Integrated Health and Social Care:

What Matters

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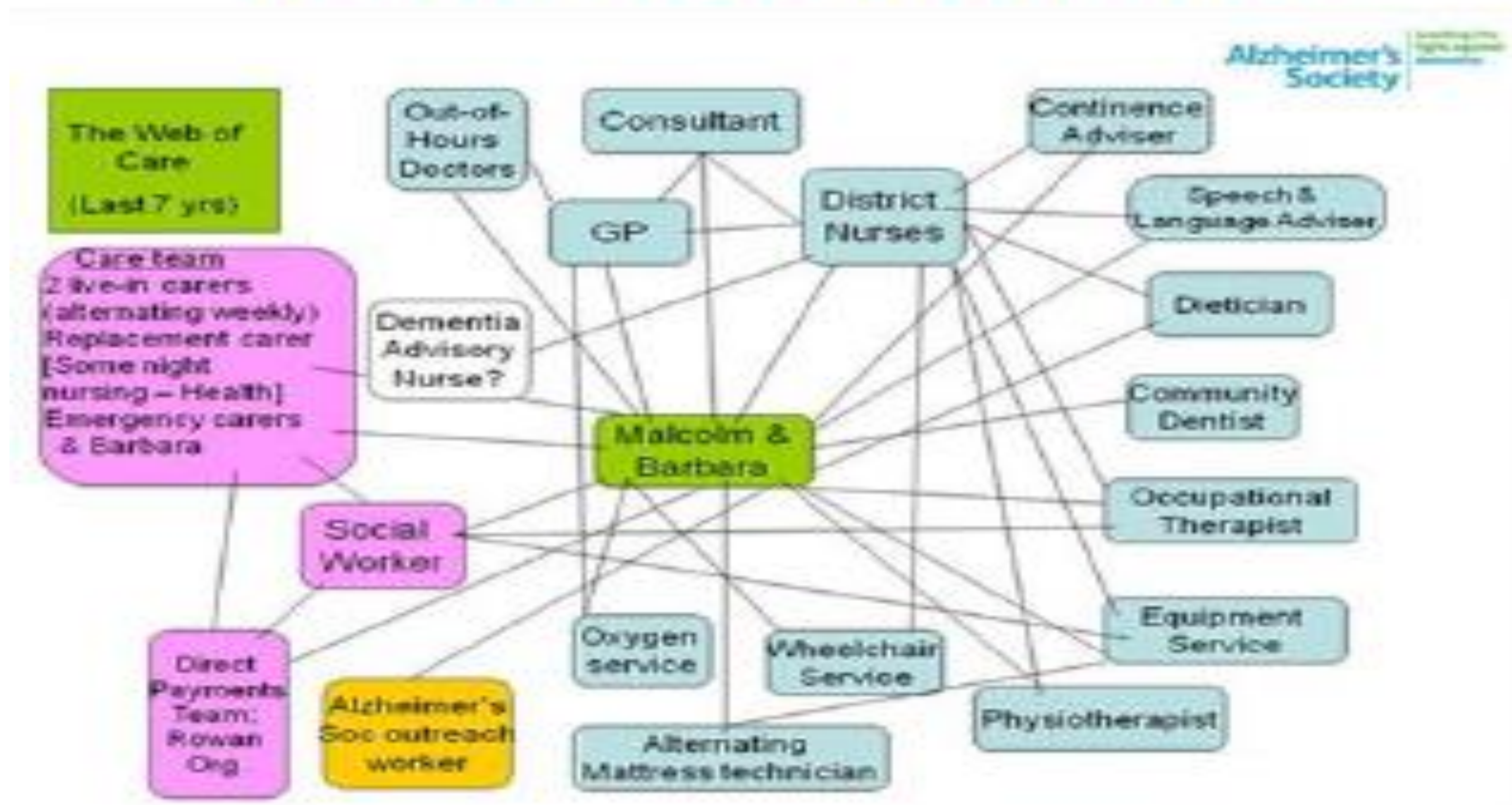
Alzheimer Web of Care



Frontier Economics (2012) Enablers and barriers to integrated care and implications for Monitor

