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Integrating health and social care

Where next?



People want services that feel joined up, and it can be a source of great frustration when that does not happen. Integration means different things to different people but at its heart is building services around individuals, not institutions. The Government is clear that joint, integrated working is vital to developing a personalised health and care system that reflects people's health and care needs.

(Department of Health/Department of Communities and Local Government 2010)

Key points

- Integrated health and social care offers three benefits: better outcomes for service users and patients; making limited resources go further; improving people's experience of health, care and support. These have been policy aspirations for more than 40 years, but patchy progress and a transformed policy and financial climate demand new ways of achieving them.
- The coalition government's proposals for National Health Service (NHS) reform will recast the relationship between the NHS, local government and social care and offer significant opportunities to improve how these services work together to achieve better outcomes.
- However, some aspects of the reform could undermine existing achievements and make it harder to integrate services in the future. There is uncertainty over the impact of the reforms, and a number of different scenarios are possible. The government's pathfinder GP consortia and early implementer health and wellbeing boards should be used to test out these issues before the reforms are rolled out nationally.
- Future integration will be driven through clinical engagement and local action, with less reliance on national policy initiatives and prescriptive guidance. Fundamentally this is the right approach, but it is unclear whether the proposed national outcomes frameworks and regulatory approaches will be sufficient to avoid unacceptable local variations in services, or whether sector-led methods such as peer review will address poor local performance. There are other tensions, for example, the 'any willing provider' proposal, which could make integration harder.

- These and other aspects of the national policy framework require closer attention to avoid unintended consequences of reform. The emphasis should be on defining the outcomes to be achieved by health and social care systems everywhere, with choices about the means of integration a matter for local decision. The role of the Care Quality Commission (CQC) should be to oversee performance across organisations and act when these outcomes are not achieved.
- The NHS and social care face unprecedented productivity and efficiency challenges. Changes will be necessary to make resources go further across organisational boundaries as well as within them. Pressures on services and budgets will test existing relationships to the limit but could sharpen awareness of the interdependency of NHS and social care resources.
- There is general optimism about prospects for closer working but also acute awareness of significant risks and challenges arising from the pace of change that could see the dissolution of existing organisations (strategic health authorities and primary care trusts) before new leadership and organisational arrangements are in place. The proposed new organisational arrangements offer a relatively fragile framework in which to construct strong new partnerships.
- Developing local measures of performance, including costs and outcomes, will be essential to enable local partners to understand local needs and how services can best be brought closer together.

Introduction

Closer integration of health and social care has been a recurrent goal of public policy for at least the past 40 years. Different solutions have been proposed including full structural integration into a single system. Other models are geared to overcome barriers and facilitate closer joint working and sharing of resources to give a seamless service. The successful integration of health and social care offers three potential benefits:

- better outcomes for people, eg, living independently at home with maximum choice and control
- more efficient use of existing resources by avoiding duplication and ensuring people receive the right care, in the right place, at the right time
- improved access to, experience of, and satisfaction with, health and social care services.

The coalition government has made clear its commitment to the integration of health and social care, beginning with a pledge to break down the barriers between health and social care funding and culminating in proposals for the reform of the NHS and adult social care. In the context of the intense financial and demographic challenges facing both services, this paper offers a fresh assessment of the prospects for integrating health and social care and the opportunities and challenges arising from the government's proposals. It is not yet clear if this approach to integration is simply the latest in a long line of policy initiatives, or if this is a qualitatively different model. In either case, the likely consequences need to be examined.

Alongside policy shifts towards localism in public services and local government and the Big Society, these changes could herald a new era of opportunities and challenges for how these two services interact with each other.

The King's Fund held two expert seminars in autumn 2010 to develop new thinking in this area, bringing together senior policy experts and NHS and social care leaders to discuss the barriers and aids to integration at national and local levels, focusing in particular on the White Paper *Equity and Excellence: Liberating the NHS* (Department of Health 2010c) and the financial challenges facing all services.

This paper draws on the discussions that took place at both seminars which sought to consider the following questions.

- Will the coalition government's policies create conditions for successful integration that has eluded many previous initiatives?
- What opportunities could GP-led commissioning offer to develop new approaches to integrated care?
- How far will pressures on social care budgets – and the productivity challenge facing the NHS – hinder or help integration?
- What policy changes or adjustments would be helpful in promoting closer working of the two services?

What will drive future health and social care integration?

The impact of world recession on UK public finances and the shift from a 'big state' to 'big society' view of public services call into question past approaches to health and social care integration. In this section of the paper, we summarise the key contextual elements within which health and social care integration will be pursued in the next few years.

The financial challenge: care in a cold climate

The scale of the financial challenge facing the health and care system is unprecedented. This has become even clearer since the seminars, as the implications of the 2010 spending review begin to translate into budget projections. As well as the productivity challenge facing the NHS, the inadequacy of current funding arrangements for social care has long been recognised, and an independent Commission on the Funding of Care and Support has been charged with producing recommendations for a fairer and more sustainable system. There is general agreement that the closer integration of resources could secure long-term gains in efficiency, quality and productivity. *The Operating Framework for the NHS in England 2011/12* (Department of Health 2010e) has confirmed the expectation that the NHS and local government should work together to achieve this. It will be essential that there is a good understanding of the reciprocal relationship between health and social care spending. The evidence about the interdependency of NHS and social care resources is the subject of a separate paper (Humphries 2011).

The demographic, cost and demand pressures facing public services create both challenges and opportunities for health and social care integration. The continuing rise in emergency hospital admissions will sharpen the focus on preventing admissions, as well as speeding up treatment, and encouraging timely discharge. Increasing numbers of patients are living with multiple long-term conditions, and their complex needs often span the care and cure sectors. The need to transform the NHS from a reactive episodic system into a proactive wellness service will lead to more widespread use of preventive approaches. This should drive closer integration of primary health care and social support to people who may be at risk of hospital, residential or nursing home admission. From a different starting point, it is becoming clearer that the key to making best use of reduced social care resources is to ensure that people are not drawn into formal services earlier than necessary, and that interventions are geared to restoring independence (Association of Directors of Adult Social Services and Local Government Association 2010).

The new policy landscape: liberating the NHS?

The NHS White Paper *Equity and Excellence: Liberating the NHS* (Department of Health 2010c) heralds the most sweeping changes in the history of the NHS. The abolition of primary care trusts (PCTs), the creation of general practitioner (GP) consortia, a national commissioning board and local health and wellbeing boards will create a new structure in which future efforts to integrate services will take place.

