

ONLY CONNECT

POLICY OPTIONS FOR INTEGRATING HEALTH AND SOCIAL CARE
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INTRODUCTION

To explore the issues involved in achieving closer integration of health and social care, the Nuffield Trust held a series of seminars led by experts in this field between November 2008 and January 2009. The series built on previous work by the Trust on integrated care and focused on areas of the country in which primary care trusts (PCTs) and local authorities have experience of working together on issues of common concern. This briefing paper summarises the discussions that took place at the seminars, discusses emerging messages, and identifies the policy implications.

Key points

- The flexibilities provided by the Health Act and the option of becoming a care trust have enabled PCTs and local authorities in a number of areas to establish closer integration of health and social care services, and to develop joint approaches to improving the health and wellbeing of their populations.
- What works in one area may not work in another, because of variations in context and in relationships between stakeholders.
- The journey towards integration needs to start from a focus on service users and from different agencies agreeing what they are trying to achieve, rather than from structures and organisational solutions.
- Partnership working depends critically on leadership by elected members and PCT board members, and by senior managers.
- Alongside integrated governance arrangements, the development of integrated health and social care teams that are aligned with the work of GP practices serving the same localities has contributed significantly to the progress made in integrating services.
- In the areas covered by the case studies presented here PCTs and local authorities are working in partnership, but more work is needed to bring in other partners, particularly those providing acute hospital services.
- Future policy on integration needs to be tight on ends and loose on means and the choice of means should be a matter for local decision, taking into account variations in context.
- The new Care Quality Commission has a potentially important role in assessing the performance of NHS bodies and local authorities in promoting integration, and in using its leverage to spread the examples of innovation described in this briefing paper to other areas.

BACKGROUND

The needs of people with learning disabilities or mental health problems and those of older people are rarely either just ‘medical’ or ‘social’. The importance of joint approaches to addressing these needs has been recognised by policy-makers ever since the production in the 1960s of long-term plans for the future of hospitals and what were then called ‘health and welfare services’. The challenge throughout this period has been to turn policy aspirations into practice. This challenge has been acknowledged in *High Quality Care for All* (Secretary of State for Health, 2008), which announced that a Minister-led review would be established to explore what more needed to be done to promote health and social care integration.

Since the Health Act 1999, moves to achieve closer integration of health and social care in England have focused on the use of three flexibilities introduced under Section 31 of the Act. These 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.

THE SEMINAR SERIES

The Nuffield Trust seminar series explored what had been achieved using Health Act flexibilities and the powers available to care trusts by drawing on experience in three areas at the leading edge of integrated working in England. The seminars were led by managers and clinicians intimately involved in integrated working, and addressed the following questions:

- What is being achieved in care trusts? This was the main theme of the seminar led by Peter Colclough, Chief Executive of **Torbay Care Trust**.

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 in areas such as the care of older people and mental health under a single statutory body. They are NHS bodies but include local authority councillors on their boards.

In a review of experience of partnership working in the public sector, the Audit Commission noted:

Working across organisational boundaries brings complexity and ambiguity that 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, p.2)

It was against this background, of the need for partnership working and yet the difficulties that have arisen in practice, that the seminars took place.

- How are PCTs and local authorities working together on health and wellbeing? This was the main theme of the seminar led by Anita Marsland, Chief Executive of **Knowsley PCT**, and colleagues.
- How is practice-based commissioning contributing to closer integration of health and social care? This was the main theme of the seminar led by Peter Melton, PEC (Professional Executive Committee) Chair, **North East Lincolnshire Care Trust Plus**.
- What options are there for the future in the context of the current Minister-led review announced in *High Quality Care for All*?

CARE TRUSTS: THE TORBAY EXPERIENCE

Torbay is one of the three NHS Kaiser Beacon¹ sites (Ham, 2006); all three sites contain care trusts. This reflects the focus of the sites on service integration and the interest in using care trusts as one means of achieving integration.

