Describe and discuss an example of inter-professional working or learning with which you have been involved: Improving Integration between Primary Healthcare and Social Care for the Frail and Elderly Population

Abstract body

"Healthcare is on Mars, and Social Care is on Venus"- Interview participant, 2018.

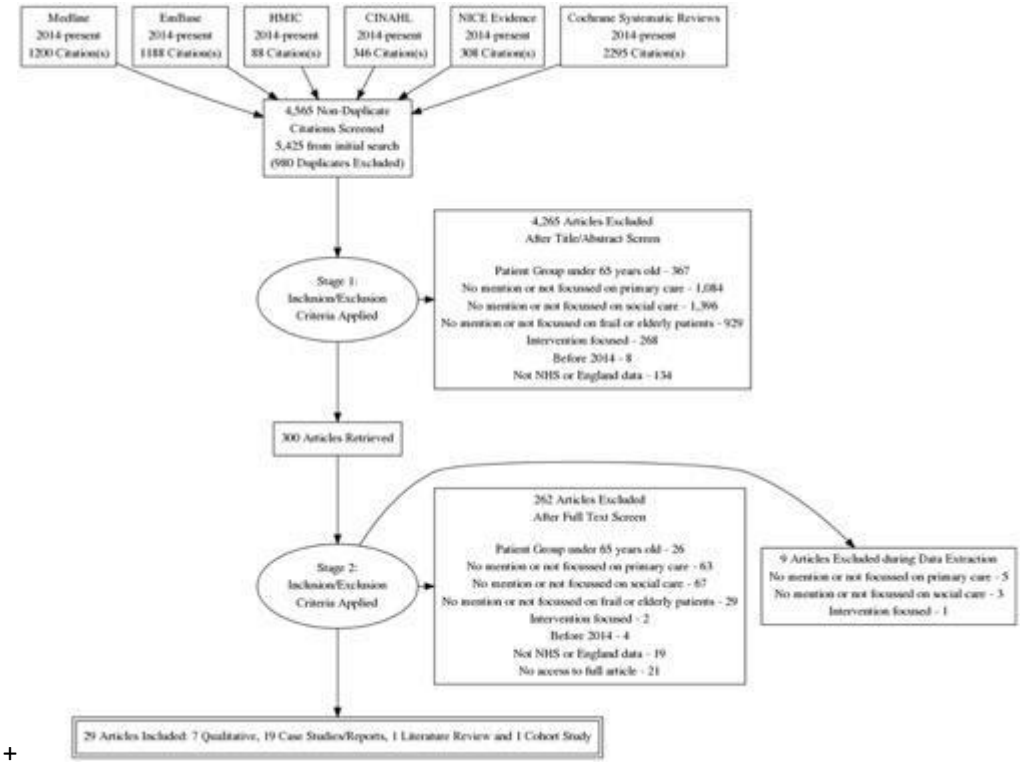
Healthcare and Social Care are fragmented. Current patients experience a broken system based on reactive rather than proactive measures of patient care provision. Ironically, it is the past successes of the NHS that has led to its 'precarious position' today, with advancements in medicine and technology resulting in an ageing population, increased demand for services, and amplified expectations (Appleby, 2018). Despite NHS efforts, existing service-delivery frameworks cannot sustainably look after the current population; hence, there is a need for integration: allowing patients to coordinate their care, with people who work together, around their needs (National Voices, 2013). For the NHS, this means disease prevention and cost efficiency.

Following the 2014 Five Year Forward View, there has been a mass movement towards more preventative medicine, as opposed to a 'crisis-led' approach (Goodwin, 2016). This shifts the focus towards refining General Practice, Accountable Care Organisations, and Primary Care overall. Likewise, Social Care plays an equally important role in the community, particularly with regards to caring for the growing frail and elderly demographic. Interprofessional collaboration remains the crux of a successful healthcare service, allowing the personalisation of care and improving quality (White & Sanderson, 2018; Hildebrandt, Schulte & Stunder, 2012).

However, 'care needs have evolved, but care models have not' (Jones, 2015). Therefore, my team and I opted to delve into the possibilities of Improving Integration between Primary Healthcare and Social Care for the Frail and Elderly Population. Firstly, using the constructivist paradigm, we aimed to identify the existing barriers to integration through a Systematic Literature Review (SLR) and then confirmed these barriers whilst further adding to the literature through qualitative semi-structured interviews with relevant stakeholders. Secondly, we aimed to develop solutions proposed by the interviewees to tackle these barriers.

