Government of **Western Australia**
Child and Adolescent Health Service

Service Integration Literature Review

Child and Adolescent Health Service

Strategy and Planning

December 2020

Healthy kids, healthy communities

Compassion | Excellence | Collaboration | Accountability | Equity | Respect

Neonatology | Community Health | Mental Health | Perth Children's Hospital

Executive Summary

This report is the first phase of developing an integrated care model for the Child and Adolescent Health Service (CAHS) Midland Community Hub (MCH). Funded through the Sustainable Health Review (SHR), the MCH aims to provide integrated care for children and families by co-locating CAHS Community Health services, Community Child and Adolescent Mental Health Services (CAMHS), and Perth Children's Hospital (PCH) outpatients as well as partnering with key service providers within the Midland community. The overall aim of this review was to summarise evidence-based literature to provide frameworks and recommendations regarding service integration, integrated care models, community hubs, and place-based service delivery.

This review focused on peer review articles, government and research institute publications published between 1999 and 2020 that investigated integrated health services, community hubs and place-based service delivery. A total of 34 articles were included and identified the following recommendations:

- CAHS needs to define an integrated care system specific to the services it provides
    - Seamless, flexible, close to home, meets individuals' needs
- The level, extent, type and breadth of integration at the Midland Hub needs to be defined
- The eight principles of integrated care (1) can provide a framework to conceptualise CAHS' integrated service model
- Key perspectives (2) are integral to planning an integrated care model: manager, policy-maker, care professional, service user, community, evaluator and regulator
- Community hubs enable accessible, flexible and responsive high-quality services and can benefit from co-design with community agencies and families towards a family-centred approach
- Place-based service delivery emphasises the importance of community engagement and understanding of social determinants to guide care to consumer and community needs

This review is intended to provide the background knowledge to guide stakeholder consultations, principle project selection, and service delivery model development for implementing integrated care at the MCH. It is strongly recommended that engagement with children, families and workforce in the design, implementation and evaluation of services is conducted by CAHS to ensure the integrated care approaches are suitable to the community and sustainable. This may include supporting access to other government and non-government services across health, education, welfare, and social sectors.

Contents

Tables and Figures

Defining Integration & Integrated Care

There has been increased pressure for governments to develop integrated health systems as a solution for improving patient experience and health outcomes (3). The child health sector is dedicated to innovative initiatives for integrated care approaches (4) but the first step is defining integration and integrated care. Across the literature the term 'integration' has over 175 definitions, with meaning and scope varying by discipline and profession (2, 3, 5, 6). This review's working definitions are:

Integration refers to a set of practices (e.g. processes, methods, tools) used to address fragmentation and provide integrated care (2, 5, 7-10). Integration is not an outcome, but rather an adjustable approach to improve service coordination. Integration can change system level funding, management and organisational structure, administrative functions, and/or service delivery aspects of organisations. Integration requires a patient-focused approach (11).

Integrated care is the culmination of processes to provide comprehensive, coordinated, and continuous service delivery, as experienced by the service user (2, 3, 12). It has the aim to improve consumer experience, care outcomes, and cost efficiency through improved coordination between two or more agencies within or across sectors (11-13). Integrated care is sometimes synonymous with coordinated care which is identified as easy access to seamless care across settings, tailored to consumers' needs (14).

Service Coordination is a process of integration to assist clients to access services and locate resources to address unmet needs resulting in coordinated and comprehensive care (14).

A fundamental principle of integration is that there is no single model of integration that suits all settings and circumstances (2), so contextual understanding of population, service needs, governance, workforce and resources must be established before planning and implementation (10).

Benefits of integrated care

Anticipated benefits of integration include improved coordination of services, accessibility for consumers, clinical outcomes, health literacy, self-care, quality of care, consumer experience, staff satisfaction, as well as service and cost efficiency (7, 15). Evaluating integration can be challenging due to multi-component strategies, criteria not being specific or measurable, lack

of comparative models to measure impact, and difficulty in standardising measuring tools due to complexity of healthcare (3, 16).

A meta-analysis of 167 studies found integration led to perceived improved quality of care by patients and staff, increased patient satisfaction, improved access to care, and some reduced waiting times (16). The study noted that results found in one country may not translate to another due to environmental contexts. The authors commented that it was unclear which individual elements of integrated care were causally associated with positive outcomes, and the meta-analysis didn't review organisational changes, which is a key factor of integrated care within theoretical models. The most common elements of integrated initiatives across the analysed studies were integrated pathways/plans, multidisciplinary teams, and case coordinators & managers.

