

Integrated Care and Support

**Promoting Partnerships across
Services, Improving Lives**



About the European Social Network (ESN)

The European Social Network (ESN) is the independent network for local public social services in Europe. It brings together the organisations that plan, deliver, finance, manage, research, and regulate local public social services, including health, social welfare, employment, education and housing. We support the development of effective social policy and social care practice through the exchange of knowledge and expertise.

About this report

This report presents details of the questionnaires, practices, and meeting discussions of ESN's Working Group on Integrated Care and Support that between 2018 and 2021 analysed the integrated provision of support and social services for four population groups:

- Children and families with a focus on child protection;
- Youth with a focus on young people leaving state care;
- Adults with mental health problems;
- Older people with complex needs.

The responses to the questionnaires and the identified and assessed practices represent interesting examples of the breadth of work being undertaken in this area. The publication provides an overview of relevant principles, initiatives, and practices across different European countries on cooperation between social services and education, health, and employment to support children and adults' social inclusion.

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Introduction

The European Social Network (ESN) set up a Working Group on Integrated Care and Support to enable professionals working in social services across Europe to share experiences on advancing integrated care and support for people with multiple needs. This is in recognition of the importance of closer cooperation between social services and other sectors such as education, employment, health, the police and housing in addressing the complex issues facing society, with the intention of improving both outcomes for people using services and efficiency of the services they use.

A previous report, [Integrated Social Services in Europe \(Montero et al, 2016\)](#) identified how social services can work with agencies such as education, employment, and health to provide integrated support. Previous ESN thematic reports have provided a comprehensive analysis of social services working with specific population groups, such as:

- [Mental Health \(2011\)](#) on the importance of integrated community care for people with mental health problems;
- [Investing in Children's Services, Improving Outcomes \(Montero 2016\)](#) provided a comprehensive analysis of children's services in Europe;
- [Putting Quality First \(2021\)](#) on the contracting of long-term care for older adults with complex needs.

As these reports show, there has been increasing recognition that improved outcomes for people using services are more likely through improved coordination across services and sectors in relation to planning, assessments and service provision.

The Working Group met once a year between 2018 and 2021 and, on each occasion, focused on a different target group across the life cycle, from children and youth through adults with complex needs to older people with chronic conditions.

2018: Children and families with a focus on child protection

In 2018, the focus was on children and their families. This involves the coordination of social, education, health and other services that focus on providing services to address the problems families face. In the long term such support could prevent children from being taken into care or support the development of more effective inter-agency plans for children already in care.

2019: Young people leaving care

The second working group meeting was convened in 2019 to engage participants from social services and beyond (health, housing, education, the police and justice) to explore the opportunities and challenges of integrated support and care for care leavers on the basis of their experiences and practice examples provided by participants.

2020: Adults with mental health problems

The third working group meeting in 2020 examined policy, legislation and strategies for providing integrated support for adults with mental health issues, including the coordination of social services with other sectors to support and meet the needs of people using services such as health, education, housing, or employment.

2021: Older people with complex needs

The 2021 working group meeting focused on the effectiveness of approaches to support and improve outcomes of integrated health and social care for older people with complex needs, supported through the presentation of best practice examples and latest research.

Methodology

The Working Group on Integrated Care and Support ran from 2018 to 2021 to examine social care and support across the life-cycle, focusing on a particular target group each year. The working groups are designed to act as a vehicle for mutual learning between social services across Europe on the implementation of effective approaches to integrated care and support, culminating in a collection of practice examples.

In order to obtain a clearer picture of how integrated working was being put into operation across Europe, ESN members were asked to complete a questionnaire for each working group meeting.

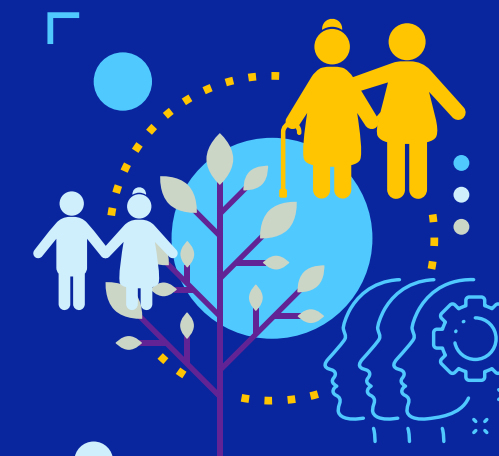
The questionnaire covered three key areas:

- information on the organisation responding to the questionnaire, e.g. the type of services they provide for the population group;
- reports on their experience of integrated care and support (e.g. how it is managed and funded, and key success factors);
- description of a specific practice designed to provide integrated care and support.

Each year, a meeting was held to discuss and analyse the results of the questionnaire, and present practice examples identified through the questionnaires.

29-30 November 2018, Lisbon, Portugal

The 2018 meeting of the Working Group involved 20 participants from ten countries as well as four members of ESN's staff. Ten countries were represented: Belgium, Finland, Germany, Hungary, Malta, Norway, Portugal, Spain, Sweden and the UK. Participants outlined practices in place in their countries and the initial findings from the questionnaire were also presented. There were also round table discussions providing opportunities to share experiences and identify effective approaches.



26-27 September 2019, Edinburgh, Scotland, UK

The second Working Group meeting analysed and expanded on the responses to the questionnaire distributed among ESN members ahead of the meeting. The meeting was attended by directors of social services from 12 countries who discussed the effectiveness of approaches to support and improve outcomes for young people making the transition from care to adulthood.

07-08 September 2020, Online

The third Working Group meeting welcomed over 100 participants over the two days, with keynote addresses of representatives from the public and private sectors, the European Commission, the European Parliament, and the World Health Organisation. Practices from Denmark, Italy and Latvia and national strategies on mental health in Malta and Finland were presented, together with the European Council conclusions on the economy of wellbeing on promoting good mental health.

27-28 April 2021, Online

The fourth Working Group meeting was attended by directors of social services from 19 countries who discussed the effectiveness of approaches to support and improve outcomes of integrated health and social care for older people with complex needs, supported through the presentation of best practice examples and latest research. The event included panel and interactive group discussion.

Defining Integrated Working

Not surprisingly there is no universally accepted definition of **integration** and there are a multitude of models. The literature points to the lack of clarity about what it actually means, as well as the wide variety of terms used to describe it (see, for example, Sloper, 2004; Atkinson et al., 2007). These terms include partnership working, joint working, multidisciplinary and interdisciplinary working, which are often used interchangeably and without explanation (Oliver et al., 2010). Atkinson et al. (2002) concluded that “there might be value in refining descriptors and vocabulary associated with inter-agency activity to advance general awareness and understanding of its processes and outcomes” (p.225), but little progress has been made in that direction.

The difficulties in the language have implications for evidencing the impact of integration. Without a shared definition and understanding it is not possible to establish whether integration has happened and how, if at all, it links with

outcomes. Despite this lack of clarity and an absence of consistent evidence on effectiveness, **integrated working** has become a key policy area across Europe (Barnes and Melhuish, 2017).

The reality is that integrated working takes many different forms. There is not one template for establishing or implementing similar models (Cameron et al., 2008) and there are different visions for what the way forward should be. It can be between organisations or different services within departments. It can be ‘vertical’, joining up different levels of provision within one service, such as preventative and statutory sections of social care. It can also be ‘horizontal’, involving, for example, multidisciplinary teams, with professionals drawn from health and social care. Integration may involve services collaborating but may also involve commissioners when budgets are pooled (Curry and Ham, 2010).

On the basis of an extensive literature review, Robinson et al. (2008) actually concluded that research showed that a full integration of services was not necessarily the way forward: ‘Rather, a looser arrangement allowing the right people to work together at the right time to deal with the right issues, was felt to be more powerful’ (p.3). Others, like Percy-Smith (2005) and Townsley et al. (2004), have suggested viewing integration on a continuum, working from a model where organisations work autonomously within their own boundaries at one end and full integration at the other.

It was evident from the responses to the questionnaires and discussions in the meetings that, in line with what is known from research, the activities described as ‘integrated’ covered the spectrum from ‘agencies working together on a project’, through collaboration and cooperation, to fuller integration, involving a combination of shared management, co-location, multidisciplinary teams and, more rarely, shared IT systems.



Drivers of Integrated Working



Creative ways of organising and delivering services are being proposed to meet the growing demand for improved service user experience and outcomes for people using services. **Key drivers and aims for integrated care and support** can be categorised broadly at an individual or micro level, an organisational or meso level and a system or macro level.

At an individual or micro level, integrated care and support aims to wrap services around the person, so that their care and support is more personalised (Stoop et al, 2020).

At an organisational level, the aim is to increase collaboration and co-ordination between services to reduce fragmentation and prevent 'gaps' in services.

At a system level, integrated care and support aims to create more sustainable public services through maximising cost-efficiency, by reducing duplication of services, for example.

Children, Families and Youth

There are many instances where poor communication between agencies has been blamed for tragedies in child and youth protection, such as the death of Victoria Climbié in 2000 in England (Laming, 2003) and Savanna in 2004 in The Netherlands (see Bruning, 2007). These cases

and many others have been used to support calls for more integration to encourage services to work together more effectively (see Laming, 2003; Kuijvenhoven and Kortleven, 2010).

It is now widely accepted that families with complex, multi-layered problems require an integrated package of support (Platt, 2012; Ward, et al., 2014). However, while many projects and agencies capture service users' feedback on aspects of the service they have received, very little research has been conducted that captures service users views of the benefits that they might attach to integrated working (Cameron et al., 2014).

Integrated working seems particularly suited to the early identification and management of risk, improved information sharing, and shared decision-making, and it has been more widely adopted by preventative and early intervention services (Siraj-Blatchford and Siraj-Blatchford, 2009). Integrated working practices are seen to have the potential to address the multidimensional nature of many problems faced by families by allowing access to the expertise of more than a single professional.

In line with what is known from research, the main drivers for change in nearly all the responses to the questionnaire submitted in 2018 and in descriptions of the practices identified were first the desire to establish preventative approaches. A second driver was to achieve improved outcomes for children and families by avoiding the most intrusive interventions such as removing a child from their family's care. In some cases, this meant new services had been established, for example the National Association of Social Workers in Italy has been involved in the establishment of reception centres for unaccompanied children seeking asylum.

Policy and legislative changes were also significant when attempting to do things differently. While there were references to specific pieces

of legislation to mandate integration, such as the Italian Law 328 (2000) and the Children and Young People (Scotland) Act 2014, there were far more explanations of how legislation covering aspects of child and family life has supported the development of greater integration. In Scotland, Children's Services are responsible for social work with children and families, as well as services for early years, young offenders and education services. It developed different ways of working with a range of agencies – police, prisons, courts and the voluntary sector – to provide focused support for vulnerable families. The work was supported by an Integrated Children's Services Plan for 2013–16, *Reach for a Better Future*, which set out how multiagency services would allow professionals more opportunities to work together to improve outcomes for children, young people and their families. It only focused on services provided on a multiagency basis, and services provided by individual services and agencies were set out in separate plans.

In Hungary, for example, there is no one piece of legislation, but various laws relating to child social care, health and education contain elements that support the provision of integrated support. Even in countries without specific legislation or policy directives some professionals and agencies had decided that the only practical way to improve service delivery was through greater collaboration. The Rainbow Project in Arad, Romania brings together a range of professionals to provide support for families who are at risk of having their children taken into care or who might otherwise abandon their children. It offers, amongst other things, child-care, education, counselling, recreational activities and independent life skills.

Integration may also be a way of making the most effective use of resources. In recent years this has been another powerful driver. As many countries have faced the reality of declining resources for public services, agencies have adopted new ways of working which, in turn, have frequently involved adopting more integrated approaches to service delivery (see Solar and Smith, 2016; Barnes et al., 2018). In a few instances, the need to achieve savings and deal with pressures on services were mentioned, as was the need to break down barriers and provide more seamless services. Ghent Public Centre for Social Welfare (OCMW), Belgium has worked to demolish the traditional divides between professions. The Flemish government

has done much to encourage greater collaboration and Ghent has designed a service to allow the early detection of families in need by placing social workers in schools and allowing appropriate support plans to be developed. The collaboration is judged to work well and be leading to families receiving earlier and more sustainable help.

Montero and colleagues' (2016) study looking at how local public services are working together to improve people's lives highlighted that a recurring aim in integrating social services was to improve outcomes for service users (see also Pasco et al., 2014; Carlisle, 2010). However, they also identified that multiple drivers lead to more integrated service delivery, including a commitment to prevention, new policy and practice, and research evidence that signals the benefits of new models of care (Devanney and Wistow, 2013; Webber et al., 2013; Collins and McCray, 2012).

Findings from the 2019 questionnaire on supporting the transition to adulthood of young people leaving care revealed that the most important reasons for cooperation with other sectors were:

- Legal and policy developments;
- to promote more preventative approaches;
- to improve outcomes for young people leaving care.

Cooperation with other sectors in response to financial difficulties was also acknowledged to be very important by ESN members from eight countries.



Adults and Older People with Chronic Conditions

Health and social care systems and services are facing significant challenges due to population ageing, increased demand for services and limited financial resources. Creative ways of organising and delivering services are being proposed to meet these challenges in long-term care. Integrated care and support is seen as a possible solution to the growing demand for improved service user experience and health and social care outcomes (WHO, 2016).

