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Facilitating integrated delivery of services across organisational boundaries: Essential enablers to integration

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Abstract

Introduction: Integrating services is a key tenet to developing services across the United Kingdom. While many aspects of integration have been explored, how to facilitate integration of services remains unclear.

Method: An exploratory qualitative study was undertaken in 2015 to explore occupational therapists' perceptions on integrating service provision across health and social care organisational boundaries. The views of practitioners who had experienced integration were sought on a range of aspects of integrating services. This paper focuses on the facilitators for delivering integration and the essential enablers are identified.

Findings: Numerous factors were noted to facilitate integration and three essential enablers were highlighted. Leadership, communication and joint education were recognised as playing a central role in integrating services across organisational boundaries; without these three essential enablers, integration is liable to fail.

Conclusion: Integration is a process rather than an event; continued emphasis will be required on leadership, communication and joint education to progress integration achievements made to date.

Keywords

Integration, leadership, communication, joint education

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Introduction

Integrated care across sectors has been an ambition in health and social care for some time and is a current priority across the United Kingdom (UK) (Ham et al., 2013). Each of the home nations emphasise the significance of integrating care; more specifically in Wales (Welsh Government (WG), 2010), England (NHS England, 2014), Scotland (Scottish Government, 2011), Northern Ireland (DoH, Northern Ireland, 2011). Integrating services is recognised as beneficial for staff and service users, with the alternative presented as 'confusing, disconnected services [that] fail people and do not make best use of scarce resources' (WG, 2011: 7). This topic is of international relevance (see for example Leichsenring, 2004) and impacts across the gamut of health and social care professionals. Various aspects of integration have been explored; nevertheless, how to facilitate integration remains unclear.

Since 2011, one local authority area in South Wales has sought to integrate the adults with physical disability occupational therapy services across the local authority (LA), acute health setting and the community resource team (CRT: employs LA and Health occupational therapists). Although this group share a common profession, they

have different employers, pay scales, performance targets, cultures, customs and practices. Integration can be found in many guises (Fulop et al., 2005) (see Figure 1), and in this study has led to staff retaining their original employer and work base but with a focus on integration of the patients' experiences. This picture aligns with Ramsay et al.'s (2009) normative integration (Figure 1), whereby care is integrated based on an 'ethos of shared values and commitment to coordinate work' (Lewis et al., 2010: 12). Features of the new service include following the patient in and out of the acute setting, a common operational manager and a focus on delivery of a seamless service for their client groups. This study explores the experiences of the occupational therapists from the Health and LA sectors who are now working with an integrated approach across organisations to identify barriers and enablers to

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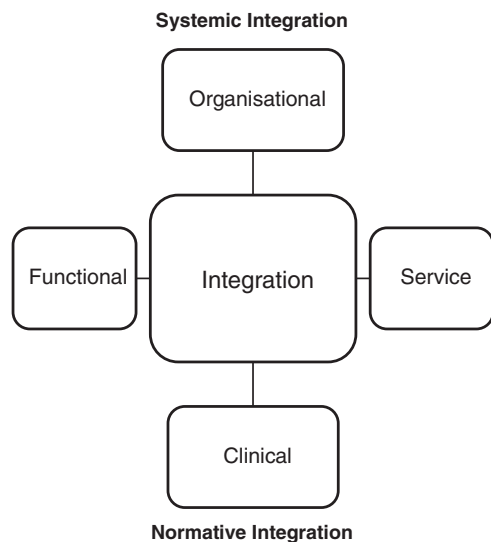


Figure 1. Typologies of integrated care. Adapted from Ramsay et al. (2009).

integration. In this study, enablers are the essential elements (Minkman, 2012) required to achieve integration. The main aim of the study was to critically explore staff perceptions of the process of integrating occupational therapy services across LA and Health settings and how to facilitate integration. The research question posed is: ‘What do staff perceive are the essential enablers to integrating occupational therapy services across health and social care?’

Literature review

There is a plethora of literature on the advantages of integration across health and social services (see Curry and Ham, 2010; Ouwens et al., 2005; Rosen et al., 2011; for occupational therapy, see Mountain, 2001). This study focuses on the enabling factors rather than the benefits of integration, and the literature review reflects this.

