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Steering the Integration Agenda: Stable Leadership Needed

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Service Integration

Overcoming barriers between the health and care sectors to achieve service integration has been the goal of successive UK governments over many decades, although its four countries have chosen different pathways and timescales to reach it.

While Northern Ireland was first past the post and can offer 46 years of experience in what challenges are being faced in attempts to bring the sectors together at present, Scotland, Wales and England are all now pushing forward the integration agenda with increasing urgency.

In Scotland, the government (Public Bodies Act 2014) sets out the legislative framework for integration, allowing Health Boards and Local Authorities to integrate health and social care services in two different ways. They can either delegate the responsibility for planning and resourcing service provision for adult health and social care services to an Integration Joint Board or opt to take the lead responsibility for this themselves.

The Scottish Government has made a clear statement on what it means by integration:

Integration is not an end in itself. It will only improve the experience of people using services when we all work together to ensure that we are integrating services as an effective means for achieving better outcomes. When we refer to “integrated health and social care", we mean services that are planned and delivered seamlessly from the perspective of the patient, service user or carer.

Last year the Welsh Government allocated an extra 20 million pounds to the existing 35 million pounds which was invested in 2014-15 in schemes to enhance integrated working by health and social care services. The focus in Wales has been on improved outcomes for older people and helping address the pressures on unscheduled care. The government claims some success already in reducing unnecessary hospital admissions.

In England the biggest experiment in integration, dwarfing all other models, is “Devo Manc". In March last year, in what has been sold as a trailbreaking move, Greater Manchester and the National Health Service (NHS) England signed a memorandum agreeing to bring together health and social care budgets – a combined sum of 6 billion pounds. The initiative saw NHS England, 12 NHS Clinical Commissioning Groups, 15 NHS providers and ten local authorities agree a framework for health and social care, with plans for joint decision-making on integrated care a key target (Manchester City Council 2015).

It is too early to judge the achievements of England’s other appointed pioneers in integration, now numbering 25. The pioneers, encompassing a broad range of health and care economies ranging from large urban populations in cities such as Leeds or London to the rural counties of Worcestershire, Staffordshire and Cheshire, have varying ambitions. What they have demonstrated to date is a strong commitment to innovation and recognition of the need to engage in a degree of risk-taking.

The arguments for effective health and social care integration from a patient perspective have been made and won. An ageing population, often with complex co-morbidities, requires well-coordinated care from different professionals, services and organisations. Fragmentation leads to gaps, which in turn delivers poorer outcomes.

However, lack of finance is the issue which currently dominates every discussion on health and care, with the NHS charged with making 22 billion pounds efficiency savings by 2020 and social care budgets under pressure as never before. When people’s needs are not met by the social care system, which is an increasing reality in the current climate, their dependence on the NHS increases. The common example is elderly people kept in hospital because of a delayed assessment, care home place, home care package or home adaptation.

Aside from improved patient experience, the government is also eyeing integration as a way of unlocking desperately needed savings in the system. However, evidence from international studies to date suggests that there is no guarantee that financial benefits will materialise.

Supporting and extending the concept of new models of care are the “vanguards”. The first 29 vanguard sites chosen fell into three categories: integrated primary and acute care systems; enhanced health in care homes; and multi-specialty, community-provider vanguards. These were closely followed by eight urgent and emergency vanguards and 13 acute care collaborations, the latter aiming to link local hospitals together to improve their clinical and financial viability (NHS 2015).

Obstacles and Openings

The blocks to successful integration (and indeed many new models of care) are well recognised. With the exception of Devo Manc with its shared budget, they include the differences which exist in the way health and care services are commissioned and funded — particularly the latter — along with the varying methods of governance, regulation and accountability, exacerbated by the Health and Social Care Act 2012.

That said, the ingredients needed in a move to integrated services have also been identified. In 2014 a report on the progress of the initial English pioneers at the end of their first year of operation highlighted “overwhelming evidence” indicating that the key to successful transformation was “strong relationships which enable leaders to overcome organizational boundaries for the benefits of the whole system” (NHS England 2014).

The report went on: “Where it is working well, it is not because of changes imposed nationally. It is through local leaders at all levels — clinicians, health and care workers, managers and patients — taking bold steps to move away from traditional ways of working which may benefit their own organisation but be to the detriment of the whole system.”

Strong relationships take time to build and excellent, stable leadership is key to creating vision, trust and shared values and to breaking down traditional silos and changing cultures.

However, as a recent Institute of Healthcare Management(IH M) snapshot survey revealed (2015), leadership continuity is seriously under threat; half of 18 CEO s from its membership were considering quitting their post within the year. Of these, only one was looking to find an alternative position within the NHS , with the remainder seeking alternative employment in another sector or private healthcare, or opting for early retirement.

The reason for this disillusionment is not hard to find. The dilution of central interference promised by the 2012 reforms of health and social care has failed to materialise. Instead, today’s leaders are dogged by a growing burden of regulation and inspection, an increased degree of political exposure and a blame culture that should long ago have been consigned to the history books.

Yet there could surely be no better time to focus on the leadership that health and social care needs to produce the stability in the system on which successful integration depends. Leaders in both sectors deserve more support if they are to stay the course, using their skills to bring people together to collaborate in a shared vision for the future.

Risks will have to be taken — even encouraged — in the knowledge that some failures will result. Those failures, in turn, will need to be honestly acknowledged without fear of blame or retribution. And greater recognition must be given to those who lead the way in difficult and troubling times for healthcare.

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