Change management

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Introduction

"The experience of organisations that have made the transition from fragmentation to integration demonstrates that the work is long and arduous. [Managers responsible for achieving change] need to plan over an appropriate timescale (at least five years and often longer) and to base their actions on a coherent strategy" [1, p.7]

Enabling health systems to become more coordinated and integrated in how they function in the delivery of care to patients is a long-term and complex task. The process of change towards integrated care requires decision-makers to take action at a number of different levels to not only ensure that the key building blocks for integrated care are in place but that they function well together to promote continuity of care and coherence in the way care is organised and delivered. Evidence points to the need for *simultaneous* action to be taken at a number of levels to support the range of changes that are necessary – for example, in supporting shared-decision-making between patients and providers; in building inter-disciplinary teams of care professions; in creating effective networks between partners in care; and in engaging and promoting action to support changes that help to embed integrated care as an accepted and legitimate approach to care delivery.

However, despite recognition that the complexity of integrated care requires pro-active management support and action, there has been little guidance produced that might help to understand the various processes that are necessary to support change to happen [2]. This chapter seeks to articulate the components of a change management strategy for taking forward integrated care policies in practice at a local and regional level.

A conceptual understanding of change management

Any successful strategy for change depends on its mission, the resources and competencies it has at its disposal, and the environment in which it is operating. The strategic direction to be chosen for change must analyse these elements and identify what needs to be done to ensure the 'strategic fit' of the various organisations and stakeholders involved. It should be recognised from the beginning that in no health and social care system, given the history in the way care provision has been established, does integrated care emerge naturally as a solution. In order to achieve change towards integrated care there is strong evidence to demonstrate that systems must be effectively led, managed and nurtured [1].

In health and social care, leaders and managers must seek to empower people at all levels to take responsibility for an appropriate level of decision-making. This is particularly important for integrated care where evidence and experience points to the need to grow integrated care strategies from the 'bottom-up' where professionals and local communities work together with a degree of operational autonomy to lead the change process. This is why building communities of practice to support change, and investing in their ability to collaborate with each other effectively, should be seen as a core area for action within the 'change' domain. In other words, the change management process is seeking to support three core things [3[:

- Alignment – to support organisations to take on integrated care as part of their core business;
- Agility – to develop systems and processes that enable integration to happen
- Attitudes – through changing behaviours of key stakeholders by addressing cultural issues through good management practice

It is likely that significant variation will exist in the way integrated care is implemented, but a key lesson from policy reviews is that long-term commitment to change is necessary to enable reforms and changes to health systems to embed over time. To make change successful, the evidence suggests that a balance needs to be struck between 'top-down' management of change with the necessary space for innovation and emergent strategies to be created at a more local level by creating the right environment for innovation [4, 5]. Hence, participation and support across all stakeholders in health and other sectors (including policy-makers, managers, professionals, community groups and patients) is a key to success [6]. The managerial challenge is to create a step-wise process through which this can be achieved.

The evidence base

There is a lack of evidence in the written literature that has researched and articulated the process to support change when designing, piloting, implementing, assessing and scaling-up innovations that support integrated care [7]. Indeed, as Chapter 1.1 outlined, most frameworks describe the process as highly 'complex' given the range of stakeholders that must necessarily be involved in working together in devising new approaches to integrate care [8-10]. Hence, pro-active change management is needed. Yet, there is a lack of appreciation and understanding of the complexity of this process and of the tools that can help support change happen [11-13].

A planned change management strategy represents a reasoned and deliberate set of actions for managers of the system that requires a need to identify and explore new ways of working as well as challenge established practice [14, 15]. Change management, therefore, represents the 'how' of integrated care implementation through setting out the various operational tasks that needs to be undertaken to enable change to happen. The approach requires 'whole systems thinking' since it is necessary for managers to understand and capitalise on interrelationships rather than linear cause and effect chains.

Evidence from experience and research has contributed much to our understanding of the building blocks for the effective deployment of integrated care, yet the field of integrated care remains weak in terms of the implementation science to support policy-makers and managers to make effective decisions. Indeed, there is evidence to suggest that there is a lack of appreciation of the necessary change management processes and skills needed [12]. In part, this lack of understanding is because achieving success through integrated care appears highly complex since it involves change at the nano- (e.g. with patients) micro- (e.g. with multi-disciplinary teams) meso- (e.g. through organisations of physician networks) and macro-scale (e.g. by alignment of government policies) [16-18]. Hence, efforts to reform complex systems like integrated care need to look at 'whole system' change with a priority in influencing the high-level behaviour of key decision-makers, the performance of individual sub-systems and – crucially – the interdependencies between different stakeholders and how these impact on outcomes.

A number of relevant frameworks to integrated care have been developed to explain these interdependencies as a means to understanding how change might be achieved – for example: the Normalisation Process Model that focuses on the importance of building relationships and skills in collaboration [19]; the Continuity of Care Model that tracks how chronic care to populations may be achieved through adopting different strategies at different points across the life-course [20]; and the Multi-Level Framework that sought to understand how care co-ordination between provider organisations and care professionals operates in practice [21]. None of these, however, have really articulated the management strategies necessary to achieve change.