The transfer to councils of the responsibilities for promoting partnership working, joint strategic needs assessment, public health, and health improvement, means local government will be expected to play a leading role in integration of health and social care. The proposed new health and wellbeing boards will be expected to take a strategic approach and promote integration across health and adult social care, children's services, including safeguarding, and the wider local authority agenda.

The implementation of the White Paper will create opportunities to bring services closer together. But it may also undermine existing achievements and produce unintended consequences that will hinder integration. These are explored in further detail below.

Public services - from big state to 'Big Society'

Many of the major initiatives to bring health and social care closer over the past 20 years have come from the centre and been driven through top-down targets, performance management and centrally allocated and ringfenced grants.

The coalition government is seeking a different approach to public service reform, under the banner of the Big Society '... designed to turn government on its head, taking power away from Whitehall and putting it into the hands of people and communities. Once these reforms are in place, people themselves will have the power to improve our country and our public services, through the mechanisms of local democratic accountability, competition, choice, and social action' (Department of Health 2010b).

If fulfilled, this vision would see the role of large public service bureaucracies – at central, regional and local levels – eclipsed by the devolution of power and resources to local communities and professionals. The government wants to encourage volunteering, philanthropy and social action at local level, making it easier for people to come together to improve their communities and help one another. A much bigger role is envisaged for mutuals, co-operatives, charities and social enterprises in the running of local public services. This should lead to refreshed interest in how the existing voluntary sector, as well as new organisations, can contribute to the bringing together of local services.

These three threads running through the Big Society idea – devolving power and resources, promoting local action and stimulating new non-state delivery organisations – each have different implications for how local health and care services work together. It should mean a much more localist approach to integration, with less prescription from the centre.

Reform of social care

The government's commitment to bringing health and social care closer together is further reflected in its vision for adult social care in which services are more personalised, preventive and focused on outcomes (Department of Health 2010a). This emphasises that local authorities should exploit the opportunities of the NHS White Paper to play a lead role in their communities, ensuring local services are more coherent, responsive and integrated.

As noted earlier, an important element of the government's reform agenda for social care is achieving a new funding settlement that takes account of its impact on the NHS, and

the government's wider agenda for welfare reform. This will underline growing concerns that the NHS cannot work properly without an effectively and adequately resourced social care system. Although the Dilnot commission's terms of reference do not directly refer to the interface with the NHS, it is difficult to see how a new funding settlement can be achieved without viewing health and social care resources in the round (The King's Fund 2010). The government has said it will consider the commission's recommendations alongside those of the Law Commission's review of adult social care law with a view to including a single set of proposals for the Queen's Speech in 2011.

Scenarios

It is possible that a range of different scenarios could develop as a result of the same set of reforms, as The King's Fund indicated in its response to the White Paper (Dixon and Ham 2010). Several scenarios are possible.

An integrated system

This is, in many ways, the scenario that is anticipated by the architects of the reforms. This would see the emergence of strong health and wellbeing boards that seek to involve an engaged majority of GPs. Cross-consortia relationships are strong and there is a commitment among GPs to working together at a strategic level. The health and wellbeing board offers strong local leadership, providing a focus for integrated working around the joint strategic needs assessment (JSNA). GP consortia recognise the benefits of alignment to a single local authority and seek to retain an element of co-terminosity with their respective catchments. This means that GP, public health and local authority priorities and agendas are largely aligned, and this alignment is underpinned by locally agreed outcomes that span health, social care and health and public health. There is wide sharing of data and robust peer review. GPs recognise the value of integrated working and understand the interdependence of health and social care budgets. As such, they are incentivised to work alongside social care colleagues to support patients at home and avoid hospital admission. Existing relationships across professional boundaries are built upon, partnerships are developed and skills within PCTs are harnessed by consortia. Severe financial challenge brings about creative approaches. Pooled budgets will be retained and extended. Care pathways develop across health and social care, and patients experience a seamless and personalised care package. There is investment in wellness and prevention, both 'sides' having recognised the potential for return on investment. In some areas, commissioning budgets might be integrated, but competition will exist between providers. This drives quality and safety improvements. In other areas, there may be moves towards the development of integrated care organisations that incorporate both commissioners and providers. The NHS Commissioning Board uses accountability frameworks to promote integrated working and the independent regulator Monitor effectively promotes competition where it is enhancing quality.

A fragmented system

At the other extreme would be a scenario where we see total fragmentation of care. The loss of co-terminous boundaries means that existing relationships between health and local authorities break down. Progress made in recent years towards better joint working is undone, and the expertise that has developed in PCTs in recent years is lost to the system. Although new relationships will develop over time between the new GP consortia and social care providers, they are hampered by consortia working across more than one local authority. This means that agendas and priorities will not always be aligned and gives rise to conflict. The health and wellbeing board is weak. It has few powers over GP consortia, which are disinterested in local authorities and focus on immediate patient

care to the exclusion of wider population issues. The absence of strategic leadership sees traditional service patterns untroubled by transformational change. Severe financial challenge leads to cost-shunting, a reluctance to share data between services and inappropriate use of hospitals. Patients begin to experience fragmented care and there is little investment in prevention. Quality and safety are compromised. Strict procurement laws preclude the possibility of GP consortia developing in-house models of care that straddle health and social care, and innovation is stifled. The commissioning board struggles to hold GPs to account for integrated working as it has no process measures within the outcomes framework by which to measure it. The absence of proactive performance management means that the board intervenes only when services have begun to fail.

Stasis

Another scenario is that of very little change to the existing arrangements. GP consortia will, over time, begin to resemble PCTs but with more clinical leadership. The commissioning board will begin to take on a performance management role, and regional offices will resemble strategic health authorities (SHAs). Care trusts may continue to exist in some areas, albeit with a separation of commissioner and provider, but they will be few in number. In most areas, GPs will attend meetings of health and wellbeing boards, but such participation will be tokenistic. Boards will have little influence over consortia plans, and interaction will be transactional rather than integrated. Patient experience will vary across the country – there will be ‘highlights’ of effective integration delivering seamless co-ordinated care, and ‘hotspots’ where resources remain separate. Cost-shunting and boundary disputes flare up in response to financial and service pressures.

