Editorial

Reasons to be cheerful (about integrated care)

The problems of integration are well known. Conflicting organisational priorities, divisive performance and incentive regimes, professional territorialism, and self-interest are to name a few. We continue to read academic studies and governmental reports from most health and care systems that suggest that progress has been patchy at best, with progress in some services areas and often in only a few localities. Sustainability remains a vulnerability of more successful programmes through the loss of key individuals, withdrawal of investment or change of political winds. It is therefore easy to become overwhelmed by the challenges, the limitations and the lack of learning that often surrounds this area of practice. Despite these frustrations, we strongly believe that progress is being made in our understanding, in the implementation and, most importantly of all, in the impacts of integration. We therefore decided to use our final contribution as editors of the *Journal of Integrated Care* to highlight five reasons to be cheerful about integrated care.

Integration is now expected

As an editorial team, we are regular attendees at the conference organised by the International Foundation for Integrated Care (https://integratedcarefoundation.org/). These are a dynamic blend of academics, policy makers, practitioner, clinicians and people with lived experience. Over recent years, attendances at these events have been booming so that the 2017 conference in Dublin was attended by over 1,000 people. This compares with the old days where there was a decent attendance but events were much smaller affairs. This reflects a significant change in our collective thinking in which integration is no longer seen as something nice to have but rather a required component of a well-functioning health and care system. This is reflected in the strategies agreed by the World Health Organization (www.euro.who.int/__data/assets/pdf_file/0005/231692/e96929-replacement-CIHSD-Roadmap-171014b.pdf?ua=1), and in the national programmes being developed around the world. There is clearly much more to do – achieving consistency and sustainability of integration, ensuring that the focus is not just on reducing hospital admissions (although this is important) and having more nuance about what type of integration is right for what population and circumstance. But increasingly there is an onus on justifying why services are not providing an experience of integrating care rather than lengthy arguments and business cases about why it should be a common expectation.

Integration has people at its centre

Any manual on management or leadership of private or indeed public sector organisations will tell you that the way to be successful is to be focussed on what the customer, patient or community want to buy, receive or contribute from/to the endeavour in question. It is therefore lamentable that for so many years integrated care was much more concerned about the relationships between professionals, the financial flows between budgets and the performance against key activities. These are, of course, important enablers or indicators of the process of integration but they are not its point. People were still there somewhere in the original recognition of a problem or possibility, and improving people's lives would have been in the consciousness of people leading and implementing the associated initiatives. But it was all too easy for this focus to fade into the background somewhat with reports on financial savings and project plans taking centre stage. Research also mirrored these interests, with

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evidence reviews consistently bemoaning the lack of good evidence on the impact for people and their families. In the UK, the pioneering work by National Voices (www.nationalvoices.org.uk/publications/our-publications/narrative-person-centred-coordinated-care) has changed this dynamic through articulating a simple yet profound set of statements about what integrated care looks like for the people who matter the most in all these efforts. The Institute for Health Care Improvement's s Triple Aims have also helped by underlining that this does not mean the money has to be forgotten about and indeed the importance of considering the population as a whole (www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx).

Integration is connecting to communities

The vertical and horizontal connection of clinical decision making and interventions should be a central consideration of integrated care programmes. If not then we know that people can fall between service boundaries or be subjected to conflicting advice and support. In the past, however, our perspective on what was possible and important to achieve was often limited to these activities. This meant that we missed the importance within integrated care of taking pro-active interventions that would respond to underlying health inequalities and seek to prevent people's health and well-being deteriorating to the stage where an integrated crisis pathway is required. Alongside, this lack of prevention was a patchy acceptance that integration should include a better incorporation and strengthening of community resources and not just formal health and care services. In the past five years, there has been a broadening of our perspectives on the role of integrated care and who this should include. For example, the concept of the primary medical home is being widely adopted and it is becoming common for integrated health and social care teams to include representatives from the voluntary and community sector. Social prescribing is another representation of this trend. Increasingly, a number of systems are trying to move away from deficit-based approaches (identifying what is wrong with someone and trying to cure them), towards more assets-based approaches (which seek to identify the natural supports that people already draw on in their everyday lives and finding ways to build on these). In the UK, examples include service models such as Local Area Co-ordination, Shared Lives, assets-based community development and others (see e.g. www.scie.org.uk/future-of-care/asset-based-places).