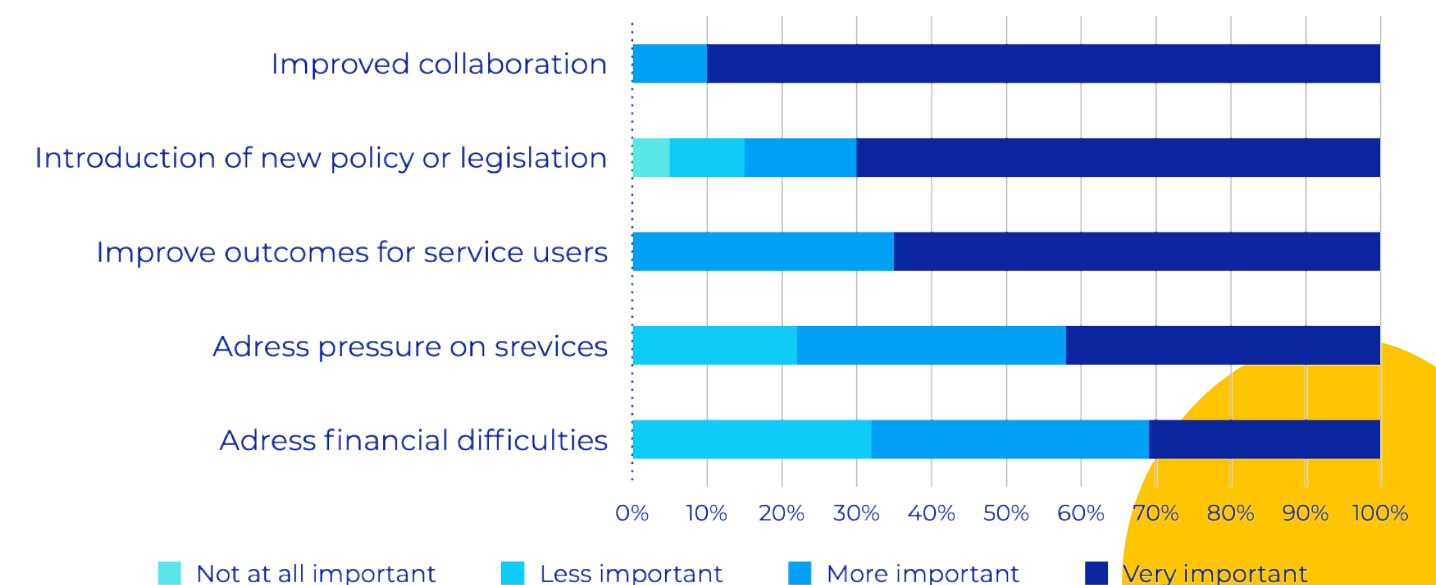
Findings from the 2020 questionnaire on integrated care and support for adults with mental health issues revealed that the most important driving forces for cooperation with other sectors were to:

- improve service outcomes, meaning the outcomes for service beneficiaries either in the community or in care settings appropriate for care of mental health.
- promote preventative approaches, meaning measures, primarily undertaken within the community which sought to identify, together with other services and the beneficiary any potential problems or issues which could escalate, requiring more intense support or potential hospitalisation.

All respondents identified as 'very important' or 'more important' to improve service outcomes. 89% of the questionnaire respondents identified as 'very important' or 'more important' to promote preventative approaches. The introduction of new policy legislation and addressing financial issues were identified as important respectively by 87% and 75% of the questionnaire respondents.

The findings are broadly in line with other studies including the report by the ESN on Integrated Social Services in Europe (2016) in which outcomes for service users was a significant motivator for integration. However, in our questionnaire, integration at a system or population level was deemed to be less important than in other published literature. Increasingly, at a policy level, integrated care is seen as the essential service delivery model to ensure the sustainability of health and social care within the context of increasing demand and limited resources.

Figure 1: Reasons for integration and co-operation with other sectors and organisations



In this questionnaire, the most important driver for integration was to improve collaboration between service providers. This point was illustrated by Mārtiņš Moors, Riga City Council Welfare Department, Latvia as follows:

“One of the first tasks is to ensure that we are ‘on the same page’ – understand [the] problem, terms, concepts and rules equally. Understanding and knowing each other and the problem better make a common ground for co-operation and co-ordinated solutions.”

In summary, integrated care and support is driven by an increased need to collaborate with other service providers for the benefit of people using services. The findings are consistent with those of the Health Foundation (2021) in which service user outcomes are recognised as a key aim of integrated care and support. The need to address financial challenges or integrate at a system or wider population level is less evident in practice, although it is commonly cited in the literature as a driver for integration (Montero et al, 2016).



Levels of Integrated Working

Integrated care and support is best described as a process or journey on a continuum rather than an endpoint, meaning that it is not a 'fixed' state, but susceptible to constant development and change (Shaw et al, 2011). There is a recognition that different integrated care initiatives are at different points on this journey. In the questionnaires, participants were asked which organisations or services, social care and social services co-operate with. Shaw et al (2011), describe the level or degree to which integration occurs as integration intensity across broadly three levels: linkage, co-ordination and full integration.

Agencies may seek to achieve a more integrated response by working together in different ways such as:

- **strategically** where joint planning and decision-making take place;
- applying **case-management schemes** where a professional has responsibility for ensuring coordination and access to the services to meet a family's needs;
- adopting **placement schemes** where, for example, social workers work in schools or in primary health care divisions;
- introducing **centre-based service delivery** where professionals from different agencies work together in one site;
- reorganising into **multiagency teams** where professionals from different agencies work together as a team.

Children, Families and Youth

There are many literature reviews and research reports on integrated working, many of which contain different typologies (see, for example, Frost, 2005; Duggan and Corrigan, 2009). It is only possible to cover a small number in this report, but several practice examples were identified and provide an illustration for each of the steps towards integrated working.

The ladder of partnership (Gaster et al, 1999), is a hierarchical typology, which consists of steps towards multiagency working.

These steps are:

- **Information exchange:** involving mutual learning, knowledge of what each partner does and could do, openness about decision-making processes, new methods of access to information.

The Directorate-General for Social Affairs and Child Protection, Hungary has established a working group involving the DG for Social Affairs and Child Protection, Education, Health, Police, Justice, Churches and non-governmental service providers in social and child care.

This working group was set up to improve the understanding of the different roles and methods of coordination between services when working with children at risk that require referral to child protection services. It meets twice a month and members maintain contact with each other in between. They have been invited to each other's training courses and can access each other's professional materials, etc. Ambassadors have been appointed within the different services. They receive training from child protection services and can disseminate the signs of risks for children within their own services.



- **Planning action:** identifying local and service needs where cross-boundary working is needed and could be effective – debating local needs and priorities, agreeing different partners' contributions, deciding actions and processes and identifying any need for new partners.

The Region of Lazio in Italy is a participating member in the **National Action Plan for the Prevention of Institutionalisation (PIPPI)**. This project started in 2010 as a collaboration between the national Ministry of Labour and Social Policies, the University of Padova and social services in local authorities. The aim of the project is to promote effective interventions which can prevent children being taken into care measures and putting the emphasis on a child-centred approach where the concerns of parents and children are taken into consideration. A local reference group including professionals and scientific experts oversees the project, including the planning, monitoring and evaluation. Multidisciplinary teams (including a case manager, professionals, and representatives of the healthcare and education services) implement the programme.¹

- **Implementing projects and service plans:** undertake joint or separate action on agreed plans, identify monitoring methods and review processes, and provide mutual feedback on successes and failures.

The Regional Government of Galicia has introduced a **protocol between health, education and social services** which establishes a system whereby education and social services can refer children who may have a developmental disorder to a paediatrician who would be responsible for decisions relating to the child. The project is guided by a working group involving health, education, and social services. A case management tool is being developed to enable joint evaluations of the outcomes for children.

- **Coordinating and cooperating** – a coordinator knows what is happening and draws on each partner as appropriate.

Mechelen Public Centre for Social Welfare (OCMW), Belgium provides integrated support for families by having one case manager through the Go Team project. A unit within the OCMW has more time to provide intensive support to families when necessary. At the beginning of the contact a questionnaire is completed by both the family members and the counsellor, which collects information on finances, health, housing, work and school. A plan and relevant objectives are drafted and agreed by the family. The case manager monitors the plan to make sure that the relevant services are engaged.

- **Collaboration and full partnership:** Involving separate and distinct roles but shared values and a common agenda – pooled resources and blurred boundaries continuously develop to meet changing needs.

¹ For more information on the P.I.P.P.I programme see ESN's Peer Review (2014) '[Innovative practices with marginalised families at risk of having their children taken into care](#)'



As described above, interagency working may also be happening at a **service user, local and whole system level** (Miller and McNicholl, 2003).

Service user level where children and families are able to access information and advice, have more complex needs assessed and get a coordinated response.

In the family centres in the Häme region of Finland, social services, health services and NGO service providers are brought together within one building, making it easier for families to access a range of different services.

Local level where teams of frontline staff across different agencies work together to provide an integrated service to children and their families.

The Institute for Research on Population and Social Policies (IRPPS-CNR) has supported a cross-sectoral network involving professionals from education, health and social services to address early detection and intervention with children with developmental disorders. Multi-disciplinary work units develop a personalised action plan for children deemed to be at risk.

Whole system level where different sectors plan, commission and manage services to achieve integration. At a national level this involves strategies designed to improve the lives of children and their families by coordinating support around the needs of children.

The Scottish policy **Getting it Right for Every Child** (GIRFEC) provides a framework for organisations to plan and provide a consistent approach. This involves examining all their processes and procedures, as well as their cultures to identify what is in line with the policy and what needs to be adapted or changed. At a local level, agencies then plan, commission and manage services to create integrated services so that service users – individual children and their families – are able to receive a coordinated response.

In the UK, the Audit Commission (1998) identified different models that ranged from large-scale strategic partnerships to small, local community partnerships. The former involved the formation of a separate legal entity – where agencies come together to form a new organisation with an identity separate from that of any of the partners, or a virtual organisation where

a separate organisation is formed but without establishing a legal identity. At the next level, staff from partner organisations are co-located but are still employed by their own agency. The final model involved partners forming a steering group that does not have its own resources, and implementation of decisions is left to the partner agencies. Although there are many typologies developed since then, this typology developed by the Audit Commission is still significant, particularly for highlighting that it is not necessary to achieve organisational integration and that contractual integration through commissioning of services may be the most appropriate route for agencies to take.

The typology **of five integration models** devised by Atkinson et al. (2001, 2005) proves to be very helpful in analysing and exploring the data provided by participants. As their roles often involved planning, procurement and provision of services, with a significant level of involvement in regulation, accreditation, inspection and research, it is not surprising that where information was provided about levels of cooperation across services it was most frequently linked with strategic and operational planning.

The five models distinguished by Atkinson et al. are:

- **Decision making groups** that provided the opportunity for professionals from different agencies to discuss issues and make decisions.

In Sweden the County of Kronoberg is implementing a strategy similar to the Getting it Right for Every Child (GIRFEC) model in Scotland. The Best for Every Child focuses on improved coordination between social services, health services, education and the police. A group of directors representing the four services meets twice per semester to set out the strategic direction and take decisions for implementing a more integrated approach for children. This forms part of a goal to move towards making care more child centred, focusing on their needs rather than the organisational priorities of the services.

- **Consultation and training** for the professionals from one agency to support others by providing consultation and/or training for them.

The Regional Government of Galicia has developed a training plan for professionals in the different services in Galicia. The aim of this training is to enable staff in different services to be more aware of each other's work, to promote methods for coordination between them and to understand the benefits of early intervention for children with developmental disorders.

- **Centre-based activity** which gathers a range of professionals in one place to offer a more coordinated and comprehensive service

The Rainbow Complex in Arad, Romania is a day-care centre offering child protection services in the broadest sense to prevent children coming into state care by providing educational and recreational activities for children, as well as support and education for parents and carers.

- **Coordinated delivery** seeks to offer a more coordinated response but not from one location.

The INTESYS project in Lisbon, Portugal focuses on the integration of early childhood education and care (ECEC) services between different sectors. Its activities include mapping services, adopting a holistic vision of children and families, developing shared indicators and integrated plans.

- **Operational team delivery** for professionals from different agencies to work together on a day-to-day basis and to form a cohesive multiagency team that delivers services directly to clients.

The Regional Government of Navarra, Spain implements the project Early Detection and Intervention for Children. The project brings together professionals connected to a child from social, health and education services so that they can create personalised family preservation plans. By carrying out joint work in teams a shared work frame is created with the family, preventing fragmented responses by different professionals.

As Table 2 shows 'co-ordination awareness of other services and effective signposting to partner agencies' is the most common approach to the delivery of a range of support services to young people leaving care according to the respondents of our questionnaire. Integrated processes and joint co-ordination of services were also common. However, still a small proportion of respondents reported limited or no co-operation with other sectors.