Of course, these scenarios describe extremes, and any number of possible scenarios are conceivable along this continuum. However, what is likely is that there will be great variation across the country in terms of impetus to integrate and progress towards delivering integrated care. The wide variety of pathfinder consortia vary greatly in size, and this is likely to be matched by variation in approach and attitude to integration.

Integration - where next?

In the light of the policy prospects above, many of the levers and tools used in the past to drive integration may become redundant, inappropriate or insufficient. Fresh thinking is needed about how health and social care services can be brought together.

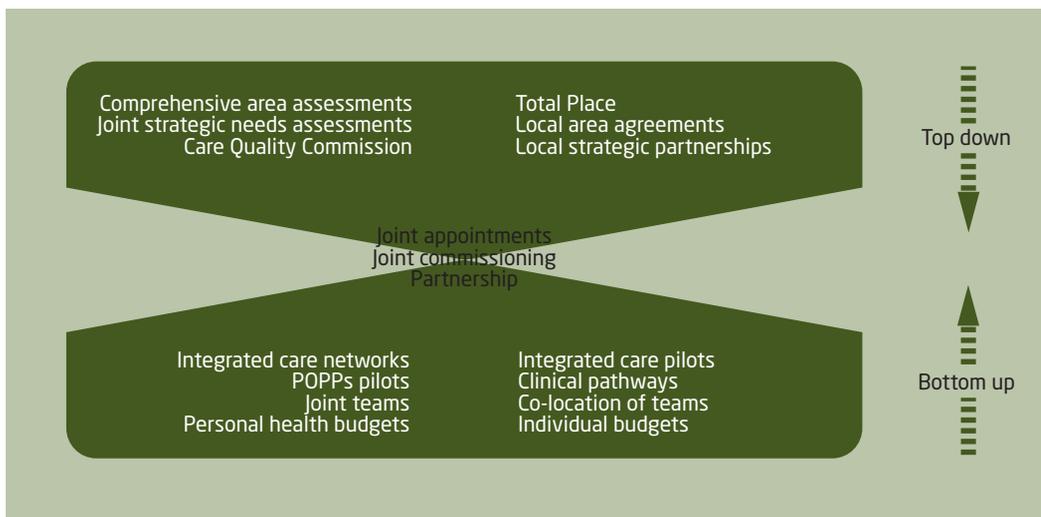
The current landscape is shown in Figure 1 (opposite). Some of these elements will continue, while many, such as comprehensive area assessments and performance assessments of individual local authorities, have already begun to disappear altogether.

What might be the dimensions of new thinking about the integration of health and social care?

The starting point should be recognition that the primary focus is on the individual patient or service user. This has been a common feature of many of the successful examples of local integration. Traditionally, integration initiatives have often focused on the organisation, the service, the budget, or the professional discipline. These represent the means to an end, not the end in itself. Policy documents in both the health and care arenas are emphasising principles of personalisation and securing the best outcomes for people, and the refrain of ‘nothing about me without me’ is increasingly heard. A person-centred perspective aspires to people experiencing one system of care and treatment, not several disconnected ones, and encompasses:

- how people access services through information, advice and referral

Figure 1 'Our integration landscape is comprehensive but incoherent and progress has been limited' (Behan 2009)



- their journey through the health and social care system and the pathways they use in navigating across a variety of organisational and professional boundaries
- their overall experience and outcomes
- the extent to which they can help shape their own experience of the system, eg, through self-care, personal health budgets and social care budgets.

Discussion at the seminars was structured around four dimensions – organisational, financial, behavioural and local (see Figure 2)– where it was suggested that new thinking is needed, either because they have been paid insufficient attention in the past, or because of forthcoming policy changes. The key issues for each dimension are described below, followed by a summary of key messages from participants.

Figure 2 New thinking about integration - a person-centred approach



Organisational

We suspect that just 20 per cent of our GPs in our area have actually read the White Paper.

(Seminar participant)

If enacted, the ambitions of *Equity and Excellence: Liberating the NHS* (Department of Health 2010c) will see the demise of PCTs and will remove an entire tier of organisation that has been the principal partner of local authorities in developing co-ordinated local services. The immediate effect will be to remove the co-terminosity of boundaries that has been built up over the past decade as a consequence of unitary local government and NHS reorganisation. The importance of structure should not be overstated, but co-terminosity is widely regarded as a feature that facilitates co-ordination across organisational boundaries. Along with the abolition of SHAs, the organisational landscape will look very different (see Figure 3). Furthermore, the movement of key managers and leaders from PCTs and SHAs could disrupt the personal chemistry and good relationships that have been nurtured over the years and that have been a key factor in bringing organisations closer together. Although not yet enacted, elements of the Health and Social Care Bill (House of Commons Bill 2010–11) are already being implemented. The formation of PCT clusters as part of the transition to GP commissioning is leading to concerns among local authorities and PCTs that existing joint arrangements will be dismantled (Dunton 2011).

