The meaning of "integrated care"
for children and families in the UK

British Association for Community Child Health
Position Statement

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Introduction

"Integrated care" is increasingly being advocated as a means to overcome perceived fragmentation of care within and between organisations that provide health care and associated services. The purpose of this position paper is to review the meaning of "integrated care" and its application to services for children and families.

The concept of integration is complex. This paper is structured into two sections. Section A outlines what is meant by integration and includes:
- Definitions of integration
- Types of integration
- Characteristics and principles of successful integration

Section B deals with its application in services for children and families encompassing focus on:
- Systems thinking
- Networks
- Learning

Section A: Integration – concept and terminology

Definitions of integration
The term integration is derived from the Latin word integer, which means 'whole or entire' used in the sense of combining two things into one, or making a group from a combination of parts. Applying integration to services should create "a state of combination that delivers completeness and harmony".

Suter concluded there is no unified, or commonly agreed upon, conceptual model for health systems integration in the literature (Suter 2009). A selection of definitions over the last decade can be found in appendix **1**

'For the user, integration means health care that is seamless, smooth and easy to navigate. Users want a co-ordinated service which minimizes both the number of stages in an appointment and the number of separate visits required to a health facility. They want health workers to be aware of their health as a whole (not just one clinical aspect) and for health workers from different levels of a system to communicate well. In short, clients want continuity of care.'

World Health Organisation (WHO)

While "integrated care" is the commonly used term there are many alternative terms (appendix 2) which cover very similar ground. The similarities and differences are not reviewed here, but the term integrated care (and its derivatives) may be used both as a ***concept and a method*** to achieve less fragmented care. The alternatives include:

There is, however, almost universal agreement that all systems consist of interconnected parts and these must come together to serve the best interests of the users of the system.

The division, decentralisation and specialisation found within healthcare and other organisations contributing to health, undermine the delivery of integrated, seamless care that is well coordinated (at one moment in time) and provides continuity (over a period of time). Kodner conceives integration not in terms of structure, but rather as a culture "essentially, integration is the glue that bonds the entity together, thus enabling it to achieve common goals and optimal results" (Kodner 2002)

The focus of integration (beneficiaries)
While the focus of integration is to improve user experience it can be focused in different ways depending on local circumstances, for example
- Whole communities/populations
- Specific age groups
- Specific conditions

Types of integration
There are as many forms of integration as there are definitions. Classifications of types of integration range from theoretical to practical.

Theoretical perspectives include meso, macro and micro integration <u>approximately</u> representing a hierarchy of three levels of integration at policy planning, provision and individual levels. An alternative approach is to consider horizontal integration (meaning integration of similar organisations) and vertical integration (meaning integration of different organisations that contribute to the complete management of a condition for a population).

Practical levels of integration include:
1. **Organisational integration -** for example either by mergers and/or structural configurations or virtual integration through contracts between separate organisations.
2. **Functional integration** – for example integration of non-clinical support and back-office functions
3. **Financial integration -** for example through the use of program budgeting for a pathway of care.
4. **Service integration** – for example, integration of the clinical services within an organisation.
5. **Clinical integration** – for example, integration of the clinical team through the use of shared guidelines and joint training
6. **Normative integration** – for example, sharing values in co-ordinating work to secure collaboration
7. **Systemic integration** – the coherence of rules and policies at various levels of an organisation
8. **Knowledge integration -** sharing the same evidence base across different organisations and professional groups.
9. **IT/informatics integration** - sharing communication, data collection, storage, analysis and dissemination strategies.
10. **Workforce integration** - integration of workforce planning, education and training, recruitment, retention and development across multiple organisations.
11. **Governance integration** - integration of governance systems across different organisations.

All these forms of integration can be considered separately or combined to various degrees, for example integration of governance might require integration of informatics and normative integration, to join the different cultures of governance between separate agencies.

Due to the broad nature of practical integration many of these forms of integration already exist within the NHS and between the NHS and other organisations who contribute to health care, however, there is a large degree of variation in understanding and practice. Interestingly the discussion in the literature focuses on provider integration with no mention of commissioner or regulator integration.