This project not only gave us a unique insight into the collaborative working between sectors, but also made us appreciate that the issue of integration is a Wicked Problem: one that has multiple causes due to varying stakeholder perspectives within a system highly resistant to change (Rittel & Webber, 1973). Within both Primary and Social Care, there is a structural hierarchy of those involved in patient care, ranging from higher-management staff to the patients themselves. Appeasing all stakeholders through 'successful' integration is almost an impossible task because of the varying definitions of 'success' (e.g. a hospital manager may view the cost savings of integration as successful, whilst the patient sees continuity of care as 'successful integration'). This is a major reason as to why many integration pilots fail. Hence, for this study we chose to focus specifically on obtaining the views of ground-level staff, because these stakeholders are directly involved in patient care and their perspectives were remarkably overlooked by the literature: General Practitioners (GPs), Practice Managers (PMs), and Social Carers (SCs).

Nevertheless, we started by analysing the literature. 29 articles from six databases were identified, coded and synthesised into themes according to PRISMA guidelines (Moher et al., 2009). All articles were published following the 2014 Care Act, a turning point for Health and Social Care integration.



+

Higher themes of 'Structural barriers', 'Funding issues', 'Suboptimal Understanding between Healthcare Professionals', and 'Lack of Patient Centeredness' were identified as major barriers to Primary and Social Care integration.

In the NHS there is a 'complex mix of [logistical] practices', impeding communication between sectors (Honeyman, Dunn & McKenna, 2016). Likewise, workforce issues have led to overworked staff and falling morale; with reduced job satisfaction and proactivity, achieving change is difficult (Croxson, Ashdown & Hobbs, 2017). Furthermore, the NHS is a 'tribal organisation', with a variety of stakeholders having different views as to how to integrate care (Davies, Nutley & Mannion, 2000). This has led to the development of 'silo mentalities', with weakened interprofessional relationships, lack of patient focus, and therefore poor continuous care delivery (Hudson, 2015). All of these issues have been perpetuated by a 'bullying culture' within the NHS and insufficient governmental funding (Moberly, 2017; Wilkes, 2015).

SLR Higher Theme	SLR Sub-theme
Structural Barriers	Fragmented Organisation Structure
	Misaligned Incentives
	Geographical and Service Restrictions
Funding Issues	Resource Constraints
	Commissioning Issues
	Deprioritisation of Integration
Suboptimal Understanding between Healthcare Professionals	Weak Communication amongst Healthcare Professionals
	Lack of Training and Support

	Health Informatics Issues
	Professional Culture
	Lack of Information Recorded
Lack of Patient Centredness	Weak Communication with Patients
	Lack of Patient Engagement
	Attitudes towards Patients
	Patient Expectations
	Culture towards the Frail and Elderly
	Culture towards Social Sector

However, these structural challenges were unsurprising given the current political and economic climate. In comparison, the more intangible issues identified in the literature, such as the toxic culture and fragile communication between the sectors, were far more interesting. Reflecting as a pre-qualified medical student, these concerns are rarely seen without shadowing workers in both the sectors. Poor Interprofessional Communication seemed to be an over-riding theme across the SLR, with ground-level staff views unconsidered. Thus, our qualitative study aimed to explore differences between the SLR and ground-level perspective, hoping to identify gaps in the literature regarding interprofessional communication.

For the qualitative research, 41 professionals across London were interviewed regarding barriers to integration (18 GP and 7 PM interviews were thematically analysed. 6 SC and 10 expert interviews were used to provide contextual information; experts ranged from the Programme Manager of the Integrated Care Pilot, to the Head of Adult Social Care in Hammersmith and Fulham, for example). It became clear that even within ground-level staff, there are discrepancies as to why successful integration has not occurred yet and how this can be fixed.