Key Problems experienced

- Silo-based working, governance and accountability arrangements;
- Lack of ownership to support ‘holistic’ care
- Limited involvement of the patient/carer in choices about care
- Lack of enablement and supported self-care and empowerment
- Poor communication and sharing of data between providers
- Fragmented care and treatment with duplication and gaps in care
- Differing advice creating confusion and poor experience of care
- Escalation of dependency and poor system outcomes

Goodwin N, Alonso A (2014) Understanding integrated care: the role of information and communication technology in Muller S, Meyer I, Kubitschke L (Eds) Beyond Silos: The way and how of eCare, IGI Global

Health and Social Care Academy

“My care is planned with people who work together to understand me and my carer(s), put me in control, coordinate and delivery services to achieve my best outcomes”
National Voices, 2012

What Matters to me

- Coordination and continuity of care
- Trusted relationships
- Accessible information and advice
- Good communication with, and between, staff

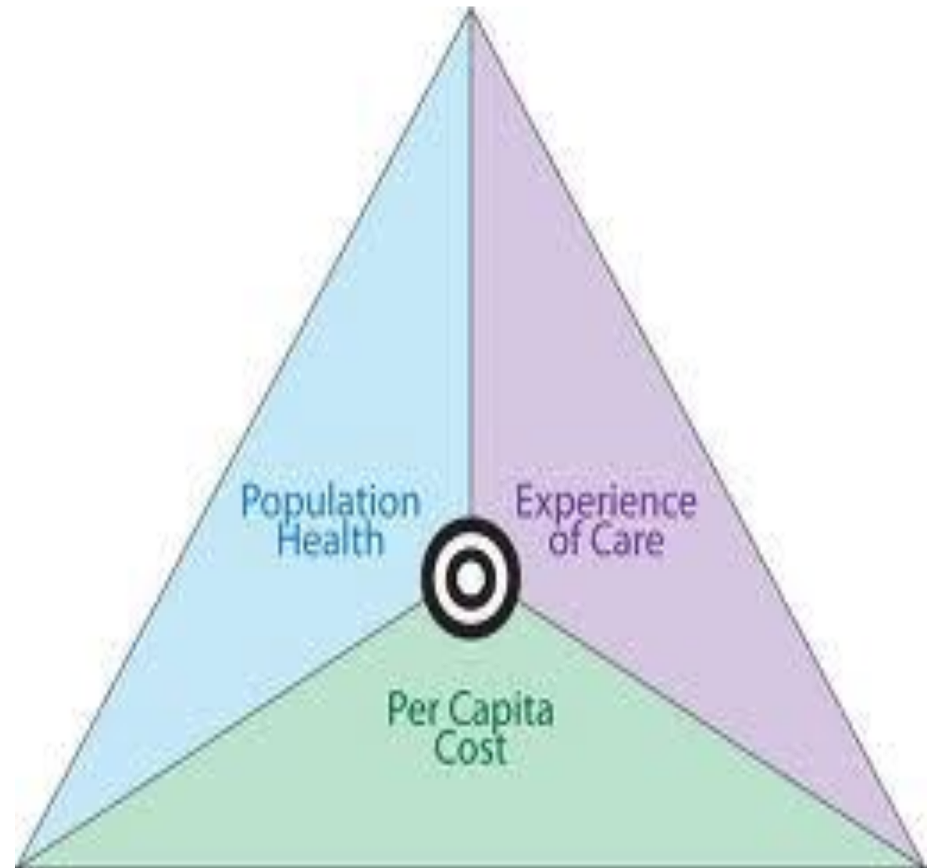
Current paradigm	Future paradigm
System geared towards acute / single condition	System designed around people with multiple conditions
Hospital centred	Embedded in communities and their assets
Doctor dependent	Multi-professional and team based care
Episodic care	Continual care and support when needed
Disjointed care	Well coordinated integrated health and social care
Reactive care	Preventive and anticipatory care
Patient as passive recipient	Informed empowered patients and clients
Self-care infrequent	Self management / self directed support enabled
Carers undervalued	Carers supported as equal partners
Low-tech	Technology enables greater choice and control

Towards Outcomes that Matter

- Integration is the combination of processes, methods and tools that facilitate integrated care.
- Integrated care is when these processes directly benefit communities, patients, carer or service users
- Integrated care is by definition ‘people-centred’ and ‘population-oriented’
- Integrated care contributes to better care experiences; improved care outcomes; delivered more cost-effectively

