

There has been an extensive analysis of the factors which have been identified as contributing to the promotion of integration. Such an analysis makes use of research and evaluation studies, policy analysis and reports and work by practitioners and professional bodies. Most of the analysis in this chapter relates to practices and lessons from experience in England. Relevant work related to the rest of the UK is discussed in the chapters on the devolved administrations. While it is possible to arrange the analysis into a few general headings, the categories can overlap or do not add much clarity in specifying the details of promotional factors. Therefore the chapter is organised under a wider number of headings based on the major factors under discussion as promoting integration.

Financial support

The promotion of integration has generally meant a degree of change in administrative structures and service delivery with related training and change costs and most initiatives or pilot projects requiring substantial investment. This is accompanied by expectations that integration will produce more cost-effective services and overall financial savings. Some government assumptions of savings have been ambitious with the Better Care Funding initiative expected to secure £1billion savings (National Audit Office, 2014). Adequate financing of integrated care has been seen as a way of reducing the need for more expensive hospital provision. The delivery of funding to assist integration has to take recognition of the different financial systems for health and social care and that users often have to pay charges or are means tested for social care, in contrast to health which is free at the point of delivery. The main way of funding collaboration has been through pooled budgets between the NHS and local authorities. Pooling of budgets has the potential for more flexibility and more sustainable funding. There has been support for the argument that health and social care budgets should be used more collectively (Oldham, 2014, p. 65). Joint funding has been a major enabler of integrated care and has facilitated networks and coordination of services and better use of resources. Pooled budgets can also promote innovations, for example, in funding career breaks. The Better Care Fund meant that a major component of the UK Government's policy to achieve integration was based on financial incentives through a single pooled budget embracing a shift in spending on acute services towards integration based prevention, personalisation

and self-directed care. Plans submitted by local authorities and Clinical Commissioning Groups tended to pool a higher amount than envisaged, leading to more centralised control (Humphries, 2015), although not actually composed of new money. Other funding arrangements supporting adult social care have the potential to increase resources for integration in England. The social care precept in council taxation has contributed as well as permitted increases in council tax. There has also been the development of direct payments and personal commissioning programmes, through which individuals can organise their own care.

Information sharing and communication

There was widespread support for the view that ‘information is the key enabler of integration’ (NHS Future Forum, 2012; Local Government Association, 2016e). The Pioneers initiative in 2015 highlighted information sharing as a key challenge along with the need for frameworks and materials to support intensive information sharing (NHS England, 2016d, p. 74). This suggests the value of sharing individuals’ data including other documentation and emphasises that health and social care professionals need to understand why information should be shared, how this is beneficial, and how information should be used to promote more integrated decision-making. Access to shared information facilitates a more holistic and comprehensive approach, helps to improve the quality of services and enhances the safety of care and support. While face-to-face communication and conversations about people may be of value, electronic records are seen as the key to success meaning the sharing of information through compatible IT systems (Cameron et al., 2015, p. 10) and specifically the interoperability between NHS IT systems extended to social care (Priest, 2012, p. 20). Progress in the sharing of data between health and social care has not gone smoothly (Ham, 2009, p. 10), while the Oldham Report (Oldham, 2014, p. 10) called for more ready access to information to improve joint commissioning and evidence bases. Technological advances will enable further advances in integrated planning and working across the system with initiatives such as mapping all individuals’ interaction with health and social care. IT systems can promote effective communication between the members of multidisciplinary teams (Goodwin, 2012, p. iv) and effective communication about people and tracking users’ care records is a major way of enhancing joint working. Care records enable integrated care provision through the viewing of an individual’s total care needs, increasing the complementary nature of care across organisations, assisting assessment and removing duplication. The shared care record has been seen as absolutely fundamental to working better together (NHS England, 2016d, p. 54). Some sites in the Pioneers initiative created an integrated care payment forum (NHS England, 2016, p. 75) to discuss payments for outcomes or standards or whole care pathway funding. In England data sharing agreements between NHS bodies and local councils are necessary (New Local Government Network, 2016, p. 44).