Table 2: Extent of cooperation with other sectors to provide integrated support for young people leaving care

	Limited or no cooperation/little awareness of other services and lack of synergy	Co-ordination awareness of other services and effective signposting	Integrated process/ services jointly co-ordinated (e.g. assessment and case management)	Integrated organisation/ team providing services
Financial support	1	5	8	4
Housing	3	7	4	4
Employment	2	7	6	3
Education	1	9	7	1
Health	3	7	6	2
Justice	3	11	2	2
Total	13	46	33	16



Adults and Older People with Chronic Conditions

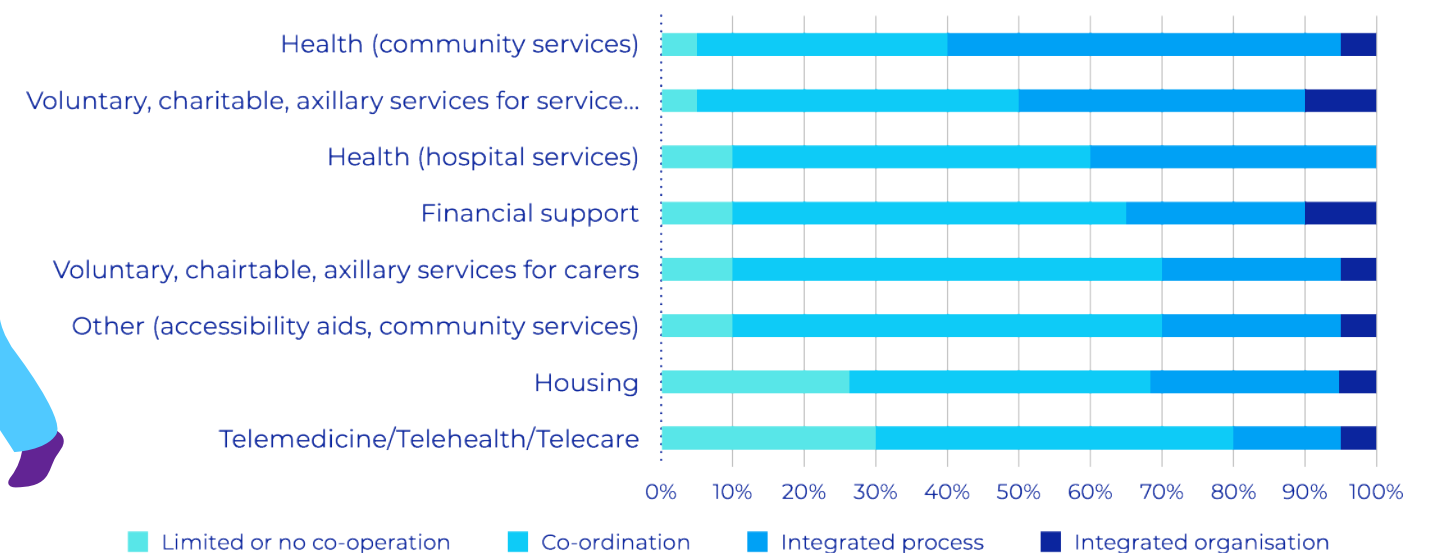
In the provision of integrated care and support for adults with mental health problems, as Table 3 shows, the most common level of cooperation with other sectors identified by the respondents was coordination, while integration is rare. What is striking, however, is that the level of coordination with health does not stand out in comparison to other sectors.

Table 3: Extent of cooperation with other sectors to provide integrated support for adults with mental health problems

	Limit or no cooperation	Co-ordination	Integrated process	Integrated organisation
Housing	25%	62.5%	12.5%	0
Employment	22.2%	55.6%	22.2%	0
Education	25%	37.5%	37.5%	0
Health	12.5%	37.5%	37.5%	12.5%
Financial Support	11.1%	55.6%	22.2%	11.1%
Community outreach	0	66.7%	33.3%	0
Total	15.7%	52.9%	27.5%	3.9%

Figure 2 identifies the organisations, sectors and services working with social care organisations to deliver integrated care and support for older people. These services include health (community and hospital services), voluntary, charitable and auxiliary services provided for service users and carers, housing, financial services support, and remote monitoring (telemedicine/telehealth/telecare). As well as identifying collaborating organisations and services, this figure also describes the degree to which these services are integrated from where there is little or no integration to a fully integrated system represented by one, merged organisation. Intermediate levels of integrated care are described where there is co-ordination between the different services or shared processes, for example, shared service user assessments or care plans.

Figure 2: Degree of co-operation between sectors and organisations



Most describe intermediate levels of integration where care is **co-ordinated** or there are **integrated processes between sectors and organisations**.

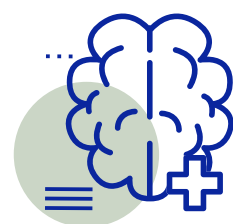
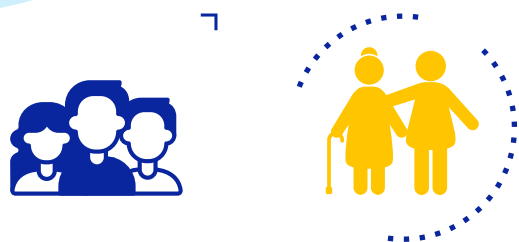
This co-ordination is exemplified by Nadezda Buincikiene, Vilnius Municipality, Lithuania: "We have partners in health care and social care, we have agreements with our partners, what are their responsibilities, how to solve problems or provide services for citizens. We contact them, discuss with them how to develop quality, how to solve resources issues, etc. It is consistent co-operation".

There are very few examples of fully integrated organisations or systems. In Sweden, fully integrated organisations are described as rare.

Graham Owen, from the Association of Directors of Social Welfare Services in Sweden explained: "There are a couple of examples of truly integrated care but generally the level is of co-ordination and in some cases integrated processes."

One such example of a fully integrated system is provided by 'This is Ten Hundred/ Vårdbolaget Tiohundra, Norrtäljemodellen, Stockholm, Sweden (See Practice Annex). Here, a high level of integration is demonstrated in which health and social care organisations are brought together in a merged organisation, which jointly provides hospital and community services in the region.





Higher levels of integration intensity tend to occur more commonly in **primary and community care services** with more limited integration with **acute hospital services**. i.e. there are more examples of horizontal integration compared to vertical integration (Heeringa et al, 2020). This was confirmed by several participants of the 2021 questionnaire: “We may engage with acute health care services in a limited way if there are concerns regarding the health care needs of somebody living in a residential service for older people” (Susan Cliffe, Health Information and Quality Authority, Ireland).

There is limited or no integration for **telecare** described in the answers to the questionnaire covering services for older people. This may be because this is a very specific service which is least relevant to some integrated care initiatives or is still being developed. Limited integration could also be due to the fact that in some countries, telecare is provided as part of statutory social care services (Carretero, 2015) and so may not be seen as a separate organisation with which to integrate. The Cared Living Service,

Riga, Latvia, however, provides a good example of where digital technologies such as automated lights, smart monitoring and fall prevention systems play an important part in supporting older people to live independently at home for longer.

In summary, when it comes to long-term care for older people most integration occurs horizontally between community health and social care organisations. This is consistent with European research literature in that models of integrated care frequently occur in this setting (Antunes and Moreira, 2011). Rarely are organisations fully integrated into one provider organisation, rather there are shared care processes. These findings are consistent with the concept of **integration as a journey along a continuum**, with different areas and countries at different stages of integration, with few achieving full integration. Many can be described still at an experimental or pilot stage (WHO, 2016).

As for the mechanisms and activities for the delivery of integrated care, these are identified in Figure 3. These include multi-disciplinary team-working, co-ordination of care through joint working, making service users or carers aware of the existence of other organisations or services – ‘signposting’, sharing information digitally, shared care plans (which service users may have access to) and the co-location of professionals in the same building.

Most describe **co-ordination** between different agencies providing care, operationalised through **multi-disciplinary teams**. **Information sharing** through shared care plans or shared technology systems is less evident and there are few instances of the service user having access to their electronic care record.

There was limited evidence of **co-location** from the questionnaire.

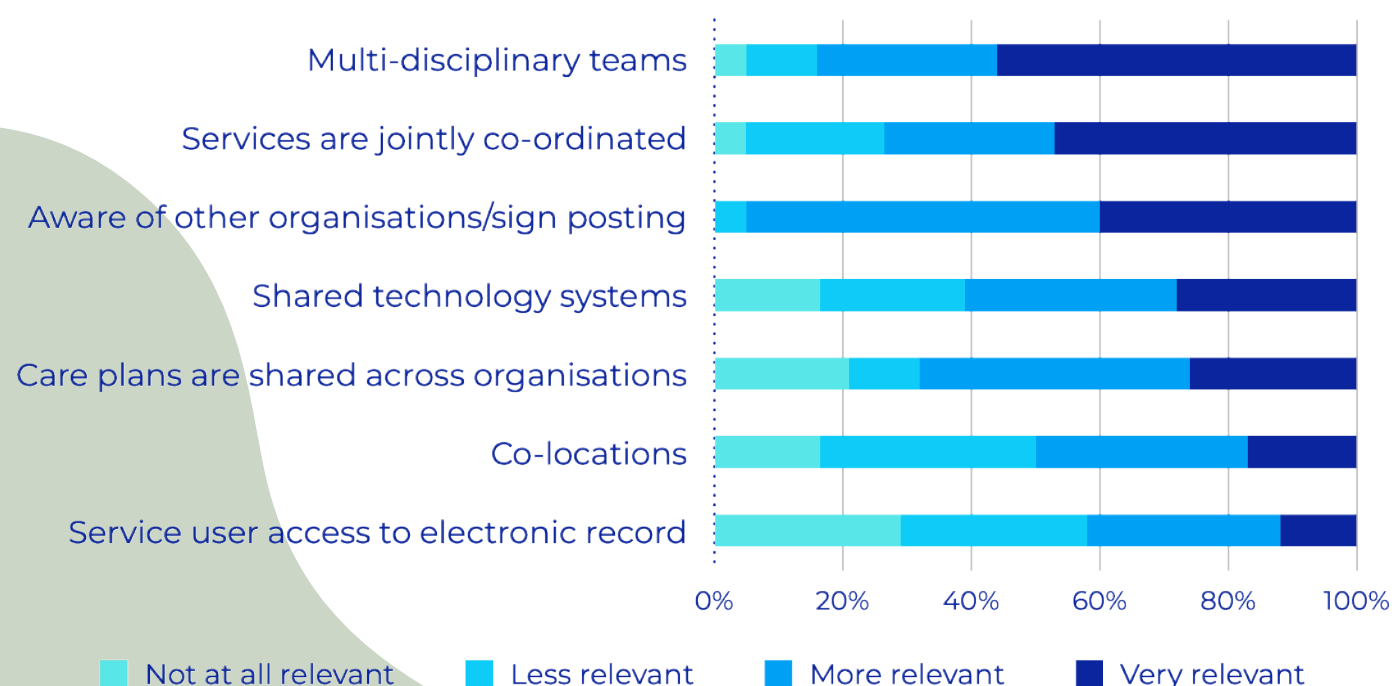
Nonetheless, the Jean Bishop Integrated Care Centre, Hull, United Kingdom (See Practice Annex) provides an example in which a wide range of health, social care, therapists and voluntary organisations work together in the same building so that older people have access to the support and care they need all in one place.

In terms of **management**, for most respondents in the questionnaire, integrated care and support was a joint management responsibility (45%). Management by one organisation was less common (35%). Where one organisation was responsible for managing integrated care this was either a merged organisation, or more likely a service where one organisation provided the majority of the care and support.

These findings are broadly consistent with the literature in that integrated care and support is frequently operationalised through multi-disciplinary teams which are the cornerstone of collaboration and integration (SCIE, 2018). Information sharing occurs often in a number of ways included shared care plans and digital data transfer. However, Desmedt et al (2017) identified a number of reasons why digital data transfer does not occur often including inadequate funding, interoperability problems between systems, inadequate technical support and infrastructure, lack of skills amongst users and providers, a lack of a legislative framework and privacy issues. This may explain why the use of shared IT systems was less evident in the questionnaire compared to other means of communication.

Although co-location may be desirable it is often not practicable in terms of geography or resources, despite being described as a catalyst for service innovation by Memon and Kinder (2017). In contrast to the ESN report on Integrated Social Services in Europe (2016), which found that most integrated care initiatives are led by a single, public organisation, mostly a local authority or regional government, our questionnaire found a shift towards joint or distributed leadership and management which may indicate an increasing maturity of integration over this time period.

Figure 3: How integrated care and support is delivered





Professionals and Agencies Involved in Integrated Working

It is worth examining the extent to which different professionals and agencies were involved in the projects for which details were provided for the various Working Group meetings. For example, for children, families and youth those participating in the questionnaire were asked to identify the role of six agencies – housing, police, health, education, employment and justice – in cooperating to provide integrated support.

For adults, respondents were requested to identify the professionals and other staff involved in integrated health and registered social care working. For social care, this includes social care workers. This group is distinct from care assistants who are unqualified/unregistered and support the activities of the social care workers. Healthcare professionals include doctors (all types), nurses and allied health profession-

als such as therapists and pharmacists. Therapists include physical therapists such as occupational therapists and physiotherapists and psychological therapists including counsellors. Volunteers are also represented. In addition, a number of supporting roles for integration were also mentioned, such as care co-ordinators and administrators.



In the questionnaires to assess integrated care and support for youth leaving care, ESN members were asked 'what were the services that their organisations focused on' and how they were prioritised.

Children, Families and Youth

While there were exceptions, housing and employment were most active in raising families' awareness of services and signposting them to information on how to access them. Justice, education and health were most engaged in working to provide a coordinated response. There were fewer mentions of agencies' involvement in integrated teams but where this was the case, health was most frequently identified, although all the agencies, with the exception of the police, were mentioned to some extent. However, when all the data are computed and the examples that were provided examined, health, education and police were most involved in the closest working collaborations.

Linkages between social care and health were designed to address identified health needs of specific populations such as high-risk families or those coping with specific issues such as mental health disorders, disability, or children's developmental delay.

It was also common for respondents to mention services jointly coordinated for specific purposes, including assessment and case management.

