



This research project was undertaken in collaboration with Vilans, Centre of Expertise for Long-term Care in the Netherlands



The Social Services network for Europe

Integrated social services in Europe

A study looking at how local public services are working together to improve people's lives

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Personalising services



The European Social Network is supported by the European Commission

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Integrated social services in Europe

Improving lives



This publication has received financial support from the European Union Programme for Employment and Social Innovation 'EaSI' (2014-2020). For further information please consult: ec.europa.eu/social/easi. The information contained in this publication does not necessarily reflect the official position of the European Commission.

About the research project

This research project was managed by the European Social Network (ESN) and carried out in collaboration with Vilans, the Knowledge Institute for Long-Term Care in The Netherlands. It forms one strand of ESN's work under its Framework Partnership Agreement with the European Commission for the period 2014-2017.

About the European Social Network

The European Social Network (ESN) is the independent network for local public social services in Europe. It brings together the organisations that plan, finance, research, manage, regulate and deliver 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 experience.

About Vilans

Vilans is the National Centre of Expertise for Long-term Care in the Netherlands. In this field, Vilans engages in innovation, research and development, dissemination, and implementation of good practices. Vilans primarily works for professionals and care providing organisations in long-term care (elderly care, care for people with disabilities), primary care, social care, organisations of volunteers in this field, user organisations, health care insurers and authorities at local, provincial, national and EU level. Vilans has a mixed funding structure and is partly funded by the Dutch government.

Project team

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European funding

This publication has received financial support from the European Union Programme for Employment and Social Innovation 'EaSI' (2014-2020).
For further information see: <http://ec.europa.eu/social/easi>

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For referencing, please use:

Lara Montero, A.; van Duijn, S.; Zonneveld, N.; Minkman, M.; Nies, H.; Integrated Social Services in Europe, European Social Network, Brighton, 2016.
ISBN: 978-0-9934556-2-9

Acknowledgements

The authors would like to thank Kim Nikolaj Japing (Policy Officer, European Social Network), Susan Clandillon (Senior Communications Officer, European Social Network) and Anita Alfonsi (Communications and Data Officer, European Social Network).

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Countries' abbreviations

AT	Austria
BE	Belgium
BG	Bulgaria
CY	Cyprus
CZ	Czech Republic
DE	Germany
DK	Denmark
EE	Estonia
ES	Spain
FI	Finland
FR	France
GR	Greece
HR	Croatia
HU	Hungary
IE	Ireland
IT	Italy
LT	Lithuania
LUX	Luxembourg
LV	Latvia
NL	Netherlands
NO	Norway
PL	Poland
PT	Portugal
RO	Romania
SE	Sweden
SK	Slovakia
SI	Slovenia
UK	United Kingdom

Executive summary

The objective of this report is to analyse how social services provide integrated support with other public services, namely education, employment and health, across Europe. The report consists of an overview of recent welfare developments, a summary of legislation and policy frameworks across European countries, a literature review of 60 international articles on service integration, and an assessment of 44 practice examples from 17 European countries. Finally, based on the input gathered at the integrated services seminar organised by the European Social Network in November 2015, the report also includes recommendations for policy-makers, practitioners and researchers.

Across European countries, different legislation and policy frameworks play a role in either stimulating or impeding progress in integrating care and support, which was initially provided by different sectors. In short, we can classify countries according to four categories: No specific policy or legislation on service integration, policies promoting coordination or resources transfer, policies promoting full structural integration, and a combination of these three. Although welfare states differ throughout Europe, there are similar issues and trends that impact service integration, including demographic ageing, the economic crisis and financial constraints, decentralisation, service marketisation and users' involvement and choice.

Based on the analysis of the literature and the practice examples, there are various reasons that may lead to integrating services. In the literature, we identified policy as the most mentioned trigger. Interestingly, this was not the case in the practice review. Even though 20% mentioned new legislation as the reason behind the integrated service, more often practitioners referred to having to deal with an increasingly bigger number of service users or pursuing prevention as the main reasons to start the process of integration.

A frequently recurring aim in integrated social services is improving outcomes for users. Even though many practices intend to be person-centered, this may not be implemented in practice. This may happen because of competing priorities or tension between standardisation and the need to show flexibility when working with users. Factors that may facilitate personalised services include defining a clear target group and involving users in service design.

Integrated service delivery may be implemented in various forms, such as case-management and multidisciplinary teams consisting of professionals coming from different sectors. Because of the amount of stakeholders involved, it is vital to streamline communication and information channels whilst at the same time keep a balance not to overly develop guidelines and procedures, as this may affect the human side of the relationships that should be established between the professionals involved. Indeed, providing clarity about roles and responsibilities facilitate intersectoral working.

When it comes to evaluation, we found that less than 25% of the reviewed articles in the literature mentioned monitoring and evaluation. In contrast, in more than 90% of the practice examples respondents indicated that they monitor and evaluate practice through formal and informal methods. However, it was not always clear what was measured and what was desired to be achieved, which became clearer when we assessed the reported effects of the practices.

The results of the analysis show that integrated service delivery is often either funded by government (e.g. with grants) or by the organisations themselves. We observed at least two different funding arrangements. A large percentage of practices is funded by a single agency, but even more practice examples featured two or more agencies pooling budgets to fund the process of integrating various forms of support. The report will analyse both approaches.

A number of elements are key to ensure the success of integrated services. In both, the literature and the practice examples, the commitment of stakeholders is frequently mentioned as a success factor. Another factor that may lead to success is the learning environment. Besides preparing practitioners for a new way of working, (joint) training may help to enhance mutual understanding. In the practice analysis, training is often mentioned as part of new integrated support, which requires new skills and new forms of joint working. In the reviewed articles as well as in the practice examples, innovation also appears to be a success factor. Giving professionals enough space and time to test new ways of inter-professional working was highlighted in both the literature and the practice review as an element that would support the long-term impact of the practice.

Ensuring the sustainability and transferability of integrated services also contributes to long-term impact. In the literature, the development of structural and procedural mechanisms are mentioned as helpful. Other elements which support the continuation of the practice include genuine commitment at all levels, interaction and trust between organisations and professionals, and securing financial resources, which was also highlighted in the practice examples. In the reviewed literature, we found examples of practices based on other programs, and practices that were implemented in other locations. The analysis also helped us to identify examples of practices that were fully or partly transferred from or to other regions, countries, service or users' groups.

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Introduction

When people talk about ‘integration’, they may refer to structural reorganisation and improved governance; for instance, having a single accountable agency responsible for commissioning services. Others mean improving cooperation between professionals from different sectors working with the same client. There are yet more who refer to integrating various strands of finance by pooling budgets or creating specific integrated funds to support specific groups with complex needs. They are all important and in some form or another they are all integration, but do they improve people’s outcomes?

That is why with the term ‘integrated services’, we refer to a range of activities implemented to achieve efficient coordination between services and improved outcomes for service users. Forms of service integration are manifold, depending on sectors, target groups, governance level (local, regional and national), the objectives and the level of integration between two or more public bodies. Different approaches to service integration may cover case-management that assesses, plans and coordinates service delivery for an individual; one-stop shops where services are provided by a single point of contact; various forms of partnership arrangements where two or more organisations collaborate or multi-professional teams, amongst others.

At European level, the European Commission adopted and Member States endorsed the [Social Investment Package](#) (SIP) (European Commission, 2013), which stressed the role of high quality, integrated and personalised services in developing people's skills and capabilities, improving their opportunities and helping them to make the most of their potential throughout the life course. Having recognised that social services are not only a safety net, but a key part of society and thus fundamental in any social investment approach, the European Social Network (ESN) is reviewing the concept of integrated services from the perspective of public social services.

Social services play a key role in reaching out to those who are socially excluded, helping them to access services, conducting needs assessments, and providing care and support. Their role is key in the process of integrating support. Various models of integrated services have been outlined in the past (Munday, 2007), but with this report we aim to revisit how these are actually implemented across Europe and, in practical terms, how integrated social services assess needs, share information, plan, manage, deliver and evaluate integrated services to ensure better outcomes for users.

The European Social Network (ESN) has worked on the topic of inter-service cooperation in the past. Cooperation between social services and other public services such as education, employment or health was discussed in 2013 by directors of social services in ESN’s working group [‘Leadership, Performance and Innovation’](#). As a follow up, we published a [thematic paper](#) (European Social Network, 2014) describing challenges and opportunities of cooperation within the public sector and providing guidance for social service managers as to how they might want to reflect upon inter-service cooperation.

In 2014, we organised a peer review in the framework of the project [Investing in children’s services](#), where we looked at cooperation between children’s services in education, health and social services in several European countries. In 2015, ESN organised two working group meetings that looked at integrated support for [people with disabilities](#) and [for older people](#). Assessed practices from both meetings have been published in [ESN’s practice library](#).

ESN has been cooperating closely with the Dutch knowledge institute Vilans to write this report that analyses how social services provide integrated support with other public services, namely education, employment and health. The aim of this report is threefold: to analyse models of service integration from a public social services perspective (mainly at local and regional level), to look at integrated social services in cooperation with education,

employment and health, and to promote a process of mutual learning on integrated services between local and regional authorities. The report includes the following parts: an overview of recent social welfare developments, a literature review, a policy analysis, a review of practice examples, a selection of case studies, drivers and barriers of integrated services and policy recommendations.

Although welfare states differ throughout Europe, there are similar issues and developments regarding the organisation of social welfare, which impact on public service provision and therefore on the development of integrated services. These will be introduced in the first chapter of this report. The following chapter includes a review of peer-reviewed literature on the topic, which aims to present the current state of play on integrated services in Europe. The research covers the different ways integration may be understood between social services and at least one of the following three sectors: education, employment and health.

The next chapter, a policy analysis from selected countries, aims to provide an overview of policy and legislative frameworks that support or impede the implementation process of integrated services. The next part, a practice analysis, aims to look at how integrated services are currently implemented by local and regional authorities. The analysed practices were submitted by ESN members and reviewed along the question: *‘How current practice on integrated services is organised, what works, for whom and in what circumstances?’* An in-depth description of 9 selected local practices on integrated services is also featured.

Based on the outcomes from the literature and practice review, barriers and facilitators for integrated services will be presented in the report’s conclusion with input from ESN members at the seminar on integrated services in Manchester on 6 November 2015. Based on this input, ESN has also formulated recommendations for policy-makers, practitioners and researchers.

Methodology

This research project was managed by the European Social Network (ESN) and carried out in collaboration with Vilans, the National Centre of Expertise for Long-term Care in the Netherlands that worked with the National Youth Institute (NJI) and the Centre for the Development of Social Policy (Movisie) to cover the education, employment, health and social sectors. The project is based on a literature review and an assessment of 44 practice examples submitted by ESN members in local and regional authorities across 17 European countries.

The first phase of the project involved conducting a literature review. Using as guidance the research question *‘What is the current state of play on integrated services in Europe?’*, a systematic review of peer-reviewed literature was implemented. In order to search for data, we used the databases ‘PubMed’ and ‘EBSCO’. Because of the broadness of the research question, a number of criteria were established. We focused on studies written in English that had appeared in peer-review journals across Europe between 2010 and 2015. Next, we selected various search terms¹. A total of 60 articles were analysed in the end.

In addition to presenting the state of play, this research aims to capture the diverse understanding and implementation of the concept of integrated services at local level in Europe. Using as guidance, the research question *‘How current practice on integrated services is organised, what works, for whom and in what circumstances?’* we drafted a questionnaire to collect practices on integrated services from public authorities across Europe. The template aimed to identify how the initiative started and what the characteristics of the initiative were. ESN launched a call amongst its more than 100 members and we received 44 complete templates with practices from 17 European countries².

¹ For an overview of the database searches and generated hits, please refer to appendix I.

² All practices have been uploaded in ESN’s practice library.

We drew on Minkman's Development Model for Integrated Care³ to help us come up with a number of questions that guided our literature and practice analysis:

Figure 1: Guiding analysis questions

- ? What may be the reasons and aims for integrating services?
- ? How can integrated services be tailored to individual needs and how may service users be involved in design and implementation?
- ? How may integrated services be organised, delivered, and managed?
- ? How may integrated services' outcomes be measured?
- ? How may integrated services be funded?
- ? What may be the elements of success when integrating services?
- ? How may the transferability and sustainability of integrated services be ensured?

Recent welfare developments

A welfare state is a governmental system in which the state plays the key role in protecting and promoting the wellbeing of its population. It does so through the organisation of social protection and inclusion in the form of benefits and social services, health, employment support and education. Although welfare states differ throughout Europe, there are similar trends that have influenced public service provision and affect the development of integrated services. These include demographic ageing, the marketisation of service provision, users' involvement and users' choice, and service co-production.

Demographic ageing

Due to the ageing population, Member States across the EU have had to deal with trade-offs between increasing financial constraints and increasing needs. In many countries, long-term care needs are only partly addressed by public service provision and responsibility for care also lies with service users and their families. Many countries in Continental, Southern and Central–Eastern Europe have been refocusing on care provision by families in their recent long-term care policies (Ranci and Pavolini, 2015). This new policy orientation might provide an answer to the growing demand for long-term care and the rising cost of its provision. However, it might be perceived as a step back on measures taken towards a greater professionalisation of the sector and female participation in the labour market as they are generally the ones performing informal care.

In addition, long-term care policies have been focusing on increasing home care through cash payments or benefits in kind for service users, in order to reduce the number of people in need of support in residential care. Home support often requires additional resources provided by family members, especially women, volunteers and neighbours. This workforce at home or at community level needs to be considered when planning integrated services for children and families, for labour market participation and for older people. Financial and social support and skills training are needed to better equip informal carers for their care duties.

Older people predominantly express their will to stay in their own place as long as possible. Care that responds to multiple needs is increasingly delivered in an integrated form, for instance, by multi-professional teams from health and social care. The provision of integrated care also requires the development of new combinations of skills to support older people with chronic conditions, such as Alzheimer's (European Commission, 2013).

The marketisation of public service provision

The responsibility for service provision, that is to say, if services should be provided by the state or by the private market, has been discussed in recent years. The tendency towards service provision by non-public entities was promoted by the "New Management Approach" that emerged under the Thatcher and Reagan governments in the 1980s in the UK and in the US (eGovPoliNet). It argues for a more effective and efficient service and benefits provision in a market where increased competition should ensure lower costs.

This market of private providers (both for-profit and not for-profit) can be stimulated by the state by contracting or enabling service users to buy services with vouchers or cash payments. Moreover, the approach argues for fewer input controls and a stronger focus on performance and impact. Under the "New Public Management" approach, service users are considered as customers and civil servants as service managers. For example, in active labour market policies introduced by many European states, the civil servant acts as a case-manager by ensuring the accessibility of various services for the unemployed, with the aim to integrate the person into the labour market as soon as possible. This approach goes along a more coordinated provision of benefits, employment support and access to social services as suggested by the European Commission in its recommendation on the 'Active inclusion of

³ For additional information about the Development Model of Integrated Care, please refer to annex II.

people excluded from the labour market' (European Commission, 2008) to Member States. The Recommendation proposes national governments to develop strategies that integrate the provision of income support, employment support and access to quality services, including childcare, housing, debt counselling and health services.

'New Public Management' has also affected the universal model of welfare provision in Scandinavian countries. For example, the 'Act on Free Choice Systems' in Sweden was introduced in 2009 in order to encourage municipalities to implement voucher models that support service user choice and higher competition between service providers. In England and Sweden, the criteria for accessing care for older people were amended to focus on those most in need and on home care, and this led to an increase in non-public service providers.

In England, the 2006 Childcare Act on early years and childcare formalises the strategic role of local authorities in organising the local childcare market in the aim to 'close the gap' between the most and least well off children. The Act lies mainly on the logic of market as local authorities are not supposed to provide childcare directly but rather to work with private providers, local authority provision being the last resort (Brennan et al, 2012).

The 'New Public Management' approach has been criticised with the arguments that private sector methods such as standardisation do not reflect the individual circumstances in social work, and that the aim to increase productivity can have a negative impact on working conditions and service quality (Buestrich and Wohlfahrt, 2008). It has been argued that in Sweden, this approach led to a standardisation of tasks and to a larger number of service users per care worker (Ranci and Pavolini, 2015). In addition, the provision of for-profit childcare has caused debates in Sweden and opponents stress a threat for quality and class-based segregation (Brennan et al, 2012). However, marketisation also goes along with strong advocacy for service users' choice.

Service Users' Choice

Choice for service users contrasts with the traditional approach to welfare, as it empowers service users to decide which services they wish to use. Associations of people with disabilities in England, Sweden and Denmark have played a major role in advocating for more freedom of choice and flexibility (Brennan et al, 2012). Some reforms in social care for adults, such as the Support and Services Act 1994 (for persons with functional impairments) in Sweden (revised by the Social Insurance Act in 2010) or the 1996 Community Care (Direct Payments) Act in the UK aimed to provide more choice to service users through monetary transfers.

In long-term care, a number of states introduced reforms based on direct payments to service users, such as Germany's universal long-term care insurance, the APA ("Personal Allowance for Autonomy") in France and the Act on the Promotion of Personal Autonomy and Care for Dependent Persons (also called 'Dependency Act') in Spain (European Social Network, 2013). In Poland, there are discussions on whether to implement a system of choice, also in order to enhance formal care and boost the care market. As highlighted above, Sweden introduced a 'freedom-of-choice' system in 2009 encouraging municipalities to promote service user choice via a voucher system.

The idea under this model is that service users should be provided with purchasing power to establish new social care markets. Although direct payments and voucher systems enable service user choice, the marketisation of services may lead to complex care markets, which may be more difficult for service users to access. In many cases, the main incentive is not empowerment of service users but cost containment in the expenditure of public funds under the idea that competition between private providers should lower down costs (Brennan et al, 2012).

The fact that now local authorities are increasingly purchasing rather than providing services directly can lead to a fragmentation of the care market through the multiplication of private providers. In addition, the development of private care markets might hinder the possibility for public authorities to plan and coordinate the provision of services by multiple stakeholders. Local case managers stand between promoting freedom of choice for service users and competition between private providers, who compete against each other to bid for services delivery, rather than cooperate in service provision.

Co-production

In times of an increasing demand for services caused by demographic change coupled with pressure on public resources, the concept of co-production asks what role service users and the wider population play in service provision and how this correlates with the role of the state and the services market.

Co-production argues that the recipient of the services and people in the wider community also play an active role in the delivery of public services. It is based on joint service delivery by the service user and the provider and on the active involvement and participation of citizens (Pestoff, 2011). For example, the involvement of children and the need to listen to them in the provision of children's services was strengthened by a shift to see children as agents of their own life (Davis et al, 2012).

Therefore, co-production differs from the traditional model of public service production where only public officials are responsible for designing and providing services. Co-production is linked to the transfer of responsibilities for service management and delivery to the local level, as municipalities are closest to peoples' needs and concerns.

Recent examples are the decentralisation reform in the Netherlands (OECD, 2014) that aims to involve volunteer and community organisations in supporting vulnerable people, or draft bills put forward by the Spanish government to strengthen its third and social volunteering sectors (European Social Policy Network, 2015).

Co-production aims for more participative forms of service provision and closer involvement of community and voluntary organisations, and may lead to a reduction of costs, higher service quality and a more democratic process by involving the public in policy. Co-production is also a pre-condition for personalisation, which is about shaping services around the needs of service users.

