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A Realistic Evaluation of integrated health and social care for older people in Wales, to promote independence and wellbeing: Interim report

A Realistic Evaluation of integrated health and social care for older people in Wales, to promote independence and wellbeing: an interim report

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(Views expressed in this report are those of the researchers and not necessarily those of the Welsh Government)

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Table of contents

List of tables

List of figures

Interim Executive Summary

1. The purpose of this report is to describe the context and the mechanisms that are used to deliver integrated health and social care service that promotes independent living and wellbeing for the older population in Wales. Ultimately, the final stages of this project will address an acknowledged gap in outcome evaluations of services that other work, existing or planned, has not addressed.

2. In June 2010 a qualitative baseline study was undertaken into a range of integrated health and social care approaches in Wales. The study was undertaken jointly between the Social Services Innovation Agency (SSIA) and the National Leadership and Innovation Agency for Health Care (NLIAH) and produced the report: *Study into integrated approaches to service delivery that promote independence and wellbeing* (March 2011). As a follow-up to the SSIA/NLIAH study, the current study re-visited the projects outlined in the report, interviewing key stakeholders to develop a more detailed understanding of whether, how, why and in what circumstances these sorts of services are effective. This interim report, commissioned by the Public Service Leadership Group's Effective Services for Vulnerable Groups Programme (ESVG), provides a critical overview of each of a range of integration projects/services, comparing them to an idealised 'testable theory' of how integration should work.

3. A realistic evaluation of the evidence gathered through the interviews is used to inform the development of an evaluation framework for integrated health and social services for older people. ESVG intends for this framework to become widely adopted as means of robustly and consistently evaluating services, while accounting for local differences in approach, context and mechanisms.

4. This interim report aims to:
    a. gather secondary research, policy and other evidence for input into a realist evaluation of the variety of approaches towards integrated care with older people;
    b. conduct primary research among local government, health and other stakeholders, in order to better understand the current landscape around service integration and delivery; and
    c. suggest an integrated health and social care evaluation framework for measuring the impact of service delivery.

5. The first section of the report is a summary of a literature review related to policy, strategy and provision of integrated health and social care services for older people, using literature sourced nationally across Britain and locally in Wales. A thorough synthesis of theoretical and descriptive evidence is used to develop a testable theory of best practice for implementing and deliver integrated health and social care. This testable theory will be used to set the standard to compare Welsh models of integrated care against. This work will be ongoing until mid-2014.

6. The second section is a continuation of the realistic evaluation, using stakeholder contributions as primary data, by gathering reports of the process and outcomes of integrated service delivery in Wales. A small selection of services and projects in Wales are outlined in detail (although not evaluated in this study), based on a small number of interviews with key stakeholders, undertaken in autumn 2012. While the integration agenda is currently fast moving in Wales, the evidence gleaned from existing models of care provision in 2012 is still very insightful. It is used here to generate and compare against a theoretical model of ‘best practice’ (known as the testable theory in realistic evaluations) and areas within programme delivery that can be improved are identified.

7. The ways in which the programme models of care are evaluated are used to inform the development of an impact evaluation tool.

Objective

8. To accumulate examples of good, efficient and effective integrated health and social care practice from literature and stakeholder interviews. This information will be used to develop a conceptual model of integrated care, with a view to constructing an evaluation framework that can be used to assess the impact of services being delivered to older people.

Method

9. A realist review of health and social care literature for older people was undertaken and interviews with stakeholders engaged in delivering health and social care to older people carried out. An initial scoping exercise was carried out to gather and synthesise current research and government documentation related to integrated health and social care services for older people in Britain and, more specifically, in Wales. Only literature from 2008 onwards was used, as the scale and pace of integrated service development has dated older research. Social Science databases were used alongside the English, Scottish, Northern Irish and Welsh Government websites, The Kings Fund Library, Nuffield publications, Department of Health (DoH), National Institute for Clinical Excellence (NICE) and the Personal and Social Science Research Unit (PSSRU) website, with associated links. Search terms used were a combination of the following: 'evaluation/impact/assessment of integrat*/intermediate/co-ordinated/joint commission* health AND social care for older people'. Information was excluded if the work was only descriptive of single service models, information was included if the models of care delivery described were based in Britain, used both health and social care services for older people and included some form of service evaluation. Grey literature and citation tracking were also used to complete the search.

10. Prior to the next stage of the study, ethical approval was sought for in-depth, semi-structured interviews, to be conducted with professionals involved with the organisation or delivery of integrated health and social care. The insight of stakeholders is an important aspect of a realist

evaluation. Indeed, evidence gleaned from a variety of sources is key to the synthesis of knowledge across the spectrum from theory to practice. Interviewing policy-makers, practitioners and other stakeholders builds a picture of the context, or reality, of delivering health and social care from differing and emerging view points.

11. Part of the overview of current health and social care practices in Wales was to revisit, though not evaluate, the 13 projects detailed in the above SSIA/NLIAH report cited above (page 3). The 18 individuals interviewed originally were approached to enlist their co-operation for a follow-up interview. 10 individuals responded. Those who were no longer in post gave contact details of another appropriate person to interview. 10 interviews with strategic leads were carried out using the original semi-structured interview schedule detailed in the SSIA/NLIAH report (2011:pp. 49). The questions focussed on 5 key themes: background; outcomes; impact; leadership and support; and the future. Some respondents were not fully able to address some of these key themes in detail. Occupying a strategic position left some respondents too far removed from the frontline working and processes of delivering care. In these cases, respondents, deferred to colleagues who were better placed to contribute specific service delivery knowledge. A further 18 semi-structured interviews were conducted with managers and service professionals from the 7 health boards, a selection of the 22 local authorities, and third sector organisations. All 28 interviews were conducted either face-to-face or by telephone. Interviews lasted 40 minutes to an hour and, with consent, were digitally audio-recorded for later transcription and analysis.

12. Interviews were used as an additional data source for the realistic evaluation, to ascertain what worked for whom (or did not), why it worked, how it worked and in what circumstances effective integrated care was delivered. The interviews were conducted to establish, from practical experience, areas of good practice and areas of practice that were less productive and effective or created barriers to service delivery. Although the use of personal accounts has inherent limitations, and our conclusions

on each of the projects are based on one or two interviews, this approach generated useful evidence that allowed us to build up programme theories of effective integration. The service delivery models/programme theories were, generally, individually tailored by project managers and implemented by practitioners to meet the local needs of the community. These programme theories were used to test whether integrated service models in Wales met the aspirations of the testable theory. The testable theory is a model of the idealised, national strategic expectations of care delivery that aspires to promote independent living and wellbeing in Wales' older population. The testable theory is based on what is understood to be best practice in integrated care.

13. The testable theory of best practice of integrated care suggests that integrated health and social care services should be integrated at directorship, executive, (macro) managerial (meso) and frontline staff (micro) levels. Examples of the mechanisms used in practice at these various levels are joint strategic roles at directorship (macro) and managerial (meso) levels, introducing joint budgets (macro) co-locating staff (meso and micro), developing single points of access and referrals (meso) and improving communication between professionals and services (micro). Examples of the expected outcomes that this organisational model would produce in a variety of contexts were as follows: a seamless service delivery between health and social care; satisfaction with care for both the cared-for and the carer; easier care delivery; enhanced wellbeing; maintaining independence; reduction in inappropriate hospital admissions; and older people being able to live longer and live well in their own homes, all at a reduced cost to the public purse.

Results

14. The programme theories, when compared to the testable theory of best practice for delivering integrated health and social care, revealed:

- The Conceptual or idealised model of integrated care formed the testable theory and can be described as a streamlined organisational structure. This idealised service structure can theoretically: a) respond to policy and strategies aimed at integrating services; and b) influence the joint delivery of health and social care. The current working models of effective integrated care in Wales, described by the programme theories, are a bottom-up approach to delivering care. Facilitating frontline, joint or integrated service delivery is an effective approach to introducing integrated health and social care. Changes to the way care is delivered gives immediate positive results, both for the service and the service user (according to anecdotal evidence from stakeholder interviews). Effective integrated structural and organisational development happens as a result of changes to service delivery, not as a precursor to service delivery changes.

- In these early days of developing integrated care service models in Wales, the context for effective care delivery is when there is a combination of strong professional leadership at the frontline of care delivery, flexible and supportive management, and 'buy-in' to the service model by GPs/primary care.

- The mechanisms that facilitate good integration are those that foster good communication between the ‘care’ and ‘cure’ sectors, are inclusive of statutory, private and third sector care and include housing and transport. Effective services are well resourced with appropriate, mixed disciplinary teams of staff. Service users have access to an identified personal key worker, referrals have swift responses and professionals who make referrals can speak to other professionals to ensure confidence with continued care.

- Good outcomes of care are not necessarily reflected in the current government performance indicators. A reduction in acute bed days, as a currency to evaluate the success of new community health and social care service delivery models, is an inadequate and unresponsive measure that

does not accommodate the increasing care needs of those with complex and chronic conditions that can be concurrent with older age.

Headline findings

A new silo of care.

a. Our evidence suggests that single budgets and co-location have the potential, though not the intention, to create another silo/sector of care. Integrated services have the potential to become standalone services in their own right with time-limited patient contact and their own referral and discharge pathways.
b. Facilitating and developing inter-professional and intra-professional working relationships is an effective way to deliver joined up community care.

Communication.

c. Unsurprisingly, effective communication is at the heart of effective integration both between and within services.

Care in the community.

d. General Practitioners (GPs) need to be integrally involved with the integrated service process. Indeed, primary care involvement is the key to providing seamless services and continuity of care.
e. However some interviewees reported that Local Health Boards (LHBs) have bypassed GP involvement when setting up new services.

Budgeting for care.

f. Separate financial arrangements between health and social care can cause competitive budgeting. Typically, February and March will see increased numbers of frail older people in acute care, instead of home care, as the local authority social services budgets become constrained towards the financial year-end.
g. Reviews of care provision are often not undertaken, as the process is time-consuming, unwieldy and involves a considerable amount of

paperwork. Departments, it was felt, do not have the capacity to carry out regular reviews. Some people are left, therefore, with care provisions that may be unnecessary, inappropriate and expensive.

h. Integrated care services may prove to be more about ‘cost containment’ than cost savings.
i. The considerable costs of management and administration need to be accounted for in the overall cost of delivering integrated services.
j. Employing managers to manage other managers adds layers of bureaucracy at considerable expense and does not necessarily make a difference to frontline care delivery.

Technology and care.

k. Currently information technology appears to limit the potential of integrating working. Health and social services’ databases are incompatible. Sharing information is therefore limited by consent and location of computers within separate services.
l. Remote digital data collection is not often possible, meaning there is often a delay in sharing up-to-date information across and within services.

Integrating management overseeing integrated care.

m. When integration is initiated by a top-down process, the actual delivery of integrated services was said to be delayed. Future evaluations will need to consider whether, or not, the considerable time and cost investment of restructuring directorate, senior management and budget strategies creates a more stable infrastructure for the development of frontline integrated service provision.
n. When integration is initiated through a bottom-up process integrated care is actively achieved at service delivery (micro) level. This is generally achieved efficiently and effectively and inexpensively by facilitating communication between professionals and services.

Planning the provision of care

o. Most integrated services are currently 'reactive services' that respond to acute care and community needs, with little input into planned, pre-emptive and preventative care.
p. The cycle and flow of integrated care is initially reactive; the cycle of change augments the realisation that pro-active care can contribute to avoided admissions, enabling longer stays in the community.
q. The third sector is very good at providing relationship-centred care and community connections. Both aspects of this type of care are linked positively to wellbeing and are currently under utilised. To strengthen the role of the third sector, organisations need support to build their capacity and resources to deliver care.
r. Co-location of staff is often a feature of co-ordinated seamless care.
s. Geographical spread and different geographical boundaries of working between GP surgeries, local health board primary care community staff, and local authority social care staff, can lead to the breakdown of communication and service delivery.
t. The LHBs are working with up to 5 different local authorities each, causing unnecessary duplication of time and effort to deliver a single health and social care service.

Evaluation of care.

u. Evaluation is often based on bed days saved, to offset finances between acute care and community care. Using bed days as currency does not necessarily reflect the success of a service. The increasing size of the over 65 population will inevitably manifest itself in increased demand for services. The number of bed days used by over 65s will increase and the number of bed days saved will also increase, proportionate to the increase in the population who could potentially use acute services. Percentages of people receiving days of acute care, compared to days receiving community care, may be a more appropriate measure to reflect the effectiveness of service delivery to promote independent living.

v. National policy and strategy aimed at reducing the number of acute beds is counter-intuitive to the demographic health needs of an ageing population whose care is based in the community. Acute health needs of the increasing population of older people will still require that these needs are met by secondary/tertiary care. Cost savings that are based on a reduction of over 65 acute bed day usage, in a growing population of older people, will not reflect the impact of integrated care delivery, even if the proportionate reduction in admissions is maintained and the average length of stay in hospital is reduced.

w. Lack of appropriate national outcome measures and standardised benchmarking of figures causes insecurity around the accuracy of using local performance measures to report on service delivery.

Future implications for new ways of delivering health and social care

15. The integrated care agenda is an effective vehicle to promote change in health and social care delivery.

16. Commissioning care between the statutory sector and the private sector and third sector, creates an environment that can capitalise on the opportunity to restructure and manage organisational change from frontline delivery of care to effective management and joint strategic roles at directorship level.

17. Joint budgeting beyond Section 33 arrangements is considered as one of the next necessary steps to break down the barriers to integrating health and social care provision in the statutory sector. However, the unintended short and long-term consequences of such an action would require close scrutiny.

18. A single IT system is a pre requisite for effective integrated care. In the absence of a fully integrated system consideration should be given to the development of an integrated platform for use between the 7 local health boards and the 22 local authorities to promote an integrated care agenda.

19. Ultimately if the local health board and the local authority are going to introduce services that share input into an individual's health care, then it would be sensible to work with GPs. Ultimately, through government mandate/governance the public's health care is the GP's responsibility. GPs contribute to over 90% of all health care contacts and should, therefore, play an integral role in integrating services, as they have to take on the risk and responsibility for patient care.

20. The production of a robust integrated health and social care evaluation framework is an essential step. A framework would act as a guide to integrated care services, as to how the impact of care delivery on service users and the impact of systemic changes on services can be assessed. There was a call among our respondents for the government to standardise, benchmark and produce measures and evaluation practices to be used across Wales to measure the service user benefit, effectiveness and cost of delivering integrated care.

21. Data collection for evaluation is imperative but it needs to be incorporated in, and be part of the referral, assessment, review, discharge and readmission process of service delivery. Any development of an evaluation framework needs to take into account the depth and variety of data that already exist at local, organisational and national levels. Any additional collection of data could seriously impact on the quality and quantity of care given to the service user as it distracts attention away from care-giving. Data collection beyond these circumstances puts undue time pressure on those delivering frontline services. This ultimately affects care and adds to the financial burdens of both the NHS and local authorities.

22. Service provision in the community, by default, is based on the assumption that older people would like to remain in their homes. It does not take into account the meaning older people attach to their homes at certain transitional stages of their health-related quality of life. Appropriate care

delivered in the right place, at the right time, to and by the right person is the key to good quality care for older people.

23. Put simply integrated health and social care appears to be most effective when it is facilitating communication, rather than organisational restructuring, and appears to be more about cost containment rather than cost reduction and investment.

1 Introduction

Overview and Objectives

This report is a realistic evaluation (Pawson & Tilley, 2011; Wong, Westrop, Pawson & Greenhalgh, 2013; Pearson, Hunt, Cooper, Shepperd, Pawson & Anderson, 2013) of the various ways in which integrated health and social care services are provided to older people in Wales.

The study is an important element of the Welsh Government's work on service integration for older people. The Effective Services for Vulnerable Groups Programme, as part of its 'Promoting Independent Living' workstream, applied to the Technology and Strategy Board in 2011 to fund a Knowledge Transfer Partnership, to examine methods for assessing the impact and costs of integrated health and social care for older people.

Like all 'realistic' approaches, the evaluation is structured around a theory of how integrating health and social care is meant to bring about more favourable outcomes for services and the older people they serve. A review of literature is used to build a testable theory - an idealised concept of integrated care - and this conceptual model is then tested against existing and emerging service models in Wales. These models are described as the 'programme theories' underlying the realistic evaluation. In line with realistic evaluation methodology, the evaluation is structured around the context (C) of care, and the mechanisms (M) used to deliver care that contribute to the outcome (O) of care. This is known as the CMO configuration. Thus the report is a three part process of evaluation:

1. a scoping exercise to understand the policy context of integrated health and social care;

2. a formative evaluation, to understand the mechanisms that have been developed to deliver integrated health and social care; and

3. a summative evaluation culminating in the development of an evaluation framework to assess the impact and outcomes of integrated care delivery.

The first part of the report the (scoping exercise) comprises a targeted, limited review of the academic and government literature on the theories and working practices of delivering integrated health and social care in the UK. It explores 'why' care should be integrated and ‘for whom' integrated care delivery models will work well. A working, testable theory will be developed and will take into account the heterogeneity of services delivered to older people (mechanisms) in a wide range of cultural, social and economic circumstances (context) to establish 'what' is considered ideal or best practice to achieve the desired outcomes of integrating health and social care, namely independent living and wellbeing.

The second (formative) part of the report is an outcome analysis of the mechanisms of delivering integrated care in different contexts throughout Wales. This section looks at a number of integrated health and social care services developed for older people across Wales to establish 'what' is it about a particular service that works well and ‘for whom’ the service proves most beneficial. Semi-structured interviews with service leads, managers, professionals delivering services and data audits are used to gather service information on where, how and why services are delivered and to whom.

The underlying hypothesis/assumption is that:

1. models of health and social care where services are integrated are thought to be more conducive to preserving older people’s independence than separate services;

2. living independently is better for older people’s wellbeing; and

3. integrating services can improve both the effectiveness and efficiency of service delivery, thus producing the same or better outcomes at lower cost.

More specifically, the context and mechanisms in which services are delivered to older people vary across Wales and the expected outcome of any new intervention with an older person is to promote independent living and wellbeing as far as possible. The second outcome is to deliver a good service cost effectively, and, by implication extend that service to more people.

The third (summative) part of the evaluation will bring together the theory and the practice to develop a suggested framework to evaluate the impact of delivering integrated health and social care against the pre-set, desired outcomes of cost efficiency, effectiveness and benefit; independence and wellbeing. This evaluation framework suggests there is a difference between the counterfactual (the absence of the integrated service model) and the outcomes of a new model of service delivery. The evaluation takes into account the actual outcomes of delivering a service or intervention, compared to the expected and unexpected outcomes for both the service user and the service deliverer. The final section of the realistic evaluation will produce a refined theory of integrated care that aims to develop an explanation of why aspects of contexts, mechanisms and outcomes work together in reality in Wales. The third stage will report separately in mid-2014.

Background

In 2011, the Public Service Leadership Group's Effective Services for Vulnerable Groups Programme (ESVG), commissioned a qualitative baseline study into integrated approaches to service delivery that promote independence and wellbeing. The study, commissioned to inform the direction of the Programme's work on 'Promoting Independent Living', was carried out and published by the Social Services Improvement Agency and National Leadership and Innovation Agency for Health (SSIA/NLIAH) in March 2011. It identified three practical steps that would aid the scale and pace of integrated health and social care delivered to older people in their homes:

- firstly enabling and facilitating ongoing learning transfer between new models of working;

- secondly, supporting organisations to become more effective at measuring the impact of their approaches to service delivery; and
- thirdly, engaging government departments such as SSIA and NLIAH to support the elements of good practice identified through the study.