There were a number of examples where social workers were based in other agencies, such as in Ghent where they work from a school and Malta where they are based in agencies addressing individuals with drug and alcohol problems.

The Children First Practice in Ghent in Belgium places social workers in schools. Although they are embedded in schools, they are still employed by the social welfare agency, Public Centre for Social Welfare. This allows schools to work closely with the Public Centre for Social Welfare to ensure more integrated support for children and families.

In **Malta the Foundation for Social Welfare Services (FSWS)** is implementing a strong shift in policy towards providing more integrated support to children. This is supported by strategic alliances and activities but also in practice. For example, social workers with child protection experience have been placed in specialist alcohol and drug services, enabling a broader view to be taken by these agencies when working with families. Similarly, every school now has a child protection social worker to help identify and support children who may be at risk.

The least intensive form of 'integrated' working identified involved increasing awareness and improving understanding of other services so as to provide help to children and their families in the most efficient and effective ways.

Despite the fact that housing was involved in some examples of the integrated approach to service provision overall it was the agency which was involved to the least extent. However, as discussions at the Lisbon Working Group meeting confirmed, a lack of enough suitable social housing in many European countries aggravates the level of social problems across societies and is one which social workers often have little power to influence.

Aftercare plans were reported to be a very important priority in Malta, the Netherlands, Portugal, Romania (at a local level) and in Scotland. The principles of preparation and planning are enshrined in legislation in Scotland and the rest of the UK. Pathway plans are developed to assess young people's needs. They explore the following dimensions of need: health and development; education, employment and training; emotional and behavioural development; identity; family and social relationships; practical and other skills for independent living; financial arrangements; accommodation (Department for Education, 2015, p. 21-23).

Accommodation and housing, employment and psychosocial support were most frequently identified as being of the highest priority to meet the needs of young people leaving care.

Wider research also illustrates the importance of emotional support and relationships alongside the provision of formal support and financial or practical support (Dima and Pinkerton, 2016; Munro, Mølholt and Hollingworth, 2016; Geenen and Powers, 2007; Wade, 2008).

Adults and Older People with Chronic Conditions

From the questionnaire to assess integrated care and support for older people, in the majority of cases (90%), social care workers (qualified), nurses and care assistants were involved in delivering integrated care and support. Physical therapists and doctors also made a significant contribution. Psychological therapists and volunteer workers were less frequently represented with more limited involvement of pharmacists.

Staff involved in facilitating integration processes played an important role. These **non-traditional, new emerging roles** are focused on care co-ordination and signposting to other agencies. In Malta, **social welfare professionals** undertake initial assessments.

“The aim of social welfare professionals is to conduct home visits and carry out assessments of basic needs and refer to the appropriate services”

Alfred Grixti, Foundation for Social Welfare Services, Malta.



In Lithuania, **social care coordinators** connect the different health and social care services: “Vilnius has developed the role of social care coordinators. [They are] responsible for the co-ordination, planning and organisation of the required services (health, social and other), quality supervision and control” (Nadezda Buncikiene, Vilnius City Municipality, Lithuania).

In the UK, **care navigators** signpost or direct service users to relevant agencies, as Susanne Wald, Swindon Borough Council, UK explains: “We have developed community care navigators within [Family Doctor] practices, supporting people with multiple health and social care needs ...and link them into community-based support”.

In summary, a wide range of health and social care professionals are involved in delivering integrated care and support for older people across sectors. Consistent with the literature, so-

cial workers and nurses were involved in nearly all our examples, as would be expected in this target population. There are, however, some professional groups which are under-represented namely, pharmacists and psychological therapists. Similarly, although there are some instances of integrated physical and mental health services, this is generally not the case (Wakida et al, 2018). This is echoed in the questionnaire.

The development of new roles focused on care co-ordination are an important component of integration and are now commonly cited in the literature and in our practice examples. These individuals are frequently ‘boundary spanners’ in which practitioners from different organisations span the intellectual and practical boundaries that separate them (Aungst et al, 2012). These new roles aim to enable more holistic care, and facilitate continuity and co-ordination of care across organisational boundaries (Gilburt, 2016).



Involvement of people using services in integrated support planning and delivery

There is a growing imperative to place people and communities at the centre of care and support services. This is particularly important for people with multiple health conditions and care needs managed by different providers. Cypionka et al (2020) argue that service user involvement in goal-setting and decision-making enables people using social services to adapt to changing service delivery models. However, the situation varies significantly across countries and population groups.

Children, Families and Youth

There are few studies that reflect on the views of children and families on integrated services. An exception is Sloper's (2004) review of facilitators and barriers in interagency working in children's services. She concludes that:

"The demands placed on families by having to deal with many different professionals and agencies have been well documented... as have the difficulties in obtaining information about the roles of different services, the problems of conflicting advice and the likelihood that the children's and families' needs will fall into gaps between different agencies' provisions" (p.572).

Article 12 of the United Nations Convention on the Rights of the Child acknowledges that children and young people have the right to express views and the opportunity to be heard in any judicial and administrative proceedings affecting them. The principle of involving children in care and care leavers in care planning and decision-making processes is also embedded in child welfare legislation. However, in practice there are wider variations in the extent of children and young people's participation within and between countries.

Nearly all the projects identified in the questionnaire on children and families were committed to involving children and/or their families in the development of their services. In most cases this was through consultative exercises, including those that collected feedback on services and those that contributed to planning decisions. Unfortunately, the descriptions provided of how this happened did not always differentiate between children and families as users of the services and their wider role in participating in decisions on planning or delivery. A very small number reported having worked with families to co-design a whole service or at least some aspects but few details were provided.

The questionnaires differentiated between levels of involvement in the planning and delivery of integrated support for young care leavers in the following ways:



Informed: young people are provided with an explanation about how the services they receive work and why decisions are made

Consulted: young people fill in questionnaires and attend meetings but their views may not influence planning or decision-making



Co-design: young people are involved in designing services, based on their experiences and ideas (genuine influence)

Engagement: young people are given more opportunities to express their views and may be able to influence some decisions.



Evaluation: young people are asked to evaluate services.

As Table 4, below shows, there was widespread acknowledgement of the importance of involving young people leaving care in the planning and delivery of services. Two thirds of respondents viewed the principle of young people's engagement as very important and three-fifths acknowledged the value of the co-design of services.

Table 4: Rating of the different ways of involving young people leaving care in the planning and delivery of services

	Less Important	More important	Very important	No opinion	Total
Inform	3	7	8	0	18
Consult	4	6	8	0	18
Engage	1	5	12	0	18
Co-design	2	3	11	2	18
Co-produce	3	6	7	2	18
Evaluate	4	6	8	0	18

However, responses to 'how they involve care leavers in the planning of integrated support' suggests that in day to day practice the aspirations of higher levels of participation may not always be realised. Although most respondents thought co-design was very important in principle there was only one local authority in Belgium that reported that "care leavers were involved in designing services, based on their experiences, and ideas and they had genuine influence".

Table 5: Respondents' perspectives on young care leavers' involvement of planning and delivery of support within their organisational context

Level of involvement	Country
Inform	Romania, Latvia, Spain, Italy
Consult	Malta
Engage	Sweden, Germany, Italy
Co-design	Belgium
Co-produce	Netherlands
Evaluate	Portugal, Slovenia

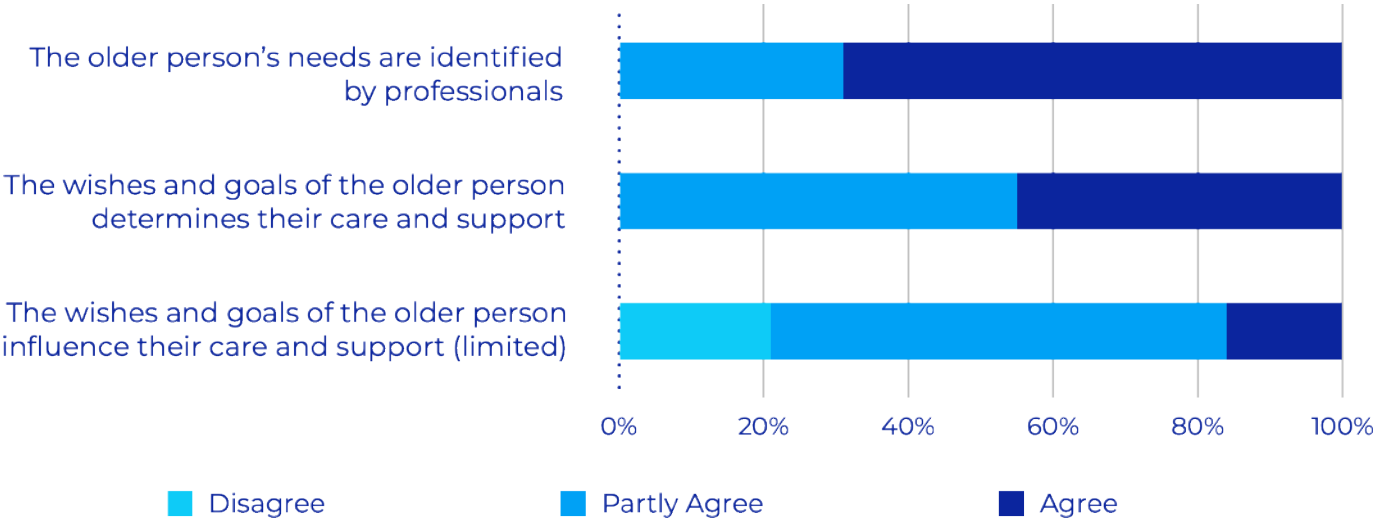
Adults and Older People with Chronic Conditions

Figure 4 presents three levels at which older adults are involved in their care in terms of determining how their needs are assessed and met.

- The lowest level of person-centred care describes a situation where professionals identify the needs of the services user.
- At the next level, the wishes and goals of older people influence their care and support but in a limited way.
- The highest level of person-centred care describes a situation where the care and support are wholly determined by the person themselves.



Figure 4: The extent to which integrated care and support is person-centred



Predominantly service users were involved in their own care by being given information, were consulted about their care, or are otherwise engaged at **an individual level**. This is illustrated by Graham Owen, Association of Directors of Social Welfare Services, Stockholm, Sweden: “There are examples of co-design but the majority of services use information and consultation.” However, in some cases service user involvement was entirely lacking: “Unfortunately, in reality there is no involvement of the older person in the decisions that are taken for their support” (Georgios Vellis, Fyli/Attica Region, Greece).

Service users were less commonly involved at a more **strategic level** including co-design and co-production of services or co-commissioning. In Ireland, feedback from older people is sought as part of quality inspection in residential care homes: “Inspectors engage with those living in older peoples services during every inspection in order to ensure that their experiences are reflected in all our reports” (Susan Cliffe, HIQA, Ireland).

Most integrated care organisations (52.6% in our questionnaire), did however, involve **service user organisations** in service design and delivery. This is described by Susan Cliffe: “Service user representation groups, largely drawn from the advocacy sector, engage proactively with [organisation] in relation to their members and their experience of services” (HIQA, Ireland).

The questionnaire findings are consistent with the literature which shows lack of involvement of older people in care. The ESN 2021 Working Group meeting on integrated care and support for older people included a discussion on **user involvement** which highlighted some of the reasons why, in general, service users were not involved in the design or commissioning of services at a strategic level. One reason may be that their involvement at this level is not mandatory and so organisations planning or delivering services for older people are not obliged to seek their views. It was also noted that organisations needed to make greater efforts to ‘reach out’ or target a diverse range of older people in terms of gender, age, or socio-economic characteristics. This is necessary to ensure services truly address the needs of all older people. These discussion outcomes show that further action may be required to encourage and facilitate user involvement at different levels.

Carers support needs were also discussed in the framework of the Working Group meeting on integrated care for older people. Carers needs are assessed according to 58 % of questionnaire participants. The type of support available broadly falls into four categories: advice, emotional support, direct care for service users, which enables carers to have breaks from their caring responsibilities, and financial support.

Advice is commonly practical or financial advice such as the costs of services or information on benefit entitlements.

Emotional support is also evident in over half of the examples given by questionnaire participants.

Direct care for service users in the form of day care or home support is also prevalent, but there are concerns for some around the lack of capacity. Overnight care in the service users’ home is more limited, according to questionnaire participants, as is relief/respite care in hospital, which are only available in around 20% of cases.

Direct financial/in kind support as recognition of their work such as re-imbursement for transport or in the form of vouchers for example, is limited.

Consistent with the literature, although care needs are commonly assessed, there is, in general, a mismatch between identified support needs and available services, especially for respite care for older people. According to the Family Caregiver Alliance (2006), the health and social care landscape primarily centred around older people compared to their informal carers. The ESN 2021 Working Group meeting highlighted that many informal carers do not identify themselves with the term ‘**carer**’ which inhibits both access to needs assessment and support. Some carers may be hard to reach for this reason. This may highlight the need for better outreach to inform informal carers about their rights and the services available to them.



Financing Integrated Working



ESN report on Integrated Social Services in Europe (2016) identified four main types of funding for integrated care services:

- joint/pooled funding where two or more agencies pool budgets to fund services;
- single agency funding;
- funding within existing resources such as staff time or other resources;
- and mixed funding which is partly public and partly private.

But, according to Borgermans et al (2017), in most EU countries, funding is allocated to individual service providers and institutions rather than networks of organisations with shared goals. Tomlinson (2003) and Serrano (2003) speculate that where economies of scale have been achieved through integration, the public purse may benefit. However, these aspirations have not been confirmed by subsequent research (Brown and White, 2006; Nolte and Pitchford, 2014; National Audit Office, 2017).