Degrees of integration
Like networks there are degrees of integration ranging from:
- **Linkage** – an informal, largely opportunistic, working together
- **Coordination** - a regular, structured response to facilitate communication and collaboration, often sharing evidence/training/audit across organisations
- **Managed integration** - formal working relationships between organisations often based on joint governance arrangements.
- **Full integration** - the creation of a new entity that consolidates responsibilities, resources and finances into a single organisation or system in order to deliver the entire pathway of care, often within a network.

Principles of successful integration
Successful integration must be of benefit predominantly to the user's of services and also "add value" to the whole system. National Voices who represent the interests of patients have recently published their principles (2011) for integrated care:
- be organised around the needs of individuals (person-centred)
- always focus on the goal of benefiting service users
- be evaluated by its outcomes, especially those which service users themselves report
- include community and voluntary sector contributions
- be fully inclusive of all communities in the locality
- be designed together with the users of services and their carers
- deliver a new deal for people with long term conditions
- respond to carers as well as the people they are caring for

- be driven forwards by the commissioners
- be encouraged through incentives
- aim to achieve public and social value, not just to save money
- last over time and be allowed to experiment (

The concept of "added value" essentially means improvement in effectiveness, efficiency and equity maintained over a period of time i.e. sustainably.

Characteristics of successful integration

Integration is a complex process and evaluation of the impact of initiatives to improve integration are not well documented in the literature. There is a consensus that successful integration depends on:

1. **Integration of parts across the whole pathway**
- Cooperation between all the organizations/services/teams that contribute to pathway
- Improved access to range of services in a timely manner
- A great emphasis on prevention, health promotion and health protection at all times

2. **Patient focus**
- Family-centred philosophy; balancing individual and family needs
- Family engagement and participation
- Community-based interventions complementing family-based interventions

3. **Geographic/population coverage**
- The population covered must be of a sufficient size to make efficient use of the management overheads to support integration based pathways
- Where integrated commissioning is not possible, the geographical coverage of different commissioning organisations should be similar
- All individuals residing in a defined area can benefit equally.

4. **Standardized care delivery through inter-professional teams**
- The evidence base for inter-professional teams working together in a network across the whole pathway should be the same
- There should be provider-developed, evidence-based care guidelines and protocols to endorse one standard of care regardless of where patients are seen

5. **Quality improvement**
- All teams/services/organisations are committed to evaluation of their work, continuous quality improvement and learning
- Service delivery is supported by relevant measures of experience, safety and outcomes to drive reflection, learning and change

6. **Information systems**
- Data to support measures that matter are regularly fed back to stakeholders.
- Information systems enhance communication and information flow across the whole pathway.

7. **Organizational values, culture and leadership**
- There are shared values across all contributing organisations
- Leaders with vision who are able to instil a strong, cohesive culture

8. **Stakeholder engagement and alignment**
- Users of services, providers of services, commissioners and regulators must be actively engaged in the process of planning delivery and improvement of services
- All stakeholders should share the same purpose of improving health, reducing inequalities and being sustainable

9. **Governance structure/accountability**
- Strong, focused, diverse governance represented by a comprehensive membership from all stakeholder groups
- An organizational structure that promotes integration across settings and levels of care

10. **Financial management**
- Aligning service funding to ensure equitable distribution for different services or levels of services
- Funding mechanisms must promote inter-professional teamwork and health promotion
- Sufficient investment to ensure adequate resources for sustainable change

11. **Political support**
- The concept of integrated care must have support from politicians and national "leaders"
- National organisations should model integrated working to create synergy between national and local integrated care initiatives

12. **Workforce planning**
- Service planning and workforce planning should not be separated as they are interdependent
- Integrated working, requires integrated teams, and competencies for team working should be developed

Conclusions

Integrated care, however defined, appears to be associated with a number of positive outcomes, including improved system performance, better clinical results and enhanced quality and patient satisfaction. Improving coordination, continuity and timeliness is central to service integration initiatives.

However integration is a complex multilevel, multimodal, concept that is not an end in itself but a way of bringing professionals, teams, services and organisations together. Integrated care entails achieving alignment, synergy and collaborative working within and between services focused on prevention, cure and rehabilitation. The culture of integration crosses traditional boundaries of health, education, social care, criminal justice and other sectors, frequently making use of organisational structures and networking arrangements to bring together the whole system.