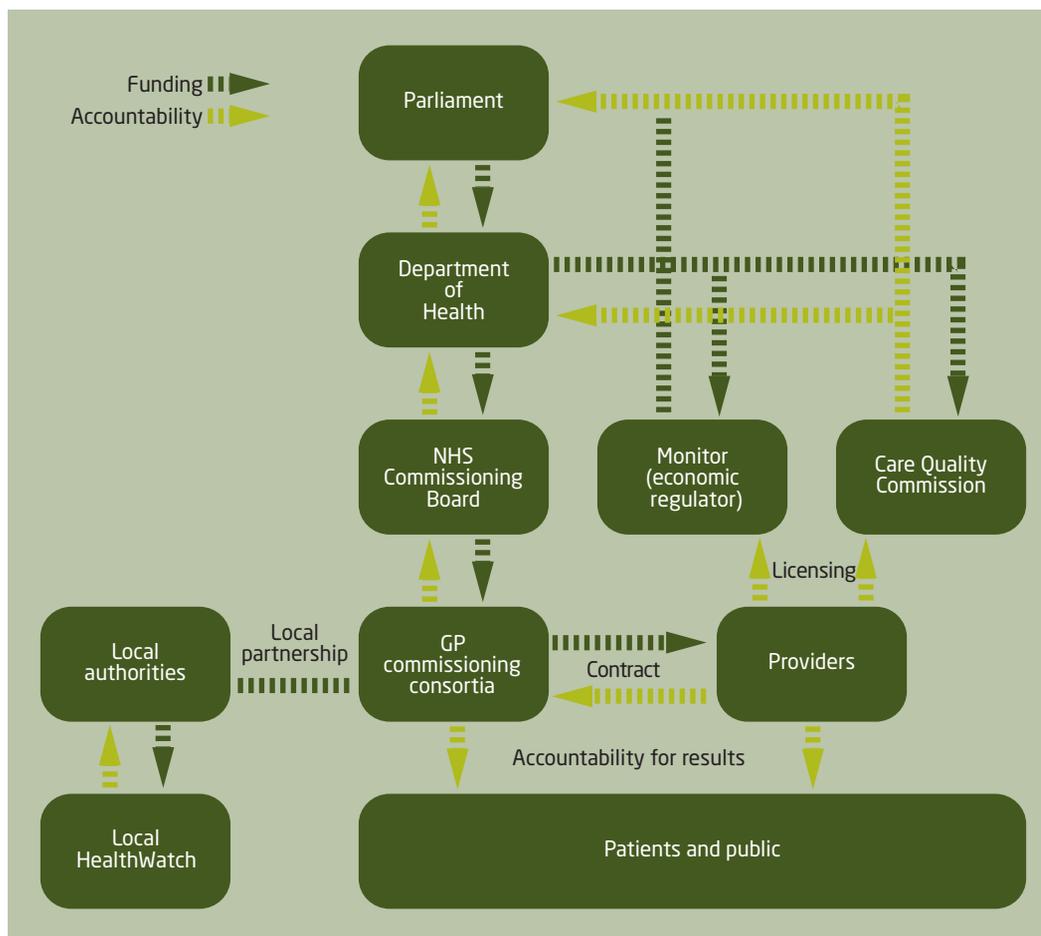
Such major changes also raise questions about whether existing joint agreements on resources that have worked well in some places – for example, integrated commissioning and pooled budgets – might be at risk, and how continuity of care will be maintained while discussions take place between local authorities, GP consortia and the commissioning board about future arrangements.

It is clear that future commissioning arrangements anticipate that **GP consortia** will be centre-stage – a new set of players with whom relationships and understanding need to be developed, in many cases from scratch. The shift could create powerful new levers. GP consortia will have significant financial incentives to support people to live at home and to avoid hospital admissions. Because this cannot be done without an effective interface with social care and other community services, this could re-energise local interest in partnerships.

GP consortia will have statutory responsibility for commissioning the majority of NHS services, including most community health services, and mental health and learning disability services as well as acute and urgent care. Local authority experience of commissioning in many cases could present an attractive ‘offer’ to consortia as they take on these new responsibilities.

However, the governance arrangements proposed in the Bill do not require consortia to involve other health and social care professionals. Given the importance of multidisciplinary working across professional boundaries to achieve integrated care, this could be a weakness. To date, 177 groups of GPs, covering around two-thirds of the country, have applied to join the government’s pathfinder scheme. This should enable many of the issues to be tested out so that lessons can be learnt before consortia are rolled out nationally. It is important that there are opportunities for such policy learning to take place and to inform the pace of implementation.

Figure 3 The new landscape



(Department of Health 2010c)

The new **NHS Commissioning Board** will be an independent non-departmental public body which will hold GP consortia to account for the quality of services they commission, the outcomes they achieve for patients and their financial performance. It will directly commission primary care, dental, ophthalmic and community pharmaceutical services as well as specialised services such as prison health care. The board will have a specific duty to foster integrated working by encouraging consortia to work closely with local authorities in arranging services, in particular through the use of joint arrangements under Section 75 of the NHS Act 2006. In relation to its local commissioning responsibilities, the board will have a duty to ‘have regard’ to the joint strategic needs assessment and joint health and wellbeing strategy.

The Health and Social Care Bill extends the role of local authorities in the health system by creating **health and wellbeing boards** and giving them responsibility for public health. The aim is to strengthen democratic legitimacy and ensure that commissioning is co-ordinated across the NHS, social care and public health. The interface between GP consortia and local authorities will be critical in ensuring that services meet the full range of local population health needs. There will be a duty on health and wellbeing boards and consortia to produce a joint strategic needs assessment for their local area and a joint health and wellbeing strategy to meet those needs. Local authorities will be enabled to delegate any of their functions to the board, thus making it easier to co-ordinate other services that impact upon health and wellbeing, such as housing or environmental health. Boards will be able to require the NHS Commissioning Board to send a representative to discuss its local commissioning responsibilities.

The Bill envisages that health and wellbeing boards will be the key local bodies charged with integrating local services and bringing together NHS and local government commissioning. However, the provisions of the Bill do not appear to equip the boards with sufficient powers to do this. For example, while consortia must consult them in drawing up their commissioning plans, there is no requirement for them to have regard to their views. And while the Bill would place a duty on boards to promote integration, there is no equivalent duty on consortia.

So although partnership does appear to be a key word in the vocabulary of the White Paper's proposals, the distribution of powers and duties proposed in the Bill appears asymmetrical, with responsibility for achieving integration located in the part of the new structure with the fewest powers to make it happen. There is a risk therefore that health and wellbeing boards will be no more effective in driving local integration than have been previous initiatives such as joint consultative committees. Their achievements will depend on their ability to influence local partners rather than the exercise of formal duties and powers. Bearing in mind the loss of co-terminosity between local authorities and PCTs, the new organisational arrangements offer a relatively fragile framework on which to construct the new partnerships that will be needed.

Finally, the Bill appears to make possible the continuation of care trusts where commissioning consortia and local authorities agree. It also creates opportunities for consortia and foundation trusts to become care trusts. Existing care trusts that have both a commissioning and a providing function will need to change to one or the other function only. While the Bill offers some protection for existing care trust arrangements, the continued requirement to separate commissioning from provision creates a structural obstacle to the evolution of integrated care organisations. There is growing evidence of the potential of these bodies to break down barriers between services and achieve truly integrated care (Curry and Ham 2010).