Previous studies on the integration of occupational therapy services are sparse. Donnelly et al. (2013) explored the integration of occupational therapy into primary care, while Forsyth and Hamilton (2008) examined a social services occupational therapist’s views on integrating with health. Donnelly et al.’s (2013) Canadian study employed four case studies and explored the interprofessional team’s view of occupational therapists integrating into primary care. Their findings point to the need for an understanding of occupational therapy, a culture of collaboration and finally the need for trust and understanding. Forsyth and Hamilton (2008) undertook a postal survey of occupational therapists in Scotland and England, with a 72% return rate. Forty-one responses were analysed. Although the findings indicate positivity about integration across health and social services, the process is reported to be hindered by different cultures and different organisational priorities. In addition, practical aspects such as budgets and resources, specialist skills and assessments did not facilitate integration. These occupational therapy-specific

findings indicate a will to integrate, but a need for the environment to be conducive for it to occur.

The wider literature includes experiences from the home nations and overviews of integrated care. Those actively seeking to learn lessons from other countries include Heenan and Birrell (2006) from Northern Ireland, Hutchison (2015) from Scotland and Morgan (2013) learning from and for Wales.

Heenan and Birrell (2006) undertook a qualitative study. Findings from interviews with senior managers in health and social care ($n=24$) and three focus groups with professional health and social care staff ($n=16$) in Northern Ireland point to four key areas for consideration: holistic working through programmes of care; integrated management and interprofessional issues; hospital discharge and the hegemony of health. Although Northern Ireland has a long history of integration of health and social care, Heenan and Birrell (2006: 63) note the need for a ‘culture of integration’. They highlight that providing integrated structures alone will not spontaneously lead to integrated service delivery.

A mixed methods approach was employed by Hutchison (2015), with interviews with senior national stakeholders ($n=6$) and a follow-on questionnaire to senior management and professional leads. Eighty questionnaire responses were analysed. Core challenges were noted to be a lack of accountability, lack of integrated budget and decision-making, and finally organisational cultural differences and governance uncertainty. The paper explores these areas and concludes there is a need for transformational change, and key leadership traits will be required.

With consideration of the Welsh perspective and drawing on literature from the UK, Europe and Canada, Morgan (2013) concludes no one country can offer a single ‘how-to’ set of guidelines that can be used across all localities. From this he encourages professionals to utilise their own experiences to facilitate the adoption of innovative approaches.

The home nation experiences here offer a perspective mainly from a senior level or from the literature. A common theme is that the need to develop a culture to enable integration and structures alone will not support a shift to integrated services. This study will seek to add to these findings by exploring how to develop a ‘culture of integration’ (Heenan and Birrell, 2006: 63), with experiences taken from frontline practitioners.

An overview of integrated care is provided in several papers. Cameron et al. (2012) undertook an update of their previous systematic review (Cameron and Lart, 2003) considering the factors that support or hinder joint working between health and social care. They identify three wide-ranging themes including: organisational issues; cultural and professional issues; and contextual issues. These broad areas are unpacked within the review, with the implications for practitioners outlined. Cameron et al. (2012) note the need for a transparent and appropriate management arrangement, as well as a need for practitioners to reconcile their professional

values to ensure the success of the integration. More recently, Mackie and Darvill (2016) critically reviewed current evidence to identify the elements required to successfully implement integrated health and social care in the community for people with long-term conditions. From their analysis of seven papers, they report co-location of teams, communication, integrated organisations, management and leadership, capacity and resources, and information technology as key. Again, in conclusion they note the shortfall of evidence in relation to integrated health and social care teams, and the need for further research, to enhance the validity of the body of evidence.

Emergent themes from the literature include several areas of concordance around themes for integrating services such as culture, yet a lack of consensus on the essential enablers. Minkman (2012) notes the somewhat discordant conclusions many authors arrive at (Nolte and McKee, 2008; Shortell, 2009; Shortell et al., 2000; Smith and Clarke, 2006). Focusing on quality, Minkman (2012) suggests key areas for further investigation, in particular the need to identify the essential elements of integrated care and how these relate to each other. This study centres on the essential enablers for integration of occupational therapy services across health and social care and seeks the views of frontline practitioners.

