



the BRIEFING

Exeter HS&DR Evidence Synthesis Centre May 2024

Effective data-sharing between health and social care for the care of older people: A qualitative evidence synthesis

Data-sharing between healthcare and social care is essential for the delivery of integrated care. Potential benefits of integrated care include improved clinical outcomes, patient and carer experiences, and cost-effectiveness.^{1,2} Providing integrated care is particularly important for older people, as they are more likely to suffer from multiple or long-term conditions. These can be complex to treat and require the involvement of different professionals.^{3,4}

This is a summary of a qualitative evidence synthesis on the effectiveness, acceptability, and implementation of data-sharing between health and social care regarding the care of older people. The provision of information systems that support data-sharing across organisational and professional boundaries is a long-standing policy objective in the UK.⁵ This review is intended to further understanding on how to ensure effective data-sharing.

We found that:

- ◆ data-sharing initiatives need to support multiple, complementary methods of data-sharing and allow different professionals to build relationships.
- ◆ further research is needed on technologies allowing data-sharing, such as those that were rapidly implemented during the Covid-19 pandemic, to ensure digital solutions are being used effectively.

Following from these findings, we suggest co-production is important when developing data-sharing initiatives, to understand how data-sharing and shared data systems can be made more effective, whether within, or by changing, current ways of working.

Data-sharing (in this review):

when information about an individual patient is transferred between organisations, or care professionals belonging to different organisations, across the health and social care boundary

Exeter HS&DR Evidence Synthesis Centre

We are one of three research groups in the UK commissioned by the National Institute of Health Research HS&DR (Health Services & Delivery Research Programme) to conduct syntheses of evidence about the organisation and delivery of healthcare (Project number 16/47/22). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health and Social Care.



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What is this review about?

Our aim was to identify factors that are perceived to influence effective data-sharing between healthcare and social care, including private and voluntary sector organisations, regarding the care of older people.

How did we do this review?

Finding the literature: We searched eight bibliographic databases for studies. We also searched the citations and reference lists of included studies.

Eligibility criteria: we included qualitative studies (e.g. using focus groups or interviews) which:

- Focused on older people.
- Focused on data-sharing between health and social care organisations and/or professionals.
- Were conducted in the UK.

What did we find?

Twenty-four studies were included in the review. Most studies scored highly on the quality appraisal checklist.

Population: most studies were of older people with complex needs e.g. multi-morbidity. Some were focused on specific populations, such as people with dementia (2 studies) or people with Parkinson's disease (1 study).

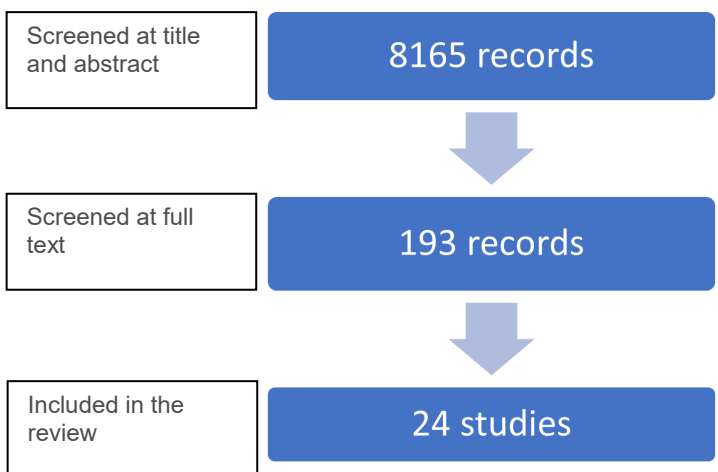
Participants: studies included health and social care professionals (11 studies), patients and carers and professionals (11 studies), older people (1 study), not clearly reported (1 study).

Professionals sharing data: a range of professionals were involved in data-sharing. From the social care sector, these were most likely to be social workers or care home staff. Nurses and doctors were the professionals most involved in data-sharing from the healthcare sector.

Methods of sharing data: some studies focused on one method of data-sharing, such as shared records systems (2 studies), paper-based records (2 studies), or multi-disciplinary team meetings (1 study). In most studies multiple (but not all) methods of data-sharing were used, with other methods including emails, telephone calls, and face-to-face conversations.

Study selection, data extraction and assessment of study quality: Studies were screened by two reviewers for inclusion, who then carried out data extraction and appraisal of study quality. We used a standard tool, the Wallace criteria, to assess study quality.

Data were analysed by identifying themes and comparing them between studies.