Advances in the use of technology can also improve communication with patients, clients and carers, mainly through providing access to information or advice increasingly on a personalised basis. It has been reported that there is a wealth of evidence from Pioneer sites in England using technology, particularly

assistive technologies, to monitor people outside of traditional care settings (NHS England, 2016, p. 58). These technologies, remote patient monitoring, and video conferencing can operate to detect early deterioration, improve care at home and contact with professions. Telecare uses electronic equipment to measure vital signs at home and can alert carers. Telecare is a telephone based monitoring service that can include electronic sensors so people can live safely and independently. Northern City Delivery Telehealth offers schemes to help meet users' entire health and care needs (NHS England, 2016, p. 60). Assistive technology can also be used to promote prevention. The city of Leeds also developed telecare technology for emergency use by older people and telethon for people with chronic conditions.

Leadership and management

Effective leadership is widely referred to as a necessary requirement to initiate and deliver integrated care successfully. Efficient and stable leadership is seen as essential to develop partnership arrangements (Priest, 2012, p. 13) and manage multidisciplinary teams. There is a requirement to lead staff engagement in a joint enterprise in one direction, facilitating the inclusion of senior and middle management. Professional bodies, such as the Association of Directors of Adult Social Services, have endorsed the view that strong leadership and commitment from the top help integration (ADASS/NHS Confederation, 2013). The leadership of integrated projects requires the replacement of traditional leadership approaches, needing different knowledge, skills and behaviours and an emphasis on the importance of place (Fillingham and Weir, 2014). Leadership needs to adapt to complex cross-organisational structures and deal with change, improvement, and relationships across diverse teams. Leadership to promote integration has been seen as characterised by a desire to create collective identity and ownership, sustained long-term commitment, and boundary spanning across organisation levels and professional identities (Petch et al., 2013, p. 13). Leadership has also been related to instilling a vision and Oldham (2014, p. 19) describes leadership as key to developing a persuasive vision and a shared outcome among those involved.

Leadership is multi-layered and required both within and between organisations and across professional boundaries. The NHS Future Forum (2012) noted: 'Whether at the level of commissioning or provision, the development of shared goals, culture, plans, governance, procedures and practices is a complex and difficult task, often requiring years of effort from leaders and staff.' Leadership is required to ensure that there is commitment and alignment within and between organisations. It ensures that there is clarity about aims and objectives, vision and direction of travel. It enables an understanding of broad, long-term objectives rather than a focus on individual or team successes or targets. For optimal effectiveness, initiatives spanning a number of organisations or boundaries require strong leaders with the legitimate authority to lead. Creating and communicating a shared vision of integrated care is of the utmost importance. A collective leadership culture is characterised by collaboration both within and

between organisations. Health and social care is delivered by a broad range of organisations with differing values, cultures and governance. Shared leadership enables working in partnership with the best health outcomes for service users. It requires that leaders work collaboratively to achieve agreed collective objectives rather than simply focusing on their particular components (West et al., 2014). A 2012 national evaluation of the Integrated Care Schemes identified strong leadership as pivotal to their success. Strong leadership was identified as central to the success of pilots. Whilst leadership was required at all levels, the importance of clinical leadership was highlighted; GPs and other clinicians had the ability to engage with their professional peer group regarding the credibility and feasibility of the intervention, and to motivate participation.