Method

In response to the research aim and question, a qualitative approach was adopted to explore practitioners' perceptions of the topic of integration. Semi-structured interviews and one group interview were undertaken from July to September 2015 with 11 occupational therapists. In order to fulfil the inclusion criteria, interviewees had to be Health and Care Professions Council (HCPC) registered occupational therapy staff who had been delivering occupational therapy services, for the LA or Health employer, within the named LA since 2011 (or earlier, that is, pre-integration). This latter criterion was essential to ensure participants had experience of working in this context before, during and after integration.

Ethics approval was secured from the University's College of Human and Health Science Ethics Committee and consent to approach staff was given by the Health and LA organisations. Written consent from participants was secured at interview. Recruitment was undertaken via flyers and supported by word of mouth from early interviewees. Everyone who came forward to be interviewed and who fulfilled the criteria was interviewed. Interviews took place at locations of the interviewee's preference, generally on work premises.

From a potential pool of approximately 20 staff, 11 people volunteered to be interviewed. All participants were female. Six people were located in the LA, four were based in the acute health care setting and one from the CRT service. Three interviewees were in management roles and eight in direct clinical roles. Eight one-to-one interviews and one group interview were undertaken and audio recorded with participants' consent. Due to the small

population, the interviewees' organisations are not identified in the findings, to retain anonymity. Instead, each interviewee was assigned a number and all names used are pseudonyms.

Semi-structured (open ended questions) interviews were undertaken with the following key topic areas in the interview guide: changes in practice; facilitatory factors for integration; hurdles preventing integrating services. Interviews were transcribed and data entered into Nvivo (QSR, 2012) to facilitate analysis. Data analysis was undertaken with thematic analysis employing Braun and Clarke's (2006) approach. This thematic analysis method calls for six steps: 1. Familiarising yourself with your data; 2. Generating initial codes; 3. Searching for themes; 4. Reviewing themes; 5. Defining and naming themes; 6. Producing the report. A sample of the analysis highlighting steps three, four and five can be found in Table 1.

Findings

The research aimed to gain an understanding of practitioners' views on integrating occupational therapy services across Health and LA boundaries. Interviewees note there is 'never just one thing' (No. 7) that enables integration to occur. There is a need for a 'perfect storm' (No. 8) of people and events coming together. Figure 2 shows some of the factors identified by participants that they recognise, to varying degrees, as having potential to contribute to successful integration.

Many of the items in Figure 2 can be seen to include process factors that consume time and can easily form the central focus of activity to enable integration. They are noted by participants as important to the smooth running of the integration process, and have been identified in previous integration studies (for example see Mackie and Darvill, 2016). When practitioners were asked what are the enablers that are essential to facilitating integration, three themes were identified: leadership; communication; and joint education (Figure 3). The findings from this study suggest that while the factors in Figure 1 are important and advantageous to resolve, if the three essential enablers in Figure 3 are ignored then integration will not occur. Findings are reported through summaries of these themes and illustrated by direct quotations.

Leadership

Several aspects of leadership are raised by participants, including knowledge, qualities and authority. The knowledge of a leader is raised across many interviews and centres on the strategic level:

One of our biggest breakthroughs came when our chief exec offered a return to the floor session. So we invited him down and he sat in a room with us, asked us what we wanted. So I gave him my little wish list and [he] said why isn't any of this happening? And I said because I have tried for years and there is a glass ceiling

Table 1. Example of thematic analysis.

