



# discussion paper

June 2010 Issue 8

## Where next for health and social care integration?

### Key points

- Health and social care integration covers a range of models, not a single solution.
- Local factors such as good relationships, commitment and joint strategy and vision can enhance integration.
- National factors and complexities can hinder it.
- A new model based on 'neighbourhood' and involving a Total Place approach could enable health and social care integration to develop further.

Health and social care integration and local accountability are not new concepts. They have been considered as options for improving local service delivery since as far back as 1974 when community health services and social care were split between the NHS and local government. Today, rising demand for health and social care, combined with increasingly scarce resources, is leading to renewed interest in 'integrated care' as a potential solution.

The NHS Confederation and the Association of Directors of Adult Social Services (ADASS) have developed a joint programme of work looking at the issues around the commissioning and provision of integrated health and social care services. This discussion paper is one of the first outputs from a work plan which will continue throughout the year.

### Background

"Integration is a process. It's something you do in order to achieve something, not an objective of itself."<sup>1</sup>

Places as diverse as Herefordshire, Torbay, North East Lincolnshire, and Hammersmith and Fulham have already shown that a range of locally integrated structural solutions are possible. However,

this is only one part of the overall picture. There has been a tendency to give less consideration to the impact of other models of integration – for example, pooled budgets, integrated teams and joint appointments – which have been developing more widely, at a faster rate and with potentially greater impact on local services.

There are a range of options both in place and under development

**'The new government is set to make radical changes to NHS commissioning, with the introduction of GP-led commissioning'**

and, if the full potential of health and social care integration is to be realized, we will need to develop a more detailed understanding of our current situation. This would include the success factors for existing integrated working arrangements, and what needs to be considered nationally to support the nascent integrated care approaches.

The new government is set to make radical changes to NHS commissioning, with the introduction of GP-led commissioning and changes to the governance of primary care trusts (PCTs), with partially elected

PCT boards and other board members to be appointed by local authorities. The public purse will be under increasing pressure and efficiency savings will continue to affect local services. In the current financial situation, the acid test will be whether different, more integrated local models can deliver public services that are high quality, cost effective and tailored to personal need. The recently unveiled coalition agreement includes commitments to:

"Radical devolution of power and greater financial autonomy to local government and community groups" and "break(ing) down barriers between health and social care funding to incentivise preventative action" along with "the local PCT act(ing) as a champion for patients... working closely with the local authority and other local organizations."<sup>2</sup>

To make this a reality means looking at new models, which have the potential to work in new environments and reflect the new landscape of the independent NHS Board, devolution of budgets to GP commissioning groups and greater community control of public health budgets.

The NHS Confederation and ADASS' joint programme of work is informed by three pieces of new research: a national survey of PCT chief executives and directors of adult social care carried out by Richard Gleave for the Department of Health (DH);<sup>3</sup> the findings of a research seminar hosted jointly by the NHS Confederation and ADASS in January 2010; the findings of a recent research project which interviewed leaders from 14 of the PCTs in the first wave of Total Place pilots. These are also linked with the Confederation's recent