Perhaps the most famous approach to change management adopted in health care settings has been Lean Thinking [22] and related improvement methodologies in health care that have sought to improve quality and safety in healthcare [23]. By focusing on the effectiveness of teams and the promotion of evidence-based and cost-effective care pathways, the manager has been provided with a new suite of tools through which to transform care. The Lean approach in health care has been strongly developed with many tool-kits and support agencies advocating its use. Whilst Lean is highly relevant to the management of integrated care the biggest criticism labelled against it that it focuses on 'doing right things' (i.e. eliminating waste through efficiencies) rather than 'doing the right thing' (i.e. focusing on quality of outcomes and effectiveness). Lean also tends to work best for specific diseases or for predictable care processes but is perhaps less relevant for people with variable care trajectories [24].

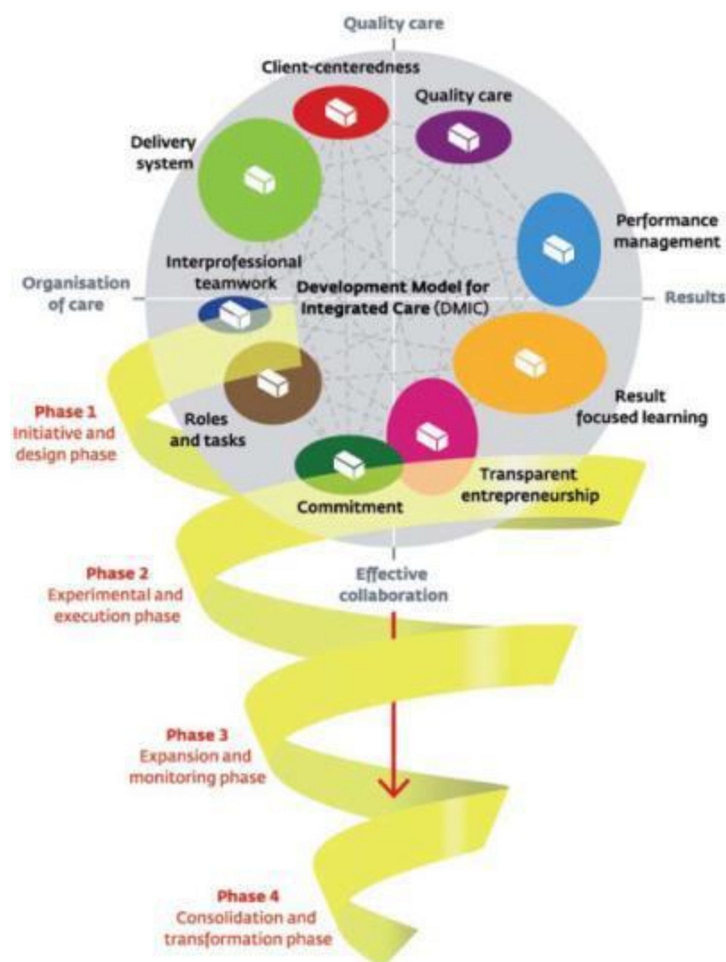
In the field of integrated care, the most coherent approach to date that seeks to explain how the management of integrated care may be taken forward is the Development Model for Integrated Care (DMIC) [10]. Unlike other work, the DMIC was specifically designed to help managers and leaders reflect on whether the essential elements for integrated care were in place and, in particular, established a four-phase programme for change: design, experimentation, expansion and monitoring, and then consolidation.

The DMIC is a complex evidence-based model since it includes 89 unique elements for action grouped into nine clusters. These clusters provide a basis for a model for the 'comprehensive quality management' of integrated care. In particular, in terms of change management, the model highlights the conditions necessary for effective collaboration such as commitment, clear roles and tasks and entrepreneurship. The model can be used for self-assessment and evaluation and provide inspiration and insights for further improvement. The DMIC is an important resource since it also shows that certain attributes of integrated care are more important at different

phases of implementation. For example, in younger collaborations it stresses how the management of change should focus on building inter-professional teamwork and defining roles and tasks. The DMIC can also enable a situational analysis to be undertaken to examine any deficiencies in the competencies needed to achieve integrated care in practice (for example, the lack of attention on quality of care and performance management).

The DMIC was developed in the context of the policy innovation in the Dutch context of Care Groups that encouraged primary care providers to utilise new financial incentives (bundled payments) to support chronic illness care to people with specific diseases such as diabetes. Whilst the DMIC approach has been applied with some success in other settings, for example in the context of stroke care in Canada [25], there remain some caveats to how the model might be adapted to the needs of populations with physical and mental health co-morbidities and complex health and social care needs.