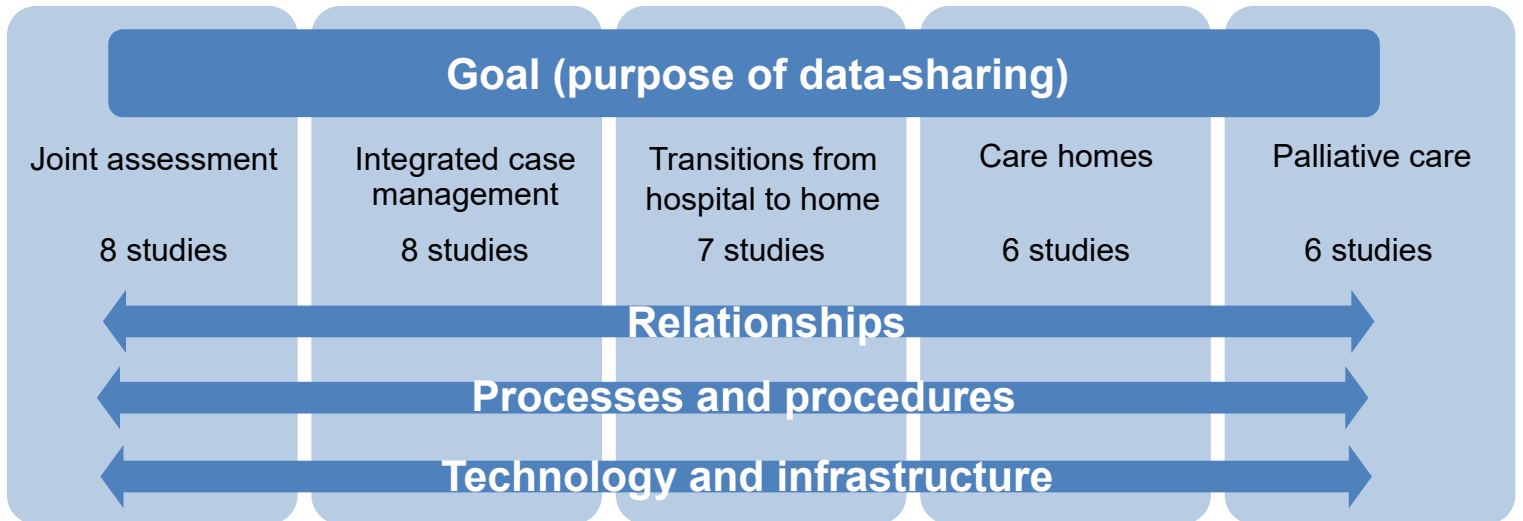


Findings were organised into four main themes:

- **Goals** (the specific purpose and context of data sharing).
- **Relationships** (between individual professionals as well as organisations).
- **Processes and procedures** (intra- and inter-organisational).
- **Technology and infrastructure** (the methods and means of data sharing).

In the first theme, **Goals**, we found five purposes of data-sharing: joint (health and social care) assessment, integrated case management, transitions from hospital to home, for residents of care homes, and for palliative care.

We grouped the studies into five 'clusters', reflecting these purposes of data-sharing. There were factors that influenced data-sharing in all clusters of studies in each of the three other themes, as represented in the diagram below.



In **Relationships**, interprofessional relationships were important in supporting data-sharing. Certain methods of data-sharing, such as multi-disciplinary team meetings, offered opportunities for professionals to build trust and respect, and gain knowledge of each other's roles. Professional prejudice and hierarchies, leading to mistrust and misunderstanding, hindered data-sharing.

Within **Processes and procedures**, data-sharing was supported by the wider policy and service delivery context e.g. provision of integrated care. This could be used to build a shared vision of care, creating context for formal agreements between organisations e.g. on mechanisms for data-sharing or the use of standardised assessment tools. These then needed to be translated into working practices within organisations. Failure to support new working practices e.g. by not providing the necessary resources, led to a disconnect between policy ambitions and day-to-day reality.