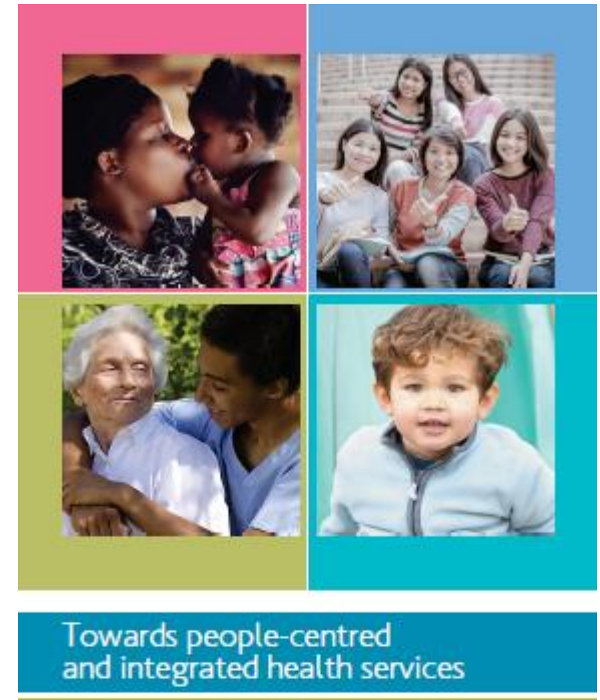
Triple Aim

- Improving the user's and carer's experience
- Improving the health of people and populations
- Improving the cost-effectiveness of care systems



WHO Global Framework on Person Centred and Integrated Health Services

- Creating an enabling environment
- Empowering and engaging people
- Coordinating services
- Strengthening governance and accountability
- Reorienting the model of care



