Dear Social Service Practitioners,

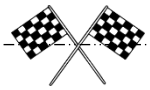
Promoting Integrated Care and Collaboration

It is common to hear the exhortation to promote integrated care and collaboration. What do people generally mean when they say this? It could often mean a combination of the following ideas from being person-centric, having services delivered by one main provider, having two or three systems talk to each other to having a one-stop centre or a one-stop service delivery. As we all know, while all these sound very good, they often include quite different ideas and are not easy to construct or translate into practice. At the national policy level, it is about having adequate resources to ensure a balanced service system where there are good primary and community care services, as well as acute health and residential care provision. It is about using funding to shape organisational and individual responsibilities that result in integrated practice and service models.

Currently, we have a coherent regulatory and inspection system for health and social care but we could do a lot more in the area of supporting family carers by strengthening integration between the formal and informal systems of care. The focus now is on supporting carers to work with the formal structures. The innovative approach would be to have the formal structures be more responsive to the carers who are after all going to carry the heavy lifting for the longer haul after clients are discharged from acute services. With the changing demographics and ageing population, housing policies are increasingly being shaped to support older people by ensuring that communities have appropriate services for them.

Where resources allow, it will be ideal to support innovative approaches that offer choice, flexibility and control by older people. As we think harder about these ideas, we should challenge ourselves to consider new integrated service models, strengthen intensive care management for older people with complex needs and introduce assistive technology to support people in remaining independent in their own homes.

A Starting point



Perhaps one way to begin to take on the challenge is to consider new ways of organising the structures, systems and staff roles, which may sometimes mean combining different roles. Other ideas may include allowing older people and carers to be more involved in how the services they need are coordinated. Yet another possibility is to have ways for integrated information to be given to older people and their carers. Often for carers, information and well integrated information can be an important way to empower them. Starting with the end in mind, the integrated care that we want to create is a well-planned and well organised set of services and care processes that target at the multiple needs or problems of a client or patient. And for most instances, these multiple needs are often complex needs.

What are some areas that the system should minimise in order to achieve greater efficiency? These will include duplicated assessments, separate and sometimes contradictory decisions by different agencies as well as unnecessary delays. Carers (unpaid family, friends and neighbours) offer the majority of support to older people and they too can help with better integrated information if not services.

Poor communication and lack of co-ordination between different parts of services, and across agencies can often result in stress for those who are trying to support the older person. The lack of co-ordination which leads to inefficient use of staff time and exacerbating inter-professional conflict should be sufficient incentive for service providers to collaborate and make better use of resources. Fragmented service delivery can result in bottlenecks and gaps, which puts pressure on existing services and cause unnecessary stress and anxiety for older people and their carers.

Allocation of Scarce Resources

Any service delivery system faces the constraints of public expenditure. And the supply of services is constrained too by difficulties in recruiting staff and changing market dynamics of public and private provisions even without the complication of the interplay of insurance.

So while we re-examine service delivery models, service delivery modes and system, the challenge remains for us to find new ways of focusing expenditure on approaches that reduce the pressures on expensive services, make best use of scarce resources and also improve the quality of life for older people.

Accessibility, Quality and Financial Sustainability

Integrated care for older people therefore aims to improve access and provide a safe quality of service at a level that is financially sustainable.

Accessibility - Integration should aim to streamline access to services by ensuring that older people receive a good, co-ordinated response to their needs at any point of entry into the service system. Where possible, the older person should be served by a regional cluster of services which is a form of 'one-stop shop' even though it may not be at one physical location. The aim of this is to prevent unnecessary admissions to acute care or inappropriate long-term residential care, by providing alternative integrated services and improved support at home. Effective co-ordination among a wide range of agencies and organisations may also provide opportunities for developing communities and neighbourhoods that will support ageing in place.

Quality - Integrated care offers opportunities for better outcomes for older people with complex needs when a holistic approach is taken, services are co-ordinated, and there is continuity of care. This, however, does not necessarily translate into a seamless and timely delivery of care in the home of the older person as there are resource constraints. It is about having safe and appropriate service delivery that is based on assessed needs.

Financial sustainability - Integrated approaches in care for older people with multiple or complex needs should result in more efficient and cost-effective solutions for health and social care systems.

Barriers to Integration

Sometimes, just by removing or lowering the barriers to integration will also result in improvements. Some of these include separate funding systems for health and social care, cultural differences and problems related to organisational, structural and professional boundaries. Given these considerable challenges, it is important that integration is not seen as the answer to every issue but one that focuses on resolving problems for which some kind of co-ordinated response is essential. These are problems that have been described as 'wicked issues' because they are hard to define and have unclear causal chains and complex inter-dependencies.