Key seminar messages on organisational integration

- Participants were generally optimistic in identifying the opportunities that the new arrangements present but also recognised significant risks and challenges: the loss of key capacity in SHAs and PCTs; the pace of change that could see the dissolution of existing organisations before new leadership and organisational arrangements are in place; and the immense financial pressures facing the NHS and local government.
- GP consortia should become the new building blocks through which services are brought together. An important driver for change in some places has been the shift away from purely geographical-based provision towards GP lists. This will become more important as it becomes easier for people to change GPs. The implication for local authority definitions of 'ordinary residence' is a potential fault-line.
- Wider concern was identified about the potential for intrinsic conflict between choice and competition, especially in driving the use of resources in the acute sector, and the need for collaboration to achieve a more co-ordinated experience for patients and service users.
- Local authorities were seen as potentially valuable sources of support and expertise to GPs in commissioning, drawing on their experience in commissioning substantial volumes of care from the independent sector since 1993. But some colleagues cautioned against underestimating the complexity of commissioning health care and the need for particular kinds of expertise and capacity that has not always been present in PCTs.

- There was concern that within the new NHS structure there seems to be no place for management or leadership of the overall system, and that the regulatory role for the CQC appears to be concerned with the performance of individual organisations rather than the system as a whole. This places a heavy premium on the ability of the health and wellbeing boards to oversee the operation of the local health and care economy.

Financial

The deficits we and our local NHS face are mindblowing... without working together everything will fall apart.

(Seminar participant)

The profound organisational changes that are proposed are compounded by the financial prospects for public services that are already beginning to have a substantial impact on the relationship between the NHS and social care and the reciprocal nature of spending in each service (Humphries 2011). The 2010 Spending Review (HM Treasury 2010a) provides a small real-terms increase for the NHS and increased grant funding for social care of around £875 million a year on average over the next four years. A further £1 billion a year by 2014/15 will be set aside from the NHS budget for partnership working between the NHS and social care (£800 million in 2011/12). This will include funding for re-ablement services, which support people when they return home from hospital.

While this settlement is relatively generous compared with those for other public services, and recognises the demographic and cost pressures, the NHS reforms will be implemented alongside a 45 per cent reduction in management costs and the need to find productivity improvements of £20 billion by 2015. Local government faces an overall grant reduction of 27 per cent. With adult social care the largest area of expenditure in many local authorities, the absence of ringfencing means that social care services will be vulnerable to competing local priorities.

The key question is to what extent these financial pressures will act as a powerful catalyst for the closer alignment of health and social care resources, or as a source of conflict that will drive them further apart as they defend their budgets. The necessity of keeping people out of the most expensive parts of the system wherever possible, ie, acute hospitals and care homes, could be a potent new impetus for integration. As Appleby *et al* (2010) have argued, 'if NHS organisations do not work in partnership with local authorities to examine ways of improving the use of resources in the round, then it will be increasingly difficult to give priority to new models of care that rely less on hospitals and more on caring for people at home and in community settings'. The same financial pressures could have the opposite effect of creating divisions between the local NHS and social care partners, with the risk of cost-shunting, disputes about funding responsibilities and service boundaries, and breakdown in care co-ordination. This will be heightened in places where there are poor relationships between local government and the NHS, low trust and little history of working together. There will be particular concerns that reductions in care home placements and support for people at home may increase the number of avoidable hospital admissions and delayed transfers of care, working against NHS efforts to reduce the use of expensive acute care (BUPA 2011). Reduced social care budgets will make it much harder for councils and providers to work with the local NHS to meet its own productivity challenge, and will undermine the rationale for ringfencing NHS budgets. Conversely, it is possible that reduced investment by the NHS in services for dementia, continence and mental health could exacerbate pressures on social care services.

At present, the bulk of public funding for adult social care is allocated from the Treasury to the Department for Communities and Local Government and then distributed to councils based on a funding formula. For the NHS, the majority of commissioning resources will be allocated to individual GP consortia by the NHS. Currently there are different statutory arrangements for joint financing at the local level, set out in the NHS Act 2006. Financial arrangements that underpin joint working between health and social care will need to be thought through afresh, at both local and national levels.

If, as appears likely, future funding of health and social care will continue to be allocated separately to local organisations, there will need to be new arrangements for GP consortia, councils and the NHS Commissioning Board to align these resources where needs are overlapping or shared. GP consortia may, for example, agree that the council should commission mental health or learning disability services on their behalf. Consortia may wish to contribute towards the funding of council services such as re-ablement, or prevention schemes to help older people remain at home. The Health and Social Care Bill does make provision for pooling of budgets, so places that have already done this could continue the arrangement, providing that the consortia agree. The £1 billion of NHS money to be locally allocated to support social care over the next four years offers a positive and welcome impetus for discussions about sharing resources. It has been described as offering ‘...a unique and excellent opportunity to forge better integrated working between the health and social care systems’ (Department of Health 2011).

But as the Health Select Committee has warned, there is a risk ‘... that the sum will be focused on funding certain limited services, rather than being directed towards providing a better overall interface between the two sectors which will bring about longer-term improvements in efficiency, preventive care and re-ablement’ (Health Select Committee 2010).

There is a case for moving beyond a relatively narrow focus on joint expenditure and exploring ways of aligning the entire £121 billion NHS and social care budget. Despite exhortations to co-ordinate resources, less than 5 per cent of the combined NHS and public social care budgets are spent through joint arrangements. There is a variety of ways in which local budgets could be pooled including: the existing Section 75 Health Act powers; the community budget approach proposed in the Spending Review; the place-based budgeting put forward by the Local Government Association which in turn draws on the experience of HM Treasury’s Total Place pilot programmes (Humphries and Gregory 2010). The actual mechanisms used to fund services jointly are less important than clarity about the desired outcomes (Audit Commission 2009). A radical option would be to merge local adult social care budgets with GP consortia commissioning budgets – for defined needs or patient/user groups – to enable a completely integrated local approach to the funding and commissioning of services.

Many of the participants in the seminars emphasised the imperative for local authorities and their health partners to develop a good understanding of the needs of their population, especially those who are the most intensive users of health and care services. This requires a clearer analysis of the reasons behind the wide variations in spending, costs and outcomes from one area to another. Performance should be benchmarked against appropriate local, regional and national comparators. It is important to draw on the experience of people who use local health and care services. Developing this intelligence with health partners should enable a better shared understanding of the impact across both health and social care services in terms of, for instance, emergency hospital admissions, delayed discharges and continuing care. It follows that the focus should then be on how health and social care resources can be used together and their impact combined. An example of this is Torbay Care Trust, whose service integration emerged out of a bottom-up commitment to better meeting the needs of complex individuals in the area. The formation of a care trust enabled the alignment of financial

and other factors that helped to overcome the contractual and other complexities involved in delivering care across two services (Thistlethwaite 2011).