Figure 1: The development model for integrated care [10]



Lessons from practical experience

The development of the evidence-base to support the uptake of integrated care remains in an early stage of development yet much can be learned from the experiences of key leaders and managers who have been at the forefront of implementing integrated care strategies at a national and regional scale. Though captured through relatively few documents and presentations, a summary of the evidence would suggest that there are a number of key managerial lessons to be learned (see Box 1).

Box 1: Key lessons for change towards integrated care from practical experience

- Finding common cause with partners;
- Developing a shared and bold narrative to explain why integrated care matters, written in a way that is tailored to meet local circumstances and conditions;
- Creating a compelling and persuasive vision for change that sets out an urgent case for why 'business as usual' will not work and describes what integrated care can achieve, especially to the potential benefits of patients;
- Identifying services and user groups where the potential benefits of integrated care are the greatest;
- Understanding that there is no 'one model' of integrated care and supporting a process of discovery rather than design;
- Building integrated care from the bottom-up in a way that is supported from the top-down whilst avoiding structural solutions with an over-emphasis on cost-containment;
- Aligning financial incentives, or removing financial disincentives, for example through pooling resources to enable planners and purchasers to use resources flexibly;
- Innovating in the use of contracting and payment mechanisms;
- Supporting and empowering patients to take control over their health and wellbeing;
- Sharing information about patients with the support of appropriate information governance;
- Using the workforce effectively and to be open to innovations in skill mix and staff substitution;
- Restructuring care delivery assets, for example through less hospital-based care and more primary and community-based care;
- Setting specific objectives and measures to stimulate integrated care delivery, enable the evaluation of progress, and supported by a performance and quality management system;
- Establishing a strategic communications plan that enables a clearly defined message to be provided and understood across all stakeholders;
- Being realistic about the costs of integrated care;
- Integrated care is a long-term agenda and represents an ongoing system-wide transformation; and
- Acting on all these lessons together as part of a coherent strategy

Sources: 2, 4, 26-32

The list of key factors in Box 1 is based on the lived experience of those that have led the management of strategies to support integrated care. What they reveal is a striking resemblance to Kotter's 'eight steps' model for leading change derived from an analysis on the key strategies taken by managers in making a success of transformational change [33]. These eight steps are:

1. Create a sense of urgency
2. Form a guiding coalition
3. Create a vision
4. Communicate the vision
5. Empower others to act on the vision
6. Plan for quick wins
7. Build on the change
8. Institutionalise the change

A key observation from this work is that care systems often need to have *external* change management support to help manage the various viewpoints of different stakeholders within the various contexts for change in which integrated care will be implemented. Furthermore, since the needs for developing integrated care require an appreciation of the complexity of the task there is a need to find a balance between emergent strategies (one that adapts over time) versus approaches that seek to systematise processes. Flexibility in the management of change is therefore needed and learning networks and communities of practice need to be built to support adoption and build capabilities.

The Components of a Change Management Process Towards Integrated Care

This section examines nine core components in the management of change that, taken sequentially, sets out a sequence of actions that managers should consider when addressing the need to introduce or develop programmes that support integrated care (see Table 1). The nine steps represent a range of actions from the planning stages that define the priorities for action, to issues related to strategic planning, implementation and evaluation.

Table 1: Nine Core Components of a Change Management Plan

1. *Needs assessment* 2. *Situational analysis* 3. *Value case* 4. *Vision and mission statement* 5. *Strategic plan* 6. *Ensuring mutual gain* 7. *Communications strategy* 8. *Implementation and institutionalisation* 9. *Monitoring and evaluation: developing systems for continuous quality improvement*

Needs assessment

Integrated care represents a strategy that recognises the fundamental seriousness of the challenges faced by health and care systems to meet current and future demands [34-35]. Yet, at a local and regional level, it can often be difficult to find 'common cause' amongst local stakeholders on the priorities for action that need to be taken in local communities to overcome system fragmentations through new approaches to care integration [26]. One of the core issues in the change management process is that organisations will be asked to work together and, as a result, share their sovereignty in pursuit of the greater good of the population they serve – and this is not always easy [2].

A first step, therefore, is for the different key stakeholders to develop an objective understanding of population health needs to support the underlying rationale for integration and to promote priority setting. This might be achieved, for example, through the development of a Joint Strategic Needs Assessment (JSNA) that looks at the wider determinants of health and needs of a local community. Though the process varies in different countries across Europe, it usually involves local health authorities with a responsibility for population health to work alongside public health departments, municipal authorities (social care), housing and other sectors to examine the current and future health needs of a local population. Such JSNAs might typically focus on a specific patient cohort (e.g. people with chronic illness or older people with frailty) and enable priority-setting by mapping the flow of financial resources spent on key priorities and/or examining gaps in care provision [36].

Situational analysis

Understanding change management towards integrated care faces a series of problems related to implementation including issues such as the legacy of existing service provision; changing environmental pressures; changing technologies; varying degrees of complexity of organisational systems; the many competing views of stakeholders; and the potentially adverse impact of unforeseen event or unintended consequences of different strategies. Managers therefore face the challenge in adopting the right tools and strategies for the circumstances they face.

