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Research Article

Truly Integrated Care Centred on the Individual: My Personal Vision for Wales

Summary

This paper offers my personal vision of truly integrated health and social care centred on the individual for Wales. This vision of an integrated health and social care system is simple - a seamless and efficient service. Wales in particular has a strong opportunity to develop a truly integrated health and social care system with the following key elements. A) Shared language B) Build and expand your evidence-base C) Clarity of purpose D) Be realistic and embrace change E) Keep learning and challenging data F) Policy and service effectiveness. How do we measure the effectiveness and impact? The answer is simple and concise – we use every metric available.

Introduction

This paper offers my personal vision of truly integrated health and social care centred on the individual. As a caveat, this vision is entirely presented for the context in Wales and draws from my 22 year career in the Welsh National Health Service (NHS) plus 10 years in grass roots politics as a Community Councilor. This paper therefore has limitations, is open to challenge and may not apply to other settings. At best, this paper is a discussion paper although it also shows how the vision might be objectively measured and tested.

To start with, the Welsh context can be briefly presented as follows. Wales is a relatively small country of about 3 million residents. Since 1999, there has been a Welsh Government with devolved powers to make policy decisions about the NHS and Local Authorities [1]. Wales is also relatively small geographically in that travel between any parts of the country is possible within one day. Furthermore, Wales is facing the dual challenge, like many other countries, of increasing demands upon health and social care services but reduced resources.

My vision of an integrated health and social care system is simple - essentially a seamless and efficient service. Seamless means that individuals that move between health or social care, or indeed between the various layers of healthcare, do so in a manner that gives them an experience of being with the same service provider. To characterize the opposite extreme, a non-seamless service is one where breakdowns occur. Suppose a deaf patient requires sign language support and this is needed for a primary care appointment. Possibly the support is then absent for a referred secondary care appointment. A seamless service would clearly anticipate this need.

Efficiency is key. Theoretically, we can design 'perfect systems' but if it is unaffordable it is unachievable. The efficient system must be affordable, do-able, measurable, flexible, responsible and modifiable.

The elements to the vision

Health and social care integration is not easy, otherwise joint systems would be the standard service model in many countries. Indeed, it might never be fully achieved because needs change and so a driver for integration might be continuous quality improvement.

Wales in particular has a strong opportunity to develop a truly integrated health and social care system because it has the advantages of size and Government powers to make a vision reality.

Some of the key elements to the vision are outlined in the following paragraphs. These are drawn 'real time and real world' experience from within Wales although they may have application elsewhere.

Shared language: Integrated care has a language, for example horizontal between health and social care and vertical within the NHS for primary and secondary care [2]. There is also emerging jargon, such as co-production [3], which is the involvement of service users in the design and delivery of services. It is only when health and social care organizations really speak a shared language that integration occurs. Crucial to this is the role of unpaid careers who support all services [4].

Build and expand your evidence-base: One of the key challenges is about the evidence-base. Locally sensitive evaluations are therefore essential and can help support both horizontal and vertical integration. On the former, there is evidence that training home care staff to better manage skin wounds in older people can substantially reduce District Nurse calls [5]. On the latter, visually impaired patients often get quality services from the family Doctor but there may be a need to develop secondary care [6].

Clarity of purpose: For example, the terms health and healthcare may be conflated [7]. The former is about personal choice and responsibility with the latter delegated to a healthcare professional. If improving health reduces pressures on healthcare – and by extension social care – then this clarity of purpose is needed. In Wales, an example is that a simple measure of promoting aspirin compliance for patients after heart attack or stroke could reduce pressures on the NHS and social care [8].

Be realistic and embrace change: One of the traps of integration is that in principle it is easy to conceptualise. The problem is that in reality, delivery can vary and there can be inequalities. Constantly evaluating the reality of service provision is therefore needed to understand any inequalities and how they might be mitigated [9]. Related to this is that our own professional values and behaviours are also key [10], not least because they have the potential to strengthen or weaken inter-agency work.

Keep learning and challenging data: Integration will always require ongoing learning because needs change, priorities emerge and the evidence develops. The dignity in care example is pertinent to both health and social care, with Wales having a dedicated policy programme. There was evidence on the effectiveness of the programme [11,12] and the Welsh NHS adopted this as a top priority. In moving forward, there is a need to keep learning and challenging the collected data to ensure programme delivery.

Policy and service effectiveness: The final point relates to policy and service effectiveness. Falls and fractures are a major cause of morbidity and mortality in older people. There is evidence that more could be done within Wales.

There appears to be opportunity to connect between policy areas, for example boosting bone health and preventing fractures [13]. There also appears to be under-provision of a fracture liaison services that could help avoid major fractures, for example the neck of femur [14].

Discussion

The previously set out vision offers a whole system approach. It requires effective policy, efficient use of resources, a highly skilled workforce, utilizing data appropriately and inter-agency working. There is no pretence that this is easy, however, it is all achievable and most importantly, is also in the provenance of Welsh control.

