care does not entirely depend on top-down, centrally driven planning, but in the absence of good collaborative working it does need incentives, including financial incentives, to promote local joint working. Systems that rely totally on informal processes – particularly between providers only – may have more problems in sharing risks and finding win–win situations. It may be particularly difficult for informal partnerships or networks to deliver when their plans reach the implementation stage, especially if the players are in competition.

Decision-making may also be more difficult and complex where organisations are forming new partnership or network arrangements. These new partnerships may have to concentrate on broad strategy and leave the detailed implementation to smaller collaborative teams, with clear and specific agreements on what, how and who will deliver (Nies 2003). There may also be difficulties where values and cultures clash – for example, where there is a lack of harmony between the values of health care personnel (especially physicians) and the overall goals of a whole-system approach (Åhgren 2003).

Power imbalances, particularly relating to financial clout – for example, between the acute health sector and others, or between commissioners and independent providers – may make it more difficult to achieve planning partnerships and agreement on implementation. Different funding streams for health and social care services, and budgetary pressures, may also impede joint developments and implementation of plans where there are fears of picking up the other partner's deficit or losing the ability to reallocate resources (Banks 2002).

Supports

Strategic planning for integrated care is supported by national policy that provides financial and other incentives to whole-systems approaches and that addresses legal and other barriers. For example, in England, legislative changes have been introduced to allow for the pooling of budgets. National policy can play a key role in setting the broad vision and standards while allowing for local implementation, innovation and autonomy (*see* Banks 2004).

Leadership at senior and middle levels is crucial in providing a strong local vision of how services should develop. Senior and middle managers must also support activities benefiting older people and the system as a whole. In some instances, this may mean making decisions that may not appear to have short-term benefits to the organisation but are likely to be beneficial in the long run.

The process of working together and collaborating to plan and deliver local strategies for integrated care is supported by:

- **a local history** of collaborative working, with good communication and trust between all local stakeholders
- **an organisational culture** that puts older people at the centre, is willing to take risks, and is open to new ideas
- **agreement on joint strategies** for recruiting and retaining staff and an ability to develop and introduce new roles, and reinforce the benefits on all sides of planning together and implementing change.

Key points

- **Planning for a whole system of services that offers a comprehensive and co-ordinated range of services underpins the delivery of integrated care for individual older people.**
- **Action in one part of the whole system can have an impact at a different point – for example, lack of care services in the community can prevent timely discharge from hospital. Services are thus interdependent.**
- **A balanced system will include prevention and rehabilitation services to support older people to stay well at home and restore their independence.**
- **There are different tools to support mapping and planning services and to facilitate the collection of key data. Involvement of all the partner agencies, with staff at different levels, and older people and their carers is crucial in understanding how local services operate in practice and what needs to change.**
- **Ideally, there are four key steps for all the partners to take in planning for integrated care:**
  - **Agree shared values and vision.**
  - **Share understanding of the current and future needs of service users and supply of services.**
  - **Agree priorities for change.**
  - **Agree specific, timetabled plans for change to achieve reconfigured services.**
- **Putting these plans into practice is challenging, and requires a range of incentives to promote collaborative planning and implementation of change to achieve a more balanced local system of care.**

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Chapter 12
Information management

Pieter Huijbers

Establishing integrated care for older people not only involves organising a co-ordinated arrangement of care structures and processes – it also has implications for information management. This is because good communication – about the needs of the older person and about the professional activities that aim to deal with these needs – is essential for working in an integrated way. The flow of various kinds of information between professionals and their organizations, known as ‘information flow’, is pivotal to co-operation.

Some useful principles and tools for documenting and distributing patient information have already been developed in the field of acute and long-term care, but in an integrated care system, which may include not only medical professionals but also, for example, care workers and occupational therapists, there are special requirements for information and information flow. Moreover, an integrated care and services system specifically designed for older people may have further additional requirements and features.

A manager considering how to manage information in the context of integrated care may ask questions such as:
- Should the information management system be paperwork-based or computer-based?
- Should we develop a system tailored to our needs, or can we use an off-the-shelf solution?
- How should we develop it, and what do we need to take into account?
- What legal and ethical issues do we need to consider?

This chapter is intended to offer answers to these and other questions, and to provide some information, insight, considerations and recommendations on issues related to information management in integrated care.

Although the word ‘ICT’ regularly appears in this chapter, most of the statements and principles that are made here apply to non- or semi-ICT based information systems as well. The chapter is primarily about information management and its use and users rather than technology or ICT, but it assumes that ICT will be used.

Definitions

In current practice, there are many forms of integrated care for older people, many of which are detailed in other chapters of this resource book. In this chapter, when we talk about the integrated care system, we refer to it in a generic sense, in whatever form it takes in practice. So in this chapter, when you read the phrase ‘integrated care system’, think of your own integrated care system, or the one that you are going to develop.

The information management system is probably the most important supportive process to modern care. It has two important constituents:
- the place where the information about a patient and the care process is stored (the 'patient record')
- the ways in which this information is added, distributed and used by various health care workers that interact with the patient. This process is known as 'information flow', which can be formally defined as the transfer of documented client information and client-linked care information among professionals, or between professionals and managers, in an integrated care system. Information flow is an indispensable supportive process in any integrated care system.

Together, these two components – the patient record, and the specification of information flows – comprise the 'care information system'.

It is worth mentioning that 'information management' does not include oral communication between a health professional and a patient, nor handing out general disease information to patients. These forms of communication are known as patient information and patient education.

Finally, as this chapter refers mainly to information management in the medical sector, we use the term 'patient'. However, the same points apply to clients of non-medical care and services.

Objectives and intended outcomes

Throughout this resource book, there are references to the importance of an accessible and accurate information system. Information is important to:
- professionals
- organisations
- patients or clients and their carers.

The following sections explain why it is important to each of these groups, and point out types of problems that can be prevented or resolved with good information management.

Professionals

Professional communication is very important in integrated care. In their work, professionals generate information that has to be registered and documented, either to be used by themselves at a later date or to be exchanged with other professionals and with managers for administrative reasons.

A good information system offers user-friendly methods of registering, retrieving and displaying information. It ensures that the information passed between members of staff is up to date, reliable, timely, and easy to understand.

Good information management should make the integrated care process more efficient and effective. Using an effective information system to store and retrieve administrative information about a patient prevents duplication and saves time. Access to clinical information (to those with permission to access it) may be absolutely necessary for the work of a professional. In other cases it may not be essential, but can widen and deepen the insight into the problems of a patient of client, thus allowing better quality of care.

Using an information management system opens up greater possibilities that can contribute to integrated working – for example, better planning, improve co-ordination, and better co-operation in assessing, treating and routing patients.

Professionals may benefit further from an information management system if there is a link to an internal or external (internet) database of professional knowledge – for example, detailing a supply of providers and other professionals, or disease and care information. Also a decision-support system can be very useful for guiding a professional, or a team of professionals, through a complicated decision-making process in diagnostics and care needs assessment, in order to arrive at the best possible decisions.

Organisations

A good information management system can benefit organisations in many ways. First, it can encourage care-providing organisations and their managers to take greater interest in providing care that is higher quality and more efficient, and higher rates of client satisfaction. To the extent that an information system can facilitate quality of care for individual patients, the patients themselves will attach importance to a well-functioning system.

Using aggregated information in an information system enables organisations to assess the costs, cost-effectiveness and quality of their integrated care system. This creates the opportunity for administrative, financial, and strategic planning, and for quality improvement and research purposes.

Patients, clients and carers

Patients or clients are usually not considered direct users of a care information system. However, they do receive important indirect benefits from efficient information exchange, because of the increased quality of care that it may (and should) produce. In an investigation of the Netherlands Federation of Patients and Clients Associations (NPCF), patients of hospitals and day clinics ranked a good exchange of communication between their doctors as being of paramount importance, above all 30 other items on quality of care (Janse *et al* 2002).

Patients – just like professionals – complain about having to provide the same information over and over again. A care information system can be specifically set up to prevent this duplication of data.