A recent systematic review (10) stated integrated care models don't necessarily result in the anticipated outcomes, but suggested this is due to misalignment of integrated care aspirations and the reality of practicality implementing such models. The report stated evidence of reduced health service use, improved quality of care, but little evidence on cost effectiveness. This paper also critiqued meta-analyses as difficult due to diversity and context of interventions and measures, as well as distinguishing causative from cumulative changes. The review suggested integration should be a strategy rather than an intervention to be evaluated.

Individual reviews have found benefits but should be considered in the scope of their intervention, the demographic targeted and the way integration was enabled. A Boston USA study found improved patient and family experiences, increased partnerships between professionals, ease of accessing services and obtaining referrals, reduced family expenses, impact on parental employment, school absences, and Emergency Department (ED) visits (4). A German town's integrated care networks of physicians measured improved health outcomes, more appropriate access, increase in perceived quality, and potential cost effectiveness (17). The Nuka system in USA increased patient satisfaction and reduced hospitalisation but questioned the transfer of healthcare ownership to consumers as burdensome because of health literacy requirements. An aged care company in the Netherlands reported lower costs without loss of quality of care or patient satisfaction through shifting care model from managerial and admin to clinical autonomy and accountability (17). Canterbury, New Zealand reported reduced diagnostic waiting times and spending, fewer admissions and re-admissions, and shorter length of stays, and increased capacity for elective surgeries (4). This study noted that workforce shortages and financial challenges were not solved by this program. New South Wales HealthOne program for chronic and complex patients (18) reported fewer ED presentations, shorter stays, improved communication and

planning between departments and agencies as well as improved service coordination for clients due to introduction of GP Liaison Nurses as case managers.

Taxonomies of Integration

Degree

Leutz (15) and Kodner & Kyriacou (19) first described three levels of integration intensity: linkage, coordination and full integration. Prichard *et al* (20) modified terms for linkage and coordination (co-location and collaboration respectively) and included a fourth level (individual; identifying a lack of integration). Levels of integration are summarised in Table 1.

Table 1. Levels of integration

Integration Level	Characteristics
Individual	• Agencies provide individual services • Little to no communication • No shared vision, values, or funding
Linkage/ Co-location	• Agencies promote continuity of care through facilitating communication and referrals between services • Personnel aware of roles and responsibilities of other agencies, refer clients where appropriate • Agencies are engaged with the community and respond independently to needs • Services might co-locate with joint planning but maintain own vision, funding, and governance
Coordination/ Collaboration	• Agencies identify fragmentation and discontinuity and formalise process and structures to address this • Agencies operate within current systems but share information, support transition, and define structures and responsibility to coordinate care across services • Open communication between agencies and engaged with community, to respond collectively • Shared vision, culture, and funding
Full integration	• Agencies pool resources across systems, develop a new organisation with comprehensive services attuned to specific populations or groups • Common resources (i.e. medical records) rather than sharing information across systems • Partnership approach to achieve shared outcomes in response to the community, possibly through multi- or interdisciplinary teams

Adapted from (2, 15, 19, 20).

Extent

Horizontal integration occurs between collaborating or competing networks or agencies that operate at the same stage of delivering services (3). This can be between health services, social services, and other service providers that support a specific client group (3, 9, 21).

Vertical integration focuses on coordinating agencies at different stages in the process of delivering services (3). This can be a single organisation controlling a whole care pathway between community health and acute services (3), or primary and tertiary care (2, 9, 10, 15, 22). This type of integration aims to manifest best practice care pathways for specific diagnoses, and/or transition from hospitals to community-based care (9).

Sectoral integration is the combination of horizontal and vertical integration through multidisciplinary teams and networks of primary, community, and secondary care providers (9).

Horizontal and vertical integration use different techniques and change and leadership theories (7) and can occur as real (merging physical assets or infrastructure) or virtual (formation of alliances, networks, contractual arrangements) (3). Shaw *et al.* (2) identified integration between primary, second and tertiary health as 'internal integration', and that health and social work as 'external integration'.

Types of Integration

The literature identifies six broad types of integration: systemic, normative, organisational, administrative/functional, clinical, and service. Each type has defining characteristics, summarised in Table 2. There are some differences amongst definitions. Valentijn *et al* (7) referred to normative and administrative integration as underlying mechanisms rather than their own types, and WHO (3) identified systemic and normative integration as "mechanisms by which integration is characterised". Other literature isolated elements within the six types: 'professional' integration (7, 9) is within service integration, 'cultural' is part of normative (9), 'technological' is captured in administrative or clinical (8, 9), and 'financial' is part of administrative or systemic (8, 19). Two papers reported 'patient-centred' integration (9, 21) but this should be considered a principle of integrated care as all aspects of integration require it. Shaw *et al* (2) surmised that clinical and service integration results in linkage and coordination levels of integration, whereas full integration occurs through organisational and systemic levels.