Torbay has a population of 140,000 with a higher than average proportion of over-65s (23 per cent). It has a low-wage economy and differences in life expectancy of eight years between wards at the extremes. The care trust is based on a previous history of good relations between the PCT and the Council, coterminous boundaries, political support, involvement in the Kaiser Beacon site programme and a joint desire to improve performance and service delivery.

The most important reason for integration was a concern to deliver better and more coordinated outcomes for patients. This was epitomised by 'Mrs Smith', a fictional 85-year-old requiring support from different health and social care professionals. The test of integration is whether it achieves this result and overcomes the fragmentation and lack of coordination that often characterises the experience of users like Mrs Smith.

Integrated teams

Key features of the service are five integrated health and social care teams organised in zones or localities that are aligned with general practices. Each team has a single manager, a single point of contact and uses a single assessment process. Budgets are pooled and can be used by team members to commission whatever care is needed by service users like Mrs Smith. The aim is to ensure that service users experience care that is effectively coordinated, with different professionals aware of what each other is doing and working together within an agreed framework.

These features were developed through a pilot in Brixham, a locality serving 23,000 people. The early results from the pilot were impressive but the existence at that time of a PCT and a local authority, each with its own systems, was a barrier to full integration of care.

Recognition of this led to discussions that eventually resulted in the formation of the care trust. Local authority staff were transferred to the NHS under the Transfer of Undertakings (TUPE) procedures.

For each team, the focus is on knowing their population, focusing on the most vulnerable, and managing their care. This is done in partnership with GPs and the teams deal with all cases, including long-term conditions, palliative care and people with disabilities. They seek to proactively manage vulnerable service users making use of patient-held yellow folders accessible to any professional involved in their care. Referral processes have been streamlined and are now much simpler.

The Brixham pilot found in early analysis that there were around 83 users who were at the tip of the 'Kaiser triangle' (those with the most complex conditions) in a population of 23,000 and were therefore most at risk. Similar proportions have been found in the other localities that have been established. These are users who need to receive intensive support from community matrons and the integrated teams. However, implementation has not yet been established on a consistent basis because of variation in interpretation of the criteria, and increases in the number of people identified. A further experiment is underway, to try to bring consistency in this key element of integrated practice.

Achievements

A number of improvements have occurred. Intermediate care services are now available in each of the zones via the single point of contact, and these enable access to occupational therapists, physiotherapists, and district nurses within three and a half hours if urgent (these cases comprise 25 per cent of the total), and five working days for non-urgent cases. A weekend working pilot scheme has recently started, and a support worker in an intermediate care role has been developed, with posts in each zone team. (See Table 1 overleaf.)

1. The Kaiser Beacons were chosen to lead the way in exploring lessons to be learned from Kaiser Permanente, the US managed care organisation.

TABLE 1. IMPROVEMENT IN ACCESS TO INTERMEDIATE CARE SERVICES AT TORBAY CARE TRUST

OUTCOME AREA	APRIL 2006	OCTOBER 2008
Community equipment provided within seven days of request	90%	99%
Patients assessed within 28 days of referral	72%	83%
Care packages in place within 28 days of assessment	67%	97%

These changes have led to improvements in the Commission for Social Care Inspection (CSCI) rating, as well as improved user and staff satisfaction. The achievements of Torbay have also been recognised in the *Health Service Journal (HSJ)* awards for 2008, in which the care trust was winner of the award for managing long-term care.

Emerging lessons

The following lessons have emerged in the three years the care trust has existed:

- the importance of working with elected politicians on the care trust board and of engaging with scrutiny and accountability arrangements
- the benefits of assimilating all staff – whether from the NHS or the local authority – onto the new contractual arrangements for NHS staff set out in Agenda for Change
- the challenge of getting managers from the NHS and local authority to work in new ways – this has been more difficult than getting front line staff to do so

- the place of direct payments and personal health budgets in integrated working may be the biggest cultural challenge to overcome.