A further issue is that of putting the client first – a factor that is of great importance within the field of integrated care. A good information management system can help increase client and patient involvement in a number of ways:

- Patients are positively involved in that they have to give consent to the storage and use of information about them in the care information system, except in an emergency, where problems may arise and the patient is unable to give consent.
- National legal arrangements may give patients the right to check and modify personal information. For this reason, patients should have the opportunity to check and, where appropriate, feed into or modify the information about them.
- Patients can have a voice in specifying the conditions under which parts of the information may be used, and can grant authority for its use by specified professionals and managers.

Patients benefit from information management systems when a health professional discusses the information in their record with them. This increases transparency between both parties. Research indicates that involvement of the patient can increase the extent and accuracy of information (Ueckert *et al* 2003).

Finally, although not strictly part of a care information system, it is possible to provide patients and their carers with information about their condition by providing online content through a website linked to the care information system. This is certainly possible when the care information system is ICT based, as Doupi and van der Lei (2003) found in the case of burn care.

The rights and voice of individual patients are strongly advocated by older people's organisations and patient groups, and general patients' associations such as the Dutch NPCF, mentioned on p 181. All this means that information systems can contribute to the empowerment of, and a clear role for, the patient and (especially in the case of frail older people) their informal carers.

Models and approaches

ICT versus paper-based systems

An information management system must support fast, accurate access to information. In integrated care, this means it should facilitate the exchange of information between health professionals and those from other disciplines, working in different settings and organisations. Information that is generated by one professional in the integrated care system has to be made accessible to the others.

The traditional paper-based information can barely do this – in fact it can hardly even be called a 'system'. The information may be complete and centrally stored, but it is hard to update and move through the care system. Alternatively, different items of information may be stored with different organisations or professionals, which makes it easy to update the information but difficult to produce a complete set of patient information. In either scenario, the exchange of information is slow.

The literature on computer-based patient records cites many advantages of ICT systems. Compared to paper systems, ICT is more reliable, accurate, accessible, modifiable and manageable, and can be more easily protected. Concerns about privacy and non-disclosure are often expressed, but in fact a paper file is at least equally vulnerable to violation of privacy. If information has been generated by means of computers, by keying it in directly, it is impractical to convert that information into a printed hard copy and apply that for circulation and use of information and leave the stored digital information unused.

Finally, and most importantly, ICT offers a number of new possibilities that are particularly important for integrated care. These include:
- the ability to make particular parts of information available to specified individuals
- the possibility to monitor, receive alerts and work proactively
- the capacity to involve patients, clients, carers
- the facility to support co-ordination and case management better than paper files

- enabling the administrative and financial data of patients or clients to be easily combined
- enabling working with aggregated data for the purpose of accounting, assessing cost-effectiveness and quality, and macro-planning and research.

The obvious disadvantage to ICT is that it requires invstment in hardware, and possibly dedicated software, training, management and maintenance – which is costly. However, the advantages outweigh the disadvantages – for example, when a patient moves to a different type of treatment or a different area of the health or social care system, there is no longer the need to initiate a completely new file, or to issue a special transfer file as the patient is discharged from one stage to the next.

One might wonder whether an integrated care system that does not use ICT is really 'integrated' at all. Integrated care systems are modern organisational arrangements in care, with very specific features. Unless the cost is prohibitive, it is appropriate to use modern information management principles and technology that support these features. Advances in information management and technology are such that, even nowadays, initiating an entirely paper-based information system in care – let alone one that is based on oral information – is of limited use.

Practice example: ERDIP

In many European countries, national experiments and developments in information management in integrated care are taking place. In the UK, the NHS Information Authority's Electronic Record Development and Implementation Programme (ERDIP) has seen health communities across England carry out detailed work piloting different aspects of the development and use of electronic health records and information management. Some of the projects have direct bearing on integrated care for older people, such as those on developing information management in integrated pathways, integrated care record services, and electronic links sharing information between health and social care professionals.

Source: NHS Information Authority (2003). *See also* Practice example: Satakunta Macro Pilot project (p 184)

Principles of storing and using health care information

For integrated care systems, three feasible approaches of distributing information exist in practice:

- **the chain-like system**, where each organisation has its own information system and files. Exchange is on an ad hoc basis, on request only, or information is passed along in a standardised record to the next organisation in the chain as the patient moves through the integrated care system
- **a centralised network set up**, where all organisations of the integrated care system organise their care information system according to agreed requirements, and files are managed centrally
- **a mixed central–decentralised approach**, where the participants in the integrated care system keep their own information system but make specified information accessible for their partners. Management of information and files is decentralised, but files are linked. This allows a 'virtual' electronic patient record (EPR) to be created, which is composed automatically and instantaneously when a request for information is made.

The centralised approaches are easier than ever to set up and run, thanks to recent developments in ICT. Keeping or creating a central information record of a patient is an attractive thought and makes practical sense. By centralising the patient's record, the information becomes separate from the individual organisations in the care chain, making it easily accessible to those inside and outside of the chain, where this is required. As such, it allows a much more direct form of control or management of an individual case by, for example, the patient him or herself or the case manager. Updating the information in a centralised system may also be simpler than in a decentralised system.

However, there are many potential drawbacks to the centralised approach. Centralising information requires each care provider to use a common language and uniform information format so that they can access the information and amend the files. The need for this uniformity means there needs to be an agreed and accepted standard on the technical aspects of the system. In addition, care providers have to invest in technology and training so that personnel can actually use the system.

Overall, the mixed approach seems particularly attractive. This approach is currently being applied in a number of experimental projects in the health care field, such as the Satakunta Macro Pilot project below.

Practice example: Satakunta Macro Pilot project

In Finland, the development of integrated care is strongly dependent on the development of ICT tools supporting this type of care. The government took a leading role in stimulating the integration of care and services and in developing supporting ICT applications. One major experimental environment was the Satakunta Macro Pilot project in western Finland.

Macro Pilot was an extensive project involving the development of seamless care and service chains with the optimal use of ICT. In the city of Pori (pop. 76,000), the project carried out a specific sub-project on the care of older people. The information system components of the project were:

- an 'interactive regional information system' for professionals combining primary care, hospital and social service information
- a public internet information system for citizens and professionals, with information on providers, and including updating procedures
- ICT-based auxiliary services to support independent living for people with special needs
- an electronic identity card providing access to personal data, warranting data security and authenticating users.

The sub-project demonstrated the importance of ICT-based information, and hence of information exchange. The new operational care arrangements and the ICT aspects of the project were both successful. Further sub-projects developed new integrated service chains for specific sub-groups among older people, such as diabetes, dementia, COPD and rehabilitation. From 2004, the results will be implemented nationwide.

Source: Hänninen (2003)

Practice example: Co-operation between health and social services

In Blekinge, Sweden, a dedicated ICT-based information system model has replaced a routine of sending faxes to various components of the regional care and social services system before a patient is discharged from hospital. The care system relates to the co-operation between a regional hospital, local primary care teams and social services departments.

Source: www.ehma.org

Practice example: The Resident Assessment Instrument

The Resident Assessment Instrument (RAI) is a system used worldwide, primarily for assessment and care planning (*see* Web links, p 193). It has patient record documentation features that make it well suited to a health information system in integrated care (whether for home care, residential home, nursing home, mental health care or hospital). ICT-based applications have already been used for funding, quality improvement, benchmarking and care assignment. The RAI is considered to be a good generic health information system because it promotes the use of common language and because it stresses the importance of a functional approach.

Source: Frijters *et al* (2001)

The implementation process

The information requirement assessment

It is too simple to say that all the information available to members of the integrated care system must be available to all the other members. Nor is it true that every member of the system needs to have access to all the available information about a patient. This would be impractical and cause information overload – and it may be forbidden by law or regulations.