**Figure 1. Typology for degrees of health and social care integration<sup>4</sup>**

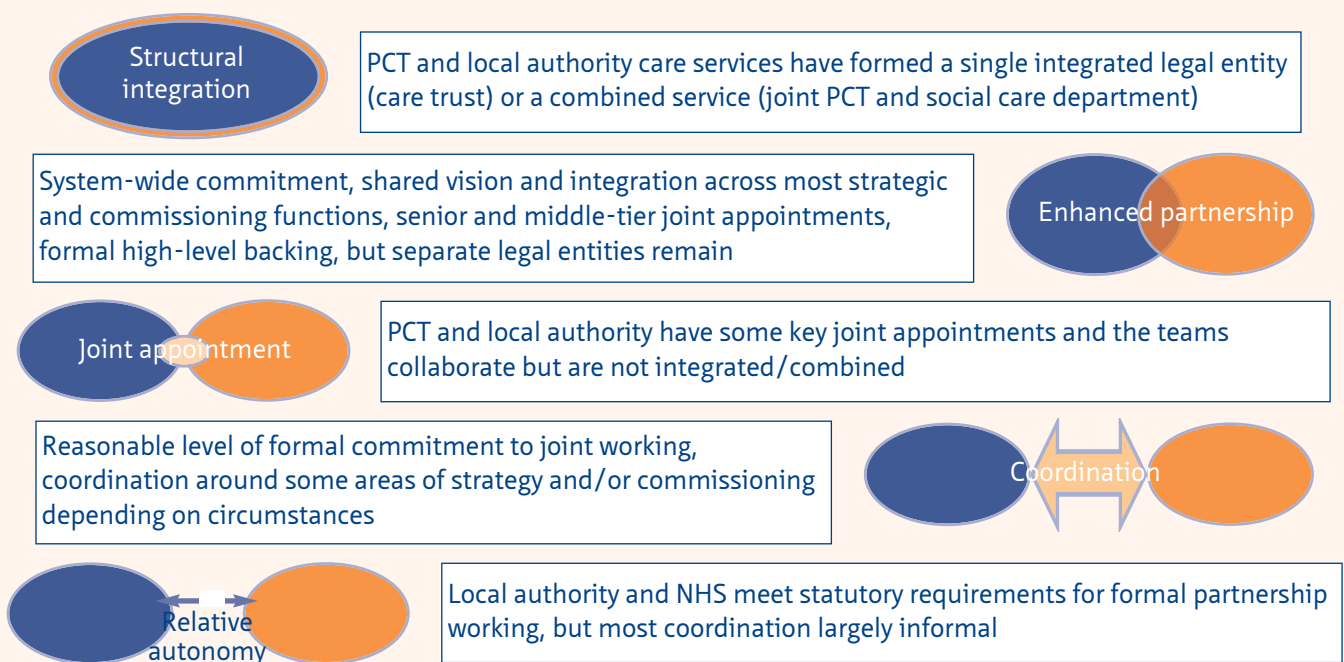
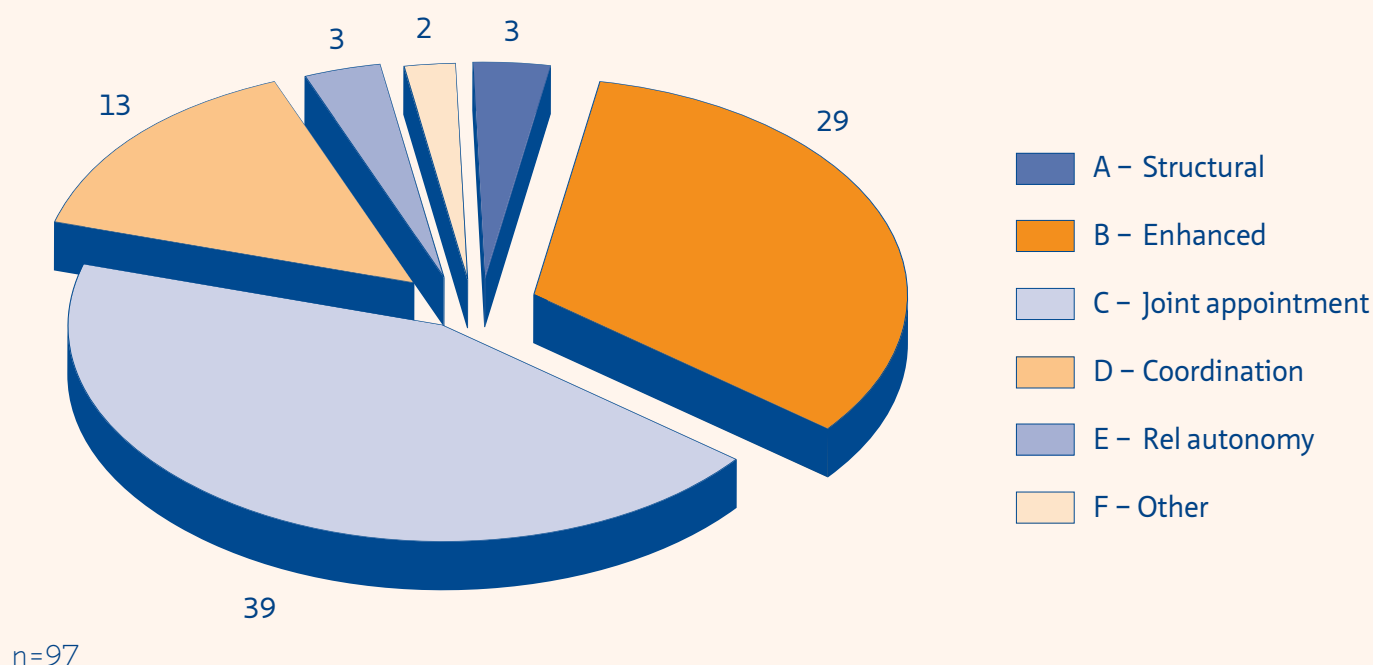