Looking ahead, a priority is to build on good relationships with South Devon Healthcare NHS Trust and establish closer integration with secondary care and specialist services. As the health reform programme goes forward, the future of directly provided services will have to be addressed.

Many of the social care services that were previously provided in-house have now been outsourced, for example, domiciliary care teams and former local authority residential homes. Experience from Torbay suggests that integrated teams should not be outsourced. They are a complex mix of commissioners and providers and much of their work is micro-commissioning for service users.

WORKING TOGETHER FOR HEALTH AND WELLBEING: THE KNOWSLEY STORY

Knowsley has a population of just over 150,000 with significant social, economic and health needs. Health needs across the borough are dominated by cardiovascular disease, cancer and respiratory disease, with mortality levels significantly higher than those in England and Wales. Life expectancy for both males and females is well below that for England. For males, it can vary by as much as ten years when comparing wards across the borough, with similar differences seen in female life expectancy. Such variances are unacceptable to both NHS Knowsley and the local Council alike.

From the very beginning of the partnership between the Council and the PCT, a decision was made to place the needs of Knowsley residents at the forefront of public service. The focus initially was on health and social care but recently this has been extended to encompass leisure and cultural services. The aim of the partnership is to improve people's lives and to tackle inequalities. The partnership's vision is of: "Working together for a better, healthier life for everyone in Knowsley."

The focus is on prevention, empowerment and engagement, care closer to home, and the provision of personalised high-quality services. The aim now is to bring together the PCT and all of the Council's health responsibilities into a single, overarching strategic arrangement.

Partnership arrangements

The partnership started in a policy vacuum. However, this proved to be an advantage because it created opportunities: there were very few rules or constraints on how to work in partnership, other than the broad flexibilities offered by the Health Act. Anita Marsland was appointed to the joint post of PCT Chief Executive and Council Executive Director in 2002. Her Council role now covers adult social care as well as leisure and cultural services in a new directorate of Wellbeing Services.

The partnership is known as Knowsley Health and Wellbeing and was established in 2004 under Section 31 of the Health Act (now Section 75 of the NHS Act 2006). The Health and Wellbeing Partnership Board, chaired by the Council leader and the PCT chair, provides overall direction, with day-to-day responsibility

resting with the Partnership Management Board. The latter is chaired by the PCT Chief Executive/Council Executive Director and includes managers, clinicians and user representatives, as well as elected members and non-executives from the PCT. The partnership agreement provides for single accountability with dual governance.

In terms of management arrangements, there is a single executive leadership team. Commissioning is organised through five executive leads covering secondary care, prevention, community services, primary care and urgent care. These arrangements ensure that the strategic planning and commissioning for services across Health and Wellbeing is truly joined up, resulting in a single set of strategic objectives, a combined business plan, and joint resource planning. These then filter through to all levels of the organisations.

Responsibility for children's services rests with the local authority director of children's services. The executive leadership team receives clinical input from the professional executive committee and it works closely with three practice-based commissioning consortia.

Achievements

The Health and Wellbeing Partnership Priorities are: alcohol harm, teenage pregnancies, childhood obesity, circulatory, cancer and respiratory disease linked to high levels of smoking, mental health including dementia, support for carers, and independence and inclusion for older people. These priorities are based on a joint strategic needs assessment. There are agreed health and wellbeing outcomes and a good fit with the local area agreement.

An example of work done in the partnership was the review of services for people with learning disabilities. These services were relatively high-cost and it was agreed that savings of £1 million were needed (out of a budget of £9 million). These savings were realised by joint work between the commissioners and the providers, rather than through the use of tendering and the market.

Partnership working has allowed much more flexibility in the use of resources. For example, £4 million of NHS

funds have been used to support neighbourhood projects that are focused on 'worklessness'. The priority attached to these projects reflects the broad scope of the approach adopted in Knowsley and the emphasis placed on tackling the social and economic determinants of health. The partnership also makes extensive use of pooled budgets and other financial flexibilities and has managed the partners' contributions to the pooled budgets flexibly, recognising respective budget pressures in particular years.