It is important to specify carefully what information is required, and by whom. An information requirement assessment will state what information the patient record should contain, when data may be added, changed or used, and by whom, and how it should be handled in information flows. The assessment is made up of four main steps:

Step 1: Examine your current processes

Study the patient flowchart of your integrated care system. This will contain information about health and social care professionals in the care network, group meetings and case managers, and should illustrate the process of your integrated care system. The flowchart can be seen as a network. Each node, or spot where two more lines intersect, specifies (potential) communication and co-operation. List the (potential) connections between the network nodes in the flowchart – in other words, list all possible relationships and processes between individual workers, or groups of workers, that co-operate in the integrated care system. The nodes are the potential producers and users of information, the connections limit the kind of information that they receive and send out.

Step 2: List all communication

List all occurrences, or potential occurrences, of communication between care professionals. Then, list all the types of communication and message connected to processes in the network. These may include requests for actions or progress reports, and the results of these requested – and other, unrequested – actions. One key report that will be important to all nodes is that of initial intake and assessment. Another is the end-of-care report (at discharge or death).

Each 'message' implies a modification or amendment to the patient record. In this way, all actions of professionals will be registered in the patient record, no action of a professional and between two professionals goes unnoticed to the care system. The message should also include 'meta-information' – information about the message itself, like details of sender and recipients, the time and, if necessary, instantaneous notification of the amendment, to the person who requested it. The standard email format (with a sender, recipient, time, subject, message, and so on) might be a simple but suitable conceptual model for the message.
Modifications of the patient record are considered indications of a change in the status of the patient, which will have to be evaluated in the integrated care system process.

Step 3: Identify the information needs of other system users

The third stage is to add to this analysis the information needs of other users potentially connected to the integrated care system. This includes those who are not directly involved in the care process but need information for financial or management purposes. Identify these types of users, assess their information needs, decide to what extent these may be met by the information in the patient record, and agree about how they can use it.

Step 4: Check your findings

Check the resulting model of information requirements once more with all staff in the integrated care system. The resulting information will provide the specifications for your care information system.

The principles of information requirement assessment are generally simple. However, in a complicated integrated care system, it may be problematic to assess the business processes of the network, and hence, to identify the detailed information requirements linked to the process. In cases like this, it is wise to resort to experts and expert methods, such as the 'dynamic essential modelling of organisations' (DEMO) method. DEMO is a procedure that enables managers to perceive the organisation as a system of communicating actors who create information (*see* DEMO in Web links, p 193). From this, the managers can specify the most suitable information management infrastructure.

Checklist: Other points to consider at the development stage

✔ **Decide whether you need a specially tailored solution** Whether you are buying an off-the-shelf system, designing a new system, or using an existing one, the four steps shown above must be applied.

- ✔ **Check the legal and ethical implications of storing personal data** There are also issues about personal information. Each country has its own arrangements to protect individuals from undesired disclosure of personal details, and particularly health information – for example, the UK's Data Protection Act.
- ✔ **Take a broad look at your existing information management practice** Current and expected information management practice and processes of participants in the integrated care system may clash with a new care information system if not investigated and analysed thoroughly.
- ✔ **Do your research** Make use of existing information, such as studies, reports, and experiences of other organisations – particularly on general health informatics and electronic health records. Investigate whether there is a national stimulation or development programme in place – for example, ERDIP, p 183).
- ✔ **Consider including financial and administrative aspects of care** This may increase its effectiveness for financial and senior managers and thus increase chances of necessary commitment from them.

Managers are responsible for specifying user requirements, but they will probably leave technical matters to health information managers and ICT experts, who have the skills to translate user requirements into a care information system model or an ICT system.

A manager will need to perform an investment analysis and calculate or estimate the cost of implementing an information management system. A cost-effectiveness analysis or a return-on-investment analysis can help reinforce the organisation's commitment to implement the new system.

Implementation

Even if the development stage has been very effective, implementation can fail if there is a poor connection between development and implementation stages – particularly in terms of the people involved. It may not be possible to ensure that all those who are involved in implementing the information flow model are also involved in the development stage. It is vital to inform, motivate and train them from very early on.

A test run should be carried out before the system is fully implemented, with demonstrations of how the system should work. The demo should run as smoothly as possible, as any failure will have an impact on people's confidence in and commitment to the system.

The new system should be phased in one department at a time. Each department has its own implementation team, which gives the feeling of ownership, encouraging the commitment of all staff.

At this stage, various participants may start to feel that using the care information system will place unexpected burdens on them. For a hospital, working with a care information system may be routine, but for a self-employed GP or nurse working alone, the new system may appear to be an additional burden. In the long term, the information management system should make things easier for everyone involved, but an adjustment period must be factored in to prove its merits.

Consolidation

At this stage, the care information system is further developed into a set of routine-based procedures that are resistant to negative influences, such as lack of co-operation, and that are open to further improvement and extension. This is done through ongoing evaluation and systematic quality improvement. This involves setting a number of explicit evaluation criteria, such as:

- technical functioning
- support
- use and compliance
- cost-effectiveness
- staff dedication, competency and discipline.

Staff

Who to involve

Creating a distinction between several categories of staff can ensure a better attitude towards the care information system and hence also towards their competencies and roles. These categories may include:

- **Project group staff** These staff are involved in developing, implementing and evaluating the care information system. Their enthusiasm can dictate the smooth implementation of the system, so they must also manage resistance to change and support the need for upskilling.

- **Staff interacting directly with patients** These staff include doctors, nurses, specialists, assessment experts, psychologists and social workers, all of whom will use the information system. They need to fully accept the system, and be motivated and competent to use it, through training.

- **Decision-making managers and top managers** They may not use the care information system, but they need to have a full picture of how it works, its benefits, and the issues surrounding it. They must be fully committed and show leadership.

- **Care co-ordinators** This group includes anyone with care co-ordinating tasks – particularly the case manager. The care information system must enable and support the co-ordinator to do his or her job efficiently and effectively.

- **Care information manager** There needs to be a care information manager, who is ultimately responsible for a good information flow. This includes:
    - the overall running of the system
    - setting up and maintaining user access
    - updating information
    - securing and backing up the data
    - providing documentation and training
    - organising a help desk
    - evaluation of the system.

- **Administrative staff** This includes any staff whose responsibilities include planning, routing or billing. They will have access to certain information held on the system for agreed purposes.

- **Staff who do not use the system** Support for colleagues who are using the information management system need to be encouraged.

Competencies and qualifications

Whether or not the manager has a background in information management or health information, ultimately what is required is the skill to manage across disciplines.

Responsibilities and tasks should be clear for all staff. This is particularly true for staff who are responsible for feeding data into the system, and staff who are permitted to access certain types of data in the system.

For other staff involved, the first competency required is awareness of working in an integrated care system network, and an awareness of interdependencies. Everyone involved needs to contribute to an optimal information exchange, ideally through support and training.

Support

The manager should support staff using the care information system by providing them with:

- sufficient hardware and a well-performing system
- training dedicated to the care information system
- a help desk accessed by telephone for emergencies and email for non-urgent questions, plus accompanying documentation or a handbook
- an on-screen help tool
- evaluation meetings, feedback of results and offering them a role in the evaluation process.

Training

Training of all staff, including the case manager, is required to enable them to become motivated and gain the skills for information flow within an integrated care system. Staff who are accustomed to using standard computer applications may not necessarily be experienced in using dedicated systems. The case manager needs to be trained in using the system too. Training should be offered in all or some of the following:

- general ICT knowledge
- specific care information system knowledge, such as entering data, retrieving data, using the system for specific tasks and managing the system
- the function of the care information system in the integrated care system
- the roles and rights of patients
- legal and ethical issues.

Monitoring and evaluation

The topic of 'evaluation' has a dual meaning in the context of care information systems. First, a care information system is a very useful tool in monitoring and evaluating the integrated care system because it offers the possibility to analyse aggregated data on processes, outputs, outcomes and finance. Second, the care information system has to be evaluated itself, in the context of the integrated care system.