The literature on change management commonly shows how achieving change rests on actions at a number of levels, for example: the *political* system where formal and informal configurations of power influence decision-making; the *technical* system of existing human, technical and financial resources available to produce more integrated service delivery; and the *cultural* system that encompasses organisational values and behaviours of those influenced by changes [37]. In other words, managers need to recognise that change towards building the technical competencies of integrated care will be significantly influenced by economic, political and cultural forces that may be beyond their control.

One of the key methodologies to enable the change management process is the use of diagnostic tools to assess the current situation in relation to what is trying to be achieved. These situational analyses attempt to yield insights on the 'strategic fit' of new approaches like integrated care amongst key stakeholders and are often used to justify change management programmes and/or to prioritise the focus of change.

Value case development

One of the most pressing concerns in the process of developing integrated care strategies is how to convince key stakeholders, and particularly health insurance organisations or those holding the financial power, of the 'value case' for investment. A 'value case', however, looks at more than just the potential financial returns from the development of integrated care, but looks at the benefits to patients and whole communities of the approach (e.g. from the perspective of living healthier lives through to the development of stronger local economies).

The focus on value cases is important since it helps to develop the shared vision and set of common goals across different providers or teams. Hence, value cases do not just to articulate the aims and objectives of integrated care based on the needs of local populations, but they also represent a pro-active process through which to engage partners in care and build social capital. Hence, in the design phase of an integrated care initiative, there needs to be inclusion of all relevant stakeholders in preparing the case for change and, in so doing, establishing a shared understanding, a shared vision for change, a degree of mutual respect on each other's roles in the integrated care enterprise, and the development or election of respected professional and managerial leaders whom people trust to take initiatives forward.

There are many examples internationally about how this approach has been used to create a convincing argument for change. For example, in Canterbury, New Zealand, the creation of the 'value case' and subsequent mission was supported between different provider agencies through a mantra of 'one system, one budget' [30]. In other words, an argument was constructed in favour of an integrated health and social care system as a means to improving patient care as well as balancing the financial budget. To support this, more than 1500 managers and professionals completed learning courses – named *Xceler8* and *Collabor8* – in which staff themselves were tasked with coming up with projects for change with help from planners, funders and business developers. Rather than a full 'business case' with a cost/benefit analysis the underlying questions discussed were of the value for improving patient and staff experiences.

Vision and mission statement

Change management theory argues that it is important to articulate a vision of the future with a compelling case for change. Evidence from experience suggests that is especially true for progress on the journey towards integrated care that would otherwise be slow unless it is possible to describe an alternative and better future that motivates and inspires care providers to work differently [2, 3]. This includes developing a clear understanding of what integrated care means for all those involved, including those delivering services but also for those living in the community. Important in this process is to create a sense of urgency (that business as usual will not work) but also to centre the narrative based on improvements in care and outcomes to people and for quality improvement in bold but reachable terms. The vision and mission also needs to be co-produced with key stakeholders, including patients (and perhaps even led by service users).

A common strategy has been to develop a shared narrative of the future to explain why integrated care matters to both care providers and to patients. In England, the national strategy for integrated care has been underpinned by 'the narrative' developed by National Voices, a non-profit organisation representing the views of patients and patient groups [38, 39]. The purpose of the narrative has been to articulate a national vision for person-centred coordinated care and it has proven hugely influential in establishing the overarching purpose of national strategies.

Strategic plan

A strategic plan is the document that is used to communicate within and between the organisations involved in the planning and delivery of integrated care the core actions and critical partnership elements necessary to achieve shared goals and outcomes. The development of a strategic plan has the advantage of committing a range of organisations involved in funding and delivering care to a collective set of objectives and actions to guide what needs to be done, by when and why. An effective strategic plan, therefore, helps to tie together networks of care professionals and otherwise separate organisations into a collective agreement, sets the terms of engagement between the different parties, their key roles and responsibilities, and the range of outcomes and performance indicators that may be used to judge whether integrated care strategies have been successful.

Ensuring Mutual Gain

One of the most important issues at stake in the development of effective partnership working within programmes that support integrated care is not just related to the development of a 'shared vision' that enables key stakeholders to recognise the 'inter-dependencies' that each have in working together to achieve a better outcome for patients and communities. What appears to be just as important is the ability to ensure that all partners in care fully understand and accept their roles and responsibilities to the extent that a high degree of trust and respect exists between partners in care, a trust that is built on the knowledge that each partner is contributing fully and as expected. The building of trust, therefore, requires all partners to recognise and value the level of commitment and reciprocity of actions of others. In other words, each partner recognises the 'mutual gain' that can be made through collaborative actions. Hence, it is essential that any partnership which focuses on integration recognises from the outset that a 'win-win' scenario needs to be supported otherwise there is a risk in undermining the degree to which partners in care are willing to cooperate with each other.