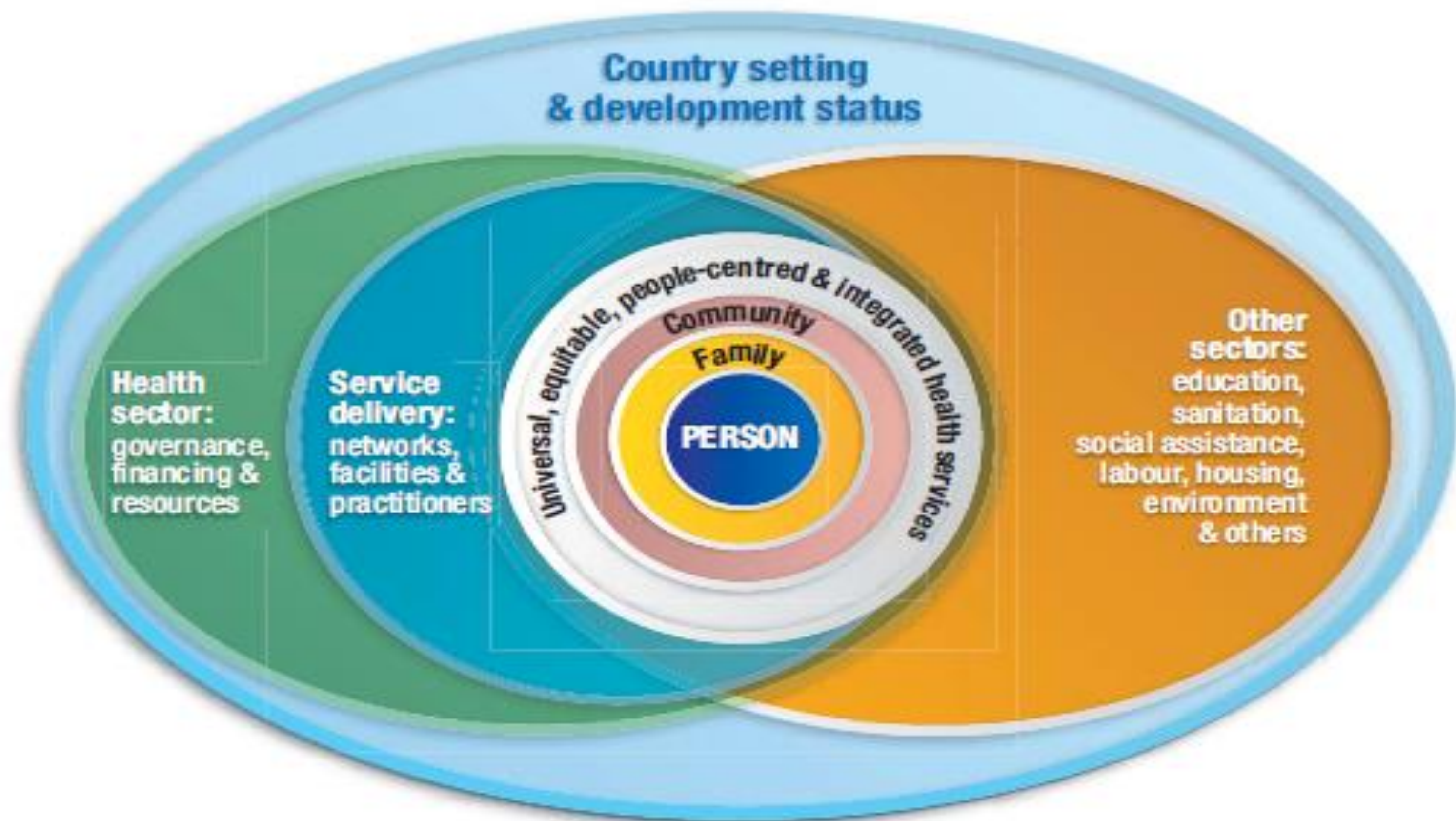
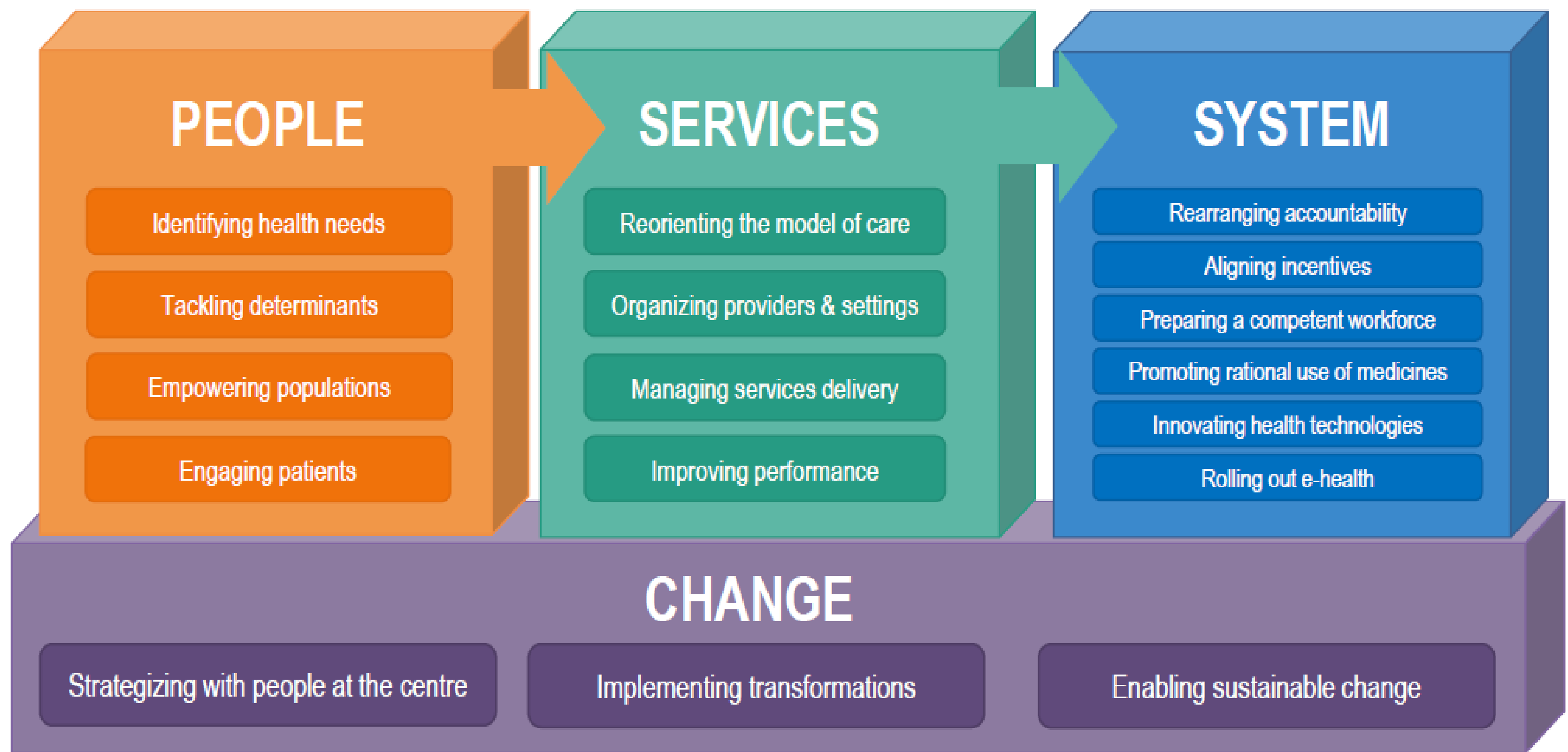


