THE INTEGRATION OF HEALTH AND SOCIAL CARE

JUNE 2012

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1. Background

As part of the growing body of literature on integrated care in the UK, much attention has (rightly) been paid to learning from the experiences of doctors, nurses and other clinicians who are heavily involved in integrative processes. To offer an additional perspective, the BMA designed a project to look at doctors’ experiences and views of three distinct forms of integration:

- **Real integration**, including vertical and horizontal integration, focusing on structural change.
- **Virtual integration**, including service and clinical integration, focusing on relational or behavioural change.
- **Integration of health and social care.**

To inform our work, we conducted two surveys of members, in August and October 2011, and published an interim report of our findings in December of that year.

The report highlighted that doctors are largely unsure of the meaning of integration, what it involves and have little direct experience of integrative processes. Nevertheless, the survey respondents displayed openness to change in the organisations and systems they work with. They placed strong emphasis on improved clinical outcomes and better patient experience as the most important measures of success for integration. As such, a clear evidence base that demonstrates the longer-term clinical benefits would be necessary for doctors to support efforts to integrate.

Overall, our findings were consistent with the existing literature on integration which does not find rearranging organisational structures through mergers to be absolutely necessary or even sufficient to produce genuine joint working and more coordinated care. Instead, the emphasis is often placed on good information sharing and effective, professional relationships across disciplines and organisations.

This report – one of three new reports from the BMA – looks in more detail at the integration of health and social care in England specifically. It looks at the importance of integration and the different forms of integration that have been tried. Using existing literature and our 2011 survey results, it identifies the barriers to greater integration of health and social care and explores how integration might be successfully achieved through greater partnership working. It also recommends how doctors can be encouraged to facilitate greater integration between health and social care, to successfully overcome some of the existing barriers.
2. Introduction

The closer integration of health and social care has been a goal of successive governments for decades. Various different methods have been suggested and tried, ranging from measures to facilitate joint working and sharing of resources to enabling full structural integration. Before examining why integration has become so important, it is helpful to look at the historical barriers between health and social care and the efforts made to address them in the past, to gain an understanding of the current situation.
3. The history of health and social care integration

1948-1997
With the establishment of the NHS in 1948, older and disabled people were divided into those deemed to be sick, who were placed in hospitals, and those needing ‘care and attention’, who were placed in residential homes. Local authorities provided residential accommodation for older and disabled people ‘in need of care and attention which is not otherwise available to them’. They could charge for residential and community social services, but not for services defined as ‘health care’, such as health visitors.

Throughout the 1950 and 60s, concerns were expressed over the divisions between health and social care services and the resulting disjointed care for patients and service users. In 1970 a single social services department was established in each local authority, emphasising the need for a co-ordinated and comprehensive approach to social care, supporting families, detecting need and encouraging people to seek help, but failing to further integrate social care with the NHS.

In the 1970s, there was increasing concern about the perceived division of care into a tripartite service – hospital, GP and local authority services - which organisationally and financially seemed to have little to do with each other. As many people required both the NHS and social services, co-operation between the two was seen as desirable. Local government and the NHS were reorganised into coterminous, larger, tiered units to enable closer integration of preventive and after-care services between the NHS and local authorities. Joint financial arrangements were introduced to assist co-operation, enabling NHS funds to be used on collaborative projects with local authorities and NHS bodies and local authorities were required to co-operate “in order to secure and advance the health and welfare of the people of England and Wales”. Joint consultative committees were created, to advise on the planning and operation of services of common concern. However, the financial constraints of the 1970s and the further reorganisation of the NHS in the 1980s meant these efforts to encourage collaboration were not hugely successful and little progress was made up to the election of New Labour in 1997.

