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A Publication for Community Care Partners
by the Agency for Integrated Care

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Aug 2012 - Sep 2015
Last updated April 2016

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- **Integrated Care**

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Integrated Care

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mosAIC's Regular Reads aims to give relevant, useful information to Community Care partners for the improvement of their operations. This section features journal articles that highlight latest research findings as well as good, evidence-based and innovative practices. While the articles aim to keep Community Care partners informed of current developments in the sector, the views and opinions expressed or implied do not necessarily reflect those of AIC, its directors or editorial staff.

The generation strain: Collective solutions to care in an ageing society

Most care for older people is provided by family members but there is a growing 'family care gap' developing as the number of older people in need of care outstrips the number of adult children able to provide it. The plan should thus be to build new community institutions capable of sustaining the changes ahead and adapting the social structures already in place such as family care, public services, workplaces and neighbourhoods. This report provides four major recommendations that should be addressed by the five-year funding settlement across the health and social care sector in the United Kingdom. They include: new neighbourhood networks to help older people stay active and healthy, help busy families balance work and care and reduce pressures on the NHS and social care; care coordinators providing a single local point of contact to replace the 'case management' currently provided by adult social services by 2020; the option of a shared budget to enable those using community care to arrange it collectively; and stronger employment rights for those caring for people who need more than 20 hours of care a week.

McNeil, C., & Hunter, J. (2014, April 24). The generation strain: Collective solutions to care in an ageing society. Institute for Public Policy Research. Retrieved July 4, 2014.

Search for the full-text article at www.ippr.org

Accountable care organisations in the United States and England

The health system in England is facing the challenges of an ageing population, an increasing number of people with multiple, long-term conditions and a difficult financial climate. To meet these challenges, a more integrated approach to care delivery is needed to improve both the quality of care and patients' experience. Today, people need care across different settings such as hospitals, primary care, clinics, nursing homes and home care agencies. Care across settings is not co-ordinated, resulting in duplication of cost and effort, and gaps in information and communication. In the United States, accountable care organisations (ACOs) have been developed to provide a more integrated approach to care. This report examines the different types of ACOs emerging in the United States; their performance; assesses the future for ACOs; and discusses the implications for these developments for integrated care initiatives in England.

Addicott, R., Walsh, N., Ham, C., & Shortell, S. (2014, March 27). Accountable care organisations in the United States and England. The King's Fund. Retrieved July 4, 2014.

Search for the full-text article at www.kingsfund.org.uk

Learning for care homes from alternative residential care settings

This review explores the learning from delivery of care in residential services for children and young people; residential services and supported housing for people with learning disabilities and hospice care; and considers how this can be

applied in care homes for older people. It is highlighted that while there is limited evidence of its effectiveness, there are ideas that could improve the culture of care homes, care experiences, as well as support for staff; there are residential care homes in other sectors that have created positive organisational cultures and increased relationship-based care for improving the quality of care offered; and care experiences can be improved through greater involvement of service users and their families.

Burtney, L., Figgett, D., Fullerton, D., Buchanan, P., & Stevens, K., et. al. (2014, April). Learning for care homes from alternative residential care settings. Joseph Rowntree Foundation. Retrieved July 4, 2014.

Search for the full-text article at www.jrf.org.uk

Care closer to home

This report looks at how community health professionals in New Zealand are working with one another and with hospital-based clinicians to provide more services in community settings that translates to 'care closer to home'. The focus is to keep New Zealanders healthy and out of hospital. It highlights some of the many initiatives that health professionals are undertaking with the aim of providing better, integrated care. They cover: health checks for students at school; support to stay well at home; mental health support in the community; staying on top of rheumatic fever and skin infections; managing medication after a stroke; telemedicine; hooking up to IV drip closer to home; getting back on your feet; tidying up the medicine cabinet and staying well; and taking care of diabetes.

Care closer to home. (2014, February 28). Ministry of Health, New Zealand. Retrieved 1 April 2015.

Search for the full-text article at www.health.govt.nz

The quest for integrated health and social care: A case study in Canterbury, New Zealand

This study looks at how the District Health Board for Canterbury, New Zealand, sets out to achieve its goal of providing integrated care for all. It examines the drivers for change, the leadership values shown by key players and considers the lessons that can be learnt from the Canterbury experience. Systemic changes put in place since 2007 has resulted in reducing hospital admission rates since good-quality general practice was available. However, the study cautions that it takes time to create a new system. In the case of Canterbury, it took six years to complete the journey. In addition, the systems transformation was achieved with a leadership that quickly became collective, shared and distributed.

Timmins, N., & Ham, C. (2013, September 12). The quest for integrated health and social care: A case study in Canterbury, New Zealand. The King's Fund. Retrieved October 2, 2013.