Fig 1. Conceptual framework for people-centred and integrated health services
Country setting
& development status
Health sector:
governance, financing & resources
Service delivery:
networks, facilities & practitioners
Universal, equitable, people-centred & integrated health services
Community
Family
PERSON
Other sectors:
education, sanitation, social assistance, labour, housing, environment & others

The European Framework for Action on Integrated Health Services Delivery



10 Lessons from 85 cases across Europe

- 1. Put people and their needs first
- 2. Reorient the model of care
- 3. Reorganize the delivery of services
- 4. Engage patients, their families and carers
- 5. Rearrange accountability mechanisms
- 6. Align incentives
- 7. Develop human resources for health
- 8. Uptake innovations
- 9. Partner with other sectors and civil society
- 10. Manage change strategically

Lessons from transforming health services delivery: Compendium of initiatives in the WHO European Region. WHO, Copenhagen 2016

Seven Key Lessons: Goodwin 2015

(Goodwin, 2015, forthcoming)

Theme	Characteristics
1 Population-health management	The ability to have an in-depth understanding of the health needs of communities supported through data that can provide intelligence on the priorities that should be addressed
2 Primary and secondary prevention	The ability to support people to live better with their conditions, for example through educational programmes or self-care support
3 Personalised care co-ordination	The ability to plan and co-ordinate services effectively around people's needs helps to overcome fragmentations and improve care experiences ad outcomes
4 Effective ICT systems	Care professionals must be able to communicate well with each other and people must be able to interact effectively with care providers in a way that supports shared decision-making.
5 Integrated delivery system	Care systems need to be responsive to people's needs, especially during times of crisis. The inability of provider networks to respond in real-time means that care co-ordination efforts are undermined.
6 Building social capital and collaborative capacity	Promoting shared values and understanding can help provide the necessary commitment to take integrated care forward.
7 Research and evaluation	Measuring, monitoring and responding to evidence to judge or benchmark care quality and outcomes is essential to improving quality of care through integration

Public Bodies (Joint Working) (Scotland) Act 2014

People are supported to live well at home or in the community for as much time as they can and have a positive experience of health and social care when they need it

- Principles for integrated health and social care
- Integrated governance : body corporate or lead agency
- Integrated budgets for health and social care
- Integrated oversight of delivery
- All adult care groups +/- children's services & criminal justice
- Strategic and locality planning
- Nine national outcomes for health and wellbeing

Health and Wellbeing Outcomes

1	People are able to look after and improve their own health and wellbeing and live in good health for longer.
2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5	Health and social care services contribute to reducing health inequalities.
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
7	People who use health and social care services are safe from harm.
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9	Resources are used effectively and efficiently in the provision of health and social care services.

The right care for me is delivered at the right time

John's mobility is restricted after his recent fall. It's important to him that he maintains his independence and that he can look after himself. John's local health and social care team visit him at home at different times of the day to check he's ok, eating well and taking his medication. All the different services are working well together and this is enabling John to stay in his own home.

My individual circumstances are considered

Graham has a bipolar disorder and a heart condition. His GP referred him to a social worker specialising in mental health, and also the practice nurse who helped him understand his heart condition and how he could manage it. She signposted him to a local cardiac rehabilitation group. Through the social worker, Graham was put in touch with a peer support worker who has helped him to regain his hope

I am able to look after my own health and wellbeing

Following her diagnosis with dementia, Mrs Taylor and her family received a great deal of support from a specialist third sector organisation that the practice nurse put them in touch with. This included helping them to learn about self-management and the chance to join a peer support group in a nearby town. They found the mutual support provided by the group invaluable.