The NHS Confederation (2016) addressed the dimension of leadership in negotiating the complex system of public and personal accountability of transcending organisational boundaries and responding to local needs. Williams (2012) has argued that the leadership role needs to focus on four main areas: promoting common purpose; developing a collaborative culture; facilitating multi-agency teamwork; and supporting team communication and skills. Williams also emphasised the value of trust in inter-agency teams building a collaborative culture, the value of knowledge as a powerful driver, and the value of encouraging teams to share leadership functions. Miller et al. (2010) suggest leadership of integration activities requires an ability to simplify complexity and to tell a coherent story, and suggest a special leadership paradigm within the complex and fragmented health and social care landscape. Attention is also drawn for leaders from a social care background to confront their historic position of having less influence than health staff. However, a rather different emphasis is suggested by Close (2010) who sees the leadership role for promoting integration as requiring bridging rather than bonding, in pursuing collaborative leadership. Health and Wellbeing Boards will aim to provide strong collective leadership direction which appears to be a significant challenge across different organisations and territories (Baggott, 2013, p. 83). While there has been strong support for a commitment to collaborative working and new leadership skills or style it has been seen as an under-researched area of practice (Fillingham and Weir, 2014, p. 31). Timmins (2015) drew attention to the view that NHS leaders had relatively little training or experience in managing systems as opposed to organisations, although that was necessary given the complexities of integrated care.

A shared vision and culture

A shared vision and shared values have been regarded as a strong integrative driving force for some time (Hudson, 2007) and described by Goodwin (2013, p. 22) as 'the development of a clear joint vision shared by all stakeholders'. This entails stressing the importance of developing support for the vision, also described as a culture of integration (Ham, 2009, p. 11), including a shared view of why integration matters. An essential starting point is a 'shared vision and commitment from a leadership coalition to create significant drive and

momentum' (Local Government Association, 2016b, p. 6). Securing the commitment and understanding of staff to a vision, aims and outcomes has been identified as crucial to effective joint working. Collaboration is part of the vision or culture necessary as a key ingredient to make a success out of integration. This is a vision of a common purpose reflecting shared ownership and it has been noted that this is particularly important as full structural integration is not common (Weatherly et al., 2010). An important dimension of a clear joined-up vision is a holistic focus with an ability to see the whole picture (Miller et al., 2010). Such a holistic dimension means stepping away from a medical or social care silo and embracing a vision and culture stretching across boundaries. It helps to promote integration if the benefits and outcomes are a shared goal. It has also been suggested that a shared language is important in identifying common goals for the whole integrated system or objectives to work towards, described also as a narrative that can be used and adopted to shape services (National Collaboration for Integrated Care, 2013). A number of other considerations may promote a clear joined-up vision. All staff need to see how an overall vision is productive and that a strong narrative based on the vision should give compelling support for integration (Monitor, 2012, p. 12). The vision and narrative should apply at both national and sub-national levels and have a long-term commitment to integrated working.

In a document produced by four main bodies in England, the NHS Confederation, the Local Government Association, ADASS and the NHS Clinical Commissioners, a shared vision of integrated care is held to have as essential characteristics holistic care, co-production, commitment to change, a focus on prevention, local governance, common information and technology, and integrated workforce planning (NHS Confederation/Local Government Association, 2016). The promotion of integrated care is also seen as dependent on the acceptance of cultural change in the implementation of the vision. Petch (2012) argues that there is a need for the acknowledgement of cultural change, as seeking to retain an existing culture leads to a struggle for dominance. The drive to deliver integrated care and support should lead to the emerging of a new cultural identity, informed by a clear vision. This view is challenged somewhat by Glasby (2016) who suggests successful joint working depends on working with different professional values and cultures to avoid a lack of trust which requires meeting each other halfway. A pragmatic suggestion has been that as health and social care staff often speak different languages, the role of 'system translators', to communicate the benefits of integration, instil new ways of behaving and promote change, is significant (New Local Government Network, 2016, p. 56).

Education and training

More integrated professional training for those who work together has an important role in breaking down barriers. Team building and multidisciplinary decision-making are seen as areas for attention, whether through training or forums for professionals to understand the concept of integration and encourage

changes to practice, sharing information and joint accountability (Kassianos et al., 2015). A flexible approach to in-service training with ways of utilising staff, resources and information is regarded as valuable. An integrated care workforce also requires training in areas such as unified assessment and care coordination (Goodwin, 2013, p. 5). Multidisciplinary working has to be encouraged in a context of strong traditions of specialism. The idea of communities of practice has also been mooted as a way of promoting collaborative working. Communities of practice are groups of six to 10 practitioners in frontline practice who meet regularly to identify learning for improved practice (Cornes et al., 2013). Communities of practice involve people interacting, undertaking joint tasks, and sharing insights. They are valued as acting to overcome fragmentation and isolation, encouraging face-to-face contact and building collaborative networks (Miller et al., 2016, p. 177).

