King's Fund

Community Care Debates

The Future Organisation of Community Care

– options for the integration of health and social care

Contents

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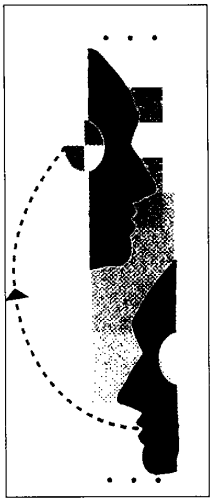

Organisational solutions to problems arising in community care were discussed at a debate organised by the King's Fund. The debate took place during a period of continuing organisational upheaval associated with the NHS and Community Care reforms. Calls were nevertheless being made for further radical change in the organisation of health and social services.

People from different backgrounds agreed that current arrangements in community care are far from satisfactory. An overwhelming majority believed that improvements could be made by creating a single authority responsible for commissioning local health and social care services.

Local government and the NHS

Bob Hudson, Nuffield Institute for Health

In 1941, the then Minister for Health (the National Liberal, Ernest Brown) made an announcement in the Commons which committed the Government to a co-ordinated system of voluntary and municipal hospitals based upon local government. Aneurin Bevan's subsequent surrender to the doctors led to hospital services being run by quangos rather than those municipalities which had done so well during their short responsibility for hospitals following the abolition of Boards of Guardians in 1929.

Arguably, this is the point in health care history where we took a wrong turning, resulting in fragmentation within health care services, an artificial distinction between health care and social care, a neglect of preventive medicine and an absence of democratic control at local level.

Since that time, matters have got steadily worse. At a formal level, local government has continued to lose functions (community health services in 1974) and residual control of health care (loss of representation on the reformed NHS), and is now being threatened with the further loss of both its providing and regulatory roles in relation to social care. At the same time, the NHS has cost-shunted large parts of its continuing care functions onto local government without any accompanying resources. NHS trusts are now seeking a change in the law to enable them more easily to provide social care. There is also a distinct possibility of mental health being put into the hands of a new *ad hoc* body.

Within health care, the accelerating pace of hospital discharge has placed increasing burdens upon both primary and community health services, as well as social care, yet *Choice and Opportunity*, a White Paper on primary health care, is issued which scarcely mentions the role of local government. Meanwhile, health authorities are expected to meet *Health of the Nation* targets which are more properly the province of local authorities. The *status quo* makes no sense.

There is now a growing constituency for change, and the fact that there have been too many pointless changes in the past should not blind us to the need for a more appropriate and lasting change in the future. The case for extending the local government role in health care is powerful for several reasons:

- ***discernible service benefits.*** There is a greater likelihood of service integration where health, social services, environmental health, education and housing are all present within the same organisation. Efficiency gains should be greater, cost-shunting less, forward-planning more coherent and locality purchasing more feasible.

- ***greater democratisation and accountability.*** Despite some efforts to 'listen to local voices', the fact remains that the emphasis in the NHS is on reporting upwards to the NHSE and the Secretary of State, rather than outwards to local communities. The public remains in deep ignorance of the roles, responsibilities and membership of NHS agencies, and in any case has no means of calling them to account. It cannot be healthy for a mature democracy to have no local control over local health care. This is not to say that local government is perfect. It certainly needs some overhaul, but it remains the only feasible democratic option for effective local accountability.

- ***the failure of inter-agency collaboration.*** The case for health–social care organisational integration would be reduced if it could be shown that fragmentation could be addressed through inter-agency collaboration. But there is no substantial evidence to suggest that joint consultative committees, joint care planning teams, joint finance, community care plans, joint commissioning or other collaborative mechanisms have been anything other than marginal in their impact.

- ***the failure of health care commissioning.*** There is a tendency to perceive the NHS as a skilled commissioner in comparison with local government, but this is far from being the case. Strategic planning and commissioning have not been a strong feature of GP fundholding, while health authority commissioning is often ill-founded, with no effective strategy, volume or pricing practice. Meanwhile, the purchaser-provider split is spreading across whole areas of local government activity, offering the prospect of reconfigured commissioning for health and social care without a return to the old provider-driven system.