In response to these conclusions, and acknowledging the pivotal importance of impact and cost measurement, the Welsh Government sought funding from the Technology Strategy Board for a 2-year Knowledge Transfer Partnership (KTP) with Swansea University's Centre for Innovative Ageing. A KTP academic Associate was recruited in July 2012 to design and carry out detailed research into the integration of services for older people, with a particular emphasis on ways of assessing outcomes and impacts on both the services and older people. These outcomes were to be measured over three parameters, namely wellbeing, independence and cost.

Promoting independent living is one of the key work streams of the Effective Services for Vulnerable Groups (ESVG) programme. Also the two parameters it focuses on, namely wellbeing and independence, are the core features of the success of delivering the policy and strategy laid out in *Setting the Direction* (2009), *Sustainable Social Services* (2012), and the *Social Services Wellbeing Bill* (2013). The government agenda is driving forward the delivery of integrated health and social care services that actively promote independent living for older people for longer. The main aims of this agenda are to provide more health and social care closer to and within the home in order to:

- keep older people who do not need acute care out of the acute care setting, thus reducing inappropriate use of hospital beds;
- keep older people connected to their home and community, with the aim of reducing the possibility of isolation and loneliness;
- promote ownership and control over personal care needs;
- create an independent not a dependent care culture;
- provide holistic care from home to hospital to home/residential care;

- reduce duplication and increase awareness of services delivered across all sectors to older individuals;
- streamline services and care to better meet the individual needs of the older person;
- provide proactive as well as reactive care;
- drive down the cost of care for older people; and
- respond to the changing demographics of an ageing population.

Thirteen examples of integrated working were identified in the original SSIA/NLIAH study, as means of delivering quality, effective and efficient standards of services to older citizens and communities with the view to maintaining independent living and wellbeing. Presently, however, there are no formalised ways, or standardised outcomes, to measure the success of the delivery of care for the individual service user, the ease of delivery of service or the cost of delivering an alternative service. Measuring the success of care with older people, beyond the established medical model of assessment where care = cure, is complex. Ultimately the primary purpose of delivering integrated is care is to improve the quality of care, improve the patient experience and increase the cost effectiveness of care. These aims form the rationale and basis to measure the impact of care (Curry & Ham, 2010). Costing care is equally as complex and the lack of analysis of the reported costs of interventions is of equal concern. Ultimately, this means that decisions regarding the future of care delivery are being made with very limited evidence of the effectiveness or cost efficiency of new service delivery models.

Measuring service user benefit is complicated and affected by the multi-faceted and multi-layered effects of dealing with organisational and institutional structures. These structures influence profoundly the experience of the service user, the ease of service delivery (for both staff and service user), the constraints of the cost of care and national government policy and strategy and national performance indicators. These layers of influence and complexity have been categorised as macro-level (national policy and

strategy), meso-level (organisational and process factors) and micro-level (delivery of service and the end user experience), to clearly differentiate the roles of each sector (Curry & Ham, 2010). The evaluation of integrated health and social care delivery for this project is largely determined by three implicit assumptions, based on the NLIAH/SSIA work and the Bolton Report (2011). These are 1) that enabling older people to live independently for longer in their own homes can promote and enhance wellbeing; 2) streamlining services at all three levels will improve the efficiency of service delivery, improve certain 'softer' dimensions of service delivery, such as dealing with complexity, and improve decision-making ability and leadership and; 3) integrating services will reduce the cost of care. It is generally assumed that older people would like to remain in their own homes for as long as practicably possible and this is thought to enhance wellbeing.

2 Method

A realist review of literature and stakeholder feedback of integrated health and social care for older people.

Evidence sourced from a variety of literature and primary research among integrated care services will be synthesised and then evaluated using the basic methodology outlined in a realistic evaluation (e.g. Pawson, 2006, 2013; Pawson & Tilley, 1997, 2004, 2011). Realistic evaluation is a theory-driven approach to evaluation that seeks to inform and shape the development of policy and practice. The underlying premise of realistic approaches is that social programmes/interventions are based on implicit and explicit assumptions about how programmes (service models) will work.

The realistic evaluation method goes beyond answering questions of effectiveness and efficacy (what works and how?) as the social world, in reality, is complex. All outcomes of social and/or health programmes are contingent on mechanisms used to deliver services and the context in which they are embedded. Realistic approaches are sympathetic to this complexity

and are designed to help answer the question of ‘what works, for whom, in what circumstances, in what respects and how?’ The conceptual building blocks of realistic evaluation are:

- Mechanisms – the process or processes of how subjects/beneficiaries of a programme respond to the resources and opportunities provided by the programme;
- Context – the features of the operating environment and conditions that are relevant to how successful those mechanisms are in meeting their intended purpose (negating or conducive);
- Outcomes – the intended and unintended consequences of implementing a programme, which can be mixed and multi-layered; and
- Context-Mechanism-Outcome configurations – models showing how programmes are believed to produce their intended outcomes (programme theories, logic models and theories of change) (Pawson & Tilley, 2011).

In the particular context of integrated health and social care for older people in Wales, it is worth noting that practices have not generally been based on empirical theories of what works, developed and tested through rigorous evaluation (although empirical evidence undoubtedly features in their designs). They are instead underpinned by implicit assumptions of how the ‘model’ of care will work and how it will improve on what existed before. It is these assumptions this evaluation will seek to uncover, compare, and contrast with the methods incorporated into the programme theories, which compare models of care delivery to the testable theory of integrated care.

Because the movement towards integrating health and social care in Wales has not in the past been explicitly theory-based, and there is no unifying programme theory at present, there are no ready sources of data and information to monitor integrated services against. This limits somewhat the strength of evidence available to make qualified judgements on effectiveness

and develop the initial programme theories that relate to and will be appropriate for integrated health and social care delivery in Wales.

In this study, practitioners of integrated care were approached and interviewed to capture primary evidence as to their perceptions of what types of integrated care work in different situations. The primary evidence, along with the evidence from the secondary data sources, is therefore essential for the evidence synthesis, as it elucidates the thinking around integrated care practices, rather than relying only on objective forms evidence. The value of this research is to provide a systematic exploration of how and why integrated services work, to answer some of the many questions policy-makers need to consider before making practical decisions about the future of service delivery (Greenhalgh, Wong, Westhorp & Pawson, 2011).

It is important to note, at the outset, that while perceptions of practitioners were gathered in relation to the projects or services they are involved in, this study does not attempt to evaluate the services/projects. It produces summaries, but these are for the express purpose of generating a general theory of integrated service delivery. When reading and interpreting the information on each of the projects/services, it should be borne in mind that the information is, in many cases, based on a single interview with one key stakeholder.

The realistic review of literature, synthesis and evaluation of both literature and stakeholder information comprises three stages. In the broadest of terms, Stage 1 is a realist review and evaluation of secondary data taken from the wider context of health and social care and the integrated care literature, which will culminate in a testable/general theory of integrated care. Stage 2 sees the validity and applicability of the general theory tested, by comparing primary evidence from actual services that use transforming mechanisms to deliver an outcomes in Wales. The primary evidence is comprised of stakeholders' perspectives on organising and delivering integrated care in Wales and this evidence is organised into a set of programme theories. Stage 3 is a synthesis and an evaluation of the programme theories, compared to

the testable theory of the concept of integrated care. The theory is refined to help understand which mechanisms of care work best and in which context they could work to produce the good outcomes in Wales.

Stage 1

The literature and interviews were analysed to understand how services have developed, from what was, to what is and to what services could be, in order to deliver good integrated care to older people in the community.

First an understanding of integrated services was gained:

- ⇨ to explain the situation and context of service delivery in order
  - ⇨ to manage the expectation of what is likely to happen; and finally
    - ⇨ to develop and compare programme theories (service delivery models) to the general theory of what is expected to happen using a conceptual integrated service delivery model (See Fig 2 on p36) and a general theory of integrated care, which identifies how and what works for whom and why in what circumstances.

The testable theory is then tested and compared to the assumption that integrating health and social care will improve the service delivery and the experience of the service user, with the aim of promoting independent living and wellbeing. The new testable general theory then becomes:

New outcomes	**=**	**New mechanism**	**+**	**New context**
Independent living and wellbeing		i.e. reablement service		Integrated health and social service delivery by a variety of professionals in a community setting, managed by a single service

More specifically:

The mechanism to make integration happen is the restructuring of health and social care services and the processes needed to deliver seamless care in the community. The context is the national strategy and policy that is requiring

health and social care to meet the demands of an ageing population in Wales and the need to reduce the cost of care to this burgeoning cohort. The context of care is the strategy and policy that is driving integrated care forward, whether the context is National (in this instance Welsh), regional (e.g. rural or urban) or organisational (e.g. services based within a local health board or local authority). The varying contexts are likely to impact on the design of the service and the desired outcomes achieved for the service user.

Desired Outcome	**=**	**New mechanisms**	**+**	**context**
Independent living and wellbeing		Restructure of health and social care services Restructure the processes needed to deliver seamless care in the community		National strategy Requirement to meet the needs of an ageing demographic Requirement to reduce cost of care for this population

This stage of understanding is theory-driven, based on desired outcomes that are hoped for by introducing integrated care.

Stage 2

The second stage of a realist's understanding uses 'general theories of change' to understand the organisational and social mechanisms that transform outcomes. The realistic evaluation of the expectations of these policies and social programmes will be discussed. In situ examples of integrated care are evaluated using the conceptual matrix of the second stage of a realist evaluation:

Context (C)	=	**Mechanism (M)**	+	**Outcome (O)**

The realistic evaluation will test the general theory against the actual circumstances of the integrated health and social care services delivered across Wales. The programmes of integrated care will only have successful 'outcomes' if the right 'mechanisms' or opportunities and practices have been applied appropriately to the situational conditions 'context'. The new testable

theory will be evaluated against the individual programme theories of each service under scrutiny using the CMO configuration:

context considered	+	**mechanism of service delivery**	=	**outcomes produced**

Within this methodological structure, the context of care delivery is considered at three levels - macro (strategy and policy), meso (management and administration) and micro (service delivery and service user) (see Table 1).

Table 1: Levels of organisational structure with examples of Context, Mechanisms and Outcomes

	Context	**Mechanism**	**Outcome**
Macro	strategy & policy	government directives	organisational redesign
Meso	LHBs & LAs	Joint directorships	integrated service design
Micro	separate services	community resource team	seamless care

In this sense, the context and type of care delivered shapes the decisions that are being made on how to deliver integrated health and social care services. The mechanisms and processes that are put in place to facilitate changes in delivery of health and social care provision for older people are then considered by the outcomes produced from the new ways of working. The realistic evaluation is conducted to establish what works, for whom and why, and in what circumstances?

Procedure

A search of integrated care literature was conducted. Only literature from 2008 onwards was used, as the scale and pace of integrated service development has dated older research. Social Science databases were used alongside the English, Scottish, Northern Irish and Welsh Government websites, The King's Fund Library, Nuffield publications, Department of Health (DoH), National Institute for Clinical Excellence (NICE) and the Personal and Social Science Research Unit (PSSRU) Website with associated links. Search terms used were a combination of the following:

'evaluation/impact/assessment of integrat*/intermediate/co-ordinated/joint commissioning health AND social care for older people'. Information was excluded if the work was only descriptive of either health or social care models; information was included if the models of care delivery used both health and social care services and included some form of service evaluation and was related to older peoples care. Grey literature and citation tracking were also used to complete the search.

The literature review was used to define integrated care provision and identify theoretical concepts associated with delivering integrated care to older people. The review looked specifically at: the different contexts in which integrated care is delivered nationally and more specifically in Wales; the different mechanisms used to deliver integrated care; and what the expected and observed outcomes were. The evidence was then evaluated and synthesised into a generic testable theory of integrated care.

Participants and Procedure

The realist evaluation also made use of stakeholder feedback as primary data to inform theory development. Potential interviewees were recruited from the original contributors to the SSIA/NLIAH report in 2011.

After ethical approval, 28 in-depth, semi-structured interviews were conducted with professionals involved with the organisation or delivery of integrated health and social care.

The 13 projects detailed in the report were revisited. Projects were representative of the wide variety of mechanisms used to deliver integrated care in a variety of LHB, LA and third sector settings. Additionally, further interviews were conducted with practitioners in general practice and acute settings. The 18 named individuals interviewed initially were approached to enlist their cooperation for a follow-up interview. Ten individuals responded. Those who were no longer in post gave contact details of another appropriate person to interview. Ten interviews with strategic leads were carried out using the semi-structured interview schedule detailed in the SSIA/NLIAH report

(2011: pp. 49). The questions focussed on 5 key themes: background; outcomes; impact; leadership and support; and the future. Some respondents were not fully able to address some of these key themes in detail. Occupying a strategic position left some respondents too far removed from the frontline working and processes of delivering care. These respondents, deferred to colleagues who were better placed to contribute specific service delivery knowledge. Subsequently, a further 18 semi-structured interviews were conducted with managers and service professionals from the 7 local health boards, a selection of the 22 local authorities and third sector organisations that represented different types care being delivered in different settings and geographic locations.

Each contributor was approached by e-mail. After a positive response, and with consent, the interviewee was contacted on the telephone to arrange a convenient time for an interview either face-to-face or over the telephone. The interviewee was sent a copy of the original SSIA/NLIAH report and the question schedule. Each interview was recorded with permission and transcribed. Interviews lasted a maximum of one hour and each interviewee was thanked and debriefed with a summary of the aims and objectives of the study.

Interviews were then used as an evidence source for the realistic evaluation, to synthesise alongside the evidence gathered from the literature review, to ascertain what worked for whom, why it worked (or did not work), how it worked and in what circumstances effective integrated care was thought to have been delivered. The realistic evaluation was conducted to establish, from people's experiences, areas of good practice and areas of practice that were less productive and effective and created barriers to service delivery. Further service evaluation of effectiveness and impact of the care delivered can be used to inform whether new ways of integrated working delivers at a national strategic level which has set out to promote independent living and wellbeing in Wales' older population.

3 Results: Part 1

Integrated service provision

Rarely do people present to health and social care services with single concerns. Most have ‘co–morbidities’ with needs that are met by a variety of professionals across several organisations, public, private and voluntary. 'Put simply, people do not live their lives according to the categories we create in our welfare services' (Dickinson, 2008. p. xiii). Therefore, in order to deliver effective and individualised care, most practitioners will work across sectors and professions. How practitioners work across services has been described by Leutz (1999) in his 'Laws of organisational integration' into three models of service delivery through linking, coordination and full integration.

Goodman et al. (2012) translated Leutz's theory into practice models and describe how inter-professional working happens through collaboration, individual case management and integrated team working. An evaluation of the three types of working, as to which was more effective for service delivery and the end user and which was more cost efficient, was inconclusive. There were, however, key features of effective service delivery with older people in the community with complex care needs that did make a difference to the service user. These were: continuity of care with a key worker; relationship-centred care with both the patient/service user and family/carer(s); shared reviews; good links with primary care; and responsive care at times of crisis.

Pearson, Hunt, Cooper, Shepperd, Pawson & Anderson (2013) sought to establish when, how and for whom integrated/intermediate services worked best. They suggested, at an organisational level, that effective working practices were facilitated with collaborative decision-making with the service user for co-ordinated care. The professionals were seen as key to delivering effective services by building relationships, knowledge and meaning to the care with the service user, which focused on the longer term goals of care rather than confining care to achieving positive functional outcomes.

The contexts for delivering the most cost effective care in the home were:

- When people were referred from home and residential based care and not from discharge from hospital;
- Services were cost effective when working to capacity;
- People with complex care needs, and those who lived on their own, benefited most from intermediate care services, although understandably these conditions were associated with higher overall costs compared to other service users and some comparable forms of care, such as acute admissions.

Pearson et al. (2013) suggest that appropriate care delivered in the appropriate setting is cost effective. Complex and chronic conditions treated by intermediate care services at home were marginally more expensive than hospital in-patient care (Pearson et al., 2013, pp96, 101). However, intermediate care services, on the whole, were either cost comparable or cost less than traditional acute or residential care pathways. Furthermore, Dickenson et al. (2013) described the key features and value of delivering integrated services, suggesting it acts as a 'framing concept' and a package to deliver 'inherently good care.' i.e. care that is given in the right place at the right time to right person. Hence, integrated care is often perceived as an appropriate vehicle for service restructuring to deliver 'good care'.

As such there appears to be a ready sense of acceptance for change through staff 'buy-in' which is an essential element to prompt and promote new models of care. The strategic focus and 'shape' of care is on the home being the hub of emotional, psychological and practical care and support, for both the service user and the care-giver. Thus the home is seen as the platform to provide holistic care which can be described as "bio-psychosocial" care defined by the service user in collaboration with significant others and health and social care professionals" (The House of Lords report, *Ready for Ageing*, March, 2013). The *Ready for Ageing* report emphasises the need for more focus on prevention, early diagnosis, intervention and managing long-term

and complex conditions among older people. The report highlights the need for joined up care delivery that is centred on the individual and tasks the government to produce an outline and framework for integrated care delivery that enables the older person to engage with care decisions and the self-management of their condition and situation.

The barriers to integrating care have been clearly outlined by Goodwin et al. (2012) from The King's Fund, who attempt to explain the 'integrated care conundrum' as better ways of delivering co-ordinated care to people with complex and multiple health conditions. They suggest the systematic barriers to integrating care can be related to certain policy and organisational features:

- Arguably in the commissioning of care, stronger incentives are needed to encourage collaborative care to address fragmentation and duplication;
- NHS culture focuses on measuring organisational and operational performance and not performance across organisations and systems;
- The absence of a single outcomes framework to promote joint accountability;
- The culture of the NHS is often seen as being permission-based or 'risk averse', which strangles service development;
- The divide between primary and secondary care in the NHS;
- Time and resource limitations;
- Absence of robust shared electronic records.

Overcoming the barriers to integrating care and bringing reality to the rhetoric has been a longstanding process. The national evaluation of partnership working with older people in England (Personal -Social Services Research Unit (PSSRU), 2009) and the RAND Europe and Ernst & Young (2010) progress report both highlight the variety and complexity of different services that have developed to meet local care needs, in spite of the presence of the above barriers. Although there are common features in most of the care delivery models, the lack of consistency in models of integrated care suggests

one size does not fit all. This means the questions of “what is integrated care?” and “what is the case for implementing it?” are very pertinent for this evaluation.

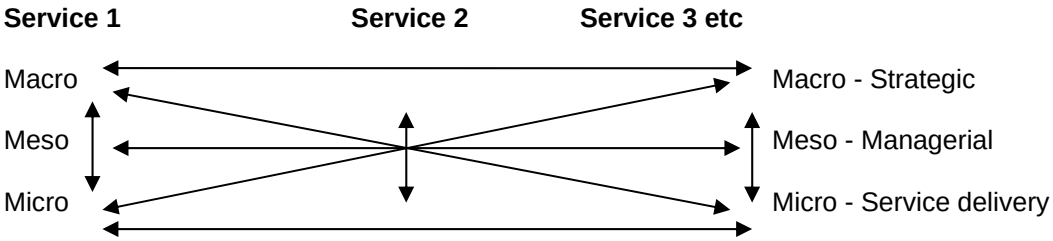
Conceptual and theoretical frameworks of integrated care

There are many definitions of integrated care and these are surpassed by the numerous ways of delivering integrated services. The term ‘integrated care’ has been used to describe a continuum of activities from health services available through a 'one-stop-shop' day care facility operating within a social care model, through to joint commissioning of services, joint budgets and joint management. ‘Integrated’ service delivery is sometimes used to describe what may otherwise be described simply as partnership working. Single referral structures, single assessment processes and single access points to information are seen as significant operational structures to integrate health and social service delivery. A useful working definition of integrated care, for the purposes of this evaluation, is:

> *A single system of needs assessment, commissioning, and/or service provision that aims to promote alignment and collaboration between the care and the cure sectors (Ham, 2008).*

Integrated health and social care can be seen to happen in three different ways and at three different levels (Curry & Ham, 2010). In a three-by-three view, vertical integration is described as integration between strategic (macro), managerial (meso) and delivery levels (micro) (see Figure 1). Horizontal integration is the integration achieved between one or more services at all three levels and this can be based on good working relationships between services, joined up working and holistic health and social care. Diagonal integration has rarely been considered, but relationships between services, and at all levels within services, are essential for managers and practitioners to understand how care is delivered and organised between services.