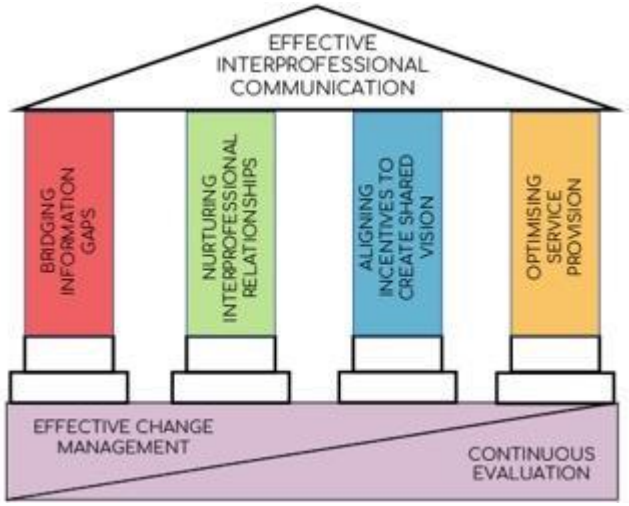
GPs placed a strong emphasis on poor accessibility to social care, citing problems involving a lack of clear guidance of who to contact when referring frail patients. They purported overworked staff and funding issues as major barriers, concurrent with the literature. PMs, however, viewed service structure and workforce challenges as prominent barriers. Interestingly, they both highlighted a lack of contact and inefficient Multidisciplinary Team (MDT) meetings with the social sector as main reasons for poor communication, rather than NHS culture. Despite GPs acknowledging a 'lack of mutual trust' and a silo-working culture, they could not pinpoint why it existed; the PM views, contrastingly, were heavily focussed on changing service structure, particularly ensuring health and social care were interoperable from a technological stance. These findings were fascinating when compared to SC and expert interviews: they emphasised how both sectors have different target objectives, and these misaligned incentives mean interprofessional communication is not required. Over many decades, this has resulted in a hierarchical divide and 'superiority complex' in healthcare, causing doctors to distrust social care and a need for clinical communication workshops to diminish this rift (Elliot & Nicholson, 2017). Even GPs stated that ideally medical students should be taught about social care from an early stage of their training, improving interprofessional understanding

and long-term collaboration. This is disconcerting from a patient perspective, as they believe all medical staff should be working towards the same objective: good patient outcomes.

Solutions proposed by the interviewees were also thematically analysed, and mainly focussed on improving information delivery (via technology, MDTs, regular contact) and changing the deeprooted discordant culture between sectors via education.

GP Barrier Higher Theme	GP Barrier Sub-theme	PM Barrier Higher Theme	PM Barrier Sub-theme
Accessibility of Social Sector	Lack of Awareness of Services	Workforce Challenges	Staff Training
	Overworked Staff		Changing Roles in Social Care
	Logistical Challenges		Overworked Staff
Interprofessional Relationships	Lack of Regular Contact		Poor Information Delivery
	Interprofessional Culture		Lack of Integration Incentives
	Ineffective MDT Meetings		Lack of Systems Awareness
Infrastructure	Human Resources		Inefficient MDT Meetings
	Funding	Service Structure	Lack of Resources
	IT Systems		Geographical Boundaries
			Funding
			Lack of IT Interoperability
			Lack of Adequate Information
			Access to Social Care

Further themes from the SLR and qualitative study about why integration pilots fail include the fact that they are rarely continuously evaluated and that change management is often overlooked (Bass, 1990). It is critical to adopt a suitable metric for consistent evaluation of communication prior to implementing a pilot; currently, the 'performance predicament' indicates that costs of communication initiatives are easier to measure than benefits, resulting in failure to prioritise this barrier when targeting integration (Garnett, 2005). Furthermore, it is important to have a plan for effective change management to reduce resistance to change and maintain stakeholder engagement (Kotter, 1999). With these principles and previous research, we developed a framework for organisers to consider when implementing new integration pilots: The Pillars of Communication.



Using this creative framework, planners have clear interdependent 'pillars' to build when forming their pilots for integrated care, and an evident foundation that is required for any integration pilot to be a success. Having member-checked our findings and the framework with many of the interview participants, the feedback received was vastly positive and we are looking forward to developing this further. Having learnt that medical students need to understand social care roles during their training ('nurturing interprofessional relationships'), we have developed a teaching scheme at Imperial College London that we hope to implement in the curriculum. Likewise, in order to improve social care accessibility ('optimising service provision'), we developed a mock website that incorporates all social care workers and General Practices within the borough of Hammersmith and Fulham that we shared with the borough's IT lead, receiving positive feedback.