The options for extending the local authority commissioning role in health care encompass three areas: acute care, community health services and preventive health care. The extension to acute care is the most problematic, since the catchment areas of local authorities may not be large enough to match the requirements of hi-tech specialties, and there could be difficulties accessing the expertise needed to make informed commissioning decisions. The other two areas merit immediate consideration. Of the five 'settings for action' identified in *The Health of the Nation* (i.e. healthy hospitals, healthy cities, healthy schools, the workplace and the environment), only the first is within the effective influence of the NHS. Local authorities are far better placed to prosecute this agenda than the NHS.

Equally, there is a powerful case for making local government responsible for commissioning community health services – little more than a return to the pre-1974 position – along with the new opportunities for contracting with GPs offered by the above-mentioned primary care White Paper. There would inevitably be some skirmishing about where the boundary between acute and community health services should be drawn, but the potential dividend from a relatively small reconfiguration is considerable. The attractions of a combined department covering preventive work, the care of acute and chronic illness, residential and nursing home care, respite care, rehabilitation and support at home are enormous.

The stance of the Conservative Government on all of this is at least consistent: local government is despised and should play an ever-diminishing role in public affairs. The timidity of the Labour Party is more puzzling. It really is time to undo the damage inflicted by Bevan's concessions to the doctors 50 years ago. ❑

People from the following organisations attended this debate:

Age Concern England, Age Concern Greater London, Alzheimer's Disease Society, Anchor Housing Association, Association for Public Health, Brighton and Hove Unitary Authority, British Medical Association, Department of Health, Greater London Association of Community Health Councils, Greater London Forum for the Elderly, Havering Borough Council, Institute of Public Policy Research, King's Fund, Lambeth, Southwark and Lewisham Health Authority, Leonard Cheshire Foundation, Long Term Medical Conditions Alliance, MIND, National Council of Hospice and Specialist Palliative Care Services, NHS Confederation, NHS Executive (Anglia and Oxford), NHS Executive (South Thames), North and Mid Hants Health Commission, Nuffield Institute for Health, Office for Public Management, Richmond upon Thames Borough Council, Society of Public Health, Surrey County Council, Wiltshire County Council, Wolverhampton Metropolitan Borough Council.

Closing the divide

Ray Jones, Wiltshire County Council

The current separate structures for health and social services planning and provision often lead to a fragmentation of services, buck-passing, cost-shunting, duplication and inefficiency. There is also a concern about a local 'democratic deficit' for health services, whereas for local government social services there is sometimes a concern that local constituency and political interest conflict with rational planning and management. The implication is that organisations which are out of step may have considerable difficulty in moving forward together.

What might happen?

In recognising an increasing overlap of interests between adult care social services and health care, and between child care social services and the special education responsibilities which are now the major part of the local education authority's remit, it is timely to give serious consideration to new organisational structures and responsibilities, while recognising that, whatever structures are created, it will still lead to boundaries with other organisations which will need to be spanned.

In relation to adult care social and health services there are particular opportunities to look towards closer integration within primary care teams, while also recognising the need for specialist integrated secondary care services, such as community mental health teams and community teams for people with learning disability.

Integrated primary care teams offer the potential of improved local, and less stigmatised, access to social services, as well as to health care. Clinicians, nurses, social workers, occupational therapists and other staff working together from the same location also offer opportunities for better co-ordinated services and a range of multi-disciplinary skills and perspectives to benefit service users.

However, if integrated primary care teams are really to realise their full potential, they require good-quality on-site integrated general management and control of devolved budgets. The willingness to move in the direction of larger integrated primary care teams is limited by the concerns about the democratic accountability which is lacking in the model of GP fundholding as GP small businesses. There is a need for a new organisational framework and accountability for primary care.

One option would be to integrate primary care and community health trusts into a new provider structure with GPs contracted as skilled clinicians within the new structure. The new organisational arrangements could also facilitate the integration of social services staff as employees within the new structure. Board membership for the new organisation could include either locally elected representatives or local people nominated by local councils.

There are also a number of options for the possible creation of local health and social care commissioning authorities, working to national standards, targets and criteria, with a local health and social care commissioning authority as a part of local government or as a combined authority (noting, for example, models which have been established for police, fire and probation services), and with a combined authority including county council, district council and central government nominees.

Will it happen?

Considering the pace of change which has taken place recently, it is highly unlikely that things will be the same in ten years' time. The role and responsibilities of local government have changed dramatically within the last ten years, especially in relation to housing and education. The idea of integrating social services child care responsibilities and special education responsibilities is increasingly gaining momentum, and this is reflected in a number of local authorities establishing children's services sub-committees to seek to span the social

services and education child care responsibilities. At the same time the boundary issues between health and adult care social services responsibilities are not going to go away, and joint commissioning seems only to offer an interim and limited solution.