Education in working together has not been developed into a major driver of integration, particularly at undergraduate level, but it has been operating at the level of local education and training boards (McCricrick and Hughes, 2013). There have been developments in postgraduate training, particularly for health and social care management working across shifting boundaries, inter-professional working and facilitating integration. Williams (2011) notes the role of trained boundary spanners, operating across and within collaborative areas with particular competencies, knowledge and attributes, including managing in different forms of organisation, and dealing with multiple accountabilities. With the need to grow the social care workforce and develop new qualifications a range of skills has to be taught, including making judgements, counselling, and developing skills related to the practice of integration (Dickinson, 2014). New roles and ways of working which are relevant for integrated care can be built on the existing skills of the workforce or new boundary-spanning skills (Gilburt, 2016). Working on a basis of skill-mix or equipping individual staff to use skills which cross traditional professional boundaries is still problematic. A study of key localities with initiatives promoting integration found extensive training and team development programmes evident across all the sites including training staff in new ways of working with shared records, identifying gaps in roles, and involving staff in new care modes and evaluation (Local Government Association, 2016e, p. 4). Other programmes have been developed on a continuing educational basis for health and social care managers and commissioners (Miller et al., 2016, p. 170). A number of bodies and initiatives have been set up to produce resources, reports and guidance for use and consultation. The Better Care Exchange is a collaborative network enabling collaboration, information and knowledge sharing, and the sharing of good practice for delivering integrated care. Support is supplied also to Health and Wellbeing Boards and to Clinical Commissioning Groups (SCIE, 2016). NICE has also developed a local practice collection as a national resource, while the Integrated Care and Support Exchange (ICASE) supports local authorities, Health and Wellbeing Boards, Clinical Commissioning Groups and GPs. The National Collaboration for Integrated Care and Support also provides resources to promote integration. Local Education and Training Boards (LETBs) were set up under Health Education England (HEE) and have been given a key role in promoting a joined-up

approach across health and social care (McCrick and Hughes, 2013). This has meant looking at skill-mix, including developing health care related skills in social care services linked to integrated care pathways.

Co-location

Co-location of health and social care staff has been reported to be an important, even necessary, element in the success of joint working (Cameron et al., 2015, p. 10). Co-location leads to informal contacts, easier communication and facilitated learning across professional boundaries. Priest (2012) states that the creation of co-located integrated teams is one of the most commonly cited ways to improve working together and suggests that co-location should be considered in all areas where integration is operating and seen as a key factor. Co-location in England will usually involve staff from different organisations and therefore is important in promoting working collaboratively. Co-location also has advantages in facilitating important informal contact and developing relationships. The argument has been made that integrated teams must have co-location and alternatives a weakness (Hudson, 2011, p. 7). It has also been argued that there is mixed evidence for the importance of co-location (Maslin-Prothero and Ben-nion, 2010). A further advantage claimed for co-location is that it can provide a single entry point to care, and help operate care pathways and holistic assessments (Weatherly et al., 2010, p. 21).

Flexible roles

A commitment to the introduction of flexibility in work roles has been supportive to promoting integration (Cameron et al., 2015, p. 10). The opportunities for this type of innovation are more likely to occur for frontline staff within multi-agency teams or in aspects of domiciliary care or intermediate care. Flexibility means that there is a willingness to bend traditional professional boundaries with skill-mix and staff substitution, for example, with social care workers allowed to take blood pressure or samples. A more open approach may arise in reactions to the changing needs of users or in rapid responses, in forms of role substitution or sharing (Goodwin, 2013, p. 13). Generic working practices are more achievable in well-established systems of integration. Flexibility in response may also be identified in developing creative and innovative integrative delivery to problems, although this assumes the freedom to take such decisions and training in risks. Adaptability is also desirable in identifying priority and in setting key performance standards for projects and services (Oliver et al., 2014, p. 55).