Despite the dilemmas and unknowns inherent in integrated care there is widespread support for, and clear principles/characteristics that should guide implementation. It is a great deal more than integrating health and social care management structures, indeed it could be argued that without a shared understanding and approach to integration, merging organisational structures is unlikely to be successful.

The King's Fund concluded that policy-makers should encourage the emergence of clinically integrated groups and integrated provider networks, based on patient choice wherever possible, and linked through contractual integration. (King's Fund 2010)

Section B: Applying integration to services for children and families

The NHS has experienced multiple changes in management and organisation structures in recent years, particularly in England. This includes the demise of District Health Authorities, the formation of community units, Primary Care Groups, Primary Care Trusts, experiments with GP Fund-holding, Independent Treatment Centres, the introduction and abolition of Strategic Health Authorities, Regional Offices and now the introduction of Clinical Commissioning Groups, Foundation Trusts, Social Enterprise Organisations and Community Interest Companies, and separation of public health functions into Public Health England, and public health responsibilities from health back into Local Authorities.

Very few of the changes have been systematically evaluated and the repeated changes would suggest that they were not as successful as anticipated. It is probably true to say that none of these changes in management and organisation structures have led to a significant improvement in the way that services are experienced by children and families.

Policy initiatives such as the National Service Framework, Every Child Matters and strategies to reduce crime and disorder have had some impact, but associated implementation strategies have not been integrated at a national or local level, so consequently have not created an alignment and synergy between organisations.

Kodner suggests that "integrated care is like a country. It demands a culture of its own, one that spans differing organisational and professional mindsets, eliminates boundaries and biases, and shares a common space to facilitate a much-needed interagency collaboration and interdisciplinary teamwork on behalf of the patient" (Kodner 2009)

BACCH is therefore proposing that to achieve "integrated care" the focus should initially be on culture and thinking, rather than a focus on management structures. That is not to say that management structures are not important, but there are more important cultural differences between all agencies contributing to the health and well-being of children and families that need to be overcome and this is of a higher priority at this moment in time. Eventually, when there is a shared culture and governance across organisations, coupled with team co-location and working, and when local management integration can be demonstrated to improve quality, or reduced costs, then it should proceed. The immediate priority must be to develop a culture of integrated care across organisations, services, and teams by developing pathway based networks.

Systems thinking
A *health system* has been defined by the World Health Organisation (WHO) as "all organisations, people and actions whose primary intent is to promote, restore or maintain health." Its purpose is to "improve health and health equity in ways that are responsive, financially fair and make the best use of available resources".

At its simplest, systems thinking proposes that all parts required to achieve the outcome desired, should be in place and working well together. Systems thinking should be combined with the values derived from international Conventions and Charters, such as the UN Convention on the Rights of the Child, into a practical framework for service planning, delivery and improvement.

This requires alignment and synergy at three levels - between policymakers in government departments, the organisations responsible for the distribution of resources, namely the commissioners of services, those providing services and the agencies responsible for governance through inspection and regulation.

All these different agencies should come together, share the same objectives (to improve health, reduce inequalities and be sustainable), share the same values (for example those developed by the Children's Interagency Group, or the Council of Europe child friendly health care guidelines, share the same governance systems and all contribute to continuous quality improvement through innovation and learning.

Collectively they should ensure the right things are done using the right evidence, for the right families, in the right way, in the right place, at the right time to achieve the right outcomes, all the right cost. Achieving this will not only be effective, efficient and equitable but also safe and improve family experience of services.

Pathway based networks
From a patient/user perspective they have a "journey" through services which should be safe, (no unexpected events) deliver the outcomes they want, in a way that is experienced as a "user friendly" or 'quality' service.

From a service providers perspective, groups of journeys could be called "pathways" where the component parts are delivered by teams of individuals who work well together and strive together to improve the service they deliver.

Finally from the perspective of a service planner they want a "network" of services which cover a number of pathways with no unnecessary waste (neither omissions/duplications or unintended consequences) which optimally balances investment in prevention, intervention and habilitation therefore continuously adding value to the invested resources.