Integrated budgets are getting personal

Linked to the spread of assets-based approaches above, we have also seen the development in some countries of personal health budgets and direct payments in health care. This is something we have long championed (see e.g. Glasby and Hasler, 2004) and an idea which feels long overdue. For example, for years, people in England could receive direct payments (and later personal budgets) for the "social care" aspects of their lives, but not for their health care – even in situations where a local area had a single assessment process, an integrated team, a pooled budget and an integrated management structure. Having choice and control over one set of services, but not over others, flew in the face of the partnership agenda, and made no sense whatsoever. Fortunately, the prohibition of direct payments in the NHS in the mid-2000s was soon overturned, and there have been a series of policy initiatives, pilots, evaluations and case studies to help demonstrate what is possible when we are clear with people how much is available to spend and allow people to be more imaginative and creative about how joined-up needs can be met in a joined-up way. This is a very different notion of integration to ones we have seen before – enabling people to integrate their own care and support in a way that makes sense for them, rather than trying to focus on changing organisational structures, management teams and IT systems to integrate care top-down. Throughout these developments, the *Journal of Integrated Care* tried to play its part, publishing a number of key articles on the personalisation agenda, implications for partnership working and lessons learned from the field.

Integration is becoming researched

Whilst there are debates to be had about the realities of evidence-based decision making in national and local policy and investment strategies (i.e. what do we mean by evidence, what is feasible to be studied, etc.), there is no doubt that the more high-quality evidence that we have the better. Research suffers from similar imbalances to much of the health and care system in that there is considerably more funding for particular types of integration research than others. So, for example, a systematic review of say stroke, cancer or diabetes care is much more likely to identify robust articles than those looking at reducing loneliness or the role of social care services. There is also a tension between positivist and interpretivist knowledge paradigms regarding what provides a higher order of evidence that feeds into the fault lines between professional perspectives. Despite all these limitations, there is no doubt that, over the last five years, the amount, the quality and the diversity of research regarding integration have improved. Furthermore, there are numerous large scale studies in progress which should further add to our knowledge and understanding over the next five years too. In the past, some policy makers used to worry that there was not enough evidence on which to base decisions. Now we have lots of evidence – albeit there is always more we need to know – and the challenge is how to act on this knowledge as best we can. The forthcoming special issue of the *Journal of Integrated Care* focussing on evaluation will be a good opportunity to debate these issues.

A journal to be proud of

Finally, all these reasons to be cheerful have had a direct impact on the *Journal of Integrated Care* over the last five years. The journal has always been blessed with a very loyal readership and authorship (as well as all the people who review articles, advise the editorial team and help to promote the journal through their networks). However, when we became editors, the success of the journal was due in large part to the hard work, constant vigilance, networks and sheer persistence of Peter Thistlethwaite, the journal's founding and longstanding editor and champion. We were honoured not only to take on the role of editors, but also nervous that these were big shoes to fill and that we might not be able to keep up Peter's momentum and drive. In the end, we need not have worried. Such has been the importance of integrated care over the last five years (and such has been the support we have received) that the journal seems to have gone from strength to strength. In our last editors' report, we see that over 18,000 articles were downloaded in 2017 (compared to under 9,000 in 2013). Readers come from all round the world (the UK, Australia, Malaysia, the USA, China, Canada, New Zealand, Sweden, the Netherlands and Germany are the top 10 countries downloading articles), and our main authors in 2017 were from Australia, the UK, the USA, Canada, New Zealand and the Netherlands. Our most viewed special edition was around integrated care in Australia, downloaded over 1,100 times in 2017 alone. Of particular, pride to us as editors is the ongoing focus on policy and practice learning from the four countries of the UK (a key feature of the journal's mission), with special editions on integrated care in Wales (with abstracts translated into Welsh) and on practitioner-led research in Scotland, and key papers on lessons from Northern Ireland, Scotland and Wales. We have continued to receive submissions from "old hands" as well as those writing an academic article for the first time, with academic and practice contributors providing valuable insights into how integrated care can be achieved. In our co-editor, Axel Kaehne, we have found a friend and colleague who has the networks, values, passion and ambition to take an already strong journal on to a new level – and we are delighted to see that the journal is in such good editorial hands going forwards.

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Reference

Glasby, J. and Hasler, F. (2004), *A Healthy Option? Direct Payments and the Implications for Health Care*, Health Services Management Centre/National Centre for Independent Living, Birmingham.