Figure 2. Degrees of integration reported in survey<sup>4</sup>



paper on senior joint appointments<sup>5</sup> that surveyed senior leaders whose posts cut across the traditional boundaries between health and other local public services.

### The current situation

Integration is a term open to wide variations in interpretation, from structural solutions through joint appointments to open book accounting across local public services. A working definition developed as part of the DH's recent survey may be useful in establishing the range of models being considered (see Figure 1). This survey yielded 97 responses from the 150 localities across England who were asked for their views on the extent to which integration was already in place and what had helped and hindered its development.

While the majority of areas had not moved as far as a structural solution, most reported some degree of integration (see Figure 2).

However, also of interest are the factors which respondents felt had aided or hindered joint working. The main factors that promoted integrated working are locally determined – local leadership, vision, strategy and commitment. Conversely, with the exception of changing leadership, the top factors that respondents felt hindered integrated working are nationally determined – performance regimes, funding pressures and financial complexity (see Table 1 on page 4).

The reasons for this delineation are unclear but several different interpretations could be considered:

- **Is there is a different role for local partners and national government in issues of joint working?**

The study seems to reflect the crucial role of local relationships in the development of sustainable local partnerships. The government's role here could be defined as an enabling rather than delivery one – to develop a framework of policy for use with local interpretation.

- **Does the centre have more capacity to do harm than to do good?**

Without the involvement of local systems in policy development, the national framework has the capacity to throw local initiatives into disarray. Competing government policies with differently nuanced performance regimes can confuse and add complexity which might otherwise be avoided.

**Table 1. Factors helpful to and hindering local integration<sup>4</sup>**

Helpful factors*	Hindering factors*
Friendly relationships (35)	Performance regimes (40)
Leadership (31)	Financial pressures (34)
Commitment from the top (26)	Organisational complexity (30)
Joint strategy (24)	Changing leadership (26)
Joint vision (24)	Financial complexity (22)
Co-terminosity (20)	Culture (19)
Additional funding (16)	Commissioning (15)
Patient and user focus (14)	National policies (14)
Front-line staff commitment (13)	Local history (14)
Joint commissioning (13)	Data and IT (14)
Central guidance (13)	Planning (12)
Joint appointments (11)	Workforce (11)
History of success (11)	Other (3)
Other (5)	

\*numbers in brackets show number of reports of this factor in the survey

**• Are these results a feature of local leaders seeking to claim credit where there is success and shift blame where there is failure?**

It is easy to suggest that unwarranted success is claimed for local systems, but the difficulties outlined by the survey and in our previous report seem to correspond with each other and with more informal reports of the factors supporting integration.

One message that is evident from these responses is the importance of softer, relational aspects of partnerships as a catalyst for integrated working. ‘Vision’, ‘commitment’, ‘relationships’ and ‘focus’ all feature as highly

effective factors in the survey responses. This implies that national initiatives to push local partners to work together may be ineffective. Placing duties on local leaders to collaborate may send a strong message, but based on these responses it seems unlikely to produce the more informal conditions that local leaders feel are most important.

