Editorial

Is all integration local?

In the latest edition of the *Journal of Integrated Care*, North Devon's Andrea Beacham observes that:

It is clearly difficult for local commissioners and providers to attempt to join up services which have evolved independently within separate government departments and national bodies […]. In the absence of established guidance, many areas in England are forging their own paths, tackling the barriers that arise on the way and taking a variety of approaches with varying degrees of success.

In one sense, this has probably always been true – across England, across different parts of the UK, and beyond. Reflecting back on his often-cited article on the "five laws of integration" (Leutz, 1999), Walter Leutz later concluded that "all integration is local" (Leutz, 2005, p. 9):

This was not one of the original laws, but perhaps it should have been. On the one hand is the notion that each integration effort has to be implemented locally in a way that is consistent with the particulars of local systems and personnel. On the other is the idea that larger policies should facilitate rather than dictate the structure and pace of local action.

However, this insight seems even more the case in the current policy and financial context, with different health and social care communities trying to find ways of meeting rising demand with increasingly inadequate resource. For colleagues in the English NHS, moreover, there is a strong sense that current structures, controversially introduced through the 2012 health reforms, are increasingly unfit for purpose. As a result, there is significant local soul-searching underway as to how to overcome the current fragmented system whilst staying within the bounds of what many see as an inadequate and unhelpful legal framework. Against this background, there is often a desire to look to other health systems for good practice, learning from others and borrowing good ideas wherever we can find them. While this can work well when we adapt the lessons learned for our own context and use international examples as a way of giving us new insights into our own system, it can be less successful when we try to incorporate apparent "solutions" wholesale and uncritically.

With all this in mind, the current edition of the journal draws on a series of local case studies, national evaluations and international studies to identify key barriers and success factors, top tips, things that innovators wished they had known at the start and outcomes achieved. Three of the papers (Bob Erens *et al.*, Andrea Beacham and Mark Swift) are based on contributions initially presented at the King's Fund Integrated Care summit. When considering early findings from the evaluation of the Integrated Care and Support Pioneers in England, Bob Erens *et al.* explore the start-up phase of a series of local developments that will then be tracked over time – filling a key gap in the literature in terms of longitudinal impacts. In particular, they highlight an "integration paradox":

[…] as more effective integration becomes increasingly pressing to improve outcomes and secure sustainable services within an increasingly adverse financial setting, so it becomes increasingly difficult to bring about because the same environment increases the imperative to keep core services afloat, and can lead to a retreat into more "siloed" ways of working.

Next, Beacham describes the One Ilfracombe programme, describing local attempts to produce better health, economic prosperity and a high-quality living environment as part of the Department for Communities and Local Government's Neighbourhood Community

Budget pilots. This involved creating a new not-for-profit company limited by guarantee, together with three multi-sector teams (the Ilfracombe Works team, chaired by a local business leader; the Living Well team, chaired by a local GP; and the Town team, chaired by Ilfracombe's police inspector). In addition to reflecting on the role of the local, the regional and the national, this fascinating paper concludes with a call to action:

> In the past, we've tried to implement solutions without a real understanding of the problem, we've designed and implemented those "solutions" in silos, not systems, and we've tried to tackle the symptoms, not the cause. We've accepted the landscape of complex and fragmented public service provision as the one we are stuck with – even though we know it hinders service users – because numerous policy attempts over at least the last decade have failed to change it. The public sector needs to become less puzzling to those it serves if it is to be more effective in tackling entrenched problems. It needs to join up all the pieces of support available to improve people's health including those that improve social, economic and living environments if we are serious about prevention and reducing inequalities.

Moving from Ilfracombe to Halton, Mark Swift describes the Community Wellbeing Practices offered to patients at all local GP practices. Working with a local social enterprise, this seeks to build on local community assets and community-based support in order to respond in a different way to the social needs of patients presenting to primary care. Key to the success of this work appears to have been the willingness to have "courageous conversations" and a recognition that the nature local of deprivation and inequalities was such that traditional services models were unlikely to be effective. What works in Halton might not work in Hertfordshire, Hartlepool or anywhere else beginning with "H", but the description of the journey to more community-centred approaches contains a series of key lessons about integration and the role of local cultures, geography and leadership.