Figure 1: Interaction of services at all organisational levels



However **intra**gration, that is vertical and horizontal integration within a service, has also been exposed as a challenge to service delivery (for example referrals made between specialists and referral practices between community, primary and secondary health care). In some circumstances, referrals of care are not seamless, especially at transition points between professional referrals and service referrals.

The next section of the report will consider the published literature that has described the case for health and social care integration nationally (British) and locally (Welsh). The national response to care delivery has been, and is arguably centred on the ageing population and increased prevalence of chronic health conditions and complex, multiple care needs. The following section identifies models of integrated care. These models are used as an evidence base to develop a conceptual model of integrated care. This model will be used as a testable theory of best practice. The Welsh models of integrated care delivery will then be compared to the testable model of care.

The British national context

In response to the growing concerns around Britain's increasingly ageing population, the *Care Quality Commission* (2011) pointed to the major improvements that need to be made in service delivery to older, frail individuals. *The Delivering Dignity* (2013) report makes a number of recommendations to improve care. Specifically, a lack of joined up care has been identified and described as a huge frustration for patients, service users and carers. Significant reforms are needed to address the quality of health and social care. Systemic failings in care for people with multiple issues who need co-ordinated care are said to make a 'compelling case for integrated

care, both as a national policy and in terms of local care redesign and delivery' (Goodwin et al., 2012 pp 3) with an emphasis on action.

As well as the challenges posed by the increasingly ageing population, there has been an international response to the challenge of delivering health and social care to a wider and more diverse audience, within the context of unprecedented financial circumstances arising from the recession(s). Against this particular backdrop, The King's Fund (Ham & Walsh, 2013) drew together several important considerations for developing local integrated care services. These points are based on ‘shared narratives’; vision and goals with joint leadership/governance and pooled resources; information, backed up with support for creativity; and empowerment to deliver responsive, bespoke services, rather than prescriptive services. The 'success' of a service is generally judged by assessing output measures and targets. Outputs are constantly evaluated to assess whether they deliver on service objectives and are cost effective. The evaluations available do not, generally, assess the impact of the service on the service user. Most service designs, therefore, do not benefit from a detailed understanding in this respect and rely instead on output measures to assess impact. An example of the incongruence of using outputs as a standalone measure is the death and discharge hospital performance measure. The output measure accurately explains how many people leave the hospital, but the outcome for the patient is at polar extremes, they leave the hospital either dead or alive.

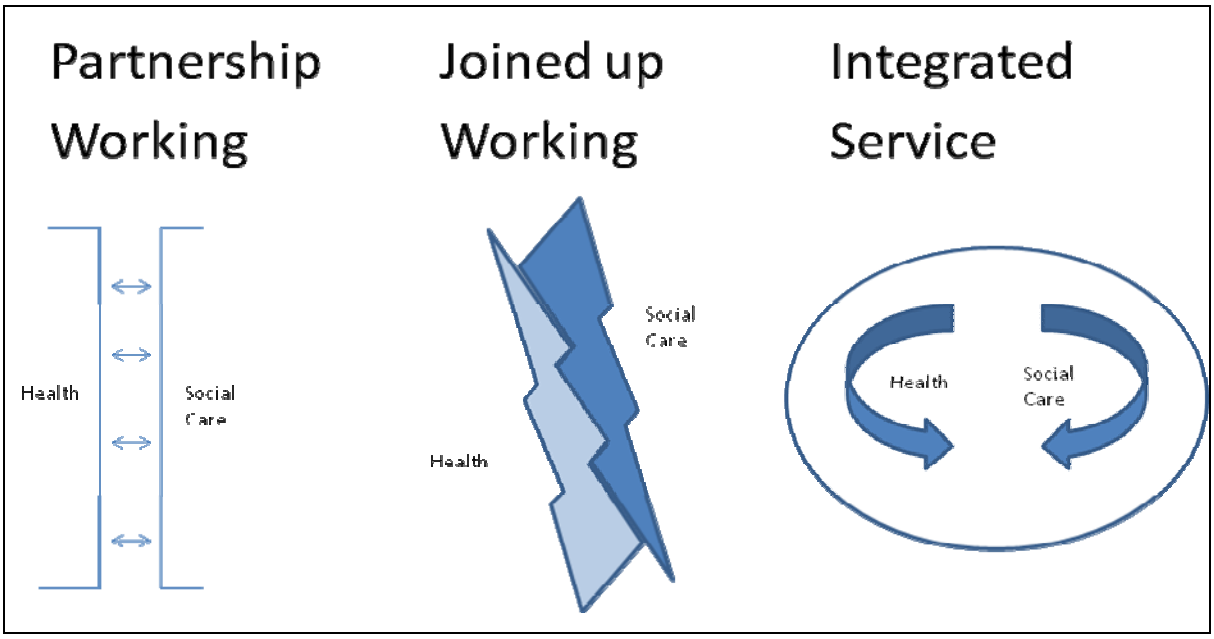
Closer to home, the *Partnerships for Older People Project* (POPP), piloted in 29 local authorities in England, claimed the various service delivery models saved hundreds of thousands of pounds, ranging from £0.80 to £1.60 for every £1 invested in a POPP pilot. A saving of £2,166 per person was cited in relation to reductions in outpatient appointments. The evaluations of these projects by the PSSRU (2009) also claimed that people who had received POPP services after tertiary intervention had an improved health-related quality of life in the order of 2-25%. However, these figures were comparable to the Health-Related Quality of Life of the average older British householder. The POPPs were funded through the Department of Health and the initiatives

were led and orchestrated by health, using multi-agency and multi-disciplinary teams. 'Integration' in this instance was more akin to joint working, using collaborative and virtual structures to encourage working across sectors. The POPPs are examples of bottom-up integration, whereby integration of care happens at the service user and delivery level (the micro-level of care). Bottom-up integration has proved to be pivotal to demonstrate service efficiency and savings, as there is a 'critical mass' of service use for cost savings. PSSRU figures suggest that just over 1 in 10 of the projects were not cost effective compared to antecedent care pathways. They also note that although cost reductions were demonstrable, especially for the projects that focused on hospital discharge, the impact on the budgets between health and social care was negligible, as the claim for monies between local authorities, primary or secondary health care projects did not happen. Although micro-level integration delivered cost reductions, the evidence suggests that unless there are structures and strategies in place at meso and macro-levels, these cost savings will not be realised in practice.

An example of a bottom-up approach to developing integrated care services is Torbay's Care Trust, established in 2005. Based on a shared patient-centred vision for care, the evidence suggests three key factors were required for successful service development: the central role of GPs in the provision of community care; the appointment of co-ordinators of health and social care; and an initial focus on service delivery when redesigning services (micro-level changes to care delivery). Integrated service development in Torbay was staged; the first stage was to encourage staff buy-in at all levels and with social, primary and secondary health services. The second stage was the appointment of care co-ordinators, who worked directly with allied health and social work professionals. The third stage was sharing of data - initially between IT platforms, then through a single system accessed by all link workers. The fourth stage was the recognition that change happened through stability and retention of staff, who were directly engaged with management of frontline service delivery. Meso-level changes occurring latterly in service redesign and macro-level management and direction have less impact on the delivery of integrated care services.

The care context in Torbay is a relatively small, mixed urban/rural area with three major towns and an above-average-age population of older people, many without local extended family care networks. Around 2003 the health service was being restructured and Torbay council, including its social services, was struggling to perform at National level. The management of community care teams was initially led by health services through a GP network and a close working relationship with a social worker. The initial context of care provision was akin to partnership working, diagrammatically represented in Figure 2 over the page. The formation of the primary care trust brought together community health through joint working relationships between health and social care and currently through the Torbay Care Trust. It now operates using a fully integrated care model. The impact of the services on the level of care experienced by the service user has been tracked using outcome measures, such as the increased amount of social care provided for over 65s and the reduced number of non-elective bed days occupied by the over 65s. Reported personal outcomes do not feature. Cost benefits to the service user now need to be translated into actual financial savings. Efficiencies accrued through integrating care need to result in cost reductions to care, which need to be reflected in the budgets against the initial £2 million investments. Real-time savings may remain elusive, as the underlying level of need increases, in line with the ageing of the population. Integrated care may be more about containing, rather than reducing costs, by reducing the costs-per-head of delivering care (Thistlewaite, 2011).

Figure 2: Models of the types of health and social care working arrangements that show the transitions that need to take place in order to achieve fully integrated working



Another example of successful integrated health and social care working is in Salford (Syson & Bond 2010). The context surrounding the development of integrated care in Salford is markedly different to Torbay, yet there are overriding similarities that underlie the success of the care delivery. The large and diverse city to the west of Manchester had a history of integrated working through supporting vulnerable groups requiring intermediate care. In 2005 Salford responded to the Wellbeing Strategy for Older People and established a pilot integrated health and social care team, specifically to serve the needs of the older population. Salford City Council and Salford Primary Care Trust worked together to support older people, by closely aligning practice-based teams to work within GP clusters. The main similarity with Torbay is the bottom-up approach to implementing services and the close involvement of GPs. The Salford pilot immediately set up a whole system integrated model approach (see Figure 2) to deliver care using a single manager; co-locating staff practicing within locality-based GP clusters; and using a single point of access and assessment for referrals and shared IT. The desired outcomes from the new way of working were defined as simpler and quicker access to services; increased process efficiency; improved service user experience; reduction in hospital admissions and lengths of stays; and staff learning. The

predominantly qualitative pilot evaluation (Syson & Bond 2010) reported improved service provision that met the needs of the service user with 100% satisfaction rating that the service has provided appropriate care. The service model used in Salford can be described as integrated at a micro and meso-level with good vertical and horizontal integration between professionals, managers and services. At macro-level there was little evidence of integration with no formal integrated service level agreements for staff or budgets and no reported costing of care against other ways of delivering services for older people.

Torbay and Salford provide a snapshot of the contexts that can promote and facilitate the development of integrated care and demonstrate some of the mechanisms that were used to implement the care. A closer look at the new ways of delivering health and social care in the two areas identifies the significant changes in the mechanisms used to deliver integrated care and how they impact on service delivery. One example of such a mechanism is the integrated assessments of older people, introduced to reduce repetition of information and duplication of paperwork, with the view to streamlining the assessment for process efficiency. Clarkson, Brand and Challis (2011) looked in detail at how a mechanism of care delivery, such as an integrated care assessment, could impact the service user, the professionals delivering services and the process management efficiencies integrated assessments could generate. The results showed the benefits of integrated assessments were far-reaching, as the subsequent care delivered after assessment was positively targeted (by significantly reducing physical deterioration for the clinically assessed frail older person and delayed care home or hospital admission) and identified the clinically frail who needed to enter a care home. Accurately identified health and social care needs were translated into more appropriate care home admissions, which increased the costs to the NHS, but reduced the cost burden to social services.

A single mechanism introduced to facilitate change, such as an integrated assessment implemented at micro-level, can have an impact on service user outcome and can have further significant impact at meso and macro-level.

Again these findings emphasise the effectiveness of a bottom-up approach to facilitate full scale integration (Clarkson et al., 2011).

Northern Ireland is using the single assessment tool (NISAT) for older people, as a mechanism for the ongoing facilitation and co-ordination of care and communication between professionals. The NISAT has also been used for gathering data to use for monitoring services and identifying areas for improvement. The context for Northern Ireland is unique in that it already has meso and macro health and social care integration, unlike England, Scotland and Wales. Northern Ireland has a developed integrated health and social care management arrangement that has delivered care services since 1973. Introducing the NISAT as a new mechanism is intended to enhance the efficiencies at service delivery (micro-level) and also for managers and directors at meso and macro-level to identify areas of service delivery that may need adjusting. Taylor (2012) details the process of the development and implementation of the NISAT and the effect this service delivery mechanism has for the service user, the care professional, the managers and the policy-makers. In the development of the NISAT, Northern Ireland is recognising that accurate assessments and reviews are essential, as they determine and shape service delivery - be it health, social, housing, transport, third sector or informal care.

The 40-year evolution of a top-down approach to integrated care in Northern Ireland is unique in the British context. In Scotland, Wales and England the joint approach of having one agency, one employer, one vision, shared aims and objectives and one source of funding is something to be strived for, to complete the holistic picture of integrated care. Yet even with this structure in place, Northern Ireland still has similar difficulties with care delivery and has the second most expensive per-head health and social care delivery costs of the four British nations (O'Neil 2012 cited in Heenan, 2013). Heenan (The King's Fund, 2013) noted the key difficulties of delivering integrated care in Northern Ireland includes the dominance of health care, cultural differences in engagement and support for the service user, separate training and GPs not being fully engaged in the whole systems approach. This demonstrates that

structural integration of services does not necessarily facilitate effective integrated working at the 'coal face' of care.

The Scottish example, in the pursuit of integrated care, has focused heavily on strategic enablers to promote integration and partnership working between health, social and third sector care delivery. Despite these efforts, the spending on health and social care per capita is the highest among the UK nations. Steel (2013) reports on the intractable barriers that inhibit integration between service sectors. Despite these, Steel reports (The King's Fund, 2013) successful pockets of partnership working, which demonstrates that individual services that have strong leadership; a shared vision centred on patient wellbeing; and the willingness of staff to communicate and work together for the best interests of the individual receiving care; are a successful formula for frontline integrated care delivery. The platform that facilitates working in this manner is based on mutual respect and trust of frontline staff working together to achieve a common aim. This manner and form of integrated working functions irrespective of meso and macro management, structural organisation, strategy and policy.

A systematic review of the integrated care literature (Reed, Cook & McCormack, 2005) suggested that integration of health and social care services at the micro service delivery level has the greater impact and is of greater benefit to the service user and the service provider. Mere structural organisation at a meso-level is not a sufficient condition for integration to take place (Glendinning, 2003). Macro integration strategies have the power to break down barriers to integration (such as finance directives) and to prompt inter-agency working. But the inter and intra-professional working relationships (the meso and micro systems) need to be supported to achieve effective integration (Reed et al., 2005). However, integrated care can be reflected between professions, settings, types of care (acute and chronic), organisations and sectors. The way in which they are integrated can be described as separate services working together; as partnership services that have joined up or co-located; or are using multi-disciplinary teams and single services delivering both health and social care (see Figure 2). These types of

working relationships often reflect a stepped progression from partnership working through to integrated service, which services need to pass through in order to deliver the ultimate in health and social service integration (that is holistic care).

Trivedi, Goodman, Gage, Baron et al. (2013), along with Goodman et al., (2011), define the different ways of working with the generic term inter-professional working, yet recognise the different ways this is achieved (through case management, collaboration and integrated team working). These terms are similar to those processes and ways of working illustrated in Figure 2. Trivedi et al. (2013), through a comprehensive systematic review of literature, and Pearson et al. (2013) with their in-depth realist review, come to the conclusion that there is little evidence to support that any particular form of inter-professional working is more effective or cost effective than another. There is, however, potential that integrated care models delivered in the community could reduce hospital and care home use. More often than not, evaluations and monitoring show different patterns of care delivery and different use of care but these are rarely translated into real-time cost reductions and savings or user-defined outcomes.

Different ways of working can be reflected at the different levels of working. The Northern Irish example has used a top-down approach to integrating services and the rest of the UK has been redesigning services at all levels to achieve integration at all operational levels. A conceptual understanding of integrated care based on the literature review appears to support an integrated service at all levels that remains focused on the individual. Policy, strategy, organisational management and care is delivered by effective inter and intra-professional working relationships, within a single structure to produce quality outcomes for the service user. Table 2 represents these relationships of a joint management and organisational structure, directorates, budgets and professional integrated care delivered to the end user. However, the diagram represents how the promotion of joint policy and strategy, that facilitates commissioning of inter-agency and inter-sector working may, in the future, emerge as a silo of care that works with and alongside primary and

secondary health services and local authority social care. Integrated care could become a series of standalone services, with one agency or sector delivering one combined health and social care service and another delivering another combined health and social care service.

Table 2: A conceptual model of integrated health and social care at macro, meso and micro-levels.

Level of organisation	Feature of organisation	Feature of organisation	Feature of organisation
	Health primary/secondary care	**Integrated care**	**Social/private/third secor/informal care**
	Policy	Policy	Policy
	Strategy	Strategy	Strategy
Macro	Directorship	Directorship	Directorship
	Budgets	Budgets	Budgets
	Commissioning	Commissioning	Commissioning
	Management	Management	Management
	Administration	Administration	Administration
Meso	Accounting	Accounting	Accounting
	Staffing/HR	Staffing/HR	Staffing/HR
	Location	Location	Location
	IT systems	IT systems	IT systems
	Data Audit	Data Audit	Data Audit
	Point of access	Point of access	Point of access
	Referral pathway	Referral pathway	Referral pathway
	Assessment	Assessment	Assessment
	Care plan	Care plan	Care plan
Micro	Review	Review	Review
	Record access/IT	Record access/IT	Record access/IT
	Record storage/IT	Record storage/IT	Record storage/IT
	Care teams	Care teams	Care teams
	Data collection	Data collection	Data collection
	Location	Location	Location

Table 2 is a summary of what the literature is presenting as the idealised concept of integrated care that each of the British nations are striving towards. It represents and gives some examples of the macro, meso and micro view of the organisational context, mechanisms and outcomes related to integrated care delivery, from policy to working environments. The oval shapes that overlay the diagram represent the different sectors that deliver care - one for health and one for social care. The ovals span the organisation they represent and where they intersect in the diagram represents where the two

services deliver integrated care. This model is a way of visually representing how integrated health and social care are at each level of service operation. It is also used to represent and compare the programme theories later on the report to the testable theory. This generic model of care set out in Table 2will be used, for the purposes of this realist evaluation, as a testable theory for the mechanisms of integrated care. It will be used to represent and compare the testable theory to the programme theories generated from the stakeholder interviews. Whilst this rational, linear and reductionist way of looking at integrated care systems paints a picture of 'what works', in reality ‘what works’ is a product of what seems right in a particular place at a particular time (the context) and 'for whom' (the outcome) (Hudson, 2011).

The testable theory provides a baseline to test service delivery models. In reality these move towards looking at the complex systems that evolve and adapt to work best within local circumstances. These are often the bottom-up approaches to finding solutions for delivering good care that are not led by policy, but developed pragmatically by professionals in practice. Effective integrated services often emerge through a developmental process of professional discretion to improve practice. Such developments then need to be supported into being. An example of this would be the development/evolution of the Torbay model cited above. The conceptual model of integrated care needs to be tested against the various programmes of care that are being developed across the UK. The evidence suggests that each service is adapted to meet local need. In Wales these vary from rural to urban environments and care has to be delivered across vast geographical areas which are organised by single health boards and multiple local authorities.

In order to look at the context and outcomes of integrated care strategies the following section will describe the early progress of integrated care in Wales from policy to practice using the above idealised model of integrated care as a reference point to compare against (i.e. how does practice in Wales compare to this idealised model for delivering integrated care?).

The idealised model will act as the testable theory for the realistic evaluation (cf. Pawson & Tilley, 2011), for examining the impact Welsh policy and strategy decisions have had in practice. The current practice of integrated service delivery will form the programme theory and will be compared to the testable theory. This, in turn, will be evaluated within the context of the political climate, the mechanism of service delivery and the outcomes this produces.