Partnership working has enabled the PCT to offer financial brokerage support to the local health economy. Additional capital funding of £850,000 has also been generated over recent years and is being invested in developing services to improve the health and wellbeing of Knowsley residents. The total revenue spend is now around £400 million and the view taken is that this resource belongs to the people of Knowsley and should be used wherever it would benefit them most.

The Council and the PCT take a collaborative approach to estates strategy. They have a number of shared sites and buildings and are actively developing further initiatives to improve services to their residents. The Health and Wellbeing headquarters was opened in 2003, and is co-located with the Council's administrative headquarters. This shared headquarters building generates savings in rental and running costs of £40,000 per year. Having a single executive leadership team has also released savings of around £230,000 per annum. The headquarters building incorporates a walk-in centre that was developed without central government funding and which is demonstrating a positive impact upon emergency ambulance and accident and emergency (A&E) demand.

An ambitious PCT-driven estate strategy has delivered four primary care resource centres with a range of integrated services and staff teams accommodated. The Tower Hill Primary Care and Community Resource Centre accommodates a full Council community centre, multi-purpose games pitches and library access point. Built alongside a local primary school, the centre promotes active community engagement and involvement for all ages.

Another development, on Longview Drive in Huyton, delivers a similar level of opportunity, as it sits adjacent to the local primary school and Sure Start project. A

further scheme which has just opened in the Halewood area of the borough includes a range of NHS services (nurse-led treatment centre, GP practices, pharmacy, outpatients' service), alongside a neighbourhood learning centre, Post Office, Council 'one-stop shop' and voluntary sector resources.

The achievements of Knowsley have been recognised by its ranking as a three-star organisation for six years running by CSCI and the rating of the PCT as excellent by the Healthcare Commission (one of only nine PCTs to achieve this). It was also highly commended for its work on primary care innovation in the *HSJ* awards for 2005. Knowsley has been recognised for its work on smoking cessation, social marketing, men's health and estates developments through a series of awards.

Emerging lessons

A number of lessons have emerged from experience in Knowsley. The following factors were important in facilitating progress:

- a great deal of goodwill and commitment from the partners and a high level of trust, starting at the very top in the relationship between the Council leader and the PCT Chair
- an integrated communication strategy to ensure key messages are communicated across the organisation
- leadership at all levels of the organisation, to bring staff on board and to nurture their creativity.

Several challenges remain, including:

- human resources and workforce issues, particularly regarding differences in contracts, pensions, and terms and conditions
- legal and governance issues can be a barrier; experience in Knowsley suggests these should not be tackled at the outset: trust and commitment need to be built first
- integration needs to be sustained when individuals move on and partnership working therefore needs to be 'hard-wired' in.

A fundamental lesson is that the focus needs to be on the vision and on developing leadership, rather than on structures.

PRACTICE-BASED COMMISSIONING: LESSONS FROM NORTHEAST LINCOLNSHIRE

The journey on primary care-led integration in northeast Lincolnshire started in 1996 with the formation of an out-of-hours cooperative led by local GPs. It was one of the first in the country and reduced the level of complaints about this service from 14 per month to 14 per year. Northeast Lincolnshire then became one of the 40 national pilot areas for locality commissioning after the 1997 election and this evolved into the primary care group and PCT. The current arrangement centres on commissioning groups based in four localities.

Underpinning these developments were a number of facilitators. For example, the primary care estates strategy reduced the number of premises from 38 to 11. This enabled the co-location of health and social care in the same buildings. Work has also been done on an integrated IT strategy and the development of integrated mental health provision from 2005. North East Lincolnshire Care Trust Plus was established in 2007. It therefore took ten years to get to this point, mainly because of the need to negotiate with the local authority, where historically there were weaknesses in leadership.

A care trust-plus differs from a care trust in that partnership working involves all services. In northeast Lincolnshire, responsibility for adult social care commissioning and provision have transferred from the local authority to the PCT, whereas responsibility for public health has transferred to the local authority. Children's services are led by the local authority with health visitors and school nurses seconded to realigned multidisciplinary teams (Shepherd, 2008).