Person- and user-centred

An emphasis on the person-centred focus of integrated care has been seen as promoting integration through the close involvement of users or putting people at the centre and making the care system more navigable. The user focus has

been seen as important in driving forward the integration agenda. Developments of individual care plans, pathways and care coordination are valuable aspects of integrated approaches. Alakeson (2013) suggests that developments at the level of the individual suggest that the individual user is best placed to integrate care, and this may be as significant as structural integration. There is broad agreement that the assessment process, care coordination and interdisciplinary process must involve providers and users. Protocols of guidance are needed for the multiple providers in relation to risk, preventative care, elective and unscheduled care. Gregory (2015) refers to the example of Trafford Clinical Commissioning Group and Trafford Council having a person-centred approach through robust shared guidelines; care protocols; consultations between professionals; technological support; and a focus on quality assessment.

Care pathways and care coordination are one major manifestation of a person-centred approach. Care coordination tends to flourish at the level of multidisciplinary care teams and at local and neighbourhood level (Goodwin et al., 2013) although there may be variations in the holistic nature of care coordination. It is also easier to promote person-centred integrated services in some areas of need, for example, dementia. Shared decision-making, close communication, organisational support, and risk-taking are identified as advantages of integrated care for dementia (Woolrych and Sixsmith, 2013). Also developing has been the idea of a single named care coordinator or care navigator who would act as a first point of contact who leads in assessment, and liaises and works with all health and social services to ensure that providers tailor person-centred services (NICE, 2015). Guidelines for a care coordinator would apply to older people with social care needs and those with multiple long-term conditions. The most radical form of user control is through personalised and individual budgets which have the potential to bring together health and social care individual budgets providing a vehicle for more holistic whole person care. Personal budgets and personalised care planning can provide opportunities for integrated care commissioning and a pilot study, an Integrated Personal Commissioning Programme, has been launched (NHS England, 2015). This operates through a partnership between NHS England and the Local Government Association and nine demonstrator sites were created to redesign models of care for people with complex needs. A caveat is that person-centred planning does not always result in person-centred outcomes.

As a general principle the importance of the engagement of users has been well established but more so in social care delivery than in healthcare (Beresford, 2016). It has been argued by Ham (2009, p. 1) that the journey to integration should start from a focus on service users. The Department of Health's Future Forum analysis (2011) saw users and carers as key drivers of integration which can contribute to building support for integration. Initiatives in promoting integration have usually sought to embrace user engagement (Goodwin et al., 2013, p. 18). Public engagement has an important role as well in explaining and justifying the priority given to integration. There is a further benefit in the general promotion of integration through participation and co-production leading to greater user and public satisfaction (Cameron, 2016, p. 9).

Legacy of joint working

A previous history of joint working has been seen as supportive of integration, enabling new initiatives to be built on an existing foundation (Cameron, 2013, p. 4). A history of successful joint working is an advantage in taking processes forward, although Weatherly et al. (2010) note that the advantage is difficult to quantify. Lotinga (2015) has also noted that local history and context are crucial in shaping the nature of local joint working initiatives. The major developments in the Manchester city region since 2016 have been based on an integrative approach in operating since 2010. It can be suggested that any movement to a degree of joint working where previously there were clear silos between health and social care will be of value in promoting integration.

GP engagement

Securing the support and active engagement of GPs in integration initiatives has been well established as a measure that would help realise the aims of joint working, cracking old boundaries, creating a groundswell of involvement, and improving the relationship between GPs and social workers (Lotinga and Glasby, 2012). The anticipated benefits are well rehearsed but there have been barriers to major engagement. The growth in the numbers of people with chronic multiple conditions has provided some imperative. Studies have suggested how GP involvement can be encouraged or improved. Problems with lack of resources or staffing in GP practices can be tackled through more collaborative arrangements between neighbouring practices (NHS Future Forum, 2011, p. 25). Successful attempts have been recorded of more joint working between GP practices and local community care staff (Tucker and Burgis, 2012). There can be better guidance at encouraging general practice to adapt more rapidly to provide a platform (Goodwin et al., 2010, p. 9). It has been suggested that more 'hard wiring' can be put in to promote joint working, with teams of social workers linked to GP clusters and using small-scale opportunities to establish integrationist activities. Mainstreaming closer relationships is viable as GPs are often keen to improve collaborative working (Mangan et al., 2014). In England CCGs and HWBs have been important structures although with integrated initiatives in promoting GP engagement.