The first step is to decide on the methods and frequency of the evaluation. There are no definitive answers, as these depend on the specific integrated care system. In general terms, the evaluation should include features of the care information system with regard to clients, professionals and the organisations involved. Evaluation criteria can be derived from the goals

and set up of the specific care information system, but several factors that need to be considered in an evaluation fall into the following four categories:
- processes
- outputs
- outcome
- finances.

Processes

In terms of processes, the following factors may be included in the evaluation:
- technical details of the care information system (by experts only)
- the quality of data as experienced by the users, in terms of completeness, availability and accuracy
- staff use and experience of, and behaviour towards, the system.

Outputs

The extent to which staff are using (and not using) the information system can be measured by looking at changes in the numbers of users, of patients whose details are in the system, and of reports. It should ascertain whether the benefits that the professionals gain from the system are greater than the investments they put in, so that they continue to use it.

Outcome

To evaluate the outcome, look at the goals that the care information system was originally designed to achieve. Check whether these have been met, and look at evidence of whether the information system really supports the integrated care system's process.

Include patients and staff in the evaluation. Check whether the staff who use the system are satisfied or not. While they themselves may have no explicit goals to achieve for the care information management system, they may (or even should) have noticed the change in the way their care is organised.

Finances

A care information system may be costly, but if it contributes to reducing the cost of care then it will ultimately be cost-effective. This should be considered in the evaluation. Finally, the evaluation should also verify whether the financial managers' investment in the system is worthwhile, in terms of the administrative and financial tasks for which it is used.

Barriers

The barriers to setting up a care information system tend to manifest themselves primarily in the implementation stage of the system, rather than at development or consolidation. Any new integrated care system is likely to meet with some resistance and reluctance from autonomous organisations, but implementing a care information system has some specific problems. Each organisation that co-operates in a given integrated care system will have its own information systems, will use its own documentation, such as forms, and will follow its own procedures. It may be resistant to changing all this and implementing a new care information system.

If the participating organisations are truly involved in the integrated care system, the more technical problems of sharing information can be prevented and overcome through good consultation. Practical problems can be solved by people in the workplace while technological problems can be left to the experts. However, it is important not to underestimate this issue. If an organisation's co-operation in the integrated care system forms only a marginal part of their total activities – such as a hospital that co-operates in an integrated care system for stroke patients – these organisations may be reluctant to have the rules dictated by other, seemingly minor, participants. It is important to find out who is going to adapt to whom, and how far they will go.

Additional potential barriers to implementing a new information system include:

- failure to inform, motivate and train the people that have to implement the new system
- a lack of awareness of the necessity of a formal and well-structured care information system (which can be remedied by showing that there is always informal information exchange)
- the implementation of new ICT that is not user-friendly or suitable, and is shunned by staff (remedied by involving staff in purchasing)
- privacy legislation that may prohibit social care organisations from using existing health care data, or that requires consent for every single use of the electronic patient record.

One final barrier is presented by health professionals who are anti-ICT and anti-information sharing, for a number of reasons. Their objections might include 'I'm not allowed to make my patient information available to other people' or 'ICT is incompatible with human interaction, which is the essence of care'. This can be remedied by demonstrating that they need information from colleagues and from professionals working in other disciplines, and by reinforcing the fact that shared care requires shared information.

Supports

To increase the likelihood of a well-functioning care information system being brought about in the first place, an absolute precondition is the co-operation, or the firm and true intention to co-operate, of every potential partner in the integrated care system.

The care information system is dependent on an integrated care system – and indeed, is part of it. So each factor that contributes to the setting up of the integrated care system will also contribute to the care information system itself. However, there are additional factors outside the integrated care system. Developments in health information and automation can – and will – guide the development of care information system for integrated care.

These additional factors include:

- a culture of sharing both information and any existing experience of ICT and health information
- a national health information strategy, initiative and support
- commitment and support from top managers (this is indispensable)
- demands for functionality that can be provided only by using ICT
- belief in good functionality of care information systems.

Key points

- Integrated care involves co-operation between professional workers and co-ordination of care. Both require intensive communication and sharing and exchange of information.
- The types of information stored and communicated include documented patient or client information and patient- or client-linked health and social care information. This information supports the care process and managers use it for managerial purposes, such as billing and patient logistics.
- The main features of an information system are storing information and supporting communication. Information on each patient is stored in the patient record. The ways in which this information is amended, distributed and used by various health and social care workers that interact with the patient are known as 'information flows'.
- An ICT-based information system is more reliable, accurate, accessible, modifiable and manageable and easier to protect than a paper-based system. ICT offers new possibilities that are particularly useful for integrated care.
- Implementing an information system requires charting all the types of messages that may circulate between professionals in an integrated care system. Professionals, managers and social and health information experts all play a role in the implementation process.
- Patients and their carers have their roles as well: they need be involved in decisions on principles of privacy and data protection, access to information, and ways of checking and changing their own records.
- Obstacles to implementing an information system in integrated care can arise at the organisational level as well as at the individual level of professionals. Managers need to negotiate the commitment of their organisations to the integrated care system. The level of dedication of professionals and other users can be enhanced by providing training, support services and user-friendly equipment.
- It is not possible to have an excellent integrated care system and a failing care information system, and one cannot mend a failing integrated care system with an excellent care information system.

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Web links

www.demo.nl – website for the dymanic essential modelling of organisations (DEMO) method.

www.ehma.org – The European Health Management Association, which managed the CARMEN network, the group that produced this resource book. CARMEN publications and other materials can be found via the EHMA website or by emailing info@ehma.org.

www.interrai.org – website for interRAI, a collaborative international network of researchers working to improve health care for elderly, frail or disabled people.

Chapter 13
Quality management

Marja Vaarama

Integrated care is the collaboration of multiple services around a client with multiple needs. Many problems with quality occur as a result of failures in communication and co-ordination of services. Put another way, improvements in one link of the chain may be neutralised by a failure in some other link. If the co-ordination and collaboration between the relevant professionals and organisations takes place only on ad hoc initiatives, there are various potential factors that can prevent a high-quality, cost-effective care from being achieved. If, on the other hand, the various actors work as a network or a team, with shared goals and protocols, then the integration is better structured, and there is a better chance of reaching the quality objectives (*see also* Chapter 2).

According to the Saskatchewan Commission on Medicare (2001), 'Health care organisations that systematically emphasise quality are the best places to work. They respect and maximise the contributions of all staff, they reduce the amount of unnecessary and ineffective work, they reduce error rates and they produce better outcomes and job satisfaction.' There is no reason to assume that this would not apply also to social welfare services.

As yet, there is little experience or literature on quality management for integrated care in Europe, but, taking the nature of integrated care into account, it must also be based on collaboration and information exchange. Working in an integrated care system certainly makes quality management more complicated, but there are models that can be used, and lessons that can be learned, from the research and practice of generic quality-management approaches.

There is a wealth of practical experience demonstrating that systematic quality management has increased people's motivation in relation to quality and awareness of costs, thus leading to improved performance. Experience has also shown that improvements in quality can be achieved with small changes in attitudes and daily routines (Olsson 2003). Research points out that 85 per cent of health care quality is determined by the system performance. In other words, quality is a result of teamwork rather than of an individual profession (*see* Medical College of Georgia, Web links, p 210).

This chapter is about these models, approaches and lessons. The key message is that quality management in integrated care is a continuous learning process for all participating in it. The arguments do not directly depart from any special model or certain terminology and, due to the lack of models on quality management for integrated care, it draws heavily on generic quality management approaches. This illustrates the first lesson about introducing a quality management system in integrated care: accept that there are several approaches and terminologies for quality and that this diversity can be overcome only by common discussion where diverse professional cultures are respected as equally important.

Definitions

Quality management

The objective of quality management is to support the provision of best possible care outcomes and efficient use of resources. It is expected to facilitate:

- better quality of life for the client and their families, through better targeted and co-ordinated services with good professional quality and continuity of care
- more efficient use of resources
- increased transparency and accountability
- prevention of risks and mistreatment
- the bringing together of different professionals.