This echoes the findings of our work on the impact of senior joint appointments across PCTs and local authorities. In the main, these were people in joint PCT chief executive/director of adult social services positions and similar issues were highlighted as incentivising joint working:

“Almost all of the work of synthesizing national requirements on financial reporting and quality standards is borne at local level by the integrated organisations themselves. .... Policymakers should seek to create an environment more conducive to local integration by recognizing that enforced structural changes or instability caused by their threat are counter-productive to joint working.”

This work also suggested that good local working cannot be centrally mandated but could be better supported by decreasing the impact of central burdens on local innovation.

**What does this mean for the future?**

Despite enthusiastic support from some leaders, experiences of joint working across the country have not been universally positive. Our workshop participants reported a lack of clarity on what integration was expected to achieve and a lack of evidence that it can realise what is promised. While the survey showed that the more integrated partnerships tended to report higher levels of benefit, the difference was modest and these opinions have not been externally validated. So where does this leave the debate on the future of health and social care integration? Are there any overall principles that could help to define a framework within which local models could be developed? We examine some ideas below.

### Integration based on outcomes not targets

The importance of local joint working plans being designed around clear, expected and shared, or at least consistent, outcome measures featured in all of our work. The focus on improved outcomes from integrated working can then lead to a more measured debate around the efficacy of organisational integration.

### Integration based on cultures not structures

Delegates to our workshop, who included PCT and social care leaders, did not reach a consensus on how important combined structures are to effective collaboration. Some maintained that combining social care structures with health merely creates new fragmentation between it and other council services. Developing more understanding cultures was seen as much more supportive; structural change could take time and energy away from their emergence. However, others felt that models such as care trusts could deliver more than the sum of their parts by developing a different cultural environment.

### Integration based on place not organisation

Discussions of organisational integration were felt to be increasingly eclipsed by a much bigger movement. The Total Place programme<sup>6</sup> has challenged local leaders to look beyond the traditional health and social care debate towards creating a much broader 'place mentality' that is inclusive of all public services. While it is not clear at present how and whether the new government will implement Total Place further, its commitment to greater public

involvement in local decision-making is clear:

"...Citizens (should) know how taxpayers' money is spent in their area and have a greater say over how it is spent."<sup>7</sup>

By bringing all local public services around one table, Total Place, or its successor, offers an alternative to an integration of social care with health that leads to its disintegration with other local authority departments. One social care leader in a Total Place pilot site commented that the initiative had shown in his area that collaborative working could meet objectives in all of their local organisations at once, particularly for cross-cutting issues such as drugs and alcohol. It had also helped to reframe the perspective of service redesign, from organisationally focused to service user focused.

### Integration based on delegation not transfer of functions

By delegating, as opposed to transferring, functions to each partner depending on their skills, as is the case in Total Place, a response has the potential to avoid some of the power struggles that often result from more formal arrangements. But while there was agreement on the potential of Total Place to produce a real change in joint working, a need for caution was also felt. With less than a year of piloting complete, it is still too early for the programme to have demonstrated any hard evidence. These sentiments were echoed and expounded by interviews conducted for this paper with 14 PCTs working in 11 of the 13

**'Discussions of organisational integration were felt to be increasingly eclipsed by a much bigger movement'**

Total Place pilot sites (see box on page 6).

### Integration based on clinical and professional engagement

Independent of their views of how local leaders could better work together, there was considerable optimism at the workshop around whether front-line structures could be changed to encourage more bottom-up joint working. There was promise in mixed professional teams of front-line workers from a range of organisations. Experience has shown that linking GPs, social workers, community services and public health professionals could be a powerful force for good if they could be more directly involved in, and accountable for, the overall priorities of the locality. A range of opinions exist on how the roles and incentives of front-line professionals should be changed to enable this, but the recognition of the role of GPs in commissioning by the new government gives room to make greater involvement a reality.

### The role of central government

As previously stated, the role of the centre in directly stimulating better local joint working may be one with limited value. However, government has an important role to play in creating the conditions under which local areas can make progress. The burden of multiple regulatory frameworks on local organisations trying to cooperate

## Total Place: interviews with PCTs in the pilot sites

Interviews were conducted with chief executives or Total Place leads from 14 PCTs, covering 11 out of the 13 first wave pilot sites. Questions included how involved their organisations had been, what the Total Place methodology had added to their existing work, and what should be done with the programme once the pilot phase was over.