Decentralisation

Some European countries have recently introduced laws that give more responsibility for the organisation of care to local authorities. In Sweden, the 'Ädel reform' of 1992 made municipalities completely responsible for the care of older and disabled people. Municipalities also became responsible for patients ready to leave hospital and are obliged to pay fees if a patient stays in hospital longer than needed.

In England, the 2014 'Care Act' has given local authorities new legal responsibilities to provide care and support services focused on service user empowerment, and choice and control. Local authorities 'are expected to shape the market primarily through commissioning quality, outcomes-based services focused on wellbeing' (Local Government Association, 2014).

In the Netherlands, major changes in the social sector happened in January 2015 with an important devolution of tasks from the national to the local level as the 'Youth Act', the 'Participation Act', and the 'Social Support Act' entered into force. Local authorities became responsible for the provision of welfare services, youth care, personal care, work and income.

Decentralisation in the social and health sector is the most visible example of major welfare reforms occurring in European countries over the past years, which has represented a considerable shift in the way public policies are planned and delivered. The shift involves not only the devolution of competences and resources at the local level but also the fact that local authorities are required to work in an even more integrated way especially because they have to cope with less financial resources. In this context, decentralisation appears as one possible answer to address the challenge of providing tailored and integrated services in a cost-efficient manner.

Crisis and fiscal constraints

In many countries, the economic and financial crisis resulted in increased demand for social services, coupled with reductions in public expenditure. In 2014, compared to 2008, around 9 million more people were out of work and the number of people at risk of poverty and social exclusion rose by more than 6 million people (European Commission, 2015 c.). Social protection expenditure played an important role in cushioning the impact of the crisis, whose effects on employment and income were smaller in countries with efficient social protection systems, activation measures linked to benefits, a greater availability of training and the use of short-time working arrangements (Ibid.).

In countries most affected by high unemployment and fiscal consolidation, social services have dealt with an increased number of service users (also often a new type of service users - those who were not in need of services before the crisis), reductions in their budgets and changing working conditions with reductions in staff numbers and salaries (European Social Network, 2015).

Furthermore, the implementation of reforms has been slowed down or postponed. In Spain, the implementation of the long-term care reform 'System of Personal Autonomy and Assistance to persons in situations of Dependence (SAAD)' was slowed down and some benefits were reduced (European Commission and the Social Protection Committee, 2014). In Italy, local authorities have undergone severe financial cuts in social care, while waiting times to access benefits have increased (Ranci and Pavolini, 2015).

Local authorities have had to find ways to react to decreasing revenue and increasing demand whilst maintaining service accessibility. Most of them had to concentrate on emergency measures, while access to services and benefits and eligibility criteria were tightened (European Social Network, 2015). These developments have caused a 're-thinking' process of public service provision by looking at efficiencies and savings through enhanced service cooperation. The integration of services can be seen as an answer to increasing needs and financial constraints.

Managing integrated services



International literature review on integrated services⁴

Using as guidance, the research question ‘*What is the current state of play on integrated services in Europe?*’ a systematic review of peer-reviewed literature was implemented. A total of 60 articles were analysed to identify the current state of play of public integrated services in Europe covering different ways of understanding joint service delivery between social services and at least one of the following sectors: education, employment and health.

Country spread

As the research project focuses on how social services may work with other sectors across Europe, we aimed to obtain a spread of articles from different countries. However, due to using English as the primary language of research, most articles came from the United Kingdom, followed by the Scandinavian countries (Sweden and Denmark), and a smaller number from France, Ireland, Romania, The Netherlands, Italy and Spain.

Even though the review covers various European countries, it has been difficult to carry out a cross-country comparison. There are multiple reasons for this: the substantial variation in the number of articles per country, the fact that publications are based on different research methods and the large differences in national systems and target groups that integrated support may address. Nonetheless, the retrieved articles made it possible to identify general trends, obstacles, and opportunities in integrated service delivery.

Collaborating sectors

The research focuses on improving knowledge about integration between social services with either one of more of the following sectors: health, education and employment. Consequently, various combinations of integrated services could actually be implemented to cope with new and increasing societal demands.

In this light, this study places a strong emphasis on mechanisms for integration forms that may take place across various sectors. We expect that these mechanisms that transcend cross-sectorial working provide the most interesting examples for the users of this study: those working in local and regional public authorities who may be interested in combining the support provided by social services with support provided by other public services.

Social services cooperation with other sectors		# of articles
One sector (n=37)	Health	33
	Education	2
	Employment	1
	Housing	1
Two sectors (n=14)	Health & education	6
	Health & other	4
	Health & employment	4
Three sectors (n=7)	Health & education & employment	5
	Health & education & other	2
Four sectors (n=2)	Health & education & employment & other	2
Total		60

Table 1: Social services cooperation with other sectors in the literature review

Table 1 shows the collaborating sectors that have been mapped. Whereas collaboration between social services and one other service (education, employment, or health) was most common, collaboration also took place often between social services and multiple other sectors. In fact, this was the case in 38% of the reviewed articles.

The findings reveal a divergence in the amount of articles per collaborative arrangement, e.g. there is a vast amount of literature on cooperation between social and health services, whilst there was no substantial literature on cooperation between employment and social services. This is the reason why, as explained above, we limit ourselves to describing trends rather than cross-country comparisons.

Target groups

Most articles mentioned the age group the integrated service arrangement served. Figure 1 shows that almost half of the articles focused on adults. There are also practices that focus on multiple target groups; for instance, children as well as their families. Services may even focus on all age groups. This was identified as a common approach in practices that aim to serve deprived neighbourhoods.

Target group by age (n=57)

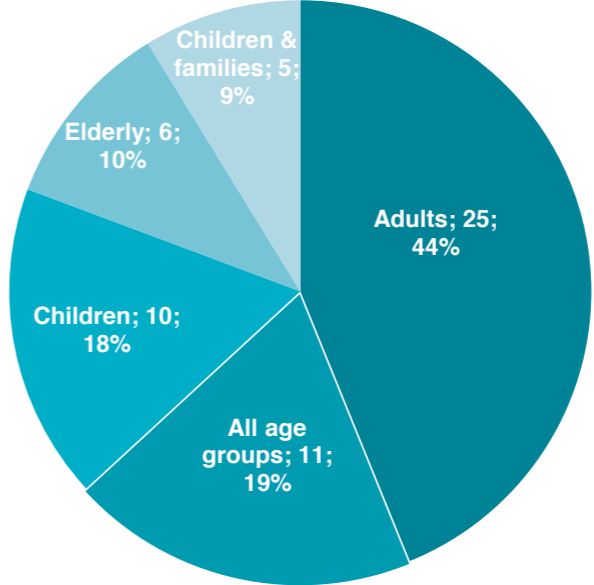


Figure 2: Target group by age

The analysis

The seven questions outlined in the methodology were used as the generic framework to describe the findings obtained in the literature review. Since the topic ‘integrated services’ is such a broad and diverse subject, the analysis may come across as abstract at times. In light of this, we have used examples of integrated services⁵ presented in the literature review to illustrate how the concept may actually be implemented.

⁴ For editorial reasons, the amount of sources has been reduced to the most relevant per issue addressed in the literature review. For a full list of references, please refer to the bibliography or contact the authors.

⁵ These are *not* the practices provided by ESN members. The latter will be presented in the practice review, discussed in pages 42-69.

? What may be the reasons and aims for integrating services?

We began by exploring the reasons as to why collaborating approaches or structures between social and other services may be set up; for instance, what triggered the collaboration and towards which common aims were professionals working when joint work started.

Often there is not just one clear reason as to why services may set up a collaborating/integrated structure and most of the time there are multiple drivers leading to integrated service delivery. There are a variety of drivers for intersectoral collaboration guided by policy and professional developments and the input of research.

In 25 articles, we found that services were integrated as a consequence of new policy (Duffin, 2010; Rudkjøbing et al, 2014). Literature shows that various trends may lie at the basis of new policies.

First, governments have seen the need to respond to societal challenges through actions encouraging integrated service delivery (Collins and McCray, 2012; Watson et al, 2014). As an example, the Swedish government noticed that the country was facing increasing rates of lifestyle related diseases, which led to an increase in health care costs. In light of this, the government developed the National Public Health Policy (2008) to create the necessary social conditions to stimulate healthy behaviour amongst Swedish citizens (Mahmud et al, 2010). The policy brought forward the so-called 'Health Square', in which health and social care professionals jointly promoted a dialogue with the population. Here, a central initiative had to be implemented at local level and therefore governmental action was required at both central and local levels. A second example may include a decentralisation of government's tasks leading to local authorities having to design new services to respond to their new responsibilities (Hunter and Perkins, 2012).

Second, the professionals' realisation that there are certain societal trends that can only be tackled through cooperation across sectors is also a reason for integrating services (Durie and Wyatt, 2013; Hunt, 2012). This is particularly the case when users fall under the competence of different services (Germundsson and Danermark, 2012) and services are fragmented (Hansson et al, 2010; Kellehear, 2013).

Third, research may be a driver for integrated service delivery when it documents that intersectoral work may be the best form of addressing complex needs. Integrated service delivery may also be inspired by other practices (Jormfeldt et al, 2014; Jormfeldt et al, 2014; Molina et al, 2013). That is, implementing a particular programme because the practice had positive effects in another location.

In this section, we also want to look at what the collaborating sectors may want to gain when setting up collaborating structures. Similar to the drivers of service integration, a collaborating joint effort may pursue multiple aims. The most frequently mentioned are: transforming the model of care, prevention, increasing efficiency and improving outcomes for users (see table 2).

Aim	# of articles
Improve outcomes for users	28
Improve service coordination	28
Reorient care system	24
Improve wellbeing	15
Prevention	7
Increase efficiency	6

Table 2: Aims of integrated services

With drivers such as new policy and practice and the input of research, the government may try to transform the existing models of care and wellbeing in order to achieve better outcomes (Devanney and Wistow, 2013; Green and Dicks 2012). Joining up structures in public service delivery can thus be perceived as a vehicle for such transformation.

These models of care may include community-oriented approaches (Durie and Wyatt, 2013; Kellehear, 2013), where community members become actively involved in the care of other citizens, and empowering people (Monaghan and Wincup, 2013), where people are enabled and encouraged to be self-reliant.

Prevention can also be the aim of service integration (Webber et al, 2013; Collins and McCray, 2012). For instance, by establishing joint case reviews in order to learn collectively from mistakes and prevent them from happening in the future (Manthorpe and Martineau, 2010). An interesting example of this approach is collaboration between mental health services and children's services in order to minimise the impact of parents' mental health problems on children themselves (Davidson et al, 2012; Hunt, 2012).

Another goal that is mentioned when joining up structures is increasing efficiency (Wilberforce et al, 2011; Williams, 2012), and in particular, becoming more cost-efficient, or producing a service as good as possible but reducing expenses through the implementation of a new collaborative arrangement (Molina et al, 2013).

Finally, improving users' outcomes is another main goal of integrated service delivery (Pasco et al, 2014; Carlisle, 2010). The pursuit of this goal places the service user at the heart of service delivery, but as we shall see next, this is not easily achieved.

? How can integrated services be tailored to individual needs and how may service users be involved in service design and implementation?

This sub-section looks at the difficulties and facilitators that practitioners may have encountered when trying to tailor services to the needs of specific groups. More specifically, we will look at how the reviewed literature captures ways in which users may be involved in service design and implementation.

In almost all articles (97%), user-centeredness is discussed. User-centeredness means tailoring integrated support provided by various services to the needs of a specific target group. Even if this is not the main aim of a practice, improving outcomes for service users seems to be of particular importance when integrating services. It is therefore interesting to explore how services may be tailored to the service user's needs and if service users themselves are included in the design of the collaborative arrangement. For example, the *Integrated Service for Looked After and Adopted Children (ISL)* in England (Golding, 2010) aims to gain maximum placement stability for children in care through inter-agency working. The collaborating organisations include social services, education and health. ISL underlines the significance of open communication lines between professionals and children themselves.

Analysing the selected articles from the literature review, we noticed that it is suggested that most practices are user-centred, or, more realistically, *aim* to be user-centred. Indeed, placing service users' needs at the heart of service delivery is a key reason to initiate intersectoral collaboration in the first place (Edvardsson et al, 2011; Jormfeldt et al, 2014).

In some cases, user-centeredness may go even further and approaches service delivery in a 'holistic' manner, which is recognising the whole person as a partner in service delivery and engaging the person's surroundings in the process (Hansson et al, 2010; Mahmud et al, 2010). Implementing this approach implies that a service does not target the users' problems

separately but it appreciates the interdependency and the relationship between the various issues at stake, herewith underlining the importance of integration between support provided by different sectors. However, tailoring services to the needs of service users does not automatically facilitate integrated services and the literature review indicates that practices may intend to be user-centred, but may not operationalise the aim (Collins, 2012; Hansson et al, 2012).

Various actions can be carried out in order to tailor services to the needs of the service user. These may include: clearly defining the target group (Bousquet et al, 2014; Smith et al, 2013); developing a relationship with the community (Richardson et al, 2012; Svendsen, 2010); delivering services 'seamlessly', for instance by increasing the coherence between health care and social care services (Williams, 2012); and creating support services for the target group and their environment (Mahmud et al, 2010; Molina et al, 2013; Bousquet et al, 2014).

However, the literature review shows that involving users in service design and implementation is easier said than done. While integrated service delivery is said to focus on the users' needs, the actual collaboration is mostly based on relationships between the organisations. Professionals may also lack the necessary skills to involve users (Belling et al, 2011) or take a one-size-fits-all approach, where users are expected to conform to the service's standards and priorities, rather than to their individual's needs (Monaghan and Wincup, 2013). These would hinder service users' involvement and participation.

Overall, user-centeredness can be perceived as a driver behind most integrated service delivery. Even though there are various pitfalls collaborating organisations may come across, literature shows that it is worthwhile to strive for a user-centred practice, as it improves both user's wellbeing (Kellehear, 2013; Harrison, 2011; Germundsson and Danermark, 2012) and user satisfaction (Hansson et al, 2010). Moreover, focusing on the service users helps to strengthen links between the collaborating organisations (Davies et al, 2013).

? **How may integrated services be organised, delivered, and managed?**

It is evident that steps need to be taken to establish an arrangement that supports intersectoral working when integrating services. Here, we will look at the logical chain of integrated service delivery and the requirements highlighted by the literature review when integrating support provided by various services. First, we will address ways of organising inter-professional teamwork, including facilitators and obstacles. In the process of setting up a multi-professional collaborative arrangement, we will emphasise the significance of having clear roles and tasks and we will discuss leadership. The section will end with the various forms that inter-professional collaboration may take in practice.

Organising inter-professional teamwork

Inter-professional working refers to a committed group of professionals who agree to work beyond 'silos' and collaboratively target a specific population. Inter-professional teamwork is the core of intersectoral collaboration, and in fact, it was implemented in 88% of the studies analysed in the literature. Multidisciplinary teams are used to serve service users and can also be implemented at managerial level (Borys et al, 2012); for example, to steer the practice and create joint working guidelines and training for practitioners in the front line.

An example of multi-professional working is the *PSP model* in Denmark (Sestoft, 2014), where multi-professional working is encouraged at managerial and practitioner levels. The PSP involves a partnership between three public sectors: social care, mental health, and the police. The aim of the programme is that vulnerable individuals, with whom professionals from various sectors work, do not get lost in the system. Practitioners perceived cooperation

as positive, and as a way of enhancing prevention and follow-up. There was also an improvement perceived amongst service users.

Similar to user-centeredness, merely mentioning inter-professional teamwork does not automatically accomplish it. Although multiple articles demonstrate that integrated service delivery is dependent on inter-professional teamwork, teamwork may not always be successful. In some cases, professionals simply continue their traditional way of working in silos, rather than through collaboration across sectors (Duffin, 2010). Moreover, the complexity of intersectoral working may be underestimated. Aspects such as cultural differences and the ambiguity of roles are key obstacles for successful inter-professional working (Collins and McCray, 2012) and may even lead to conflict between those involved (Germundsson and Danermark, 2012).

Another issue is competing priorities and loyalties. Practices may prioritise collaboration with service users over collaboration between professionals (Hunt, 2012) or find their organisation's own ideologies more important than inter-organisational team spirit (Carlisle, 2010). Even with the intention to encourage inter-professional teamwork, practitioners may overshoot their mark. For example, by emphasising the importance of structures rather than focusing on the essential relational aspects, such as building goodwill and trust (Hunter and Perkins, 2012).

Nevertheless, successful practices of inter-professional working also exist. Though not always operating smoothly, in the literature review, we identified 12 cases, where practitioners do actually collaborate successfully with each other. Intersectoral collaboration may be based on diverse forms, such as joint assessments (Petch et al, 2013), joint care plans (Bousquet et al, 2014), joint case-management (Green and Dicks, 2012), an inter-organisational steering committee (Green and Dicks, 2012), or working together in the same location (Hansson et al, 2012). Working together in the same location – also referred to as 'co-location' – helps to manage the cultural differences, while simultaneously improving information sharing (Hansson et al, 2012; King et al, 2012).

In sum, though inter-professional working is often mentioned as an example of integrated service delivery and may take many forms, it is easier said than done and it is not always operationalised. Nonetheless, the literature showed that there are various interventions to facilitate collaboration, such as joint assessments, joint care plans, joint case-management and co-location.

Roles and tasks

As outlined above, it might be difficult to form an effective inter-professional team. Even though there may be the will to make it happen and structural issues such as protocols, guidelines, and co-located facilities may be in place, it seems that a certain aspect is often neglected: the human side of collaboration. The literature review also reveals that when organising inter-professional teamwork, identifying and demarcating 'new' roles and tasks is key.

An example of a multi-professional team that has not always been successful is the *Health and Social Care Consortium* in Sweden, which has joint care coordinators from the health and social care sectors. They are based in the same centre and implement joint care plans. Even though the structural elements are in place, it has been documented that the collaboration does not always run effectively due to lack of knowledge about one another or lack of mutual understanding (Germundsson and Danermark, 2012).

The literature indicates that besides focusing on structural arrangements, rather than on human issues (Hendriks et al, 2012; Hunter and Perkins, 2012), many difficulties in inter-professional teamwork can be linked to dominant organisational cultures (Durie and Wyatt,

2013), a lack of clarity about new roles (Smith and Barnes, 2013), or a lack of general knowledge about one another (Germundsson and Danermark, 2012).

Then, what can professionals do to collaborate successfully? A factor that stands out in the reviewed literature is clearly identifying and understanding each other's roles and responsibilities (Hunt, 2012; Webber et al, 2013). An interesting way to stimulate professionals' mutual understanding is the establishment of virtual teams. In Scotland, as part of the implementation of the electronic single shared assessment, which aims to create a comprehensive record of older people with complex needs, there was an encouragement to create virtual teams of professionals coming from different sectors. In this joint programme, IT channels were used to improve communication and understanding between the professionals involved (King et al, 2012).

To summarise, the literature shows that it is essential to consider the *people* that are involved in the collaboration. Not only does openness and clarity about roles and tasks help prevent intergroup-conflict (Collins and Mccray, 2012) and issues related to trust and confidentiality, clear roles and tasks also lead to better regulated interaction (Rudkjøbing et al, 2014) and increased team effectiveness (Collins and Mccray, 2012).

Leadership

What has been discussed so far helps to unravel some of the complexity inherent to intersectoral working. In light of this complexity, leadership may be an important driver of success. Therefore, we explored how leadership is addressed in the reviewed articles; for instance, what are the examples of leadership and what difficulties may the leader of an integrated service structure may come across.