Quality of care

The key terms relating to quality of care are inputs/structures, process and outcomes (Donabedian 1980). The CARMEN Network (Vaarama and Pieper eds 2004) defined the quality of integrated care of older persons as involving the following elements:

- **inputs/structures** – well-trained, multidisciplinary personnel, personnel's motivation towards constant improvement of quality, evidence based and validated standards
- **process** – responsiveness to needs and preferences of the client, support to autonomy and independence, the clients' right to dignity, client centredness in planning of services, client participation, empowerment
- **outcomes** – effectiveness of care, continuity of care, client satisfaction, support to quality of life of a client.

Key tasks and terms

- **Outcome indicator** – a quantified presentation of any change in client's health or well being, that may be caused by the care they received
- **Quality criteria and quality standards** – yardsticks for evaluation. Complementary surveys are used too, to measure the degree to which the set criteria have been met
- **Quality evaluation** – comparing inputs, structure, processes and outcomes of a service with a written statement, or some other comparison point (benchmark)
- **Quality improvement** – doing things better
- **Quality indicator** – a measure that indicates the quality of service
- **Quality management** – setting the goals for care, organising the processes to achieve the goals, and evaluating results
- **Quality management systems** – these usually include a set of quality criteria or quality objectives and defined operational standards for quality, as well as indicators to measure quality
- **Quality measurement** – collecting data to give a numerical representation to the quality of care the client receives.

Sources: Evers *et al* (1997), Øvretveit (2001), Vaarama and Pieper (2004b)

Objectives and intended outcomes

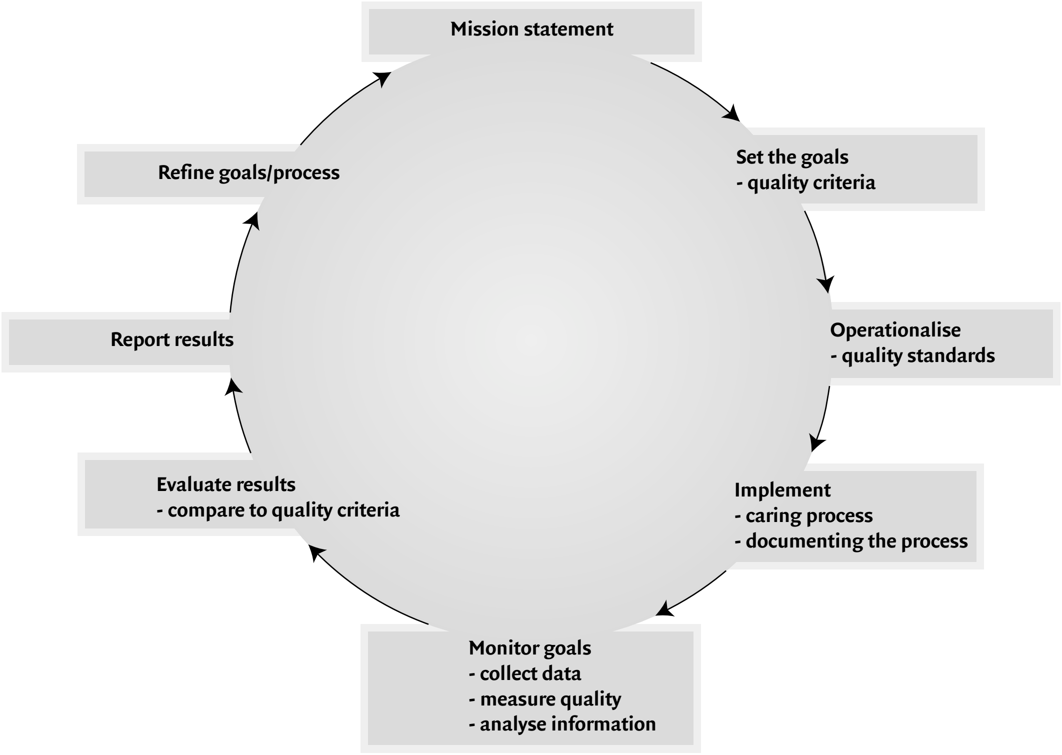
In integrated care, the quality of a multiple service can be evaluated only in terms of looking at a chain of actions taken by different organisations and professionals that are co-operating or transferring responsibility from one to another – for example, from hospital to home. So the mission statement, outcome objectives and measures, processes, and protocols must be agreed by all actors participating in the care network.

Clarifying the objectives is the starting point for defining right outcome measures. To be able to say what sort of outcomes should be evaluated, one has to ask questions such as:

- What are we trying to achieve?
- What exactly is meant by 'better care'?
- What do 'empowerment' and 'dignity' mean in the care process?
- What do 'professional standards' mean in practice?

This activity should be organised as an iterative and interactive process involving everyone participating in the care chain. Multi-agency structures and protocols are needed to add coherence to the objectives. This collaboration should also involve clients and their carers, and should empower them with a meaningful participation. That way, the quality management process becomes a dynamic learning process during which the quality of care improves step by step. Building up co-operation for quality between different professionals, units and organisations serving the same clients is the starting point for implementing any quality scheme in an integrated system. Fig 11 illustrates this learning process.

Fig 11: The cycle of quality management



The three levels of quality management

Quality management can be divided into three separate levels:

- the client level
- the inter-organisational, network or care chain level
- the system or societal level.

These are explained below:

Client level

At this level, the objectives of the care of an individual client are set, the interventions are customised to meet individual needs and circumstances and documented in the care plans, and the delivery and processes are recorded. The quality management questions at this level may be:

- How well did the given care match the client's needs and preferences to his or her care plan?
- Did the given care meet the professional standards?
- Did the interaction with the client realise the goals of dignity, empowerment and carer involvement?

The client's needs are not static, but change over time, so a regular monitoring and evaluation is needed to make the necessary adaptations in time. (*See also* chapters 4 and 6).

Inter-organisational, network or care chain level

At this level, the quality management questions concern issues such as co-ordinating the delivery of the multiple services to the client, the collaboration of the professionals, ensuring unity within the objectives and goals of frontline professionals, and the degree to which professional standards of care in practice are met. Two topics especially important to monitor at this level are the simultaneous dimension (contents of care and logistics) and sequential dimension (care following the needs of the clients) of integrated care. (*See* Chapter 1).

System or societal level

At this level, the quality management questions deal with issues such as access to care, financial sustainability of the care system and equity of distribution – in other words, who loses and who gains, how equitable the distribution has been in relation to the client's needs or needy groups, how great these needs are, and what types of unmet needs can be identified. System-level quality management is expected to increase accountability and to provide information for evidence-based decision making.

Models and approaches

There is a range of models and approaches, of which total quality management is the leading option for integrated care. Regarding the evaluation of the quality of care, there is a range of measures available, but none is tailored for integrated care. Measurement of cost-effectiveness of integrated care is especially demanding.

Total quality management

Total quality management (TQM) is currently the most common quality management strategy, and the existing models and approaches are more or less applications of that strategy. TQM is a management philosophy central to the organisation's goals, rather than a tangential activity. The goal is to produce an organisation-wide plan with specific quality goals. This involves work being done to get all personnel committed and enthusiastic about quality – all the way down from top management to the 'floor' level.

TQM aims to cross departmental and disciplinary boundaries. When it is first applied, it requires a substantial investment in training, and involves an ongoing process of quality improvement rather than a one-off setting of quality standards. TQM emphasises the prevention of mistakes and defects before they occur, rather than correcting them retrospectively (adapted from Pollit 1997. *See also* Pieper 2004 and the ‘quality’ website, Web links, p 210).