Within this methodological structure the historical context of Welsh policy and strategy is considered, because this has driven the development of integrated health and social care services.

The mechanisms the Government has put in place to facilitate change are considered against the mechanisms and processes that have been implemented to deliver changes in health and social care provision for older people. The outcomes of these ways of working are considered in the next section of this report. The qualitative evidence gathered from directors, managers and professionals involved in integrated care services are then synthesised and evaluated.

The Welsh Context

The Welsh Government implicitly recognises the shortcomings, limitations and challenges that exist within the current NHS system, given that it was first established to meet the needs of a Welsh population where 48% of people died before they reached 65. It is widely recognised that significant changes will be required to meet the challenge of an ageing population. Historically health and social care had GPs at the core of the model, with health staff meeting much of the social and health care needs of the community. Health care was divided into primary care (where GPs had their own personal patient lists and were paid per person) and hospital-based secondary and tertiary care. The demands placed on health and social care during and post World War II prompted the restructuring of health and social care provision, dividing services in order to meet the emergency medical needs required during war and the unprecedented social needs caused by war.

Britain is now entering a phase of unprecedented need for health and social care. It was estimated that 11.1% of over 65s (currently 1 million people) have such limited ability as to warrant the need for a carer to facilitate activities of daily living such as putting on shoes and socks, washing and getting in and out of bed (Jagger, Nuffield Trust, 2012). This figure is projected to rise to 14% in 2030 representing 1.9 million over 65s who will have care needs. This projection alone represents a mismatch between available funding, spending and demand that without reform spending would need to rise to 12.7 billion by 2022, an increase of 37% (Dilnot Commission, 2011; Nuffield Trust, Dec, 2012).

A change in approach to service delivery is clearly required, as the prevalence of disease increases in later life; indeed by 2020 almost 50% of Welsh people will be over 65, with an increased life expectancy of 87 for women and 84 for men (Office for National Statistics). The corresponding years of poor health to be expected in that lifetime has increased to 11.6 years after 65 for women to 10.1 years after 65 for men. Integration of health and social care responses to chronic conditions is considered an appropriate response to meet the changing care needs posed by the changing demographic.

The Welsh Government has proposed, through the *National Service Framework (NSF) for Older People* (2006) a 10-year strategy based on the *Together for Health* (2011), *Making Connections Strategy for Older People* (2007), *Designed for Life* (2005) and the *Sustainable Social Service* (2012) reports and reinforced by the *Social Services and Wellbeing Bill* (2013). The NSF response for older people's care targeted a three-stage programme with 10 key standards and 6 themes based on whole system working and integrated action to promote older people's health and wellbeing. At the core of this strategy was multi-agency working, multi-disciplinary teams, single management structures, single budgets, joint priorities, protocols, accountabilities and joint information systems that could service single point of access and referral, and a unified assessment process. This strategy has set

the tone for integrated health and social care delivery to promote independent living and wellbeing in Wales.

Whilst models of integrated care delivery have been developed in Wales and encompass the various facets of integrated care delivery, from joint budgeting to management and staffing, in our view meaningful assessments of the effectiveness and cost-effectiveness of these services have yet to be produced. The same can be said of information regarding service user benefit.

In England, however, some evaluative evidence has been gathered. Services identified as delivering integrated care have been scrutinised and the general consensus is that integrated care is cost effective. Indeed, some sources estimate that for every £1 spent on social care there was a subsequent saving of £2.65 (Government White Paper, July 2012). The comprehensive evaluation of the Partnerships for Older People Projects (POPPs), which were funded almost entirely through the health budgets, suggested that for every £1 spent on the actual POPP service there was approximately a £1.20 additional benefit to the NHS. These savings accrued through reducing emergency bed days, reducing overnight hospital stays by 47% and reducing visits to A&E by 29% in approximately a quarter of a million POPP service users (PSSRU, 2009). However, although there appears to be a cost-saving element to integrating care in England, there is comparatively little evidence around the corresponding service user benefits from integration.

This has significant implications. Simply having estimates of cost savings should not be basis enough for policy-makers to decide on the types of integrated care to be implemented. Indeed systematic, rounded evaluation should be designed alongside service delivery initiatives to examine the variety of integrated services and understand the determinants of effectiveness, from both economic and service user perspectives. This report goes some way to addressing these issues, but does not capture (or intend to capture) the full complexity and variation that exists in integrated service provision.

Failings in older people's care across the UK are evident. A number of audits, inspections and investigations have revealed long-standing and unacceptable variations in the standard of care that older people receive, both from the NHS and social care services across Britain.

Older adult social care across Britain is being reviewed. It is currently largely funded by local authorities, through a combination of central government funding and locally raised council tax and personal finances. Older people's adult health care provision is free. Provisional data for 2010-2011 showed that expenditure on adult social care across the UK for the over 65s was £7.42 billion, representing only half (50.8%) of the net expenditure on adult social care. In the same period approximately 40% of the NHS budget for acute mental health, primary care and prescribing by GPs was spent of the over 65s. The recent Government White Paper (July 2012, *Caring for our Future: Reforming care and support*), debate in Parliament accepted that there needed to be a greater emphasis on integrated health and social care. The directive is to introduce pooling of budgets, single commissioners and/or a single commissioning body to drive joint working. New ways of joint commissioning of services are projected to be in place by 2014. The changing nature of care priorities in older people with complex and multifaceted needs will, by definition, drive forward specialist integrated care services fit for the purpose of meeting these specific needs.

In Wales, the Welsh Government's First Minister has pledged to promote reablement services from 2013 (Bolton Report, 2011). Reablement has been promoted as a response to promote independent living for older people, through social care provision, led jointly by social services and the NHS. The focus of care will be centred on the 'home as the hub of health and social care'. The introduction of integrated community response teams has been recommended as a new way of working across the health and social care divide. Limitations in recruitment are presently hampering progress. There is a shortfall of social workers and qualified health staff in Wales. Recruitment and retention of staff will remain a feature of concern, as more than a third of

staff working in the NHS in Wales are over 50 and due to retire in the next 10 to 15 years. Rurality in Wales is another significant factor in driving up community care costs. Making the home the hub of health care can mean extensive staff costs in both time and expense of qualified staff driving for extended periods of their working day. In contrast, and as it currently stands, using the hospital as the health hub focuses the cost of transportation on the individual not the service provider.

Promoting independent living in the older population, keeping older people in their own homes for as long as possible, is a key feature of future health and social care service delivery. It is commonly acknowledged that the majority of people want to remain in their own homes. Community response/resource teams, reablement interim facilities that act as a transition place between hospital and home and day centres appear to be the generally accepted response to promoting independent living (Bolton, 2011).

The introduction of integrated health and social care services aims to reduce what is often called 'bed blocking' in hospitals, increase discharges and reduce delays in older individuals' discharges and transfers to other services, reduce emergency admissions and reduce A&E visits. Various approaches have been instigated to prevent unplanned hospital admissions. These include improved screening and monitoring, falls programmes, home mobility facilitation aids and community engagement, which set out to combat the increasing problems of loneliness in the older communities. Many of these first line approaches are delivered informally or through third sector agencies that offer domestic support through befriending schemes and care and repair.

The Welsh Government strategy to drive forward reform has been a 3-stage response to set the scene for change. The first strategy, between 2005 and 2008, was to establish a baseline assessment of services, establish strong leadership to steer change and instigate changes to how services are commissioned. (*Designed for Life* (2005) and the *NSF for older people* (2001)). Strategic framework 2 set out to review and assess if the new ways of working were fit for purpose and Strategic framework 3 was to conduct a

strategic review of services between 2011 and 2015. It was assumed that establishing a unified assessment process (UAP) and an integrated care data set management system would promote integrated working, streamline services and reduce time-consuming repetition of paperwork to deliver a seamless integrated health and social care service.

The former Welsh Office for Research and Development (WORD) was tasked with the responsibility to maintain a core data set with performance indicators for a joint review of services (*NSF for older people* (2001: p.186). The UAP was designed to yield quality, evidence-based care information for the review. Lack of buy-in to the UAP by health services, however, apparently hampered any meaningful evaluation of services. Anecdotal feedback from staff performing assessments found the UAP lengthy and unwieldy and not user-friendly to either the staff or the patient. The main shortcoming of the UAP was that it was designed to be an electronic system, yet was implemented on paper.

The All-Wales Alliance for Research and Development were tasked to use the NSF toolkit to evaluate how services were performing against the indicators of acceptable care. The *NSF for older people* (2001) also places heavy emphasis on the routine collection of data and user satisfaction surveys to evaluate outcomes. However, published evidence of the use of either the NSF toolkit or the Service user Survey to evaluate service outcomes over and above service outputs is sparse and not readily available.

There is a continuing lack of evidence to evaluate the current integrated health and social services delivered to older people. The lessons learned from the implementation of the UAP suggests future evaluations need to have buy-in at all levels and have appropriate help and support, in order for services to take ownership of evaluation as a vehicle for improving service delivery. In this sense, evaluation needs to be more than a post-hoc or add-on activity. We would suggest that evidence for service evaluation needs to be considered at the outset and actually should be integral to service design, as well as to monitoring and assessing various aspects of service delivery.

The Welsh public health strategy (*Setting the Direction*, 2010, *NSF for older people*, 2001) assumes that creating the home as the health hub and platform for older people's care is to both achieve independence for longer and provide a cost-effective way to deliver services. The available evidence to substantiate these assumptions, however, is not yet conclusive. Indeed there is little empirical basis for asserting that delivering care in the home is more or less cost effective and/or efficient than hospital-based care, even though these assumptions have clearly underpinned recent policy and strategy. The figures produced by the Department of Health (England) for benchmarking costs, suggest that an average week in a hospital bed costs approximately £1600; residential nursing care costs £568, and high intensity home health and social £244 per week (*Predicting Social Care Costs*, The King's Fund, PSSRU, 2011). These figures are not inclusive or representative of the overarching administrative costs consumed by local government and local health boards. Presently, evidence collected to register cost savings is based on the number of acute hospital bed days that are saved through expedited discharge from hospital and preventative, planned, proactive care delivery that is designed to reduce emergency, unplanned and extended admissions to acute care. Indeed, to some degree the proactive stance of the Welsh Government in promoting the integrated care agenda has met with a degree of success using this measure (cf. Guardian, 2013)

The unintended consequences of using saved bed days as a unit measure for cost saving, however, is the inclusion of these figures to justify the overall strategy for reducing the number of available hospital beds. However, acute and chronic conditions likely to be present in the older population will require more beds in the longer term, even if the fruits of integrated care provision reduce the proportion of older people admitted to hospital.

There are, however, limits to the conclusions we can draw from such a narrow evidence base. The real impact of integrated community care needs to be evaluated in a broad context, to include service user benefit; the cost-efficacy

and efficiency of service delivery; administration; infrastructure; and management.

Joint working arrangements between health, social, and third sector services are considered as an 'inherently good thing', but not necessarily an 'intrinsically good thing' (Glasby et al., 2012), as the desired working arrangements are intended to provide seamless, better quality services, with improved outcomes for the end user (Ham, 2008). Outcome-based assessments with older people are not usually standardised to a typical medical model of recording an improved health status. A more accurate measure of the effectiveness of care for older people with deteriorating health should be based on the achievement of individual goals or targets, which are set realistically to reflect the unique circumstances of the older person. These achievements may be focused on stabilisation or condition management, or to the more intensive forms of delivering care that can promote a 'good' end-of-life care experience for the service user, their families and loved ones.

Goals, targets, and achievements may also be unrelated to health benefit and, therefore, involve even more ways of measuring or assessing the impact of the service, for example: quality of life; activities of daily living; social contact; exercise; benefits advice; or handrails along a corridor (Safer Homes, 2012). Providing integrated services that meet the needs of complex and multi-faceted care makes it difficult to ascertain which service, or combinations of services, were more effective than others at meeting an individuals' needs. There is no doubt about the interdependency of health and social care; improving the health of older people significantly affects social care expenditure and appropriately timed and placed social care has the potential to significantly reduce health expenditure (UK Government White Paper, 2012).

This interdependency is the basis for the argument for delivering holistic care. Ideally, care may need a holistic, as well as an individual response. An evaluation of the impact of delivering holistic, integrated health and social

care, is necessary to gain a clear understanding of whether this form of care delivery actually benefits the end user in the ways expected.

Service user outcomes can thus be more accurately assessed using qualitative outcomes, as well as the quantitative, data-driven outputs. Soft outcomes are those based on service users' experiences, perceptions and attitudes, in relation to their wellbeing, individual goal achievement and levels of independence.

Welsh responses to facilitate the development of integrated health and social care

The Welsh Government intends to transform the way in which health and services are delivered. Demand for health and social care has outstripped supply across the board and will continue to do so.

Currently, 1-in-5 people are over 65 (DoH July, 2012) and it has been projected that in Wales there will be 1-in-3 people over 65 by 2030, and double the current number of over 85s (IPC's Daffodil's Care Needs Projection System). The prevalence of people living with complex and chronic conditions is, therefore, expected to increase in line with this projection. In a period of austerity, the containment of health and social care costs will need to be addressed in a systematic, effective and efficient way.

At the current level of spending on health and social care, the Wales Audit Office (press release 16.7.2013) predicts a funding gap of £210 million for 2013-2014. Living with complex and chronic needs requires costly personal health and social care, which is being addressed by the implementation of community integrated health and social care services that can respond appropriately and reduce incidences such as unscheduled care and emergency admissions to hospital. In Wales in 2011, 25% of all emergency admissions were people over 75. During our life course, with complications in older age, 50-60% of the adult social care budget is typically spent on the over 65s, who make up one fifth of the population (2008-9). Also, the average cost of health care rises proportionally with age: over 55 average health care

costs are £5,500 per year, over 55 median health care costs are £24,000 per year, and over 80s average health care costs are £35,000 per year (The King's Fund, 2011).

Clearly, there are long-term issues around delivering appropriate, cost effective care that can meet the needs of the individual. An example of when the systems are not achieving cost efficiency, effectiveness and benefit to the individual is reflected in 80% of all hospital beds being occupied by the over 65s and 40% of all patients in hospital beds not being in need of acute care. Integrating health and social practices is a response to these issues, driven by the changing context of health and social care needs in the Welsh population.

The Welsh Government also has a vested interest in the evaluation of integrated health and social care delivery for older people, as it is perceived that integration will promote independent living and alleviate the pressure on acute services to provide non-acute health care. In order to understand integrated care services, it is advisable to draw on the experiences of those involved in planning, delivering and managing integrated services, as well as those receiving the service. The next section will examine a variety of approaches that have been developed to drive the necessary changes in health and social care service delivery.

Mechanisms used to change health and social care in the Welsh context

The National Service Framework for Older People (2006), and *Designed for Life and the Sustainable Social Service* (2011) promote the principles laid out in *Making the Connections* (2004), *Bevan Commission Report* (2012) and the *Beecham Review* (2006), all of which advocate joint provision of frontline services, based on whole-system working and integrated action to promote health and wellbeing for older people. At the core of the National Service Framework strategy is multi-agency working; multi-disciplinary teams; single management structures; single budgets; joint priorities; protocols; accountabilities; joint information systems that could service single point of

access and referral; and a unified assessment process. This broad strategy set the tone for integrated health and social care delivery for older people.

In the report *NHS in Wales: Why we are changing the structure* (2009: pg. 3), the Welsh Government stated: 'We need to provide more care closer to people's homes and more self care programmes to help people live more independent lives and provide more joined up services between health and social care.' This report outlined the radical re-organisation of the Welsh NHS into 7 local health boards, and advocated the need to develop integrated health and social care services. *Setting the Direction* (Feb, 2010) and the *John Bolton Report* (April, 2011) also emphasised the drive to integrate health and social care delivery, and bring together primary, community and secondary care services to work seamlessly with local authorities and other partner agencies.

The policy and strategy directives recognise the importance of an integrated service framework to act as a guideline for service development. *The Social Service Health and Wellbeing Consultation* (2012) is also setting a framework of parameters to define wellbeing, and service providers are calling for a set of national standardised indicators and benchmarks to measure and evaluate integrated service delivery. Standards are currently set locally. Over the last 10 years, there have been attempts to bring together relevant information to act as a guide for setting up and evaluating services. Currently, the Welsh Government's *Together for Health* (2012) states that it will develop a national approach to measuring health-user experience. Since all health boards were required to produce quarterly financial performance reports by March 2013, the Welsh Government intends to use the data to show how health services compare. In terms of meeting the agenda for integrated services, it would be timely to include social care.

The former Welsh Office for Research and Development (WORD) was tasked with creating and maintaining a core data set with performance indicators for a joint review of services (*NSF for older people*,2001: p.186). The unified assessment process (UAP) was designed to produce quality electronic,

evidence-based care information for the review. Lack of buy-in to the UAP by the health services, however, along with the incompatibility of the UAP with some existing IT systems, has limited the prospects for evaluation of integrated services. The reluctance to use the system has also limited the ability to share information across sectors. The NSF toolkit was designed to compare how services were performing to the indicators of acceptable care, using the Self-Assessment Audit Tool (SAAT) (WAG, 2007). The NSF for Older People (2001) currently emphasises the importance of routine collection of data, and the user satisfaction surveys to measure or evaluate service outcomes over and above service outputs. The General Medical Services Quality Outcomes Framework (QoFs) also consists of indicators and measures that provide statistics on the patient experience. This wealth of information needs to be utilised, brought to the fore and used to evaluate services for public benefit.

The Health Care Inspectorate Wales (HIW) currently monitors care against another set of standards by spot-checking information in hospitals. The standards are set by the Fundamentals of Care (FoC), a health care initiative launched in 2003, to monitor and improve the quality of care for acutely or chronically ill, frail or disabled people. To overcome the lack of evaluation of services, the FoC developed the *All-Wales Older People's Experience Tool*, proposed as an add-on to the Fundamentals of Care toolkit. This is a hospital-based project, designed to capture older people's data within the All-Wales Nursing Dashboard system (launched in June 2012). The dashboard system is a computerised FoC toolkit, used on hospital wards to measure care delivery against the key indicators of care laid out in the Health and Social Care document *Doing Well, Doing Better* (2009). It was originally designed to drive the quality agenda. There are some criticisms that the dashboard has missed an opportunity to jointly collect information about social care needs. It could be argued that the experience of receiving care is just as important to the patient as the outcome. The FoC national audit toolkit went live in hospitals in 2009 and is based on 11 key indicators of care, namely: toilet needs; oral health and hygiene; eating and drinking; personal hygiene and appearance; comfort and pain; rest, sleep and activity; relationships;

independent living; safety; respect; communication and information; and, more recently, anxiety and depression. Although this system is currently hospital-based, there are suggestions that the 'dashboard' should be used in the community using mobile technology. The information collected on the dashboard is a mixture of closed questions with some open statements that are designed to capture a limited snapshot of the patients' experiences of care. This was monitored through All-Wales FoC audit, carried out in 2011, and published in *The 21st Century Health Care, progress report* (2012).

NHS Wales governance (WAG, 2009) acknowledges that there needs to be 'improving access to care and experience measure of patient satisfaction' at a national level, to provide some coherence and structure to developing and evaluating health and social care across the 22 local authorities and 7 local health boards in Wales. Social care is currently being delivered by the local authorities to 100,000 people across Wales, yet this is only a small part of the care picture. Almost 70-80% of all care administered is informal, and thus difficult to collate information on, evaluate and improve. Informal care is nevertheless an important form of care provision.

