Integrating Health and Social Care in England: Lessons from Early Adopters and Implications for Policy

Chris Ham
Professor of Health Policy and Management

John Oldham
Honorary Senior Fellow

Health Services Management Centre, University of Birmingham

Contact details: c.j.ham@bham.ac.uk

ABSTRACT
This paper reports on experience in making use of Health Act flexibilities and care trusts. Three areas were chosen for study because they were known to have attached priority to health and social care integration and were at the leading edge of development. Drawing on discussions at a series of seminars at which the experience of each area was presented and reviewed, the paper identifies a number of emerging lessons for the future of integration in a context in which the Government has established a Minister-led review to explore what more needs to be done to encourage integration.

KEY WORDS
care trusts; partnership working; health and social care integration

Introduction

Achieving closer integration of health and social care has been a policy priority in England for almost half a century. Since the *Health Act 1999*, attention has focused on encouraging local authorities and NHS organisations to use the flexibilities introduced under Section 31 of the Act in order to integrate their services. These flexibilities are:

- lead commissioning, under which one authority transfers resources to the other, which then leads in the commissioning of both health and social care
- integrated provision, under which one authority takes responsibility for the provision of both health and social care
- pooled budgets, under which authorities

transfer resources into a single budget which is managed by one of the authorities on behalf of both.

Alongside these flexibilities, care trusts have been set up in some areas to promote integration. Care trusts were first announced in the NHS Plan in 2000 and powers to create them were included in the *Health and Social Care Act 2001*. Care trusts combine NHS and local authority responsibilities under a single statutory body and focus on services such as the care of older people and people with mental illness. They are NHS organisations, but include local authority councillors on their boards.

This paper reviews experience in three areas (***Box 1***, below) that were early adopters in the use of Health Act flexibilities and the development of care trusts. It goes on to identify the policy implications that have emerged from this experience. The paper was written in the context of a review by the Audit Commission that concluded:

Working across organisational boundaries brings complexity and ambiguity that

Box 1: THREE EARLY ADOPTERS

Knowsley has a population with significant social, economic and health needs. A partnership known as Knowsley Health and Wellbeing was established in 2004 under Section 31 of the *Health Act 1999* (now Section 75 of the *NHS Act 2006*). It built on the appointment of a joint primary care trust chief executive and council executive director in 2002. The Health and Wellbeing Partnership Board provides overall direction, and day-to-day responsibility rests with the Partnership Management Board. There is a single executive leadership team and the partnership has focused on improving the health of the population, tackling health inequalities and making effective use of all the resources in the area.

North East Lincolnshire has given priority to primary care-led integration. It includes co-location of health and social care in new primary care premises, work to integrate information technology and development of integrated mental health provision. Building on these developments, the North East Lincolnshire Care Trust Plus was established in 2007. A care trust plus differs from a care trust in that partnership involves working across all services and not just health and social care. Under this arrangement, responsibility for adult social care commissioning and provision has transferred from the local authority to the primary care trust, whereas responsibility for public health has transferred to the local authority.

Torbay established a care trust in 2005 to promote closer health and social care integration for older people. It is based on a previous history of good relations between the primary care trust and the local authority, coterminous boundaries, support from local politicians, involvement in the NHS Kaiser Beacon site programme (Ham, 2006) and a joint desire to improve service delivery. Efforts to achieve closer integration have focused on establishment of five health and social care teams organised in zones or localities aligned with general practices. Each team has a single manager and a single point of contact, and makes use of pooled budgets to commission services based on a single assessment process.

can generate confusion and weaken accountability. The principle of accountability for public money applies as much to partnerships as to corporate bodies. The public needs assurance that public money is spent wisely in partnerships and it should be confident that its quality of life will improve as a result of this form of working. Local public bodies should be much more constructively critical about this form of working; it may not be the best solution in every case. They need to be clear about what they are trying to achieve and how they will achieve it by working in partnership (Audit Commission, 2005 p2).

Lessons from experience

The influence of local history and context

Each of the examples in ***Box 1*** demonstrates the influence of local history and context on health and social care integration. This is illustrated in the contrast between Torbay, which chose the care trust route as the means of achieving closer integration of older people's services, and Knowsley, which used Section 31/75 flexibilities to create a Health and Well-Being Partnership Board as the vehicle for addressing areas of common concern between the primary care trust (PCT) and the local authority. Knowsley considered the care trust option, but decided that it offered no advantage over the use of Health Act flexibilities.