Participants' quotes	Key words	Theme
I think she [integration manager] has kept us informed and come to our meeting so we do feel more integrated with health because of that. (No. 4)	Informed	Communication
I think everyone that works being very sort of forefront and respectful of change, a lot of people find change very difficult, um communication, not just within OTs [occupational therapists] but to other services as well and to the people who are referring to our service. (No. 6)	Communication: intra- and inter-professionally	
They [clients/service users] certainly get a more timely, prompt service, because there is that whole picking up the phone, that whole talking to each other, because like before there was that whole ping pong ping pong could have lasted for days: 'I'm not taking it' 'it's not our [referral]'. (No. 3)	Pick up the phone Spontaneous communication	
I've always thought in my head that all integration does is give permission to people to talk about the work and design the work in a way that makes sense in terms for the outcomes for the service users. (No. 7)	Permission to talk	
You need to set the strategic direction, draw up your action plan and leave it to the people who are doing the job to help you get there. (No. 3)	Strategic direction	Leadership
SH [integration manager] introduced integration to us and how things were going to pan out and that it was going to be a lengthy process and she showed us what direction it was likely to go in. And SH has been coming to our monthly meetings and feeding back on things that are happening in the hospital and within [the team] so it has been really good. (No. 2)	Setting the vision	
[The team leader] wasn't as positive or proactive, not helpful about sharing information. The manager of the [team] at the time was pulled in so many different directions she couldn't, nobody could be expected to keep a handle on everything that was . . . the expectation on [the team] to deliver was so huge. (No. 8)	Failing Lack of support	

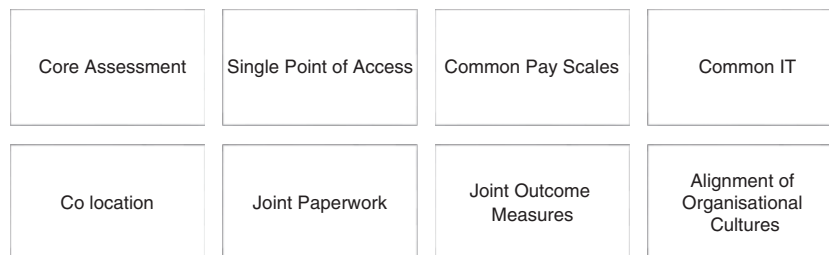


Figure 2. Factors potentially contributing to successful integration.



Figure 3. Essential enablers for integration.

and I can't get through it. By August the chief executive turned around and said this, this and this are happening, and I have been released to do project work to make this this and this happen. (No. 3)

Several interviewees also commented on the importance of leadership at the operational level:

Ruth [occupational therapy integration lead] introduced integration to us and how things were going to

pan out and that it was going to be a lengthy process and she should [tell] us what direction it was likely to go in. And Ruth has been coming to our monthly meetings and feeding back on things that are happening in the hospital and within Frailty so it has been really good.

Interviewer: Has that made any difference?
Yes, it has helped us understand the process a lot more and the issues the hospital OTs [occupational therapists] have. I suppose you can be in your own bubble a little bit, working in the community. (No. 2)

At the strategic level, knowledge includes the necessity for leaders to have familiarity and awareness of the potential for occupational therapists to provide operational solutions. At the operational level, the requirement is for leaders to have knowledge and understanding of operational occupational therapy needs. The need for the knowledge to be shared across organisations was also identified:

I think having Ruth in post was important as we were being led in the same way. Without that we would have remained two distinct groups, more separate. But I think having Ruth as the overarching person to pull both parts together... I think without that it would have been difficult. (No. 1)

The qualities identified include the leadership style:

Leadership style is crucial. If you impose your will on a group of professional people it is not going to go down very well. They are professional, they are autonomous, they are free thinking and they are also free moving, and if they want to go they can, so this whole 'it's my will': no, no, no.

Interviewer: So it is about engaging staff?

Absolutely. Set the strategic direction, draw up your action plan and leave it to the people who are doing the job to help you get there. (No. 3)

An autocratic leadership approach is noted to be less productive, particularly with empowering professional staff. Accessibility through visibility is recognised as key:

When Ruth came into post that really helped to – well, it put us all on an even footing. (No. 1)

I think Claire [new integration lead] is quite good at the moment as she is coming in and spending time with us and the team... to see what is going on, and she is here and in health and seeing an overall picture. (No. 9)

She is a more visible force. I suppose she is the permanent one now. (No. 10)

The need for visibility across organisations is apparent, suggesting the leader who is not identifiable by staff will be less able to facilitate integration.