The Local Government Reform changes which are now being introduced have also failed to build solid foundations for the future. Trying to explain the structure of local government in the United Kingdom is increasingly difficult, with in some areas unitary authorities and in others a three-tier structure of county councils, district councils and town and parish councils. There must also be a concern for the future about the sustainability of authorities which have been given major responsibilities, including education and social services, but with populations of fewer or little more than 100,000 people. Put alongside all of this the interest in a structure of regional government, and it seems unlikely that local government structures and responsibilities will remain unchanged for very long.

The world is certainly not standing still. We are in the midst of a debate about the future organisational arrangements for mental health services and *Achievement and Challenge*, a White Paper on social services, has been published. The White Paper moves us even further in the direction of local government not directly providing services but retaining strategic planning, commissioning and purchasing responsibilities. The ground for radical and fundamental change seems therefore to be even more fertile (or threatening) amidst a landscape of debate and review of the welfare state 50 years on (and 25 years on for social services).

However, there are a number of processes which will militate against integration, including the power of professional and managerial interests to argue against it, the tension and conflict between central and local government interests which may be politically unbridgeable, and a realistic recognition that organisational change is costly, disruptive, and is never a panacea.

In the meantime...

In the absence of an immediate integration of health and social services planning and provision, it is still possible to seek operational integration. The establishment of joint teams with a single manager to provide services across the health and social services divide, and a greater emphasis on joint commissioning and lead agency arrangements, continue as an option, albeit an option whose potential will be limited by competing interests, agendas, and regulations. It would, however, be assisted if we all recognised that the vested interest reflected in holding on to territory and blaming across the boundaries leads to inefficiency, gaps in services, and conflict which traps service users and patients in the divide between health and social services organisations. In the absence of immediate organisational integration, we could still choose to behave differently ❑

Time to experiment

Richard Poxton, King's Fund

There is general dissatisfaction about the current rate of progress in pulling together the health and social care systems. Working relationships have generally improved but service change remains difficult to achieve. It is not clear whether existing collaborative arrangements should be strengthened or a new organisational model adopted. In these circumstances some controlled experiments should be tried.

Joint commissioning

The implementation of the NHS and Community Care reforms revitalised once more the debate around the organisation of health and social care. The new distinction between commissioning and purchasing on the one hand and the provision of services on the other added a new twist and potential complexity. From 1993 interest in joint commissioning grew, as agencies sought to develop their commissioning roles in order to achieve a greater cohesiveness in both the assessment of needs and how these were addressed. The Department of Health's 1995 Guidance spoke of 'joint responsibility for translating an agreed health, housing and social care strategy into action for the benefit of service users and carers'.

Since then work by the King's Fund and Nuffield Institute (among others) has demonstrated the significant problems encountered by agencies across the country as they strive in a variety of ways to achieve change through joint commissioning. Working across health and social care boundaries (not to mention housing) was never meant to be straightforward. There are various reasons for this, including the following:

- the systems are complex and very different;
- there are too many other distractions (budget crises, organisational upheavals, new policy initiatives, etc.);
- collaborative skills within agencies are in short supply;
- there is often a lack of effective consensus on the way forward for service development (e.g. care of older people at home).

In the early discussions of the Department of Health Joint Commissioning Group, the possibility of integrated agencies was seen as politically unacceptable, if not downright naïve. Since then the mood has changed so that integrated purchasing for mental health services is now being openly considered. This development may be seen as at least in part due to the generally vastly improved relations between health and social care agencies. But so far this has not translated into significant service change. Examples of real joint commissioning (in the sense of being strategic and systematic) are rare. The problematic implementation of the Continuing Care Guidance has shown the intractable nature of some of the boundary issues as soon as they are exposed to sharp analysis. Collaborative achievements are more often than not due to the efforts of specific individuals and therefore often not sustainable.

Integrated health and social care agencies: arguments for and against

But will integrated agencies make the breakthrough? One major problem is that it is often not clear enough precisely what service changes are being sought. And if integration is to be tried, should this involve commissioning and purchasing, or the provision of services, or both? There is no clear agreement whether integration should be under local authority auspices or should involve a new 'mid-way' agency. Incorporating social care within the NHS seems to have fewer supporters.