1997-2010
The new government placed great emphasis on improving the effectiveness of the relationships between the health service and local authority social services. It talked about partnership, integration and joined-up thinking, and the interdependence of health and social care. Partnership working was strengthened, both in terms of commissioning and delivering care, and at the strategic planning level. NHS bodies and local authorities were allowed to pool their resources, delegate functions and resources from one to another and enable a single provider to provide both health and local authority services.

1 Department of Health The New NHS – Modern, Dependable December 1997
Care Trusts were introduced in 2001, to commission and/or provide integrated services covering health, social services and other health-related local authority functions. They allowed for a greater level of integration between health and local authority services “enabling patients’ needs to be addressed holistically, the synergies of joint working to be exploited and patients to benefit from a seamless provision of their care needs”\(^2\).

In January 2006, the Labour Government published the White Paper ‘Our Health, Our Care, Our Say’, which set a new direction for the health and social care system via personalisation and putting the needs of patients and service users at the heart of service improvement. The following year the Government’s vision for transforming adult social care was published, containing an emphasis on partnership working to create a more seamless system. ‘Putting People First’ set out the expectation that local authorities should undertake ‘authentic’ partnership working with the local NHS, other statutory agencies and third and private sector providers to create a new, high quality, fair, accessible and responsive care system.

‘High Quality Care For All’, published in June 2008, identified the need for previously fragmented services to be better co-ordinated and integrated in order to provide supportive, person-centred care that would facilitate earlier and more cost-effective intervention. These interventions, it stated, should benefit the individual, their carers, the wider system of health and social care and, ultimately, society as a whole. It also set out plans to create new integrated care organisations (ICOs), designed to bring together health and social care professionals from a range of organisations. Following this, a two year Integrated Care Pilot, featuring 16 sites, was set up in 2009\(^3\).

**2010 onwards**

The Coalition Government has continued the drive to achieve greater integration of health and social care services. It quickly set out its intention to “break down barriers between health and social care funding to encourage preventative action”, recognising the interdependence between the NHS and social care services\(^4\). As a first step, it was announced that an additional £1bn funding per year, to be available by 2104/15, would be set aside from the NHS budget for partnership working between the NHS and social care\(^5\). In January 2012 the NHS Future Forum published its report into integration, which featured a set of recommendations to “make integration happen”. These included:

- The Department of Health (DH) should seek greater alignment and coherence between the national outcomes frameworks for the NHS, public health and local authorities;
- Local commissioners should fully and properly explore the potential benefits of joint commissioning and pooled budgets for key populations; and

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\(^2\) H M Government Health and Social Care Act 2001 May 2001

\(^3\) The evaluation of the pilots was published in March 2012.

\(^4\) Department of Health Equity and excellence: Liberating the NHS July 2010

\(^5\) H M Treasury Spending Review 2010 October 2010
• The NHS Commissioning Board should work with local commissioners to introduce measures of service interoperability in contracts.\(^6\)

The Government accepted all of the recommendations and has used the Health and Social Care Act 2012 (the Act) to introduce measures to further promote integration. The Act creates a duty for clinical commissioning groups, the NHS Commissioning Board and Monitor to promote integrated services for patients between the NHS and social care (and other local services) where this would improve quality or efficiency or reduce inequalities of access and outcome. The NHS Commissioning Board will be required to promote innovative ways of demonstrating how care can be better integrated, for example by exploring moves towards single budgets for health and social care. Local authorities will be responsible for promoting partnership working, joint strategic needs assessments, some aspects of public health and health improvement, meaning local government will be required to play a much larger role in integration of health and social care services. Furthermore, health and wellbeing boards will be expected to promote integration across the NHS and social care.

The Government has committed to publishing a White Paper on social care in 2012, following on from its vision for adult social care, which highlighted the need for more personalised, preventative services focused on outcomes. The White Paper should further address the integration of health and social care services, including tackling how social care services should be funded, with the recognition that the NHS cannot function properly while the social care system remains inadequately resourced.

