Collaboration in the Context of Integration of Health and Social Care

Lessons from Norway, England and Scotland

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This is an event report from the first seminar in a three-part series titled Conversations in Health and Social Care. The event was held at the University of Edinburgh on April 22, 2013. This report summarizes the key themes from the working group discussions.
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Background
On the 22nd April 2013 more than 100 researchers, practitioners, policy makers, managers and people using health and social care services gathered at the University of Edinburgh to participate in a half day event: “Conversations in Health and Social Care”. The event was the first of a series of three seminars funded by the College of Humanities and Social Sciences and the School of Health in Social Science at the University of Edinburgh, the overall aim of the series being to stimulate conversations between diverse stakeholders around key issues facing health and social care. This first event focussed on the concept of collaboration in the context of the integration of health and social care.

Improving collaboration between health and social care has been a central theme in policy across the UK and beyond for more than ten years. In Scotland, this focus is intensifying with legislation pending that will require every health board and local authority to put into place structural arrangements for integration. These developments echo those in Norway, where improving collaboration is a central plank of reform for health and social care. Indeed, learning from other policy environments was a key focus of the seminar which included presentations from Professor Helge Ramsdal from Ostfold University College, Norway and Professor Bob Hudson from the University of Durham who spoke to the English experience. In addition we were delighted to welcome a delegation of 11 staff and students from University College Ostfold who shared the Norwegian experiences around integration in discussions in small working groups.

After a welcome from Dr Ailsa Cook of the University of Edinburgh, the event started with presentations from Professors Ramsdal and Hudson who reflected on the place of collaboration within Norwegian and English health and social care systems. Following these presentations, participants worked together in 9 working groups to consider the following questions:

- What does effective collaboration look like?
- How can we promote collaboration across sectors and agencies?
- How can structural approaches to integration reinforce collaborative arrangements?
- What are the barriers and threats to collaborative arrangements?
- What can we learn from different policy contexts about good practice in supporting collaboration?

Participants in each working group recorded their responses to these issues on “post it notes” which were posted onto flip charts for discussion by the group.

The seminar concluded with a plenary discussion led by Catherine-Rose Stocks Rankin from the University of Edinburgh. This session provided an opportunity for all participants to consider some of the key themes emerging from the small group discussions.

This short report summarises some of the key themes and findings that emerged from the discussions on the day and pulls out some overarching conclusions. For more discussion and resources relating to this event and others in the series, please visit our blog http://conversationsinhsc.wordpress.com/.
Presentations

From Hierarchical Steering to Dialogical Governance: Collaboration in Health and Social Care, the Norwegian Experience
Professor Helge Ramsdal

In his introduction to this presentation Helge Ramsdal outlined key features of the Norwegian context, many of which were familiar to the predominantly Scottish audience. Not only is Norway a country with a small and geographically dispersed population, but there are high levels of decentralisation with much decision making happening at a municipality level. The health system wrestles with familiar challenges of increasing demand for provision caused by an ageing population, higher levels of disease and also increased scope for treatment brought by technological advances. This goes hand in hand with a lack of co-ordination and integration (either vertical or horizontal) and an insufficient focus on prevention.

Professor Ramsdal went onto outline that in 2009 the Norwegian Government launched the Co-ordination Reform, that sought to cement a clearer role for the patient in their care and to improve joint working between acute health services and the municipally run primary care and social services. In particular, Ramsdal argued that in a departure from previous significant reforms, the Norwegian Government has adopted a more flexible approach to implementing this reform, presenting a direction of travel, but without prescribing how it will happen. However, over time it has been clear that the Norwegian Government has lost patience with the slow pace of reform and as a result is introducing a range of mechanisms to encourage collaboration, including fiscal mechanisms that pass costs of hospital care to social services from the day that someone is declared fit for discharge.

Professor Ramsdal concluded by raising some questions about the impact that this new more dialogical approach to governance will have and whether it will indeed address issues of vertical integration or widen the schism between municipality and hospital.

Routes to collaboration: policy divergence across Scotland and England
Professor Bob Hudson

A key theme of Professor Hudson’s presentation was the extent to which the Scottish health and social care policy context is diverging from what is going on in England. In particular, Bob Hudson identified four dimensions of divergence: structures, organisational focus, policy levers and ideology. He characterised the English health and social care system as being subject to much more structural change than the Scottish system, experiencing relentless re-organisation at local and national levels. The more hierarchical approach seen in Scotland was contrasted with a market orientated approach developing at a pace in England, with commissioning and competition being the key levers to integration. Thus he identified the Scottish and English systems as being based on very different ideologies, with the Scottish system largely rejecting markets and focussing on the role of people using services and third
sector organisations in the co-production of health and care, which is in contrast to the market driven English system that sees people using services as consumers.

Professor Hudson concluded his presentation by reflecting that of the three main models of policy implementation: networks, hierarchies and markets. The evidence suggests that network approaches are most likely to promote collaboration. This is not a path, however, currently being followed by the administrations in either England or Scotland.