Arguments in favour of integration focus upon the opportunities which it will offer:

- holistic needs assessments leading to seamless service provision;
- greater equity based upon nationally agreed standards;

- greater efficiency and cost effectiveness;
- clearer lines of accountability;
- more focus on both the promotion of good health and the prevention of ill health;
- a service system which is easier to understand by users and the public generally;
- more effective user and community involvement in decision making;
- a boost for commissioning by combining skills, knowledge, experience;
- bringing a more local democratic element to NHS decision making, while protecting social care from the worst of local political excesses;
- countering excessive and conflicting professional interests.

Arguments against integration point to the practical difficulties, the risks involved and general lack of certainty:

- different boundaries at health and local authority level and between primary care practitioners;
- more change causing further disruption and lowering of morale;
- the 'charging issue' (i.e. health is free at the point of delivery while social care mostly is not) would have to be addressed;
- service development would be further delayed by organisational upheaval;
- Housing, social security and other key components could be left more adrift;
- any fragmentation of the NHS would be detrimental;
- present emphasis on collaboration should be further developed (e.g. joint purchasing);
- while problems undoubtedly exist, it is far from certain that organisational arrangements are the root cause;
- there is only limited success at best of existing integrated agencies (e.g. Northern Ireland, housing and social services departments in England).

A way forward

Although integrated agencies offer a real attraction, not enough is known to be sure that the change will bring about the desired outcomes. Nevertheless, the indications are that something different should be tried if progress through collaboration is to be maintained.

A small number of willing pilot sites should be recruited across the country to test out different versions of the integrated approach. Before this could happen it would be necessary to undertake further careful design work. Pilots should receive adequate support, not least so as to ensure that current responsibilities are not affected.

Emphasis should be placed on the specific service outcomes being sought, rather than concentrating solely on organisational and process change.

In the interests of equity, these developments should take place within the clear parameters of a national programme which puts effective analysis, evaluation and dissemination at the core of future developments across the health and social care boundaries. ⌟

Strengthening collaboration in community care

Chris Vellenowet, NHS Confederation (formerly NAHAT)

The provision of seamless care is a commendable goal. However, several important studies of the community care reforms have shown that an individual's needs are seldom met by one agency. Collaboration of both public service and voluntary bodies working from a base of shared values is a prerequisite for the delivery of harmonised services.

NAHAT's own view is that a real partnership, based on jointly agreed strategies, combined funding, strengthened shared working arrangements, with a clear lead role, is the best way to provide effective community care.

The health perspective

The NHS was founded on the concept of a nationwide service providing equitable access to health care with national funding, governance and accountability. This has resulted in both a generally equitable and cost-effective service. The NHS reforms give the 100 or so health authorities in the country the task of reflecting local needs within national strategies and within the framework of cash-limited capitation funding, which recognises some elements of the local characteristics of the population.

Social services, however, are part of local authorities – autonomous and locally accountable, albeit tightly constrained by central government. With the creation of smaller local authorities and larger health authorities the disparity between their populations is being exacerbated. Common boundaries are disappearing, adding to the complexities of collaboration.

Integrated health and social care agencies

The idea of integrated health and social care agencies looks attractive. The Northern Ireland model is often cited. But decisions in the province still distinguish between health and social provision, and local government is much more limited than in the rest of the UK.

Creating integrated health and social care agencies responsible for commissioning community care would create a new divide of both health and social services. In health service terms the location of the divide at some point between acute care and primary care would depend on the definition of community care and its relationship to continuing care.

Further, a new statutory authority, interposed between health authorities and local authorities would involve major constitutional and structural change. Major funding issues would arise. How would the services be funded – nationally or locally? Would services be free at the point of delivery or would there be means-testing and charges? In order to maintain a national equity in the commissioning and delivery of provision of services, accountability would need to be to a government minister. With an inevitable distancing between national priorities and local decision-making, local variations in the range of services would increase, despite the fact that the public, users, health authorities, and probably social services too, all favour greater uniformity and equity.

Separating community care from both NHS and local authorities risks it becoming marginalised. If other client groups followed this example, the NHS as we know it could disappear.