Key seminar messages on financial integration

- Financial pressures and the productivity challenge will force change. Some health and social care economies have already begun to quantify costs and savings across organisational boundaries.
- Information is key to managing resources effectively across the health and social care system, especially the use of real-time performance data.
- Understanding local patterns of spending, costs and outcomes against appropriate comparators (local, regional, national) should be the basis of local partnership working and management of the whole system of care. 'Meta-metrics' are needed to capture savings and performance across this whole system.
- Although Health Act flexibilities have been useful, they have not been crucial to many examples of local integration where budgets have been shared rather than integrated. Clarity about desired outcomes is more important than the specific mechanisms used to bring resources closer together.
- Health and wellbeing boards would be well placed to take forward place-based budgeting, drawing on the potential identified in the Total Place pilot programmes.

Behavioural

I've been a GP in this town for over 30 years and it's the first time I've been inside the Town Hall.

(Seminar participant)

There is a growing body of evidence about the importance of behavioural aspects of organisational change. The experience of health and social care integration in recent years suggests that closer attention should be paid to this aspect in future policy.

First, a common theme in many evaluations of partnerships and integration initiatives has been the personal chemistry between key local players, the quality of relationships between people and organisations, and the time needed to build up mutual trust (NHS Confederation 2010). Organisational structures do not automatically cause these behaviours, but can be the consequence of them. The experience of care trusts in England suggests that where relationships were good to start with, integration improves them, but where they were poor to start with, integration causes them to deteriorate further (Freeman and Peck 2007). It would seem that, regardless of whether integrated care is organised via formal agreement or loose alliance, relationships are key to making it happen.

Second, a major thrust of the coalition government's reforms is the devolution of power and responsibility to professionals. This aspect of the NHS reforms has been emphasised repeatedly by the government and the aspiration is supported by evidence. Engagement of frontline professionals has been crucial in several case studies of successful integration (Hamilton *et al* 2005; Ham 2009). Much of the literature stresses the importance of relationships, clinical engagement and leadership in the success of integrated care; certainly, those networks that have been imposed from above have struggled to develop as a result (Goodwin *et al* 2004). Similar observations have been made about the Swedish Chains of Care model: where relationships were allowed to evolve between clinicians, more successful networks developed (Ramsay and Fulop 2008). Enthoven reflects that the United States has achieved high levels of performance in integrated care, not through contracts and transactional reform but through engaging clinicians (Enthoven 2002).

The behaviours of frontline professionals and how well they work together and with other disciplines will directly affect how people experience services and how far this is 'joined-up'. More attention should now be given to the role of clinicians, particularly GPs, as leaders of local integration, rather than the managerially or organisationally driven approaches of the past. Traditionally, most GPs have operated as self-employed contractors and as clinicians with a primary concern for the individual patient. This has not usually required much in the way of organisational allegiance (other than to the practice) or interorganisational collaboration (beyond individual patient care). Being in the driving seat of commissioning – including getting the right interface with social care services – will demand a different skill set. Behaviour change will become a crucial ingredient of success.

What does this mean for policy? Can the system be designed to encourage clinician engagement and collaboration? Some levers of this nature are already being developed, for example, the NHS Operating Framework has adjusted the tariff so that acute hospitals will be responsible for support and re-ablement for 30 days following a patient's discharge from hospital, thereby disincentivising premature discharge. The government is proposing that a proportion of GP practice income should be linked to the outcomes that practices achieve collaboratively through commissioning consortia and the effectiveness with which they manage NHS resources. Some of these outcomes might by their very nature be easier to achieve through integrated arrangements with social care, such as intermediate care. There might be further opportunities presented by the reforms to incentivise collaborative behaviour such as unbundling the tariff and reconfiguring resources around care pathways. There are some examples in the United States and Canada of integrated care packages for older people (eg, Integrated Service for Frail Elders (SIPA) in Canada and the Program of All-inclusive Care for the Elderly (PACE) in the USA) where providers of care integrate and provide health and social care in-house, buying in specialist care as and when it is needed. The model of care is based on multidisciplinary teams that are responsible for the ongoing care of the patient and also for a capitated budget.

This raises a deeper question about the extent to which the policy drivers underpinning the NHS reforms encourage collaborative behaviour. The proposed policy of 'any willing provider' should help to promote innovation, but an increasingly fragmented array of competing providers may then make it harder to offer people an integrated experience of care. As noted earlier, tensions could arise between the use of competition and choice to drive up standards and the need for collaboration to ensure different services work well together. Since publication of the Bill, it has become clear that the economic regulator Monitor will have far-reaching powers that represent an ambitious attempt to operate a system of market regulation within the NHS. There is a risk that Monitor's duty to promote competition will result in integration and collaboration being seen as anticompetitive. Indeed, some have questioned whether the pursuit of a market is appropriate for the NHS; in some areas of health care – such as in the provision of specialist cancer and cardiac services – there is a need for collaboration through networks and it is important that legislation does not brand such provision as anticompetitive (Ham 2011).

Although GP consortia could potentially re-energise local co-ordination of services, there is a risk that overly rigid rules on procurement and opening up the market may inhibit the ability of GPs to 'make' as well as 'buy' services in partnership with social care commissioners. This would work against the government's stated aim of devolving power to frontline professionals and putting local GPs in the driving seat. As we have argued elsewhere, alternative approaches could be developed in which there is choice between systems in which commissioning and some, or all, aspects of service provision are integrated (Dixon and Ham 2010).

Key seminar messages on behavioural integration

- Relationships and behaviour are fundamental to progress. Opportunities for integration will be limited if working relationships are not effective. These take time to develop and have to be nurtured. These softer aspects of organisational development cannot be mandated.
- The White Paper has triggered first time conversations between GPs and councils. Early discussions suggest that they both have the same concerns but there is a need to break down barriers. There are signs that some GPs are seeing their local council as a source of support and help – an island of organisational stability – but others may be suspicious of the ‘political’ element of local government. Overall, the interest and commitment of GPs is seen as variable.
- Health and wellbeing boards can fulfil a strategic role in promoting collaborative behaviour and helping local partners recognise their mutual dependency. For this to happen, GPs should be seen as fully engaged members of boards rather than external partners.
- Some aspects of the reforms could make it harder to integrate services. The adoption of ‘any willing provider’ might lead to rigid models of procurement that exclude innovative providers and impede the opportunities for consortia to make as well as buy services. Similarly, the absorption of community health services into acute foundation trusts was seen by some as a barrier to the future integration of these services with wider primary and social care.