It has been stated that the wider importance of good professional relationships should not be underplayed as part of a strategy to promote integration and create staff satisfaction (Priest, 2012, p. 14). While building relationships between colleagues is always beneficial, it is especially advantageous to build bridges between health and social care staff and related professionals and to create integrated team working and understanding (National Collaboration for Integrated Care and Support, 2013). Wistow (2011, p. 9) even describes effective personal relationships and mutual confidence as important lubricants of integration.

Evidence and research

It is a truism that a strong foundation of evidence will promote the acceptance and introduction of integrated care. Priest (2012, p. 13) notes that the most important evidence will relate to the linkage between integration and improvements in patient care. Also closely related is the identification of examples of good practice. Measuring outcomes and experiences is an essential task and use can be made of the national outcomes frameworks for both the NHS and adult social care. It has been suggested that research and evidence are more valuable and useful than central government guidance (ADASS/NHS Confederation, 2013). Analysis can also be made of existing data sets. The National Collaboration for Integrated Care and Support (2013) has urged all localities to strengthen the evidence base. The sharing of knowledge and evidence has also been seen as a key cornerstone of effective integration, in areas such as multidisciplinary case management (Morris, 2012). More research and evidence are necessary to match the priority now given to promoting integration and to make up gaps in research. The evidence that integration can improve clinical and care outcomes is stronger than evidence of improving efficiency (Bevan Commission, 2013). Areas where research is needed include the impact of independent providers on integrated approaches. Effective mechanisms are required to make research findings and their implications for practice readily available and the Social Care Institute for Excellence, the King's Fund, the National Audit Office and other organisations play a significant role. Monitor (2012, p. 11) encouraged networks to share learning, evidence and ideas. The National Audit Office (2014, p. 45) also urged the integrated care Pioneers to collect and share evidence. The importance of research and evaluation is demonstrated in the extensive work that the government has commissioned on the Pioneer and Vanguard projects.

Integrated teams

The operation of integrated teams, usually in Great Britain within a divided health and social care structure, has become one of the most high profile aspects of integration. Integrated teams have been described as the most frequently evaluated models of integrated working (Cameron, 2016, p. 8). Working in teams seems central to putting integration into effective operation and is the main vehicle for creating multidisciplinary capacity drawn from different professional groups. Williams (2012, p. 557) sees the transfer of tacit knowledge between professionals in teams as the 'key to integration'. In some service areas integrated teams are now well established, for example, community mental health teams, and there have been rapid advances in crisis intervention or rapid response teams, in hospital discharge teams and also major developments in reablement teams. It has been suggested that there is no evidence that one form of management is inherently superior but Petch (2013, p. 21) sees as the key issue a shared team ethos and relaxing into more inclusive identities. There have also been initiatives with forms of integrated commissioning teams in England