Children, Families and Youth

Half of respondents of the questionnaire on integrated support for children reported that the moves which they had taken to closer integration had been funded through existing resources within agencies, while the rest explained that it had been supported by additional funding from one or two agencies or, more unusually, by support from government or an independent organisation.

Economic evaluations have highlighted the cost-benefits of investing in services and support for young people leaving care to improve outcomes for this group and to reduce longer term dependence on the State (Peters et al., 2009; Deloitte Access Economics, 2016; Hannon et al., 2010). Questionnaire respondents on youth leaving care were asked how their inte-

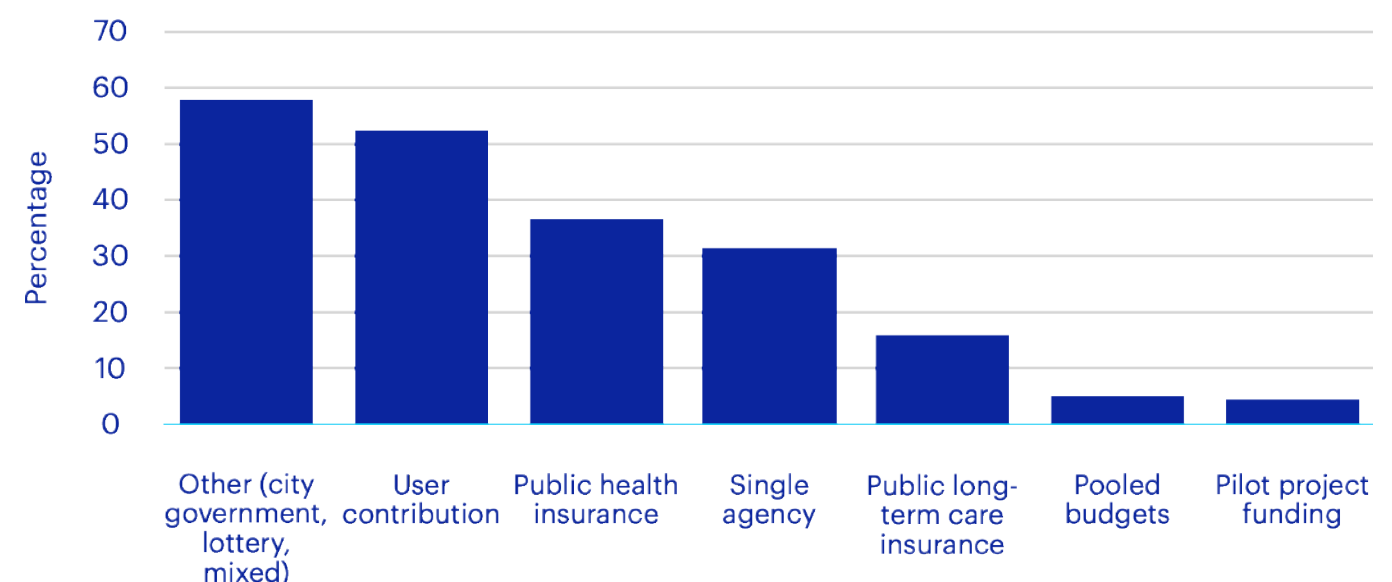
grated support services for care leavers were financed. The most common responses were also using existing resources (staff and funds), though some mentioned pooled budgets, or a combination of national and EU funding.

Adults and Older People with Chronic Conditions

Figure 5 identifies the range of funding sources available to integrated health and social care providers. This may be through a single organisation, such as a local authority or healthcare provider, or funded through public or private insurance. Specific to integrated care is the concept of pooled budgets where responsibility for funding is shared across different provider organisations. Similarly, so called 'seed-funding' or pilot project funding may be allocated to set-up or evaluate an integrated care initiative. Given the diversity, complexity and lack of information about how integrated care is funded, a category of 'other' was included and members were invited to describe novel ways in which integrated care was funded. Importantly, the prevalence of service users financial contribution to care was also sought.

As expected, the financing of integrated care and support presents a mixed picture. In relation to how integrated services for adults with mental health problems are funded, Finland, Malta and Latvia indicated as main resources **governmental and municipal budgets**. Malta and Finland pointed out also to **EU funded projects**. Denmark, Spain, Slovenia, and the UK responded that the integrated services are funded through **existing resources** (already available staff and funds). Only UK, Spain and Malta indicated funds coming from **pooled funding** of more agencies sharing their budgets. In the UK, housing and community support service is jointly funded from existing funding from health and social care, while in Malta joint funding is managed at ministerial level.

Figure 5: How integrated care and support is financed



Commonly, **service users** were asked to contribute financially to their care in over 50% of the examples. This is often means-tested.

This is described by Georgios Vellis, Fyli/Attica Region, Greece: "Some of the services are funded by beneficiaries themselves, which depends on their income", and is echoed by an example from Latvia: "The client is responsible for paying for social care services. If the clients' income (mainly old age pension) does not cover all the fee (and in most cases this is the case), the municipality pays the rest" (Mārtiņš Moors, Riga City Council Welfare Department, Latvia).

Health insurance either specifically for long-term care or public health insurance was also prevalent. Funding is frequently provided by a **single agency**, such as a local authority and is separate from health budgets, as described by Jiri Horecky, Association of Social Services Providers, Prague, Czechia: "The funding system is different in the health care sector and the social sector."

Very rarely are budgets **pooled**, but there are exceptions as Sue Wald from Swindon Borough Council, UK, explains: "Each team is jointly funded from an aligned budget". In Sweden, a pooled budget is provided only for **integrated care pilot projects**: "Separate funding [is the norm]. Joint funding is provided for the pilot project" (Graham Owen, Association of Directors of Social Welfare Services, Sweden).

Other **mixed sources of funding** were also apparent, for example: "It is financed using various means: dependency system, European funds, own budget of public administrations and co-payment of people using services" (Luis Touya, Social Services Management Authority, Castilla y Leon, Spain)

This highly complex picture is also described in a review by Mason et al in 2015, which like ESN's report (2016) found that pooled budgets are common. This contrasts with the new questionnaire findings in which **single agency funding is more common**, as described by Borgermans et al (2017). However, part of this discrepancy might arise from the definitions of 'joint or pooled' funding which may describe each organisation contributing to a single 'pot' (pooled), or services are co-funded by different organisations according to their contribution (joint). The latter is most common, but further information is needed in this area.



Facilitators or Barriers to Integrated Working

Integration can be difficult to operationalise. Not only does it require a commitment from all those involved, it also depends on an ability to address structural impediments embedded in organisational cultures. The literature is replete with factors that both support and hinder integrated working.

Facilitators

Amongst the most commonly mentioned factors is the importance of clarity over both aims and objectives and roles and responsibilities. Of equal importance is the commitment of senior managers, effective leadership, training and support for staff, and robust structures around planning, financing and commissioning, alongside secure funding arrangements.

Although training and learning opportunities and resources were considered to be very important by many responding to the questionnaire and taking part in the meeting, the **commitment of stakeholders** and **effective leadership** at every level were reported to be the key factors in supporting the delivery of integrated services.

Over half of ESN members that responded to the questionnaire on youth leaving care reported that leadership and effective management and the commitment of stakeholders were very important. Half also acknowledged the importance of co-production.

"In the absence of systemic solutions, local leaders are most important for developing integrated support" (Janusz Korczak Pedagogical University, Poland).

"A good leader is needed to coordinate organisations and ensure agreements at a higher level, e.g. who is going to finance what, which mandate do the individual organisations have, who takes which decisions. These matters need to be well-attuned, so that basic workers can work without disruption in an integrated team" (Ghent Public Centre for Social Welfare, Belgium).

"Strong and solid political leadership is essential for breaking the inertia of working in rigid silos and for facilitating the coordination and integration of services" (Regional Government of Galicia, Spain).

Alongside committed leaders, stakeholder engagement was seen to be an essential requisite for establishing a receptive environment for integration:

"Commitment of stakeholders is the base of all activities. Working out and testing new, efficient models is essential to adapt to needs. For all that, sufficient resources are needed. The attitude of leaders determines achievement-oriented work and implementation. The leader is the key person to motivate employees" (Directorate-General for Social Affairs and Child Protection, Hungary).

In responding to the questionnaires, many also pointed out that leadership and stakeholder commitment had to be accompanied by learning opportunities aligned with new ways of working, as well as sufficient resources to sustain these. There was also a consensus amongst those participating in the meetings that an important starting point was the commitment of staff to new ways of working. This, in turn, depended on embedding a shared understanding



of how and why things were changing as well as providing, as far as possible, assurances that this would continue to be a priority.

In discussions during the Working Group meetings participants agreed that successful implementation of integration depended on the extent to which there was a positive and receptive climate across the organisations involved. Johnson et al. (2003) examined the role of organisational climate in relation to integrated working and found a positive relationship between organisations that encouraged teamwork and flexibility with increased levels of integration. Huxley et al. (2011) found that secure professional identity within multidisciplinary teams was associated with higher levels of perceived integration, and Gardner (2003) identified a positive relationship between organisational identity and staff confidence in working practices.

In relation to children, just as it is vital to be completely transparent with staff, it was considered to be as important to achieve this with families. A number of participants to the Working Group referred to the distance, and frequent antipathy, that existed between some parents and the agencies that worked with them. Good communication was considered to be key to success.

Domian et al. (2010) examined factors that influenced the abilities of mothers who were perceived to be at the highest risk for child maltreatment in a home visiting programme. They found that practitioners felt that better communication and information sharing were needed to improve multiagency practice and that this would be helped by the adoption of a common language that would be used with families. The

introduction of new arrangements provided an opportunity to reshape this relationship and open new dialogues with families, particularly as many were designed to offer more intensive support than had previously been available in an attempt to route families away from more disruptive interventions.

While not all research has confirmed the benefits of **co-location** (Cameron and Lart, 2003; White and Featherstone, 2005) others have argued that co-location is an essential component of integrated working (see, for example, Park and Turnbull, 2003; Memon and Kinder, 2016). There are subject – specific studies that indicate the benefits of co-location. For example, McNaughton and Paskell (2014) found that professionals reported that co-location was effective in improving the identification of boys and young men at risk of sexual exploitation. Those attending the Working Group meetings were overwhelmingly positive about the advantages of co-location in opening up the possibility of meeting and addressing specific needs in one place, even though there was very little experience of it in practice.

Adults and Older People with Chronic Conditions

The findings from the questionnaire on integrated care for older people allow us to categorise broadly facilitating factors for integration as:

- team processes,
- resources,
- and management and leadership.

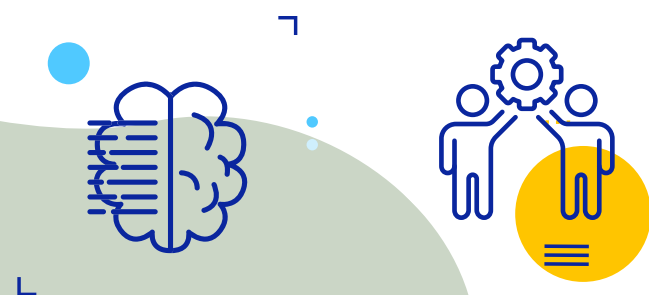
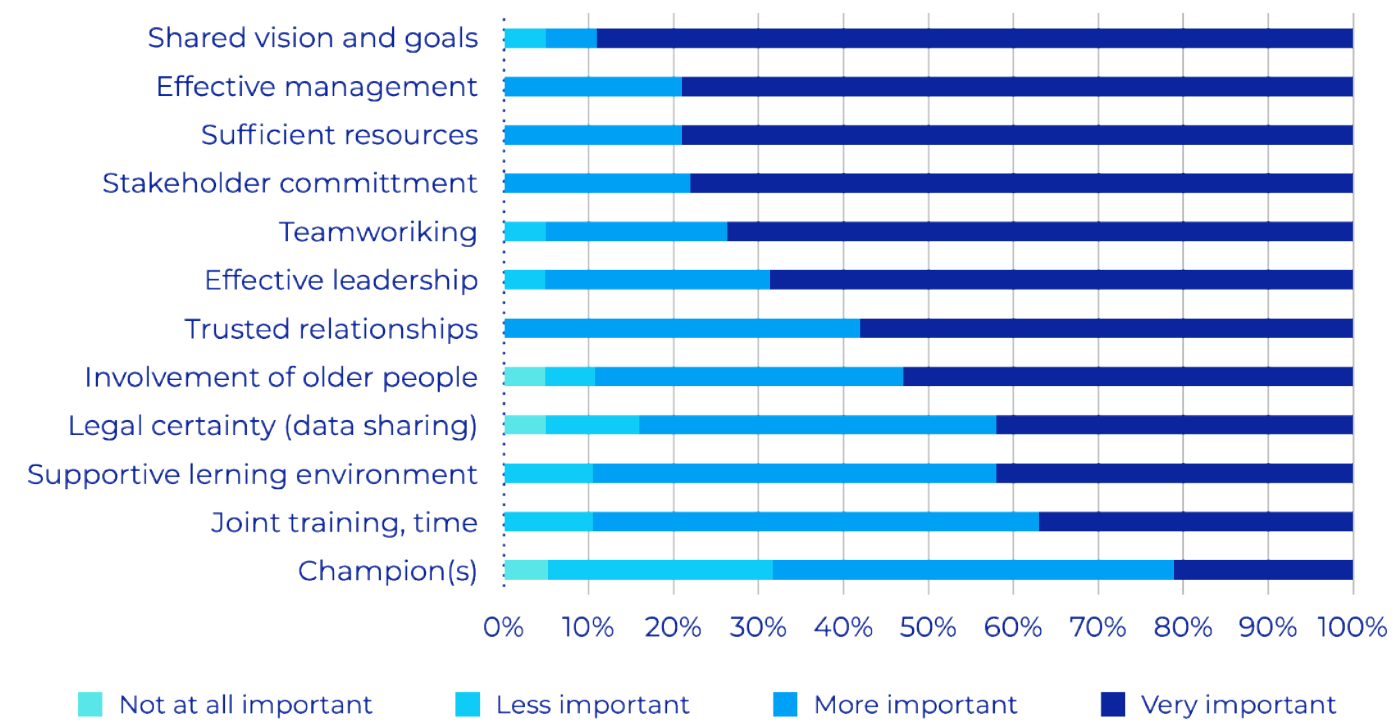


Figure 6: Facilitating factors for integrated care and support



Overwhelmingly, **shared vision and shared goals** are seen as the most important facilitating factor for integration.