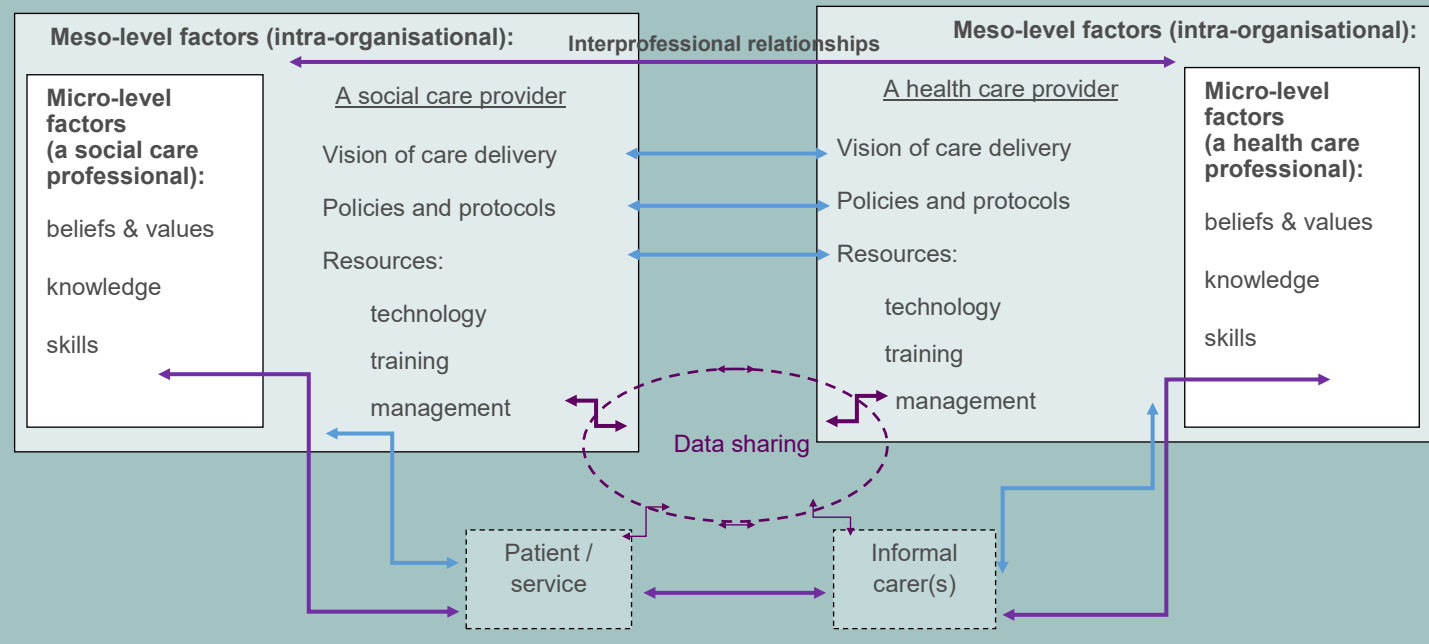
Two main factors influenced effective data-sharing in the theme of **Technology and infrastructure**. Firstly, it was important that technology was seen as a tool that could be used to support data-sharing, to record and retrieve data, usually alongside other methods of data-sharing, rather than a solution to all problems with data-sharing. This required consideration of how professionals interacted with the technology and with each other. Secondly, awareness of the care delivery system as a whole among professionals, in terms of the information needs of others and their use of information, also supported data-sharing.

In each cluster of studies specific factors also influenced data-sharing. In the joint assessment and integrated case management clusters, cultural differences between organisations and professionals prevented data-sharing. Data-sharing in the context of patients transitioning from hospital to community was affected by the different priority and value placed on this process by hospital and community-based professionals. Professional status was a particular problem in the care home cluster, whilst for palliative care it was the lack of legal frameworks to enable data-sharing.

This diagram brings the themes together, showing where they sit within the data-sharing system, and interactions that affect the effectiveness and acceptability of initiatives to improve data-sharing.

Macro-level factors: policy (e.g. vision of integrated care delivery to remedy fragmentation and related policy initiatives); funding (e.g. pilot projects); legislation (e.g. GDPR)

Meso-level factors (inter-organisational): shared vision of care delivery and specific arrangements between health and social care providers (alignment of care delivery practices that regulate, encourage and provide resources for data sharing).



Macro-level: factors external to the organisations and individuals that are sharing data, such as wider policies and a legal framework that enable data-sharing at ground level.

Meso-level: factors relating to the culture and practices in different organisations which need to be aligned across organisational boundaries. These include a shared vision of care provision and policies and protocols to reflect this.

Micro-level: factors affecting the behaviour of professionals, and patients and carers, such as their beliefs, values, knowledge and skills.

What are the implications of this review?

Our findings have implications for initiatives to improve data-sharing between health and social care. They indicate the importance of building interprofessional relationships, ensuring that professionals are able to share data in multiple ways to enable effective data-sharing, and wider support for data-sharing at a policy and organisational level.

Contact Us

Sian de Bell
s.c.de-bell@exeter.ac.uk

Zhivko Zhelev
z.zhelev@exeter.ac.uk

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