One of the key considerations has been the size of localities needed for commissioning and provision. For commissioning, a population of around 50,000 is needed. This was felt to be too big for the effective provision of services. In the end, North East Lincolnshire Care Trust Plus decided on four localities, each with around 40,000 people.

Achievements

On integrated provision, there are a number of developments:

- Integrated practice-based provision, in which community nurses moved to be employed in the practices.
- Building-based integrated provision, including the co-location of health and social care in new buildings, and the development of a vulnerable adults register.
- Integrated provision developed from the work of commissioning groups, for example for diabetes and sexual health. On diabetes, the practices achieve their Quality and Outcomes Framework (QOF) score under the new contract but know they are not reaching hard-to-reach groups and are therefore working collectively in localities to address this.
- Integrated provision across the care trust, for example in emergency care, where an integrated urgent care centre is being set up, co-located with A&E and involving community nurses.

On integrated commissioning, the following initiatives have been taken:

- the establishment of a cardiac collaborative at the commissioning group level, based on work done on cancer and falls, and taking a social marketing approach
- a care trust-wide review of residential and nursing home care, and a review of vascular services
- a northern Lincolnshire-wide initiative following Lord Darzi's Next Stage review, involving PEC chairs and social care leads across two PCTs.

Less progress has been made to date on health and wellbeing and tackling health inequalities. Areas for action include reaching hard-to-reach groups, as in the diabetes project mentioned above; work on cervical screening and increasing uptake; and the work of the children's trust, which is developing a wellness model and philosophy.

In the future, the likely development is one of four integrated commissioning groups involving health and social care and greater community involvement. The Electoral Reform Society is helping with this by identifying three thousand members split between the commissioning groups. These members will then elect three people to work with the groups and to give them greater legitimacy, as a form of community governance. A federal approach will be taken to strategic commissioning, involving all four groups, and there will be four mini-local strategic partnerships focused on health and wellbeing. On the provider side, there will be six integrated provider arrangements; four will be focused on long-term conditions, one on planned care and one on emergency care.

The experience of northeast Lincolnshire had shown that primary care-led integration can be a powerful lever for driving change. An inclusive approach is needed based on integration champions and recognising it takes time. The focus needs to be on outcomes and organic organisational change. The emphasis should be on supporting preferred providers and using external supply only as a last resort. Unintended consequences have to be managed along the way – for example, the care trust directors had seen the Government’s integrated care pilots as a distraction even though they were central to the work being done.

Emerging lessons

A number of lessons have emerged from experience in northeast Lincolnshire. The following factors have been important in facilitating integration:

- leadership and co-sponsorship from all parties
- a focus on improving outcomes for patients and users
- the need to build integration over time because it takes time
- organisational migration: the care trust needs to evolve from collaboration and integration on the ground

- the potential for using levers effectively – for example the review of GPs operating under personal medical services contracts had shown scope for saving £4 million by moving to the General Medical Services (GMS) contract
- above all, the need for trust, respect and understanding between the partners.

Underpinning these factors, the PEC chair’s own commitment to the local area (in his own words “born and bred there and likely to die there”; Melton, 2008) was critical. Other GP colleagues were in a similar position.

The following challenges have to be overcome:

- a lack of vision on some issues, such as the emergency care centre
- agendas that are not aligned
- technical challenges, such as moving practice nurses to new contracts under the Agenda for Change reforms when community nurses moved to employment in practices (in order to harmonise working arrangements)
- immature relationships, for example engaging new elected members after elections
- resistance from some key players, for example clinical directors
- how to reconcile the drive to integration with the emphasis on choice and competition: this had surfaced in the national programme to procure additional primary care capacity from new providers which was at odds with what was happening on integration
- organisational protectionism and the need to do more to involve the acute trust in the work taking place
- the current processes for external audit of both finance and quality find it difficult to accommodate the approach to integration taken in northeast Lincolnshire.