Search for the full-text article at www.kingsfund.org.uk

Evaluation of the first year of the Inner North West London Integrated Care Pilot

The Inner North West Integrated Care Pilot was started in July 2011 to: improve outcomes for patients; create access to better, more integrated care outside hospital; reduce unnecessary hospital admissions; and enable effective working of professionals across provider boundaries. This evaluation, from September 2011 to July 2012, describes the implementation of the integrated care pilot and the initial impact, with the aim of helping the pilot to progress beyond the first year. Among its findings include the fact that healthcare professionals were very committed to the integrated care pilot and that international evidence points to the

fact that integrated care takes years to develop, and a minimum of three to five years is needed for such initiatives to show impact in relation to activity, patient experience and outcomes.

Evaluation of the first year of the Inner North West London Integrated Care Pilot. (2013, May). Nuffield Trust. Retrieved October 2, 2013.

Search for the full-text article at www.nuffieldtrust.org.uk

Integrated care in Northern Ireland, Scotland and Wales: Lessons for England

This report examines the context in which health and social care is provided; identifies policy initiatives that promote integrated care and the impact of these initiatives; and considers the barriers and challenges to achieving integrated care. The authors in each of these three countries wrote their papers which consider these issues and reflect on what England can learn. They alsodrew on their respective experiences of what has been achieved or otherwise. The conclusion is that the structural integration of health and social care will not be beneficial in themselves but has to be done in tandem with other changes, such as action to share information both within the National Health Service (NHS) and between health and social care, and a willingness to provide financial support and adaptability to enable the introduction of new care models.

Ham C., Heenan, D., Longley, M., & Steel, D.R. (2013, July 16). Integrated care in Northern Ireland, Scotland and Wales: Lessons for England. The King's Fund. Retrieved August 22, 2013.

Search for the full-text article at www.kingsfund.org.uk

Nursing home transitions in California

Some people might encounter difficulties moving back from a nursing home into the community, particularly if they have been in the home for a long time or if they are living with a disability for the first time. However, such transitions can be done successfully with the availability of housing coupled with services and assistance from a transition coordinator. This project gathers views of those leaving nursing homes on how the transition process may be further improved and provides policy recommendations based on feedback from consumers.

Nursing home transitions in California. (2013, April). The National Consumer Voice for Quality Long-Term Care. Retrieved August 22, 2013.

Search for the full-text article at http://theconsumervoice.org

Search for "Nursing home transitions in California" / Select second option: "California Consumers for Quality Care, No Matter Where"

Explaining the barriers to and tensions in delivering effective healthcare in UK care homes: A qualitative study

This study explains the current delivery of healthcare to residents living in the UK. It looks at why hospital admissions occur and identifies the barriers and solutions in improving healthcare. Through discussions held at 32 care homes with primary care professionals, it identified five themes: complex health needs and the intrinsic nature of residents' illness trajectories; a mismatch between healthcare requirements and GP time; reactive or anticipatory healthcare; a dissonance in healthcare

knowledge and ethos; and tension in the responsibility for the healthcare of residents. It was found that the healthcare of care home residents is difficult because they have complex and unpredictable needs with GPs and staff having insufficient time or skills and training to meet those needs.

Robbins, I., Gordon, A., Dyas, J., Logan, P., & Gladman, J. (2013, June 17). Explaining the barriers to and tensions in delivering effective healthcare in UK care homes: A qualitative study. BMJ Open. 3. Retrieved August 22, 2013.

Search for the full-text article at http://bmjopen.bmj.com

Care across settings: Challenges, successes, and opportunities

This study argues that while focusing on care delivery in a particular setting improves care in that particular area, it ignores others. The end result is that even successful quality improvement interventions have focused attention on the location of care rather than on the patient receiving that care. But people, especially the elderly and those with chronic conditions do not need care in one setting only. Ideally, healthcare should be of equally high quality across settings, including within an acute care hospital, in an emergency department, at the doctor's office or similar ambulatory setting, in the home, and in nursing homes. And, just as importantly, care should be of high quality through transitions, when a person moves from one care setting to another.

Care across settings: Challenges, successes, and opportunities. (2013, March). Robert Wood Johnson Foundation. Retrieved May 2, 2013.

Search for the full-text article at www.rwjf.org

GPs could become 'integrated care managers' in future NHS

A panel of general practitioner (GP) leaders discussing the future of the profession at the Pulse Live conference agreed that GPs could become 'integrated care managers' charged with navigating patients through the health and social care system. GPs could play the role of gatekeeper to wider public services. Integration was essential for the future as it would reduce demand for hospital admissions and hospital stays. The three goals for health services that were laid out were chronic disease management; improved clinical informatics and genomics; public health gains and integrated care.

Davies, M. (2013, May 1). GPs could become 'integrated care managers' in future NHS. Pulse. Retrieved May 22, 2013.

Search for the full-text article at www.pulsetoday.co.uk

Making integrated care happen at scale and pace: Lessons from experience

This paper is intended to support the process of converting policy intentions into meaningful and widespread changes on the ground. It summaries 16 steps that need to be taken to make integrated care a reality. They include finding common cause with partners and being prepared to share sovereignty; developing a shared narrative to explain why integrated care matters; developing a persuasive vision to describe what integrated care will achieve; and establishing shared leadership, among others. It provides some policy changes that will enhance the local leaders' capacity for action.