However, one of the core problems with integrated care is that it usually not the case that the benefits of involvement are equally shared compared to the effort or workforce that is needed to make it happen [39, 40]. As a result, it can be difficult to bring partners to the table to discuss integrated care where it is perceived that some partners might gain, yet others lose. Moreover, the issue is not simply related to budgetary or financial concerns but also involves issues related to perceptions of authority, to social and professional status, to workload and effort, to intellectual property and, often, to the competitive advantage different care providers might gain in terms of gaining clients (patients) at the expense of others.

Collaborative partnerships and networks are necessary to achieve integrated care, yet the evidence demonstrates that these can be time-consuming, resource-intensive and unstable leading to the observation that there is a high failure rate in such innovations [9, 42-44].

The recognition of the need to articulate 'mutual gains' and build 'tie-ins' is important since it establishes the 'baseline' that underpins the nature and expectations of the collaboration that recognises their underlying interests. A useful conceptual framework by Bell et al (2013) can help to evaluate the strength of the collaborative process across five key themes:

1. The degree of shared ambition (the shared commitment of the involved partners)
2. Mutual gains (understanding the various interests of the involved partners)
3. Relationship dynamics (the relationships and degree of trust displayed between each partner)
4. Organisational dynamics (governance arrangements across the partners)
5. Process management (the skill with which managers help negotiate relationships between partners over time) [45]

A good example of this is recent research that looked at the comparative effectiveness of 69 Dutch Care Groups enrolled in a Ministry of Health initiative to create integrated care primary care programmes to support the management of chronic diseases such as diabetes or COPD [46]. The research found that difference in the perceived success of the different programmes was *not* related to issues related to shared ambition. Rather, they relied heavily on the explicit voicing of interests of the partners in determining the 'mutual gain' to be made, primarily by setting out the preconditions for what a successful partnership would look like and ensuring that managers and decision-makers 'steered' the process of integration to ensure that these partnership preconditions were maintained. Relationship dynamics between partners in care, therefore, are a key to the successful functioning of professional and organisational partnerships that in turn are reliant on the continued brokering of the 'contract' between them and the 'gains' that each expect.

Communications strategy

Often missed, but important in the literature, is the need to create an effective communications strategy and plan that delivers clear and consistent messages to all key stakeholders, but specifically to organisations and professionals tasked with delivering change at the clinical and service level (e.g. doctors, nurses and patients). Lessons from managerial experience suggest that effective communication of the vision requires multiple channels is needed as a means to develop relationships (for example, the internet and social media) and therefore needs to be achieved using consistent and simple language.

As many of the proposed changes for care integration are likely to be complex and have a direct impact on vested interests as well as patients it has been suggested that an experienced communications manager or team is likely to be essential to engaging and aligning teams and organisations. The nature of communication

management might include: ensuring that all senior managers are aware of, and own, the narrative for integrated care; developing a communications and engagement strategy; establishing and managing a wide range of communication channels at a local, regional and national level (where required); and developing media releases to provide updates and briefings on progress, good news stories and case examples of best practice, and dealing with enquiries to build relationships [47, p.11]

Implementing and institutionalising the change

The next key element in the management of change involves the implementation of the change in practice, both in terms of 'system' (e.g. joint financing, governance and accountability) and 'services' (e.g. joint delivery through the development of teams). Often, the change process requires the initial piloting of options with the intention of 'institutionalising' or rolling-out the lessons learned for wider adoption afterwards. Moving from small-scale programs is important in order to deliver benefits on the scale needed to make a significant and transformational impact on the way care is delivered [48]. There are, however, very few examples of tool-kits which have sought to address the issue of scaling-up of pilots, though one is the DMIC model cited earlier in which 'phase 4' of the model supports strategies for consolidating change [10].

Table 2: Examples of indicators of maturity to integrated care change management

Examples Dimension	Objective	Maturity Indicator
Readiness for change	Compelling vision, sense of urgency, stakeholder support	Public consultations, clear strategic goals and milestones, stakeholder engagement
Structure and governance	Sustains and delivers new systems of integrated care, presence of effective change management	Funded programmes, effective communication, governance and accountability in place
Capacity building	Investment in training, skills and technologies of the workforce, including systems for continuous quality improvement	Developing of funding and availability of courses to support bottom-up innovation and workforce development

Monitoring and evaluation: developing systems for continuous quality improvement

A common weakness in approaches to integrated care is that not enough time and effort has been placed to agree the specific objectives for integrated care and how to measure and evaluate outcomes objectively. In particular, it is common that the lack of evidence for cost and impact can lead to significant problems (and programme failures) when seeking to embed programmes within wider health system funding streams [46]. In practice, therefore, managing change requires the ability to measure and monitor outcomes in a number of areas including: user experience, service utilisation, staff experience and the costs of delivering care. Progress towards these goals must be measured frequently to support learning and inform implementation.

For health care systems it is important to adopt and use a set of measures that align with the main elements of a national, regional or local strategy for integrated care. However, the complexity and the necessary variety in how integrated care strategies need to be developed means that outcomes and measures need to be chosen to suit local and national priorities. Many countries and regions have sought to establish a set of key measures and indicators for people-centred and integrated health services as a means to monitor and manage performance [e.g. 49-50] and a summary of the range of measures that have been used has been usefully summarised through work supporting WHO's Global Framework on People-Centred and Integrated Health Services [6].

