The holy grail of health and social care integration

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EDITORIALS

The holy grail of health and social care integration

Cost savings may be hard to identify but the real benefits are human

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According to a recent report by the National Audit Office (NAO),[1] "nearly 20 years of initiatives to join up health and social care . . . has not led to system-wide integrated services" and "there is no compelling evidence to show that integration leads to sustainable financial savings or reduced hospital activity."

The only strictly incorrect element in the NAO's critique is the timeline: we have been trying to integrate care for much longer, going back at least as far as the joint care planning, joint finance, and joint consultative committees of the 1970s. We also saw joint hospital discharge protocols in the 1990s, the growth of multidisciplinary mental health and learning disability teams, national guidance on joint commissioning, pooled budgets, a single assessment for older people, the creation of care trusts (integrated health and social care organisations), and the advent of joint strategic needs assessments—not to mention Labour's integrated care organisation pilots; the Coalition government's Better Care Fund, integrated care pioneers, and vanguards; and greater regional devolution of health spending.[2-5]

While progress has been made over time, health and social care remain separate entities with different legal frameworks, different budgets, different cultures, different geographical boundaries, different accountability mechanisms, and different approaches to whether services are free or means tested—all of which make joint working difficult at the best of times. With rising need, challenging NHS finances, and draconian cuts to local government, the pressures we face mean that there is an even greater incentive to guard our organisational boundaries more jealously and to focus only on core, internal priorities. Money, after all, can damage the closest of relationships—and joint working between health and social care might be no different.

Over all this time, we have learnt at least three lessons. Firstly, we must beware of structural "solutions." Although major structural change looks bold, it often gives simply an impression of change, morale and productivity tend to fall, and positive service development usually stalls. In both public and private sectors, organisational mergers tend not to save money, and many commercial mergers fail.[6-10] Despite this, structural change is still a favourite tactic, with the NHS experiencing repeated reorganisations. Often this means that the potential benefits of the first reorganisation are not realised before we move on to the next one; time and energy are wasted in the process; changes are often cyclical (with the same structures coming and going over time); and front line staff quickly become disillusioned and change weary.[11]

Secondly, it's difficult to stay together in a system not designed with integration in mind: while a number of local areas have tried to develop long term relationships and new approaches they have struggled to maintain these as policy priorities change.[12-14] According to a famous article on the "five laws of integration," you can't integrate a square peg into a round hole.[15] As the NAO argues, three longstanding barriers are misaligned financial incentives, workforce challenges, and difficulties with information sharing. These arguably need national rather than local action to resolve.

Finally, we have learned the hard way that silo-based approaches don't work for people with complex needs. While attempts to integrate care have struggled to save significant amounts of money, they can sometimes improve patient experience and make services more person centred. They can also have some positive effects on hospital admissions and length of stay for some conditions.[16]

So even if we don't know how well integrated care "works," we do know that unintegrated care typically doesn't. As far back as 1998, Labour set out the case for greater joint working in stark terms, and—for all the challenges rightly raised by the NAO—this analysis remains true:

"All too often when people have complex needs spanning both health and social care good quality services are sacrificed for sterile arguments about boundaries. When this happens, people, often the most vulnerable in our society and those who care for them, find themselves in the no man's land between health and social services. This is not what people want or need. It places the needs of the organisation above the needs of the people they are there to serve. It is poor organisation, poor practice, poor use of taxpayers' money—it is unacceptable."[17]

Whenever an older person becomes the subject of a dispute over "bed blocking," when a mental health and a learning disability team argue over who should take referral of a service user with a "dual diagnosis," when a young person with a disability turns

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18 and faces a lack of coordination between children's and adult services, the result is always damaging, distressing, and counterproductive. There may be financial and organisational costs, but the main impact of poor integration is human.

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