Editorial

Looking down the right end of the integration telescope

Over the past few weeks, the editors of the *Journal of Integrated Care* have been working with our editorial board to refresh our mission as a journal. Similar to all initiatives that seek to make a meaningful contribution to improvement, it is vital that we have a clear sense of what we are hoping to add to the study and implementation of this field. We believe that the statement below reflects our aspirations:

> The *Journal of Integrated Care* provides leading research and practice insights in the field of integrated care. Based in the four nations of the UK, it has an international reputation and an editorial board that reflects this global reach. It offers a supportive and responsive environment for authors from all professional backgrounds to publish rigorous studies and discussion papers at the cutting edge of research, practice and thinking in integrated care. Our peer reviewers are committed to a timely response giving clear and constructive feedback.

Fulfilling this mission will require us to gather insights not only from high-quality research studies and evidence reviews, but also to learn from those with practice and policy wisdom. The present issue nicely reflects this blend of evidence, and our widened focus to gather learning from an international basis.

Networks are often suggested as a means to foster connections between those with a common interest in order to achieve individual and shared objectives and to grow a community of practice. They respond to the collegiate values of many of those who work to promote integration and can potentially provide a relatively low cost means to better connect professionals and between individuals and their families. Networks commonly begin with a few people with a passion who experience personal or professional fragmentation and discover others with a shared belief in the potential to achieve change. Initially successful, the challenge becomes how to sustain networks in the long term when the instigators have moved elsewhere or finally run out of steam. It can also be difficult to repeat the initial network in other localities where the need may be as great but the champions are lacking. The first paper in this edition by Barbara Murphy and colleagues is a must for anyone with an interest in networks as it provides tangible insights into how they can be developed and sustained on both a national and local level. The Mental Health Professionals Network (MHPN) was established in 2008 in Australia to connect those from different disciplines within public and private practice in order to strengthen professional practice, enhance clinical pathways and ultimately improve outcomes for individuals. This is delivered through an online professional development programme and face-to-face practitioner meetings in local areas. The webinars have received more than 160,000 viewings between 2010 and 2016, with participation rates per webinar trebling during this period. In 2016, there were 380 supported local networks, 1,171 meetings and almost 15,000 attendances. Each local network has to include three or more disciplines and have the participation of at least one general practitioner. The independent evaluation suggests that membership of a MHPN network has led to increased awareness of the role of other professional, greater inter-disciplinary communication and improvements in patient referral processes.

Inter-professional collaboration is also the focus of our second paper. Outi Jolanki and colleagues have researched the perspectives of doctors and nurses working in primary care settings in Finland. Unlike many countries, most working age people in Finland access health care services through their employers which means that primary care centre patients

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are largely children, older people, and those who are unable to secure employment. Responding to the needs of this population will therefore often require communication with other services and professionals but the research participants highlight that exchanging information was often difficult with these organisations. This was thought to result in duplication and a reliance on the patient to provide continuity of care. Home care was a common exception to this, with the introduction of central service centres for home care providing easy access to this staff group. Addressing the general problem of poor communication required the primary care professionals to undertake additional work outside their core role to connect the patient with the right services – an example of emergent boundary spanning as described in our final paper by Needham *et al.*

In the first of two perspectives, John Wilderspin draws on his many years of working as a provider and commissioner within health and care services to consider the common assumptions that lie behind our belief in integrated care. In particular, the often repeated principle that diverting care from hospital to community services will be beneficial to individuals and be more financially efficient. He suggests that whilst we often focus on the challenges and impacts of the transfer of resources this is the "wrong end of the telescope" and instead we should be looking from the perspective of the individual and their family – do they experience joined up care at the time and place of their choosing? Wilderspin then provides a further challenge based on learning from good practice examples of integrated care. He argues that we should be focussing on how to improve integrated support to enable them to be more effective and efficient rather than looking to demonstrate the cost-benefits of community services vs acute. This would provide a more positive paradigm to guide our improvement efforts.

The second perspective by Stewart Greenwell and Daniel Antebi takes up some of these themes and considers the transforming of health and care systems to be more people centred and community orientated. Their immediate focus is that of Wales but their insights will transfer to other contexts and systems looking to move to a more integrated model. They propose that achieving such transformation requires challenging the existing power dynamics between services and the public to create services in which people are seen as allies, rather than passive beneficiaries of professional and managerial wisdom. This will require nurturing of communities to support them in developing sufficient resilience to recognise and express their innate strengths and abilities. They conclude that: "A cultural and conceptual change in how we deliver public services is needed, requiring a change in who decides what is required and how. Relationships between agencies, professions and citizens need to be more creative and innovative".

Axel Kaehne provides a novel perspective on the conceptual and theoretical foundations of integration studies. In his paper, he maps some of the components of current integration thought to the elements of Thomas Kuhn's notion of a scientific paradigm. This allows him to examine the scope, nature and depth of, what Kuhn called, group commitments, the presuppositions and assumptions that scientists share when working in a specific field. Kaehne shows that integration studies draw on resources that do not produce a viable and complete scientific paradigm in Kuhn's sense. Integration has more work to do, so Kaehne argues, in incorporating the patient's perspective that acts as motivational force and primary impetus for so many integration programmes.

In the next contribution, Jill Manthorpe and colleagues take a closer look at the way in which dementia services may be joined up. Dementia is the "twentieth first century disease", they write, but what integration means for dementia services has not been fully explored as yet. Their conclusion, that fully integrated dementia care is most likely to be expressed in care homes, may evoke an important debate about the nature and most appropriate constellation of care in this field. Their paper also highlights the need for further work by policy makers and practitioners to define what integration could mean in dementia care.

In the final paper in this edition, Catherine Needham and colleagues consider the "emotional labour" of boundary spanning. This concept describes the effort required to present oneself differently to how one feels inside either by suppressing one's natural emotions and/or presenting an alternative mask of emotions. It was first identified in relation to the work of flight attendants but is now recognised as being a feature of many professional roles including those in health and care. In relation to integrated care we have generally discussed the emotional impacts of working with those from an alternative professional background, being isolated from our usual peer group and adjusting to unfamiliar organisational norms and values. Needham *et al.* highlight that a further aspect relates to the degree to which working with citizens across boundaries was an explicit expectation of a job role, or one that has emerged over time. Both have their distinct emotional demands and the authors argue that these should be recognised by employers when recruiting, developing and supporting people to fulfil such roles. They also underline that with the right support boundary spanners may find their emotional labour to be a rewarding aspect of their role.

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