Small Group Working: Key Themes

Key themes which emerged from the group discussions included:

- The need for communication, including a clear vision, strategy and clarity of role within and between organisations.
- The significance of investing time and financial resources in the complex interpersonal and organisational interactions needed for integration to be successful.
- The importance of understanding, and merging, different organisational systems. Examples given included HR systems, IT systems and organisational hierarchies.
- The significance of people at every level of health and social care organisations being committed to making integration work, and the need for the areas of communication, resources and organisational systems (listed above) to be addressed in order for that to happen.

The materials (post-it-notes and flip charts) from all of the working groups were inputted into Nvivo (a qualitative data analysis software tool). This enabled queries to be run which established the most common words and phrases used across all of the groups to each of the questions. Responses to the four questions have been captured below. Most responses were 2-3 word phrases, though some groups had written more lengthy responses. Below, we outline response to each of the questions in turn.

1. What does effective collaboration look like?

The most common word used in response to this question was ‘shared’. This included: common shared understanding; leadership - demonstrate - shared understanding of ALL issues; shared language; shared definitions e.g. outcomes; shared vision; shared information on client needs; shared focus on meeting outcomes; Shared targets/ objectives.

The word “outcomes” also figured highly within responses to the nature of effective collaboration: effective collaboration= achievement of outcomes for the individual - integrated care; importantly shared definitions e.g. outcomes; a true focus on personal outcomes for the individual- maintaining quality; improve outcomes for service users; shared focus on meeting outcomes; outcomes for individual at centre; outcomes more important than structure; basing it around needs and outcomes of those users; talking and agreeing outcomes with all affected agencies; equity, positive outcomes/ measures, satisfied staff and patients.
2. How can we promote collaboration across sectors and agencies?
A word frequency count on all the responses to how collaboration could be promoted showed that the twenty most common words used in response to the “promote” question were: working; shared; leadership; staff; training; clear; communication; co; levels support; care; collaboration; education; care; finance; leaders; one; system and culture.

Further exploration of ways in which “working” was related to the promotion of collaboration revealed the following: all working to same goal; open honest discussion and joint working; true partnership working across the sectors; working and learning together; shared modes of working; develop champions/ leaders for integrated working; use of new ways of working rather than suppressing creativities; incentivising working through performance management; avoid working in silos wherever possible.

3. How can structural approaches to integration reinforce collaborative arrangements?
The most common word used in response to the question on structural approaches to reinforcing collaboration was “joint”. This included: Joint management; joint funding; joint training; joint resources; joint commissioning organisations with ‘clout’; Joint head-accountable for delivery.

The next most frequently used word was “shared”: shared services; shared costs; shared understanding at different levels; shared policy; shared modes of working; shared vision; shared management; shared objectives and performance measuring; shared physical premises and shared working at every opportunity.

4. What are the barriers and threats to collaborative arrangements?
A word search on all responses to the barriers and threats to collaborative arrangements revealed the most commonly used word to be “lack”. This included: lack of trust; time to learn and grow (lack of); lack of time; lack of sign up by practitioners; lack of knowledge/ clarity of each other’s’ roles; lack of IT integration; lack of will or perceived benefit; lack of funding/ finance; lack of structure; lack of leadership.

A further common word used in relation to threats was “different”: different languages, different management; different agencies; different governance arrangements; different reports for different targets; different values; different terms/words; different administrative processes; different agendas.

“Change” was also identified as a barrier: don’t like change; change takes time; the reason for change is driven by resources; change in working conditions; change is difficult; poor change management skills.
### Key Themes from Small Group Working: Table Format

<table>
<thead>
<tr>
<th>Most commonly used word</th>
<th>What does effective collaboration look like?</th>
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<td>Lack of trust; time to learn and grow (lack of); Lack of time; Lack of sign up by practitioners; Lack of knowledge/clarity of each other’s’ roles; Lack of IT integration; lack of will or perceived benefit; lack of funding/ finance; lack of structure; lack of leadership.</td>
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**Conclusions**

The working groups produced a range of common concerns about the necessity for communicating across the two spheres of health and social care. The need for communication was particularly evident around ideas such as: values, cultures, experience, organisational purpose, processes, and impacts. These concepts seem to underpin both the mechanisms for productive collaboration as well as their barriers. Working to opposing purposes or with different pathways and processes can be a barrier to effective collaboration. So can the different cultures which operated in the health and social care systems. Participants voiced the need for shared languages, shared cultures and values, and a drive for sustainable change.

When asked who or what should lead this change, delegates promoted the idea of individual leadership as well as organisational leadership. Some delegates felt that it is each individual’s responsibility to find ways to integrate, to learn to work across boundaries. Others highlighted that those who work in senior management positions should model good collaboration for their organisations.

Useful comments were made in the closing discussion about the role of the third sector. Representatives from voluntary organisations spoke about the need for long-term planning and stability for organisations working with the health and social care sectors. Others talked about the importance of pilots and the need to develop and promote the learning from successful pilot-projects. The seminar also benefited from insight from service users. Our end-of-day discussion highlighted the need to ensure effective engagement with service users and carers. Participants highlighted the importance of public events which enable service user inclusion.

While the question of leadership is still open for debate, it was clear that there are gains to be made from integration. Collaboration seems to be a tool worthy of further exploration. This event highlights the willingness of the delegates to talk across cultures, languages, values and purpose. We’d like to thank those who came to this event and provided us with their insights and experience.