Finally, practitioners report components of authority (such as influence and responsibility) within a leader as fundamental to supporting the process of integration:

One of the key enablers, I think, as well as permission, is actually having the ability and the skill to bring the OTs together in a way and Jane [Education lead] and Ruth are very skilled and Jane is very skilled at what she does. So we had the skills to do it but we needed Simon's [chief executive] permission, he just said you're doing it, to the [organisation]... and he gave Ruth permission to take that lead. (No. 7)

This can be demonstrated through joint decision-making or as the giving of permission alongside leadership skills

and knowledge. Possessing the requisite level of authority offers permission to work and influence across organisational boundaries or manage staff across organisational silos.

Communication

Every participant refers to the importance of communication across boundaries, with a request for 'better communication, less urban legends' (No. 3) to enable integration:

I think integration is just permission for people to talk and try and work things out in a better way, and if that leads to building up enough trust to handing your staff over to be managed. (No. 7)

Top-down communication is acknowledged with the need to set a vision and strategic direction identified within leadership. Bottom-up communication is seen as essential to actively supporting new ways of working and to sharing a common understanding of operational circumstances. The need for horizontal communication across the profession is recognised and noted to be improving in many areas, but not in all:

I think it [communication following integration] improved significantly. I think there was more picking up the phone to ring the community OT and just to problem solve sometimes. We've this person, do you know them from the past, what is their home set up, what have you tried before? Whereas prior to the integration, although that opportunity was there no one really thought to pick up the phone to your colleague who knew this person really well. It was as if permission had been given that you should and can do it. (No. 5)

Participant 5 goes on to say communication is more than just a process:

I guess partly it was not trusting other people's knowledge and skill but it's that we are specialist because we are health, and we are specialist because we are community OT, and we are specialist because we are reablement, and no one else knows what we do and no one can possibly do what we do. So breaking down those sorts of barriers and then people felt more comfortable to ring up and you knew who you were chatting to because a lot of people didn't know each other face to face either so it was in the joint training sessions you were able to meet people and you knew who they were talking to on the end of the phone and knew what their skill mix was to ring them. So communication definitely improved. (No. 5)

Areas of limited communication across the profession are noted to stifle integration and sharing of patient/service user information and so impact on care.

A range of approaches are suggested to support continued improvements to horizontal communication. These processes span across formal and informal, skills and client centred. Here theory returns to practice: ‘you get your key people don’t you, what do they call them in the management of change – boundary spanners?’ (No. 8). The role of supervision across teams is widely recognised to open up the potential for communicating across areas:

Before integration, the health OTs wouldn’t have been supervised by us; they would have been supervised by health, senior OTs in health. So that has changed. I think the fact that we are supervising different staff, I think that helps because you get to know how each other works better. So if I am supervising two health OTs, you get a best picture of how they work, and the system of where they are working, and more training and meeting together. (No. 4)

Rotational staff are viewed positively: ‘Some people do rotations where you have to rotate every 6 months so you get to know that area and you get to know the people working in that area’ (No. 9), though at times they are seen to rotate out of an area too quickly. Nevertheless, rotating more staff in and out of the community and hospital settings does offer an opportunity to develop communication links and common understandings.

Joint education

In effect, joint education could be considered as a sub-set of communication as it fulfils the same purpose; nonetheless, practitioners recognise the remit of joint education is much broader. Joint education allows an individual to develop their own skills but, maybe more importantly, offers the opportunity for networking:

Interviewer: What do you think would be the key enablers for integration to occur?