As can be seen, integrating health and social care services has been on the agenda, with varying degrees of urgency, since the 1950s. Yet there has been relatively little progress towards achieving the kind of integration sought by policy makers. Some of the main reasons behind this, including lack of leadership and conflicting organisational priorities, are discussed in chapter 6.

A full history of integration between NHS and social care services can be found at Appendix A.
4. Why integrate?

“Multidisciplinary working across organisations should improve clinically important outcomes”
Survey respondent, August 2011

“Working in community child health I am fully aware how much more effective we can be when we work together across agencies to help children and families. When it works well there is less duplication and better support for families. I’m sure this could be successfully replicated over other areas.” Survey respondent, August 2011

To many, the case for integration is clear. The population of England is ageing and will continue to do so. The percentage of the population aged over 85 years is set to double over the next 20 years. Many of these people will live with significant, often complex, health and social care needs. It is accepted that the current system does not always deliver the integrated care that people need and want, with gaps between different services and sectors, inefficient and unreliable transitions resulting in duplication, delays and missed opportunities.

Alongside rising demand, the NHS and local authorities are facing severe financial constraints and being asked to make significant savings. There is growing recognition that the system needs to deliver better value through improving outcomes and cost-effectiveness. One way to achieve this is to integrate.7

Aside from meeting the financial and demographic challenges identified, literature tells us that integration can also be beneficial for individual patients and service users. National Voices has identified the lack of joined-up care as a source of huge frustration for patients, services users and carers and that “achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety”8.

Recent evidence from the evaluation of the national Integrated Care Pilots in England has shown a number of benefits for staff, patients and service users that resulted from integration initiatives:

- More care plans and better coordination following hospital discharge;
- Staff enthusiasm about their pilot’s progress and its potential for future impact;
- Staff belief that patient care had improved over the previous year;
- Net reductions in overall secondary care costs for sites focusing on case management of elderly people at risk of hospital admission9; and
- Reports of a wide range of local service improvements.10

8 National Voices Principles for Integrated Care October 2011
9 It should be noted that there was an unexpected increase in emergency admissions for patients who received an intervention. The evaluation makes the assumption that the reduction in overall secondary care costs balances the increased costs of emergency admissions, but this needs more work and is likely to vary considerably depending upon the types of integrating activities being pursued. The additional/new costs incurred from interventions were not included in the cost analysis.
10 RAND Europe and Ernst and Young LLP National Evaluation of the Department of Health’s Integrated Care Pilots March 2012

The integration of health and social care
It is easy to see why integration continues to appeal. However, doubts have been raised as to the clear evidence that shows how integration can achieve these aims. It has been argued that there remain significant gaps in the evidence base with little knowledge of the long-term impact of such initiatives. The argument continues that the most likely improvements following integrated care activities are in healthcare processes. Improvements are less likely to be apparent in patient experience or in reduced costs and are not likely to be obvious in the short-term. It is also important to remember that certain groups have been identified as being most likely to benefit from integration, such as frail older people, people with multiple chronic and mental health illnesses and people with disabilities. Integrated care is not necessary for all forms of care and should be targeted at the patients and services users most likely to benefit.

5. What does integration look like?

Integration of health and social care can take different forms, ranging from the merger of organisations to initiatives to enable closer working between professionals and teams. This chapter briefly examines these different approaches to integration.

Organisational integration

Perhaps the best-known example of organisational integration in England is Torbay Care Trust, which was created in 2005 and brings together PCT and adult social care services into one organisation (responsibilities are delegated to the trust, not transferred). Key benefits identified from integration in Torbay include:

• £250,000 in savings in the first year due to integrated management structure, which was used to develop services;
• A new IT system for all staff to enable better sharing of information;
• Improved access to intermediate care; and
• A 24 per cent fall in emergency bed day use for people aged 75 and over.