(Crossman, 2015). NICE (2015) has also begun to give detailed guidance on the nature of community based multidisciplinary support and recommend the composition of mental health teams. Integrated care teams operate on a localist basis whether on geographical administrative hubs or centred on GP practices or community health centres. Beacon (2015) suggests that the GP practices, nurses and social workers developing stronger relationships increases the capacity of integrated care teams. Other evidence suggests that effective integrated teams need a strong team ethos (Williams, 2012), while Cornwell (2012) argues for the importance of team leaders and for high status and remuneration. Evidence from Northern Ireland suggests that team leaders can and should be drawn from any of the professions making up the team (Heenan and Birrell, 2009). Although cultural factors are important in the success of integrated teams (Fillingham and Weir, 2014, p. 30), more technical factors of access and exchange of information, scale of resources and co-location are also important. Team working itself can bring benefits through reducing errors, sharing risks and greater job satisfaction, although simple labelling as a team does not automatically ensure success (Miller et al., 2016, p. 174). The most effective configuration of integrated teams and specialist initiatives may also depend on local needs while localities may decide on different priorities or innovations (National Collaboration for Integrated Care and Support, 2013, p. 8). Integrated neighbourhood teams have also developed with wider interventionist services (NLGN, 2016, p. 58). As integrated teams become well established they can provide continuity in care and practice. Some allowance, though, has to be made for the fact that organisational arrangements may not produce a totally holistic approach or eliminate all differences in professional approaches. Integrated teams provide an arrangement to construct new services, for example, a frailty service.

Commissioning integrated services

The process of commissioning services is of importance in supporting the growth and effectiveness of integrated provision. The models of integrated commissioning for health and social care can range from all services to specific groups or conditions or localities. The main model of joint commissioning in Great Britain has been between a local authority responsible for social care and a health board or trust and has encompassed joint arrangements or one body having delegated responsibility. Oliver et al (2014) argues that a single holistic commissioning plan reflects best real integration. Oldham (2014, p. 14) argues that commissioning whole person care is one of the drivers that has sufficient power to change fragmented provision. In practice commissioning in England takes place mainly between Clinical Commissioning Groups and local authorities. Recent reforms have enabled local communities to increase their focus on commissioning and ensure the kind of care and support that best meets their needs (National Collaboration for Integrated Care and Commissioning, 2013). Health and Wellbeing Boards have a key role in building alliances to support and promote integrated commissioning and to scrutinise local commissioning plans (Humphries and

Galea, 2013). Greater local control and flexibility have also been encouraged over commissioning and pooled budgets (EY, 2015). Engagement with the providers of services is a further dimension as it will often be the providers who are directly delivering the integrated services. Thus the standards for integrated services have to be made specific in contracts, even implying new types of contract (Goodwin et al., 2013, p. 10), especially with independent providers who have more limited awareness and experience of integrated principles. The commissioning bodies also have responsibility for ensuring the quality of services and the standard of outcomes. Oldham (2014, p. 23) suggests that commissioning has focused on inputs rather than collective outcomes. Independent providers can also be supported and encouraged to work and learn from each other (Local Government Association/NHS Clinical Commissioners, 2015). The lesson being developed is that successful integration is dependent on good commissioning.

Other promotional factors

A number of other factors have been mooted as having a role, if not such a significant role, in promoting integration as the factors discussed above.

Integrated decision-making and governance

This refers to the idea that there should be unified decision-making at senior management level as opposed to multidisciplinary cooperation at senior level. Following the Flexibilities legislation there was a focus in England for a period of joint senior appointments covering health and social care across trusts and local councils. This strategy has rather fallen into disuse. Attention has moved to either creating integrated structures with integrated joint posts, as in Scotland and Northern Ireland, or bringing together major decision-makers. Managing care coordination has been seen as a crucial enabler but not an easy task (Oldham, 2014, p. 36). Robust and clear governance arrangements are cited as essential enablers in integrating initiatives for undertaking joint work across organisations (Local Government Association, 2016b, p. 48). New organisational forms may have to be developed to facilitate joint action on integrated care in Great Britain. Specialist community trusts, joint boards, networks, agreements, business units are all possibilities. Enabling more localised decision-making has also been advocated to have all integrated arrangements responsive to local or devolved needs. Inter-professional collaboration needs equal influence and respect and to avoid imbalance against social care.

Frontline integration

It can be argued that integration is promoted by ensuring frontline staff are merged in an integrated ethos as far as possible, meaning, practically, that there should be contact between professionals in wards and offices on the front line (Cornwell, 2012). Also important is the integrated ethos as a way of thinking about providing care, rather than as a specific plan. There can be variation in

the depth of integrated working across organisational boundaries (Petch, 2012a, p. 78). Also relevant is the degree of flexibility that can be made operative in frontline working between staff groups.