An important aspect of developing a monitoring and evaluation framework is that it can be used to bring relevant stakeholders together to define the outcomes through which integrated care strategies should be judged and, as a result, promote joint ownership and collective responsibility to achieving key goals. Including key

stakeholders in how care systems will be held to account supports the inclusive process of developing a vision and driving change forwards.

A final key element of a change strategy is to utilise data and information from the monitoring and evaluation process to build-in a process for continuous quality improvement. For example, to identify 'high impact' changes that would most benefit patients, or reduce variation in standards between provider teams. In essence, an 'improvement process' is needed to help clarify or re-frame objectives, redesign processes, address capabilities, integrate risks, develop performance measures, learning from performance measures and, crucially, create a feedback loop for improvement over time. Two key aspects for this include: first, the need for managers to properly engage service providers, communities and service users; and, second, the need to build in 'rapid cycles' of building and re-building strategies for change following their implementation and assessment of progress.

Building an Enabling Environment

The change process towards integrated care can take considerable time and effort to achieve but enabling the environment within which the management of change is to be taken forward is a necessary process and catalyst for change [33]. This includes three core tasks:

- the building of *a guiding coalition* of leaders and key stakeholders to drive change forward from the top-down;
- the building of *support for change* from the 'bottom-up' within and between key professional groups and the communities of practice where integrated care is to be deployed is a core requirement for success, including the development of a shared set of norms, beliefs, values and assumptions that help to enable change to happen; and
- the development of *collaborative capacity* at a local level that enables and supports professional groups to work together effectively in multi-disciplinary or multi-agency teams that new approaches to coordinated and integrated health service delivery will require

Developing a guiding coalition

There is a significant amount of literature that describes the importance of developing a 'guiding coalition' of partners at a political and senior level in order to agree on the collective aims and mission of integrated care and so provide the mandate to people working within different parts of the health care sector to co-operate with each other and co-ordinate activities. For example, reflections on the process of development of strategies to support chronic care management in the Basque Country emphasised the importance of taking the integrated care agenda to a 'policy level'. As a result, bottom-up approaches to innovation were supported by a regional research institute which monitored progress whilst at a national level there were regular meetings convened by the Ministry of Health which included public administration, professional associations and patient representatives to discuss the burning issues and how they may be addressed on the national and regional levels.

Pulling together a 'guiding team' of key people and organisations is also highly relevant at a local and regional level to champion integrated care and to lead change amongst key professional and patient groups. The effectiveness of such approach is often cited as a key step in change management strategies [51]. To make such as approach effective, key issues include: choosing key managers with the position power, credibility and ability to drive the change process; and developing an inclusive and multi-disciplinary guiding team with the management skills to control the process [51]. Developing such front-line commitments requires the removal of barriers to integration by policy-makers, supporting the observation that creating an enabling environment for change requires both top-down and bottom-up initiatives [1, 4]

Building support for change

Evidence suggests that building support for change across networks of health and social care providers and other local stakeholders (such as patient representative groups) is complex and adaptive in nature [3]. A key reason for this is that each stakeholder usually will have a different perspective on the purpose of integration. Hence, politicians, managers, clinicians and patients are likely to have different priorities and different levels of understanding – integrated care will mean different things to different people. Moreover, attitudes to change are reliant on relationship-driven behaviours and inter-personal connections. Building support for integrated

care between key stakeholders is thus a socio-cultural task akin to 'nation-building' through developing notions of community and citizenship.

The building of such support, then, requires being 'inclusive' at the design stage with those who would benefit or be influenced by the networks created as a result of care integration. Even so, a number of key managerial tensions will remain when building support for change including:

- Achieving a centralised position through which to wield managerial authority; yet to ensure the right balance between trust and control so as to encourage rather than alienate partners in care;
- Avoiding mandating change from the 'top-down' but to maintain it through peer-led approaches; yet there is a tendency for professional and organisational capture of activities by dominant 'elites' that need to be avoided;
- Promoting mutual interdependencies, for example through joint targets on care outcomes or quality improvement targets; yet networks need to continue to provide 'net worth' to participants to ensure their engagement;
- Driving change through senior managers, yet recognising the relationship between physician-leaders and managerial-leaders remains underdeveloped [52]

The major problem in building support for change, therefore, is one of control as all activists for integrated care realise that they have relatively little direct power (e.g. hierarchical, financial, knowledge) and so suffer from a lack of authority. As a result, managers need key skills in brokering inter-personal relationships and act as 'boundary spanners' that help to connect people together or unlock barriers to partnership working.

Ultimately, overcoming the 'governance gap' requires the network members themselves to sign-up voluntarily to collective governance rules, for example through a network constitution based on the notion of dual accountabilities. Contracts across care pathways or disease-based programmes appear less easy to maintain than those which focus on population health. Harmonising incentives, targets, audit and governance are important but come after network members have provided the 'mandate to be managed' both technically and culturally.