Local

If the aim is for a thousand flowers to bloom, does there need to be a head gardener?
(Seminar participant)

There is a resurgence of interest in local examples of successful integration. This chimes with the coalition government’s emphasis on devolution of power and responsibility to the local level and a shift away from local reliance on national guidance or top-down prescriptions about how integration should be tackled.

The development of policy along permissive rather than prescriptive lines is supported by evidence from a survey of PCT and local authorities suggesting that the main factors promoting integrated working are locally determined – local leadership, vision, strategy and commitment (Gleave *et al* 2010). 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).

There has been growing interest in a completely different approach to bringing resources closer together by focusing on the needs of places – and the resources within them – as opposed to organisations (Humphries and Gregory 2010). The evaluation of HM Treasury’s Total Place programme offered promising evidence that this approach to local public services can deliver better outcomes and improved value for money (HM Treasury 2010b). The NHS and local government have been central partners in many of the 13 pilot programmes. The thinking behind the Total Place programme is now being developed into broader approaches to ‘place-based budgeting’, with the Local Government Association (LGA) arguing that ‘local government and local partners must determine themselves the best spatial geography and devolved governance arrangements for how local public service resources are used’ (Local Government Association 2010). The government says it will work with the LGA to understand the potential benefits of

Table 1 Factors helpful to and hindering local integration

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)
Frontline staff commitment (13)	Local history (14)
Joint commissioning (13)	Data and information technology (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	

(NHS Confederation 2010)

place-based budgets and look at the potential application of these approaches to cross-cutting areas of health spending that require effective partnerships with local authorities and other frontline organisations, for example older people's services and substance misuse (Department of Health/Department for Communities and Local Government 2010).

The emphasis on place is complemented by the government's wish to strengthen local democratic legitimacy and the new roles it is proposing for local government and the new health and wellbeing boards. This in turn complements the existing duty of councils to carry out joint strategic needs assessments of the health and wellbeing needs of their local populations.

Increasing attention has also been paid to approaches that have focused on the integration of frontline services. In Torbay, for example, the development of single locality health and social care teams – aligned with GP practices, using a single assessment process and pooled budgets – is having a demonstrable impact on the use of hospitals, and enabling older people to receive care outside of hospital (Thistlethwaite 2011). Elsewhere we have illustrated the benefits of closer alignment of health and social care resources in areas such as intermediate care and prevention (Humphries 2011).

However, in practice, local progress has been mixed and highly variable. For example, there is a 30-fold variation in the proportion of people whose discharge from hospital is delayed (Care Quality Commission 2010). Formal joint expenditure still accounts for a tiny proportion of total health and social care spend – just 3.4 per cent in 2007/8 (Audit Commission 2009). There is also some evidence that integration of services for older people is well behind that of learning disability and mental health services (Gleave *et al* 2010).

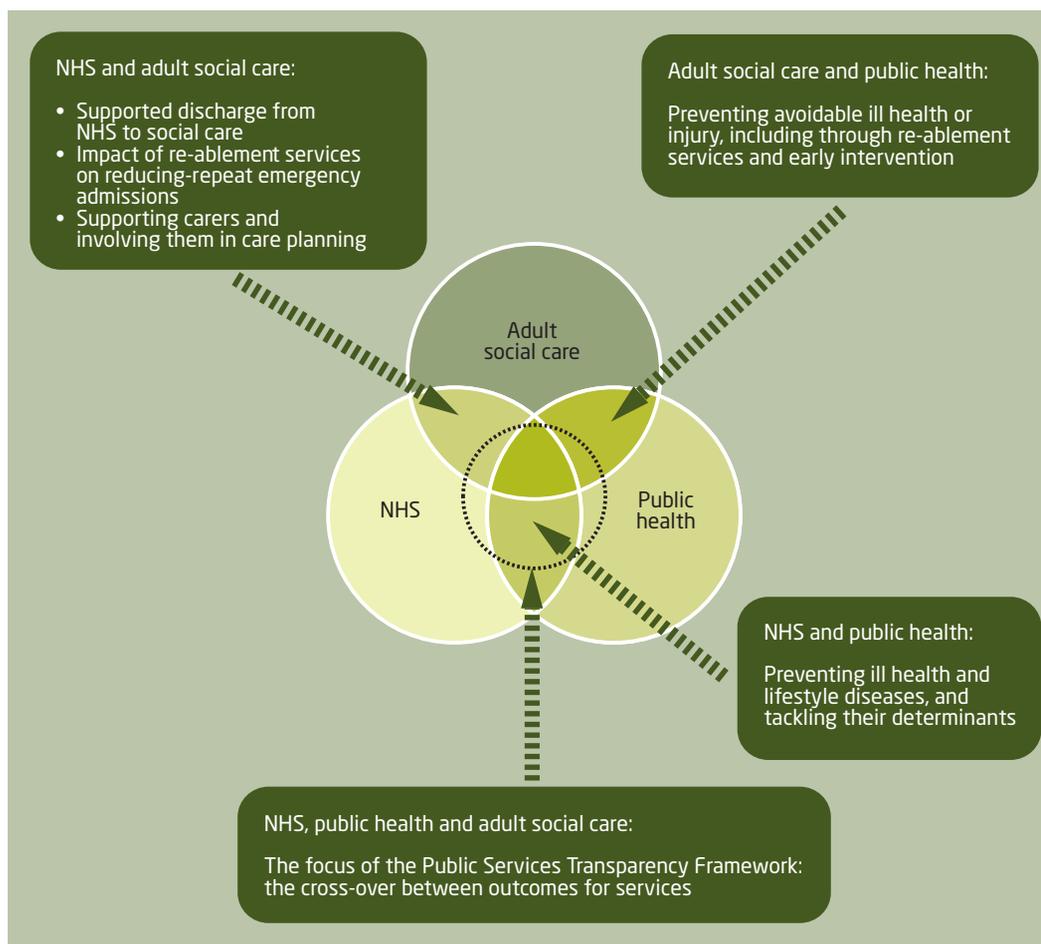
So will the localist approach proposed by the government enable closer integration of health and social care at a local level? The survey results mentioned above (Gleave *et al* 2010) suggest that it might. However, there is a risk that an overly permissive approach will result in a duplication of efforts between localities trying to achieve the same thing – certainly, this was the case under practice-based commissioning, where local interpretation of national policy led to power play between various actors and a

stagnation of progress in some areas (Curry *et al* 2008). Another risk is that the loss of co-terminous boundaries will stall progress because some consortia might find themselves working across two or more local authority areas, each with its own set of priorities.

