Social care and the NHS: how to change the framework of joint working

The NHS and social care systems are turning 70, and for almost as long as they have existed, there have been attempts to join up the services and improve coordination. Despite multiple reorganisations, however, efforts have had limited success. ***Melanie Henwood*** *explains what the conclusions and recommendations of new analysis by the Care Quality Commission tell us about operating these parallel but separate organisations.*

"A system designed in 1948 can no longer effectively meet the needs of increasing numbers of older people with complex health and care needs." So concludes the Care Quality Commission (CQC) in the report of its review of care for older people in 20 local care and health systems in England. This is both very timely – with the future of care funding and a Green Paper now due in the autumn – and potentially game-changing. The fact that health and care services can achieve better outcomes when they work together is not a new conclusion, and neither is the observation that joint working is not easy, particularly in a system characterised by fragmentation and competition.

Indeed, as Chief Executive Sir David Behan observes in his Foreword, *"These are difficult problems to solve. There have been attempts to integrate health and social care since the 1970s."* And none has yet fully succeeded. But this isn't simply a repeat of familiar messages and laudable appeals for people to cooperate to improve integration, rather this is moving the debate to another level and concluding that we know enough about what makes a difference and what needs to change to make it happen everywhere. In short, the time for excuses and procrastination has passed; there needs to be a new game in town.

The system reviews examined how well older people move through the health and social care system, with a particular focus on the interface, and identifying what improvements could be made. There were plenty of examples of good practice, but equally many instances where the systems did not work in the best interests of people who use services, their families or carers, because organisations were not sufficiently joined up.

The areas where joined up care pathways need to happen to maximise outcomes for older people are well known, and the CQC analysis identifies the barriers and enablers around key issues of:

- Maintaining health and wellbeing in the community;
- Care and support in a crisis;
- And step-down care and delayed transfers of care.

But what are the factors that predict success or failure? CQC suggests that there are a number of 'ingredients' required, and in particular:

- Common vision and purpose shared by system leaders, to work together;
- Effective and robust leadership and governance across the overall performance of the system;
- Strong relationships at all levels;
- Joint funding and commissioning;
- The right staff with the right skills;
- The right communication and information sharing channels;
- And a learning culture.

Of all these variables, CQC underlined that *"strong, collective leadership is the single most important enabler for success in providing high-quality health and social care for people."* This seems to be the key to unlocking genuine joined up working and integration, but the structure of health and care services is not generally organised in ways that support and demand whole system focus, so much as maximising individual organisational success. People who try to cross boundaries and to achieve cross-system objectives *"have a challenging job, often without mandate and ownership of resources for the task."* The requirement, argues CQC, is for a new approach to leadership, *"where leaders are supported and encouraged to drive system priorities collectively."*

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In addition to changing organisational culture and relationships, such a shift also requires different metrics and outcome measures to drive it forwards. Whatever the stated values and objectives that senior managers may argue they sign up to in supporting better joint working to improve outcomes, typically their performance is measured at an organisational level rather than that of the wider health and care system.

Targets and measures developed for parts of the system with an apparent aim of improving performance (such as around Delayed Transfers of Care) may be inimical to the pursuit of wider system objectives and may indeed produce unintended consequences of merely transferring pressures from one part of the system to another. Different lines of accountability for care and health both locally and within national governance can create tensions and contradictions. If joint working is to be better incentivised at the local level, CQC argues there has to be a more coherent national framework of accountability that aligns system oversight, regulation and funding.

The system reviews identified examples of positive outcomes achieved by health and care organisations working together with "a clear, agreed and shared vision, strong leadership and collaborative relationships". But the critical conclusion – and in many ways the most damning finding – was that such efforts were often *despite* the conditions in which they were working rather than because of them. In other words, despite decades of the 'only connect' mantra being repeated by successive governments, and opprobrium being heaped on those who fail to achieve the outcomes attained in some localities, the conditions in which "joined up working across organisational boundaries can flourish are not yet in place."

Local managers and leaders have a central role to play in agreeing joint goals, developing plans to achieve these, and pooling budgets to deliver on objectives; but this also requires long-term stability and funding agreements from central government departments, and sustainable funding reform "that addresses social care and the NHS together." In addition, it is also central government that must address the CQC's other recommendations for changing performance management to a single joint outcomes framework; developing joint workforce planning strategies; and introducing legislation to enable CQC to regulate local systems rather than individual organisations.

The challenge is to tackle the fundamental and underlying structural and systemic barriers to joint working and integration. The CQC analysis focused particularly on older people, but the same principles will be true for meeting the needs of anyone with complex and multiple needs which cross organisational boundaries of care and health (and other services). This is in many ways the swansong report from Sir David Behan who is retiring from the CQC this summer. This valedictory call to address the unresolved issues, and to question "whether leaders working locally and nationally have the bravery and conviction to lead the charge" should resonate through Whitehall and Town Hall.

About the Author

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