Table 2. Types of integration

Types of Integration	Characteristics
Systemic	• Coordinated and aligned policies, rules, regulatory frameworks at various organisational levels • Also known as an 'integrated delivery system'
Normative	• Shared values, culture, and vision across organisations, professional groups and individuals • Develop common goals, identify and address communication gaps, build relationships and trust, and enable collaboration
Organisational	• Coordinated formal or informal structures, contractual or cooperative arrangements, governance systems, and relationships across organisations (e.g. pooled budgets, umbrella organisational structures) • Occurs through mergers/collectives, virtual networks, or contracts brokered by purchaser
Administrative/ Functional	• Aligned non-clinical support and back-office functions • Examples include financial systems/budgets, shared accountability mechanisms, HR, strategic planning, management, quality improvement, and information technology (IT) systems including shared or compatible electronic medical records • Required to be flexible, linking finance, management and information systems around service delivery • Requires shared policies and practices but does not necessarily mean standardisation.
Clinical	• Integrated care provided through coordinated information and services as a single or coherent process for consumers, within and/or across professions. • Requires developing extended clinical roles, guidelines, protocols, and inter-professional education.
Service	• Different clinical services provided are integrated at an organisational level, such as through teams or multidisciplinary professionals (separate from organisational integration)

Adapted from (2, 3, 7, 10, 23, 24).

Breadth

The breadth of integration is defined by the scope of targeted population size (3, 7).

Micro level or 'clinical' integration is the coordination of person-focused services "in a single process across time, place, and discipline" (7). In practice, it can be limited in helping individuals with multiple co-morbidities or chronic conditions (7). Models include case management, individual care plans, patient-centred medical homes, and personal health budgets (3).

Meso level integration can be organisational and/or professional, with horizontal and/or vertical extents. Organisational integration pools skills and expertise through inter-organisational relationships and governance mechanisms, which can be hierarchical, market-

based, or informal networks/voluntary collaborations. This type of integration can have difficulties with opposing cultures, professional roles and responsibilities, clinical/service approaches (19), bureaucratic structures, levels of expertise, and funding mechanisms and regulations (25). Professional integration develops through relationships between individuals within or between organisations based on shared competencies, roles, responsibilities, and accountability (7). This level of integration is often used for providing services to a group or population with the same disease or condition (3). Models include the Chronic Care Model (CCM), and integrated care models; PRISMA for the elderly and frail, Sweden's *Chains of care*, Scotland's clinical networks, and Germany's Disease Management Programmes for chronic care (3).

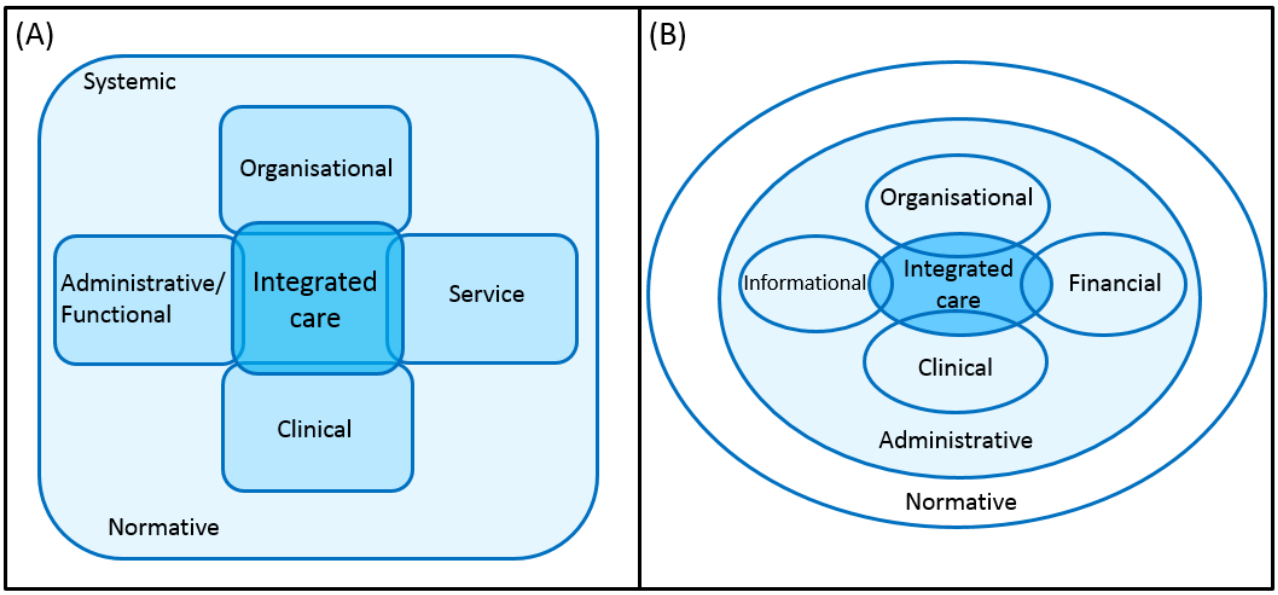
Macro level integration creates specific structures, processes, and techniques within a system with the primary focus of peoples' needs. It can occur through consolidation, merging, co-locating or virtual connections, and can include joint planning, support services, and case management, centralised intake and budgeting, and shared information management systems (14). Providing integrated care to an entire population relies on stratifying needs and tailoring services (3). Models include Kentucky IMPAT, Ontario CCAC (King 2006), USA's Kaiser Permanente (KP) insurance group, USA's Veteran's Health Administration (VA) services network, and Basque's chronic care health services (3). Australia's First National Primary Health Care Strategy (26), identified regional service integration as a priority, relying on integration of care between primary and hospital sectors (meso-level) and networks to assist in planning and delivery (macro-level) (26). Successful macro level integration benefits from shared information systems and reporting on performance for continuous improvement (3).