For its part, North East Lincolnshire focused initially on integrating services through primary care and only in 2007, after 10 years' experience, was a decision taken to become a care trust. In this case, organisational integration resulted from a track record of integrating services, and the chosen vehicle in North East Lincolnshire was a care trust plus which encompasses all services, not only those provided for specific groups such as older people and people with mental illness.

The more general point here is that care trusts have not been used extensively to promote integration; only 10 areas have chosen this route. One of the factors that have inhibited more widespread adoption of care trusts is concern that they are first and foremost NHS organisations that risk reducing local democratic control over services and accountability to the population served. This is particularly the case with care trusts that are responsible for mental health services. Torbay was able to address this concern through intensive work by the PCT in engaging with elected councillors and reaching agreement that a care trust would bring benefits to the population.

As these examples illustrate, what works in one area may not work in another because of variations in context and in relationships between stakeholders. This underlines the need for there to be a menu of options available to support integration, rather than a single solution.

Integration needs to start from a focus on service users

A clear lesson from these areas is that the journey towards integration needs to start from a focus on service users and from different agencies agreeing a shared vision for the future, rather than from structures and organisational solutions. This is exemplified by the emphasis in Torbay on delivering better and more co-ordinated outcomes for Mrs Smith, a fictional 85 year old requiring support from a variety of health and social care professionals. The test of integration is whether it achieves this result and overcomes the fragmentation and lack of co-ordination that often characterise the experience of users like Mrs Smith (Lavender, 2006).

The importance of starting from a focus on service users is underlined by evidence from Northern Ireland showing that structural integration does not necessarily lead to service integration (Heenan & Birrell, 2006). As the experience of Knowsley demonstrates, it is possible to achieve

service integration in the absence of structural integration by effective local leadership and a commitment to develop partnership working over a sustained period. Of course, structural change may be desirable once integrated working has become firmly established, as the example of North East Lincolnshire shows, but seeing it as the result of integration rather than its cause is likely to be helpful.

The role of leadership at the top

Partnership arrangements depend critically on leadership by elected councillors and the members of PCT boards. In Knowsley's case, the Council Leader and PCT Chair have worked closely in developing integrated governance structures to the extent that they have been described as being 'joined at the hip'. Also important in that area has been the leadership of the Joint Chief Executive and her commitment to take forward partnership working. The Chief Executive's local government background played a significant part in this process, enabling as it did the development of fully integrated arrangements at all levels. Her appointment as a council executive director as well as PCT Chief Executive symbolises the approach that has been taken in Knowsley. The leadership of the PCT chief executive in Torbay was also a key factor in the progress made in that area, which included intensive work with elected councillors and others to underscore the benefits of a care trust.

The importance of integrated health and social care teams

In emphasising the nature of governance arrangements, the critical importance of integration at the front line of care should also be recognised. In all three areas, the primary motivation to integrate has arisen from a concern to ensure that people using services experience benefits, whether in improved health and well-being or in care that is co-ordinated more effectively, as in the example of Mrs Smith in Torbay. This objective has been pursued by bringing together community health and social care teams and aligning the work of these teams with GP practices serving the same localities. The co-location of these teams and the adoption of a single point of access and a single assessment process have helped to ensure that service users receive more responsive services with fewer hand-offs and delays. This has often involved giving higher priority to social care and other forms of support in recognition that health services are only one element in the package of care needed by users. In North East Lincolnshire, co-location was facilitated by a primary care estates strategy that enabled health and social care teams to come together in the same building. Work was also undertaken to develop an integrated IT strategy to facilitate the sharing of records and information about users.

The need for evaluation

The need to strengthen arrangements for evaluating the impact of the means that have been put in place in Torbay, Knowsley and North East Lincolnshire should be emphasised. The value of the work that has been done has been corroborated by external recognition, as in awards from the *Health Service Journal* for Torbay and Knowsley, and in improved performance ratings by the Healthcare Commission and Commission for Social Care Inspection. The next step is to conduct independent evaluations using appropriate methods to establish the outcomes achieved in these areas and how they compare with areas in which partnership working is less well developed. These evaluations also need to analyse the value for money of the services provided in areas that have adopted partnership approaches.

Implications for policy

What, then, are the policy implications of the work reported here, in the context of the Minister-led review of future options for health and social care integration?

Current policies contain sufficient flexibilities

A clear message is that the current legislative and policy framework contains a wide range of flexibilities. These flexibilities have enabled local leaders to make real progress in achieving closer integration where there has been the vision and will to do so. When asked what else central government should do to support integration, the universal response of these leaders was that government should keep its distance and not put barriers in the way of partnership working. From this perspective, the lack of direction from government and the creation of a permissive policy framework can be seen as a strength rather than a weakness.