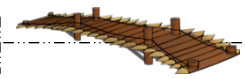
Starting Integration with a Shared Vision

One might ask why having a shared vision is particularly relevant for integration in social care? This is critical as social care is provided by a range of organisations and sectors – statutory, voluntary or non-governmental, private, professional and community – that have very different perspectives, agendas and values. The challenge then is how to bring about this "working together" amongst the many organisations and sectors. Governmental agencies can play a crucial role in getting the systems more aligned if not integrated as a first step and in getting systems and possibly networks to adopt a collaborative and integrated working style. Integrated care is a means to an end and the end goal and rationale for it needs to be embraced by the various agencies. There is no doubt that we all share the noble desired outcome of making sure that older people have a comfortable quality of life and that they and their carers are listened to, have some say in the services they use, and are in control of their situation and in the setting of their choice.

Range of Services

Almost every wish list often show that a pre-condition for integrated care is to have a full range of services available, across health, social care, housing, transport, education, leisure and other sectors, and to ensure that they are accessible to users. Services need to be delivered across organisational boundaries, with clear access points and pathways, and with ways of assessing and guiding older people through them. In essence, services need to work together as a single, comprehensive, integrated whole system. 'A whole system approach which places the older person at the centre will benefit older people by providing the right support, at the right time and by addressing the entire range of their needs' (Carrier 2002)[1]. The irony is that there is perhaps no model of good integrated care because good integrated care comes from the context of co-ordination and a commitment to working together as 'integration' has a number of dimensions. Integration may be described along a spectrum ranging from tolerance to co-operation, joint planning and in our context inter-ministerial and national committees comprising both governmental and non-governmental representatives, as well as partnerships and joint projects.

Working across Processes and Systems



While we have a shared direction and approach towards integrated care, there is much that can be done to join up processes to enable structures to work better.

[1] Carrier J (2002). Integrated Service for Older People. Building a whole-system approach in England. London: Audit Commission.

As a guiding principle, we need to keep in mind that integrated care has to be appropriately targeted and that integration is not the solution to all problems. For sustainability, policies must support differentiated responses to complex and simple needs to ensure cost effective and appropriate responses.

It is in working across processes and systems where professionals and social administrators can play a role in making collaborations and shifting of perspectives possible in order to make integrated services a reality. Collaborations happen when there is experimentation in processes and systems. Integrated service can happen when we adopt a more user-centric perspective and re-deploy resources in systems. We begin to bring about integration when we are prepared to share "power and control over processes and systems" and help these to adapt to respond better especially to complex needs.

Practical Perspective on Coordination

Every forum, platform and consultation asks for coordination. Coordination that is highly dependent on a relevant one-stop service centre, be it physical or virtual, will involve high cost and will be manpower intensive. This would make such a vision unattainable. So what is a practical and sustainable approach to coordination? The objective to achieve access to services must therefore be that individuals and agencies who are able to navigate the system themselves. This will mean a more direct access to appropriate help. This is possible in most instances where information is fairly readily accessible and the way to get the help is fairly straight forward even though one needs to manage the expectation of waiting and processing time. Managing expectations must include giving applicants and the potential users a sense of the time required for the whole process. For a small cluster of individuals and families with complex and multiple needs, having an agency to lead in case management or coordination will help because of the difficulties in getting systems to adapt to the unique circumstances. This is a targeted approach. For this matter, a case with complex need or a case with multiple needs may not require coordination at the systems level when agencies are able to negotiate or broker the schemes and processes to help the families.

Furthermore, with the setting up of IT infrastructures and the sharing of information and data being made more adaptive for service delivery, agencies can play their respective roles and take on the responsibility of facilitating and helping those who need help. As practitioners, we can play our part in the various roles and responsibilities we have to help clients, patients, service users and their supporters. We do this collectively by pulling together services, both formal and informal, to enable as many of those with needs to continue to draw on their strengths and resources with complementary external resources to live a life of dignity.

Ang Bee Lian
Director of Social Welfare
4 April 2016

Other References:

Banks, P., and Care and Management of Services for Older People in Europe Network (CARMEN) (2004). *Policy Framework for Integrated Care for Older People.* Lenus, the Irish Health Repository. London: The King's Fund. Retrieved from https://www.kingsfund.org.uk.