It should be noted that meso and macro level integration are also person-focused but becomes a more relative term (14), and macro level models generally include elements of meso and micro level plans (3). Each breadth can have blind spots – micro level doesn't include financial and human resources issues, meso levels may not be broad enough at considering agency services and has difficulty balancing shared accountability with healthcare provider decision making autonomy (7) and macro level can miss the full requirements of families (14).

Modelling Dimensions of Integration

The integration model has developed due to identifying different dimensions - beginning with conceptualising the degree of integration (15, 19), later adding the types integration and their interactions (Figure 1 (23, 24, 27)).

Figure 1. Models of integration interactions



Figures directly from (A) Lewis et al (24) and (B) Rosen et al (27).

In 2013, Valentijn *et al* (7) incorporated the types of integration with breadth and extent, incorporating a population health perspective into the 'rainbow' model (10). Figure 2 is a modified version of this rainbow, with re-categorisation of professional integration as service integration, and functional integration to include the 'administrative' type described in Table 2. Normative and administrative integration support clinical, service, organisational, and system types which operate at the micro, meso, or macro level. Population-based care embraces a public health approach, the person-focused care "empowers people through health education, shared decision-making, supported self-management, and community engagement" (9). The rainbow model does not incorporate levels of integration (Table 1) which is visualised in Figure 3 (20).

Figure 2. Integration model incorporating level, extent and breadth.

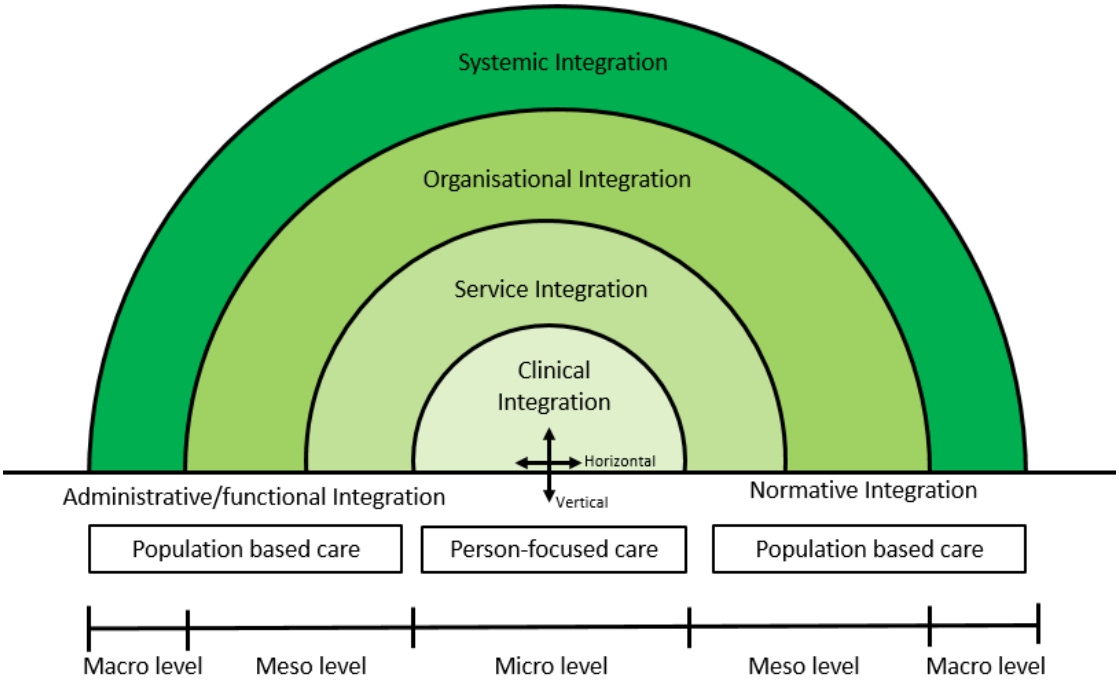


Figure from Valentijn et al (7). Person-focused and population-focused care involves biomedical, psychological, and social factors.