Reflecting on attempts to promote physical activity, Sandy Whitelaw *et al.* report on the use of structured quality improvement techniques in Dumfries and Galloway to facilitate more integrative public health and to overcome longstanding limitations in the literature. Drawing on broader theoretical insights, they set out the process adopted, outcomes achieved and lessons learned. As they argue:

> At the onset, this paper highlighted a series of critiques in this area: formal learning processes tend not to be used; there is relatively little empirical assessment of efforts to formally explore processes of integration; what has been done tends to be relatively superficial; and the focus of this work has been on clinical and care integration rather than emergent integrated public health work. This case study has sought to address all of these.

Moving further afield, Clare Harvey *et al.* set out a framework for the development, implementation and evaluation of an integrated model of care for people living with long-term conditions in New Zealand. Informed in part by a previous nurse-led respiratory pilot in Hawke's Bay and by the Icelandic Nuka Health System, a Liaison Nurse consultant will work with the person, their family and the community, and helps to break down traditional boundaries between primary and secondary care. While eventual outcomes remain to be seen, the project appears to have arisen in part from a recognition that previous approaches to service delivery would not be sufficient to resolve health inequities in an area with significant deprivation, high incidence of long-term conditions and particularly poor outcomes for Maori and Pacific island people.

Reporting on developments in North Queensland, Michelle Foster and her co-authors explore the impact of the Geriatric Evaluation and Management service model and on providers' perceptions of older people's care transitions. By focusing on the experiences of front-line workers from community and primary care, acute care and sub-acute care settings and interfaces, the study sheds light on the realities, working practices, tensions and trade-offs that practitioners strike in their daily work. While so much policy and guidance

talks about what ought to happen, genuinely understanding what does happen and why seems a crucial first step in bringing about longer-term change.

In the USA, Sherry Ball and co-authors explore the introduction of care co-ordination agreements (CCAs) as part of the Specialty Care Neighbourhood initiative within the Veteran's Health Administration (VHA). The largest integrated healthcare system in the USA, the VHA has already implemented patient aligned care teams, with a primary care provider, nurse care manager, clinical associate, administrative clerk and a social worker. However, communication between primary and specialty medical care remains problematic, and this paper highlights the way in which innovations such as CCAs can improve the dissemination of information, improve various work processes and achieve greater clarity in terms of roles and responsibilities. However, it is not a panacea, and such developments needs to go hand-in-hand with other approaches which seek to build relationships, as well as with other practical tools such as electronic medical records.

In the final paper, Marlieke den Herder-van der Eerden *et al.* describe the experiences of leaders within the field of palliative care seeking to create more integrated services in health in Belgium, Germany, Hungary, Ireland, the Netherlands, Spain and the UK. Drawing on a wider European research project (InSup-C), this element of the study sought to identify some of the most promising practices when trying to join up care for people with cancer, chronic obstructive pulmonary disease and chronic heart failure. While key mechanisms included multi-disciplinary teams and meetings, most communication was informal (e.g. via regular phone-calls) rather than through formal processes or settings. Even where electronic patient records existed, these tended to be restricted to certain organisational settings or to the palliative care team alone, and were rarely accessible across a network or region. Where progress was being made, it was often due to relationships, as well as to a general increase in awareness (in medical education and in the general population) around the importance of more person-centred palliative care. Amongst the barriers were divided systems with few places left for professionals from different backgrounds to come together to work on joint priorities, as well as a series of financial disincentives to joint working built into many of our policies and structures. Despite many positives, the specialists interviewed in this study were struggling to scale up existing innovation, and to embed good practice in everyday practice.

Ultimately, all this brings us back to the over-arching question – is all integration local? From the papers in this edition of the *Journal of Integrated Care*, our answer would be a resounding "yes" – but it is interesting to note that the same themes seem to emerge time and time again, from Halton and Ilfracombe, to Western Europe, Australia and the USA. While all integration is undoubtedly local, perhaps there is also "nothing new under the sun"?

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References

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