Training. All to sit down in the same room, all together to discuss these issues. (No. 9)

I was going to say the same thing – a forum to get people together and actually ask from the ground level up, because I think that sometimes. (No. 10)

Joint training offers an opportunity to build relationships with colleagues across organisations and recognise each other’s areas of expertise:

I think things that have helped have been that we have done joint things like joint training or joint working with a patient cos sometimes that helps people to see that actually we do know – I think that joint working even on a training day or sitting together and that general discussion that goes on and the identification of others’ skills. (No. 1)

Overall, participants expressed a wish to see improved working relationships, as this has the potential to lead to

a ‘fluidity in thinking’ (No. 11) when managing difficult or complex situations. As the significance of joint training as a key enabler is recognised, the speed at which it is rolled out gathers momentum:

I went on training a few weeks ago and there were a lot of staff there but they were all from another town which to me is West which we wouldn’t be speaking to on the phone because normally our clients just wouldn’t go up to those Western hospitals as they would be based here. So actually I’m recognising people but I probably wouldn’t work alongside them because of the distance. (No. 10)

Caution is needed to ensure the staff get the opportunity to ‘rub shoulders’ with relevant staff: people who are engaged in the process of integrating local services rather than out of area.

The three essential factors identified in the findings will be explored further in the discussion, and implications for occupational therapy will be considered.

Discussion and implications

In line with previous studies (Cameron et al., 2012), practitioners note that context is key and interviewees were mindful that it is difficult to see occupational therapy in isolation as so much was going on during the integration time period. The timeline was blurred, with other significant contextual factors such as the development of a Frailty service and changes in waiting list management. There is also an awareness amongst practitioners of different models of integration (such as across organisational boundaries, across professions, the role of generic working); different populations (different inequalities, population expectations); and different regional demands (local hospitals serving local communities or district general hospitals providing regional services) impacting on context. As a result, participants note the need for care with the transferability of integration models and a varying weight of expectation that can occur from within the occupational therapy community and beyond, without full comprehension of the contextual settings. However, the possibility of learning from different approaches is welcomed by the participants.

The findings on essential enablers support previous papers on the concept of generating a culture of integration (Cameron et al., 2012; Heenan and Birrell, 2006). The findings do not create a ‘how-to’ guide (Morgan, 2013) but offer areas that require specific attention to maximise the potential for integration to succeed. Counter to Mackie and Darvill’s (2016) findings of six key areas required for integration, this study suggests a focus is required on three factors: leadership, communication and joint education need to be prioritised to avoid being overly side-lined by other potential time-consuming process areas (Figure 2) that need attention, but not at the expense of the essential enablers.

Forsyth and Hamilton (2008) identify many practical aspects, such as budgets and resources, as potential

obstacles for integration. No evidence was apparent in this study to support Forsyth and Hamilton's (2008) findings. Approaches and attitudes to integrating services may have changed in the intervening years since Forsyth and Hamilton (2008) undertook their study. The concept of integration is no longer new or unusual, and attitudes and expectations may have changed in this time.

Limitations and future research

Several limitations are acknowledged for this research. The first is the small sample pool. This was acknowledged before starting the study and was not considered an obstacle to achieving the aim of the study. A small population is not perceived as a concern in the qualitative literature (Creswell, 2013). However, a limitation that must be considered is the experience of the practitioners. Although an essential sampling criteria was for participants to have been employed throughout the integration process, their involvement outside this will have varied. They will not all have had the same breadth of integration experience and this may affect their responses at interview. Some may consider the focus on integration across health and social care (rather than across professions) a limiting factor. Themes identified here can be employed to study larger cross-professional integrated teams in the future. Finally, an additional limitation that was not anticipated was the lack of engagement from one team. There may be several reasons for the lack of engagement and this would benefit from further investigation in the future.

Conclusion

When exploring an enabling environment for integration across organisational boundaries, a range of factors are identified in this research. Attention is drawn in this study to three essential enablers: leadership, communication and joint education. These act as elements of a foundation that combine to build trust and respect across individuals, teams and organisations, thus enabling integration to occur. Without these key factors present, and regardless of the other enabling factors, integration will struggle to succeed.

Key findings

- Leadership, communication and joint education are identified as essential enablers.
- A range of process findings were identified as contributing to integration, but contrary to previous research, areas such as common budgets and combined resources are not recognised as prime enablers to integration.

What the study has added

This study of occupational therapy services adds to the literature on integrating services, drawing out the essential enablers from the multitude of other activities demanded during the process of integration.

Research ethics

Ethics approval was provided by Swansea University College of Human and Health Science Ethics Committee on 11 April 2015.

Declaration of conflicting interest

The author declares that there is no conflict of interest.

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