Figure 3. Model of degrees of integration

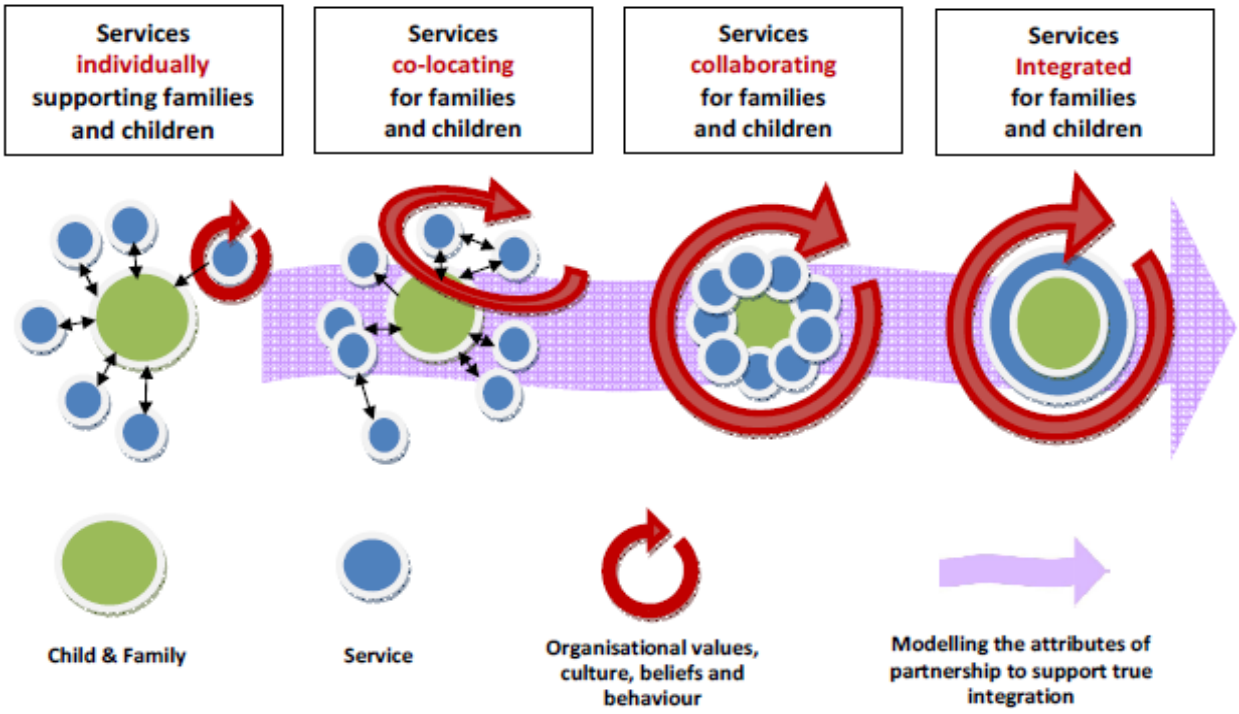


Figure from Prichard et al (20).

Key Principles of Integrated Care

The eight principles of integrated care (Figure 4) were first proposed as part of the NHS service integration model (1). Each principle has the underlying value of patient focus to implement family-centred practice.

Figure 4. NHS eight principles of integrated care.

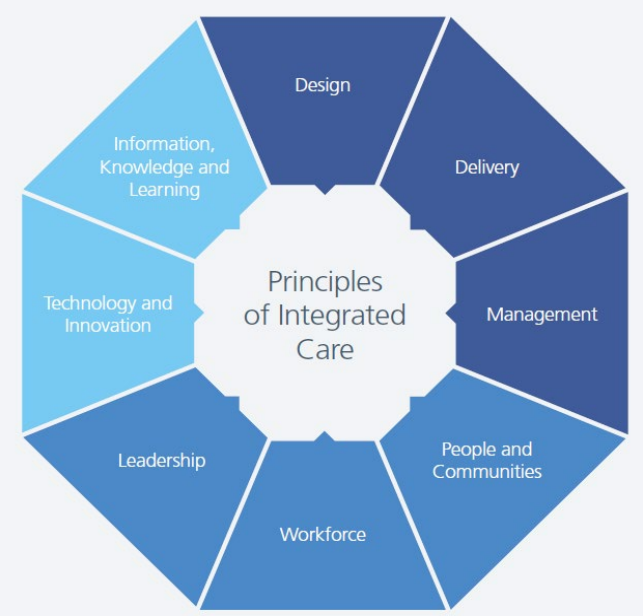


Figure from NHS (1).