Ham, C., & Walsh, N. (2013, March 21). Making integrated care happen at scale and pace: Lessons from experience. The King's Fund. Retrieved May 2, 2013.

Search for the full-text article at www.kingsfund.org.uk

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Patients' experience of integrated care

This report provides a snapshot of patients' and carers' experiences of cancer care in the United Kingdom, based on a survey of people living with cancer and their carers. The report shows that cancer patients need better integrated care and also suggests some recommendations for future action to improve integrated care: securing quicker referral from general practitioners to hospitals for testing and diagnosis; ensuring patients find out the results of their tests as quickly as possible; providing patients with access to a named clinical nurse specialist or other "key worker" throughout the care pathway; supporting patients to feel involved in key decisions about their treatment and care; and putting systems in place to ensure records and test results are available to all clinicians and staff.

Patients' experience of integrated care. (2012, November 20). Cancer Campaigning Group. Retrieved January 2, 2013.

Search for the full-text article at www.cancercampaigninggroup.org.uk

Proposed model of integrated care to improve health outcomes for individuals with multimorbidities

Multimorbidity refers to the coexistence of multiple chronic conditions. Recent studies have shown that there is a high prevalence of multimorbidity among those below the age of 65. Hence, there is a need to develop care models to manage these people effectively for the purpose of mitigating the impact on these individuals and the financial burden on the healthcare system. One such model was implemented in a care facility in Nova Scotia, Canada, that treats those with multimorbidities. It addresses the specific healthcare needs of this complex population with integrated and coordinated care modules that pays attention to the patients' needs instead of the disease. This article looks at the results of a pilot evaluation of this care model.

Sampalli, T., Fox, R.A., Dickson, R., & Fox, J. (2012, October 24). Proposed model of integrated care to improve health outcomes for individuals with multimorbidities. Patient Preference and Adherence. Retrieved January 2, 2013.

Search for the full-text article at www.ncbi.nlm.nih.gov/pubmed

A stitch in time – The future is integration

This report looks at integration and collaboration in health and social care. It highlights the benefits of this inclusive approach such as better quality of patient care, encouraging innovation and development, and cost savings. It cites successful models of integration within the United Kingdom and from Western Europe that have innovative partnerships between the public sector, private sector and independent organisations such as foundation trusts. The organisations cited are Barchester Healthcare; Torbay and Southern Devon Health and Care NHS Trust; Ribera Salud Grupo from Spain; and South Karelia Social and Health Care District of Finland.

NHS Confederation. (2012, June 21). A stitch in time – The future is integration. Retrieved September 7, 2012.

Search for the full-text article at www.nhsconfed.org

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Avoiding preventable hospital readmissions by filling in gaps in care: The community-based care transitions program

The Community-Based Care Transitions Program in the United States aims to reduce preventable hospital readmissions by encouraging partnerships between community-based organisations that provide elder services and hospitals, nursing homes, rehabilitation facilities, and other post-acute care providers. This article describes the structure of the programme, profiles five early adopters and highlights the challenges ahead. It also looks at a number of technology solutions that have been developed to educate patients, track their progress after discharge, and identify gaps in care.

Hostetter, M., & Klein, S. (2012, August/September). Avoiding preventable hospital readmissions by filling in gaps in care: The community-based care transitions program. Quality Matters, The Commonwealth Fund. Retrieved September 7, 2012.

Search for the full-text article at www.commonwealthfund.org

Integrating palliative medicine with dementia care

This article highlights that aggressive treatment and hospitalisation of a late-stage dementia patient may contribute to their deterioration. Instead, comfort care might be the best solution. Palliative care can be integrated with dementia care by incorporating it in the early care planning of dementia diagnosis and maintained until death and later with family and friends' bereavement care. The article looks at assessing and managing symptoms, prognostication in severe dementia, nursing home residents with advanced dementia, advance care planning and communication, caregivers and caring for the family and hospice care. Barriers to end-of-life care in dementia can be overcome by offering patients a blend of restorative, maintenance and palliative care services.

Mehta, Z., Giorgini, K., Ellison, N., & Roth, M. (2012, March/April). Integrating palliative medicine with dementia care. Aging Well. 5(2): 18. Retrieved July 6, 2012.

Search for the full text article at www.agingwellmag.com

Integrating health and social care in Torbay: Improving care for Mrs Smith

This paper focuses on health and social care integration in Torbay, United Kingdom. It looks at the importance of integrated care and provides a background of the work done in Torbay and the system of collaboration that was developed between the primary and secondary care clinicians. It provides a detailed account of the process of change adopted and the experience of implementing a pilot project in Brixham. The perceptions of the team members on the progress of the integrated care project are also documented along with a framework to measure the progress towards integration. The successful factors, doctors' feedback, the opportunities that emerged and the impact of the project are detailed.

Thistlethwaite, P. (2011, March 31). Integrating health and social care in Torbay: Improving care for Mrs Smith. The King's Fund. Retrieved April 7, 2011.

Search for the full text article at www.kingsfund.org.uk