At a more local level, even with the establishment of a guiding coalition, evidence demonstrates that there can be considerable resistance to change towards integrated care amongst professional groups and providers. This is not simply an issue related to differing funding and incentives or pre-existing professional roles and tasks, but a more deep-rooted concern related to the lack of understanding of the importance of integrated care and why change should be embraced. This demonstrates the importance that needs to be paid to pre-existing cultures, norms and values and how to potentially understand and recognise such issues when introducing change at a local level. Building support for change at a local level is thus essential and requires participants and stakeholders to be included in the design and development of solutions to ensure a collective vision and common understanding for change so that new ways of working have a greater chance of success.

In theoretical terms, the process might be termed as a 'soft systems methodology' which understands that, in the real world, a complexity of relationships exists and which need to be actively explored. Hence, understanding relationships and building social capital is an explicit activity that requires understanding the challenges of integrated care without first imposing a preconceived structure or solution to the issue. As explored above, empirical evidence suggests that avoiding 'mandated partnerships' and 'top-down' imposition of new ways of working is important for integrated care to become an accepted idea, and that inclusiveness of people in the design and development of new approaches to care is important in the process (as is the subsequent assessment of impact and ideas for continuous improvements and change).

Building support for change is therefore an explicit component that requires understanding of the challenges of integrated care to promote inclusiveness and fostering a collaborative culture that builds the commitment of local leaders, staff, managers and the community [3]. The experiences of key people who have led the process of health service transformation commonly cite that achieving clinical integration is fundamentally about changing the culture of health care; it's more sociological than technological [27, 29, 31]. Healthcare culture, manifest in silo-based working in specific professional groups and organisations, appears to be the biggest barrier to change and requires new ways of thinking and new competencies including: systems thinking; collaboration in teams; quality management and process improvement science [29].

Developing collaborative capacity

The changing needs of patients with more long-term and complex problems highlight the need for care delivery to become reliant on a greater number of care professionals and organisations. Such changes clearly carry a greater risk to patients given the problems that might result from fragmentations in care. Developing effective and reliable multi- and inter-disciplinary teams and care networks is therefore important, yet the process is not always achieved with great success due to problems in team-based skills with the right skill-mix [53].

Evidence suggests that consistent efforts need to be taken in the long-term to help build the collaborative culture necessary to take integrated care forward at a local level. Creating effective teams is a change management process in its own right and the development of evidence-based approaches to supporting effective teams and team-building has become widespread across Europe [54]. Such support has been shown to be successful in breaking down silos and promoting inter-professional education and learning [55]. This task can be supported by a number of component strategies including education and training in multi-disciplinary working to support effective networks and teams,

The issue of developing a collaborative culture has often been put forward as a key ingredient to making a success of integrated care. A characteristic underpinning the success of case studies of integrated care is often the personal commitment of staff—both managers and professionals—to go that 'extra mile' by working beyond the boundaries of their job description in order to achieve the best results for their clients and in supporting colleagues to do the same. Lying behind this finding is sometimes a range of explicit strategies that promote a strong ethos amongst staff to 'do the right thing'—for example: promoting the needs of clients before themselves; supporting knowledge-sharing; and enabling role-substitution and subsidiarity through staff empowerment [56]

There have been concerns about the time and cost implications of this kind of approach to change management given the lack of any guarantee that stakeholders can be sufficiently motivated to support change. Hence, the problem with promoting the idea that a values-driven approach should be a pre-requisite to the successful adoption of integrated care is that the weight of both evidence and experience predicts that such a process requires considerable time and effort. Moreover, given the mismatch of motives that exists when integrating the work of professionals and organisations, such efforts often go unrewarded and/or require continual negotiation. Hence, rather than being perceived as a catalyst for change, leaders and managers tasked with applying integrated care 'at scale and pace' might instead focus on driving forward the organisational solution or introduce various financial inducements in the hope this will be more effective. Given the evidence, such an approach would be a mistake. When looking at successful implementation strategies in integrated care it is clear no short cuts exist—it takes vision and commitment over the long-term to build the collaborative capacity necessary to take integrated care forward.

The facilitating role of managers and decision-makers in supporting the process of change

The evidence for the successful adoption of integrated care provides considerable emphasis on the role of individual managers and decision-makers in driving change forward. Lessons from evidence and experience strongly indicate that there needs to be a person, or team, with the necessary skills and responsibilities for facilitating partnerships and brokering effective networks of organisations and the development of well-functioning professional teams. Establishing collaborative practice requires hard work and effort to develop the necessary inter-dependencies between partners in care. Often, this requires challenging often well-established cultural ways of working to build-in collective values and thinking. Hence, the successful adoption of coordinated/integrated health services delivery in practice requires long-term and continuous effort to support and nurture change. As a managerial task, achieving care integration is as much about changing culture as it is about the management of resources or the application of technical processes.