Lyngso *et al* (8) identified elements which were deemed essential in integrated care which can be grouped within the eight NHS principles (Table 3): IT/information/communication, organisational culture and leaderships, commitments and incentives to deliver integrated care, clinical care, educational, financial incentives, quality improvement and patient focus. Leijten *et al* (11) created the SELFIE framework which also has principles that align to Table 3: service delivery, leadership & governance, workforce, technologies & medical products, information & research and financing.

Turner *et al* (17) and the NHS identified four outcomes which should be considered in a cross-disciplinary manner for all principles: (i) population health, (ii) patient experience, (iii) cost-effectiveness, and (iv) staff/provider experience. Nicholson *et al* (26) proposed the importance of change management which requires resources, takes time, and should be managed locally.

Table 3. Principles of integrated care

Principle	Characteristics
Design	• Shared vision, values, and goals/objectives of service integration • Systematic assessment of patient, community and staff needs • Agreed roles, responsibilities, and accountabilities of organisations including decision making and problem-solving processes • Collaborative involvement in planning, policies and procedures to foster a culture of integration • Linked success (or failure) of individual components so that success relies on collaboration • Formal agreements, incentives, and procedures to foster collaboration • Acknowledging importance of social health determinants and that maturity of new care models can take 5-7 years

Principle	Characteristics
Delivery	• Defined commissioning, contracting, budgeting, pooled resources (admin/consumables) and performance management • Create multidisciplinary teams while maintaining professional autonomy. This includes agreed referrals and transfer care chains • Integrated clinical pathways for comprehensive care management using evidence-based clinical practice guidelines • Learning and team development supported by change management at all levels of the system • Effectively communicate to all stakeholders how the system will work and grow. Longer appointments may be needed for clients and professionals to engage in new ways of working
Management	• Establish governance mechanisms and standards early to facilitate decision making, aims and outcomes • Agreed roles, responsibilities, and accountabilities of individuals • Invest time into building and maintaining relationships across the system • Address practical challenges of group accountability • Create an environment for staff to feel valued and rewarding, focused on making a difference
People and community	• Engage with consumers and community service providers from development through implementation to evaluation- raises awareness of priorities, validity, equity and how best to involve them • Develop methods to reach vulnerable or under-served groups • Shared decision making between professionals and consumers, this may require training for staff • Time is required to build trusting relationships • Encourage ownership of health through avoiding jargon and develop health literacy
Workforce	• Involve staff in processes to benefit from knowledge and experience • Cultivate cross-professional and cross-organisational relationships in addition to multidisciplinary teams • Develop boundary-spanning roles e.g. care coordinators • Ensure change management support • Establish audit, feedback and quality improvement to support system learning & facilitate sustainable change. • Recruit and retain staff with personal values and behaviours which align with organisational values
Leadership	• Adopt a collaborative system-wide leadership approach • Implement shared decision making, shared vision and values, clear accountability and performance-based management • Identify and empower local leaders and champions to drive forward improvement initiatives • Challenge historical hierarchies (common in medicine) • Create a culture of trust, open communication, reflection and adaptive learning to support innovation & improvement at all system levels
Technology and	• Identify user experience (professionals and client) and commercial interests of software suppliers. Diversity of services and software

Principle	Characteristics
Innovation	suppliers influence whether data sharing occurs through integration or interoperability • Develop information governance, systems, processes, and policies to enable sharing of data across services and sectors, including electronic medical record (EMR) • Provide training for new information systems • Use advanced analytics to drive improvements in care • Requires infrastructure • Enables risk management • Support multidisciplinary team meetings, remote working, consumer monitoring, care closer to home, and consumer records to be reviewed by professionals and the consumer themselves. • Supports change management
Information, Knowledge and Learning	• Identify need for data - a population, consumer case mixes and needs, service quality and/or professionals required for a network • Utilise data to monitor, evaluate and provide feedback loops to both consumers and staff to sustain transformational change • Develop communication strategies for disseminating data analysis • Create neutral space for collaboration • Implement staff education, learning and development opportunities • Implement robust and secure data sharing agreements and protocols accounting for legal and ethical implications • Adopt ways of working to adapt to improvements through accountability for performance and a reflective and continuous improvement focused culture • Design staff education, training and development in multidisciplinary settings for improved clinical and non-clinical communication • Support client education and ownership of health and feedback to inform professionals' understanding of client journeys

Adapted from (8, 11, 17, 19, 26).