The Social Services Improvement Agency (SSIA) was set up to look at ways to improve social care in Wales, acknowledging the many ways social care is delivered. The SSIA commissioned a report: *Better Support at Lower Cost*; on improving efficiency and effectiveness in services for older people in Wales (Bolton, 2011) and the Welsh Government paper The *Sustainable Social Services: A framework for action* (2011), makes the case for a national outcomes framework and high-level markers/indicators, which will help shape service design and be used to measure progress. The use of such a framework is intended to drive forward policy and practice for integrated service development, to ultimately improve outcomes for the end-users of health and social care.

Other ways to improve health care have been outlined in the 'Chronic Conditions Framework', designed to promote active management of high-risk groups, instead of reactive and crisis management of care. This is intended to

reduce pressure on acute hospitals. *The Working Differently, Working Together: 5 year vision* (2012) suggests there will be a quality delivery plan for Wales 2012-2016 (to be published). Objective 4 is centred around integrated care and monitored by *1,000 Lives Plus* (NHS Wales, 2013) to achieve excellence. Objective 3 is to promote independent living; integrating health and social care; promoting health; increasing rapid responses to care in the community; enablement/rehabilitation; admission avoidance (presently 50% of hospitalised patients do not need surgery); and create multi-sector community response teams.

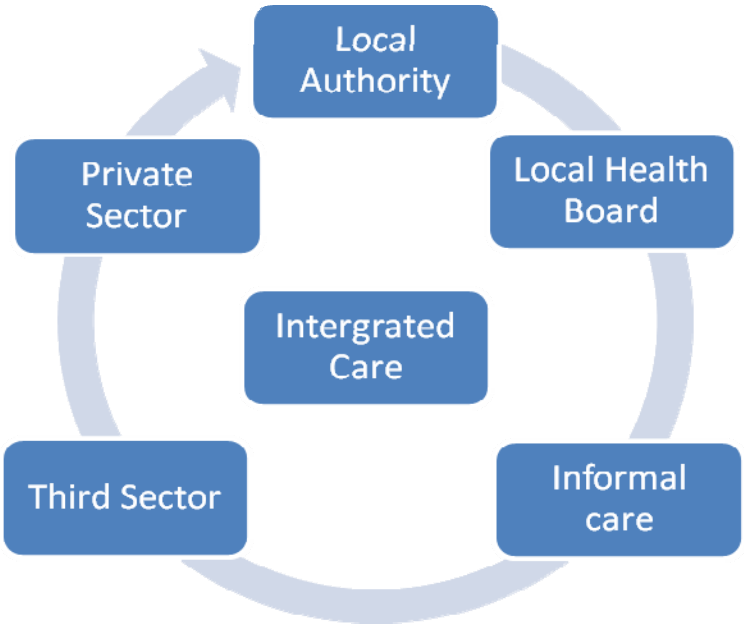
However, policy and strategy, largely developed with a longer term view, has not wholly kept pace with service development and local initiatives to integrate health and social care. New ways of delivering services are happening at a scale and pace across Wales and there is a concerted effort to make integrated happen. Services are organically evolving at local level to meet the needs of the community and policy and strategy is being developed alongside this activity. A selection of these approaches to delivering services will be explored in the next section of this report.

The mechanisms used in Wales to deliver integrated care to older people.

Care is generally considered to be administered by five sectors: Local Authorities; Local Health Boards; the private sector; the third sector; and informal care. The sectors operate independently and come together when necessary to meet specific care needs. These sectors of care have also been referred to as 'care silos', functioning within their own specialism of care delivery. Silos of care are further divided into specialism's, such as primary, secondary and tertiary care in the health sector. Historically, there have been difficulties with delivering integrated care at all organisational levels (macro, meso and micro) as well as the difficulties with co-ordinating care at different stages on the care pathway and when different types of care required. Difficulties occur when the complex care needs of patients require them to be referred, transferred and/or jointly administered by one or more service

provider. Breakdowns in service provision can happen from both within a sector (health or social care) and between sectors. Integrated care has been seen as a means of easing transitions between care sectors and facilitating joint, collaborative, partnership and coordinated services, which can meet complex care needs and avoid some of the frustrations caused by duplication of services, time and effort. Figure 3 is an example of some of the possible and potential working arrangements that need to align in order to deliver appropriate and meaningful care to people with multiple and complex care needs.

Figure 3: The silos of care



Owing to the size, scale and diversity of the five sectors, it is unlikely that they can be wholly amalgamated. In our view, there is some evidence that a separate health and social care or wellbeing sector is emerging to provide integrated care services. Of significant concern with this model is that integrated care has the potential, we feel, to create a sixth silo of care that feeds into and from the other sectors. In this scenario, integrated care would constitute a mixed provision of care, requiring management, administration and cost in its own right. In a situation where reducing costs is one of the main drivers for integration, there is a danger this may negate some of the main anticipated benefits of pursuing integration.

The mixed provision of care appears to fall into the following categories:

Transitional Care (moving patients between sectors and services).

- Expediting discharge from the hospital to home, some form of residential or nursing care or sheltered housing;
- Reducing unnecessary lengths of stay in hospital - planning care at admission through to discharge;
- Triaging unscheduled care, avoiding inappropriate admissions to hospital;
- Reablement - short-term intervention which is either residential or community-focused; and
- Rehabilitation - short-term intervention which is either residential or community-focused.

Community Care

- Community resource teams - offering care in the home;
- Community response teams - offering care in the home and referring as necessary to other services; and
- Acute response teams - services designed to manage crises with responses maintained within the community, thus avoiding unnecessary hospital admissions.

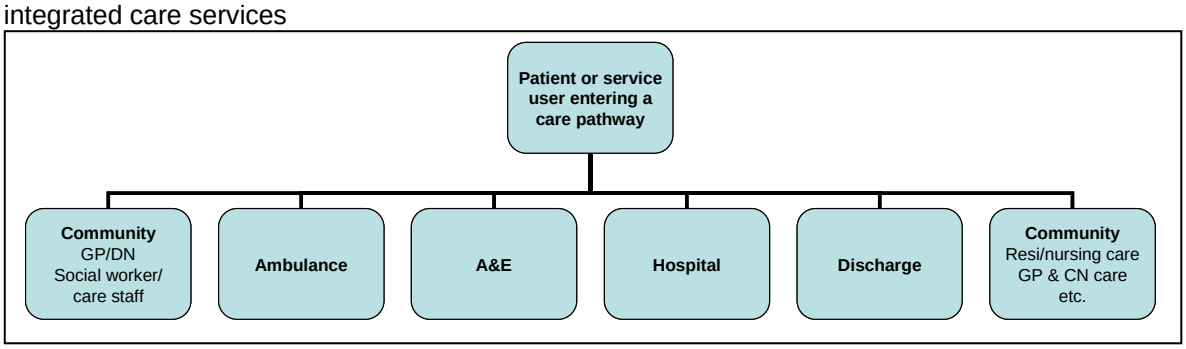
Preventative/Pre-emptive and Planned Care

- Preventative care, such as equipment provision and repair of housing;
- Pre-emptive/planned care such as screening for risk, and risk stratification methods to identify 'at risk' patients and 'hot spots' of care needs; and
- Pre-emptive and planned care, such as falls programmes, and planned admissions for surgical care and treatment.

The integrated service approaches listed above are hospital- and/or community-facing services that provide care pre or post-hospital admission with subsequent care provided in the community.

These types of care models intercept standard care pathways at different points, and this is illustrated in the diagram below (Figure 4). Figure 4 provides a summary of the type of services that have been developed across Wales in response to the need to provide better, more efficient and effective care. Most of these services rely on cost savings brought about through reducing the unnecessary and inappropriate use of hospital beds to justify their development and maintenance, rather than emphasising the improvement of health and wellbeing outcomes for older people.

Figure 4: Contact points along the care pathway that lend themselves to positioning integrated care services



The following descriptions (Table 3) have categorised these contact points. Some examples of service delivery models from across Wales are also provided, to show how services have been developed to meet different care needs at different points on a care pathway.

Table 3: Examples of integrated care services that enable smooth transitions between contact points on the care pathway [1]

Older person entering a care pathway					
⇩	⇩	⇩	⇩	⇩	⇩
Community	**Ambulance**	**A&E**	**Hospital**	**Discharge**	**Community**
Examples of services and approaches to care at each contact point					
Risk stratification	CRTs Bhowmick model	Triage at the front door	Key worker	Key worker	Time limited health and social care services
Co-morbidities	ARTs	A&E GP			Rehabilitation
Social and health risk factors	Integrated health record	ARTs			Reablement
Post code risk	Palliative care				Residential care
Weight	ACPs				Nursing Home care
Age/lifestyle	ADRTs				CRTs
Pharmacy technicians	Triage 999 calls				Social care in home
Chronic condition management					Day care facilities
Falls prevention					Respite care
Community Resource teams					3rd Sector care
Social care/state/private					Private sector care
Telecare/IT/Alarms					Informal care
3rd Sector care					Housing
Benefits advice					Supported
Befriending					Extracare
Signposting					Telecare/IT/alarms etc.
Transport					
Meals/shopping					
Cleaning					
Day care facilities					
Supported Housing					

[1] Acronyms:
ACP .....Advanced care planning
ADRT .....Advanced Decision to Receive or Refuse Treatment
ARTs -.....Acute response teams
CRTs .....Community response or resource teams
DN.....District Nurse
GP.....General Practitioner
IT.....Information technology

These can be broken down into different categories:

Pre-service intervention

Involving risk stratification, risk identification, risk management and care planning involving GPs and GP records, as well as public health and pharmacy technicians. Service examples include a falls prevention programme, home adaptations, dietician consultation etc.

Non-acute medical service intervention and social care

- Community resource and/or response teams to facilitate care at home.
- Accessed through referrals to the single point of access communications hub.
- Co-ordinated care in the community delivered by LAs and third sector.
- Co-ordinated health care in the community delivered by GPs through MDTs or virtual wards.

Front hospital-facing service intervention

Crisis and Emergency responses:

- GPs use the Bhowmick Model or engage Acute Response Teams.
- Triage 999 calls. Non-acute emergencies are redirected back to the GP, the out of hours GP or the A&E GP. Then a Bhowmick model response or an acute response team is activated. That is a care plan is activated by specialist nurse using a combination of necessary services.

Hospital-facing services

Admission to acute care:

- Patient identified to a key worker who plans discharge from the outset.

Discharge from acute care:

- Care pathway implemented and actioned at point of consultant discharge.

- Community response teams or reablement teams take over (short-term).

Community-facing care

Integrated service delivery providing care packages to the person in their own home facilitated by a community resource team and delivered in conjunction with GPs and the voluntary sector (longer term care package).

Presently, the varied ways in which integrated care is delivered entails responsive approaches to the unique needs of those receiving services. The organic development of uniquely appropriate services is an indication that a one-size-fits-all integrated care model is an unrealistic prospect. However, the testable theory offers an idealised view of integrated care, which many of these services do 'fit' into to some degree. Having one definitive model when reshaping service design, therefore, is probably not appropriate.

The following section is a closer review of some of the examples of these services in Wales, and explores how each service model or programme theory works best for whom, why, and in what circumstances.

Results: Part 2

These major themes are discussed in more detail below and are related to each of the individual services in scope for the evaluation, taking account of the local context, the mechanisms used to deliver services and the outputs and outcomes they produce.

For the realistic evaluation, the models of care that are reported are considered as programmes of care service delivery. As such, the way the integrated service is delivered is represented as a 'programme theory' (sometimes called a logic model, theory of change or log frame). The actual model of care (the programme) will be compared to the conceptual model of integrated care (the testable theory outlined in Figure 2).

The summaries below are generated, in many cases, on the strength of one interview. While this approach has inherent limitations, it is useful in this particular context, as it provides valuable insight into how and why integrated services are thought to work, allowing us in turn to generate, and assess against, a general theory. The services/projects described in this section have not been evaluated as part of this study. This should be firmly borne in mind when reading and interpreting the information.

Bridgend Integrated Care services

Bridgend County Borough Council and Abertawe Bro Morgannwg University Health Board.

Key Features		
Context	**Mechanism**	**Intended Outputs/Outcomes**
Remodelling of adult social care to align with integrated health and social care projects	• integrated referral management centre	• living independently
	• community resource team	• reduce emergency admissions
	• community network team	• reduce delays in transfer of care
	• long-term care team	• reduce residential care placements
	• public health prevention service	
	• interface development between secondary and community care	

Degree of integration:

Macro: limited

Meso: some joint administration, shared resources and co-location

Micro: predominantly micro-level integration with inter-professional integrated working

Table 4: Programme Theory of Integration (Bridgend, December 2012)

Level of organisation	Feature of organisation	Feature of organisation	Feature of organisation
	Health primary /secondary care	Integrated care	Social/private/third /informal care
	Policy	Policy	Policy
	Strategy	Strategy	Strategy
Macro	Directorship	Directorship	Directorship
	Budgets	Budgets	Budgets
	Commissioning	Commissioning	Commissioning
	Management	Management	Management
	Administration	Administration	Administration
Meso	Accounting	Accounting	Accounting
	Staffing/HR	Staffing/HR	Staffing/HR
	Location	Location	Location
	IT systems	IT systems	IT systems
	Data Audit	Data Audit	Data Audit
	Point of access	Point of access	Point of access
	Referral pathway	Referral pathway	Referral pathway
	Assessment	Assessment	Assessment
	Care plan	Care plan	Care plan
Micro	Review	Review	Review
	Record access/IT	Record access/IT	Record access/IT
	Record storage/IT	Record storage/IT	Record storage/IT
	Care teams	Care teams	Care teams
	Data collection	Data collection	Data collection
	Location	Location	Location

Overview

Bridgend Integrated Health and Social Care Services work to deliver community care, long-term care and prevention. The services range from community resource and reablement teams, a referral management centre, a pharmacy technician, community networks and public health interventions.

The integrated teams have four targets to work towards. These are:

- Promoting independent living:
  Using Telecare, reablement and Bridgestart services to reduce anxiety and social isolation, by maintaining community networks.
- Reducing Emergency admissions:
  Intervention at point of access using the community response team, using a pharmacy technician to review medication, reduce emergency calls and admissions from residential and nursing care.
- Reducing delays in transfers of care:

Referrals go straight to the reablement team for a speedier discharge, hospital referrals seen by a social worker, referrals allocated to locality network teams, restructuring rehabilitation services.

- Reducing Residential/Nursing care placements:
  Using reablement facilities and care.

Services are currently being monitored for performance at a local level, an organisational level and national level, using the national performance indicators. National performance indicators suggest an improved rate in delayed transfers of care for social care reasons, and an increased percentage of older people were supported in the community as at December 2012.

Current difficulties:

- The current climate of change and remodelling means services are constantly evolving.
- New working arrangements need to be established and roles fully defined.
- Capturing data that indicate sustainable improvements to delivering services.

Current successes:

- The progress of integrated care development.

Future considerations:

- As the projects begin to deliver changes in operational processes, new data capture arrangements need to introduced.
- Data capture needs to be reviewed. Data need to be compared against benchmarked costs of care. A closer working relationship with finance is needed to cost care delivery.
- The introduction of one shared health and social care database.
- Constant monitoring of unintended outcomes when new services are adopted.

- More feedback from staff and service users is needed to ensure that the desired outcomes of care can be tracked through the care process.
- Better working relationships need to be developed with General Practitioners.

Summary

The context of service development in Bridgend, as of December 2012, was based on the need to respond to directives to develop integrated health and social care, with the view to streamlining services and reducing costs. Performance indicators are used to monitor the flow of service use, but do not indicate the impact of service restructuring on the end-user experience. Anecdotally, the changes made have been well received by the professionals working within the new services and the service user.

The shapes on Table 4 represent where health and social care are integrating at different levels of service organisation. The shapes intersect predominantly at the base of the table in the micro/service delivery section suggesting that Bridgend have used a bottom-up approach to service redesign with the view to developing an integrated macro structure as services develop. This model of service development is following a linear trajectory working towards the conceptual goal of integrated care at all organisational levels. The current team are working towards evaluating services, costing the new ways of delivering care, and collecting service user reports to evaluate the impact of care.

Cwm Taf Primary and Community Services

Cwm Taf Health Board, Merthyr Tydfil County Borough Council, Rhondda Cynon Taf County Borough Council.

Key Features		
Context	**Mechanism**	**Intended Outputs/Outcomes**
New ways of working are being developed to meet health and social care needs of the community in line with Government objectives	• single point of access for referrals to Intermediate Care and Reablement	• living independently
	• single point of access to @Home services	• reduced use of services
	• community reablement teams	• reduce delays in transfer of care
	• communications hub	• individual goal attainments for service users
	• co-location	• avoid inappropriate admissions to hospital
	• enhanced discharge services, interface between secondary and community care	
	• single therapy-to-therapy referral	

Degree of integration:

Macro: limited.

Meso: some joint administration, shared resources and co-location.

Micro: predominantly micro-level integration with inter-professional integrated working.

Table 5: Programme Theory of Integration (Cwm Taf, December 2012)

Level of organisation	Feature of organisation	Feature of organisation	Feature of organisation
	Health primary /secondary care	**Integrated care**	**Social/private/third /informal care**
	Policy	Policy	Policy
	Strategy	Strategy	Strategy
Macro	Directorship	Directorship	Directorship
	Budgets	Budgets	Budgets
	Commissioning	Commissioning	Commissioning
	Management	Management	Management
	Administration	Administration	Administration
Meso	Accounting	Accounting	Accounting
	Staffing/HR	Staffing/HR	Staffing/HR
	Location	Location	Location
	IT systems	IT systems	IT systems
	Data Audit	Data Audit	Data Audit
	Point of access	Point of access	Point of access
	Referral pathway	Referral pathway	Referral pathway
	Assessment	Assessment	Assessment
	Care plan	Care plan	Care plan
Micro	Review	Review	Review
	Record access/IT	Record access/IT	Record access/IT
	Record storage/IT	Record storage/IT	Record storage/IT
	Care teams	Care teams	Care teams
	Data collection	Data collection	Data collection
	Location	Location	Location

Overview

Cwm Taf Health Board is working together with Rhondda Cynon Taf and Merthyr Tydfil County Borough Councils to deliver integrated care to the older population. Whilst there are four Localities across Cwm Taf Health Board area, the initial focus on integration is within the Merthyr Tydfil Locality, following the recent reorganisation within adult social care. A vision for our Integrated Locality Model has been agreed, together with a set of principles which will govern its development. The Cwm Taf Regional Collaboration Board has made Integrated Localities one of its priority work programmes and work is being taken forward on two levels, namely Integrated Services and Integrated Locality management. In relation to the latter, work continues to identify how health and social care structures can be aligned to support integrated Locality Management. A successful bid was submitted to Welsh Government for ESF funding to support this work in early 2013.

With regard to Integrating Services, the approval of a £1.5m “Invest-to-Save” bid is a significant enabler in integrating and enhancing existing services, supporting the implementation of Setting the Direction. As a result of the investment, existing community services will be organised differently and provision broadened to support a more robust community infrastructure to manage patients who may have traditionally been admitted to secondary care. The aim is to intervene earlier in the patient pathway to prevent deterioration of conditions, or the patient reaching crisis point where the only option available is hospital admission.

The @Home services include:

- Community Integrated Assessment Service (CIAS)
- Community Ward
- Community IV Service

The local health board and local authority are committed improving access to services such as reablement and intermediate care, which have been proven to support individuals in maintaining their independence. The local authority has reconfigured its services to offer new referral pathways in to these services on discharge from acute hospital settings. A proportion of the Invest-to-Save funding is being utilised to increase the capacity of these services.

The three organisations have made greatest progress with integration within the area of reablement. Teams are made up of social workers, occupational therapists and physiotherapists. Other services are promoted, such as equipment and adaptations into the home, and telecare pendants. Referrals are mainly from hospitals at point of patient discharge and inter-professional, and inter-service referrals. Governance of the new service is in place at service managerial level to promote inter-service working.