The alternative model of local authorities taking over the role of local health commissioners for part of the NHS (as proposed by the Association of Metropolitan Authorities) is seriously flawed. This would undermine the NHS, fragment its organisation and the delivery of care, to the detriment of patients, the public, those working in the service and, indeed, the taxpayer. Local authority discretion in purchasing would be an illusion, unless some of the finance was raised locally. This in turn would endanger the equity of

the NHS. The plan has support from neither Conservative nor Labour Parties.

A combined health–social services agency dedicated exclusively to community services might be funded by ring-fenced central resources. However, boundaries across client group services, and boundaries between professionals and with other crucial elements, such as housing and social security, would remain, as would the familiar operational difficulties. The boundaries between acute, continuing and community care are of particular concern. It is hard to envisage even medium-term gains for users.

NHS primary care-led commissioning would inevitably be involved in dealing with newly fragmented services. Lifting out the community care elements of health and social services would damage the potential continuum of service that lies within current structures. The King's Fund monograph, *Community Care and the Prospects for Service Development*, shows that turbulence created by reforms stunts service development for many years.

Joint commissioning

NAHAT believes that a renewed emphasis on joint commissioning seems the most pragmatic and realistic approach. Despite the mismatch of boundaries and populations, it would help greatly for health authorities and local authorities to be able to contribute to a common pool to be used for joint strategic plans. There would need to be a relaxation of the statutory limitations on transfer of funds between health and local authorities.

A common funding pool would enable providers to deliver more effectively a more co-ordinated service. Practically and politically, extension and strengthening of existing joint commissioning seem the most realistic, because they involve both health and local authorities in the full breadth of community care. This is not merely an extension of present arrangements. NAHAT proposes drawing both health and social services purchasers into a single commissioning executive, responsible for delivering the agreed strategy. Neither health nor local authorities would lose authority and influence. Further from such an approach could arise:

- the creation of unified commissioning plans;
- the removal of perverse incentives and inefficiencies resulting from diverse funding streams;
- the positive association with primary care in its commissioning or fundholding role;
- the creation of opportunities for shared training and development.

The engagement, to a clearer management focus, of housing agencies and voluntary bodies in supporting community care initiatives and of users through consultation would be improved.

Conclusion

Concerns about health and social services in a community context are almost certainly more about constraints on funds and priority-setting than they are about issues of organisation. However, strengthening collaboration with a clear lead arrangement, coupled with the provision for a mediation or arbitration mechanism, and freeing up statutory funding limitations across the social care–health care divide, is a pragmatic and fruitful way forward. ❑

Discussion

People attending the debate considered the issues raised and made the following points

The pressure for change

There has been a national failure to create an effective system of community care. Despite many examples of innovation and good practice, there are unacceptable variations in service quality and access. Poor performance in both health and social services highlights funding problems and the difficulties of joint working. This has been most apparent in services for people with continuing health care needs, where the NHS and local authorities can appear to be competing not to provide services for particular groups of people. Spectacular failures in the system – as in the case of people with serious mental health problems – have led to increased unease about current organisational arrangements.

It is not surprising that, in this context, the idea of reorganising community care (yet again) should emerge. Calls for this kind of change are not, by and large, coming from service users and their families. However, statutory and voluntary organisations alike are beginning to look for fresh solutions to long-standing problems on the health and social care divide. Central government has given respectability to the notion of merging health and social services into a single agency, as one possible option in its recent Green Paper on mental health.

The forthcoming general election provides a good opportunity for all political parties to consider new options to address problems in community care and to lay out their policies on the future role of local government and the NHS. A certain amount of lobbying to influence those political agendas is evident among professional, managerial and lay interest groups.

Merits of a single agency

Integrated health and social care organisations would be more likely to possess a shared vision and values concerning support for people with long-term illness and disability. Current confusion about the respective responsibilities of the NHS and local authorities would be swept away. Such agencies would have greater financial clout, controlling the combined resources currently allocated to separate bodies.

Single agencies would be more likely to achieve better service co-ordination, most especially for people with learning difficulties or mental health problems. Moreover, service users would no longer have to endure multiple assessments of their needs by different professionals using different eligibility criteria to inform decisions about service allocation. Arbitrary decisions about 'health' and 'social' care needs might come to an end.

Integrated purchasing would have the advantage of combining information on the needs of individuals and populations to guide commissioning at different levels. There would also be common contracting currencies and a greater inclination to invest in multi-professional education and training.

Other options

Improvements in community care could be brought about by relying more on user-controlled commissioning. The Direct Payments legislation offers opportunities here, although current arrangements would need amending to prevent privatisation and service disintegration. The development of user and carer collectives offers scope for greater influence and control over commissioning plans.