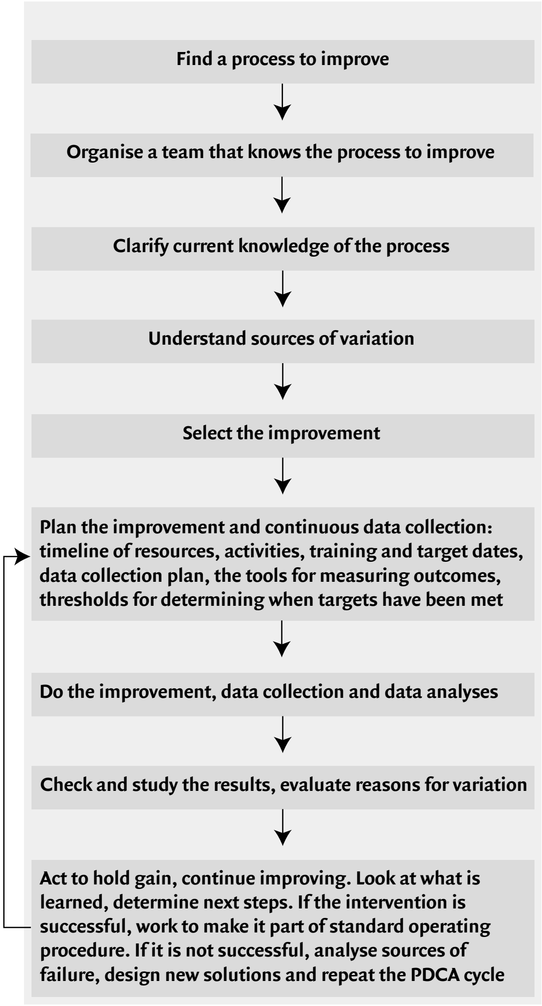
Quality awards

Quality award schemes are not quality systems as such, but they do offer a basis on which a scheme can be built, and are increasingly used to build up quality management systems for care organisations. One example is the European Quality Award. There are also many national awards available (*see* Øvretveit 2001).

Continuous quality improvement

Continuous quality improvement (CQI) is a widely used application of TQM. Rather than creating a culture of blame if things do not go well, the focus is on a team approach to improvement that rewards the group when things get better. One much-liked and often-applied model of CQI is the Deming cycle (plan–do–check–act). In the health care field, this is often applied as the FOCUS-PDCA model. The model implements nine steps to diagnose quality problems and focus on quality improvement in practical work, illustrated in Fig 12.

Fig 12: The FOCUS PDCA model



Source: American Hospital Corporation (1989)

State inspection schemes

National or regional governmental agencies inspect or accredit care organisations to see whether they meet the defined standards. One example was the UK Commission of Health Improvement, which audited services every four years or whenever a serious quality problem was suspected. Nowadays, state initiatives, too, have moved away from control, moving instead towards stimulating quality development, as can be seen from the Finnish and Dutch examples presented later in this chapter.

Accreditation

This is where governmental or non-governmental accreditation agencies award a 'credit' to a service to indicate that it has met defined standards. The best-known scheme in health care is the US Joint Commission for the Accreditation of Healthcare Organisations (*see* Web links, p 210).

ISO 9000

ISO 9000 is a set of generic international quality standards. The scheme certifies whether an organisation meets standards for a quality management system. Under the ISO 9000 approach, an organisation seeks registration for particular processes or systems. It pays a fee and, after a period of preparation, the chosen process or system is assessed by an approved, external, third-party assessor. If the assessor decides that the process meets the requirement of the standard, then the organisation can display its accreditation on its products and literature. The ISO 9000 has been used most often in laboratory and non-clinical support services.

Peer review

Peer review concentrates on whether providers meet clinical or other standards of care. Here, the work of an individual professional or group of professionals is assessed by a group of fellow professionals. The review can vary from systematic assessment with defined standards to more informal peer review visits, where the assessments are offered in a supportive way, with a view to encouraging improvement. The peer review may be internal or external to the organisation under review, it can be voluntary or mandatory, and the frequency of the reviews can vary greatly. There may or may not be sanctions in use, and the outcomes of the review may be confidential, or may be freely available within the public domain. For example, the UK National Health Service Medical Audit is a form of internal peer review, while the US Medicare Program Peer Review is external.

Benchmarking

The basic idea of benchmarking is straightforward. First, an organisation identifies one or more of its processes where it wishes to make quality improvements. It then looks for one or more other organisations that appear to have achieved high degrees of excellence in that same process, and designs and implements a plan for raising its own performance up to or beyond the level of that of the benchmark.

Practice example: Benchmarking

The Netherlands government uses benchmarking to stimulate quality and efficiency of care, and it has developed performance indicators for home care providers, in consultation with them. The dimensions measured were: efficiency in terms of costs and outputs, quality of care as evaluated by clients and staff, and stakeholders' appreciation. It constructed a combined score to identify 'best practise organisations'. This enabled organisations to compare their own performance to general performance, and to the performance of organisations providing similar types of care.

Analyses of the dimensions allow indicators, as factors that contribute to the specific value on that dimension, to be traced. With relevant refinements and adaptations, benchmarking has also been applied for nursing homes. One of these refinements has been that the indicators will be clustered in dimensions according to the INK management model, the Dutch counterpart of the European Organisation for Quality (EOQ). (This management model is derived from – and is quite similar to – the European Foundation for Quality Management – EFQM). This will allow better insight for managers on how the results are derived, and how to improve their management.

Source: Huijbers (2003)

The breakthrough series model

This collaborative model was developed in Sweden in palliative care, but it can also be implemented in other fields of care. Olsson (2003) describes the model with the phrase ‘small changes – great improvements’. The model does not require any major surveys or drawn-out decision processes to get started. Cross-professional teams from different organisations and authorities are drawn from personnel working at the hub of the profession, who must ask themselves the following three questions:

- What do we wish to achieve?
- How do we know that a change is an improvement?
- What changes can we make that will result in improvements?

The changes are measured regularly from the time that a decision has been taken on what is to be improved and what should be measured.

The model project has provided useful lessons for improving the quality of palliative care. The most important of these has been that great improvements can be made using very small means and very quickly. In one example, a teaspoon of turnip rape oil every day eliminated both anxiety and constipation in dementia patients at a nursing home. In another, regular pain checks using the ‘VAS’ scale resulted in reduced silent suffering among palliative patients in a nursing home. In a third case, writing down stories from the lives of clients when they were welcomed into the nursing home was used to create care based on individual needs and requirements.

The first breakthrough series took nine months and the second took six. During the process, many teams members bonded, and the collaboration has provided a starting point for improved co-operation in other, quite different, areas. This Swedish group is now planning a breakthrough series on dementia care.

Residential assessment instrument (RAI)

This is an internationally validated, comprehensive assessment instrument for long-term care of older people. It offers tools and processes for:

- comprehensive needs assessment
- standard documentation
- validated indicators for evaluating quality improvements and costs.

The results can be computed at the individual client level, the organisation or team level, and on higher aggregated levels.

RAI was originally developed in the United States as a response to criticisms about the quality of long-term care of older people. In order to use it, one must apply for a licence from InterRAI. InterRAI is an organisation of the developers of the RAI-instrument, and it owns the copyright of it (*see* InterRAI, Web links, p 210). At present the RAI-instrument is already validated – or in the process of being validated – in many European countries, and is likely to be one of the most-used assessment and evaluation instruments in the long-term care of older people in the future.

EverGreen 2000 Plus

This software application is a strategic macro-level quality-management system for the social and heath care of older persons. It includes key indicators of need, supply, staffing, costs, effectiveness of goal attainment, labour productivity, economy of care, and equity in terms of access to services and unmet need. The application offers two modelling options ('trend extrapolation' and 'planning by targets') for systems improvements, and enables the user to simulate the costs of alternative options.

The software, which is maintained by the Finnish National Research and Development Centre for Welfare and Health (STAKES), makes use of existing care registers. If these are not available, it is possible to build up the database by collecting the data separately. The results are given in popularised tables and graphics and designed to be understood by lay people, rather than only specialist planning experts.

This system facilitates fact-based decision-making and planning. Supported by a collaborative planning model, it brings the social and health care planners, professionals and other stakeholders together to plan, monitor and evaluate the care of older persons, to identify the needs for improvements at the system level, and to compare alternatives to be able to select the most promising one.