Through this year-long project, I was able to witness the intricacies involved in integrating care for the most vulnerable in society. Prior to the project, like many other students, I believed that the reason care was not fully integrated was because of logistical challenges and funding issues on the basis of governmental austerity measures. However, I have come to realise that there are greater intangible barriers to integration that have slowly developed over many years; poor interprofessional communication and a culture of silos has resulted in resistance to change and misunderstanding of each sector's roles. Thus, in order to truly integrate Primary and Social Care, interprofessional relationships must be nurtured and effective interprofessional communication must be achieved, leading to holistic patient-centred care.

Abstract extra text

Appleby, J. (2018) Does personal politics affect attitudes towards the NHS? BMJ: British Medical Journal (Online). 360, Available from: https://search.proquest.com/docview/2009098685. Available from: doi: 10.1136/bmj.k888. Bass, B M. (1990) From transactional to transformational leadership: Learning to share the vision. Organizational Dynamics. 18 (3), 19-31. Available from: https://www.sciencedirect.com/science/article/pii/009026169090061S. Available from: doi: doi.org/10.1016/0090-2616(90)90061-S. Croxson, C H., Ashdown, H F. & Hobbs, F R. (2017) GPs' perceptions of workload in England: a qualitative interview study. British Journal of General Practice. 67 (655), e147. Available from: doi: 10.3399/bjgp17X688849. Davies, H T., Nutley, S M. & Mannion, R. (2000) Organisational culture and quality of health care. Quality in Health Care: QHC. 9 (2), 111-119. Available from: http://www.ncbi.nlm.nih.gov/pubmed/11067249. Available from: doi: 10.1136/qhc.9.2.111. Elliott, M. & Nicholson, C. (2017) A qualitative study exploring use of the

surprise question in the care of older people: perceptions of general practitioners and challenges for practice. BMJ Supportive & Palliative Care. 7 (1), 32-38. Available from: http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med8&NEWS=N&AN=25168 076. Available from: doi: //dx.doi.org/10.1136/bmjspcare-2014-000679. Garnett, L. (2005) Administrative Communication: Domains, Threats, and Legitimacy. In Handbook of Administrative Communication, edited by James L. Garnett and Alexander Kouzmin, 3 – 20. New York: Marcel Dekker. Goodwin, N. (2016) Understanding Integrated Care. International Journal of Integrated Care. 16 (4), Available from: https://doaj.org/article/5c1debe82d4e4401942333986163f795. Available from: doi: 10.5334/ijic.2530. Hildebrandt, H., Schulte, T. & Stunder, B. (2012) Triple Aim in Kinzigtal, Germany. Journal of Integrated Care. 20 (4), 205-222. Available from: https://koha.kingsfund.org.uk/cgi

bin/koha/opac-detail.pl?biblionumber=105969. Available from: doi: 10.1108/14769011211255249. Honeyman, M., Dunn, P. & McKenna, H. (2016) A digital NHS? An introduction to the digital agenda and plans for implementation. The King's Fund. Hudson, Annie. (2015) Social work: a "forgotten" piece of the integration jigsaw? Journal of Integrated Care. 23 (2), 96. Available from: https://search.proquest.com/docview/1680098682. Jones, P. (2015) New Care Models: empowering patients and communities - A call to action for a directory of support. NHS England. Kotter, J P., (1999) Leading change: The eight steps to transformation. The Leader's Change Handbook. San Francisco: Jossey-Bass, pp.87-99. Moberly, T. (2017) Bullying culture in NHS starts at top, says royal college head. Bmj. 356 Available from: http://dx.doi.org/10.1136/bmj.j1192. Available from: doi: 10.1136/bmj.j1192. Moher, D., Liberati, A., Tetzlaff, J. & Altman, D G. (2009) Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. PLoS Medicine. 6 (7), e1000097. Available from: http://www.ncbi.nlm.nih.gov/pubmed/19621072. Available from: doi: 10.1371/journal.pmed.1000097. National Voices. (2013) A Narrative for Person-Centred Coordinated Care. NHS England. Rittel, Horst W J. & Webber, Melvin M. (1973) Dilemmas in a General Theory of Planning. Policy Sciences. 4 (2), 155-169. Available from: https://www.jstor.org/stable/4531523. Available from: doi: 10.1007/BF01405730. White, J. & Sanderson, J. (2018) Making the case for the personalised approach. Available from: https://www.england.nhs.uk/blog/making-the-case-for-the-personalised-approach/. Wilkes, L. (2015) A design for life: how councils and housing associations can collaborate for impact.

New Local Government Network. Available from: A design for life