### Key findings

All but one of the PCTs felt that the pilot had been worthwhile. Some found it hard to see exactly what the Total Place methodology had added that would not have been achieved through their existing joint working. The short timescale of the pilot had forced them to choose areas of focus where there were existing initiatives to improve joint working, as there wasn't time to start anything new.

The counting methodology was seen as useful, and in some cases had produced results the organisations involved had found surprising.

Some felt that Total Place also provided a framework for a more systematic approach to joint working – service area by service area, local need by local need.

The majority felt that their PCT had been an equal partner in their pilot. Of the remainder, three felt that they were not equal because the local focus chosen was one where the NHS had a limited contribution to make. Only one PCT felt their pilot had been overly local authority-led.

The process so far has excluded healthcare providers, to its detriment. Hospital and community trusts, in

particular, were identified by many as priorities for the next stage of the work.

The value of Total Place is sufficient for it to be used across many more localities. Having been complimentary about the flexible approach the government took during the pilot – in allowing places to adapt the methodology in many different ways – leaders should be supportive of the multi-track solutions (single and innovative policy offers) proposed in the evaluation report.

They were wary of attempts to define Total Place as producing fundamental shifts in the relationship between central government and local areas. Some had only been working on Total Place for seven months before they began composing their final reports. Leaders were keen to stress that they were not yet able to demonstrate any concrete improvements in outcomes or realisation of savings on which to call Total Place a success. Most also felt that their joint working was very good prior to becoming a pilot, so as yet the methodology is untested in localities with more troubled relationships.

The content of the programme is as much cultural as it is methodological. The core message of taking a public services-wide approach and seeking to ground this in evidence-based assessments of local needs and resources is one already filtering into the thinking and behaviour of the NHS, social care and other public services. The government's ability to directly control such a movement is limited.

has been well documented, and disincentivises formal joint working.<sup>8</sup> The financial pressures faced by the health and care system in future years present pressing challenges to government. Ongoing uncertainty over the future of how the social care system will be funded to cope with the needs of an ageing society is of acute concern to local

health and social care leaders. While we know that the social care commission is set to report within a year, the implementation of its findings will require a degree of political stability. Further delays to a substantive solution to this problem will prevent local systems from being able to plan collaboratively for the long term.

The duty of government to create the right conditions for joint working must be balanced by an acceptance that something additional is needed to add impetus at the local level too. While there is excellent practice in a small number of localities, in most areas leaders' attention has been diverted by issues seen as more urgent than integrated working.

This creates a mismatch between the local rhetoric on the potential of joint working, the numerous freedoms that are already afforded by central government, and the lack of progress that has actually been made.

### Where does this lead us?

The impact of an ageing population and of the rise in long-term conditions means it is vital that health and social care integration remains a key component of the system for the future. The intuitive attractions of integration still remain. A clear plan for care which runs across health and social care boundaries with fewer hand-offs should provide an enhanced patient/user experience and enable quality and outcomes to be better measured along a whole pathway. Delivering care in the most appropriate surroundings, with the right mix of staff and service offer, improves the ability of care to be proactive and quickly responsive as needs change. However, it is also clear that the prize of holistic and personalised services, delivered close to home, must include a wider service range, including housing, leisure and benefits, which are not necessarily included in typical integrated approaches. An approach that does not include the entirety of what local councils and their partners can offer will only deliver partial solutions to the needs of citizens and communities.

As budgets are devolved down to GP commissioning groups, there is an opportunity to align other public services to work more closely with communities to commission flexible and

responsive services that are driven by jointly developed outcomes.

A more local and community-based approach would allow services to be linked with an understanding of the overall amount of public money available. It would encourage greater community involvement in determining priorities, building on local assets and linking better the local service offer to population needs. It would also enable clinical engagement in the development and delivery of services to be at a meaningful scale and scope. In building this approach a number of risks would have to be managed and minimised so as to avoid fragmentation of the service offer. For example, within local hospitals working with several commissioning groups with different models of reablement. It would also need effective risk pooling arrangements to ensure that all neighbourhoods would always receive a minimum service offer from all partners, and robust needs assessment and budget weighting to ensure that deprived areas with more needs were not disadvantaged.