Within Merthyr Tydfil there is a purpose-built facility to co-locate health and social care staff. The opening of the Kier Hardie Health Park in September 2012 provides a unique opportunity for the further integration of services.

Current difficulties:

- Co-ordination of staff.
- Gaining confidence and respect for quality service provision.
- Some costing of care is carried out, but this is limited. The true cost of care is elusive, as is the comparison of the cost of care of delivering within the new model, compared to previous ways of working.
- Limited referrals from GPs and district nurses to the new @Home services.
- Service developments have been slower than hoped for, because service provision is over and above traditional ways of delivering services and creates extra demands of staff working practices.

Current successes:

- Gaining written consent from service users to share information between multi-disciplinary teams (MDTs) and overcoming some of the issues created by separate IT systems.
- Reablement is focused on goal attainment and the service user manages the care. The service tries to limit dependence on care.
- Reablement manages risk well using a variety of technology and equipment.
- The revised pathway to access social care services on discharge. Ward staff conduct the initial assessment of care needs and this saves time and duplication of effort.
- A discharge liaison officer based within the Reablement service in RCT has decreased the time taken to discharge patients from hospital.

Future considerations:

- Health and social service alignment needs to be improved by introducing strategic alignment of services.
- Discharge co-ordinators need to be in place for A&E (consideration to use the bed managers for this task).

- Limiting reablement services to six weeks of care may need to be reviewed.
- Complex care does not always fit the reablement model.
- One shared health and social care database.
- Constant monitoring of unintended outcomes when new services are adopted, the concern is over-dependency on care and inadequate reviews of care.
- Improved working relationships need to be developed between social care teams and primary care.
- Further development of the @Home model. Reablement and Intermediate Care.

Summary

The context of service development has been a response to government directives and to demonstrate that new ways of delivering services can demonstrate cost avoidance for health and social services. The programme theory in Table 5 shows the intersection of the health and social care shapes is predominantly in the micro section of organisational integration, this is a bottom-up approach to service change, with integration happening to a lesser extent at the meso and micro-levels. Macro-level involvement is driving change, via government funding, through the Invest-To-Save Fund. This fund was set up to promote cost saving initiatives that need financial input to promote long-term change and savings for the public purse. The demonstrable outcomes that give examples of the benefits of the new service delivery for the service user are currently being assessed. Outcomes are currently defined by output measures that give an indication of service level performance.

Hywel Dda Integrated Care Models Hywel Dda Health Board, Carmarthenshire County Council, Ceredigion County Council, Pembrokeshire County Council.

Key Features		
Context	**Mechanism**	**Intended Outputs/Outcomes**
Provision of care closer to home in a rural setting. Focus on managing risk and pre-emptive care	• strategic integration of directors and managers	• good governance
	• acute response teams (ARTs)	• provision of care in the community
	• community response teams (CRTs)	• co-ordinated care
	• multi-agency support teams (MAST)	
	• communications hub	
	• weekly multi-disciplinary (MDT) meetings	
	• third sector brokers	
	• enhanced discharge services	
	• risk identity/stratification and management, virtual ward	
	• Integrated health record	

Degree of integration:

Macro: Joint directorship and development of Section 33 financial arrangements between services.

Meso: Joint administration, some sharing of resources.

Micro: predominantly multi-disciplinary working between service providers.

Table 6: Programme Theory of Integration (Hywel Dda, December 2012)

Level of organisation	Feature of organisation	Feature of organisation	Feature of organisation
	Health primary/secondary care	**Integrated care**	**Social/private/third/informal care**
	Policy	Policy	Policy
	Strategy	Strategy	Strategy
Macro	Directorship	Directorship	Directorship
	Budgets	Budgets	Budgets
	Commissioning	Commissioning	Commissioning
	Management	Management	Management
	Administration	Administration	Administration
Meso	Accounting	Accounting	Accounting
	Staffing/HR	Staffing/HR	Staffing/HR
	Location	Location	Location
	IT systems	IT systems	IT systems
	Data Audit	Data Audit	Data Audit
	Point of access	Point of access	Point of access
	Referral pathway	Referral pathway	Referral pathway
	Assessment	Assessment	Assessment
	Care plan	Care plan	Care plan
Micro	Review	Review	Review
	Record access/IT	Record access/IT	Record access/IT
	Record storage/IT	Record storage/IT	Record storage/IT
	Care teams	Care teams	Care teams
	Data collection	Data collection	Data collection
	Location	Location	Location

Overview

Hywel Dda has invested much time and effort in developing an integrated management structure, to provide a strategic response to the provision of integrated working. Strategic integration has been used as the platform to springboard service development. Shared understandings and financial arrangements are happening at chief executive level, director level and head of services level. Frontline inter-professional working, through multi-disciplinary weekly team meetings, remains underdeveloped, but it is acknowledged that the culture of the caring professionals have been demanding better integration 'for years' and as a result have organically built good working relationships across services. A communication hub, and the integrated health record for emergency services are now in place to co-ordinate referrals, but reorganisation is happening at a slower pace than desired. The single health board is having to work across a large geographical area and across several local authorities, with considerable variation in

service implementation. The health board has successfully bid for an Invest-to-Save loan to develop the use of predictive risk tools to manage public health. The health board is looking to a Results Based Accountability (RBA)-type system to evaluate services, because it recognises that community health is not a cheap option.

Current difficulties

- The need to reduce spending on acute care.
- Evaluation of services is difficult because much of the record collecting is still paper-based.
- GPs and district nurses operate their own system of community care.
- Policy is too distant from practice and is playing catch-up with service implementation.
- The LHB extends over three very different counties.
- Budget reduction and budgeting between services is complex.

Current successes

- Joint design of services to deliver care.
- The development of the co-commissioning code of practice between sectors.
- Working arrangements with the voluntary sector.
- The integrated health record.

Future considerations

- Moving forward with the Foundations for Change recommendations to evaluate services.
- Working with The King's Fund to develop a Results Based Accountability approach to service evaluation.
- Better working relationships using Section 33 arrangements with other service providers.
- Development of predictive risks and risk stratification to pre-empt care needs and plan services.

- National benchmarks and guidelines are needed to standardise service development and the evaluation of services.
- Better working relationships with GPs and district nurses.

Summary

The context of service development with Hywel Dda has been to use a top-down approach to promote changes in care delivery. Table 6 shows the intersection of the shapes that represent health and social care is largely at the top of the table in the macro section of organisational, where the focus on integration has been through strategic redesign and influenced by national policy. Care delivery has continued largely via the separate health and social care sectors. Hywel Dda Health Board covers a large geographical area, almost a quarter of the total size of Wales with a relatively small population (375,061). The focus on integrated care has been community-facing and preventative care in order to develop planned and pre-emptive care strategies. The top-down approach to implementing integrated care services across the three counties of West Wales has to a certain degree, delayed and inhibited the scale and pace of integration through frontline services. It is yet to be seen how this approach to service development will measure up to the ideal conceptual model of care, represented by the testable theory. The linear trajectory in the development of integrated care is downward, in order to achieve full integration at all organisational levels.

Gwent Frailty Project Aneurin Bevan Health Board, Blaenau Gwent County Borough Council, Caerphilly County Borough Council, Monmouthshire County Council, Newport City Council, Torfaen County Borough Council.

Key Features		
Context	**Mechanism**	**Intended Outputs/Outcomes**
Integrated adult health and social care services developed from a failing model of care delivery. Gwent Frailty Project uses a whole system model to deliver care across 5 localities, 1 local health board and the voluntary sector.	• strategic integration of directors and managers	• financial efficiencies
	• joint equipment stores	• promote independence in the community
	• pooled budgets between health and social care for some services	• reduce reliance on institutional care and move care into the home
	• frailty teams working in the community (CRTs), rapid response, hospital at home, emergency care at home, falls and reablement	• preventative care to avert crisis
	• single point of access	• Seamless coordinated delivery of health and social care
	• shared IT resources and mobile IT	• Reduce hospital admissions
	• Franchising some services	

Degree of integration:

Macro: Joint directorship and financial arrangements between services.

Meso: Joint administration, some sharing of resources.

Micro: predominantly coordinated care is delivered by different service providers, some integrated care with pooled budgets etc.

Table 7: Programme Theory of Integration (Gwent Frailty, December 2012)

Level of organisation	Feature of organisation	Feature of organisation	Feature of organisation
	Health primary /secondary care	**Integrated care**	**Social/private/third /informal care**
	Policy	Policy	Policy
	Strategy	Strategy	Strategy
Macro	Directorship	Directorship	Directorship
	Budgets	Budgets	Budgets
	Commissioning	Commissioning	Commissioning
	Management	Management	Management
	Administration	Administration	Administration
Meso	Accounting	Accounting	Accounting
	Staffing/HR	Staffing/HR	Staffing/HR
	Location	Location	Location
	IT systems	IT systems	IT systems
	Data Audit	Data Audit	Data Audit
	Point of access	Point of access	Point of access
	Referral pathway	Referral pathway	Referral pathway
	Assessment	Assessment	Assessment
	Care plan	Care plan	Care plan
Micro	Review	Review	Review
	Record access/IT	Record access/IT	Record access/IT
	Record storage/IT	Record storage/IT	Record storage/IT
	Care teams	Care teams	Care teams
	Data collection	Data collection	Data collection
	Location	Location	Location

Overview

Gwent Frailty Project works across five local authorities, one local health board and the voluntary sector. The project uses multiple mechanisms to integrate health and social care, working to meet frail older people's severe to complex needs within the community. Frailty is measured clinically according to limitations in ability and health. Services include rapid nurse-led response, reablement, emergency social care, falls co-ordination, mental health and community resource teams. These services are not ubiquitously available across the Aneurin Bevan Health Board, or indeed the five local authorities. Service users may or may not have access to a full menu of services, dependent on where they live. Community Response Teams (CRTs) ideally have a combination of social workers, physiotherapists, occupational therapists, service coordinators, rapid response nurses, discharge liaison nurse and support and wellbeing workers. The stakeholders noted that

services are still battling with the public perception that CRTs are seen as a lesser service compared to traditional acute care services in hospital.

Current difficulties

- Using mobile information technology for data collection.
- Linking systems across public sector.
- Data availability and access across health and social care.
- Recruitment delays and challenges.
- GPs' lack of confidence in the system – e.g they needed to talk directly to the CRT consultant to pass on clinical information for complex cases, a two-tier system is now in place.
- Under-use of service that can lead to inefficiencies in resource and staff use.
- The LHB covers a large area and can potentially dominate service delivery.

Current successes

- Strong leadership.
- Openness and commitment of staff to implement change.
- A performance management system based on RBA and report cards.

Future considerations

- LAs and LHB to formally sign off collaborative pooled budget arrangement.
- Programme review.
- Developing the single point of access call centre to meet demand as necessary.
- Continuous development of the CRT portal to capture information.
- Build relationships with GPs to 'market' the CRTs.
- Planning services using predictive models to be prepared for the next generation of care needs.
- Integrating care may not be about savings as much as cost containment.

Summary

The Gwent Frailty Service model was one of the first large-scale models of integrated care to be established in Wales. Gwent has received considerable investment to develop integrated care services across the five local authorities. The Gwent Frailty Service model has worked towards developing care services, in line with the conceptual model of integrated care. As such the programme model/theory (Table 7) reflects a more streamlined approach to service development at all organisational levels, more akin to the testable theory. This approach to service development and delivery has not been without difficulties. The varied contexts in which services have developed have shaped the organisation of integrated care. The services provided are not ubiquitous across the local authority areas. Integrated care is being delivered in different ways, dependent on the skill base of staff, existing resources and the perceived important needs identified by each local authority, in conjunction with the local health board.

Powys Integration of services
Powys Teaching Health Board, Powys County Council.

Key Features		
Context	**Mechanism**	**Intended Outputs/Outcomes**
Integrating adult health and social care services in a political climate that is heavily biased to **intra**grating social services.	• Joint equipment stores	• Meeting older people's individual care needs
	• Pooled budgets between health and social care for some services	• Multiple providers providing seamless care
	• Co-location	
	• IT merger, Email and access	
	• Common care for older people located in GP practices	

Degree of integration:

Macro: Separate directors and management between services.

Meso: Some joint administration, sharing of resources and co location.

Micro: predominantly coordinated care is delivered by different service providers, some evidence of integrated care with pooled budgets etc.

Table 8: Programme Theory of Integration (Powys, December 2012)

Level of organisation	Feature of organisation	Feature of organisation	Feature of organisation
	Health Primary /secondary care	**Integrated care**	**Social/private/third/ informal care**
	Policy	Policy	Policy
	Strategy	Strategy	Strategy
Macro	Directorship	Directorship	Directorship
	Budgets	Budgets	Budgets
	Commissioning	Commissioning	Commissioning
	Management	Management	Management
	Administration	Administration	Administration
Meso	Accounting	Accounting	Accounting
	Staffing/HR	Staffing/HR	Staffing/HR
	Location	Location	Location
	IT systems	IT systems	IT systems
	Data Audit	Data Audit	Data Audit
	Point of access	Point of access	Point of access
	Referral pathway	Referral pathway	Referral pathway
	Assessment	Assessment	Assessment
	Care plan	Care plan	Care plan
Micro	Review	Review	Review
	Record access/IT	Record access/IT	Record access/IT
	Record storage/IT	Record storage/IT	Record storage/IT
	Care teams	Care teams	Care teams
	Data collection	Data collection	Data collection
	Location	Location	Location

Overview

Powys is unique in that it has no acute medical services. Care needs have traditionally been met using a social care approach and integrating health and social care has been built on relationship working. The recent collaboration between Powys and Ceredigion Social Services has been resource and time intensive and has reduced the priority given to the integrated health and social care agenda. The platform for integration has been to unify IT systems and deliver a jigsaw of services to meet needs through reablement, home care and CRTs. Integrated care with Section 33 agreements has happened with equipment stores between health and social care and the third sector care and repair services and will happen next with reablement services. Providing equipment to multiple agencies has been relatively simple, using a business model to invoice sectors for the services and equipment requested from the stores (as part of a national programme).

Current difficulties

- Lack of drive by the local authority to integrate care.
- Threat of reduced funding to local authority and the cost burden falling on health.
- Evaluation of services is disjointed.

Current successes

- Integrating the IT platforms between social and health care.
- Community hospital information interfaces with community information.

Future considerations

- Integrating strategic posts.
- More joint roles at local level.
- More Section 33 agreements.

Summary

Dedicated equipment stores, jointly used by health and social care and managed by the third sector using a business model, based on guaranteed funding through a Section 33 agreement, has ensured a reliable and efficient equipment service is operating across the counties. The equipment stores are centrally accessed and located, referrals are taken and acted on immediately, as stock can be stored and called off, re-ordered, invoiced and paid for through agreed terms and conditions. Business is guaranteed, managed and accounted for. The programme model is integrated at strategic level to ensure financial stability and integrated at delivery level as a standalone service, working with cross-service needs. The overall picture of integration in Powys is a bottom-up approach where frontline delivery of care has taken the lead in structuring care to best fit the local needs of the community. Table 8 represents Powys as a whole, although the equipment stores are comprehensively integrated health and social care integration is largely seen only at frontline delivery of care.

Vale of Glamorgan Integrated services
Vale of Glamorgan Council, Cardiff and Vale University Health Board.

Key Features		
Context	**Mechanism**	**Intended Outputs/Outcomes**
Reorganisation of Adult Services for frail older people	• Community Response Teams (CRTs)	• Facilitated early discharge
	• Acute Response Teams (ARTs)	• Community health care
	• Elderly Care Assessment Service	• Cost savings
	• Homecare Support	
	• Chronic Conditions Case Management	
	• Voluntary Sector Utilisation	
	• Pharmacy Support	
	• Community Phlebotomy	

Degree of integration:

Macro: Joint directors and management between services in the Vale of Glamorgan.

Meso: Some joint administration, sharing of some resources and some co-location.

Micro: Generally integrated services at ground level.

Table 9: Programme Theory of Integration (Vale of Glamorgan, December 2012)

Level of organisation	Feature of organisation	Feature of organisation	Feature of Organisation
	Health primary /secondary care	**Integrated care**	**Social/private/third /informal care**
	Policy	Policy	Policy
	Strategy	Strategy	Strategy
Macro	Directorship	Directorship	Directorship
	Budgets	Budgets	Budgets
	Commissioning	Commissioning	Commissioning
	Management	Management	Management
	Administration	Administration	Administration
Meso	Accounting	Accounting	Accounting
	Staffing/HR	Staffing/HR	Staffing/HR
	Location	Location	Location
	IT systems	IT systems	IT systems
	Data Audit	Data Audit	Data Audit
	Point of access	Point of access	Point of access
	Referral pathway	Referral pathway	Referral pathway
	Assessment	Assessment	Assessment
	Care plan	Care plan	Care plan
Micro	Review	Review	Review
	Record access/IT	Record access/IT	Record access/IT
	Record storage/IT	Record storage/IT	Record storage/IT
	Care teams	Care teams	Care teams
	Data collection	Data collection	Data collection
	Location	Location	Location

Overview

The Vale of Glamorgan has been strategic in its approach to integrated care. A Joint Head of Adult Services and Locality Director was appointed to restructure adult services. The NHS and local authority teams also have a joint operational manager. The integrated care models have clearly defined governance channels between health and the local authority. Resources have been integrated and are co-located and jointly managed. The newly acquired funding from Invest-to-Save (2012) has been used to finance the Wyn Campaign. The Wyn Campaign focuses on services for frail older people in Cardiff and the Vale. It is a whole systems approach to develop universal, targeted and longer-term care for the older person, using community resource teams (CRTs) in the first instance. It will also develop acute response teams, risk stratification, falls programmes, a pharmacy watch and a case management approach for complex and chronic conditions.

Current difficulties

- IT and information sharing.
- Co-location is difficult with limited resources.
- Some obstruction at local level to the acceptance and value of community care.

Current successes

- Piecemeal services and action are being scaled up for whole system change.
- Invest-to-Save funding to develop the Wyn Campaign.
- Ground-level managers dealing effectively with integration between health and social care.
- Integrated teams working well with the hospital team managers.
- Well established governance.

Future considerations

- Evaluation of the service using the accumulated data.
- Integrating IT platforms, sharing information and data protection.
- Look at the cash savings.

Summary

The programme model that the Wyn Campaign is working towards is a holistic approach to integration at all organisational levels (Table 8) and is a 'good fit' with the testable theory of the ideal concept of integrated care. The current difficulties outline how certain sections of organisational arrangements do not meet the ideal of the testable theory. Invest-to-Save funds have been used to overcome some of these difficulties. The service, at the time of publication, has not been evaluated or costed, but work is underway to develop a workable approach. This will assess whether the integrated model is having an impact on the service user experience and operational efficiency, compared to previous ways of working.

Wrexham Intermediate Care Betsi Cadwaladr University Health Board, Wrexham County Borough Council.

Key Features		
Context	**Mechanism**	**Intended Outputs/Outcomes**
Joint venture between NHS, Wrexham Social Services, voluntary sector and the Community Health Council	• Intermediate care services	• Discharge from hospital efficiently
	• Frailty team	• Reduce hospital stay
	• Reablement team	• Re-able person to place of abode
		• Avoid inappropriate hospital admissions

Degree of integration:

Macro: None.

Meso: Some joint administration, sharing of some resources.

Micro: Generally integrated frailty services at ground level.