This "integrated care" approach proposes that services are outcome orientated, driven by the needs of children, families and communities, with component parts of pathways delivered by competent teams, working collaboratively in a network that strives for quality and value.

The basic component parts for a short term condition (STC) pathway include, prevention, recognition, assessment and management. This short term condition pathway may be the *initial phase* of a long-term condition pathway. Where a condition does become established, the same four components are relevant, but this time the emphasis is on preventing, recognising, assessing and managing the secondary complications of the primary condition. This is called the *review phase*. Finally there is a *transition phase* into either adult services, rehabilitation back to normality or for a minority into palliative care services.
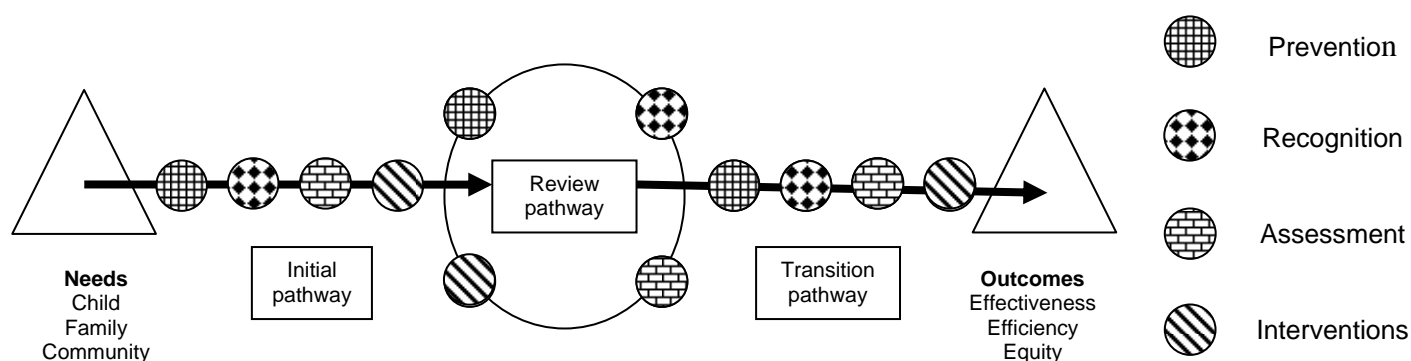
This approach recognises the impact of a condition on the life of the child and also the consequences for their family and the interface between families and communities are represented by the triangle on the left of the diagram. The need for outcomes representing effectiveness, efficiency and equity are represented by the triangle on the right of the diagram.

Each component of the pathway should be based on best evidence, delivered by trained and competent practitioners, in the right place, at the right time with the necessary support services in place for example administrative and IT systems, investigative services and measurement/improvement programmes.

The importance of prevention is recognised in each phase, prevention is not only about proactive planning for expected complications, but also the process of influencing lifestyles and the wider determinants of health through the twin actions of health promotion and health protection. The importance of addressing these elements simultaneously (essentially the link with Public Health) is often overlooked in the current systems of planning and delivering services.

This "whole systems" approach erodes boundaries between primary, secondary and tertiary health services and between health, education and social care. What is important is the delivery of any component part of the pathway in a connected and positive way to what has happened before and what happens next.

Governance and improvement systems which span organisations should identify and ameliorate the weakest links in the pathway which are identified by measures representing the output from the component parts. If this output is suboptimal then a careful examination of the structure and process of that component is the next step in the improvement process.

The two main drivers for change in existing systems arise from achieving alignment between all interested stakeholders and creating measurement systems and feedback loops to support the twin processes of continuous quality improvement and learning.

Innovation and learning

All complex adaptive systems, which include biological and ecological systems require perpetual feedback, adaption/evolution and "learning" in order to survive and be sustainable. Services for children and families are no different in requiring feedback to understand where they are working, and where they are not. Feedback requires active engagement of all stakeholders, especially users and providers of services, in the process of deciding 'what matters' how it is measured, whether it is adequate and what innovation or action is required to improve safety, experience and outcomes.