The first version ('EverGreen') was introduced in 1990, the second ('EverGreen 2000') in 1997 and the newest version ('EverGreen 2000 Plus') in 2004 (*see* Vaarama 1995, 1997, 2004). An application in English will be available in 2005.

Measuring the quality of integrated care

Monitoring and evaluation of quality of care are the core tasks of quality management.

- **Monitoring** means ensuring constant follow-up to obtain information about developments and to catch early signs of undesired developments.
- **Evaluation** must be carried out regularly – for example, monthly, quarterly, every six months, annually, or every three years – depending on whether the type of evaluation in question is routine only, or a research initiative. In evaluation, the effectiveness of action is evaluated against the set criteria and yardstick.

To be able to monitor and evaluate, one must be able to measure quality outcomes and costs. The key terms of quality measurement are quality criteria, quality standards and quality indicator:

- **quality criteria** – characteristics chosen to define quality objectives. The assumption is that if a criterion is fulfilled, the quality of care is also good. Usually, one care service has several criteria to be achieved. Quality criteria must be relevant and valid, and indicators must be reliable, measurable, sensitive, approved and not possible to manipulate
- **quality standard** – a condition set to a criteria, often expressed as highest or lowest value or allowed range. A standard can also be qualitative
- **quality indicator** – a measure that indicates the quality of measured service and usually categorised according to the three dimensions of quality (structure, process and outcomes).

There is a common desire among care managers to be able to measure the care outcomes in terms of cost-effectiveness, or – as care practitioners often say – 'cost-benefits' of care. By definition, the cost-effectiveness of care is the ratio between the costs and effects of a given care service. A service may be effective in meeting the needs of a client, but it is not cost-effective if similar outcomes could be achieved at less cost, or if better outcomes could be achieved for the same cost. This is very important information for the care managers, but there is still a lack of valid indicators that would be easy to administrate in practice.

The problem deals with measuring outcomes and costs alike and highlights the importance of choosing the right outcome measures. It might be extremely difficult to find out the only outcome measure, but a good alternative is to look at the separate dimensions of care outcomes. For example, it may not be possible to make valid measurements of the improvements in the client's quality of life that are really caused by the integrated care they receive. However, it is possible to use measures such as reduced pain, or reduced emotional or behavioural disturbance in the client or reduced burden on the principal carer, and it is always possible to ask the client about their levels of satisfaction and their subjective levels of health, mood or well being. There is a wealth of validated scales and tools available for measuring these dimensions. (*See*, for example, the Growing Older Programme, detailed in Dean 2003).

In addition to quantitative measures, qualitative information is necessary for a comprehensive evaluation of the care quality. For example, many process objectives are qualitative, and relational aspects of care (face-to-face care) must be measured qualitatively. However, when qualitative objectives are clearly defined, they can often be measured by using quantitative scales. In integrated care, defining these objectives and agreeing on respective indicators is one element of the quality management cycle described earlier.

As said earlier, it is better to take multiple outcome measures than taking just one, as this leads to more a comprehensive evaluation and increases the validity of the evaluation. This is especially true in integrated care, where several objectives for quantity, types and quality of care are set for one case, and several professionals – and usually several organisations too – are involved in the care. Evaluating the quality by looking at only some of the activities that take place would not be sufficient. So it is better to have a number of success indicators than just one. It is also desirable to have a variety of different perspectives on the same outcome. For example, in the UK Duffy *et al* (2001) have evaluated service quality in nursing homes from the point of view of residents, family and administrators.

However, having a number of outcome indicators for the same case can cause problems for cost-effectiveness evaluations. So, for cost-effectiveness evaluation, a primary outcome should be defined against which the costs can be measured and the cost-effectiveness evaluated. All the costs caused by the multiple services need to be summed up and related to the primary outcome. The primary outcome should be measured in units that enable a cost-effectiveness ratio to be calculated. It is well known how difficult cost-effectiveness is to measure, but this does not mean that it is not possible. This topic is little discussed in integrated care, so there are no models that can be presented here. Managers interested in this topic should look at the existing health-economic literature. For information about measuring cost-effectiveness of social welfare services, *see* Sefton *et al* (2003).

The implementation process

The practical implementation of quality management schemes can be separated into four steps that follow each other or are implemented simultaneously.

Step 1: Clarify your goals and prepare the introduction of the selected model well

Deciding which model to choose depends on the problem to be solved and the circumstances in which it is to be implemented. Planning carefully how to introduce a quality management system may be more important than your choice of model.

Checklist

- ✔ Clarify the objectives – what shall be improved and how?
- ✔ Evaluate the alternatives and be familiar with the conditions for the suggested model to work in practice.
- ✔ Involve staff in development and decisions about implementation; the professionals and other staff need to understand what they are being expected to implement, and be motivated to collect the data and use the model/tools in question.
- ✔ Include all other relevant stakeholders to ensure that the necessary resources, equipment, facilities, time and skills for implementation are available. This must be true too for every link in the implementation chain: the more links the more difficult it will be to satisfy this requirement.
- ✔ Motivate and involve clients and carers – be sure you have their acceptance.

Step 2: Create motivation and 'common ownership' of quality

Integrated care is all about co-operation within and between different actors, professions, roles, organisations and other systems. Cultural and professional differences between these various elements are significant. To ensure ownership of a common quality effort, everyone involved must have the chance to discuss and decide which concepts and goals they will adopt, how to fit them to their own work, and what are the basic values of their work (in other words, a mission statement). Step by step, the following activities may lead to a commonly shared quality system.

Checklist

- ✔ Prepare for the fact that it is not easy to get different people, professional and organisational cultures and languages talking together, so employ the right methods to foster common growth (*see* Chapter 9).
- ✔ Provide clear information about the model, its intended benefits for the clients, professionals and organisations, and the responsibilities it brings about.

Emphasising the professional gains of better quality care may be a good way of getting diverse professionals interested in this joint effort.

- ✔ Document the agreed objectives, processes, measures, responsibilities and procedures into a common protocol to which everyone participating in the integrated care has access.
- ✔ Involve clients. Remember that they are the recipients of the desired or undesired outcomes of care. When their quality has been defined and evaluated, make sure they are heard. There is a significant body of experience, guidance and research about how to involve older service users in effective and inclusive ways (*see* Chapter 3).
- ✔ Set up self-evaluation between the professionals or within teams. This may be a good way to start as it can provide ideas for further development.

Step 3: Organise the integrated quality management and support for implementation

Quality improvement is a continuous learning process, and in an integrated system it must be carefully organised. The organisation needs to provide a clear framework for shared quality management, and must ensure the managers and personnel feel motivated to continuous training and self-education.

Checklist

- ✔ Involve all staff who are relevant to the client, from kitchen to boardroom.
- ✔ Nominate a quality manager for each client, as well as for each integrated team.
- ✔ Elect a team of a dedicated top managers to co-ordinate integrated quality management. This should be made up of responsible quality managers of participating organisations or teams.
- ✔ Organise training on integrated quality management for the managers and all personnel participating in the integrated care, before starting the practical implementation.
- ✔ Set up extra training for staff who will be measuring client satisfaction, analysing problems in processes and developing systematic responses, and evaluating the results and communicating them to others.
- ✔ Ensure a coherent set of common criteria and quality indicators is available to facilitate the quality improvement and evaluation of achievements in practice.
- ✔ Establish a common documentation system based as far as possible on the existing information systems.

Step 4: Choose right-outcome measures

It is crucial to have right-outcome measures. To choose these measures, organise a process in which all organisations and key professionals are involved.

Checklist

- ✔ Clarify key objectives and convert them into measurable outcomes.
- ✔ Define these distinctly for structure and inputs, process, outputs and outcomes.
- ✔ Assess the costs and outcomes systematically. Indicators on process and structure are easier to collect, but they do not tell you about the outcomes.
- ✔ Adopt a multiple perspective to obtain a more comprehensive evaluation.
- ✔ Use qualitative evaluation to look at individual and organisational experiences, views, meanings, motivations, ways of acting and interacting, and resistance.
- ✔ Examine the equity – access to, and use of – services in relation to need.