Table 10: Programme Theory of Integration (December 2012)

Level of organisation	Feature of organisation	Feature of organisation	Feature of organisation
	Health Primary /secondary care	**Integrated care**	**Social/private/third /informal care**
	Policy	Policy	Policy
	Strategy	Strategy	Strategy
Macro	Directorship	Directorship	Directorship
	Budgets	Budgets	Budgets
	Commissioning	Commissioning	Commissioning
	Management	Management	Management
	Administration	Administration	Administration
Meso	Accounting	Accounting	Accounting
	Staffing/HR	Staffing/HR	Staffing/HR
	Location	Location	Location
	IT systems	IT systems	IT systems
	Data Audit	Data Audit	Data Audit
	Point of access	Point of access	Point of access
	Referral pathway	Referral pathway	Referral pathway
	Assessment	Assessment	Assessment
	Care plan	Care plan	Care plan
Micro	Review	Review	Review
	Record access/IT	Record access/IT	Record access/IT
	Record storage/IT	Record storage/IT	Record storage/IT
	Care teams	Care teams	Care teams
	Data collection	Data collection	Data collection
	Location	Location	Location

Overview

The hospital-based Intermediate Care Team was a consultant-led initiative. It developed in response to a government directive and some Welsh Government funding. The aim was to integrate care to reduce hospital admissions and speed up discharge. It uses a time-limited, 4-week, supported care package followed, if necessary, with a referral to a reablement team or social services. A key worker is allocated to an older person deemed as frail, either at a hospital admission assessment, in A&E or in a community-based care setting, and an exit care strategy is formulated. Patients are screened and mid-range needs are managed by the intermediate care team. The staff (an on-call social worker, two senior nurses, a physiotherapist, an occupational therapist and the voluntary services) work effectively by mutual co-operation. They are not co-located, do not share a budget, and do not operate within a hierarchical management structure.

Current difficulties

- Insecurity around project finances made staff recruitment and retention difficult.
- Different traditions and targets between health and social care are not always compatible.
- More time is needed to educate referring health professionals as to the value of the service.
- Complex care and conditions cannot be managed by intermediary services.
- Leadership structure is unclear.

Current successes

- Good qualitative patient/service user feedback.
- Patients' needs are picked up earlier in the system (at admission) and care support/reablement can be planned.
- Expedited discharges.
- Mutual co-operation of staff.

Future considerations

- Better engagement with GPs.
- A results-based accountability method is being used to evaluate the service. This needs to be completed and published.

Summary

This example of integrated health and social care for older people used for Wrexham is a service that has been championed by a geriatrician, employed by the Local Health Board with limited government funding. Hence, the extent of integration is limited to delivery/micro-level, with some joint responses from human resources, administration and finance when necessary. As such, health and social care only intersect at the micro-level on Table 10. Strong leadership at ground level has driven the service forward and there is some evidence to suggest that the service saved money in the first 6 months of operating. Qualitative reports suggest that service users appreciated being able to liaise with the key worker concerning their care needs.

Torfaen/Anglesey/North Powys Emergency Response Care
Consultant-led acute community response - the Bhowmick Intervention Model.

Key Features		
Context	**Mechanism**	**Intended Outputs/Outcomes**
Consultant-driven service to ensure best care for older people and prevent unnecessary hospital admissions	• Consultant-led multi-disciplinary team (MDT) caring for patients through a virtual community ward	• The home is the hospital
	• Referrals from GPs	• Avoided hospital admissions
		• Ongoing care is facilitated
		• Avoids unnecessary use of emergency services
		• Promotes dignity in care

Degree of integration:

Macro: None.

Meso: None.

Micro: Integrated frailty services at ground level.

Table 11: Programme Theory of Integration (Bhowmick Model, December 2012)

Level of organisation	Feature of organisation	Feature of organisation	Feature of Organisation
	Health Primary /secondary care	**Integrated care**	**Social/private/third /informal care**
	Policy	Policy	Policy
	Strategy	Strategy	Strategy
Macro	Directorship	Directorship	Directorship
	Budgets	Budgets	Budgets
	Commissioning	Commissioning	Commissioning
	Management	Management	Management
	Administration	Administration	Administration
Meso	Accounting	Accounting	Accounting
	Staffing/HR	Staffing/HR	Staffing/HR
	Location	Location	Location
	IT systems	IT systems	IT systems
	Data Audit	Data Audit	Data Audit
	Point of access	Point of access	Point of access
	Referral pathway	Referral pathway	Referral pathway
	Assessment	Assessment	Assessment
	Care plan	Care plan	Care plan
Micro	Review	Review	Review
	Record access/IT	Record access/IT	Record access/IT
	Record storage/IT	Record storage/IT	Record storage/IT
	Care teams	Care teams	Care teams
	Data collection	Data collection	Data collection
	Location	Location	Location

Overview

This model of care has been implemented successfully in Torfaen (2006), Anglesey (2011) and is now being promoted in North Powys (2013). The Bhowmick care model is designed as a preventative service to intercept inappropriate admissions to hospital for the older frail persons, to prevent unnecessary use of the emergency services and to prevent protracted and unnecessary stays in hospital. The service development has largely been championed by a consultant geriatrician. The service uses a medical model of care and the staff is trained accordingly. Collaborations are nurtured between social services and local authorities at all levels; along with psychiatric services, palliative care, the ambulance service, minor injuries units, secondary care, biochemistry, haematology, radiology, district nurses, residential care homes, the voluntary sector and GPs. Urgent and emergency calls to the GP or Ambulance Service are screened and referred to the consultant geriatrician. A health care worker or senior nurse responds within

the hour, completes a full assessment and takes bloods. Results are sent to the consultant/nurse, discussed with the GP and the person is treated within their own home if appropriate. A full MDT meets every morning to discuss all patients (between 10 and 14) on the community virtual ward. Patients are discharged back to their GP and statutory services with the appropriate care packages in place.

Current difficulties

- Co-ordinating services.
- Selling/marketing the service as a concept of care.
- Generating confidence in the service provision.

Current successes

- Clinician-to-clinician care.
- Older person can be treated in their own home with all the resulting benefits.
- Current resources are strategically used to enhance service provision.
- The suggestion is that the service is highly cost effective when using hospital bed avoidance as an output measure.

Future considerations

- The viability of implementing this service model across Wales for the older frail people.

Summary

This programme model of care (Table 11) is focused on older peoples' care. It has been driven by clinicians, one in particular, and health care professionals working alongside each other to develop integrated primary, secondary, community and social care. GP involvement has been central to the ongoing success of this service. The open dialogue channels between the geriatrician, health and social care team and the GPs have been crucial to success. This is a bottom-up approach to developing integrated care services and is said to be efficient, cost effective and beneficial to the service user.

Housing Improvements and Associated Support
Care and repair.

Key Features		
Context	**Mechanism**	**Intended Outputs/Outcomes**
Joint venture between NHS, Social Services and the voluntary sector	• Section 33 agreements	• Enabling people to remain in and manage their own homes
	• Disabilities facilities fund	• Facilitate the hospital to home transition, accelerating discharge
	• Care and repair agencies across Wales	• Provide adaptations and home improvements to have hospital at home
	• Rapid response adaptations to people's homes	• Reduction in hospital and residential care
	• Enabling services and advice	
	• Minor adaptations to the home	
	• Falls prevention	
	• Telecare	

Degree of integration:

Macro: Strategic facilitation to allow joint working arrangements and funding.

Meso: Some joint stores.

Micro: Collaborative services at ground level.

Table 12: Programme Theory of Integration (Care and Repair, December 2012)

Level of organisation	Feature of organisation	Feature of organisation	Feature of Organisation
	Health primary /secondary care	**Integrated care**	**Social/private/third /informal care**
	Policy	Policy	Policy
	Strategy	Strategy	Strategy
Macro	Directorship	Directorship	Directorship
	Budgets	Budgets	Budgets
	Commissioning	Commissioning	Commissioning
	Management	Management	Management
	Administration	Administration	Administration
Meso	Accounting	Accounting	Accounting
	Staffing/HR	Staffing/HR	Staffing/HR
	Location	Location	Location
	IT systems	IT systems	IT systems
	Data Audit	Data Audit	Data Audit
	Point of access	Point of access	Point of access
	Referral pathway	Referral pathway	Referral pathway
	Assessment	Assessment	Assessment
	Care plan	Care plan	Care plan
Micro	Review	Review	Review
	Record access/IT	Record access/IT	Record access/IT
	Record storage/IT	Record storage/IT	Record storage/IT
	Care teams	Care teams	Care teams
	Data collection	Data collection	Data collection
	Location	Location	Location

Overview

Care and Repair Cymru is a pan-Wales voluntary sector organisation providing housing-based equipment and repair services, and installing ability and reablement aids within the home. In providing these services it has successfully collaborated with the statutory services and the Welsh Government. Care and Repair Cymru provides services to a network of 22 Care and Repair agencies across Wales. The agencies are funded by a variety of means including: core funding from the Welsh Government through the rapid response adaptations programme (RRAP); disability facilities grants; and Big Lottery and charitable donations. The aim of delivering care and repair services is to enable people to live more independently in their own homes. As a third sector organisation, Care and Repair is accountable to their many donors and have developed systems to measure the social and economic benefits of delivering care and repair using a business model.

Current difficulties

- Insecure financial arrangements in terms of both the amount, and the longevity and consistency of the funding streams.

Current successes

- Delivering efficient, responsive and effective services.
- Impact measured and assessed using the Handy Persons Financial Benefits Toolkit (O'Leary, Linney & Weiss, 2010).
- Peoples' needs are being assessed and responded to earlier using pre-emptive preventative home improvement adaptation services.
- Preventative home safety measures have decreased the percentage of jobs needed to be carried out at hospital discharge, reducing delays.
- Self-referrals enable people to take ownership and management of their care, thus facilitating independent living for longer.

Future considerations

- Development of arrangements between S=social services and health through Section 33 arrangements and Memoranda Of Understanding.
- Developing more secure long-term funding arrangements.
- Developing the preventative services that reduce the risk of falls both in and away from home.

Summary

As a third sector organisation, Care and Repair offer a standalone service integrated through macro-level agreements. It can deliver care through self-referral and joint working arrangements. This model of care delivery differs from the other programmes explored in this report. The integration of health and social care at the micro-level is independent of the wider institutional care delivery at the macro-level. This is diagrammatically shown by the two independent shapes on Table 12. The service delivers totally integrated health and social care, but through a separate organisational structure. This programme of care does not 'fit' the conceptual model of care but is highly efficient in delivering integrated services with limited meso-level integration.

Voluntary Sector Brokers working with Community Resource Teams
Pembrokeshire Action for Voluntary Services.

Key Features		
Context	**Mechanism**	**Intended Outputs/Outcomes**
Joint venture between NHS, social services and the voluntary sector to fill the "needs gap" between social and health care	• Voluntary sector brokers that work with MDTs from health and social services	• Enabling people to remain and manage within their own homes and communities
	• The continuing health care project funding	• Facilitate the hospital to home transition, accelerating discharge
	• Partnership working with the Health Board	• Meet the needs of patients outside of the health and social care models of working

Degree of integration:

Macro: Strategic facilitation to allow joint working arrangements.

Meso: None/limited.

Micro: Collaborative services at ground level.

Table 13: Theory of Integration (Voluntary Sector Brokers, December 2012)

Level of organisation	Feature of organisation	Feature of organisation	Feature of organisation
	Health primary /secondary care	**Integrated care**	**Social/private/third /informal care**
	Policy	Policy	Policy
	Strategy	Strategy	Strategy
Macro	Directorship	Directorship	Directorship
	Budgets	Budgets	Budgets
	Commissioning	Commissioning	Commissioning
	Management	Management	Management
	Administration	Administration	Administration
Meso	Accounting	Accounting	Accounting
	Staffing/HR	Staffing/HR	Staffing/HR
	Location	Location	Location
	IT systems	IT systems	IT systems
	Data Audit	Data Audit	Data Audit
	Point of access	Point of access	Point of access
	Referral pathway	Referral pathway	Referral pathway
	Assessment	Assessment	Assessment
	Care plan	Care plan	Care plan
Micro	Review	Review	Review
	Record access/IT	Record access/IT	Record access/IT
	Record storage/IT	Record storage/IT	Record storage/IT
	Care teams	Care teams	Care teams
	Data collection	Data collection	Data collection
	Location	Location	Location

Overview

Voluntary sector brokers were funded through the Health Board's Continuing Health Care Project, with the aim of providing a more holistic approach to care. Specifically, brokers work within integrated health and social care teams and liaise with key workers to deliver 'extra' services, which may be beyond the health and social care remit. The type of care interventions could include, signposting to voluntary groups, referral to benefits advice, or facilitating engagement with a community group. The two voluntary broker posts have been filled by health workers and are deemed to be part of an integrated, holistic care team, as they attend the multidisciplinary team care meetings.

Current difficulties

- Lack of confidence of health and social care staff in using voluntary sector services.

- The brokers become another point of contact over and above the key worker.
- Information sharing has yet to be formalised. Brokers generate their own paperwork.
- The integrated team only use the social service records not the health records.
- Restructuring of services can be disruptive to care.

Current successes

- The brokers are flexible and responsive to a variety of patient needs.
- The brokers are a neutral point of contact.
- The brokers are an informal care service that asks what they can do for the service user not what the service can do for them. Relationship-centred care.

Future considerations

- Co-location in the communications hub to promote joint working.
- Brokers based at the hospital to support discharge services.
- Evaluation of the patient stories that are collected by the brokers.
- Measure the impact of the voluntary broker service.
- Develop capacity in voluntary sector services that cause delay in service provision (lack of funding).

Summary

This programme model of care (Table 13) is not a 'best fit' model when compared to the testable theory. Qualitative reports suggest the service is meeting the needs of the client base, regardless of whether this model of service delivery compares to the idealised conceptual model of care (Table 2). There is no clear evidence as yet to suggest that the investment in the brokers is cost effective in reducing the individual patient/client care costs or organisational expenditure. The broker service is technically a bought in service to compliment the integrated multidisciplinary team; the programme model operates at micro-level only.

Integrated Health and Social Care Programmes across Wales British Red Cross.

Key Features		
Context	**Mechanism**	**Intended Outputs/Outcomes**
A large charity with service level agreements with Local Authorities and Health Boards across Wales to jointly deliver a variety of care packages	• Gofal Big Lottery Care in the Home package	• Delivering joined up holistic services
	• Home from Hospital care	• Supporting people with needs in the community
	• Transport	• Delivering care in a crisis
	• Equipments services	
	• Intermediate care service 8-12 weeks	
	• End of Life Care	

Degree of integration:

Macro: Strategic facilitation to allow joint working arrangements.

Meso: None/limited.

Micro: Collaborative services at ground level.

Table 14: Programme Theory of Integration (Red Cross, December 2012)

Level of organisation	Feature of organisation	Feature of organisation	Feature of organisation
	Health primary /secondary care	**Integrated care**	**Social/private/third /informal care**
	Policy	Policy	Policy
	Strategy	Strategy	Strategy
Macro	Directorship	Directorship	Directorship
	Budgets	Budgets	Budgets
	Commissioning	Commissioning	Commissioning
	Management	Management	Management
	Administration	Administration	Administration
Meso	Accounting	Accounting	Accounting
	Staffing/HR	Staffing/HR	Staffing/HR
	Location	Location	Location
	IT systems	IT systems	IT systems
	Data Audit	Data Audit	Data Audit
	Point of access	Point of access	Point of access
	Referral pathway	Referral pathway	Referral pathway
	Assessment	Assessment	Assessment
	Care plan	Care plan	Care plan
Micro	Review	Review	Review
	Record access/IT	Record access/IT	Record access/IT
	Record storage/IT	Record storage/IT	Record storage/IT
	Care teams	Care teams	Care teams
	Data collection	Data collection	Data collection
	Location	Location	Location

Overview

The British Red Cross operation in Wales has expanded over the last six years and this process has been facilitated by: joint service level agreements; memoranda of understanding and Section 64 working arrangements with local authorities; local health boards; and joint working arrangements with other third sector organisations to deliver specialised services. A large grant from the Big Lottery ensured the development of the Gofal Home from Hospital care package in North Wales. It offers short-term care packages for 5-6 weeks, jointly delivered with health and social services. Services delivered in the south of Wales include tenancy support, respite and residential care, and end-of-life care (delivered via the Marie Curie Foundation). The services are delivered by a combination of paid and volunteer staff. Funding services is a continual challenge, with few consistent and reliable sources of income. Some services are commissioned, while some are funded by charitable donations. The British Red Cross aims to deliver services with a measurable level of

impact, as it is continually accountable to its funding providers and operates within high levels of scrutiny, standards and audits, in order to secure continuity of funding.

Current difficulties

- Building relationships with funding organisations for continuity with finance.
- Amalgamation of the local health boards has taken longer than anticipated.
- Conformity with data management across services is limited.
- Payment for commissioned services is often delayed.

Current successes

- Joint budget arrangements between health, social services and the third sector.
- Improvements in the third sector at delivering reliable and sustainable services.
- The British Red Cross is good at responding quickly and appropriately in times of crisis.
- The public and the third sector working alongside each other.
- Charities are readily accepted as neutral/'no strings attached' care-givers.

Future considerations

- Between 70-80% of care given through the British Red Cross is delivered by volunteers. Assessments are carried out by paid professionals. The challenge is to increase the capacity to meet the predicted increasing levels of care needs.
- Evaluation of the impact of the Gofal scheme to alleviate social isolation associated with loneliness. The British Red Cross is mapping areas of isolation in the over 50s population in Wales in order to target care.

- Working with smaller charities to ensure they are not squeezed out of the marketplace. Smaller charities want to offer integrated care and work jointly with health and social services to satisfy unmet need identified in some older people.

Summary

The model of integrated health and social care between the third and statutory sectors is associated with standalone services that deliver joined up and seamless care. Table 14 represents this by using one shape only to identify the British Red Cross as an integrated health and social care service in its own right. The success of delivering care in this fashion is being evaluated and presently comes in on budget with target funding and delivers patient benefit. This model of commissioned integrated care for older people in the community should be compared to the statutory sector's equivalent attempts to deliver integrated care, in order to determine what works, why and how.

Stakeholders who interact with integrated health and social services

General Practitioners

Overview

Creating the home as the hub of health, or a hospital at home model, will influence the ways GPs have to practice. GPs facilitate almost 80% of all health contacts and are ultimately responsible for their patients' health whilst they are in the community. Therefore, the delivery of integrated care services in the community is of concern to a GP and GPs need to be confident in the care that their patient is receiving from any service. Health services delivered in combination with social services, through community resource teams and acute response teams, without the GPs knowledge, or with delayed knowledge of the intervention, can lead to miscommunication and lack of confidence in care. Delivering acute care in the community is also of concern, because some care techniques need the consent and presence of a GP, but may be carried out by a separate, specialist team. Currently the new ways of integrated working do not provide a good interface with GPs. The general response is for mutual respect and co-operation to be extended towards GPs from the managers/planners of the new service delivery initiatives.

Integrated service providers need to work more closely with GPs to provide better services and co-operation between primary care and joint working. Currently there are only limited numbers of referrals from GPs into integrated care services.

Current difficulties

- Lack of knowledge about what services are offered.
- Lack of confidence in the care.
- Lack of capacity and flexibility of new services to deliver as quickly and easily as a district nurse.
- Lack of face-to-face interaction or direct communication with the care-giver (nurse, occupational therapist, physiotherapist, social worker).

- Services not yet embedded into the system.
- Technological limitations to data sharing.
- Current successes.
- Use of iPad technology in the community and docking the iPad data to update the current health record.
- Direct contact with other health professionals for clinician-to-clinician referrals.
- Direct link to the social services emergency hot line.
- Video conferencing for MDTs.