However, whilst this approach has worked well in Torbay, it is far from certain that it would be successful in other, different sized areas, with different populations, different needs and different histories between professionals. It is also worth considering that this type of merger may be unsuited to the new NHS architecture. It is not clear if CCGs will be permitted, or able, to take on delegated responsibilities from local authorities to create Care Trusts or equivalent bodies. If this were permitted, existing relationships may break down and expertise may be lost to the system as PCTs are abolished, making it more difficult to create the stability and leadership required to successfully merge services. Furthermore, health and wellbeing boards, which are tasked with bringing together the NHS, public health and local authorities, to co-ordinate health and other local services, seem to be the new focus of Government attention in the quest to achieve integration. Enabling more formal partnership working and better communication between health and social care professionals, without going down the road of merging, seems to be emerging as the dominant policy aim.

Partnership working

A good example of an existing initiative to enable greater integration of care through partnership working is Knowsley Health and Wellbeing. Formal partnership arrangements were put in place in 2004, originally between health and social care services and subsequently extended to cover leisure and cultural services. The partnership aims to achieve prevention, empowerment and engagement, with a focus on care closer to home and the provision of personalised high-quality services through strategic agreements across traditional service boundaries.

The partnership has a single executive leadership team and executive leads responsible for commissioning. This management structure helps to ensure that strategic planning and commissioning for services is joined up and results in a single set of strategic objectives, a

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12 Two further BMA reports are available on organisational mergers and integration services without structural change.
13 King’s Fund Integrating health and social care in Torbay: Improving care for Mrs Smith March 2011
combined business plan, and joint resource planning. These then filter through to all levels of the organisations involved in the partnership.

This approach has been beneficial in different ways. It has allowed greater flexibility in the use of resources, allowing NHS funding to be used to support projects tackling the social and economic determinants of health, such as worklessness. It has also enabled the PCT and local authority to take a collaborative approach to estates with shared sites and buildings. This has saved on rental and running costs and has enabled the provision of integrated teams and services at various shared centres.

The evidence from Knowsley demonstrates that “it is possible to achieve service integration in the absence of structural integration through effective local leadership and a commitment to develop partnership working over a sustained period.” There are many other instances of partnership working, where professionals have come together to try to provide a more seamless service for patients and service users, without formal partnership arrangements being put in place. The appeal of this approach is reinforced by the findings of our first survey. Doctors identified creating joined-up care pathways, sharing IT systems and creating shared guidelines and protocols across organisations as the three most important factors to integrating health services, rather than merging organisations. It is clear that doctors share the view of policy makers that integration can be achieved through more effective partnership working rather than having to rely on the more extreme approach of organisational integration.

“What matters is that professionals work together according to shared and agreed protocols with mutual respect for each other and the patients they are treating. The organisation does not necessarily have to be integrated to do that.” Survey respondent, August 2011

Given these different approaches, success can only really be judged on a case-by-case basis; it is not possible to come up with a one size fits all description of what success looks like. It is also important to remember that judging the success, or not, of schemes to integrate care will often depend on who is being asked, as different groups will place value on different things. For patients and service users, success will likely be measured against improved health and wellbeing and a better, more seamless, experience of care. For doctors and other staff other measures may include improvements in healthcare processes, unseen by patients, and better communication between professionals. Evidence from the Integrated Care Pilots identifies this potential mismatch in judging success. The report states that the majority of staff who had direct contact with patients and service users thought that their care had improved over the previous year. However, whilst patients and service users felt they had more care plans and better coordination following hospital discharge, they also felt there was less continuity of care, poorer communication from professionals and less involvement in decision-making. This demonstrates how the different groups involved in integration can develop different views on success. Measuring the success of initiatives to integrate is discussed in more detail in the next chapter.