In the literature review, we identified various arrangements that facilitate the management of integrated services. For instance, the co-location of staff (Petch et al, 2013), or collaborative leadership, where the leadership is shared between various people (Williams, 2012). Another facilitating factor may be to appoint independent leaders with dual disciplines (Wilberforce, 2011; Léveillé and Chamberland, 2010), as this may make it easier for leaders to relate to professionals from different sectors.

For example, *Serious Case Reviews (SCRs)* in Wales were established to learn from mistakes in safeguarding adults. In such reviews, cases are reviewed retrospectively by the involved agencies, which appoint an independent chair. As a neutral person takes the lead, practitioners feel more at ease, which has been documented to contribute to the success of this practice (Manthorpe and Martineau, 2010).

However, the studies also identified difficulties in relation to leadership, including a lack of confidence in the leader (Davidson, 2012), a perceived imbalance in power (Mahmud, 2010), and insufficient support and guidance (Devanney and Wistow, 2013; Edvardsson, 2011). In fact, there may not even be a team leader at all (Smith and Barnes, 2013).

This can lead to confusion and lack of guidance, which hampers the implementation of an intersectoral working arrangement. Moreover, the absence of a leader may lead to complications in the deployment of resources (Devanney and Wistow, 2013). Nonetheless, careful selection in choosing the leader is required to ensure that the leader has appropriate training in managing a multi-professional team (Belling, 2011). This is particularly the case as managing integrated services may be complicated by the increase in staff as a consequence of the collaborative arrangement (Rani, 2012).

In light of the complexity of integrating services, support and guidance as well as clarity about roles and responsibility are key to success when implementing integrated support provided by different sectors. The leader can play a key role in bringing together

professionals from various sectors; for this, he/she needs to be equipped with the resources and skills to cope with the complexity of the arrangement.

Delivery

Although the human side of collaboration requires special attention (roles and tasks, leadership), structural arrangements deserve attention, too. These include mechanisms and procedures that streamline the process of bringing together and delivering different forms of support in an integrated manner, such as information exchange platforms and the use of ICT.

The delivery system encompasses many components, which mainly relate to the way communication takes place between professionals and users as well as between professionals themselves. As communication is an important aspect of collaboration, a shared delivery system can be the basis for integration (Mahmud, 2010; King, 2012). ICT in particular becomes increasingly important in ensuring effective delivery. Collaborating agencies can for instance use shared electronic records to integrate service delivery (King, 2012).

Although ICT becomes increasingly important, there are also obstacles related to the use of ICT. For instance, individual agencies may only be able to access part of the records (Hansson, 2010), the IT systems of collaborating agencies may be incompatible (Davidson, 2012; Hall and McGarrol, 2013), or there may not be a shared electronic system at all (Pittam, 2010). Another challenge revolves around privacy, as information sharing between organisations may lead to confidentiality issues (Hansson, 2012).

A way of streamlining the delivery process is the implementation of shared assessment or shared care plans (Hamonet-Torny, 2013; Miller and Cameron, 2011). Yet, this can be hard to achieve, as the integrated practice that developed a *Common Assessment Framework (CAF)* in the UK shows. The CAF was implemented to encourage a common way of assessing and responding to children's needs. However, due to different backgrounds, collaborating professionals used the CAF in different ways, which has had the opposite effect and sometimes led to a mismatch between the user's needs and the services offered (Collins, 2012).

Clearly, the mechanisms and procedures that streamline integrated service delivery should be given careful consideration. In fact, neglecting this aspect may lead to issues around accessing information (Hansson, 2010; Webber, 2013), time delays (Belling, 2011), uncertainty about which pathway a service user needs to follow (Hemmings and Al-sheikh, 2013), slow decision-making around confidentiality issues, and fear of losing control amongst professionals (Hansson, 2012).

In other words, investing time in the development of a well-functioning delivery system has many advantages. Literature shows that it stimulates information sharing between agencies and provides clarity about where users need to go for particular services, minimises duplication and repetition (Devanney and Wistow, 2013), and helps integrated service delivery to become more coherent and seamless (Williams, 2012). An example of such approach is the *Community Integrated Intermediate Care Service* in Wales, which was a collaborative effort between health and social services to provide services at home. By integrating services, co-locating facilities and operating through a single point of contact, service provision became more coherent and seamless (Williams, 2012).

? How may integrated services' outcomes be measured?

Measuring the effects of practice is key to improve its effectiveness and therefore its quality. However, as we shall see, measurement does not always take place due to a variety of reasons, and this has also an impact on quality.

It is striking that only 13 out of the 60 reviewed articles mentioned monitoring and evaluation. This may be due to a lack of reference to performance management or the fact that data is not (yet) solid enough. First, evaluation or monitoring may simply not be carried out. Practices may refrain from regular monitoring due to their lack of capacity (Hunt, 2012). It may be also due to their lack of appropriate tools to measure the inputs and outputs of an intervention (Goodman, 2011). This makes it difficult to track the impact of the intervention over a longer timeframe.

As for articles that refer to performance monitoring, in one of them (Borys, 2012), evaluation and monitoring was introduced at various levels by means of collecting information on processes and outputs, but also on outcomes indicators. In another case (Ojo, 2012), the contract between stakeholders was monitored and evaluated with key performance indicators, reviews and teleconferences.

However, in other cases, those managing the integrated service structure may request feedback through a tick box survey, which merely reinforces their policy goals and aspirations and is unlikely to be successful (Devanney and Wistow, 2013). Constructive criticism, such as valid feedback that may help to improve the service, monitoring and evaluation would be more helpful in identifying bottlenecks and enhancing performance and results for service users.

Service quality: effectiveness

Monitoring and evaluation are not the only aspects that contribute to the performance of service delivery. We also explore other elements that may enhance service quality; for instance, whether there is evidence regarding its effectiveness.

A concern that is frequently mentioned around quality is the lack of evidence about effectiveness (Taylor-Robinson, 2012; Miller and Cameron, 2011). The lack of evidence can have a direct impact on delaying the development of intersectoral collaboration (Hendriks, 2012). Although many authors plea for more evidence-based practice, the fact that collaboration takes place across sectors makes it difficult to evaluate effectiveness, as different sectors may value evidence differently (Taylor-Robinson, 2012), and it is not easy to decide what good evidence may look like.

On a positive note, the amount of evidence is increasing (Watson, 2014; Stickleby and Hui, 2012). In fact, ten of the reviewed articles indicate that the practice is based on evidence. For instance, stemming from empirical research (Bousquet, 2014; Chamberlain, 2012), from other practice examples (Monaghan and Wincup, 2013; Smith, 2013), or both combined (Borys et al, 2012). This is a promising development for future integrated service practice; as the creation of an evidence base encourages mutual learning and the development of an increasing body of evidence to base further integration on.

All in all, even though measurement of a practice may enhance integrated service delivery, due to a variety of reasons it is often not carried out. This might influence the quality of the service, as often there is no evidence as to what the effects may be. Taking this into consideration, it would be helpful if practices were based on elements, which have proved to work. Moreover, through continuous assessment, bottlenecks can be identified and actions can be taken to correct them, as continuous monitoring and evaluation are key to improve practice quality.

How may integrated services be funded?

Financial arrangements are a key element when deciding upon a certain service structure. However, most articles are not explicit about the funding arrangements – only 22 out of 60 mention them. Therefore, it is not easy to establish how practices may be financed or where the funding may come from. There could be governmental funding available for integrating various forms of support coming from a range of sectors. However, it may also happen that as the organisations are requested to deliver integrated services, they would need to fund the arrangement themselves.

Four articles indicate that pooled budgets in combination with joint contracting of services may be an option in integrated service delivery (Devanney and Wistow, 2013; Williams, 2012). When individual agencies commission integrated care individually, the different organisational budgets may lead to fragmentation in commissioning and implementation of services. Combining funds from different organisations - also referred to as 'pooled budgets' - may help overcome this issue. Nonetheless, it is not without difficulties as there may be concerns about resource distribution between the various organisations involved (Devanney and Wistow, 2013).

Besides, there never seems to be sufficient funding. There may be a lack of funds due to financial savings (Hansson, 2010). It may even be that the practice is completely dependent on governmental funding and that practitioners have no influence on the budget (Green and Dicks, 2012). Even if there is external funding to finance the coordination/integration process, after an initial period, collaborating organisations may need to come up with funding by themselves (Chamberlain, 2012; Blanchard et al, 2013).

Though funding may frustrate the integrated services' process, not much is said about how to overcome the issue. Indeed, the authors tend to refrain from being specific about funding arrangements. Pooled budgets have been referred to as an option to overcome financing fragmentation, but concerns have also been raised in regards to resource distribution between the organisations involved in the arrangement.

What may be the elements of success when integrating services?

The various aspects we have been discussing around user involvement, the organisation of service delivery, management and leadership, funding and evaluation all play a role in ensuring success. In addition, it is worthwhile to consider three more aspects that may further stimulate success in integrated services: the commitment of the stakeholders involved, the professional learning climate and innovation.

Commitment

Whether all relevant stakeholders are aware of the inter-dependencies between sectors and whether they are all on board is fundamental in the process. Often professionals' busy schedules constitute a difficulty. In fact, the most common issue regarding commitment is that practitioners give a lower priority to inter-professional working than to other tasks (Collins and Mccray, 2012; Golding, 2010). It deserves to be noted that this does not necessarily mean that practitioners are unwilling to collaborate. It could be that professionals are unclear as to what is the purpose of integrating services and they may feel it is not useful to spend much time on this process (Mahmud et al, 2010), or that there is a lack of time and resources (Davidson, 2012; Edvardsson, 2011).

Insufficient time may lead to poor communication, which in turn can cause conflicting decisions and rivalry within the inter-professional team (Golding, 2010). In addition, a perceived lack of commitment may discourage others (Germundsson and Danermark, 2012).

As highlighted by the *Champion's Initiative in Northern Ireland* (Davidson, 2012), a way to prevent this may be to identify in each team a champion with responsibility for addressing difficulties to improve joint working.

However, we also assessed articles that mention the presence of highly committed stakeholders. In these cases, the professionals involved usually understand what they are spending their time on, and have clarity about the goals and purpose of the process (Webber, 2013). Besides the aim, the effects of the practice should be perceived as important (Molina, 2013; Richardson, 2012).

As differences between organisations may hamper commitment, it is helpful to collectively develop a shared vision or aim for practitioners to work towards (Williams, 2012; Pittam et al, 2010). This facilitates a feeling of commitment as well as trust among professionals, who should have sufficient mandate for action (Borys, 2012; Miller and Cameron, 2011) and also be allowed freedom and space to exert their own opinions and judgments (Bousquet, 2014).

Learning

Training can play a key role in ensuring the success of the integrated services process. In many cases, professionals receive training in order to prepare them for the new way of working (Chamberlain, 2012; Chiatti, 2013). This can take place before they start working in the collaborative arrangement as well as during the process.

But training is not the only manner in which learning may be stimulated, practices can opt for team meetings to share experiences and advice (Rani, 2012; Blanchard, 2013) or feedback sessions between the collaborating partners (Rudkjøbing et al, 2014; Petch et al, 2013). The collaborating actors can also learn from each other by identifying best practice and gaps (Hunt, 2012) and combine those with information from monitoring and evaluation to inform the development of new goals (Borys, 2012).

In addition to team learning, stakeholders can choose to focus on a more 'individualistic' type of learning; for instance by having practitioners reflect on their own practice (Léveillé and Chamberland, 2010) or self-evaluating themselves (Hogg and May, 2012).

Innovation

Integrated public service delivery can be perceived as a search for new ways of working with a specific target group. The most evident facilitator for integrated services as described by the literature is autonomy (Germundsson and Danermark, 2012; Jeffers, 2011). Professionals should have enough space and time to test new ways of inter-professional working (Germundsson and Danermark, 2012). Moreover, the stakeholders need enough space to take into account local considerations in implementation (Monaghan and Wincup, 2013; Borys, 2012). In this light, it is very important to make the practice more centred on locally identified needs. Besides encouraging innovative behaviour amongst practitioners, it is also helpful to make innovation a priority on paper (Manthorpe and Martineau, 2010; Hansson, 2012).

Nonetheless, the complexity of integrated working should not be underestimated (Davies, 2013). If there is one thing we can learn from this review, it is that intersectoral professional collaboration is difficult and there should be room for concerns expressed by each organisation involved (Davies, 2013) as practitioners can learn from this process and strive for innovative ways of working.

How may transferability and sustainability of integrated services be ensured?

Integrated service delivery may be inspired by other practices. That is, implementing a particular programme because it had positive effects in another location (transferability). However, as we shall see, a number of elements play a role in ensuring the successful implementation across settings. Another key element is how the effects of a practice may be sustained for a period of time (sustainability).

Transferability

Transferability may be understood in two ways: whether a practice comes from an already existing practice at another location, or whether the design of the practice in question is transferred to another context.

Only 9 out of 60 articles were specific about the transferability of the integrated service delivery that they covered. Four articles indicated that the analysed practice was based on another program (Durie and Wyatt, 2013; Jormfeldt, 2014); two of which were additionally rolled out at another location (Richardson, 2012; Borys, 2012). Five other collaborative arrangements were mentioned to have been implemented at other locations, but did not specify the origin (Léveillé and Chamberland, 2010).

In most cases, context-sensitivity is advised when contemplating the transferability of a practice (Golding, 2010; Blanchard, 2013). In other words: paying attention to local factors that may influence the practice, as the instances of service integration are not blueprints that can simply be implemented in any other location. It may not be easy to transfer the practice due to the lack of consistency among the national systems in each practice (Golding, 2010).

Awareness of the initiative that you may wish to transfer to your own context is key. Local authorities should know first about different programmes and their effects in order to consider implementing them, but as highlighted earlier on, there is a lack of evidence of practices that work.

Sustainability

Sustainability can be interpreted as the continuation or endurance of the changes of a specific programme, once the programme (and its funding) has come to an end (Mahmud, 2010).

Few studies indicated that additional research on the sustainability of the respective practice was being carried out (Pasco et al, 2014). Other studies indicated that the practice presented a sustainable solution (Molina, 2013) or a sustainable method of working (Smith and Barnes, 2013), but did not indicate why. In general, articles often focused on the elements that practices consisted of and how they developed or grew, rather than on their effectiveness or sustainability (Abendstern et al, 2012).

Sustainability can be influenced by a number of elements. Organisational restructuring is not enough to ensure the sustainability of the service integration process (Wilberforce et al, 2011) and may even frustrate the process (Devanney and Wistow, 2013). Indeed, not only the organisation itself, but also the system where it is embedded has an effect on continuity. In light of this, it is vital to consider issues that play a role in the wider system (Chamberlain et al, 2012). For instance, a sectoral, or even societal, paradigm may be needed to ensure sustainability (Jormfeldt, 2014; Carlisle, 2010). As an example, fighting stigma facilitates user-involvement in the design of mental health services (Jormfeldt, 2014).

Policies may hamper the sustainability of a practice in various ways. For instance, when there is a shift in policy priorities (Devanney and Wistow, 2013) and there is no longer a

recommendation to facilitating integrated services. On the other hand, the development of policies may also be helpful to foster inter-organisational collaboration (Pasco et al, 2014; Léveillé and Chamberland, 2010). In this light, lobbying with policy-makers to develop policy plans that emphasise the practice's goals may increase the sustainability of the practice (Richardson, 2012).

The organisations' interests may also shift (Taylor-Robinson, 2012; Smith and Barnes, 2013) and as a consequence, less effort will be made towards developing and maintaining the collaborating arrangement. Tension inherited from integrated working may complicate the continuity of the practice (Sestoft, 2014; Miller and Cameron, 2011). For instance, the need to develop standardised processes whilst ensuring flexibility when working with service users may be paradoxical (Miller and Cameron, 2011). Other issues that may impede sustainability are a short-term focus (Goodman et al, 2011), or undervaluing the practice's aims (Taylor-Robinson, 2012).

The literature indicates that developing structural and procedural mechanisms that support the implementation of the service is helpful (Hunter and Perkins, 2012). This is especially true when taking a multi-systemic approach, that is: encouraging changes at national level as well as at local and organisational levels (Léveillé and Chamberland, 2010).

Securing resources constitutes another potential challenge to ensure the practice's continuity. In addition to securing resources, there may be concerns regarding resource allocation in the joint arrangement (Devanney and Wistow, 2013). A possible way to cope with such issues are public-private partnerships (Borys, 2012) in an attempt to secure a larger budget or a clear financial model (Chamberlain et al, 2012).

The literature highlights that genuine commitment at all levels is required to ensure continuity. Indeed, professionals' commitment to a common goal (Hunter and Perkins, 2012; Svendsen, 2010) helps facilitate the continuity of a practice. In relation to this, we identified trust as a crucial ingredient for integrated working's sustainability (Taylor-Robinson, 2012). It is important to facilitate interaction between professionals; for example, through arranging meetings and encouraging dialogue between practitioners (Hunter and Perkins, 2012). On a related note, clear communication (Taylor-Robinson, 2012), contact between different sectors and governance levels (Sestoft et al, 2014), and joint training sessions (Belling, 2011) contribute to sustainability as they improve the collaborating competence of the professionals involved and improve their knowledge of one another.

To sum up, sustainability may be affected by factors at all levels: from changes in policy and legislation at national or regional levels to interaction and commitment among the professionals involved. They all play a key role in ensuring the continuation of the integrated services process, but it is particularly important to ensure financial resources and document the effects of the practice.

Policy frameworks for integrated services

This chapter aims to identify policy frameworks across Europe that may play a role in either stimulating or impeding progress in integrating care and support initially provided by different sectors.

The identification of policy frameworks, which may have supported integration, represents a learning exercise that may enable new forms of integration elsewhere. However, experience from European projects suggests that there is a gap between the rhetoric and practical implementation (Jarrett et al, 2009) which may be due to the lack of clarity about what integration actually means, overly bureaucratic governance arrangements, limited resources, inadequate leadership, professional, institutional barriers and cultural barriers (Williams and Sullivan, 2010). All of these issues are highlighted both in the literature and in the practice assessment.

The policy frameworks described below belong to the countries from which we have gathered practice examples. The selection is not exhaustive but it is an illustration of some of the policy frameworks that exist across Europe. The chapter is distributed in three sub-sections: policies for integrated children's services, policies for integrated employment and social services, and policies for integrated health and social services. Under each sub-section we have selected various countries to provide an illustration of specific policy frameworks. The aim was to review main policy trends to draw some conclusions around the main drivers for policy on integrated services and how these policies are actually implemented in practice. Finally, we attempted to group the countries according to the various frameworks identified.

Policy frameworks for integrated children's services

The development of care services over the years has reflected advances in policy and practice in caring for children, a new understanding of the nature and extent of child abuse and neglect, broader changes in the place of children in society and an increasing focus on children's rights. There has been an increased recognition of the significance of child development, and therefore the importance of a child's early years. Early intervention and prevention are seen as key to children living healthy, fulfilling lives and growing up to be responsible citizens. The coordination between different sectors, the integration of needs assessment and service planning, and the need to involve the child, the family and wider network in assessment and planning is recognisable in local public social services in a number of European countries.

The rationale of integrated children's services policy is that in order to improve the outcomes for children and therefore improve their life chances, a more holistic approach to their needs is required (Scottish Office, 1998). Various policy programmes for children's services have sought to put into practice key principles to ensure that public services provide full and appropriate support for children and young people.