With the new range of responsibilities of the PCT outlined in the coalition agreement, the greater involvement of local authorities in decision-making on public health and specialist commissioning cements the potential for joint working. However, the engagement of local GPs and health staff remains a priority if 'neighbourhood' becomes the new currency for place. The proposed model will need developing to ensure we can address key challenges and questions.

### Key questions

- Can we define a meaningful size of neighbourhood between health and local authorities that enables local patterns of deprivation or health or care usage to be identified?
- Can we deliver integrated services that can be tailored to very local needs – or indeed in a truly personalised manner?
- Can we bring clinicians, other professionals and local councillors with us in the development of neighbourhood approaches?
- Do we have the data to disaggregate budgets to neighbourhood level in a meaningful way?
- Will there be the will to move money around local partners in an innovative way?
- How will we engage others, for example third sector or for-profit providers, in the delivery of services that may vary locally within wider contractual arrangements?
- How can we engage the public at this level in a more meaningful way and balance outcomes developed at a community level with outcomes set by national policy?

This paper is intended to stimulate discussion. We are anxious to develop these ideas and continue the debate as the new government's policy positions become clearer and implementation becomes a reality. Your comments, concerns and suggestions are welcome. Please contact [jo.webber@nhsconfed.org](mailto:jo.webber@nhsconfed.org) or [mary.gillingham@adass.org.uk](mailto:mary.gillingham@adass.org.uk)

## References

1. NHS Confederation (March 2010), *Putting our heads together: what makes senior joint posts work?*
2. HM Government (May 2010), *The Coalition: our programme for government.*
3. Presentation on 'snapshot of integrated working' survey to ADASS Spring Seminar, March 2010.
4. Presentation on 'snapshot of integrated working' survey to ADASS Spring Seminar, March 2010.
5. NHS Confederation (March 2010), *Putting our heads together: what makes senior joint posts work?*
6. HM Treasury and CLG (March 2010), *Total Place: a whole area approach to public service.*
7. HM Government (May 2010), *The Coalition: our programme for government.*
8. Audit Commission (2009), *Means to an end.*

## The Primary Care Trust Network

The PCT Network was established as part of the NHS Confederation to provide a distinct voice for PCTs. The Network aims to improve the system for the public, patients and staff by raising the profile of the issues affecting PCTs and strengthening the influence of PCT members.

The NHS Confederation is the only independent membership body for the full range of organisations that make up today's NHS. Its ambition is a health system that delivers first-class services and improved health for all. As the national voice for NHS leadership, the NHS Confederation meets the collective needs of the whole NHS as well as the distinct needs of all of its parts through its family of networks and forums. The PCT Network is one of these.

For further details about the work of the PCT Network, please visit [www.nhsconfed.org/pctn](http://www.nhsconfed.org/pctn)

### Further copies or alternative formats can be requested from:

Tel 0870 444 5841 Email [publications@nhsconfed.org](mailto:publications@nhsconfed.org)  
or visit [www.nhsconfed.org/publications](http://www.nhsconfed.org/publications)

©The NHS Confederation 2010. The use of this publication is covered by the conditions of Creative Commons Attribution-Non-Commercial-No Derivative Works License: [www.creativecommons.org/licenses/by-nc-nd/2.0/uk](http://www.creativecommons.org/licenses/by-nc-nd/2.0/uk)

You may copy or distribute this work, but you must give the author credit, you may not use it for commercial purposes, and you may not alter, transform or build upon this work.

Registered Charity no: 1090329

INF24001

## NHS CONFEDERATION



The NHS Confederation  
29 Bressenden Place London SW1E 5DD  
Tel 020 7074 3200 Fax 0844 774 4319  
Email [enquiries@nhsconfed.org](mailto:enquiries@nhsconfed.org)  
[www.nhsconfed.org](http://www.nhsconfed.org)