14 Ham, C. Only connect: Policy options for integrating health and social care April 2009
6. Barriers to integration and how to overcome them

“Care should be designed around the patient rather than our current fragmented, non-communicative system – which has so many hurdles it’s more of a steeplechase than a care pathway!” Survey respondent, August 2011

“I work in an ‘integrated’ organisation which has wonderful ideas for its services on paper but which, in practice, is beset with problems resulting from lack of effective sharing of information and truly joint working, with constant arguments resulting from the lack of pooled resources.” Survey respondent, August 2011

As has been shown, although integration of health and social care has been a long-term aim of successive governments, little progress has been made towards achieving it to any great scale on the ground. Evidence from the Integrated Care Pilots indicates that integration between health and social care was extremely difficult to achieve, with fewer than half of the staff members surveyed stating that patients received care that could be described as a ‘seamless service’ by the end of the pilot period. Using our survey results and the existing evidence this chapter identifies some of the key barriers to achieving integration through the use of joined-up care pathways, and those barriers which are particularly felt by doctors. These help to explain why integration of health and social care remains hard to achieve and, therefore, relatively uncommon.

The next question is how to overcome them. Taking as a starting point the belief that integration can be achieved without merging organisations, how can integration be encouraged and enabled across organisational and service boundaries? And how can doctors be encouraged to facilitate greater integration in their local area? Our survey shows that doctors believe collaborative cultures with shared values, good professional relationships and effective leadership are essential if integration is to get off the ground. These elements are also vital to securing what should be the key measures of success of efforts to integrate, confirmed by doctors in our survey – improved clinical outcomes and better patient experiences. As the Integrated Care Pilots evaluation states, “To be successful in improving quality of care for patients and service users schemes need to be well led and managed, and tailored to local circumstances and patient needs.” Therefore, this chapter also makes some key observations that could assist in overcoming the barriers and facilitating these different elements in order to give initiatives to integrate the best chance of success.

“Takes care from the patient’s perspective and identifies issues which may not be apparent from a view of part of the process.” Survey respondent, August 2011


17 The decision to ask about joined-up care pathways was taken following the August 2011 survey, which identified joined-up care pathways as the most important factor for doctors in the integration of healthcare services. The subsequent survey therefore focused on this as an integral element of achieving integration.

“No need to reinvent the wheel – share best practice.” Survey respondent, August 2011

6.1 Stability

“Constant changing of structure creates administration and inhibits us from getting on with treating patients. We have rotated through many ideas for the structure of healthcare over the 30 years, none are any better than the previous one. Pick a system and stay with it… doctors on the ground will tweak it to make it work. The problem is every time a system has been in place long enough for us to start to make it work, it gets changed. Give us stability, not constant restructuring.” Survey respondent, August 2011

Policy and system stability is essential to enable integration to become established. Although integration of health and social care has been a policy goal for decades, there have been numerous different initiatives and ideas put forward as the best way to integrate by different governments and policy makers. Recent evidence has confirmed that it is very difficult to produce rapid change in a system as complex as health and social care19, yet ideas are seldom given the time to become established before something else is introduced. When this is placed alongside the frequent structural and system changes seen in the NHS it is perhaps not difficult to understand why integration has not taken off in any major way. It is unlikely that doctors and others working in the NHS, both clinical and managerial, would prioritise integration with social care in the face of other, higher profile goals such as reducing waiting times, and the knowledge that further change in policy direction or structure, which might render their efforts pointless, was inevitable. Policy and system stability is essential to enable integration to become established.

6.2 Organisational and professional differences

Organisational differences

When asked about the most important barriers to achieving joined-up care pathways, almost half the doctors in our October 2011 survey identified conflicting organisational priorities as the biggest problem. This is particularly important when thinking about integrating health and social care services, or parts of services, as professionals will be working for different organisations and departments within organisations, each with its own strategic goals and objectives. Ways to overcome these organisational differences need to be identified and put in to practice if doctors are to view efforts to integrate more positively.