These have translated in different ways in which agencies may work together (Cameron and Lart, 2003, Atkinson et al, 2001). Some examples include working at strategic level, where joint planning and decision-making takes place; placement schemes, such as social workers working in schools or in primary care divisions; centre-based service delivery, where professionals from different agencies work together in one site (although not necessarily in an integrated manner); a co-ordinator pulling together different services; multi-agency teams, where professionals from different agencies work together on a day-to-day basis as a team; and case-management, where a professional has responsibility for ensuring a co-ordinated service for families.

Belgium

In the field of children's policies, the federal government produced in 2013 and 2014 annual plans with the aim to develop an integrated framework in the fight against child poverty. The key principles guiding these plans are: an integrated approach in line with the 3 pillar approach of the European Commission's Recommendation on investing in children (Official Journal of the European Union, 2013), multi-level governance, and alignment with the aim of achieving the poverty target in the Belgian National Reform Programme (Official Journal of the European Union, 2014) and a focus on horizontal and vertical coordination.

Finland

When it comes to children and families, the most important acts in Finland are the 2014 'Social Welfare Act', the 2014 'Student Welfare Act' and the 'Government Decree on Child Healthcare, Schools and Student Healthcare'. These acts emphasise the importance of multi-sectorial approaches to the organisation of services for children and families. For instance, the 'Social Welfare Act' states that social welfare must be implemented in collaboration with actors in different services in a holistic way taking into consideration the clients' interests.

The responsible social welfare official has to ensure that the right professionals are involved to evaluate and fulfil the service user's individual needs. The law is implemented through a programme called KASTE (National Development Programme for Social Welfare and Health Care) around the idea that social welfare and health care structures and services are to be organised in a person-oriented and financially sustainable way, along the lines of the 'Social Welfare Act'.

France

A government initiative, called the 'County Family Support Plan' (*schémas territoriaux d'aide aux familles*), was designed to try to overcome services fragmentation for children and families. The family support plans are managed by the State, the Family Allowance Fund (CAF) and the county council. These integrated plans include dimensions such as information, early childcare, home services and mediation. It serves to formalise the involvement of all stakeholders on a given territory.

In the field of child protection, the 2007 legislation focused on prevention and established a single, acknowledged coordinator for all social and family policies (the president of the county council). This global approach is supported by new tools: a county observatory gathering all stakeholders, a multi-annual and a multi-stakeholder plan for child protection.

Sweden

New regulations have been introduced in the 'Social Services Act' in regards to the municipalities' responsibility in regards to child protection. The National Board of Health and Welfare together with the National Agency for Education have published guiding materials to help professionals in social services, health care and schools to identify early signs of neglect and work cooperatively to support children who may need care.

The UK

The underpinning principles of child protection are similar across the four countries of the UK, with the welfare of the child being paramount and parental rights not superseding the needs of the child. The systems and services for protecting children across the UK, however, are often different.

For instance, in Scotland the support for vulnerable children takes place within the wider framework for supporting all children and young people; the *Getting it right for every child* (GIRFEC) framework (Scottish Government, 2015). GIRFEC is a change programme for children's services that seeks to put into practice a series of key principles that ensure public services provide full and appropriate support for children and young people. GIRFEC has three key elements. First, a holistic approach to wellbeing, where wellbeing has eight components against which children and young people are to be considered: safe; healthy; achieving; nurtured; active; responsible; respected; and included. Second, a named person who acts as a single point of contact who could be approached by families, children and young people themselves, and other professionals where there are concerns raised about individual children. Third, a child's plan or a single planning document around the needs of children and young people who require additional help than 'standard services'.

The elements were enshrined in the 'Children and Young People Act', which defined wellbeing in statute and set out duties on local authorities and health boards for ensuring all children and young people up to the age of 18 have access to a named person and those requiring a child's plan receive one. The duties are expected to commence in August 2016, though named persons and child's plans are currently provided across much of Scotland in any case.

Policy frameworks for integrated employment and social services

Reflecting the increased importance of activation measures across Europe, almost all Member States have implemented some reforms to improve the performance of public employment services (PES) during the late 2000s. In most cases, this entailed introducing administrative incentives (alongside the approach of new public management), increased managerial autonomy and various forms of decentralisation; for instance, incentives for closer cooperation with social services, or even service integration at local level (Mosley, 2011; Struyven, 2004).

In most EU countries, PES have become the main agent of employment and social policy, responsible for both the newly registered and the long-term unemployed. As Table 3 (European Commission, 2015 b.) shows, twelve Member States have transferred both benefit administration and services to the PES, for both the newly registered and the long term unemployed. Just in three countries, these functions are integrated but they may be served by either joint PES-local authorities offices (in Norway) or just by the municipalities (in Denmark and Poland). Several Member States have integrated some functions (usually service provision) for all unemployed but kept benefits payment separate. In a few countries, PES are solely responsible for the insured unemployed, and in a few of these (Germany and Finland) they are also jointly responsible for the long term unemployed together with the municipalities.

Client Group	PES	Joint Offices	Municipal
UI only	CY, DE, FI, IT, NL		
UA only		DE, FI	DE, NL
UI for all functions, UA for ALMP only	AT, BE, EE, HU*, LT, LV, RO, SI		
UI and UA for all functions	BG, CZ, ES, FR, GR, HR, IE, LUX, PT, SK, SE, UK	NO**	DK, PL

Table 3: Role division between PES and municipalities in EU Member States in 2014⁶

⁶ Source: European Commission, 2015 b. (written by Agota Scharle) based on Mosley, 2011; EEPO PES Business Model, 2014; and Peer Country reports. Note: UI= Insured Unemployment benefit, UA=Unemployment Assistance (for those who have exhausted or have not qualified for UI), ALMP= Active Labour Market Policies.

Denmark

Until 2007, a two-tier implementation system was operating in Denmark. The ‘insurance branch’ served the insured unemployed and activation policies were the responsibility of the 14 regional PES offices, while the ‘social assistance branch’ was delivered by the municipalities that provided activation measures for the uninsured and issued means-tested social benefits (Bredgaard and Larsen, 2009; Weishaupt, 2011). The coordination between the local PES units and municipalities was limited to information exchange (Hendeliowitz and Woollhead, 2007).

In 2007, the local government reform reorganised the governance structure of Denmark. Instead of the previous 271 municipalities, 98 larger municipalities were created and the 14 counties were restructured into five administrative regions. The reform intended to address the problem that many municipalities had been unsuitably small to solve tasks efficiently and lacked sufficient capacities of planning (Hendeliowitz and Woollhead, 2007; The Danish Ministry of the Interior and Health, 2004).

Regarding employment policy, the reform brought a shift of responsibility from regional PES offices to municipalities, often labelled as the “municipalisation” of the Danish labour market governance system (Weishaupt, 2011; Weishaupt, 2014). 91 jobcentres were opened at the local level (the seven municipalities with less than 20,000 inhabitants do not have a separate job centre, but are in binding cooperation with neighbouring larger municipalities). Under the roof of jobcentres, the PES services and all municipal services for the uninsured are available at the same place.

Germany

Before 2005, the unemployment benefit was administered by the Federal Agency for Employment, who was responsible for the re-integration into the labour market of the insured unemployed, while social assistance was the responsibility of the municipalities. The Hartz IV reform combined these two schemes to reduce the fragmentation in the delivery system and end the different treatment of unemployed benefits’ recipients (managed by the Federal Agency for Employment) and the social assistance’s recipients (managed by the municipalities).

The unemployment benefit and the social assistance were integrated into one scheme, creating the ‘basic income support for needy jobseekers’. In this scheme, a new benefit called UB II was introduced, which was a means-tested, flat-rate benefit for those who were able to work, paid after the exhaustion of the unemployment benefit (UB I) or for those with no or very little work experience, for an unlimited duration. The other benefit, the re-defined social assistance, targeted working age citizens permanently not able to work or needy persons above 65 years, and a third benefit, social allowance, was introduced for children under 15 living in the households of UB II recipients (Konle-Seidl, 2008).

For the management of the basic income support scheme and the activation of the long-term unemployed, a new organisation merging the local offices of the Federal Employment Agencies and the welfare offices of the municipalities was created. The new joint agencies – the Jobcentres– are responsible for the administration and payment of the UB II benefit, the placement of jobseekers, active labour market measures and social services (such as debt-, drug- and socio-psychological counselling as well as in-kind provisions for housing, heating and clothing) for the target group.

The new joined-up agencies were explicitly modelled after the British Jobcentre Plus agencies (Champion and Bonoli, 2011) and the whole Hartz IV reform was inspired by other

European examples considered as best practice, more particularly the United Kingdom, the Netherlands or Denmark (Konle-Seidl et al, 2008).

Finland

Strengthening conditionality and improving service integration have been two basic policy directions in Finland over the past years. The projects of the last two decades mostly focused on the long-term unemployed (LTU) and other ‘hard-to-place’ groups. This process culminated in the opening of LAFOS Centres that offer multi-sectoral services supported by cross-ministerial network governance.

Before the establishment of the LAFOS Centres, there was a split between the employment offices and the municipalities (responsible for social services). The unemployed, who were eligible for labour market support typically had to resort to social benefits too as the amount of unemployment benefit was too low (Arnkil, 2004). However, state officials at PES offices and municipal officials worked separately, to a large extent ignorant about what the other was doing (Arnkil and Spangar, 2009).

The Government Employment Policy Programme (2003-2007) provided the supportive environment for the establishment of the LAFOS Centres. These centres carry out integrated services targeted at the long-term unemployed and clients that face employability problems from multiple sources (e.g. skills, health, income, social problems). Their services include employment services, social and health services, rehabilitation and social insurance. The staff of LAFOS Centres comes from various backgrounds from the employment offices, municipality social welfare offices and the national social insurance institution. Clients are assigned from the local employment services or social agencies on the basis of an evaluation of their needs. In terms of funding, half of the costs are funded by the PES and the municipalities and the other half is provided by the national ministry of labour.

The UK

The Employment Service was responsible for providing job-search related support and activation services to claimants of the Jobseeker’s Allowance (JSA) prior to the introduction of the Jobcentre Plus Offices. The Employment Agencies Act (1973 c.35) governed these employment offices. On the other hand, Benefit Agencies were responsible for the administration of benefit claims and benefit payments as well as running the Social Security Offices.

The Jobcentre Plus project, which integrated the Benefit Agency and the Employment Service into a single government executive agency, was carried out gradually from 2002 to 2007. Its primary aim was to provide integrated employment services for the working-age population (both unemployed and inactive). The services provided ranged from benefit claims processing through work-focused interviews as well as transfer to various activation programmes.

Policy frameworks for integrated health and social care services

In the field of care for adults with dependency needs, closer links between health care services (usually financed and managed at national or regional levels) and social care (usually managed and provided at local level) have been part of the policy landscape for a number of years. There have been attempts to bridge the gap between health and social care through the implementation of coordination mechanisms or care coordination networks as it was the case in France between the regional health agencies, responsible for health care and long-term care, and the county councils, responsible for social services provision.

In others, closer links have taken the form of policy frameworks favouring bodies establishing joint financial and management arrangements for community care services, co-location of

*As of March 2015 Hungary moved to the fourth row (PES providing all functions). ** Though Norway is an associated state, not an EU member, it is included as an important example of joint offices.

professionals or the delegation of responsibilities between agencies as it has been the case in the UK. There has also been increased decentralisation, where the regions and the municipalities have assumed increased responsibility for care of groups with complex needs. This entailed the introduction of a 'local primary care system' in Sweden, where most county councils and the municipalities deliver the service jointly. Also in Denmark, the municipalities have progressed towards the integration of their health and social care services after the implementation of an overarching public service reform in 2008.

In countries, such as Spain, where there is no national policy agenda on integrated support, various regions, with responsibilities for health care and specialised social services, have launched their own policies for integrating support or specific policy frameworks for certain groups, such as those with chronic health conditions.

The UK

Closer links between the National Health Service (NHS) and social care have been part of the policy landscape in the UK for many years, though the situation varies across its countries.

In *Scotland*, under the broad umbrella of community planning, foundations have been laid down for the development of place-based partnership across sectors. In adult health and social care, joint working between National Health Service Boards and local authorities (with responsibility for social services) has featured prominently on the literature as a policy driver. Thanks to the 2002 Scotland Community Care and Health Act, NHS Boards and local authorities established joint management and financial arrangements for community care services. Initially limited to services for older people, these joint bodies started to cover all types of community care services from 2004 (NHS Confederation, 2004).

The same year, the Scotland NHS Reform compelled NHS Boards to establish Community Health Partnerships (CHPs) aimed to link primary and specialist health services, and health and social care. CHPs have started to be replaced by new Health and Social Care Partnerships (HSCP) jointly run by the NHS and local authorities in each locality as a result of the implementation of The Public Bodies (Joint Working) (Scotland) Act, which requires health boards and local authorities the full integration of health and social services by April 2016.

In *England*, partnership working has been a consistent feature of government policy and the integration of health and social care has been on the agenda for a number of years. The result has been a range of different approaches and pilot projects, from the location of social workers in GP surgeries to the integration of adult health and social services in a single organisation (Lyon et al, 2006).

The publication 'High Quality Care for All' by the Department of Health in 2008 led to the establishment of 16 care trusts, which are partnerships between the NHS and the local council in which local authorities delegate some social care functions to the care trust. The features of care trusts are pooled budgets (where the partners contribute to a common budget), lead commissioning (where one partner commissions services provided by both partners) and integrated provision (where a single organisation provides both services) (Ramsay et al, 2009). 25 integrated care pilots are currently being implemented through the support of a specific fund – the Better Care Fund- to gather evidence of what works well and advance integration.

In *Northern Ireland*, health and social services have been delivered through a two-tier structure since 1970. A single health and social services board commissions services (mainly from the five territorial trusts in which the country is distributed). The trusts manage and administer hospitals, health centres, residential homes, and day centres, and provide health

and social care services to the community. For each area of the territory, a single organisation is responsible for the delivery of both health and social care.

The advantage of the structurally integrated system in Northern Ireland seems to be that a single employer with one source of funding, a single set of goals and one organisational vision is likely to avoid many of the problems of fragmentation described elsewhere (Heenan and Birrell, 2006). However, Heenan and Birrell also cited the independent review of health and social care services, published in 2005 by Professor John Appleby, which concluded that the success of integrated care varied across trusts and there was little collaboration between them.

Sweden

In Sweden, the health system is highly decentralised and organised at three levels: state, county and municipality. Primary and secondary health care is funded and delivered at county level. Regarding adults' services, municipalities are responsible for nursing and residential homes as well as home care and other social services (Adamiak and Karlberg, 2003).

During the 1990s, the municipalities assumed responsibility for care of the older people. The social care services provided by the municipalities now look after people with more complex needs. '*Local Care*', which is defined as a family and community orientated primary care system supported by an "adaptable hospital service", has been introduced by the majority of Swedish county councils, and county councils and the municipalities deliver the service jointly.

'*Local Care*' services are mainly concerned with long-term conditions, family and child health, and older people's care. Their main aim is to respond to the needs of local populations, which means that '*Local Care*' services vary between locations. Legislation requires the regions and municipalities to co-operate with each other (Strandberg-Larsen et al, 2007), hence in Sweden when it comes to delivering coordinated or integrated services collaborative networks are the norm.

An example which is often cited and has been studied in the past is the city of Norrtälje, where a structurally and financially integrated health and social care organisation was established in 2004 (Goodwin et al, 2014).

Finland

Looking at the responsibilities for health and social care delivery, the 320 municipalities are legally obliged to deliver primary health services, including public health, through primary health centres, whilst twenty hospital districts organise and deliver specialist health care. Municipalities must belong to a hospital district and contribute to the cost of specialist care for their population, but they do not provide this level of care directly (Vuorenkoski et al, 2008). The trend in the development of current legislation is to focus on service integration and on promotion and prevention, but Finland's long tradition of local self-government has led to extensive decentralisation and considerable variation in provision.

A proposal for a new act on the arrangement of services was logged in August 2014. The reform aimed at shifting the responsibility for providing social services and healthcare from the municipalities to five regional administrations. However, the reform was rejected by the constitutional committee in March 2015, and two options are now possible: the reinforcement of regions, including regional elections and the devolution of taxation powers, or the joining up of local authorities in a supra-local body with responsibility for the organisation of health and social care services.

The *Clubhouse* psychosocial rehabilitation model for people with mental health problems has been approved as part of community-based mental health policy in 100 Finnish municipalities. Clubhouses (CH) work as needs-based integrators and collaborators by building bridges across different sectors from psychiatric services towards normal everyday living in the community. *Clubhouses* do not offer clinical services and focus only on members' social needs for learning new skills, education and vocational training, independent housing and employment, and can be considered like 'coordination hubs of case-management'. The clubhouse model is not compulsory by legislation but it is incentivised through a financial mechanism provided by the Ministry of Health and Social Affairs.

Regarding older people, the act 'Supporting the Functional Capacity of the Older Population and Social and Health Care Services for Older Persons' regulates cooperation between the municipalities and other public bodies, companies and non-for profit organisations to support the wellbeing, health, functional capacity and independent living of older people.

France

Regarding the provision of health and social services, France's 13 regional health agencies' regulatory competence covers both health care and long term care, enabling them to take initiatives to bridge the gap between these two levels. However, they do not cover social services, which are devolved to the 101 Départements. Coordination policies have been implemented since the 1980s, but they have failed to really bridge the gap between health and social care. There have been social care coordination mechanisms (called CLIC) and health care coordination networks, but they were unable to trigger the necessary changes to lead to a shift.

The legal framework does not enable information sharing about patients' health conditions between professionals who work outside the health sector. Because of this gap, specific programmes have been developed covering a certain population. One of them is Houses for Personal Autonomy (MAIA), which was introduced through the 2008-2012 Alzheimer Strategy but was targeted at integrating services for older people aged 60+. The model, adapted from Canada, was based on a national framework but implemented locally. It led to a greater dialogue between the organisations responsible for health and social care, implemented case-management and a shared grid to analyse people's needs in the most possible holistic way.

However, the new health law, adopted by the French parliament on 18 December 2015, is modifying the legal framework for exchanging and sharing patients' data, which will then be accessible to all the professionals of the newly introduced 'care teams'. For the first time, professionals outside the health sector will be part of these teams, including social workers and social care workers. Primary care doctors will coordinate the care teams and have a key role in their composition (Legifrance, 2015).

Denmark

With the 2007 local government reform, almost all public services became the responsibility of the municipalities. In 2006, 63% of public spending was spent at the regional/municipal level in Denmark as opposed to 20-30% in other OECD countries (Mploy, 2011). Specifically, in 2007, 48% of the public budget was allocated to the municipalities (Hendeliowitz, 2008).

More specifically in the fields of health and social care, with the reform, the regions became responsible for hospitals, psychiatry and health insurance, general and specialist health care, and highly specialised institutions. The municipalities are now responsible for childcare (including health care and kindergartens), primary school (including any special education and special pedagogical assistance for small children), specialised social services (social facilities for children and adults with social and behavioral problems), elderly care, health care (prevention, care outside hospital settings, treatment of alcohol and drug abuse, home care, local dental care, specialist dental care and social psychiatry) as well as activation and employment programmes for the unemployed and integration programmes for migrants.