This was described by Mário Rui André, Santa Casa da Misericórdia de Lisboa, Lisbon, Portugal: “*Shared vision is the basis of integrated governance*” and Jimena Pascual Fernández, Regional Ministry of Social Rights and Welfare, Oviedo, Spain: “*Starting from the consensus around the integrated care model: sharing values that guide care, the model to be implemented and how to design integrated care services*”.

Integrated working requires **effective management and leadership**, however the presence of ‘champions’ is less important according to the questionnaire participants, suggesting the implementation and maintenance of integrated care and support are reliant on formalised hierarchical structures.

Unsurprisingly **sufficient resources** are also a pre-requisite for integration as is effective **team-working** and the development of **trusted relationships**. Surprisingly, education and skills development were deemed to be less important for integration, specifically **joint training** and a **supportive learning environment**.

These findings were further discussed during the ESN 2021 Working Group meeting on Integrated care for older people in which the importance of relationships between professionals, engagement, governance models, legislation and policy, information sharing and effective management were emphasised by participants. In general, the factors identified in the questionnaire echo the findings of other studies such a Nolte (2018) and Looman et al (2021).

A number of actions can be taken to win ‘hearts and minds’, **develop a shared vision** of integrated care and learn about each others organisations, **roles and responsibilities**. For example, setting up **regular meetings** and **joint training**.

In Latvia, for example, “*[joint] meetings where common goals and values are discussed and established*” contribute to a smooth implementation and in Spain: “*Continuous training, identification and dissemination of practices*” are seen as key facilitators for integration (Jimena Pascual Fernández, Regional Ministry of Social Rights and Welfare Asturias Spain).

The importance of the development of personal and trusting relationships, which takes time and ongoing commitment is cited in other studies (MacInnes et al, 2020), and confirms the questionnaire’s findings.

Barriers

Literature describes a number of barriers to integrated care, of which many mirror facilitating factors. Such barriers include, lack of resources, lack of effective management and leadership, lack of stakeholder engagement, unclear roles and responsibilities of team members, poor care co-ordination and interoperable IT systems with which to share information.

Children, Families and Youth

While authors such as Johnson et al. (2003), Huxley et al. (2011) and Gardner (2003) identified a positive relationship between organisational climate and successful integration, it is worth noting that Glisson and Hemmelgarn (1997) found that improving the organisational climate of agencies – the behaviours, attitudes and feelings prevalent in an organisation – was more significant for children’s outcomes than improving organisational coordination.

A number of studies have also pointed to the crucial importance of the capacity of individuals to be able to support integration (Brown and White, 2006; Akehurst et al., 2017). **Staff shortages and high caseloads** have been found to threaten initiatives if professionals are forced to prioritise immediate concerns. Similarly, **scale and pace of change** have been found to undermine planned integration (Humphries and Curry, 2011).

Working group participants shared their concerns that the extent and frequency of reorganisations, as well as the frequency with which initiatives were introduced, had led to cynicism across the workforce. This, in turn, encouraged an attitude that if staff did not comply with changes the initiatives would eventually be abandoned.

They were also concerned that **staff confidence** would be undermined if there was a lack of clarity, particularly about the distinct roles and responsibilities of the respective agencies and individuals. This included establishing the means by which agencies and individuals communicate and the means to address the different risk thresholds, styles and cultures that exist. These concerns reflect research which has found that tensions and differences between professionals may be barriers, particularly where there is a lack of clarity around roles and responsibilities (Rushmer and Pallis, 2002; Craig et al., 2004; McEvoy et al. 2011).





One of the most frequently identified barriers to closer and sustained integration is the difficulty of **sharing information** between agencies about people using services. Atkinson et al. (2007) and Statham (2011) point to the need for clear procedures for sharing information in order to conduct comprehensive assessments of need. There have been attempts to legislate for better information sharing but they have not necessarily addressed the problem. So, for example, in England Lord Laming found that health, police and social services missed 12 opportunities to save Victoria Climbié, often because of a failure of agencies to share information they held (Laming, 2003). In response to this failure, Section 11 of the Children Act 2004 places a duty on a range of organisations, agencies and individuals to ensure that their functions, and any services they contract out to others, are discharged when it comes to the need to safeguard and promote the welfare of children. However, agencies still report that they are encountering difficulties, either because of a failure to have a **shared understanding** of key information that must be shared or of the existence of agency-specific IT systems that are not accessible to professionals in other agencies in the same locality.

Many of those at the Working Group meetings reported similar frustrations, which some said had recently intensified because of misinterpretations of the **General Data Protection Regulation** (GDPR). While this provides a framework to ensure that personal information about living individuals is shared appropriately it should not be a barrier to agencies sharing information where and when necessary, but in some circumstances misunderstanding of its requirements has aggravated an already difficult issue.



Adults and Older People with Chronic Conditions

In mental health, all respondents to the questionnaire stated that accessibility to integrated adult mental health services is an issue. Respondents from Finland, the UK and Malta presented as personal barriers poor public transport connections and commuting long distances, especially in rural areas. Respondents from Finland, Denmark, Malta, Latvia, Spain and the UK also highlighted the lack of an integrated and coordinated approach between sectors and agencies, problems of cooperation on organisational issues between government levels resulting in fragmentation of services and provision.

The most significant barrier for integration identified across the questionnaires was a **lack of resources**. However, it is unclear, whether this relates to resources required for service delivery or more specifically funding to support the process of integration.

Finally, the ESN 2021 Working Group discussion on Integrated Care for Older People identified additional barriers to integration including the **lack of shared values** between private and public sectors and the dominance of the health sector in leading integrated services for older people, which emphasised the disconnect between organisations with different cultural identities.



Evaluation of Integrated Working

The range and differing intensity of practice contained under the umbrella term **'integrated working'**, alongside an absence of robust evaluations, have limited the level of evidence that exists. Much of the research and evaluation of evidence focuses on facilitators and barriers to integrated working and there is very little on identifying the relative merits of different approaches (Duggan and Corrigan, 2009).

However, there is more evidence of outcomes for professionals and agencies than there is for its impact on people using services. Atkinson (2002) summarises the benefits of integration for agencies and professionals as:

- increased understanding of other agencies;
- improved relationships across agencies;
- raised profile with other agencies and professions;
- improved access to other services or expertise, potentially leading to earlier identification and intervention.

Others have pointed to improvements in enjoyment of work and wellbeing (Oliver et al., 2010), understanding of other professional roles (Atkinson et al. 2001, 2002; Sammons et al., 2003), opportunities for training and development (Stewart et al., 2003; Gilbert, 2016), and the potential for improved levels of information sharing and coordination (Brown et al., 2003; Oliver et al., 2010).

There is, however, no evidence that it leads to reduced workloads (Gilbert, 2016) and very limited evidence for cost effectiveness (Brown and White, 2006; Nolte and Pitchford, 2014; National Audit Office, 2017). Potential disadvantages have also been identified for both agencies and individuals, in terms of the danger of loss of professional identity.

Children, Families and Youth

Regarding children and their families, there has been very little exploration of actual benefits and improved outcomes. Where evidence does exist, it is in relation to earlier identification of need, improvements in pre-school provision (Sylva et al., 2004), and measurable benefits attached to school-based services in terms of academic attainment, attendance, and engagement (Dryfoos, 1996).

Although, as Brown and White (2006) point out, even this limited evidence has been contested by some authors like Smith (2004) and Gardner (2003) who concluded that there was insufficient evidence to support the argument that greater collaboration between services will necessarily produce better outcomes for all children and families. While the conventional wisdom is that integrated working is a good thing, as Stewart et al. (2003) argue, and the processes of integrated working might be helpful, it will continue to be hard to address the difficulties that are involved in achieving it unless there is sustained focus on demonstrating the outcomes that result.

There was general agreement at the Lisbon meeting that focused on children and families, that even without robust evidence, integrated working leads to improved outcomes and is the preferred option. It was widely recognised that professionals and agencies collaboration is essential if children and their families are to receive appropriate support to meet what are often multiple and complex needs that cannot be addressed by one service. Much of what was discussed reflected the factors that have emerged from research.

Only three pilot projects reported not conducting an evaluation of any sort. Four projects had commissioned external evaluation teams. In at least one case, it had been conducted some time previously and it was not clear how it had been used. The others had either recently been commissioned or were about to be. The majority of respondents conducting internal evaluations were doing so either by monitoring key indicators or by asking participants to provide feedback. While these would not conform to the definition of an evaluation discussed above, they may be what was required. Many of the projects were in their early stage of formation and in the literature there is some debate about the value of undertaking outcome evaluations before integrated working is fully embedded (University of East Anglia with National Children's Bureau, 2007).

The quality of information provided on outcomes in general and evaluation findings specifically were very variable. In many instances they were reported in terms of increased levels of engagement or participation in particular aspects of the services, but sometimes responses merely reported perceptions or stated what outcomes could be expected. The outcome measures carrying most credibility are those where it is possible to measure some measurable aspect of people's lives and in this respect the information was not specific enough in some cases.

The Medical-Pedagogic Centre in the Children's Hospital in Athens, Greece, provides training for parents on how to deal with difficult behaviours displayed by their children. The pre and post measures show significant improvement in family function, a decrease in parental anxiety, and improved academic performance of their children.

The Go Team in Mechelen, Belgium, uses an evaluation method that includes qualitative interviews with families and professionals, alongside quantitative analysis of each case. The situation of each family is measured against nine criteria (such as health of the family, housing quality, and income levels) at the point when support from the Go Team starts and ends. The results show that 45 per cent of the families had not been in contact with social services prior to their involvement with the Go Team. Subsequently the study indicated that 88 per cent of families experienced an improvement on at least one criterion, whilst 53 per cent improved on at least three criteria.



Adults and Older People with Chronic Conditions

Discussions on evaluation at the working group meeting on adults with mental health problems focused on lack of quality standards for the provision of integrated services for them. Public authorities, members of ESN, are exploring working closely with private and NGO providers so that they can self-assess themselves as well as making payments based on fulfilling a series of targets.

Norfolk County Council (UK) in collaboration with third sector organisations provides housing and integrated community support services for adults with mental health issues to promote their independence. There are five supported living schemes in Norfolk with approximately 100 places. The provider delivers support to these schemes plus a defined number of support hours to people who have tenancy/own property in the locality. Service is run as 1:1 sessions or group work supporting links to local communities, resources and networks. As for the evaluation, key performance indicators, including the number of hours in supported living and community support, are set as part of the contract and a monthly return submitted by the providers.

Social Welfare Department at Riga City Council (Latvia) provides integrated individual programmes for persons with mental health problems, whose needs cannot be met with the existing community-based social services. The evaluation consists of people's satisfaction with the individual programme as well as the provider self-assessment. The programme is provided to 16 adults and four families with children.

The Regional Psychiatric Hospital of South Denmark in cooperation with 22 municipalities (social services and jobcentres) and local NGOs, provides integrated services for vulnerable adults with mental health issues through individual action plans, a joint needs mapping and joined up professionals, like a case manager. Initial evaluation suggests that collaboration has been strengthened and the citizens using the services experience a more coherent delivery.

According to Nolte (2018), monitoring and evaluation are key processes in the implementation of complex health and social care interventions

for older adults. Two-thirds of questionnaire respondents on integrated care and support for older people reported to evaluate their services, yet one third reported not to evaluate them. This finding was further discussed in the breakout discussions of the 2021 ESN Working Group meeting on integrated care and support for older people.

Participants identified reasons such as the lack of the requirement to evaluate, difficulty in gaining agreement of the outcome indicators between different agencies, lack of time and resources, mutual suspicion between health and social care sectors and a fear of negative publicity. **Reasons for lack of evaluation are rarely cited in the literature so these are novel findings.**

A comprehensive evaluation of integrated care is being carried out by the **Avedis Donabedian Research Institute**, Barcelona for the Catalan regional government (See Practice Annex). This is being conducted in two phases in order to determine the degree of implementation of integrated home care within social and health care services in Catalonia and evaluate its impact on the workforce and people using these services.