Policy should be tight on ends and loose on means

This stance makes a good deal of sense when applied to areas where the need for closer integration is understood and is being acted upon, but it may not be sufficient in other parts of the country that have made much slower progress in this direction. In these other areas, it can be suggested that government should continue to be permissive in relation to the means of integration, while taking a more prescriptive approach to the ends that local agencies are expected to achieve. By being 'tight on ends and loose on means', government would enable areas such as those whose experience is reported here to continue to build on their achievements to date while exerting leverage over other areas to up their game.

As the examples reviewed in this paper have shown, the ends of integration relate to service users and the need to demonstrate that partnership working brings benefits to users. Some of these ends can be seen as 'intermediate outcomes' whereas others are outcomes that relate to the health of the population and reducing health inequalities. The approach proposed by the Department of Health in its 'vital signs' work (DH, 2008) and by the Audit Commission in the comprehensive area assessment programme (Audit Commission, 2009) contains many examples of the kinds of outcome that could be used to assess the effectiveness of partnership working.

The Care Quality Commission can support integration

In this context the new regulator, the Care Quality Commission, has a potentially important role in reviewing the performance of NHS bodies and local authorities, not least because for the first time a single regulator will cover both health and social care. The work of the Healthcare Commission and CSCI have shown the influence that regulators have had on health and social care services, and the new single regulator has an opportunity both to build on this work and to extend its scope into the areas discussed in this paper. More specifically, the Care Quality Commission should give priority to assessing the nature of partnership working alongside its remit to assess organisational performance.

Integration takes time to achieve

In thinking through these issues, the importance (and difficulty) of developing a culture of integration and ways of thinking that support integrated practices needs to be recognised. The challenge here is not simply how to overcome organisational barriers to integration, but also how to address differences in funding and payment systems and how to encourage team working between staff from different professional backgrounds. The experience of Northern Ireland, where structural integration has not always resulted in integrated team working at the front line of care, stands as a cautionary tale (Heenan & Birrell, 2009).

Developing a culture of integration among middle managers is equally important and challenging. The strength and depth of the differences between NHS and local authority services underline the fact that the road to closer

integration can at times be both lengthy and rocky. Recognising that integration often costs before it pays (Leutz, 1999), policy makers need to make a long-term commitment to the path they eventually take if the Minister-led review is to avoid becoming just the latest false dawn in the history of attempts to achieve closer integration. The time needed to achieve integration can be reduced with support from health and social care leaders and action to bring together the work of front-line teams.

Policy coherence is needed

The other main implication is the need for a joined-up approach to policy development in the Department of Health. PCTs and local authorities have been expected to take forward a wide range of initiatives, including world class commissioning, practice-based commissioning, individual budgets and, most recently, personal health budgets. Government policy has also promoted greater use of choice and competition as means for improving the performance of services while at the same time encouraging integration and co-operation. At the local level these policies do not always appear to be the outcome of a coherent process, and this can give rise to tensions in implementation.

In view of this, the Department of Health needs to clarify and communicate clearly how the current reforms to the NHS and social care interrelate and its understanding of how moves to integrate health and social care, strengthen commissioning within the NHS and promote self-directed care are intended to be used to bring about further improvements in services for users. The absence of a coherent health and social care reform narrative is likely to hinder the pursuit of closer integration. To be sure, the recent move by the Department of Health to establish 16 integrated care pilots in England appears to indicate that the kinds of initiative discussed in this paper are returning to the heart of the policy agenda, but greater consistency within government is long overdue.

Conclusion

Health and social care integration will become increasingly important as the population of England ages and the burden of chronic diseases in the population increases. The prospect of much tougher funding of health and social care as a consequence of the economic recession underlines the need to use all public resources as efficiently as possible. Experience from areas at the leading edge of development has highlighted a number of lessons for other areas and a series of implications for policy makers. The Minister-led review of future options must avoid prescribing structural solutions and focus instead on service users and enabling the emergence of integrated health and social care teams. In so doing, the complexity of overcoming professional and cultural obstacles has to be recognised, as does the time needed to develop new ways of working. Ministers should be clear about the outcomes that they are seeking to achieve for service users and ensure that the Care Quality Commission uses its leverage to improve partnership working. Failure to work in partnership should be viewed in the same light as failure to achieve other objectives, including financial balance and services that meet acceptable standards of care.

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