The implementation of these services has translated in different ways in the organisation of each local authority. For example, in the municipality of Favskov, there are five committees: health and social care fall under the same committee, schools are integrated with children's services and employment sits in a separate department. In Horsens, employment and social services sit in one department that is responsible for providing all types of services for people with disabilities and bears the cost of these services.

Spain

There is not a specific framework supporting the integration of health and social care in Spain. The closest national policy framework is the '*System of Personal Autonomy and Assistance to persons in situations of Dependence (SAAD)*', which was introduced in 2006 to provide a comprehensive package of support across four pillars for people (including any age group), who were dependent on care.

Regional authorities are responsible for the organisation of education, health and social care in their own territories. Social services are shared between regional and local authorities, with the local level being responsible for general services, whilst the regional authorities have a responsibility for specialist services, such as child protection. In some cases, the regional governments have taken the initiative and developed their own integrated policy frameworks. For instance, in Catalonia, the regional government launched in February 2014 an integrated health and social care plan focused on people with chronic health conditions. The objective of this plan is the development of an integrated care model and an IT platform that would allow sharing records between professionals from both sectors. The government is working with the municipalities in the implementation of various pilot projects to build on their success and extend the integration process to include other population groups.

Final thoughts on policies for integrated services

Legislation and policy are usually sector-related and legal and policy frameworks for integrated services are scarce, and if they exist, they do so in relation to a specific group of the population. Another key issue when it comes to the development of integrated services related policy is the territorial and governance structure of each country. In most cases, the national government is no longer the main body responsible for managing and providing education, health, employment and social care services. Consequently, in countries, where due to decentralisation, a reorganisation of tasks and responsibilities has been implemented, it is key to adopt a multi-dimensional and multi-level approach to ensure successful implementation. In other countries, where there is not a national agenda/plan on integrating support, regions may have come to fill this gap with their own policies.

Though integration has been part of the policy debate in a number of European countries for the past few years, the situation across Europe varies considerably. There are examples where there is no legislation or policy, yet professionals have come together in multi-disciplinary teams and filled the policy gap. There are also looser integration models that may have led to a pooling or transfer of resources. These may also involve some formalisation of management and governance along with a manager or co-ordinator appointed jointly by the partners or a shift of responsibilities between agencies. Finally, we have seen some examples of structural integration, which is typically 'top-down' with a focus on fully integrated financing, planning and service management and delivery.

**Investing
in people**



International practice review on integrated services

The practice review aims to find out how integrated services are implemented in practice by local and regional public authorities. ESN launched a call to its members (social services departments mostly in local and regional authorities) and gathered 44 practice examples on integrated services from 36 organisations in 17 European countries. The question ‘How current practice on integrated services is organised, what works, for whom and in what circumstances?’ served as the basis for an analysis of current local practice on integrated services in Europe.

Country spread

The review covers a wide spread of European countries. The 44 practice examples were submitted by 36 organisations in 17 European countries: Belgium (3), Bulgaria (1), Denmark (3), Finland (6), France (4), Germany (2), Greece (1), Hungary (2), Iceland (1), Italy (3), The Netherlands (2), Poland (1), Romania (1), Spain (5), Slovenia (1), Sweden (3) and the United Kingdom (5).

Target group

The target group of most of the 44 analysed practice examples were children and young people followed by older people. Some ESN members differentiated if a practice only addressed children or also their families or children and young people. Some practices focused on professionals from different sectors working together to facilitate an improved understanding of the other service’s roles and professional base. This was the case of the practice *Interprofessional sessions* from the UK (41) involving general practitioners and adult social care teams.

Status

Regarding the status of each practice, we assessed whether practices were in the planning stage, the pilot phase or have been established or rolled out. Most practices were in the ‘*Expansion and monitoring phase*’, which meant that the practice was implemented and was also being monitored and evaluated. 30% of practices had been established and had entered a stage of continuous structural improvement related to the organisations or their financing. 27% of practices were a pilot project. A smaller number of practices were in an ‘*initiative and design phase*’, which meant that initiatives were planned but not yet implemented.

Governance level

Practices took place at different governance levels, mainly at the local level (68% of the practices) and the regional level (59%). Some practice contributors indicated that the practice addressed both governance levels as they might have been initiated by regional authorities and then implemented at local level. For example, in ES4 the contributors explained the implementation of the Plan for Integrated Health and Social Care of the regional government of Catalonia in the city of Amposta. 11% of practices described service integration at national level and it was interesting to receive practice examples that described the national policy framework and the practice matching local implementation. For example, we assessed the policy framework promoting personal autonomy for older people in France and how this is implemented in Pas-de-Calais Calais County Council, or how the Open Dialogue approach, which is a national programme in Denmark, is implemented in the city of Aarhus.

Practice overview

44 practice examples were submitted by ESN members with responsibility for public social services in 17 European countries. The following table contains an overview of the collected practices. Numbers in the first column are used in the practice review to identify the practice.

#	Country	Leading organisation(s)	Practice	Target Group	Phase	Areas of Cooperation
1	Belgium	Flemish Service for Employment	<i>Decree for the work and care programme, 25 April 2014</i>	Unemployed	Initiative and design phase	social services, employment
2	Belgium	Federal Public Planning Services for Social Integration	<i>Children first, local consultation platforms for prevention and identification of child poverty</i>	Children and families	Experimental and execution phase	social services, education, other
3	Belgium	Education Department, City of Antwerp	<i>Stay on track, a central helpdesk for school dropout prevention</i>	Young people	Consolidation and transformation phase	social services, education, employment, health, other
4	Bulgaria	Foundation Global Initiative on Psychiatry – Sofia (GIP-Sofia)	<i>Assertive community care for people with mental health problems</i>	Mental Health	Expansion and monitoring phase	social services, health, other
5	Denmark	Department of Welfare and Health, Municipality of Horsens	<i>Karriereplaner, career plans for people with disabilities</i>	Disability	Experimental and execution phase	social services, employment
6	Denmark	National Board of Social Services	<i>Open dialogue, a network-based approach for the social inclusion of people with mental health problems</i>	Mental Health	Expansion and monitoring phase	social services, health, education, employment
7	Denmark	City of Aarhus	<i>Recovery model, a peer-to-peer approach to promote the social recovery of people with mental health problems</i>	Mental Health	Experimental and execution phase	social services, health, employment, other
8	Finland	Municipal Youth, Educational and Cultural Services, City of Oulu	<i>Byström youth services, a drop-in activity centre for young people</i>	Young people	Expansion and monitoring phase	social services, education, employment, health, other

Table 4: Overview of participating practices

#	Country	Leading organisation(s)	Practice	Target Group	Phase	Areas of Cooperation
9	Finland	Northern Ostrobothnia district office of the Mannerheim Child Welfare League, City of Oulu	Family net, a family centre and welfare network model	Children and Families	Consolidation and transformation phase	social services, health, education, other
10	Finland	City of Tampere	The health and social care integrator 'Kotitori', a platform gathering older people's services	Older people	Consolidation and transformation phase	social services, health, other
11	Finland	Social services, Helsinki	Hietaniemenkatu service centre, a care and housing centre for homeless people	Homeless	Expansion and monitoring phase	social services, health, other
12	Finland	Clubhouse community centres	Clubhouse model, a psychosocial rehabilitation model in municipalities across Finland	Mental Health	Consolidation and transformation phase	social services, education, employment, other
13	Finland	LAFOS: joint service of public employment services, social and health services of the municipalities and the social insurance institution	LAFOS, the Labour Force Service Centres	Unemployed	Expansion and monitoring phase	social services, health, employment, other
14	France	Pas-de-Calais County Council	Houses for Personal Autonomy (MAIA), local implementation	Older people	Expansion and monitoring phase	social services, health
15	France	National Solidarity Fund for Autonomy in cooperation with the Regional Health Agencies and the County Councils	Houses for Personal Autonomy (MAIA), national programme	Older people	Expansion and monitoring phase	social services, health
16	France	The prevention health public service (PMI), Mainvilliers, Eure et Loir	LAEP, reception centres for children and parents	Children and Families	Consolidation and transformation phase	social services, health, education, other
17	France	Directte, regional implementation body	Implementation of the Youth Guarantee Scheme in Pas-de-Calais, provision of employment, education and training opportunities for young people	Young People	Expansion and monitoring phase	social services, employment

#	Country	Leading organisation(s)	Practice	Target Group	Phase	Areas of Cooperation
18	Germany	The countrywide network of Jobcentres	Integrated employment and social support for jobseekers	Unemployed	Consolidation and transformation phase	social services, education, employment, other
19	Germany	Federal Employment Agency	Youth employment agencies, provision of employment, education, and training services for young people	Young people	Expansion and monitoring phase	social services, health, education, employment
20	Greece	Day Care Centre, Palaio Faliro, Attica region	FrontiZo programme, preschool support for children at risk of autism and their families	Children	Experimental and execution phase	social services, education
21	Hungary	United Health and Social Care Institute, Győr	Telephone, online and physical facility service, integrated approach to improve older people's access to basic social services	Older people	Experimental and execution phase	social services, health, education
22	Hungary	Child Welfare Services	The Signaling System, cooperation procedures for child protection	Children	Consolidation and transformation phase	social services, education
23	Iceland	Municipality of Reykjavik	Home services, home-based health and social care for people with complex needs	Older people	Expansion and monitoring phase	social services, health
24	Italy	Multi-professional team, San Daniele del Friuli county	Casa Elena project, preparation for independent living for young adults with learning disabilities	Children with disabilities	Experimental and execution phase	social services, health, education, employment
25	Italy	Social Services Agency, Municipality of Bolzano	Health and social care access point, integrated services for older people	Older people	Initiative and design phase	social services, health
26	Italy	Lazio Region	Regional integrated autism programme, integrated services for people with autism	Mental Health	Experimental and execution phase	social services, health, education, other

#	Country	Leading organisation(s)	Practice	Target Group	Phase	Areas of Cooperation
27	Netherlands	Regional Public Health Service	MASS, an integrated approach between health and education professionals working with students absent from school due to medical conditions	Young people	Expansion and monitoring phase	social services, health, education
28	Netherlands	National Public Health Service	Employment project for young people with disabilities	Disability	Expansion and monitoring phase	social services, education, employment, health, other
29	Poland	Lower Silesian Centre for Social Policy	School workshops for children and families on strategies against violence	Children	Experimental and execution phase	social services, education
30	Romania	Local Council of Arad	Curcubeu centre, day care for vulnerable children	Children	Consolidation and transformation phase	social services, health, education
31	Slovenia	Association of Centres for Social Work	Helping families at home	All target groups	Consolidation and transformation phase	social services, health
32	Spain	Ministry of Health, Social Policies and Equality, Autonomous Community of Andalusia	ALBORADA, a shared information system on young children with developmental difficulties	Children	Consolidation and transformation phase	social services, health, education, other
33	Spain	Ministry of Labour and Welfare, Autonomous Community of Galicia	Galician network for early intervention, integrated services for young children	Children	Experimental and execution phase	social services, health, education, other
34	Spain	General Directorate for Children and Adolescents, Regional Government of Catalonia	Espai cabestany, a support programme for children and young people in care or leaving care	Young people	Consolidation and transformation phase	social services, education, employment, health, other
35	Spain	Managers of health and social services, Amposta, Catalonia	Integrated health and social care plan, implementation of the regional plan at local level	Older people	Expansion and monitoring phase	social services, health

#	Country	Leading organisation(s)	Practice	Target Group	Phase	Areas of Cooperation
36	Spain	Andalusian Public Foundation for the Social Integration of People with Mental Health Problems (FAISEM)	A support network of social, education, health and employment services for people with mental health problems	Mental Health	Consolidation and transformation phase	social services, education, employment, health, other
37	Sweden	Committee with professionals from social work, child psychiatry and schools, Stenungsund	Nyborg/SKIFO, a support centre for children with special social, educational and health needs	Children and young people	Consolidation and transformation phase	social services, education, other
38	Sweden	Committee of professionals working on social and health care in the municipalities of Tjörn, Stenungsund, Kungälv, and Ale	SIMBA, a support network for children, young people, older people, and adults with mental health problems	All target groups	Expansion and monitoring phase	social services, health, education
39	Sweden	Managers from different services in 13 municipalities in the Swedish region of Gothenburg	Social planning group, a cooperative approach between housing and social services	All target groups	Initiative and design phase	social services, other
40	UK	Gentoo (a group of housing firms)	'Boiler on prescription' pilot	Older people	Experimental and execution phase	health, housing
41	UK	University of Birmingham	Interprofessional capacity-building between general practitioners and social work teams for adults	All target groups	Experimental and execution phase	social services, health
42	UK	Kent County Council	Kent Integrated Care Pioneer, integrated health, social care and housing services	Older people	Expansion and monitoring phase	social services, health, other
43	UK	Northern Ireland Regional Health and Social Care Board	Single assessment tool for older people's needs	Older People	Experimental and execution phase	social services, health
44	UK	Renfrewshire Health and Social Care Partnership's Learning Disabilities Service (RLDS)	Day support for adults with learning disabilities	Disability	Initiative and design phase	social services, health, education, other

The analysis

The review looks at practice examples, where public social services collaborate with one, two, three or more public sectors, covering education, employment and health. As in the reviewed literature, most practices aimed for health and social care integration, and in some cases an additional sector. These practices have the aim to provide social and health services to people with complex needs and aim to prevent future demand for services. 25 practices included some form of collaboration with the education sector and 13 with the employment sector. These practices aim to provide various services in one place, often in the form of one-stop shops, and they usually include additional sectors.

? **What may be the reasons and aims for integrating services?**

In order to identify key drivers of integrated services, first we assess the main reasons and aims of the initiatives. Many practices indicate several reasons for integrating services and, in contrast to the literature review that mainly referred to policy, most practices emphasised as reasons the local challenges faced by service managers; for example, an increasing number of service users or the need to improve cooperation between services to be more efficient in service provision.

19 practices mentioned an increase in service users as the driver to start the process of integrated services. Other reasons were organisational, such as the need to improve coordination within public services (n=16), a better use of resources and cost reduction (n=10). Other reasons had as a focus on improving care for service users; for instance, to prevent future problems (n=13), improve the quality of the service (n=4) or improve outcomes for service users in general (n=2). Whereas national legislation was more often featured in the literature as a reason to integrate services, 9 practice examples stated that they were integrating services as a response to new legislation or policy.

Increased number of service users

19 of 44 practices noted that they started the initiative because of the increasing number of users. These practices were mainly addressed at decreasing youth unemployment and school dropout. A good example is *Byström youth services* in Finland (FI1), which started because of high youth unemployment rates in the city of Oulu. In order to address school dropout, the *MASS* programme (NL1) has been developed at the request of schools to reduce the absenteeism for medical reasons of secondary school students in the Netherlands. Though absenteeism for medical reasons is not the responsibility of compulsory education, the educational sector started to collaborate with the regional public health service to address it through appropriate care, educational adjustments and adequate support for students and parents.

The increase in the number of service users is also mentioned in practices that aim to provide integrated health and social care, particularly for older people. An example is the *Kent Integrated Care Pioneer* (GB3): “the population of Kent is predicted to grow by 8.4% over the next seven years, representing an extra 123,000 people and this will mean there are likely to be people with more than one health problem that may require a combination of health and social care services.”

Service coordination improvement

16 of the 44 practices mention the improvement of service coordination as a reason to start integrating services. This reason was particularly mentioned in the case of practices that provide support for people with complex health needs, such as older people and people with disabilities, child protection practices and those addressing cooperation between social and employment services. The *Youth employment agencies* (DE2, Germany), for example, underline the need for coordination: “Several agencies provide a range of services and assistance. However, there is a need for optimisation to coordinate and interlock this provision.”

Prevention

13 practices outlined prevention as the reason to start the practice, that is to say, to prevent the problem from escalating further. This became evident in practices addressing child poverty and the inclusion of disadvantaged or disabled children. For instance, at *LAEP*, reception centres for children and parents in France (FR3), multidisciplinary teams work with children and their parents to address children’s developmental problems as soon as possible.

Policy and legislation

A total of 9 practices from Belgium, Denmark, Finland, France, Spain and the UK started because of new legislation or policy, that is to say, the local implementation of a national policy aimed at addressing societal challenges, such as youth unemployment or demographic ageing. It is interesting to mention that we received two local practices from Pas-de-Calais County Council in France (FR1, FR4), which described the implementation of national programmes, such as the *Houses for Personal Autonomy (MAIA)* and the *Youth Guarantee Scheme*.

Other reasons that were cited for developing the practices included a better use of resources (6 of 44) and reducing costs (4 of 44). For instance, this was the case in practices that addressed integrated service provision for older people because of the pressure on health systems caused by population’s ageing. On another note, only a few practices mentioned improving outcomes for users and quality of care as the reason for starting the move to integration.

? **How can integrated services be tailored to individual needs and how may service users be involved in service design and implementation?**

Tailoring services to the individuals is essential to ensure that the actual needs of the service user are met, hence ensuring effective and efficient service provision. This should start with a process that listens to service users’ needs, it should continue with the delivery of the service addressing those needs and afterwards there should be a follow-up with the service user.

While the literature stated that practices are user-centred, but often did not explain what this meant in practice, practice examples gave more insight of the different measures to tailor services to the needs of users. Four ways how public authorities try to tailor services to the individual needs of the users were identified in the practices: provision of information (one way communication) and personal contact with service users (two way communication), personalised care or work plans, co-production and the involvement of users in the design and implementation of the programme.

Communication with service users

Many practices mentioned one or two way communication as a way to tailor services to needs, although this does not necessarily mean that service users are actually involved or that services are tailored to their needs. 30 practices mentioned that they provide targeted, clear and relevant information to service users and their families, for example by giving out reading material in a language they can understand or they develop websites, where they provide accessible information about the services they provide. 28 practices stated that they contact their users personally, by phone or have regular face-to-face conversations. Some of them noticed that this type of contact contributes to the degree to which the services are tailored to the needs of their users.

For example, the model *Recovery* (DK3) uses an emergency phone so that service users can easily contact professionals. Another way to inform service users more effectively about different services are one-stop shops where different services the service user might need are located in a single place and through a unique point of contact. For instance, in jobcentres in Germany (DE1) medical, psychological, drug abuse rehabilitation, childcare and traditional basic assistance are all encompassed within *Integrated employment and social support for jobseekers* under the same roof.

Co-production

A step further, 12 practices explicitly mentioned that they ‘co-produce’ services with service users. For instance, in the field of mental health, the *Open dialogue* in Denmark (DK2) gives adults with severe mental illnesses the opportunity to state on an equal level to the professionals what they think and need. They also choose whom they would like to include in the discussions about their situation. Most service users responded positively to this approach and felt that they were better heard and understood than before. Likewise, participating professionals reported that they developed a better understanding of the users and their situation.

Personalised plans

In terms of the delivery of services, 17 practices indicated that they worked on the basis of personalised work and/or care plans that differ from standardised plans and are based on the unique situation of the service user. In 12 of these 17 practices, it was stressed that users were also involved in designing their care plans. Users have, for example, the chance to set their own goals and devise their own action plan. For instance, in the *Youth Guarantee Scheme* in Pas-de-Calais, France (FR4), in addition to a training programme for entering the labour market, users are also helped with developing their own personalised career plan.