I coordinate my family's health and wellbeing

Jane cares for her husband who has MS and her frail mother who lives over 25 miles away. She has become increasingly depressed, worries constantly about her mum falling and has back pain from lifting her husband. Her GP put her in touch with the social work department. The local carers centre arranged a hoist and care workers to help shower and lift John. A community alarm, bed, chair sensor and falls detector have also been fitted in her mum's home which has lessened Jane's worry.

I get the support and resources I need to do my job well

Sharon is a Healthcare Support Worker and together with her other colleagues in health and in social care, they combine their broad range of skills and knowledge to deliver a joined-up service to those that they care for. This approach makes Sharon feel like she is not working in silo and it can avoid the scenario where the left hand doesn't know what the right is doing. She gets a great sense of satisfaction being in a team where the person being cared for receives the health and care outcomes that matter most to them.

Services and support are reliable and respond to what I say

Mr and Mrs Taylor's GP listened as they described their daily challenges with Mrs Taylor's dementia and diabetes. Mrs Taylor was no longer safe at home and they were both becoming isolated, experiencing symptoms of depression and anxiety. The GP, Dementia Specialist Nurse and an Occupational Therapist worked with the Taylors to agree the support that would enable them to stay well at home. The GP also arranged for a Diabetes Specialist Nurse to help Mr Taylor learn how to support his wife in managing her diabetes.

Support and services I use protect me from harm

Tariq has Down's syndrome, an associated heart condition and visual impairment. At aged 20, one of his biggest priorities was to leave home and live in his own flat. His mother was worried about whether he would be safe living alone. Tariq's social worker arranged for his specialist heart nurse to join one of the transition planning meetings so they could talk through the issues. With Tariq, they agreed that they would find a flat for him where support is available if he needs it, and that any minor risks were worth taking.

I am able to live independently

Since leaving school, Tariq has used a personal budget to employ a personal assistant to support him in his daily life. He has also used a small amount of this budget to pay for membership to his local swimming club, which has helped him to stay fit and meet new friends. Tariq continues to receive support from his social worker, GP and specialist heart nurse. This has helped him to self-manage his heart condition and visual impairment and to access different types of support when he needs it. He now feels confident in being able to live the life he has planned for.