There is of course, another dimension that needs to be given consideration. If the previous vision is about improving the delivery of health and social care, there is a further question about how to reduce the demand on these services. Again Wales has opportunities to improve the 'health' of the population, with the term deliberately put into a quotation as it is imprecise and difficult to define [15]. Indeed, health and illness are often used inter-changeably and inaccurately. For the purposes of this paper, crudely health pertains to an asset within individual control or influence.

To expand on this asset concept, we can influence our health by exercise, diet, non-smoking and moderate alcohol intake [16]. There is evidence, however, that there is variation in the provision of health promotion services across Wales [17] and whilst local sensitivity has value, there is potentially a need for stronger consistency nationally.

Technology is a key player in the health promotion agenda. This will include the full spectrum of social media, both as a way of conveying information and also of gaining views [18]. The potential for such surveys to influence policy setting in Wales remains to be achieved [19].

Closing remarks

Essentially, there are two ways to reduce pressures on health and social care. The first is to improve the health of the population so that there is less demand. A detailed discussion on this falls outside of the scope of this paper but might essentially involve a brave new dialogue with the public about their own responsibilities for health.

The second element relates to improving the efficiency of health and social care, with an emphasis on truly integrated care for the individual. To progress this may require a level of bravery to move from the current NHS and Local Authority model to a single care system. As rhetorical questions, however, is the current two stream system either fixable or sustainable?? So is change thus inevitable?

To conclude, how do we measure the effectiveness and impact of a new integrated system? The answer is simple and concise – we use every metric available, subject this to critical review and then secondary analysis – such as economic appraisal. This currently might be the missing link in Wales, namely completing the cycle of reflective practice via a process of plan, do, study, act. That is not intended to be critical but more a challenge to see Wales take the opportunity to lead the way internationally. So finally, we test the credibility of findings by publishing in the peer-reviewed literature.

Declarations

This is based on a February 5th 2016 presentation to Powys Teaching Health Board. The author has had secondments to the International Agency for Research on Cancer, academia, Welsh Government and voluntary sector. He is a fellow of the Royal Society for Public Health and holds an post in public health at Cardiff University. He published a short paper as Community Councillor on 'popular epidemiology'.

Addendum

Since writing and submitting this paper, Wales has introduced some important legislation that offers increased opportunities to enhance the delivery of integrated care. This includes the Social Services and Wellbeing Act, which has a range of measures to improve service integration and intervene early to improve outcomes for people. Another is the Future Wellbeing Generations Act, a truly visionary framework that in many ways is self-explanatory. Respectively, the two Acts need to be underpinned by a population needs assessment and well-being statement, both of which will inform the locally sensitive provision of services. Furthermore, the reporting against these two Acts provides a basis for accountability and development.

References

1. Morgan G (2016) 2020 Vision for Welsh Public Services. Perspectives in Public Health (in press).

2. Morgan G (2013) Health and social care service integration: What can Wales learn…and contribute? Quality in Ageing and Older Adults 14: 47-56.

3. Phillips A, Morgan G (2014) Co-production within health and social care – the implications for Wales? Quality in Ageing & Older Adults 15: 10-20.

4. Morgan G Unpaid Carers: Where is public health? Public health (in press).

5. Morgan G (2015) on behalf of Project Board. Inter-professional approaches to non-complex wound care in a Welsh residential home for older people. Intermediate care fund report, September 2015.

6. Morgan G (2015) Quality of primary care for visually impaired patients in mid-Wales. Quality in Primary Care 23: 259-261.

7. Morgan G (2015) The conflation between health and healthcare. Arch Community Med Public Health 1: 6

8. Morgan G (2006) Possible quality and outcome framework role to increase aspirin prophylaxis in Wales. Quality in Primary Care 14: 239-242.

9. Morgan G, Murray D, Sullivan C, Walters P (2012) Achieving age-equality in Welsh health and social care services. Generations Review 22: 10-11.

10. Morgan G (2009) Reflective practice and self-awareness. Perspectives in Public Health 129: 161-162.

11. Morgan G (2012) on behalf of North Wales Dignity In Care & Equalities Group. Dignity in care survey in north Wales. Working with Older People 16: 175-179.

12. Morgan G (2012) Policy evaluation of the Welsh Dignity in Care programme. Eurohealth 18: 28-31.

13. Morgan G (2013) Falls and fractures: A review of the literature and case-study on Wales. Working with Older People 17: 170-178.

14. Morgan G (2013) Traction and break points in Welsh policy for bone health, falls and fractures. Generations Review 23: 11-12.

15. Morgan G (2009) WHO should re-define health? Journal of Epidemiology and Community Health 63: 419.

16. http://healthylivingwales.co.uk/ (accessed February 16th 2016)

17. Morgan G (2012) Health promotion for older people in Wales: preliminary evaluation of the National Service Framework for Older People. International Journal of Health Promotion & Education 50: 45-49.

18. Morgan G, Gallagher J, Mitchell C (2011) The perceptions of older people in Wales about service provision. Quality in Primary Care 19: 365-368.

19. Morgan G (2010) Policy development and implementation. The National Service Framework for Older People in Wales. Eurohealth 2010: 15: 23-25.