Design and implementation

Another important aspect is the involvement of service user groups in the design and the implementation process of integrated services. Two trends were identified in the practices: organising meetings to collect opinions and the use of social media. Seven practices referred to the organisation of input and feedback meetings to ensure user involvement. For example, the initiators of the *Employment project for young people with disabilities* in the Netherlands (NL2) involved service users already at an early stage and invited them to planning meetings along with service providers and other stakeholders. At these meetings disabled people reflected on the programme, their experiences, what was going well but also what went wrong and what was difficult for them.

Family net in Finland (FI2) uses several dialogue approaches to find out the families’ needs and to understand what services fit best the families’ interests and requirements. The *Kent Integrate Care Pioneer Programme* in the UK (GB3) organised focus groups to discuss the changes that were to be implemented as a result of the programme and to make sure that users were part of the process. They also involved users through social media (for example, tweet chats on Twitter).

Whereas service user involvement was often not operationalised in the reviewed literature, 19 reviewed practices described how they involved service users in individual care planning or via group consultations. However, this approach was only described in measures that provide support for people with disabilities or mental health problems, unemployed and older people. We identified gaps in service user involvement in practices targeted at children and families, which did not specify how they included them in service planning and implementation. Their focus, as outlined in the literature, was mostly on the inter-organisational and inter-professional nature of the practice.

? How may integrated services be organized, delivered and managed?

We can distinguish four ways in which integrated support may be organised and delivered:

- Case-management: this category refers to the coordination by multiple professionals to meet the user’s needs.
- One-stop-services provision: all services are located in the same building, so the service user only needs to go to one place for support.
- Multidisciplinary teams: various professionals from different sectors, with different expertise and backgrounds work together in one team.
- Collaborative information/consultation exchange platform for professionals: a professional platform with emphasis on sharing knowledge and information.

Case-management

21 of 44 practices use various forms of case-management to deliver integrated support. The different forms of case-management inform, assess, plan and coordinate service delivery. For instance, in *Espai cabestany* (ES3), professionals work together to support young adults who are leaving state care. In order to work effectively, *Espai cabestany* set up a service user flow structure, based on case-management and individual work plans.

A single contact person for service users is often essential in case-management and may require the creation of a new role: a case manager who oversees available services, works in a person-centred way and has the authority to coordinate different services from different sectors. The *Single assessment tool for older people’s needs* (GB4) in Northern Ireland assesses needs in an integrated way and coordinates services through a single contact person: “The assessment is completed by a health or social care professional. Each service user is allocated a ‘key worker’ who is their contact point and who also co-ordinates the services and actions identified in the assessment.”

One-stop shop provision

Another way to deliver integrated services is through a one-stop shop approach or providing services in a single point of access. Often one-stop shops and case-management are combined, particularly in social and employment services. For instance, in the implementation of *Decreee for work and care programme* (BE1) in Flanders (Belgium), two case managers, one from employment and one from social

services, develop a plan for the same unemployed person and provide support in the same organisation.

The analysis of the *Youth employment agencies* (DE2) underlines that the one-stop shop approach is not a one-fits-all-solution and differs between urban and rural areas: “The implementation of a one-stop shop approach in rural areas demands a different approach. The lack of mobility and large physical distances require innovative implementation approaches. In four rural districts in Central Germany - Kyffhäuserkreis, Rhein-Lahn-Kreis, Gießen-Wetteraukreis and Landkreis Westerwald, where the one-stop shop approach was implemented for unemployed young people, additional innovative approaches were also implemented, including joint consultation hours, the development of a mobility ticket, information coaches and driving services”.

Multi-disciplinary teams

14 practices presented examples of services delivered by multidisciplinary teams, in most cases featuring a looser collaborative character than the case-management approach. The practice *Karriereplaner* from Denmark (DK1) and the *Employment project for young people with disabilities* in the Netherlands (NL2) describe collaboration between public services and employers to integrate people with disabilities into the labour market. As described in the reviewed literature, multi-professional teams may also work together at a managerial level. In the Icelandic example *Home services* (IS1) multidisciplinary teams of health and social care professionals in the municipality plan together home services for older people.

Specifically, in practices supporting people with mental health problems, such as in the the Finnish *Clubhouses model* (FI5) and in the Danish *Open dialogue* practice (DK2), service users become themselves part of the multi-disciplinary team. This is due to the recognition that service users are experts by experience and therefore can play a key role in providing support to their peers and contributing to improving monitoring and evaluation, as they had been previously service users themselves.

Consultation/Information exchange platforms

Other practices are organised as consultation/information exchange platforms for professionals. This is the case of *Children First* in Belgium (BE2). Before this project was implemented in 2014, the multiple agencies and practitioners working with children in Belgian municipalities did not always know each other. Therefore, often they did not share their experiences, information and expertise. The consultation platforms aim at changing this situation and provide a platform, where agencies and practitioners can share and exchange knowledge and information.

As already outlined in the reviewed literature, practices also described procedures and tools enabling intersectoral cooperation, specifically cooperation protocols and guidelines. This is often the case for practices addressing child protection or the inclusion of children at risk. The Hungarian *Signaling System* (HU2) describes a procedure between child welfare services, health services, education and justice, according to which child welfare services receive an alert and act accordingly to ensure the child’s protection and safety. There is also a public guideline on what needs to be done in cases of suspicion of child neglect or abuse, which also includes details of the tasks of the signalling system.

Some practices also mention tools to share information about service users’ records between different professional sectors, such as *ALBORADA* (ES1), which was developed by the Ministry of Health, Social Policies and Equality of the Autonomous Community Andalusia (Spain). This software is available for all professionals from

education, health and social services working with young children with developmental difficulties in health services and early childcare centres. The tool allows all professionals working in the region to access the unique records of each child to ensure continuity of care and prevent the need for individuals to have to repeat their story to other professionals.

The *Single assessment tool for older people’s needs* (GB4) is a common, validated and electronic tool that can be used by any health and social care professional. The assessment is completed by a health or social care professional. Each service user is allocated a ‘key worker’ who is their contact point and who also co-ordinates the services and actions identified in the assessment. Following assessment, a care plan is implemented to ensure the delivery of services. With this electronic tool, it is possible to capture and record large volumes of service user information and share it across professionals.

As in the reviewed literature, many practices raised human and organisational aspects as challenges for intersectoral working. Most outlined different professional cultures, no clear definition of tasks and roles and a lack of formal arrangements as possible difficulties. In some cases, it was mentioned the different status and greater weight given to health professionals over social workers. Moreover, service integration requires a change in workforce training and qualifications, as staff need to adapt to different ways of working. In the practice *Integrated employment and social support for jobseekers* from Germany (DE1), as unemployment and social assistance support were combined in the jobcentres, professionals had to perform a bigger number of tasks, which also meant the need of additional training. Since the changes were brought into force only 10 years ago, it has been recognised that there is still a lack of staff ready to work in such an ambitious context.

Integrated services management

On the basis of the practice assessment, we may distinguish three types of management approaches:

- Organisational management: integrated service delivery is managed by one organisation, for example an agency or a local authority.
- Collaborative management: this category refers to shared management between partnerships, consisting of multiple organisations or agencies.
- Professional management: the practice is managed by a single person, coming from an organisation or appointed by a multiple organisation partnership.

Most practices (33 of 44) are led by a single, public organisation, mostly by a department in a local authority or regional government. For instance, in the Hungarian practice *call-email-help centre* (HU1), which aims at providing a one-stop shop of health and social care services for older people, the leading party is the United Health and Social Care Institute of the municipality of Győr. The city of Oulu in Finland leads *Byström youth services* (FI1), which is an integrated young people’s service aimed at combating the high youth unemployment rate in the city.

In 11 of 44 practices, management is shared between different agencies, the practices involve bigger collaborative arrangements and in some cases the definition of the approach at national level and implementation at local level. For example, the *MAIA* (FR2) in France describes a national framework for the implementation of a new model of health and social care for older people at local level. Another example, the Danish practice *Recovery* (DK2), is led by a steering committee of several municipalities, regional agencies and user organisations in which all participating partners are represented. The city of Aarhus has the function of project leader, but collaborates closely with representatives from the other five partners on day to day management.

9 of 44 practices are managed by a single person who functions as a figurehead. Naturally, this person represents an organisation (organisational management) or a partnership (collaborative management). For example, the *Galician network for early intervention* (ES2) from Spain has the Secretary General of Social Policy in the Regional Ministry of Labour and Welfare as a figurehead.

External challenges to manage integrated services outlined in the practice examples matched those in the literature review, including funding, lack of resources, privacy or politics. Practices mentioned financing as a challenge because of organisations having different funding arrangements or because of lack of resources. Legal restrictions concerned privacy; for instance, around sharing service users' records. Practices also identified the dependency on political cycles and the absence of formal agreements as challenges for managing integrated services effectively.

Internal management challenges singled out in the practices include staff training and qualifications as well as agreement on priorities, tasks and roles across the different organisations involved. This was illustrated in the practice *Day support for people with learning disabilities* in Renfrewshire in the UK (GB5): "Partnership requires skilled negotiations, clarity of purpose and at time compromise. Traditionally public services have been governed by policies which can come into conflict with partner organisations and this may result in innovation being stifled."

? How may integrated services' outcomes be measured?

We also asked respondents to provide information about the evaluation methods they use, and the measured effects of their practices to give us some ideas about the effectiveness of their integrated services initiatives. Based on the information provided in the practice examples, we can distinguish five types of evaluations:

- Multi-method evaluation: performance is monitored using multiple evaluation methods, for example both a qualitative and a quantitative approach.
- Single-method evaluation: performance is monitored either quantitatively or qualitatively.
- External evaluation: an external organisation monitors the results of the practice.
- No evaluation: the practice does not monitor its performance.
- Informal evaluation: locally designed tools and/or collecting opportunistic feedback are used for monitoring the performance.

Monitoring methods:	# of practices	% of total (n=44)
Multi-method evaluation	20	45%
Single-method evaluation	17	39%
External evaluation	3	7%
No evaluation	3	7%
Informal evaluation	2	5%

Table 5: Monitoring methods (n=44)

Multi-method evaluation

20 practices indicated they use both quantitative as well as qualitative approaches for monitoring their performance. These practices were mostly initiatives at a larger scale in terms of number of service users or were the local implementation of regional or

national policies. Often seen combinations of multi-method evaluations include service user development statistics combined with service user satisfaction statistics and user feedback meetings.

An example of a multi-method evaluation was found in *Kotitori*, a one-stop shop for older people's services (FI3), which uses annual service user satisfaction surveys and individual customer feedback to measure service user outcomes. There is also a monthly follow-up of the number of phone calls, answered calls and face-to-face meetings in the information centre. Finally, the *health and social care integrator 'Kotitori'* involves external partners in the evaluation of the organisation itself and in 2014 KPMG made an audit focusing on cost-effectiveness.

The Dutch programme *MASS* (NL1), an initiative to prevent early school dropout of students with medical conditions, measured the results on students with an effect study. A quasi-experimental design with an intervention group and a control group, who received care as usual, was designed. To study the differences in development of a student's medical absence over time, a multi-level analysis was used. *MASS* also qualitatively studied the barriers and facilitators experienced by schools in the implementation of the programme.

In some cases, practices also underlined how they had moved to improving measurement methodologies. The *Galician network for early intervention* (ES2) in Spain is an example. They currently measure outputs; for example, the total number of children attending the service every year, and outcomes; for example, how many of them have had a positive development as a result of the programme. In practice, however, it was found that these indicators were not accurate enough. Therefore experts are working on a more accurate set of indicators, which will separately analyse children from the age of 0 to 3 and children aged 3 to 6.

Single evaluation

17 practices indicated that they monitor their performance by using one evaluation method, often a service user satisfaction survey or a measurement of (mental) health effects. Single-method evaluations are often used in smaller scale practices, such as in children centres or day care centres for adults; for example, the *Nyborg/SKIFO* in the Municipality of Stenungsund in Sweden (SE1), the *Curcubeu centre* in Arad, Romania (RO1) and *Casa Elena project* (IT1) in the San Daniele del Friuli region in Italy. The latter is a satellite home where people with severe mental health problems learn how to effectively manage their everyday life. Results are measured with the Vineland scale, consisting of 540 items, that evaluate individuals' personal autonomy and social responsibility from birth to adulthood. The individual under examination has to complete the test together with a person who is very close to them. Areas measured include communication's behaviour, everyday life skills, socialisation and motor skills.

Two practices reported monitoring performance with a more informal, opportunistic approach, like having a non-structured conversation with service users. Three practices hire external parties to measure the effects of their services, and yet three practices indicated not measuring performance at all.

In contrast to the reviewed literature, there was more information on evaluation methods in the reviewed practices. However, it was not always clear in some examples what was measured and what was the desired achievement. This became clearer when looking at the reported effects that were achieved through the various evaluation methods used. As with the aims, there were many reported effects so some attempt at thematic grouping has been made.

Effect	Description	Practice code				Total
Service users						
<i>improve service user wellbeing</i>	improved quality of the service, service users feel 'taken seriously', improvement of skills	BE3 DE2 FI4 FI5	FR3 FR4 GB1 GB3	GB5 IT1, NL1 NL2 SI1		13
<i>increased home care</i>	improved service provision that allows service users to stay at home	FI3 FR1				2
<i>service user satisfaction</i>	statement in service users surveys	FI3 PL1				2
<i>access to services</i>	increased information and access to available services	BE1 BE3 FI1 FI2	FI3 FI6 FR1 FR2	DE1 HU1 HU2 IS1	ES1 ES2 ES3 ES4	16
<i>single point of contact</i>	service users have one single point of contact	BE3 DE1				2
Professionals/Organisations						
<i>improved knowledge and understanding</i>	increased understanding about other sectors and different needs of service users	DK2 FI1 FI4 FI5	FR2 DE1 GR1 IS1	IT3 NL2 ES3 GB2		12
<i>less resources</i>	reduced hospital admissions, reduction of administrative 'back office' tasks	FI3 FI5 DE1	DE2 IT3 GB1			6
<i>improved co-ordination</i>	better coordination or collaboration between different services	BE3 FI2 FI6 FR1 DE1	GR1 HU2 IS1 NL2	ES1 ES2 ES4 SE1	SE2 SE3 GB3 GB5	17
<i>change in service provision</i>	services are provided using a different approach	BG1 DK2 FR4 IT1 ES5				5
<i>better information</i>	information about service users is available and can be used to outreach to service users in order to prevent future needs	FR1 DE2 GR1 IT3	NL1 ES2 ES4			7

Table 6: Reported effects of integrated service practices

The most often cited effects are an improvement in service coordination for the organisations involved and improved service access for service users. Other effects also impacted on professionals. 12 practices reported that professionals were more motivated because of improved cooperation and increased knowledge about the other sectors involved and service users' needs. 12 practices also reported an improvement in service users' wellbeing; however, it was not always clear how this was measured.

Finally, outcomes were usually linked to the initial aim of the practice. For example, practices that provided integrated care for older people reported an increased quality of the service or practices that aimed at labour market integration stated improved levels of skills or an increase in the number of employment placements. Six practices were aimed at reducing costs through the implementation of integrated care, but this is both generally difficult to measure and to demonstrate 'cause and effect'. An example is the 'Boiler on prescription' pilot (GB1) in the United Kingdom, where a general practitioner prescribes a suite of home improvements, free of charge, to patients who have medical conditions exacerbated by cold, damp homes. Their monitoring proved that GP visits were reduced by 33,3%, heating bills lowered by £30 a month and the temperature in the homes of the service users rose by over three degrees Celsius.

Two practices (*Houses for Personal Autonomy (MAIA)*, FR2 and *LAFOS*, FI6) reported that evaluations were undertaken or going to be undertaken at national level. The evaluation of the French practice is in preparation and the evaluation of *LAFOS*, done by the Ministry of Employment and Economy in 2008, showed that the reform had not been successful because it did not fully address the needs of the service users and cooperation between the organisations involved was not working properly. The evaluation recommended that public employment services, together with their networks and partners, took new decisive steps towards better customer orientation, clearer goal-setting in services, and better service integration.

? How may integrated services be funded?

Based on the information available in the assessed practice examples, we identified four main types of funding integrated services:

- Joint/pooled funding: two or more agencies pool budgets to fund services.
- Single agency funding: the practice is financed by one agency.
- Funding within existing resources: staff time and other resources are provided 'in-house'. No additional resources are used.
- Partly public, partly non-public funding: public and private organisations provide funds to finance services.

Ways to fund integrated services:	# of practices	% of total (n= 44)
Joint/pooled funding	20	45%
Single agency funding	15	34%
Within existing resources	9	20%
Partly public, partly non-public	3	7%

Table 7: Ways to fund integrated services (n=44)

Pooled funding

20 practices are financed by joint or pooled funding, but in practice we saw multiple variations of this funding arrangement; for instance, foundation funds combined with public budgets (*Curcubeu centre*, RO1), local budgets combined with national budgets (*Byström youth services*, FI1), and the combination of public budgets from different sectors, such as health, employment welfare and education (*Galician network for early intervention*, ES2).

As already outlined in four articles in the literature review, pooled funding often acts as a driver to integrate different services. Practices with pooled budgets were mostly based on political decisions. Examples included social service cooperation with employment, and practices addressing child protection. Most initiatives were rolled out at national level. Other small-scale practices with one single point of service provision also had pooled budgets such as multi-disciplinary day centres for different user groups.

Single agency funding

15 practices were funded by a single agency. In most cases, this agency is a governmental organisation: European (1), national (4), regional (3) or local (4). These initiatives are not integrated services provided by one single agency, but rather collaborative forms of working between different organisations. In the *Karriereplaner* practice (27) in Horsens (Denmark), the employment and social services department of the municipality works with people with disabilities and cooperates with employers for the labour market integration of people with disabilities in the municipality, and is completely financed by the municipal authority.

Within existing resources

Nine practices were funded within existing resources and had no additional funding, so staff time and other resources were provided 'in-house' and no new investments were made. This is the case of the *Health and social care access point* (IT2) in Bolzano, Italy which focuses on the integration of services for older people in one single agency. The *Health and social care access point* is financed within the existing organisation's budget and implied a re-organisation and re-distribution of staff.

To sum up, practices are financed by multiple organisations working with a joint budget, a budget from just one organisation or within existing resources. Challenges identified included not having sufficient resources, which may threaten sustainability and disagreements on how to use the resources. This was underlined by *Stay on track* from Belgium (BE3): "Service providers from different sectors are funded by different organisations at different governance levels. All of them have specific demands and expectations. This puts stress on the network capability."

? What may be the elements of success when integrating services?

ESN members were also asked to reflect on the strengths of their practices or which elements may be indications of success. The responses could be grouped in 6 main categories:

- Commitment of stakeholders
- Innovation: room for improvement and experimentation
- Leadership of a person or an organisation
- Resources and financial agreements

- Professional learning climate such as training and skills development.
- Staff motivation

As already discussed in the reviewed literature, commitment of the involved actors in the collaborative arrangement was also mentioned in the practices description as an element of success. In the Belgian practice *Stay on track*, the partner organisations stated that they committed to the project, because they all believed this partnership was better for their service users and the organisations involved.

Looking at innovation, 9 of 44 practices mentioned room for experimentation, improvement of services or change of service provision as a success factor. The UK practice *Interprofessional developments between general practice and adult social work teams* is a good example because professionals are specifically given time to explore, understand and challenge each other on their working practice.

Further, 8 of 44 practices recognised leadership as an element of success. Leadership here can be that of a person or an organisation, both in terms of policy or project management. In the implementation of Catalonia's *Integrated health and social care plan* in the municipality of Amposta (ES4), which focuses on improving coordination between social and health care professionals, the leadership from the presidency ministry of the regional government was highlighted as a helpful driver.