KEY MESSAGES FROM THE CASE STUDIES

The examples described in this briefing paper illustrate the way in which Health Act flexibilities and care trusts are being used to bring about closer integration of health and social care. In Torbay, the main focus has been on using integration to provide more responsive and effective services for older people. In Knowsley, the PCT and local authority have given priority to the health and wellbeing agenda and have worked together to tackle health inequalities in the population. In northeast Lincolnshire, practice-based commissioners operating within the framework of a care trust-plus have brought about closer integration in a range of services through both commissioning and provision.

Local history and context

Each of these examples demonstrates the influence of local history and context on health and social care integration. What works in one area may not work in another because of variations in context and in relationships between stakeholders. This is illustrated in the contrast between Torbay, which chose the care trust route as the means for achieving closer integration, and Knowsley, which used Section 31/75 flexibilities to create a Health and Wellbeing Partnership Board as the vehicle for addressing areas of common concern between the PCT and the local authority. Knowsley considered the care trust option but decided that this option offered no advantage over the use of Health Act flexibilities.

The more general point here is that care trusts have not been used extensively to promote integration, with only ten areas having chosen this route. One of the factors that has inhibited the more widespread adoption of care trusts is a concern that they are first and foremost NHS bodies that risk reducing local democratic control over services and accountability to the population served. Torbay was able to address this concern through intensive work by the PCT in engaging with elected members and persuading them that a care trust would bring benefits to the population.

The poor performance of adult social care services in the assessments carried out by CSCI created a 'burning platform' (Kotter, 1996) that facilitated the plans to establish a care trust in Torbay. Areas that lack such a burning platform and where elected members are

suspicious of an NHS 'takeover' of adult social care services are more likely to prefer alternative partnership arrangements, such as those adopted in Knowsley.

Focus on service users

A clear message from this work 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. Not only are debates about structures distracting and time-consuming, but the evidence shows that structural integration does not necessarily lead to service integration (Heenan and Birrell, 2006). Indeed, as the evidence from Knowsley demonstrates, *it is possible to achieve service integration in the absence of structural integration through effective local leadership and a commitment to develop partnership working over a sustained period.*

Keeping in mind the 'Mrs Smith question' that lies behind the approach taken in Torbay, and focusing first and foremost on the integration of the health and social care teams who serve Mrs Smith and her fellow users, is likely to reap bigger dividends than embarking on major structural change. Of course, as the example of northeast Lincolnshire shows, structural change may be needed once integrated working has become firmly established. However, in the absence of the imperative that drove the development of a care trust in Torbay, then building integration from the bottom up rather than the top down appears to be a more promising path.

The role of leadership

The development of partnership arrangements depends critically on leadership by elected members and PCT boards. In Knowsley's case, the Council leader and PCT chair have worked closely in developing the integrated governance structures outlined in this paper, 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 PCT chief executive and her commitment to take forward partnership working. Her 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 a key factor in the progress made in that area, and this included intensive work with elected members and others to explain the benefits of a care trust.

Integrated health/social care teams

In emphasising the nature of governance arrangements adopted in the areas covered in this paper, the critical importance of integration at the front line of care should not be ignored. In all three areas, the primary motivation to integrate has arisen from a concern to ensure that people using services experience benefits whether in terms of improved health and wellbeing or care that is coordinated more effectively. 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 has helped to ensure that service users receive more responsive services with fewer hand-offs and delays.

The integration of front line care has been underpinned by the provision of a range of intermediate care services designed to ease care transitions and to make a reality of care closer to home. Less progress has been made in the sharing of data between health and social care. All three areas recognise the importance of data-sharing in the future through the development of a common care record, and steps in this direction are already being taken.

The need to involve NHS partners

Another issue that is receiving increasing attention is the involvement of other partners, including NHS acute trusts and mental health providers. These partners have not been the prime movers in the work done so far to achieve closer integration of care, and it is acknowledged that their involvement is crucial in the next stage of partnership working. The achievement in Knowsley of eliminating delayed transfers of care shows why integration and whole-systems approaches matter as much to acute trusts and mental health providers as to PCTs and local authorities.