Designing Service Integration

No single model of service integration suits all circumstances, and so engaging stakeholders provides the context necessary for effective planning and implementation. Shaw *et al* (2) outlined which stakeholders' perspectives should be considered (Table 4), and Goodwin (12) identified client needs against suggested degrees of integration (Table 5).

Table 4. Perspectives that shape integrated care

Key perspectives shaping integrated care	
Provider	Coordinate services, tasks and client care across professional, organisational, and system boundaries
Manager	Build and sustain shared culture and values; maintain oversight or pooled resources and funding streams; coordinate joint targets; supervise diverse staff; manage complex organisational structures and relationships
Policy-Maker	Design integration-friendly policies, regulations and financing arrangement; develop appropriate care systems, processes and quality standards; support holistic evaluation of integrated systems and programs.
Care professional	Advocate for services users; provide and coordinate health (and social) care.
Service user/carer	Experience improved access and navigation across elements of care, including information-sharing
Community	Help to shape local services
Evaluator	Measure integration against national and local measures; contribute to evidence informed integration
Regulator	Register integrated providers; access care provision; monitor joined up care; eliminate poor quality and safety

Table from Shaw et al (2).

Table 5. Degree of integration according to client population needs

Client Needs	Linkage	Coordination	Full integration
Severity	Mild to moderate	Moderate to severe	Moderate to severe
Stability	Stable	Stable	Unstable
Duration	Short to long-term	Short to long-term	Long-term to terminal
Urgency	Routine/non-urgent	Mostly routine	Frequently urgent
Scope of Need	Narrow to moderate	Moderate to broad	Broad
Self-direction	Self-directed	Moderate to self-directed	Weak self-directed

Table from Goodwin et al (12).

Considerations while designing service integration should include taking a person-centred focus with stakeholder involvement, acknowledging upfront costs and delayed benefits, avoiding the sole goal of economies of scale/cost saving, identifying integration responsibilities, and recognising differences in organisations' targets, management, and culture (2, 9, 15, 17, 23, 28). Components of successful strategies include being tailored to a defined populations' needs with ability to evolve through consumer engagement, adopting evidence-based clinical pathways, aligning correctly identified incentives, shared accountability, professional commitment to learning other specialties and partnerships while maintaining autonomy and empowerment, investing in information technology, the use of

guidelines, effective leadership, collaborative and continuously improving culture and multispecialty groups (3, 9, 15, 17, 23, 29).

For integration implementation, a Netherlands study (30) published a framework (Table 6) for the integrated care process in four phases: (i) initiative/design, (ii) experimental/execution, (iii) expansion/monitoring, and (iv) consolidation/transformation. The study did not mention establishing change management, a process which should underpin all stages. Evaluation is also key to understanding the level of success, through reviewing the implementation process itself, clinical outcomes, experience of patients (which some plans fail to improve (29)), and ensuring implementation does not result in service fragmentation elsewhere (2).

Table 6. Four stages of integrated care implementation

Phase	Elements
Phase 1: Initiative and design	Define aims, client group and characteristics of care; ensure leadership commitment; commit to joint responsibility; establish dependencies; agree on referrals, tasks and authorities; sign collaboration agreements; agree on client information sharing procedures
Phase 2: Experimental and execution	Realize direct contact of professionals; use evidence-based guidelines; share client care and agreed discharge plans; ensure professionals are informed of each other's expertise and tasks; work in multidisciplinary teams; bring in specialized staff if needed; gather data on client logistics; monitor results; enact adjustments
Phase 3: Expansion and monitoring	Systematic procedure for evaluation of agreements, approaches and results; flexible adjustment of integrated care; reach agreements of introducing new partners; make collaborations transparent; use collaborative education programs and learning to innovate integrated care; involve client representatives for improvement projects; design care for co-morbidities; develop connections between databases; monitor mistakes
Phase 4: Consolidation and transformation	Offer single collaborative financial contract to financing parties; integrate incentives and link consequences to achieved goals; structural meetings with external parties; share knowledge among parties; use collaborative education programs; monitor mistakes; develop care programs for relevant client subgroups; reach agreements about letting go partner domains; reach agreements on financial budget for integrated care

Table from Minkman et al (30).

Community Hubs

A ‘Hub’ refers to the central connection point in a ‘hub and spoke’ organisational design model (Figure 5). This network consists of strategic centralisation of full services (e.g. skill-intensive) at a primary site, complemented by limited services provided across secondary sites (31). This model aims to increase efficiency and provide accessible and responsive high-quality services. Risks including hub congestion, overextension of spokes, and spoke staff dissatisfaction (31) can be managed through co-design with community agencies and families (6). Co-design with a family-centred approach can ensure hubs are an effective support strategy for children and families. Flexibility towards community needs and social determinants of health is important as hubs can be affected by “birth rates, migration, government policies and funding, employment, poverty, and family value systems” (6). Benefits of co-locating with schools and incorporating childcare and preschool education into hubs were also identified (6). There are a range of enabling and challenging factors of service integration in hubs, outlined in Table 7.