There is relatively little evidence on how services should be commissioned, delivered and regulated and this should be corrected by integrating service delivery, governance and improvement to create learning and new knowledge. This new knowledge on "what works" should be disseminated, adopted and adapted in a parallel process to that of clinical research, systematically reviewed and distilled into guidelines for use by organisations, such as NICE and professional organisations.

This new knowledge about ways of working should then be integrated with evidence of effective interventions and form part of the continuous professional development within teams and networks.

Conclusions

Integrated pathway based networks should be seen as an "integrated learning system" that brings professionals, teams, services and organisations together to reduce fragmentation and improve timeliness and continuity of care. This approach integrates the purpose, principles and evidence into a practical approach based on pathways, which continually drives quality and improvement of services into an integrated culture for the delivery of better services for children and families.

Implications of integrated pathway based networks

The implications of systematically implementing integrated pathway based networks are potentially profound. Examples include:

- Combined commissioning strategies across health, education, social care and criminal justice systems.
- Provider organisations sharing the same knowledge base and approach to implementation of evidence-based guidelines.
- Shared governance systems across organisations.
- A shared approach to measurement and improvement
- Management structures following function, i.e. based on integrated pathways
- Financing systems where resources follow patients through pathways and networks-introduction of program budgeting.
- Information systems and approaches to informatics shared across different agencies.
- Workforce planning based on the right skill mix to ensure competent teams working in networks.
- Integrating public health approaches to prevention across all pathways.
- Greater emphasis on both equity of access and outcomes.
- Combining regulation to ensure effectiveness, efficiency and equity in other words bringing together quality and economic regulators with a greater emphasis on equity.

Appendix 1

Definition	Author
The methods and type of organization that will provide the most cost-effective preventative and caring services to those with the greatest health needs and that will ensure continuity of care and co-ordination between different services	Øvretveit (1998)
The search to connect the healthcare system (acute, primary medical and skilled) with other human service systems (e.g., long-term care, education and vocational and housing services) to improve outcomes (clinical, satisfaction and efficiency)	Leutz (1999)
A concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion…[as] a means to improve the services in relation to access, quality, user satisfaction and efficiency	Gröne and Garcia Barbero (2001)
A coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors…[to] enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex problems cutting across multiple services, providers and settings.	Kodner and Spreeuwenberg (2002)
Integrated care is a term reflecting 'a concern to improve patient experience and achieve greater efficiency and value from health delivery systems. The aim is to address fragmentation in patient services, and enable better coordinated and more continuous care, frequently for an ageing population which has increasing incidence of chronic disease.'	The Nuffield Trust (2011)
Integrated care is 'the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money.'	WHO (2008)
Integrated care is 'primary care led, multi-professional teams, where each profession retains their professional autonomy but works across professional boundaries, ideally with pooled budgets and ideally with a shared electronic (GP) record.'	RCGP (2011)
Integrated care is simply about improving the patient experience and providing high quality services for a range of health (and social care) needs, delivered within a defined budget and with mechanisms for measuring clinical outcomes and patient satisfaction.	NHS Alliance (2008)
Integration can take a variety of forms, involving either providers, or providers and commissioners, who work together to deliver better outcomes at the macro, meso and micro levels.	King's Fund (2010)
Integrated care – also known as coordinated care, comprehensive care, seamless care and transmural care – is a worldwide trend in health care reforms and new organizational arrangements focusing on more coordinated and integrated forms of care provision. Integrated care may be seen as a response to the fragmented delivery of health and social services being an acknowledged problem in many health systems	Wikipedia

Appendix 2

- Managed care
- Continuity of care
- Case/care management
- Transmural care
- Patient centred care
- Shared care
- Transitional care
- Integrated delivery systems
- Organised delivery systems
- Integrated service networks
- Integrated care organisations
- Managed care networks
- Managed care plans

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About BACCH

The British Association for Community Child Health (BACCH) is a membership organisation for doctors and other professionals working in paediatrics and child health in the community. It is the largest specialty group of the Royal College of Paediatrics and Child Health. Its members work in multi-disciplinary teams across the UK, liaising not only with fellow medical and allied health professionals, but also those from education, social care and the voluntary sector.

Website: **www.bacch.org.uk**
Email: **bacch@rcpch.ac.uk**

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