Cooperation and competition

The other message from the experience reported here is the need for caution in thinking through the future of the community services that are currently provided directly by PCTs and local authorities. More specifically, whether these services should be provided in-house or outsourced is an empirical question that needs to be addressed in a discriminating way. The approach taken in Knowsley, where commissioners and providers (both in-house and independent) have worked together to improve the performance of services, illustrates the value of mature and long-term relational contracts rather than the unthinking application of market principles. In Knowsley, the ever-present possibility that services can be put to the market test helps to ensure that relationships do not become too cosy.

The experience of North East Lincolnshire Care Trust Plus underlines the fact that senior decision-makers need to be adept at interpreting national policies on the future of community services and integrated care pilots. This will ensure that they support moves to achieve closer integration of health and social care rather than making integration harder to achieve. The more general point here is that in seeking to pursue both cooperation and competition, Government policies risk causing confusion at a local level. PCT and Council leaders need to ensure that these policies are used to support local strategies and visions for the future of their services, and to provide the coherence that is sometimes lacking in national policy.

The need for evaluation

As a final reflection, the need to strengthen arrangements for evaluating the impact of the arrangements that have been put in place in Torbay, Knowsley and northeast Lincolnshire needs to be emphasised. The positive experiences reported at the Nuffield Trust's seminars are testimony to the value of the work that has been done, and have been corroborated through recognition of this work, for example in the *HSJ* awards for Torbay and Knowsley and in the performance ratings of the Healthcare Commission and CSCI. The next step is to conduct independent evaluations to establish the outcomes achieved in these areas and how these 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? A clear message is that the current legislative and policy framework contains a wide range of flexibilities. These flexibilities have enabled leaders at a local level 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 was seen as a strength rather than a weakness.

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 presented 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’; these include improving access to community services in Torbay. Others can be seen as 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 and by the Audit Commission in the Comprehensive Area

Assessment programme contains many examples of the kinds of outcomes that could be used to assess the effectiveness of partnership working.²

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 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 briefing paper. If this route is taken, then it will be important to heed the lesson from Torbay, Knowsley and northeast Lincolnshire, to the effect that it takes time to build trust and sustainable relationships, and to demonstrate the benefits of partnership working.

Developing an integration culture

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 and Birrell, 2006). It might be added that 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 underlines the fact that the road to closer integration is likely to be both lengthy

2. The Department of Health's NHS Operating Framework for 2008–11 introduced the Vital Signs approach to planning and managing NHS priorities both nationally and locally. It limits central performance management to key national priorities and beyond that only to those areas or organisations where performance is weak. Comprehensive Area Assessment (CAA) aims to provide a holistic independent assessment of the quality of life for people living in a particular locality. It will combine local performance measures from local councils, health bodies, police forces, fire and rescue authorities and others. Both Vital Signs and CAA include outcome measurements that could be used to assess the impact of partnership working on local populations.

and at times 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 other main policy implication of the work reported here is the need to ensure a joined-up approach to policy development in the Department of Health. As the case studies summarised in this paper show, 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 the greater use of choice and competition as a means for improving the performance of services while at the same time encouraging integration and cooperation. At a local level, these policies do not always appear to be the outcome of a coherent process of policy-making, and this can give rise to tensions in implementation.

The example discussed above, of the potential conflict between cooperation and competition, is a good illustration of these tensions. A further example relates to the emphasis placed on self-directed care through direct payments and individual budgets in social care, and personal health budgets in the NHS, at a time when PCTs and local authorities are also seeking to pool budgets and use practice-based commissioning to take forward the reform agenda. These initiatives are not necessarily inconsistent with each other but it is not clear that the way in which they relate to each other has been fully thought through by policy-makers.

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 next stage of reform in both services and in partnership working.

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