Five practices underlined the importance of resources and financial agreement for the success of the practice and its continuation. As underlined in the reviewed literature, the development of workforce needs to be taken seriously to enable successful integrated working. Two practices mentioned staff motivation as a success factor and four practices referred to the professional learning climate, like training and education, as an element of success. Professional learning was often mentioned in practices that implemented new integrated services requiring new skills and new forms of co-working, such as newly created agencies to address youth unemployment in France (the implementation of the *Youth Guarantee Scheme* in Pas-de-Calais County Council, FR4) and to support young people who left school without qualifications in Germany (*Youth Employment Agencies*, DE2).

An example in which the elements above are combined is the French *Houses for Personal Autonomy (MAIA)* (FR1), which describes three key success factors. First, strong political leadership and support at the beginning of the process. Second, the creation of specific education material and sessions for local implementation pilots and case-managers. Third, financial support and a dedicated team at national level are also recognised as elements of success. The practice *Day support for people with learning disabilities* (GB5) singles out lessons learnt for service integration:

- Communication – to ensure that all partners are clear regarding the actions, responsibilities and outcomes. Styles and approaches to communication need be agreed by all.
- Clear Responsibilities – the partners involved come from differing backgrounds and therefore bring a variety of approaches and styles, which need to be articulated in clear roles.
- Agreed expectations – in meeting targets and performance indicators it is essential that partner organisations have shared goals and outcomes agreed.

? How may the sustainability and transferability of integrated services be ensured?

As already outlined in the literature review, commitment, funding arrangements and procedures and mechanisms that support integrated working contribute to the sustainability of a practice. Many practices outlined the limited or short term nature of funding allocated to integrated services, a lack of clear roles and different professional cultures as obstacles to ensure the sustainability of integrated services. Therefore, it is interesting to examine the extent to which practices have extended beyond pilot status and have been established in service provision. As highlighted at the beginning of this chapter, most practices were in the 'expansion and monitoring phase', which meant that most assessed practices were implemented and were also being monitored and evaluated.

ESN members did not often mention sustainability explicitly in the description of the practices they submitted. Nevertheless, some ESN members reflected upon factors that may impact sustainability. The *Helping families at home* practice (SI1) in Slovenia, for example, noted that the continuation of their work depended on whether there was enough budget. The Hungarian practice *Signaling System* (HU2) raised dependency on political changes in government as a sustainability issue.

Sustainability is related to transferability or the extent to which initiatives have been replicated elsewhere, or have the potential to be transferred to other areas. Here, we should distinguish between *transferred practice* and *potential for transferability*:

- Potential for transferability: elements of the initiative have been taken up and used elsewhere or there is interest from outside, but the practice is not yet transferred.
- Transferred practice: a practice transferred from or to other regions, countries, service or group users.

26 of 44 practices indicated that there was interest from other organisations to transfer the concept (or certain elements) of the initiative to their own practice. 16 practices are transferred from or to other regions, countries or service users group. An example of a practice, which has been transferred from and to other countries, is the Finnish *Clubhouse model* (FI5). A clubhouse is a local community centre that provides people with mental disorders opportunities to achieve their full potential. The first clubhouse was opened in New York in the 1940s and came to Europe in the 1980s with initiatives in Sweden, Germany, the Netherlands and Denmark. Nowadays, the model is used in 20 European countries and has grown to a network of around 85 clubhouses. However, transferability also depends on the geographical setting. The assessment of the clubhouse model indicates that clubhouses for less than 20.000 inhabitants are not sustainable in Finland. Three Clubhouses have been closed based on this experience.

The *Youth Employment Agencies* (DE2) started as a pilot in Hamburg and were transferred afterwards to other cities. The assessment of this practice shows that the one-stop shop approach needs to be adapted to more flexible solutions in rural areas as highlighted above in this report. In other cases, there have been attempts to transfer the practice to other service users. For instance, the *Casa Elena project* (IT1) tested their model with users, who have different degrees of disability.

Case studies

Programme's name: <i>Original title:</i>	The Labour Force Service Centre (LAFOS) <i>Työvoiman palvelukeskukset</i>
Organisation / Country:	Ministry of Employment and the Economy / Finland
Website:	http://toimistot.te-palvelut.fi/pohjois-pohjanmaa/tyovoiman-palvelukeskus
Summary:	LAFOS is a collaboration between Public Employment Services (PES), local social and health services and the national social insurance institution. Professionals use IT-based databases to exchange user-related data. The main user group is the long-term unemployed, who have been unemployed for 12 months or longer. To access LAFOS, a referral is required. For that, professionals from PES or local public social workers assess a user's needs. This assessment considers the user's working capacity and life circumstances. Only if the user qualifies for support, the user receives a referral. In an individual appointment, professionals from LAFOS develop suitable responses to the user's needs. Any intervention is planned along the user's needs and results in an action plan. The user will find support services in the same building or information on how to access other services. The services can include support regarding social problems, the identification of rehabilitation services, and the search for suitable jobs, training or education.
Resources:	The cooperating parties fund the practice jointly.
Objectives:	<ul style="list-style-type: none"> • Decreasing structural long-term unemployment • Improving job search and easing the subsequent entry into employment for long-term unemployed people • Assisting long-term unemployed in developing and achieving person-centred and activating employment solutions
Outcomes:	<ul style="list-style-type: none"> • For service users: users felt that services were better than before in order to find jobs through web-based tools • For organisations: the service was successful in reaching better cross-governmental cooperation and broader networks
Evaluation:	An evaluation recommended PES to take steps towards better work-life balance and user orientation, clearer goals for services, and more service integration, notably for vulnerable people.

Programme's name: <i>Original title:</i>	Integrated employment and social support for jobseekers <i>Arbeitslosengeld II</i>
Organisation / Country:	Federal Employment Agency / Germany
Website:	https://www.arbeitsagentur.de
Summary:	<p>The integrated employment and social support for jobseekers provides an integrated framework for jobseekers with complex needs and workers with low wages or low income. It involves employment and social or health services. The framework is delivered through approximately 400 local jobcentres with a one-stop shop design. Three quarters of the job centres are co-management by the employment agency and the municipalities, whereas one quarter of the job centres are entirely under municipal management. The assistance includes a wide range of services (among others):</p> <ul style="list-style-type: none"> • assistance for homeless and tenants in trouble, • psychological assistance for psycho-emotional needs, • childcare services including facilities with extended service hours to ensure compatibility with shift/weekend work, • drug addiction advice and/or medical assistance (where needed). <p>Thus, the implementation of basic assistance relies on a cooperative network including a variety of organisation, e.g. schools, immigration offices, housing corporations, youth welfare services, employers associations, and third sector organisations.</p>
Resources:	Most funding comes from the Federal Employment Agency (employment services) and local authorities (social support). Additional services may be funded through regional and European social funds.
Objectives:	<ul style="list-style-type: none"> • Overcoming fragmented duties of different employment actors • Setting up one-stop shops for employment services, as well as social and medical support services; • Improving the effectiveness and user-friendliness of services
Outcomes:	<ul style="list-style-type: none"> • For professionals: possibility to follow an activating and cooperating approach as case managers with other professionals (e.g. doctors, social workers) • For service users: increased opportunities to receive services for complex needs (e.g. indebtedness, childcare, psycho-social problems within families, rehabilitation from addictions)
Evaluation:	For a unified performance measurement, a set of standardised indicators has been developed, for which data are collected. The indicators (e.g. the transition rate into employment) are assessed to analyse the outcomes and efficiency of the integrated care provision.

Programme's name: <i>Original title:</i>	Kotitori – Service integration <i>Kotitori – palveluintegraattori</i>
Organisation / Country:	City of Tampere / Finland
Website:	http://www.tampere.fi/english/
Summary:	Kotitori is a single access point for older people, their families and their carers to gain information and to receive home care services from both public and private providers. The service integrator is operated by Maxwell Care Ltd and the Nordic Healthcare Group. These private companies are responsible for the management of the network of service providers as well as for the quality control and quality standards of private providers. The City of Tampere is responsible for the purchase of health and social services and for the definition of the objectives in terms of service quality, coverage and management. Service users can access Kotitori either through a specifically designed online platform (e-Kotitori), by calling the number provided by the City of Tampere, or by accessing the walk-in office in Tampere County Council.
Resources:	The set-up of the initiative was funded by the Finnish Funding Agency for Technology and Innovation (Tekes). Nowadays, the budget of the City of Tampere and the service users jointly finance Kotitori.
Objectives:	<ul style="list-style-type: none"> • Improving information on the quality of service providers • Enabling older people to live at home as long as possible • Reducing the number of older people living in institutions
Outcomes:	<ul style="list-style-type: none"> • For service users: faster and more user-friendly access to information about services and service providers and more predictable costs of home care • For formal caregivers: facilitation of price negotiations between Kotitori and service providers and better resource management for home care services companies. • For organisations: lower transaction costs in the purchase of services and integration of service providers in one network
Evaluation:	An audit on cost-effectiveness was carried out by KPMG in 2014. The audit was based on data of the years 2009-2013 provided by the city of Tampere. Together with annual user surveys and data around service complaints of users, the identified effects of the programme were faster and easier access to services for users and higher user satisfaction.

Programme's name: <i>Original title:</i>	Nyborg <i>Nyborg skola</i>
Organisation / Country:	Social Services Department, Stenungsund / Sweden
Website:	https://www.stenungsund.se
Summary:	<p>Nyborg is a centre, where children can receive support for their educational, social, and emotional problems. Nyborg presents an integrated framework for cooperation between social, health, and education services. This collaboration brings together schools, social services and healthcare services (e.g. hospitals).</p> <p>The target group of Nyborg are children aged between 9 and 16 years old, who may have complex needs like anti-social behaviour, mental health disorders, or integration problems. Social workers often identify these children, but referrals may also come from teachers or mental health professionals.</p> <p>Professionals from all three sectors, notably teachers, social workers, and mental health professionals, engage with the children outside school hours in individual care and family care. The children attend the centre on a regular basis up to several times a week in addition to their regular education. On average, children receive services from the centre for a duration of two years.</p>
Resources:	The practice is financed through a specific budget of the Municipality of Stenungsund, which is reserved for Nyborg in order to fund its services.
Objectives:	<ul style="list-style-type: none"> • Offering help and support to children with complex needs • Improving quality of life and family relationships for the transition into a regular school
Outcomes:	<ul style="list-style-type: none"> • Improved educational performance of young people with special needs • Better relationships in families with children having complex needs
Evaluation:	An evaluation will analyse the numbers and cases of children who were involved with Nyborg.

Programme's name:	Open Dialogue
Organisation / Country:	National Board of Social Services / Denmark
Website:	http://socialstyrelsen.dk
Summary:	<p>The Open Dialogue is an approach emphasising the cooperation of professional and personal networks in order to provide services to people with severe mental health problems (e.g. people suffering from schizophrenia), who require support from local authorities. This programme involves five Danish municipalities, where professionals from several disciplines participate in the network meetings, including health professionals, social workers, and employment officers.</p> <p>The National Board of Social Services developed a manual, an assessment tool, and a comprehensive training programme. The service user has the option to involve selected non-professionals (e.g. peers) in the process. The focus of the process is on personal empowerment through individual decision-making. The dialogue is based on equality between all participants, including between users themselves and users and professionals. This allows users to participate in a conversation where their opinion is as valued as the opinions of professionals. A joint reflection of professionals and users provides a framework to analyse the conversations, and the participants are given the chance to reflect on what them and the others said.</p>
Resources:	The practice is jointly financed by the Danish Ministry of Children, Gender Equality, Integration and Social affairs and the municipalities. The ministry covers all expenses for the implementation by the municipalities.
Objectives:	<ul style="list-style-type: none"> • Offering users more choice on who to contract their services from and integrating users into the open dialogue • Producing knowledge on effective recovery strategies for people with severe mental health problems
Outcomes:	<ul style="list-style-type: none"> • For formal caregivers: better understanding of the service users' problems and improved collaboration with them • For users: increased possibilities to share individual hopes and concerns and improve understanding of one's needs
Evaluation:	The Open Dialogue approach was reviewed against relevant aspects, such as effectiveness on individuals as well as on costs and benefits. The feedback from service users has shown that through these conversations, participants feel that they are heard in a new way.

Programme's name:	Methodology for integration of health and social care services in the area of autonomy
<i>Original title:</i>	<i>Méthode d'action pour l'intégration des services d'aide et de soins dans le champ de l'autonomie</i>
Organisation / Country:	National Solidarity Fund for Autonomy / France
Website:	http://www.cnsa.fr/
Summary:	<p>MAIA is a model for health and social care implemented at the local level based on a national framework, which relies on dialogue between regulatory instances to achieve improved service integration in older people's services. National authorities collaborate with regional authorities in the formulation and implementation of relevant national policies. Via this practice, all health and social care providers collaborate with each other and with service users. The practice currently takes place in 300 different areas in France (although the target is to reach 400), with institutional coordination taking place at the regional level.</p> <p>The target group is people over the age of 60. The involved staff includes health professionals, social workers, long-term care staff, and case managers. At the level of case-management, multidimensional needs assessment are the basis for individualised action plans. The assessment criteria follow a joint model shared between the different professionals involved. A case manager assists in monitoring and coordinating with all the other professionals involved to facilitate information-sharing.</p>
Resources:	The practice is financed through health insurance funds, which are provided by the National Solidarity Fund for Autonomy to the regional health agencies. The current budget is €70 million.
Objectives:	<ul style="list-style-type: none"> • Providing older people with integrated care along their personal needs and aspirations • Minimising interruptions in the continuity of care
Outcomes:	<ul style="list-style-type: none"> • For organisations: clear rights and responsibilities • For formal care givers: better mutual knowledge and more efficient management of complex cases by professionals • For service users: a shorter pathway to find a service provider (decrease in number of contacts before finding the right one) and possibility of support by case managers in complex situations
Evaluation:	The CNSA has planned an evaluation for 2016.

Programme's name:	Renfrewshire Learning Disabilities Service (RLDS)
Organisation / Country:	Renfrewshire Health & Social Care Partnership / Scotland
Website:	http://www.renfrewshire.gov.uk
Summary:	<p>These are three examples highlighting the integrated approach for the local disability services in Renfrewshire:</p> <ol style="list-style-type: none"> 1. The collocation of day services for adults with learning disabilities has been a joint effort, with Social Work and Renfrewshire Leisure working to develop multi-purpose facilities. Day opportunities in leisure centres target adults with moderate to severe learning disabilities, some of whom have autism or other conditions like epilepsy, dysphasia, or communication difficulties. 2. The Project Search is a programme for young people with learning disabilities, promoting work alongside coaching and skills learning. The Search model is designed for young people with moderate to mild learning disabilities up to 25 years in order to bring them into employment. 3. Social and health services together with a third sector partner established Hidden Gem, which is a garden space in which adults with learning disabilities can take part in training and employment opportunities within a social enterprise. The social enterprise involves adults across the spectrum of learning disabilities who have expressed their interest in volunteering and in moving into employment.
Resources:	The funding is linked with the funding for provision and purchasing of public services. Partners have secured additional funds.
Objectives:	<ul style="list-style-type: none"> • Improving the inclusion of adults with learning disabilities • Expanding their opportunities to participate in the local community • Gaining employment opportunities
Outcomes:	<ul style="list-style-type: none"> • For service users: increased opportunities to access support, positive skills improvement & economic benefits associated with employment • For individual care givers: positive impact through the sharing of practice and receiving professional development opportunities • For service provider organisations: contribution to performance targets and development of person-centred services.
Evaluation:	Each service user has an Annual Care Plan, which will be reviewed. If required, changes to the plan will be made.

Programme's name: <i>Original title:</i>	The signalling system for the protection of children <i>Észlelő – és jelző rendszer</i>
Organisation / Country:	Directorate for Social Affairs and Child Protection / Hungary
Website:	www.szgyf.gov.hu
Summary:	<p>Local authorities have the duty to assess children's risk and put in place the appropriate mechanisms under the child protection system to ensure the child's safety. Local child welfare services maintain an early detection mechanism (the 'signalling system') to identify children who are at risk, to analyse the risk factors and to choose suitable support. The target group for this mechanism are children under the age of 18. The signalling system is an inter-organisational cooperation that involves public and third sector organisations from the health, education, social, justice, and housing sectors.</p> <p>Local child welfare services run the signalling system, and monitor the situation of children in regards to needs and risks. This service reports within the signalling system but is also active in assisting through everyday pedagogical activities and in providing specialist services if needed. The system also involves the health sector (specifically health visitors, paediatricians, and doctors), child protection services (including child protection agencies), and juvenile justice services. When a child might be at risk, these services are obliged to cooperate with the child welfare agency and other agencies under the child protection system. This might entail initiating a judicial procedure if the child's physical integrity or even the child's life is at risk.</p>
Resources:	Child welfare services are financed by national and local budgets. The amount of the central contribution from the national budget is set out in the national budget.
Objectives:	<ul style="list-style-type: none"> • Ensuring an early detection system for children at risk • Conducting a risk assessment of children's living situations • Establishing an integrated child protection system
Outcomes:	<ul style="list-style-type: none"> • For service users: easier and faster access to services • For formal care givers: learning on inter-professional cooperation • For organisations: better care and protection services
Evaluation:	The evaluation is based on statistics regarding the activities of child welfare services, including case numbers in the signalling system, type of problems and routes taken.

Programme's name: <i>Original title:</i>	ALBORADA – Information system for early intervention <i>Sistema de informacion temprana</i>
Organisation / Country:	Ministry of Health, Social Policies and Equality Regional Government of Andalusia / Spain
Website:	http://www.juntadeandalucia.es/index.html
Summary:	<p>In Spain, early childcare is an exclusive competence of regional governments. The Information System for Early Intervention (Alborada) is managed by the regional Ministry of Health, Social Policies and Equality in Andalusia (Spain). Alborada is a tool to facilitate the coordination of all the stakeholders involved in monitoring young children's development. The target group is children under six years old with developmental difficulties or at risk of developing them.</p> <p>To ensure coordination, the system is used by healthcare professionals, social workers, social educators, psychologists and any other professionals working in early childcare centres across the region.</p> <p>The main priorities of the practice are to facilitate inter-institutional coordination for the organisations involved in early interventions and to standardise the transfer of user records between the Andalusian public health system and early childcare centres.</p>
Resources:	The tool is fully financed by the regional budget of the Andalusian Government.
Objectives:	<ul style="list-style-type: none"> • Adapting interventions to the complex needs of children aged 0 and 6 years having developmental difficulties or are at risk of developing them
Outcomes:	<ul style="list-style-type: none"> • For service users: a better sense of support due to professional coordination and higher numbers of children receiving treatment • For individual care givers: improvement in the continuity of care and in intersectoral coordination • For service provider organisations: enhanced data on care for children with developmental difficulties and their families, and improved professional coordination between all public bodies and social service providers working with young children with developmental problems.
Evaluation:	The information system collects data on the prevalence and the coverage of care services for children with developmental difficulties, and includes information on the factors, causes and types of developmental problem, and the types and scope of individual services.