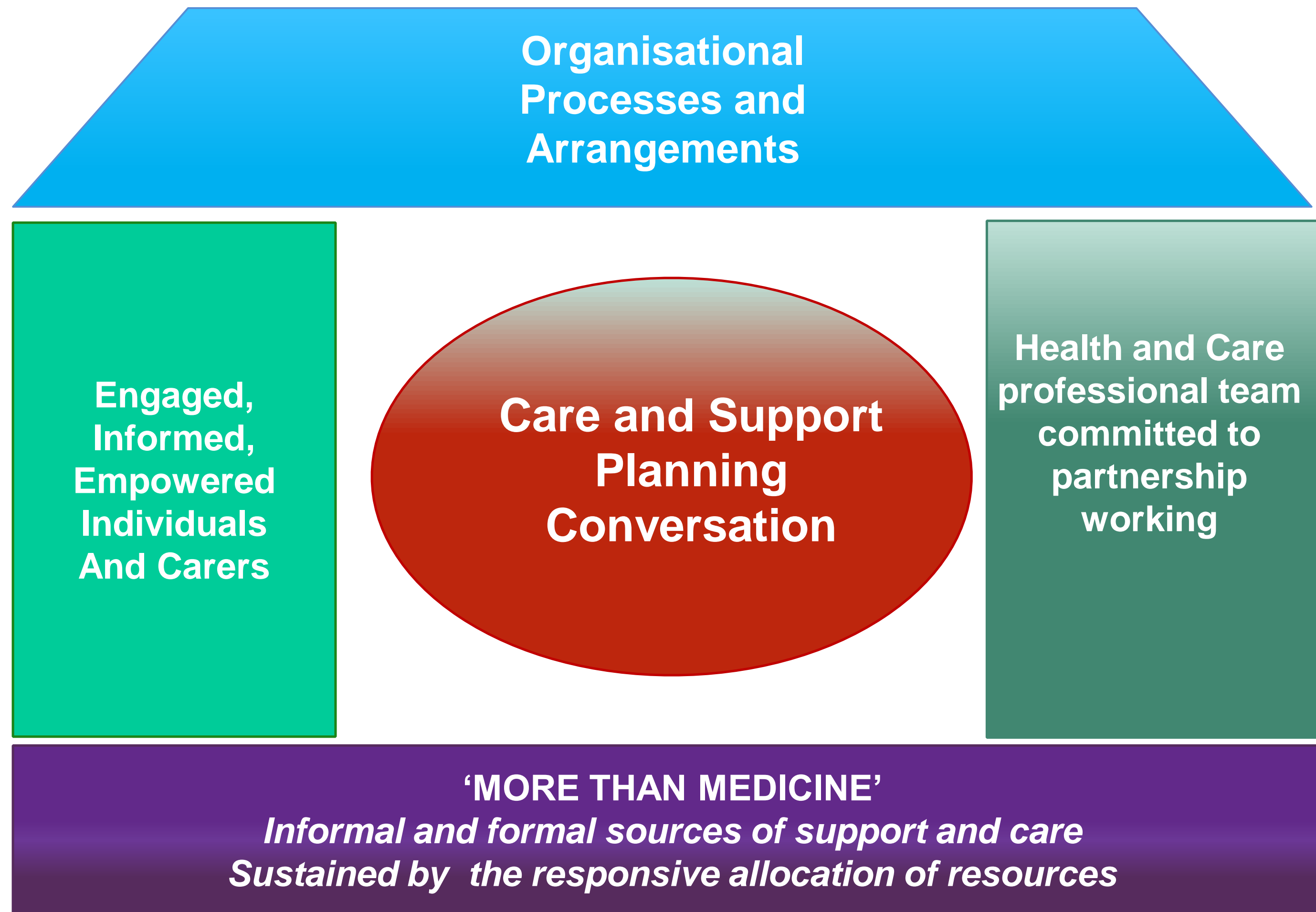
I am supported to do the things that matter most to me

From infancy, Mary has had a muscle wasting condition and now requires 24-7 assistance with all aspects of her daily life to live independently at home. Suselle receives financial support to employ her own personal assistants who support her to live well and to do the things she wants to. It's important to Suselle that she has this choice, control and the flexibility in her own life.

Outcome Level	Focus	Examples
Individual/ personal	Defined by the person as what is important to them in life	I want to be able to get back to the bowling club
Service/project	Defined by a project or service as a key focus to work towards with people	We work with older people to improve their ability to get out and about
Organisational	Defined by a local authority, NHS board or provider as a key area to work towards. Will increasingly be required to be defined across organisations	Improve the social inclusion of the older people we work with
National	Defined by government to focus activity across sectors and organisations	We live longer, healthier lives Our people are able to maintain their independence as they get older and access appropriate support as they need it

Source: Talking Points - Personal Outcomes Approach (www.jitscotland.org.uk)

Scotland's version of House of Care

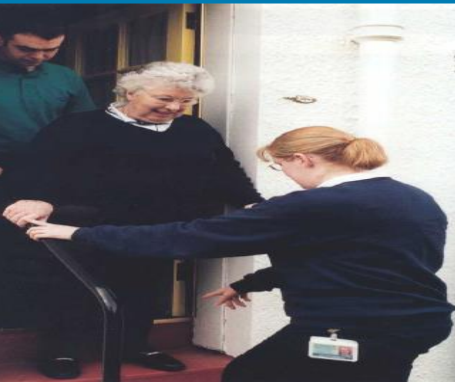


Health and Social Care Integration

Supporting people to live well and independently at home or in a homely setting in their community for as long as possible

- www.scotland.gov.uk/HSCI
- follow us on twitter @scotgovIRC

There's no ward like home



Technology Enabled Integrated Networks of Care and Support

Creating energy for change through an ability to build social capital and promote engagement and learning between partners in care … takes considerable time and effort … but is a necessary process and catalyst for change

- **http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration**

  http://www.jitscotland.org.uk/action-area/multiple-long-term-conditions/

- http://integratedcarefoundation.org/

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