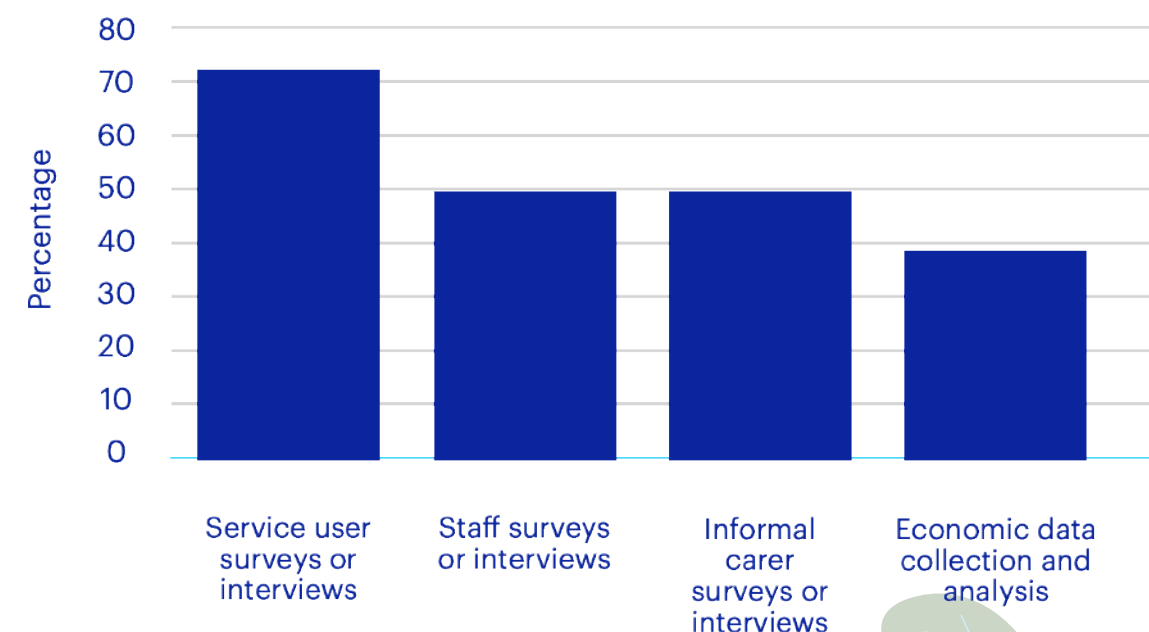
Common evaluation of integrated care takes an implementation science approach (Glasgow et al, 2012; Billings et al, 2020) in which outcomes for service users and carers, impact on staff, economic impact and implementation processes are examined. We asked ESN members what outcomes, impact and processes they evaluate.

As already highlighted above, the most common outcomes measured were in relation to **people using services**, including satisfaction with care and quality of life. The impact on **staff**, such as time and job satisfaction were far less likely to be measured. Yet the impact on staff and implementation processes are important measurements which help determine the extent to which services are sustainable in the medium to long-term and transferability to other areas/regions. Likewise, the **economic impact** regarding cost savings were far less likely to be measured even though demonstrating cost-efficiency is important for policy-makers and service providers. **Implementation processes** such as care co-ordination are also less frequently measured.

In order to measure the above outcomes, impact and processes, mixed evaluation methods are called for, such as service user, carer and staff interviews and questionnaires, as well as the collection and analysis of quantitative audit and cost data (Billings et al, 2020). ESN members were asked what evaluation data they collect and analyse.



Figure 7: How outcomes of integrated care and support are measured



Consistent with a focus on outcomes for people using services, service user questionnaires or interviews are the most commonly used data collection methods, although carer questionnaires were also carried out. Staff questionnaires or interviews are collected by 50% of ESN members who responded to our questionnaires. As highlighted above, economic data is least frequently collected. This is consistent with the aim of integrated care to improve the quality of care for older people rather than on reducing costs (Bardsley et al, 2013).

Sadler et al (2019) advocate the assessment of implementation strategies or processes in addition to outcomes to evaluate the effectiveness of integrated care programmes for older people. **Interestingly, the breakout discussion on evaluation at the 2021 ESN Working Group meeting on integrated care and support for older people identified that the Covid-19 pandemic triggered a joint evaluation of the processes involved in long-term care.**

“Care is never an end in itself, it’s always just a stage of a child’s journey into adulthood: the true outcome measure for care must be the quality of adult life the young person achieves”

Association of the Directors of Children's Services, 2013, p.1

Key Findings and Messages



The questionnaire data and the descriptions of the practices, supported by the discussion at the Working Group meetings, not only provide examples and contacts which members of the European Social Network and others may choose to follow up, but they confirm many of the findings of previous studies.

It is now accepted that support for people experiencing multiple and complex difficulties, requires coordinated support from a range of services rather than fragmented responses. All too frequently there has been a lack of coordination and a tendency to focus on one issue while failing to take into account the wider problems faced by people and by families.

Drivers and aims

- The desire to improve collaborative working between agencies for the benefit of people using services was **the main driver for and aim of integration**.
- Although commonly cited as a driver for integration, the need to address financial challenges or integrate at a system or wider population level was less evident.

Processes and methods

- The **method of cooperation** and sectors involved varies when it comes to integrated working. The responses and practices show that regarding children, families and youth, social services most often cooperate with health, education, and the police when supporting children.
- As for older adults, most integration occurs horizontally between community health and social care organisations, with some involvement of voluntary, charitable or auxiliary services.

Professionals and agencies involved

- Strategic and operational planning was the most common, with examples from county, regional, and national level of different services coordinating their operations through working groups or **multi-disciplinary teams**, where the skills of different professionals can be drawn on to create one joint (care) plan.
- Teams are usually not **co-located**, although where this does occur, integration may be accelerated, especially in terms of shared vision and stakeholder commitment. Nonetheless, rarely are organisations fully integrated into one provider organisation, rather integrated care and support was at the level of co-ordination and integration of processes.
- Co-ordination and integration of processes was also reflected in **management structures** where shared or joint management was most common.
- The responses and discussions show the importance of **gaining the commitment of staff** while establishing clear descriptions and **distinctions between roles and responsibilities**. The practices that were described indicate the importance of both the commitment of senior leadership and an integrated approach to professional support, as well as enhanced communication between agencies and professionals working together.
- **New roles**, especially **care co-ordinators** are important facilitators of integrated care and support. These individuals are frequently 'boundary spanners' in which practitioners from different organisations span the intellectual and practical boundaries that separate them.

Involvement of people, carers and families

- While the responses indicated a **commitment to the involvement of people using services, whether children, youth, families or older adults**, in many instances there was little information about how this was done, and more work was needed to translate it into practice. Findings suggest that involvement is still mostly implemented at an individual level rather than at a more strategic level such as service design or commissioning.
- Carer needs are commonly assessed, and support is available to carers, primarily through advice, emotional support and day care facilities for service users. However, there is sometimes a lack of capacity for respite services which may put carers at risk.

Financing

- Integrated care may be financed from a wide variety of sources and through a variety of mechanisms. But rarely, are budgets combined between different sectors and organisations.
- Financing integrated care is challenging for a number of reasons including inequitable allocation to different sectors and care settings, inflexible government funding arrangements and for services for specific populations, an over-reliance on fixed term contracts. As a result, funding is not tailored to the needs of people in need of care and support.



Facilitators and barriers of integrated working

- Facilitating factors for integrated care were often identified on a personal level such as a shared vision and goals, engagement of stakeholders and the development of trusting relationships. Effective leadership and management were important for integration.
- Staff investment in the time to understand each other's roles and responsibilities and agree actions through regular meetings and shared training was also considered a facilitator.
- However, barriers to integration reflect the facilitating factors and additionally include lack of interoperability of IT systems. Poor co-ordination *within* agencies is as significant as poor co-ordination *between* agencies.

Evaluation of integrated care

- As far as evaluation is concerned very few external evaluations have been commissioned. Although the information provided on practices indicated evaluations were in progress, there was only limited information on outcomes. This is not surprising. It was apparent from reviewing the literature on integrating services, that the majority of evaluations focus on the process of integrated working rather than evaluating subsequent operation or examining outcomes.
- Service evaluation is carried out through service user questionnaires or interviews as the most commonly used data collection methods. But most integrated care services do not evaluate their effectiveness.

Recommend-Actions

For practitioners

- Professionals should be equipped with the relevant knowledge and skills to implement integrated services and given time to develop trusting relationships and a shared vision.
- Management and leadership arrangements need to be established to facilitate inter-agency working.
- Organisations need to develop robust processes for integration, such as mechanisms for shared assessments and referral processes. Attention needs to be paid to internal processes as well as with external agencies.
- Investment needs to be made in shared IT systems to facilitate information sharing and enhance communication.
- Carers should be informed about the support available to them, to make them part of integrated service delivery.

For policy-makers, regulators and professional bodies

- Guidelines and policies for integrated working should be developed at regional and/or national level. However, as well as this 'top-down' approach, space needs to be created to allow locally developed initiatives to flourish in a 'bottom-up' approach.
- The emergence of new professional roles which support integration, such as care co-ordinators, requires flexibility on the part of professional bodies, governments and regulators.
- People using services, carers and families should be more involved at strategic levels such as in the co-design and planning of services. Policy-makers should consider making this involvement mandatory.
- Funding frameworks need to be created that allow shared financing of integrated services through pooled budgets. Short-term, fixed contracts do not incentivise integration, limit sustainability and should be avoided where possible.

For researchers/evaluators

- The process of integration should be examined to enhance our understanding of 'what works, for whom, in what contexts and with what outcomes'. This will help identify key or 'active' ingredients for success which will aid sustainability and transferability.
- Evaluation of integrated services should become routine practice. This should be focused on outcomes defined with stakeholders involved including people using services, their carers and families. Indicators and outcomes should be defined to include better quality of life for people using services, as well as positive impacts on staff and cost-efficiency.



Best Practice



1

Go Team, Municipality of Mechelen, Belgium

About the practice:

The Go Team provides support for families and operates in the social services of Mechelen. It was set-up following findings by the local police in 2013 that the care system was not adequately identifying and supporting some families living in extreme poverty. The Go Team includes a number of social workers who work very closely with the families, often undertaking weekly visits. They have lower caseloads so that they can provide this more intense support and base the support on motivating the families so they can empower themselves.

The team focusses on families in more severe situations facing problems such as: lack of adequate housing, unemployment, low school attendance, substance abuse, hygiene problems, and debt. The social workers operate in an integrated way with the families – addressing the multiple issues they may face. This includes helping them to access services such as benefits, healthcare, and providing support if they must attend court cases. The Go Team has connections to other services. People are referred to the team by the youth and family department of the police, student counselling centres, schools, and other public administrations. The team focuses on working with very young children and also pregnant women, because of the recognition of the importance of the very early years for the child's development.

Aims:

To provide early-intervention, addressing issues faced by families in an integrated way to improve the wellbeing and development of children.

Involvement of users:

Service users are involved through interviews and other feedback mechanisms as part of the evaluation study.

Costs and resources:

This team costs approximately € 380,000 annually and receives funding from the King Boudewijn Foundation. It is believed that the preventative work of the team saves costs in the long-term by preventing children being taken into care.

Evaluation:

The project is evaluated in a scientific way, led by Thomas More University. The process involves qualitative interviews with families and professionals plus quantitative analysis of each case. Results were measured by comparing the initial situation of each family against the point at which support from the GO team came to an end, and focused on nine criteria:

- housing
- safety
- health of parents
- employment
- income
- debt
- social capital
- cultural capital

- living situation of the children in terms of school, free time and health

Each criterion was scored on a scale from 0-10. An initial analysis on the return on financial investment is also being carried out. Mechelen received an award for the GO team practice from the King Boudewijn Foundation for being very innovative and effective in combatting child poverty.

Impact:

- About 50-60 families are reached each year.
- Improvement in the wellbeing and conditions for families and children, leading to better outcomes and preventing situations where children are taken into care.
- 45% of the families were new to social services, indicating that the project has improved outreach and connections with other services.
- 87.7% of the families experienced improvement in at least one criteria, whilst 53% improved in at least three criteria.

Sustainability and transferability:

The project is established and will continue running in the city given its success. The cities of Sint-Truiden, Genk and Brussels are looking to transfer the example of the GO team in Mechelen. The practice has also been transferred for other groups of people in Mechelen, including people with mental health problems in poverty, homeless people and people who are threatened by eviction.



Community Integration Team, Santa Casa da Misericórdia de Lisboa, Portugal

About the practice:

Created in January 2018, the Community Integration Team supports 60 young people between the ages of 16 and 25 who were referred by the Family and Children Court or the Committee for the Protection of Children and Young People.

Together with the young person, an Individual Intervention Plan is established and structured according to the level of autonomy of the young person (functional, cognitive and emotional). Individual Plans include all social aspects such as education, vocational training and employment, health, financial and domestic management, personal and social dimensions. Plans also include objectives, actions, activities, resources, deadlines and evaluation of deadlines. The process is overseen through continuous and systematic evaluations by Santa Casa da Misericórdia de Lisboa.

The tasks of the Community Integration Team are to:

1. elaborate and update the assessment of the situation of the young person;
2. implement the court's decisions and support young people to lead an independent life;
3. elaborate and execute the Individual Intervention Plan;
4. appoint a case coordinator to accompany each young person;
5. inform and prepare the young person for implementing the individual plan;

6. provide economic, psycho-pedagogical and social support to young people;
7. promote access to integrated education and training projects and oversee them;
8. monitor and evaluate each implementation phase of life-support measures;
9. inform the Committee for the Protection of Children and Young People and the court about the implementation of the plan.