Greater reliance could be placed on performance targets, which could be monitored and built into assessments made by the Audit Commission. Targets could equally be set for budget alignment, compelling separate health and social services agencies to work towards implementing agreed joint plans. National standard-setting for services used by people with continuing health and social care needs would go a long way in addressing unacceptable variations in provision up and down the country.

Cautionary notes

People with long-term illness or disability have multiple needs which do not fit neatly into health and social care categories. Furthermore, when quizzed about the kinds of help that make a real difference in their lives, they tend to rank housing, employment and income support higher than health and social services. Creating integrated health and social care agencies would therefore run the risk of excluding key elements of community care and might, in the worst scenario, prove to be an irrelevance to people with complex needs.

We do not know how to achieve a community care that is responsive to individuals' needs and preferences. We find it easier to focus on structural change as we search for a magic solution. Boundary issues will remain, whatever organisational model is chosen.

In any attempt to reorganise community care, efforts should be made to avoid creating large monolithic agencies which would prove too unwieldy to respond sensitively and flexibly to individuals' needs. Creating single agencies for particular groups of people such as those with serious mental illness, may appear attractive but it becomes difficult to extend the case for special agencies for all, including those who are old and frail, or young and physically disabled.

Attention would need to be paid to policies which require most health services to be free of charge at the point of delivery, while social care services are means-tested. It would be wise to watch out for unintended consequences. Might integrated health and social care agencies open up opportunities to start charging users for aspects of health care? On the same note, safeguards would be needed in some single-agency models to prevent health service interests – notably those of acute hospitals – dominating community care.

Strong and committed leadership will be needed to implement new organisational arrangements in community care. There are doubts about the capacity for more change among change-weary professionals and managers currently working in the NHS and local government. No push from the centre is evident as yet. In the final analysis, more change at the local level might prove futile in the absence of greater integration of central departments in Whitehall. ☐

This debate was the third in a series organised by the King's Fund. It was held in March 1997 and was chaired by Robert Maxwell, Chief Executive of the King's Fund.

Edited by Janice Robinson, Director of the Community Care Development Programme, King's Fund.

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SUMMARY

The case for organisational integration of health and social care is put forward by Bob Hudson of the Nuffield Institute. In 'Local government and the NHS', he argues that decisions made about the NHS in the 1940s have led to fragmentation within health care services, an artificial distinction between health and social care, a neglect of preventive medicine and an absence of democratic control at local level. He maintains that extending the local government role in health care – in public health and commissioning community health services – would bring discernible service benefits and more effective local accountability.

In 'Closing the divide', Ray Jones of Wiltshire Social Services supports the case for organisational integration but opts for a different model. He highlights opportunities for closer integration of adult health and social care services within primary care teams. New provider trusts could be created, combining primary care and community health services, employing social services staff and contracting with GPs. He argues for the establishment of local health and social care commissioning authorities, located in local government or constituted as combined authorities on the lines already used for police, fire and probation services.

Noting the lack of evidence demonstrating the benefits of new organisational arrangements, Richard Poxton of the King's Fund takes a more cautious view. In 'Time to experiment', he discusses recent interest in joint commissioning between health and social care agencies, pointing out that intractable boundary issues have inhibited strategic service development. He considers the arguments for and against the creation of integrated health and social care agencies, and ends by recommending pilot schemes to test out the extent to which desired outcomes can be brought about.

In 'Strengthening collaboration in community care', Chris Vellenoweth of the NHS Confederation questions the wisdom of creating single agencies responsible for health and social care. While recognising shortcomings in community care, he argues that it would be more realistic – both practically and politically – to adopt a partnership approach designed to strengthen collaboration between separate agencies. He proposes a renewed emphasis on joint commissioning, where health and social service purchasers would be brought together into a single commissioning executive. This executive board would be responsible for delivering on joint strategic plans and would draw on a common funding pool.

In the 'Discussion', people from different backgrounds who attended the debate express varying degrees of dissatisfaction with the current system of community care. Few believe that creating a single agency responsible for commissioning and providing health and social care services is the way forward. However, there is much support for exploring ways of creating integrated commissioning agencies capable of making more effective and efficient use of scarce resources. This interest in organisational integration is tempered by an understanding of the dangers and the practical hurdles which would need to be faced.

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