Future considerations

- Social worker/team alignment to the GP surgery.
- Facilitation of CRTs within primary care surgeries with associated funding.
- Referral process to CRT has to be simple, highly responsive and provide feedback.
- Assessment of risk management of patients with complex and chronic needs in the community.
- Profiling ‘at risk’ patients.
- Primary care teams working, and contained within, the same geographical locations as GP surgeries.
- Access to hospital test results available through GP portal and community care.

Summary

GPs are important stakeholders in delivering care in the community. The programme models that directly work with GPs appear to be effective at delivering care for chronic and complex care in the community that react to crisis responses (Bhowmick model). Fully integrating primary care into integrated service provision appears to be a necessary consideration for further service development.

Evidence Synthesis

In order to synthesise the data into a coherent framework, a simple thematic analysis technique (Braun & Clarke, 2006) was applied to the interview data and used to identify major and common themes that affect integrated service delivery at macro, meso and micro-levels. These themes are listed in Table 15.

Table 15: Synthesis of Context, Mechanisms and Outcomes of integrated older people's services

Context	Mechanism	Outcome
Macro		
Government has set the agenda to orchestrate change in the delivery of health and social care to older people	Financial incentives and opportunities have been made available to LAs, LHBs and the third sector to restructure services	The Integrated care agenda has been a major facilitator of change in the delivery of services for older people with buy in at all levels
Integrated care delivery has not been defined as a specific type of working practice	Services are being developed purposively according to local needs	Integration is seen as a necessary augmenter of change to meet the changing needs of an ageing Welsh population
As a result of the reduction in national budgets, cost of care for the over 65s aims to be reduced	Reducing the cost of older people's care has focused on reducing acute hospital bed days, even though increased populace will increase usage	Pressure has been placed on LHBs to better manage the over 65s' hospital admissions, lengths of stay and speed of discharge
Health and social care capacity is being reduced whilst demand is set to rise	Facilitate informal care networks and the third sector to deliver independent care. Greater financial provision for home carers and third sector funding to deliver services	Less statutory control of care for the over 65s. Maintaining independence in the community for longer may lead to a change in statutory service provision. People will only enter statutory services when their needs become acute
Delivering care in the community using the home as the health hub. Keeping people happily independent for longer	Re-ablement and community response and resource teams used to deliver care in the home and the community	Integrated care services have often been developed in isolation without the collaboration of GP primary care health services who default to acute care referral
Meso		
Holistic delivery of care	The process of delivering care is seen as well coordinated care that meets the 'biopsychosoical' and spiritual aspects of care	Difficulties with cross cultural working practices. Different goals need to become shared goals to increase collaborative working

Context	Mechanism	Outcome
Single multidisciplinary teams delivering care in the community	Co-location of staff to facilitate communication. Staff works over the same geographical locations and build teams of care around familiar communities	Silo'd services between health and social care and other services have created a variety of different care pathways for older people. 22 LAs and 7 LHBs have different geographical boundaries
Single policy and planning strategies for delivering care to older people	Joint executives and director posts	Joint executive posts do not result in enough staff to deliver services on the ground
Single management system for delivering care	Good senior management, integrated vertically and horizontally	Single management systems and administration should decrease the work load for frontline staff
Seamless delivery of care	Co-location of staff and services, co-ordinated relationship centred care	Good integrated care is relationship based. Lack of GP involvement is seen as the missing link to providing seamless community care
Single assessment and review of care needs	One assessment and review process through the Unified Assessment Process (UAP). Information uploaded onto Social Care IT system which is inaccessible to Health Care teams	Use of two computer systems to access information - slow. Remote data collection is done by hand. Sharing and updating records is unwieldy, slow and location specific
Single point of access	Standardised eligibility criteria to receive services. Triage point and referral to appropriate service.	Reduces the number of cross referrals Services limited to the knowledge of the telephone operator. Does not take account of complex needs
Single budgets for care for older people	Shared or combined and arranged budgets have created successful collaborations with Section 33 funding arrangements	Competition over funding. Insecurity around continuation of funding. Limitations of service provision outside of shared budget Insecurity over staff pay, pensions and contracts leads to difficulties with recruitment and retention of staff
Systems in place to work more easily with the private and voluntary sectors	Memoranda of Understanding with the third sector and with commissioning services provide a platform to improve diversity of care	Use of third sector service delivery provides variety and flexibility to meet individual care needs

Context	Mechanism	Outcome
Micro		
Improving services for older people in order to have their care needs met for as long as possible in their own homes and community	Integrated care provision has facilitated communication and inter-professional working with service users	The services provided are limited to the key worker's knowledge of service availability and professionalism of care
Improving the welfare and wellbeing of older people	Shared consent to use data	Sharing information between services using different IT platforms is extremely difficult
	Remote collection of service user information is traditionally done by hand Introduction of new technology for both the service user and the professional	Updating patient/user notes is time consuming and limited by mobile technology, internet connectivity and rural working. New technology can induce feelings of inadequacy or empowerment
	Keeping service users in their own homes	This can give rise to feelings of isolation and loneliness. For some especially couples it gives a sense of control over care and confident independence. Onus on transportation falls on service provider
	Changing the culture of care	May lead to loss of confidence in care that is outside of the traditional acute care response
Facilitating and supporting informal care providers	Respite care, extra benefits for care-giver and supplemented care support	Some carers, family and friends are exhausted and need extra care provision for themselves

The information drawn together in the above table and the literature review makes much of the context in which integrated health and social care services have developed, the context in which care is delivered and the mechanisms used to deliver care services. The outcomes of service delivery for the end user are less well documented. Evaluation of service delivery is limited and there is little evidence to suggest that a specific context, or a certain way of delivering care, is more or less effective than another. When comparing the programme theories outlined by the stakeholders to the testable theory developed from the integrated care literature, it is apparent there is no clear formula to delivering successful care. Macro-level integration appears to be successful when care services are commissioned by the statutory sectors and

delivered to the community by the third or private sectors, such as those described by the British Red Cross and Care and Repair. Macro-level integration between LHBs and LAs appeared to have little impact on frontline care delivery in the initial stages of service development, as seen in the Hywel Dda example. Yet, macro-level integration appears to operate as a stable platform for service redesign in the more established structure of integrated services seen in Northern Ireland. Whole systems approaches to integrate health and social care, similar to that of the testable theory, have developed out of unstable and unsustainable service contexts, such as that described by Torbay. The context for restructuring services was born out of necessity, because existing services were no longer functioning satisfactorily.

The context for meso-level integration for process-orientated service provision was co-location, integrated IT, shared referrals, assessments and reviews. The meso mechanisms used to facilitate service delivery were the use of single point of access and single health and social care assessments and review systems. This integrated administration system has had mixed effects on the end user and professional working. Single points of access can disentangle multiple referrals and care provision, but can limit referrals to 'known' services and organisations only. Moreover, they limit professional-to-professional communication channels reported as a barrier to referral by GPs.

Micro contexts of care that influence service delivery, such as geographical location, and typology of care, such as complex and chronic conditions, determine the mechanisms of care delivery. Gwent Frailty, for example, offers a range of services in different locations. Consequently, the response mechanisms vary across the counties, dependent on the available service provision, which will, in turn, alter the care outcome for the service user. As yet it is unclear which context and mechanism produces the best outcomes for the service user, to enable them to live well in their own home. What is clear is that the different programme theories described above have been developed in response to the unique contexts in which care needs to be delivered to individuals. Without robust evaluations of care it is difficult to ascertain what mechanism works best for whom, why and in what context.

4 Discussion

Appraisal of Policy and Practice

The background information given at the beginning of the report outlined the historical context of integrated service development and the case for joint services. These have been laid out in the Welsh Government's Health and Social Care and Wellbeing strategies guidance (2003 onwards) and Section 24 of the *NHS Reform and Health Care Professional Act* (2002). Such policy and strategy, we would argue, promotes integrated care as a panacea response to achieving better outcomes for and with patients at lower cost (even though the evidence for this is at best fragmented and equivocal). The latest large-scale explorations of the outcomes of integrated care at the beginning of 2013 suggest that 'best care' is facilitated through relationship building between the service user and professional, rather than internal restructuring of organisations (Dickinson et al., 2013). In one of very few comparative studies, no single feature of integrated care, nor any particular model of delivery, was found to be better than another, although Goodman et al. (2013) reported a difference between the expense of delivering collaborative care, which was marginally more expensive to deliver than case-managed care and integrated service delivery. Collaborative care did, however, give the service user more professional contact time. Contact time was considered by patients as a valued outcome of service delivery along with appointment punctuality and the relationships built with and between the professionals involved in care. Goodman et al. costed the different types of integrated care delivery and the defining factor of expensive care was not the type of care or how the care service was delivered but the expense of care was closely associated with demographic indicators. The expense of delivering care increased when the person was older, living independently and living alone. This outcome suggests that demographic indicators are important considerations when targeting care to vulnerable groups. Predicting

costs and planning services can be directly related to identified vulnerable individuals in the community who match this set of demographic indicators.

Conclusions drawn from the overview of literature and the reported experiences of delivering integrated care are still mixed and inconclusive as to what works, for whom, in what circumstances and why. The main messages drawn out of the literature and stakeholder interviews, at this interim stage, are:

- Care needs to improve;
- Delivering better more joined up care is imperative;
- The process of delivery and the perceived outcome of care are interdependent;
- Effective care delivery is based on inter- and intra-professional working relationships;
- Any service platform that promotes communication between sectors and services and promotes relationship-rich working delivers more effective and efficient care;
- Strategic restructuring of sectors bares little relevance to perceived service user outcomes;
- National policy directives are thought by some to be strategically rich but ‘action poor’;
- Integrated service delivery development is organic and locally sensitive;
- There is no one-size-fits-all model of integrated service delivery;
- There is a wealth of data collected from the service user which could be used very effectively to evaluate services. But robust, systematic evaluations are largely absent;
- Delivering integrated care may not save money in the ‘cashable’ sense, but it may help to contain the costs of intervention and, ultimately, allow for more interventions to take place;
- Integrated care can be used to facilitate change, as it is seen as an 'inherently good thing';

- Involving GPs is integral to integrated service development in the community;
- The goal to reduce beds in acute care is not a viable measure, as the baseline level of chronic and complex care needs is likely to increase as the population ages;
- IT systems are generally not compatible, meaning the transfer of necessary information for informed inter and intragrated care across and between services is limited; and
- The expense of delivering care increases when a person is older, living independently and living alone.

Many of these issued have been raised by The King's Fund in their 16-step guide for making integrated services happen and, more recently, in a published framework for integrated services (May, 2013). The framework is a collaborative or shared commitment to the major health and social care institutions in England, to provide a common language and goal for whole system working, largely aligned with the testable theory (Table 2) drawn out of the literature review.

The definitions and shape of ideal future engagement with health and social care users have also been defined by National Voices and aligned with the document *Making It Real* (Think Local Act Personal, 2013). The National partners have come together to promote widespread innovation of services across England and there is much that Wales can take from this initiative. However, delivering integrated care will always remain a work in progress, as every service is unique to its target audience. Wales needs to continue to develop local, responsive services, and the documentation produced by The King's Fund and others, such as National Voices and Talking Points, provides a wealth of information to inform local authorities, health boards, third sector and the private sector on how to develop integrated health and social care services, based on examples of successful practice. Examples of integrated practices can be summed up by the programme theories documented in the results section. The next section appraises the evidence from the 12

examples of current Welsh practice, drawing lessons from both the successful and less successful ways of introducing and delivering integrated care. The discussion will focus on how the programme theories compare to the proposed testable theory of integrated health and social care.

Appraisal of the evidence in practice

When looking at the variety of services developed across Wales in this report, each one intersects with patient/service user care in a unique way. Each service attempts to model a way of delivering care that, in theory, puts the patient at the heart of the practice and promises rewarding results for the service user, carer and family, the professionals delivering services and the public purse. The successes, at face value, are anecdotally reported but not robustly evidenced. The hard evidence in terms of the benefits to the service user, carer family and professionals is largely absent. Cost benefit of service delivery is therefore not available. Cost efficiencies in terms of the process of delivering care is measured by performance output, but whether this is cost effective when compared to traditional forms of service delivery is not yet evident. Most Local Authorities want to increase care in the community and most Local Health Boards want to see the home act as the health hub. This joint focus and vision is at the heart of restructuring services for older people to enable them to stay within their communities with the view to reducing overall health and social costs. The unifying theme was that all services were concerned with cost-cutting yet none of the services in Wales are yet able to assess whether the new ways of delivering services have a beneficial impact on the older person.

For each of the service models presented here, an integrated service has been shown to respond to needs at each relevant point of the care pathway. Most services are designed and adopted to prevent emergency responses or to react to crisis to health and social care conditions. The point at which services interact with service users are detailed in Figure 4. Most services are offered in response to a crisis. The general vision is for services to work with preventative, pre-emptive and planned care. This is seen as the next, or

another stage of service development that has largely remained as a vision, while LHBs and LAs struggle to provide services to meet immediate needs with limited resources. Overall, in the specific event of an emergency, co-ordinated responses have been shown to deliver good integrated follow-up care within the community. At the end of the day, the most valuable resource in delivering care is the frontline staff. Recruitment and retention of adequate numbers of frontline staff to deliver services required is paramount. Hence, when the focus of health and social care working is with professional practice, there is an immediate positive effect on care. The linear up-scaling or pathway of integrated service development ascends through the institutional meso management structures to ultimately provide the back-up services for frontline staff deployment. The bottom-up approach to service development is complemented by the top-down policy and strategy that gives licence to make the changes to service delivery. The context to facilitate change from silo working to integrated care working has to be a unified approach at all levels of organisational and institutional working, i.e. horizontally, vertically and diagonally, with a bottom-up and a top-down approach as the testable theory suggests. But this rarely happens, as the programmes theories indicate.

There are key difficulties to overcome in implementing successful integrated care in the community. Some of these have been overcome successfully by some of the above service models. Listed below are some of the new and necessary elements that may facilitate integrated care:

People (micro)

- Involve GPs in community care delivery.
- Clinician-to-clinician referral is essential for confidence in care.
- Educating care professionals across sectors of the benefits of referring into an integrated care service is essential for service development.
- Effective services are often driven by highly motivated professionals with the status and the compassion to develop better services for the end user.

- Integrated services are about relationships: Relationship-centred care with the service user and relationship-centred professional working arrangements.

Practice (meso)

- Consent and sharing of information is crucial to delivering joined up and appropriate care.
- Time-limited services and specialised services work well when people can be referred to other known and more appropriate long-term care packages if necessary.
- Single points of access/referrals manned by non specialist staff have limitations.
- Co-location of staff can work well if co-located in an appropriate setting i.e., within secondary or primary care.
- Vertical, horizontal and diagonal working across, between, within sectors is necessary to facilitate good working arrangements.

Policy (macro)

- Build service platforms that encourage and facilitate relationships working across, between and within service sectors.
- Care pathways need to reviewed at set points and resources put in place to enable reviews.
- Capacity needs to meet demand to ensure confidence that the service will be delivered in an appropriate and timely fashion.
- Services need to be adequately and sustainably funded.
- Strategic integration does not necessarily translate into integrated service delivery.

Summary

- At this stage of integrated service development little is known as to which configurations of health and social care work best for which circumstance. A trial and error approach is not appropriate and more

in-depth scrutiny of outcomes associated with different care combinations with different groups of people is needed.

- Effective services are often driven by highly motivated professionals with the status and the compassion to develop better services for the end user.
- Strategic integration does not necessarily translate into integrated service delivery.
- Integrated services are about relationships: relationship centred care with the service user and relationship centred professional working arrangements.

The programme theories indicate that micro-level integration of health and social care for the delivery of services for older people can happen independently and in isolation from any structural and organisational changes at meso and macro-level. Conversely it is also true that macro policy, strategy and executive-level integration can happen independently of frontline care provision with the exception of commissioned care outside of the statutory sector. Thus, the streamlined testable theory of integration, whereby all levels of organisational structure need to be integrated for effective service delivery, is not apparent in practice. Integrated health and social care delivery can be effective when the micro-levels of organisational structure are facilitated to deliver integrated care.

5 Conclusions

This report set out to better understand whether integrated care interventions in Wales work as predicted, that is to maintain wellbeing and independence for older people whilst being able to live, preferably in their own homes and their own communities with a range of care needs extending to complex and chronic conditions.

The heterogeneity of services described in the document indicates how the LHBs and LAs are responding to the health and social care needs of the local communities. The use of high-level performance indicators does not, however, give an indication of whether implementing integrated services alone will realise the strategic goal of offering health and social care for older people in the community, with the view to reducing acute care costs and enhancing wellbeing.

What is apparent are the contexts that allow integrated care to happen, namely strategic drive and policy directives, the increase in people living for longer with chronic and complex conditions, an unstable and outdated health and social care infrastructure and the desire to offer better care at lower cost in a challenging economic climate.

The mechanisms used to overcome these challenges are diverse and specific to the local context. Types of mechanisms are described on pages 35-38 and the programme theories also outline the different ways integrated services are delivered in Wales. How the current mechanisms used to provide integrated services in Wales affect the ability for older people to remain safely in their own homes (especially when their health deteriorates and their social needs become more demanding) is unclear. It is unclear because it is not yet measured. Future consideration for evaluation also needs to include the many types of housing, transport, meals on wheels and community day care facilities that contribute to the concept of delivering holistic integrated care that meets the range of needs of older people living in their communities.

Throughout this report, several unintended and undesirable outcomes of developing integrated care have emerged, and these should serve well as cautionary notes as they are, in some cases, predictable. With foresight they can be preventable. These are:

- Integrated care impacts on primary care and has the potential to create competition between services;
- Co-locating integrated health and social care with single budgets etc. are assumed to improve care services. Creating this kind of autonomy and independent service structure and facility has the potential of creating another silo of care;
- Separate integrated care services can alienate other health and service professionals who are also involved in a person's care. GPs are a prime example;
- The wider impact of delivering integrated health as well as social care in the community has largely been unexplored and has the potential to place even more burden on families and informal carers. The impact of the care-giver burden on the carer's health is well documented. Their welfare and wellbeing, as well as the secondary cost to the NHS in terms of carer fatigue and associated illness, needs to be considered in future planning;
- The increasing older population in Wales will necessitate changes to increase and tailor suitable service delivery. Using reductions in bed days as a currency to measure the success of a service is only useful in a stable population setting. In Wales (and elsewhere) this is not the case. Averages, ratios and percentage bed days compared to days that older people are supported in the community to maintain an acceptable standard of living maybe a more applicable measure;
- Too often, the service performance indicators and output measures are used to indicate the success of care delivery. However, these figures indicate only trends in the processes of delivering care. They do not

measure the impact, quality or appropriateness of the care delivered to the end user; and

- Assessment, patient notes and data collection in the community setting in Wales is still largely a paper exercise. If integrated care is to happen, there is an urgent need to introduce IT platforms that can inter-relate, collect, and share and disseminate information in real-time and across services. A lack of shared data disenfranchises organisations and individuals alike who want to facilitate integrated working.

The concept of integrated working practices and services provides a shared goal and vision to improving care delivery. Thus the concept facilitates change to restructure and reorganise care with less opposition to change. For this to happen, uncertainties and lack of trust must be acknowledged and addressed, to motivate 'buy-in' for change and service development. The confidence needed to buy-in to change is largely dependent on evidence. Evaluation of services to assess the impact of integrated health and social care delivery is essential to provide the evidence that new ways of delivering care is better and more efficient, cost effective and delivers appropriate benefits to the end user.

The focus for the future of integrated care is evaluation to assess the impact of service delivery. Further research is needed to build an integrated health and social care service evaluation framework and guidelines to act as a toolkit for assessing the impact of health and social care services delivered for older people with the view to maintaining independence and wellbeing.

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