Conclusion: Facilitators and barriers of integrated services

Across Europe, when people talk about ‘integrated services’ they may refer to structural reorganisation and improved governance; for instance, having a single accountable agency responsible for commissioning services. Others mean improving cooperation between professionals from different sectors working with the same client. There are yet more who refer to integrating various strands of finance by pooling budgets or creating specific integrated funds to support specific groups with complex needs. They are all important and in some form or another they are all integration, but do they improve people’s outcomes?

That is why, if we are to use the word ‘integration’ in public services, we ought to have some common definition. In the European Social Network (ESN), we have defined the term ‘integrated services’ as the range of activities, (depending on sectors, target groups and governance contexts), implemented to achieve more efficient coordination between services and improved outcomes for service users.

There is a variety of drivers for collaborating/integrated service delivery structures guided by policy and professional developments, as well as by the input of research. Governments may try to transform the existing models of care and wellbeing to achieve better outcomes for people. Joining up structures in public service delivery can thus be perceived as a vehicle for such transformation.

Decentralisation in the social and health sector is the most visible example of major welfare reforms occurring in European countries over the past years, which has represented a considerable shift in the way public policies are planned and delivered. The shift has involved not only the devolution of competences and resources at the local level but also community-oriented approaches in which local authorities are required to work in an even more integrated way especially because they have to cope with less financial resources.

Integrated service delivery may also be inspired by other practices, that is, implementing a particular programme because it was documented to have had positive effects in another location. Awareness of the initiative to be transferred to your own context is key. Local authorities should know first about different programmes and their effects in order to consider implementing them, but as highlighted in this report, there is a lack of evidence of practices that work.

Person-centeredness can be perceived as a driver behind most integrated service delivery. Even though there are various pitfalls collaborating organisations may come across, literature shows that it is worthwhile to strive for user-centred practice, as it improves both user’s wellbeing and user satisfaction. Moreover, focusing on service users helps to strengthen links between the collaborating organisations, which may come to the table with conflicting views in the first place.

Thanks to the analysis of literature and practice across Europe, we have been able to identify in this report several key elements that enable integrated working in public services, including inter-professional teamwork, a well-functioning delivery system, ICT and new technologies, funding, commitment, innovation, learning, outcomes measurement and sustainability.

Inter-professional teamwork

Although literature and practice demonstrate that integrated service delivery is dependent on inter-professional teamwork, it may not always be successful. In some cases, professionals simply continue their traditional way of working in silos, rather

than collaborating across boundaries. Moreover, the complexity of intersectoral working may be underestimated. Aspects such as cultural differences and the ambiguity of roles are key obstacles for successful inter-professional working.

Successful practices of inter-professional working may be based on working together in the same location (co-location), identifying and demarcating new roles and tasks and the implementation of collaborative leadership, where the leadership is shared between various people; or to appoint independent leaders with dual disciplines.

Well-functioning delivery system

Literature shows that a well-functioning delivery system stimulates information sharing between agencies and provides clarity about where users need to go for particular services; it also minimises duplication and repetition. However, the delivery system may not always be successful; the complexity of intersectoral working should not be underestimated, cultural differences and the ambiguity of roles may also have a negative impact on delivery.

A well-functioning delivery system may be achieved through the implementation of joint needs assessments, joint care plans, joint case-management or an inter-organisational steering committee at managerial level.

ICT

As communication is an important aspect of collaboration, a shared delivery system can be the basis for integration. ICT in particular becomes increasingly important for delivery; collaborating agencies can for instance use shared electronic records to integrate service delivery.

The development of an integrated ICT platform could help overcome the fact that individual agencies may only be able to access part of users’ records or that the IT systems of collaborating agencies may be incompatible. However, another challenge revolves around privacy, as information sharing between organisations may lead to confidentiality issues.

Funding

Funding is mentioned as an aspect that may frustrate integrated services; for instance, when individual agencies commission integrated care individually, the budgets of the different organisations may lead to fragmentation in service commissioning and implementation.

Pooled budgets have been referred to as an option to overcome fragmentation in financing integrated services, but concerns have also been raised in regards to resource distribution between the organisations involved in the arrangement.

Commitment

Whether all relevant stakeholders are aware of the inter-dependencies between sectors and whether they are all on board is fundamental in the process. It is important that professionals are clear as to what is the purpose of integrating services and that they feel it is useful to spend time on this process. Therefore, it is helpful to develop collectively a shared vision or aim for practitioners to work towards.

Innovation

Professionals should have enough space and time to test new ways of inter-professional working. They also need enough space to take into account local considerations in implementation.

The complexity of integrated working should not be underestimated. If there is one thing we can learn from this study is that intersectoral professional collaboration is difficult and there should be room for concerns expressed by each organisation involved as practitioners can learn from this process and strive for innovative ways of working.

Learning

Training can play a key role in ensuring the success of the integrated services process. Professionals may receive training to prepare them for the new way of working. This can take place before they start working in the collaborative arrangement as well as during the process.

But training is not the only manner in which learning may be stimulated, team meetings to share experiences and advice or feedback sessions between the collaborating partners, identifying best practice and gaps also play a key role in learning.

Outcomes measurement

Even though evaluation may enhance integrated service delivery, it is often not carried out. This may be due to a variety of reasons including lack of capacity and appropriate tools and the fact that the various organisations involved in the integrated arrangement may value evidence differently.

The lack of evaluation might influence the quality of the service, as often there is no evidence as to what the effects may be. Taking this into consideration, it would be helpful if practices were based on elements, which have proved to work. Moreover, through continuous assessment, bottlenecks can be identified and actions can be taken to correct them, since continuous monitoring and evaluation are key to improve practice quality.

Sustainability

The sustainability of integrated services may be affected by factors at all levels: from changes in policy and legislation at national or regional levels through financial resources to interaction and commitment among the involved professionals.

While the development of policies may be a helpful driver of integrated services, a shift in policy priorities may also affect sustainability. Securing resources constitutes another potential challenge to ensure the practice's continuity. Genuine commitment and trust at all levels are required to ensure continuity. On a related note, clear communication, contact between different sectors and governance levels and joint training sessions contribute to sustainability as they improve the collaborating competence of the professionals involved and improve their knowledge of one another.

The examples collected through the literature and practice review show that integration is certainly about making organisational, governance, budgetary, structural or cultural changes but most importantly integrated services is about the individual, whose needs are placed squarely at the centre of their support. There is a need to invest in the organisations' learning environment, joint training and skills development but also in the

human side of professionals' relationships, such as trust-building, common understanding and assessment. Ultimately, the aim should be to ensure that the move to integration improves people's outcomes and their quality of life.

Key elements in integrated services

- Interprofessional teamwork
- ICT
- The delivery system
- Effects measurement
- Funding
- Commitment
- Innovation
- Learning
- Sustainability

Elements	Barriers	Facilitators
Inter-professional teamwork	Continue traditional way of working in silos, cultural differences, ambiguity of roles	Multi-disciplinary teams, co-location, demarcating new roles & tasks, collaborative leadership
Well-functioning delivery system	Cultural differences, continue traditional way of working, ambiguity of roles	Joint assessments, joint care plans, joint case-management, inter-organisational steering committee
ICT –shared delivery system	Individual agencies may be able to access only some parts, systems may be incompatible, privacy	Integrated & shared ICT platform, shared electronic records
Effects measurement	Lack of capacity, lack of tools, different organisations value evidence differently	Look for evidence of what actually works & adapt it to your own context, pre/post evaluation, monitoring the effects during implementation
Funding	Lack of information about funding arrangements, lack of funding altogether for integrated services	Pooled budgets
Commitment	Low priority to inter-professional cooperation, lack of clarity, lack of time and resources	Shared vision, highly committed individuals, clarity about goals, trust, mandate for action
Innovation	Underestimation of complexity of integrated working, lack of room for expressing concerns	Autonomy, enough space & time to test new ways of working
Learning	Cultural differences, continue traditional way of working	Joint-training before and during the arrangement, meetings to share experiences, identify best practice & gaps, self-evaluation
Sustainability	Organisational restructure, political & financial considerations, organisations' interests, concerns about distribution of resources,	Sectoral-societal paradigm including policy & funding, organisations' interests, structures supporting implementation, securing financing, documenting the effects

Table 8: Integrated Services: Barriers & Facilitators

Recommendations

POLICY-MAKERS

Draft guidelines for the involvement of users and/or user associations in the formulation and development of policies.

Example: This could be done by incorporating the duty or the possibility to consult representative user associations when formulating policies but also when monitoring their implementation.

Create funding frameworks that allow shared financing of integrated services.

Example: This could be carried out through pooled budgets or shared project financing.

Support the creation of one-stop-shops across different service sectors.

Example: This could be achieved via contact points for health and social services or integrated employment centres involving social services, education and training.

Create incentives for engaging informal carers and volunteers.

Example: This could be done by devoting resources to engage volunteers and informal carers; for example, in training.

PRACTITIONERS

Equip your workforce with relevant skills to implement integrated services.

Example: This could be achieved by training on integrated services, knowledge-sharing on needs assessment frameworks, and the creation of integrated care guidelines.

Develop transparent and effective pathways for users.

Example: This could be carried out with clear referral rules, for example between health and social services, and accessible online platforms for professionals and users.

Establish leadership arrangements for cross-sectoral cooperation.

Example: This could be achieved by a formal agreement outlining the responsibilities of each sector, including staff appointment or budget allocation.

RESEARCHERS

Conduct research about the effectiveness/efficiency of integrated services.

Example: This could be done by further developing and implementing tools; for example, cost-benefit analyses or outcomes measurement frameworks, to measure the outcomes of integrated services.

Carry out participative research projects.

Example: This could be achieved by involving professionals, users and informal carers in research.

Train students and junior researchers on the benefits of applied research.

Example: This could be managed by incorporating practical study exercises across the different levels of their education.

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Useful links

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Annex I. Overview of database searches

DATABASE SEARCHES & HITS (categorized by relevance)									
	Total	Irrelevant (on abstract)	Relevant (on abstract)	Relevant (on article)	Irrel. (on article)	Relevant (on article)	A	B	
EBSCO (5 years, peer reviewed journals, english, relevant countries)	2	1	1	1	1	0			
EBSCO (5 years, peer reviewed journals, english, relevant countries)	7	3	4	4	4	0			
EBSCO (5 years, peer reviewed journals, english, relevant countries)	7	6	1	1	1	1			1
EBSCO (5 years, peer reviewed journals, english, relevant countries)	4	2	2	2	2	0			
EBSCO (5 years, peer reviewed journals, english, relevant countries)	0	0	0	0	0	0			
EBSCO (5 years, peer reviewed journals, english, relevant countries)	0	0	0	0	0	0			
EBSCO (5 years, peer reviewed journals, english, relevant countries)	6	4	2	2	2	2			2
EBSCO (5 years, peer reviewed journals, english, relevant countries)	8	8	0	0	0	0			
EBSCO (5 years, peer reviewed journals, english, relevant countries)	27	12	15	15	11	4	1	1	3
EBSCO (5 years, peer reviewed journals, english, relevant countries)	4	0	4	4		3	1	1	2
EBSCO (5 years, peer reviewed journals, english, relevant countries)	4	1	3	3	2	1			
EBSCO (5 years, peer reviewed journals, english, relevant countries)	3	0	3	3	0	1			1
EBSCO (5 years, peer reviewed journals, english, relevant countries)	24	11	13	13	1	10	8	2	2
EBSCO (5 years, peer reviewed journals, english, relevant countries)	33	24	9	9	6	2			2
EBSCO (5 years, peer reviewed journals, english, relevant countries)	14	9	5	5	2	0			
EBSCO (5 years, peer reviewed journals, english, relevant countries)	1	0	1	1	1	0			
EBSCO (5 years, peer reviewed journals, english, relevant countries)	5	3	2	2	2	0			
EBSCO (5 years, peer reviewed journals, english, relevant countries)	0	0	0	0		0			
EBSCO (5 years, peer reviewed journals, english, relevant countries)	1	1	0	0		0			

EBSCO (5 years, peer reviewed journals, english, relevant countries)	Social services & employment & joint working	1	0	1	1	1
EBSCO (5 years, peer reviewed journals, english, relevant countries)	Social services & employment & partnerships	3	3		0	
EBSCO (5 years, peer reviewed journals, english, relevant countries)	Social services & holistic	26	14	12	1	5
EBSCO (5 years, peer reviewed journals, english, relevant countries)	Social services & joint working	17	2	15	3	7
EBSCO (5 years, peer reviewed journals, english, relevant countries)	Social services & vocation & integrated working	1	1	0		0
EBSCO (5 years, peer reviewed journals, english, relevant countries)	Social services & vocation & intersectoral	0	0	0		0
EBSCO (5 years, peer reviewed journals, english, relevant countries)	Social services & vocation & partnerships	1	1	0		0
EBSCO (5 years, peer reviewed journals, english, relevant countries)	Public services & integration	79	67	12	3	3
EBSCO (search full text, 5 years, peer reviewed journals, english, relevant countries)	Social services & education & whole system	152	127	25	8	12
EBSCO (search full text, 5 years, peer reviewed journals, english, relevant countries)	Social services & employment & intersectoral	15	8	7	2	1
EBSCO (search full text, 5 years, peer reviewed journals, english, relevant countries)	Social services & employment & whole system	71	61	10	1	3
Pubmed (5 years, english)	Integrated services & Social Sector & Europe	16	9	7	2	3
Pubmed (5 years, english)	Shared Social Services & Education & Europe	36	23	13	4	4
Pubmed (5 years, english)	Shared Social Services & Health & Europe	120	102	18	4	12
Pubmed (review, 5 years, english)	Social services & coordinated services & Europe	3	2	1	1	
Pubmed (review, 5 years, english)	Social services & life-cycle approach & Europe	0	0	0		
Pubmed (review, 5 years, english)	Social services & person centered support & Europe	2	2	0		
Pubmed (review, 5 years, english)	Social services & person centred support & Europe	2	2	0		
Pubmed (review, 5 years, english)	Social services & person centred support & Europe	2	2	0		
Pubmed (review, 5 years, english)	Social services & community based support & Europe	19	10	9	2	4
Pubmed (review, 5 years, english)	Social services & health(y) cities	26	24	2		2
Pubmed (review, 5 years, english)	Social services & integral approach	6	4	2	1	1
Pubmed (review, 5 years, english)	Social services & integral care	25	23	2	1	0
Pubmed (review, 5 years, english)	Social services & integral working	20	19	1	1	2

Pubmed (review, 5 years, english)	Social services & integrated care	120	115	5	4	0
Pubmed (review, 5 years, english)	Social services & integrated services & Europe	10	5	5	1	3
Pubmed (review, 5 years, english)	Social services & integrated working	82	77	5	3	
Pubmed (review, 5 years, english)	Social services & integrated working & Europe	10	9	1	1	
Pubmed (review, 5 years, english)	Social services & integrated working & public authorities	7	5	2		2
Pubmed (review, 5 years, english)	Social services & intersectoral & Europe	2	1	1		1
Pubmed (review, 5 years, english)	Social services & shared care	43	38	5	3	1
Pubmed (review, 5 years, english)	Social services & shared services & Europe	4	3	1		1
Total		1069	842	227	80	56
						116
						60
						2

Annex II. Development Model for Integrated Care

Minkman et al. (2011) developed this conceptual model called the Development Model for Integrated Care (DMIC). It offers a distinction of four developmental phases:

1. Initiative and design phase.
2. Experimental and execution phase.
3. Expansion and monitoring phase.
4. Consolidation and transformation phase.

Furthermore, nine key elements of integrated services are defined:

1. User-centredness
2. Delivery system
3. Performance management
4. Quality care
5. Professional learning climate
6. Inter-professional teamwork
7. Roles and tasks
8. Commitment
9. Funding, leadership, and innovation

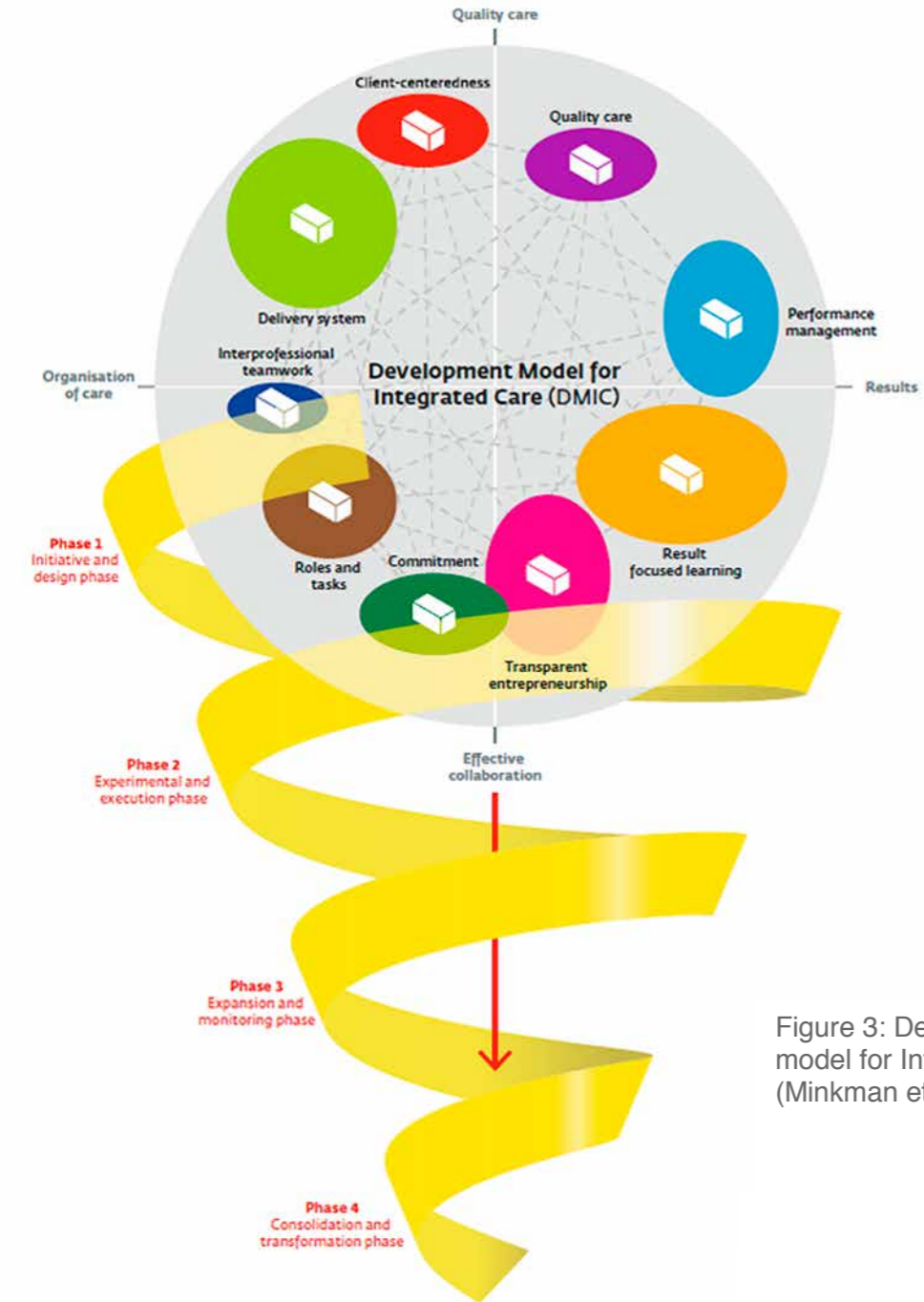


Figure 3: Development model for Integrated Care (Minkman et al. 2011).