While there is considerable research, comment and guidance on factors likely to promote integration, it is important to note the practical influence of key pieces of legislation as discussed above. The Care Act 2014, which placed a statutory duty on local authorities to carry out their care and support functions, integrated these services with those provided by the NHS and provided a new legal and policy framework for integration. In Scotland and Wales new legislation has also introduced statutory requirements to promote integration and in Northern Ireland legislation in 2009 included a statutory duty to promote integration. Legislation does set a framework for the production by respective administrations of regulations, guidance, funding, strategies, research and quality assurance.

The factors that have been identified as contributing to the promotion of integration can be categorised into seven themes/groupings and are set out in Box 8.1.

Box 8.1

Groupings of Factors Promoting Integration

Managerial.

- Leadership
- Shared/joint appointments
- Operation of integrated teams
- Collaboration between partner organisations

Resources.

- Government funding, well resourced
- Pooled budgets and resources
- Local budgets
- Special funding initiatives, for example, Better Care Funding

Integrated commissioning, integrated working and practice.

- Inter-professional working
- Sharing information and data
- Holistic approaches
- Flexible approach to tasks
- New integrated initiatives – reablement, rapid response, hospital discharge, dementia

Education, training and workforce integration.

- A shared vision and narrative
- Educational courses, initial and post-qualifying
- Training in integrated working
- Facilitating exchange of good practice
- Using workforce efficiently

Research and evaluation.

- Funding and support for research projects
- Range of research organisations working in area
- Extensive process of evaluations and reports
- Monitoring of outcomes performance
- Comparative research analysis
- Dissemination of research findings

Government support.

- Legislation and regulations
- Guidance and policy strategies
- Monitoring operations
- Organisation of pilot studies

User participation.

- User and career support
- Mechanisms for user and public participation
- Principle of co-production
- Personalisation and support for integration
- Commitment to person-centred services

The discussion in this chapter does demonstrate the complexity of determining the main factors that promote integration as well as indicating the range of views and factors which can be discussed. If the six main factors identified in this analysis are listed, four are perhaps not unexpected, which are: available finance; exchange of data and shared records; leadership; and research and training. The other two may not be anticipated, which are: a vision; and user involvement.

Some commentaries have suggested that there is evidence that strong relationships are the most important factor in leading successful integration, reflecting the core requirements to overcome traditional boundaries (NHS Confederation and Local Government Association, 2016, p. 20).

Conclusions

Reaching some conclusions on the essential factors that promote integration is an exercise that requires some reference to areas of uncertainty. There is not major support for the view that full structural integration on the lines of the Northern Ireland model is necessary to promote comprehensive integration. There is stronger support for the view that structural integration alone cannot deliver effective services (Petch, 2011, p. 6) and it has been argued that organisational change alone is unlikely to be sufficient to drive greater care coordination and integration at a clinical and social care level (Goodwin et al., 2013, p. 6). A body of evidence also shows that successful integration through partnership initiatives and pilot programmes has not been easy. There can be some disagreement

over whether some mechanisms actually promote integration or are a barrier to integration. (Glasby, et al 2012), for example, preserving line management for staff from different professional backgrounds. It has been noted that what works to promote integration in some areas may not work in other areas, because of variations in relationships or contexts (Ham, 2009). A review of the experience of the new pioneers to date found the focus on enablers such as information and technology, workforce, organisational forums, communication and engagement, and contractional mechanisms (NHS England, 2016, p. 25). It can be argued that no single element by itself has been shown to be effective (Morris, 2012, p. 257), the 'no single silver bullet' perspective (Wistow, 2011, p. 9).

It is possible to identify the key enablers without a clear list of priorities. It can be noted that some of the more successful examples in England have been pursuing integration for a lengthy period of time. In England there is still an ongoing process of experimentation and evaluation in identifying the most significant enabling factors.