The success of local integration may well rest largely upon the ability of health and wellbeing boards to bring together all the relevant actors in a meaningful way. Crucially, this will require them to engage with a critical mass of GPs whose interests may be split across more than one local authority. The Bill requires only that GP consortia seek advice from other professions. It falls short of placing upon them a duty to integrate services.

The other mechanism that could potentially be used to promote integration at a local level is the outcomes framework. As demonstrated in Figure 4, the three separate outcomes frameworks overlap with each other and, in theory, could be used by the health and wellbeing boards to leverage joint working towards shared objectives. The government's proposals offer an opportunity to co-ordinate care and to promote place-based approaches to service provision. However, there is concern that the three outcomes frameworks are not sufficiently closely aligned to promote a joined-up approach to evidence, data and transparency at a local level. The frameworks remain too separate to incentivise providers and commissioners to work across organisational and service boundaries to achieve the best outcomes. The King's Fund has called for immediate work to ensure that the outcomes frameworks align, and for the eventual creation of a single outcomes framework across the three sectors to support integrated working more effectively (*see* The King's Fund 2011).

Figure 4 Map of overlapping outcomes framework



(Source: Department of Health 2010d)

A truly localist strategy will inevitably result in variation in the speed of progress. Indeed, it is clear that some places have made much faster progress in integrating services than others over the past decade. Examples such as where integrated health and social care teams with pooled budgets commission and deliver care within a single system are small in number (Allen *et al* 2009). This is disappointing when the conditions have been so favourable: a benign financial climate; a policy culture that has offered local options (lead commissioning, integrated provision and pooled budgets) through the 1999 Health Act ‘flexibilities’ and the structural option of the care trust; and a boost to co-terminosity as a result of more unitary councils and fewer PCTs.

This poses the question of what should happen when the consequence of slow progress – or worse – is a poorer experience for patients and inefficient use of scarce resources. It is unclear whether the Bill creates the right incentives and regulatory framework to deal with this at a local level. The reduction in top-down performance management, and a reliance on outcome measures alone, mean there will be a risk that poor performance or slow progress is not addressed in a timely manner. The focus on outcomes rather than process means that the NHS Commissioning Board’s ability to hold commissioners to account for providing co-ordinated care is limited. There have been calls (for example, The King’s Fund 2011) for greater alignment of performance and outcome measures and to give the board powers to hold commissioners to account for outcomes associated with integrated care. In order for this to happen, there is a need for standardised, centrally stored data to enable comparison and benchmarking. Without standardised national data collection it will be more challenging to improve quality at the local level. The policy challenge is to create a national framework that enables local freedoms, while facilitating integration at a local level. The recent implementation of PCT clusters, which will be in place throughout the transition to GP commissioning, has been criticised for flying in the face of the commitment to localism. Leaders of highly integrated local authorities and PCTs have raised concerns that the clusters are being implemented in a top-down, ‘one size fits all’ way, instead of allowing local solutions to emerge in response to specified outcomes (Dunton 2011).

Key seminar messages on local integration

- Locally there were many examples of pragmatic approaches in which partners are developing their own arrangements to bring services closer together, on some occasions despite the national ‘rules’ rather than because of them. This chimes with evidence that central government can do more to impede partnership than promote it (Gleave *et al* 2010). This resonates strongly with the localist flavour of the coalition government’s approach.
- Although a localist approach commanded support, it was recognised that this would inevitably produce different patterns of service from one place to another. Some of these variations would be viewed as unacceptable politically, professionally or by the public – one person’s localism is another’s postcode lottery. How these tensions would be reconciled or managed is a major area of uncertainty. The use of peer review, particularly through the use of real-time performance data, was seen as a powerful lever to reducing some of these variations.
- Without any kind of national steer or framework, progress in improving services is likely to be slower. For example, the adoption of a national milestone for the number of social care users offered a personal budget has seen much faster growth in the past two years. The proposed outcomes frameworks for the NHS, social care and health would help, but there was a strong view that a single set of shared outcomes would better reflect the need to offer people an integrated experience and to measure performance across the whole system of health and care.

Conclusions

Securing the benefits of better integrated health and social care has been a longstanding policy aspiration, but progress has been patchy and variable. The transformed policy landscape and financial climate demand a fresh approach. The King's Fund seminars sought to examine whether the reforms will facilitate or hinder further integration.

The seminars took place at an early stage in the presentation of the NHS reforms, and the subsequent publication of the Health and Social Care Bill has clarified some aspects of policy. However, there still remain considerable uncertainties about the likely consequences of parts of the reforms in general, and their impact on integration and partnership working in particular. The scenarios set out earlier in this paper highlight these uncertainties by exploring how the same set of reforms could lead to a range of very different situations.

The new structure of the NHS will recast its relationship with local government and social care. This upheaval offers significant opportunities to bring about better joint working and to deliver more integrated care for individuals. Indeed, there was optimism among seminar participants about the prospects for closer working and the potential for greater clinical engagement and local action.

However, the scale of change is revolutionary, and there are risks as well as opportunities. Discussion at the seminars suggests that the success of health and social care integration at a local level will depend on a number of factors:

- the scale and pace of change in the transition to the new arrangements, which in some places could undermine local achievements in bringing services closer together
- the extent to which GP consortia are committed to partnership working and how they can be supported to embrace their new roles
- the ability of health and wellbeing boards to promote integration through exerting local influence and leadership and whether they will have sufficient powers to do this
- how far financial pressures will promote the shared planning and use of resources or conflict, for example cost-shunting
- the unknown impact of market mechanisms of choice and competition and whether this will result in disintegration rather than collaboration between providers and commissioners
- whether three separate outcomes frameworks for the NHS, adult social care and public health will offer sufficient incentives for aligning services around the needs of people rather than organisations.

It is important that the optimism and energy that was evident at the seminars is harnessed and that the mechanisms and levers that are being developed enable opportunities for greater integration to be grasped at a local level. There remain significant risks in the reforms, and it will be essential that the pathfinder programme for consortia and the early implementers network for health and wellbeing boards are used to assess these further, and that the impact of implementation continues to attract both political and independent scrutiny.

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