Figure 5. Hub and Spoke model

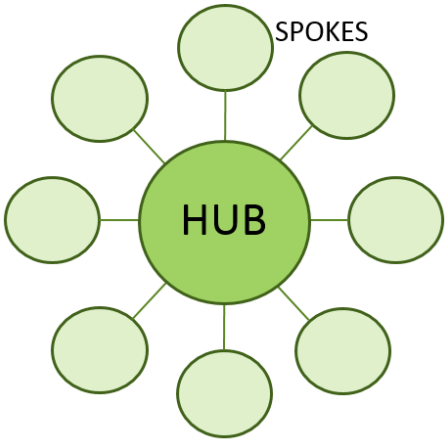


Table 7. Enabling and challenging factors of integrated service hubs

Enabling factors	Challenging factors
• An accessible, one stop shop • A platform for service integration, reducing duplication • A platform for co-design of services by service providers, families and communities • An ability to provide a range of universal and targeted services • An ability to promote parental social inclusion, confidence and sense of connectedness through educational and recreational programs. • Provision of effective hub management and leadership (leadership training) • Provision of locally relevant approaches, as identified by hub communities • Inclusion of Aboriginal community workers	• Tensions in relation to professional collaboration through unclear boundaries and conflicting cultures • Quality of hub management • Divergent national and international policies, service development, workforce strategies and government funding that are not able to be aggregated to inform strategic hub development • Difficulties with data measurement with diverse service designs and outcome indicators • Shortfalls in sustainable funding (infrastructure, staffing) • Complexities of responding to multifactorial family and community issues • Perceived loss of organisational autonomy

Content from Munns et al (6).

The factors in Table 7 highlight the need to customise service delivery and hub management, which can be achieved through partnerships with the community and interagency collaboration and identifying unmet needs in the community (6). Further research on implementation of community-based hubs is required (6).

Place-based service delivery

Place based service delivery is an approach where services are targeted to the collective issues of a geographical region or population group (32, 33). Place based approaches are gaining popularity in Australia, particularly through community centres, and have mostly targeted "socio-economically disadvantaged areas with a mix of informal and formal health and social activities" (6). Place-based service delivery aims to strengthen communities and address social determinants of health through identifying community needs, community co-design of strategies, coordinating efforts towards an agreed upon goal, community capacity development, and establishing a robust collaborative governance to facilitate joint planning (33, 34). Underpinning principles of place-based service delivery are outlined in Table 8 (33). Implementation requires addressing: characteristics of the community, roles and responsibilities in governance at a community level, level of community participation in decision making, the attributes of engaging communities with high and low social capital (degree of social networks), and the scope of capacity building in relation to the current project (32).

Table 8. Principles of place based integrated services hub

Principles of place based integrated services hub
• Articulate a shared vision and achievable goals, building shared responsibility and accountability between service providers • Universal and inclusive service base with availability of non-stigmatising and inclusive core services to all families • Information provision for parents on community facilities and service provision • Range of services with families having access to a broad range of interventions • Multiple interventions addressing several risk areas rather than single intervention strategies • Service provisions to suit a range of different needs and preferences • Accessibility with active assistance as necessary • Multiple single-entry points bringing assistance from any service attended or referral to a more appropriate service • Soft and hard entry points for universal and specialised services • Integrated services either as virtual or co-located service hub • Embedded specialist services • Active/assertive outreach for vulnerable and marginalised families • Mentoring of parents through peer support • Community based early years partnerships in relation to planning and management of

Principles of place based integrated services hub
integrated service systems • Facilitation capacity where an identified person or agency is funded to facilitate service collaboration • Integrated governance arrangements for sustainability of early years partnerships • Building a supportive culture to facilitate effective integration of professional groups, and shared responsibility for support to families • Active community participation where parents and community members are actively involved in planning, implementation and delivery of services • Commitment and support from senior government levels which is integral to sustainability of integrated service networks

Table adapted from Moore and Fry (33). Key process qualities include engagement, partnerships with, and empowerment of, parents.

Conclusion

CAHS will benefit from a shared understanding of service integration and integrated care in order to progress the development of the MCH service delivery model. A clear definition of the proposed level of integration in conjunction with utilising the eight NHS principles framework will benefit staff and consumers by setting intentions and expectations. Identifying key stakeholders can assist in ensuring relevant consultations are implemented. Ongoing evaluation is integral to ensuring community health services are responsive to community need. Finally, the literature has found that community hubs and place-based service delivery are evidence-based best practice approaches to support sustainable community health services.

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