Aims:

1. Promote the rights and protection of young people at risk in their environments by providing adequate conditions for their wellbeing and development;
2. Support the transition to adulthood for young people, providing them with skills to lead an independent life in educational, professional and social contexts;
3. Promote the strengthening of an informal support network to empower and assist young people;
4. Make it easy for young people to access the network of community services during the different phases of their empowerment process;
5. Support and encourage young people in developing their life project by providing information and advice, as well as helping them with decision making in complex situations;

6. Provide young people with psycho-social, emotional, relational, and economic support (where appropriate);
7. Strengthen resilience and self-esteem of young people in different contexts;
8. Support the implementation of life plans based on the individual life experience and context of the young person;
9. Promote the participation of young people in training, cultural, sports and leisure activities, fostering the establishment of positive relations with neighbours, schools, work context and the community in general.

Involvement of users:

The care leaver's individual intervention project is carried out by the young persons themselves with the help of the case manager.

Costs and resources:

Currently, costs are covered by Santa Casa da Misericórdia de Lisboa. The cost of the project includes a monthly fee per each young person involved in the project (maximum of €435.75 per month) plus staff salaries.

Evaluation:

Multi-method. There is a database and a monthly monitoring of progress.

Impact:

Support the social inclusion and wellbeing of young people across the different dimensions of their life to support their transition to adulthood.

Sustainability and transferability:

The project is financially sustainable. Impact indicators are being created.



3

Family centre model, Regional Council of Häme, Finland

About the practice:

A national reform, called “LAPE”, was launched in 2016-2018 to address fragmented services for children, families, and young people in Finland.

The objective was to transform services into an integrated system that responds better to the needs of children and families and includes the development of local family centres. Basic services were strengthened, and the focus shifted towards preventive work and early support. Within the region of Häme, implementation of the project is being done by bringing service professionals together. The services being integrated include social services, health services, education services and NGO providers such as churches.

New models of cross-sectoral cooperation are being implemented through common working practices, multidisciplinary service counselling and common discussion forums for management across sectors and municipalities. In some municipalities, social and health services are also co-located under one roof, but this is not a necessary requirement for implementing the family centre model. Most importantly, the family centre model creates networks for child and family services so that professionals respond together to the needs of each family, rather than making families seek out each service separately.

Practical aspects of the project in Häme include:

1. Training social, health and education professionals in a common working practice (Let's Talk About Children Evaluation – LTCE);
2. Creating forums for discussing the manage-

ment and development of services across sectors and across municipality borders;

3. Development of a new, regional service and counselling model which enhances multi-disciplinary approaches and assigns beneficiaries a case manager to oversee cross-sectoral cooperation in complex cases;
4. Developing, educating and implementing digital tools to manage cross-sectoral cooperation (eg. Kompassi –tool for assessing the beneficiary's situation);
5. Transforming working culture through joint planning and working. This involves moving away from a narrow, sector-based approach towards a comprehensive picture of each child's life situation, needs, and the resources they need.

In the future, family centres are intended to be coordinated regionally, through collaborative management practice between services provided at local and regional levels: education, health, and social services.

Aims:

Bring together different sectors to improve access of children and families to the range of services that may be required to address their multiple needs. Encourage a shift of resources towards preventative services.

Involvement of users:

The service has been co-developed and evaluated by service users.

Costs and resources:

The project receives national, regional and local funding.

Evaluation:

There was an external evaluation of the national project. There has been continuous local evaluation since 2018.

Impact:

- Lower thresholds for families to access preventative services and those that address multiple needs. Greater opportunities to identify and engage with families who may require support;
- Improved skills for addressing multiple needs, improved networks to draw on expertise in complex cases;
- Improved knowledge of the situation of children and family services, improved cost effectiveness, reduce costs for more expensive services (eg. child protection).

Sustainability and transferability:

Family centres are part of a permanent future service system. Sustaining the model is somewhat dependent on national decisions regarding the regional social and health care reform. In Häme there is wide consensus on the importance and effectiveness of the family centre model. The practice has been developed regionally in somewhat differing contexts in all 18 regions in Finland. National guidance has steered regional development, but essentially each region has been in charge in its own area.



Early Recovery Intervention (P.U.E.R.I.), National Council of Social Workers, Italy

About the practice:

The P.U.E.R.I project 'Pilot Action for unaccompanied children: Early Recovery Intervention' is a personalised reception system for unaccompanied children (UC). The project is managed by the National Council of Social Workers (CNOAS) and the Italian Home Office at reception facilities in two regions. The project is based on promoting the best interest of the child and improves the reception system for UC by providing a protective framework to prevent these children disappear. From arrival, UC are transferred to a first reception centre where three assessment interviews are held to support these children.

A multi-disciplinary team of social workers, psychologists and cultural mediators conduct the assessment. The results of the interviews help to set up a personalised reception pathway to guide their care plan and social integration. An IT system is also in place for the collection of personal data, and to monitor useful information. This information is shared with the network of services working with UC.

Aim:

The aim is to provide personalised support to improve the social integration and wellbeing of unaccompanied children.

Costs and resources:

€ 1,650,000 for staff, organisation, equipment. The project is co-financed by the Home Office and the Asylum, Migration and Integration Fund (AMIF).

Evaluation:

The activity of the professionals involved is monitored with the support of the University of Catania who supported the design and evaluation of the practice. Through an IT system, the data of children are collected to track the support provided to them and the needs they have. At the same time, risk and protective factors are identified to shape the paths that best respond to their protection.

Impact:

The project has helped to limit the loss of children from reception centres, through professional evaluations and supported transfers to reception facilities. When this practice was documented, 1,814 children had been supported and 5,603 interviews had been carried out.

Sustainability and transferability:

The project depends on funding from the Home Office which makes annual decisions on funding. The practice model is recognised for its effectiveness and has become the guideline for hotspot managers working with vulnerable adults and children in Italy. The European Commission considers this project best practice, with a member of the project now included in a European Commission working group on reception for Unaccompanied Minors. The practice could be replicated, in particular in European contexts with high numbers of unaccompanied children, in places where there is the opportunity to establish professional reception service.



United in psychiatry, Municipality of Esbjerg, Denmark

About the practice:

This project objective is to make a difference for citizens in the most vulnerable situations with a diagnosis of psychiatric problems and drug abuse. A case manager brings together professionals in different sectors (e.g. health care, social services and the job centres) to develop an action plan with the beneficiary. They do a joint mapping of challenges and opportunities and agree on the actions as well as follow-up on how the person progresses.

The plan solves first the most important challenges, secures a contact point, and a quicker and more cohesive set of measures, and it also gives everybody involved a common understanding and ownership for the plan and its follow up. Articulating the coordination between the support services available among professionals in collaboration with the person, the expected result is a more stable life for the individual and fewer hospitalisations.

Aims:

Improving the life situation of vulnerable citizens by improving cooperation and putting down barriers between psychiatric hospitals and municipalities.

Involvement of users:

Beneficiaries take part in the meetings as much as possible. The evaluation involves the beneficiaries answering a questionnaire and qualitative interviews.

Costs and resources:

The region (responsible for psychiatric hospitals) and the 22 participating municipalities are financing the project by pooling budgets for a project leader, appr. € 100,900 per year.

Evaluation:

An evaluation has been developed. However, because of Covid-19 it has not yet been completed. The concept consists of a survey and interviews of beneficiaries and professionals. 10 out of 22 municipalities have concluded the initial project and the evaluation started in June 2021.

Impact:

It is expected that the evaluation will lead to an increase in self-esteem and wellbeing of beneficiaries, who are motivated by the willingness of the professionals to help them. From an organisational point of view, an initial assessment suggests that collaboration between professionals from the various sectors has improved.

Sustainability and transferability:

The project has been made permanent in all municipalities that completed the initial stage or 10 out of 22. Implementation in another 12 municipalities is ongoing. Next step is to improve awareness of the project and formalise partnerships.



This is Ten Hundred, Norrtäljemodel, Stockholm, Sweden

About the practice:

'This is Ten Hundred' is a unique model for integrated care in Sweden. Health and social care are merged into one company – Tiohundra AB. It is a collaboration between the Stockholm Region and Norrtälje Municipality. Tiohundra AB is wholly owned by the municipal association of health and social care in Norrtälje. Norrtälje municipality and the Stockholm Region.

Tiohundra is developing a more person-centred approach to health and social care that is based on the older person's needs. The individual is placed at the centre of care, surrounded by a number of different actors who are working together. For example, technologies are being used to streamline care; hospital and primary care have been integrated; medication reviews have reduced the number of medications prescribed for older people. The organisation runs the emergency hospital in Norrtälje, health centres, psychiatry, nursing homes, and home care. The team consists of nurses, doctors, paramedics, psychiatrists, case officers and home help co-ordinators.

Aims:

The aim is to achieve cohesive care of good quality, which is accessible for the individual, and to provide conditions for innovative collaborations that improve coordination and efficiency gains.

Involvement of users:

The next step is to involve older people by finding out what is important to them. The aim is to create a dialogue with older people to see what works well and what needs to improve. The municipality consults with user organizations of patients, older people and persons with disabilities regarding planning of services. Every year, beneficiaries of home care and residential care are consulted to provide their views regarding the care and support they receive.

Costs and resources:

Initially funded by the Swedish Innovation Authority Vinnova, currently, there is joint funding and joint governance between the Stockholm Region and Norrtälje municipality. Cost-efficiencies have been made by streamlining working methods and reducing administrative costs. Costs compared to other municipalities are lower while good quality care outcomes are achieved.

Evaluation:

Service user surveys indicate high levels of satisfaction. There is a good quality to price ratio compared to other municipalities, too. There is an atmosphere of collaboration and teamworking with staff believing in the model and a feeling of making a difference.

Impact:

The Norrtälje model is recognised in Sweden and internationally, as a role model for other municipalities, county councils and regions, and is highlighted by the Ministry of Social Affairs. The innovative and effective way of working increases quality and creates added value for beneficiaries, relatives and employees.

Sustainability and transferability:

The model became a permanent service in 2016. The Norrtälje 2.0 model is a further development of the Ten Hundred project, aiming to find new and effective solutions for older people with a higher degree of dependency. Under the common concept of the Norrtälje model, there is continuing work to develop new and cross-sector forms of collaboration.



7

Evaluation of integrated care at home in Catalonia, Avedis Donabedian Research Institute, Barcelona

About the practice:

This is a baseline evaluation of the degree of implementation of integrated home care in Catalonia. A mapping exercise of services revealed two separated systems: The first, focused on healthcare and consists of home primary health care, day hospital, mental health, home palliative care, home hospitalisation, primary care and emergency services. The second, focused on social care consists of aid products, home care services, primary social care, telecare day centres, assessment teams, home care rehabilitation.

Aims:

The evaluation is conducted in 2 phases with the following objectives:

- 1: To identify and analyse the degree of development and use of the integrated care model.
- 2: To analyse the impact of integrated social and health care at home.

Involvement of users:

In phase 1, social services selected for their high self-reported assessment of home care will be interviewed in depth to explore how they are implementing good practices in the field of home care, particularly in aspects related to integrated care.

Evaluation:

Quality indicators were categorised into 5 dimensions: care and support for the person; relational aspects, including the promotion of rights and ethical aspects of care; support for family, carers, and the community environment; integrated social and health home care; management and the improvement of quality.

Phase 1: Two questionnaires are used to collect information to identify the degree of integration of social and health care in the home environment. The main barriers and facilitators will be explored in terms of the planning process; individual, group and organisational factors; process of change in the provision of services; the evaluation process and information management tools.

Phase 2: an intervention with a group of people in places where integrated care is deemed to be good according to the survey, compared to a control group. The aim is to evaluate the impact of care in terms of demand, efficiency and capacity. Indicators relate to: potentially avoidable hospital admissions, residential intake, A&E, use of social and health care services, intensity of care at home and associated costs; medication use, and mortality.

Impact:

This is an ongoing project so the impact cannot yet be assessed.

Sustainability and transferability:

This is an ongoing project so the sustainability and transferability cannot yet be assessed.



8

Cared living Extended Home Care, Riga, Latvia

About the practice:

Home care is being expanded to provide a level of intermediate care between usual home care services and long-term care services provided in residential settings. The Cared Living service is not restricted in terms of the number or hours of visits, unlike usual care. A needs assessment is carried out of both the older person and their environment. A range of welfare technologies are available such as automated lights, smart monitoring and fall prevention systems. The older person is free to choose what services they use. This helps to maintain the older person's independence at home and makes optimal use of staff.

This integrated service involves three social service providers. Riga's welfare department co-ordinated the organisations to pilot the service. This collaboration is unique in Latvia as the organisations were ready to experiment and develop this new service. The service is an example of integrated care in which a care plan is tailored to the individual and their home environment. It involves visits by care workers combined with provision of transport to the day care centre and the provision of technical aids and welfare technologies. In Latvia, these are usually separate services, provided by different service providers and on different terms, hence the innovative nature of this integrated endeavour.

Aims:

To provide solutions for older people living at home who do not want to live in long-term care facilities and for those on the waiting list of a long-term care facility.

Costs and resources:

Older persons pay 85% of their residential long-term care needs, the remaining part is paid by the municipality. The costs of Cared Living are wholly met by the Municipality; thus, this extended services costs less for the individual and enables older people to live in their homes for longer.

Involvement of users:

Beneficiaries remain in their homes, which is widely believed to be their preferred choice.

Impact:

Older people are provided with different services in their own homes. Family members are satisfied that their loved ones are safe. Staff have more control of their work schedules and can determine the time and duration of visits based on the individual's needs. For the services provider, it is easier to administer finances according to the client's needs.

Sustainability and transferability:

Riga City Council has agreed to expand the services by offering more places. The number of places increased from 15 to 45 in 2020 with a further 6 places in 2021.



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