Many studies have sought to examine the attributes and tasks that are needed of senior managers in this area [e.g. 1,4, 7, 29, 31, 33, 46, 57-58] and these can be summarised as follows:

- Start with a coalition of the willing
- Inspire vision between partners in care – action is inspired through emotion
- Involve patients, service users and community groups from the beginning
- Build an evidence base to justify thinking

- Provide managerial decision-making ‘across’ the system so that it spans organisational and professional boundaries and promotes co-operation
- Develop a consensus-style of management that includes and encourages all key stakeholders to participate as equal partners
- Engage clinicians and enable them to lead efforts for change with the freedom to innovate
- Foster ‘collaborative capacity’
- Encourage long-term commitments from managers and decision-makers to drive through change
- Invest time and support in training people in these roles as they require specific skills in managing across diverse organisational contexts and boundaries

Conclusions

The successful adoption and roll-out of strategies for the delivery of integrated care is to a large extent reliant on their being a receptive environment for change at both a national (political), regional and local level. Integrated care can be a highly challenging proposition to many individuals and organisations that may not value the change being advocated or feel threatened by its consequences. Moreover, in many cases, partnership working between different providers and professionals will represent an entirely new way of working, so requiring new skills to be developed and a change in outlook.

Figure 2: A Change Management Model for Integrated Care

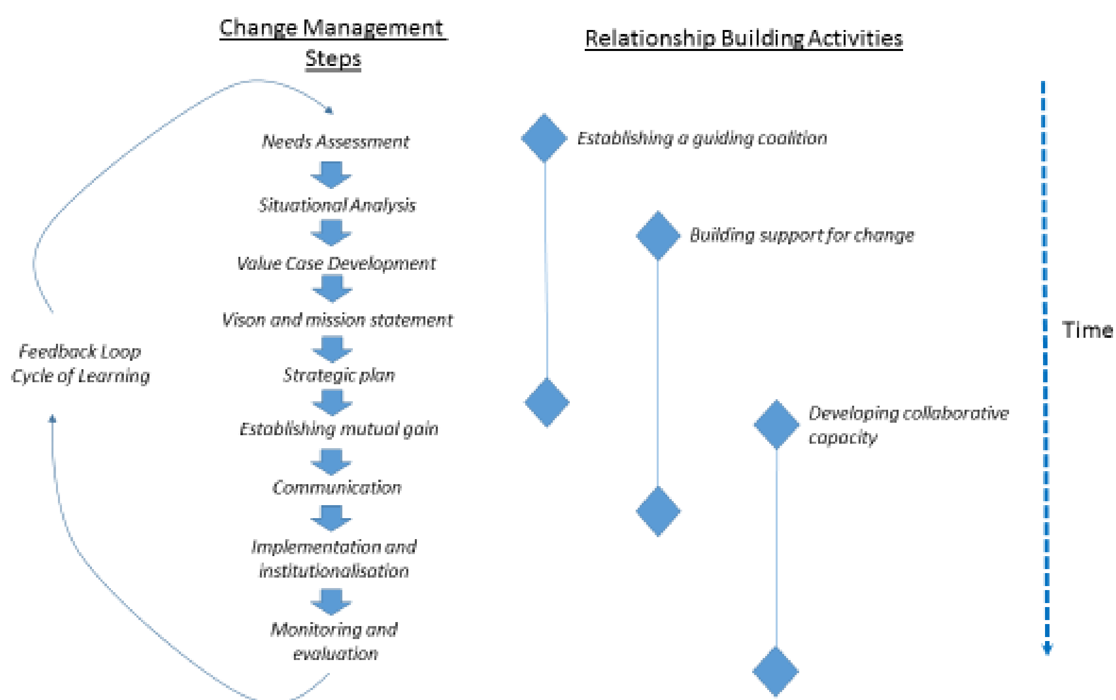


Figure 2, seeks to provide a visual representation of how these components fit together. On the left hand side of the figure are represented the step-wise progression of change management tasks whilst on the right are set out the need, over the timescale of implementation, the necessary ‘relationship building’ tasks that seek to create the enabling environment for change. It is important to recognise three key things:

1. the overlapping and continuous nature in how relationships are built over time;
2. the cyclical nature of the change management process itself in building and re-building strategies for change; and
3. how mangers and key decision-makers are essential in facilitating the process of implementation over time.

4. The evidence from experience in integrated care suggests that much has been achieved in different countries to establish a degree of consensus at a political level that may help to create an enabling environment through changes to financial and accountability rules. Yet, the evidence also shows that it is the professional barriers to change at a clinical and service level that remain the most persistent and most difficult to overcome.

This chapter has argued that the management of change towards integrated care requires the combination of two principle sets of processes: a step-wise progression of managerial tasks that come together to represent the core components of a change management plan ('management') and the ability to adapt these strategies for change in the context of the complex and multi-dimensional nature of practical reality ('environment'). Both tasks require key individuals with the managerial skills and both have a strong relationship-building component and are inherently inter-related.

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