✔ Pay attention to the 'soft' dimension of quality, including empowerment, dignity, fairness and justice.
✔ Commission external consultation to get help in determining the right indicators.

For further information relating to Step 4, see also Sefton *et al* (2003).

Monitoring and evaluation

Although monitoring and evaluating quality of care are crucial elements of quality management, in fact evaluation of the efficiency of diverse quality management systems is sparse. At the minimum, a 'before quality management versus after quality management' evaluation should be employed to evaluate whether the new system is actually improving results. 'Before' evaluation should be performed before the quality management system is introduced to the team. 'After' evaluation can be done in conjunction with monitoring and evaluation of care outcomes and costs. Monitoring and evaluation may need to be repeated several times before drawing crucial consequences – it takes time and effort to change!

Checklist: Monitoring and evaluation

✔ When you monitor and evaluate the care outcomes and costs, try to evaluate whether these outcomes and costs are due to the integrated quality management system, and whether it would have been possible to achieve these goals without it.
✔ When you see problems, look at the quality management cycle (p 197) and think about it in terms of your integrated team. Where are the problems?
✔ Find the problems early, and act on them. Clarify, organise support such as training, and revise your indicators.

Barriers

Unclear goals, insufficient resources and bad timing can hinder the entire process, reduce motivation and lead to poor results.

Another barrier to overcome is poor-quality documentation of care processes and interventions, and lack of commitment of the staff involved. Documentation of care varies considerably even within one organisation, let alone among many. This barrier has to be overcome at the initial stage of the quality management system being brought into practice.

There are also a number of potential barriers to effective collaboration between professionals. These may include:

- misunderstandings about the purpose and role of other professionals
- differing preferences and opinions
- conflict over methods, measures and resources
- attitudes about the superiority of one's own profession and a lack of respect towards others
- resistance to change.

In addition, there may be parallel policies or quality schemes implemented by the professionals and organisations participating in the integrated care network. These may compete with the common effort to be taken, and affect the legitimacy of the planned process.

Care must be also taken when introducing new models, visions and language to a working team. Welfare and health professionals may regard models taken from the commercial sector with scepticism, or even cynicism. They may also have fears about possible criticism arising from the evaluation results – especially when clients are empowered to express their opinions.

Supports

The introduction and implementation of integrated quality management can be proactively supported in many ways, and the means need not to be major and costly. To prevent barriers to effective collaboration between professionals, it is usually possible to achieve reasonable common understanding by organising enough time for group discussions about goals and results. At first glance, the aims and terminology of different organisations, or of individual professionals may appear to vary considerably, but after getting to know one another better, significant overlaps may become apparent (*see also* Chapter 9: Cultural change). A crucial and more expensive support is to produce a common documentation system that all the parties can use (*see also* Chapter 12).

In the case of parallel policies or quality schemes within the integrated network, or in the separate organisations, it is important to set out a clear contract on what policy the integrated network will follow. All professionals and organisations involved in the integrated care network need to commit to common goals, procedures, responsibilities and checkpoints, and investigate whether there are contradicting goals in some other implemented procedures. If this is the case, the network must create a consensus that bridges the old and new procedures, to ensure that the efforts towards quality improvement can be carried out as intended. These issues must be contracted in a written protocol that everyone involved can access.

Finally, for practical success, it is important that the quality management initiative has the highest level of commitment, and that it is accepted by the highest decision-making body. It is also vital that the initiative is guaranteed adequate resources, such as time and information systems, before starting.

It is a great help if there is an official policy for quality improvement accepted for the country, region or organisation in question. For example, the Finnish government has worked with relevant stakeholders to develop the Finnish National Framework for High Quality Care of Older Persons (Ministry of Social Affairs and Health/Finnish Association of Local Authorities 2001, Vaarama *et al* 2001). These national recommendations emphasise integrated needs assessment, evidence-based interventions, timely service, seamless care chains, humanity and dignity of care processes, sufficient and qualified staff, and co-ordination, collaboration and co-operation in planning, delivery, monitoring and evaluation of care. The government has also earmarked some finances to facilitate realisation of the recommendations. To support implementation, the ministry contracted with STAKES to provide a set of national performance indicators, which are available online (STAKES 2003).

Strategic tools such as ‘balanced score cards’ (Kaplan and Norton 1996) can support quality management considerably, as the experiences of the city of Helsinki tell (Valvanne 2004), but in integrated care this may apply only provided that all participating organisations share the same strategy. Also very helpful are evidence-based professional standards, or such practical results as, for example, the breakthrough model provided for palliative care (Olsson 2003).

Conclusion

The discussion about the management of quality of integrated care is sparse, and so are the models, methods and measures for it. This chapter emphasises that the quality management of integrated care is at its best a continuous learning process within the integrated network, resulting in a continuous improvement of the quality of care. To facilitate integrated quality management, a coherent set of methods and models must be taken to plan, organise, operate and evaluate all the many interrelated elements around the care of clients with complex, long-term problems cutting across multiple services, providers and settings. The goals are to enhance the quality of life of the clients, client satisfaction and system efficiency.

This chapter has aimed to find a definition for the quality of integrated care that would make the elements of quality visible for managers, thus also structuring the elements of quality that should be managed. The quality of integrated care should be seen as a result of a quality chain consisting of the elements of care structures, processes and outcomes (Donabedian 1980), and should be evaluated from the perspectives of the client, the professionals, and the provider organisations (Øvretveit 1986, 1992).

This chapter presents some practical examples of quality management approaches that are assumed as fitting to integrated quality management. The models are to be found among those based on total quality management (TQM), such as continuous quality improvement (CQI), as they are multi-actoral and based on structured collaboration. The methods of evaluation of quality of integrated care have been discussed, with a suggested approach of multiple outcome analysis. A special concern has been raised about the lack of both routinely used quality indicators and research initiatives on quality of integrated care. Integrated care particularly needs comparative quality measurement that exploits validated quality and outcome indicators. As the quality indicators for integrated care are lacking, new research initiatives are badly needed to fill the gap.

Careful planning is vital as the initial stage of introducing a scheme for integrated quality management; the way the system is introduced may be even more important than the model chosen. Multi-agency protocols need to be created in collaboration with all relevant stakeholders of the integrated system in question, to define the commonly shared strategy, objectives, methods, measures and protocols on how to ensure good quality care and efficient resource use, and how to organise continuous quality improvement in practical terms. The message is: plan your steps, involve rather than exclude, make sure everyone understands the objectives and means, and make sure that everyone is heard – including the clients and, where relevant, their principal carers.

Key points

- **Clarity of the goals is essential. Everyone should understand what is expected to be implemented and why.**
- **Ownership, motivation, attitudes and commitment are vital throughout the organisation or network.**
- **Inclusiveness is key. All staff, clients and carers should be involved in the process.**
- **Partnership is vital. Quality can be attained only through common effort.**
- **Everyone should receive the necessary training and counselling, and special quality managers should be put in place to oversee this process.**
- **Criteria and measures should be clear, relevant, valid and measurable.**
- **A good documentation system is essential for collecting data about the care process, and about evidence of quality.**
- **The IT system needs to facilitate timely information processing and routine monitoring and evaluation.**

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Web links

www.interrai.org – the website for interRAI, a collaborative international network of researchers working to improve health care for elderly, frail or disabled people.

www.jcaho.org – website of the Joint Commission on Accreditation of Healthcare Organizations, an organisation working to support performance improvement in health care organisations.

www.mcg.edu/som/fmfacdev/fd_quality.htm – website of the Medical College of Georgia’s family medicine department, which has a section summarising quality assurance.

www.quality.org/TQM-MSI/TQM-glossary.html – website providing a full glossary of total quality management (TQM) terms.

www.sentinel-event.com/focus-pdca_index.htm – website of Medical Risk Management Associates, detailing a range of tools for improving patient safety.

www.stakes.fi – the website of STAKES, the Finnish Research and Development Centre for Welfare and Health, with a range of useful resources and documents. (*See individual listings in the references for this section.*)

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