This introduces wider issues around organisational differences. The recent evaluation of the Department of Health’s Integrated Care Pilots found that pilots involving multiple organisational partners, for example spanning primary, secondary and social care services, faced challenges due to each having their own internal processes and sign-offs for decision making. This creates extra complexity and difficulty directly related to the different ways of working found in the different

organisations. Furthermore, the evaluation found that the ability of pilots to modify existing systems and practices, to make new ones possible, was especially dependent on organisational culture and perceptions of professional boundaries. In some cases, staff considered existing perceptions that different professionals had of one another as a true barrier to implementation. Improved working between professionals is one way to overcome these barriers.

**Improved working between professionals**

Communicating a collective vision, built on a strong foundation of evidence-based thinking and staff involvement and engagement, should be fundamental to any integration project.

There are various elements that can be considered when trying to create the conditions necessary for improving working between professionals. A good starting point is establishing shared values and goals. Communicating a collective vision, built on a strong foundation of evidence-based thinking and staff involvement and engagement, should be fundamental to any integration project. Schemes will be more likely to progress where staff feel involved in the development of new approaches and services and have a clear understanding of what they are collectively working towards. Staff in different organisations will be reassured that they are all pulling in the same direction and have the same priorities when it comes to integration. Indeed, evidence has shown that widespread agreement and shared values among staff seem to promote engagement and motivation.

**Integrated teams**

The creation of co-located integrated teams of professionals should be considered in all areas where integration is being discussed.

One of the most commonly cited ways to improve working between professionals is to bring together health and social care teams. Creating integrated, co-located teams of health and social care professionals has been highlighted as a key factor for success in many areas where integration has already been established. This can be further enhanced by aligning the work of the teams with GP practices serving the same localities. Evidence also points to the value of creating a single point of access and a single assessment process, to reduce duplication and develop more responsive services for patients and service users. Staff can remain as employees of different organisations but take on a new approach to working collaboratively by sharing premises, forming new integrated teams and coordinating their work. The creation of co-located integrated teams of professionals should be considered in all areas where integration is being discussed, as a proven way to develop closer, more effective working across organisational boundaries.

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21 Only connect: Policy options for integrating health and social care April 2009
This would likely prove challenging, involving finding suitable premises, moving staff to these new premises and developing and agreeing entirely new ways of working. New schemes might want to think about following the advice that has come from Torbay to consider investing in a professional approach to organisational development and change management, within an appropriate period of time. The lesson is that cultural, professional and organisational differences can be overcome, but it is a challenging process which might best be tackled with professional assistance.

The importance of creating good professional relationships as part of enabling integration should not be underplayed: 84 per cent of doctors in our survey identified it as one of the key ways to achieve joined-up care pathways. Correspondingly, almost a third of respondents highlighted closer working across professions as one of the most important criteria for measuring the success of efforts to integrate services. Evidence from existing integrated care schemes shows that closer working and greater staff satisfaction can be achieved. Staff in Integrated Care Pilots reported improved understanding of other people’s roles, responsibilities and challenges, which led to achieving common objectives more readily. Likewise, around 72 per cent of staff in pilot programmes reported that communication had improved with other organisations, further helping to create closer working across organisational boundaries. Taking this line of thought further, it has been suggested that integration can become an end in itself, rather than a means to an end, with most organisations having a much greater appreciation of how they work together than what outcomes result from partnerships.

6.3 Identifying and measuring benefits

Improving patient outcomes and experiences

To reassure doctors of the value of schemes to integrate health and social care, strategies must be clearly based on the benefits being sought for patients and service users.

To encourage doctors to play an active role in integration, schemes must be shown to be seeking the right benefits. The key measures of success for doctors are improved clinical outcomes and better experiences for patients, as shown by our survey and evidence from existing schemes. An inability to demonstrate the centrality of these benefits will create a barrier to doctors’ involvement.

In Torbay, use of the fictional Mrs Smith, to illustrate the difficulties she faced in trying to access the services she needed and navigate the system, served to place the concept of improving access to services for patients like Mrs Smith at the heart of plans. Practical benefits for patients and service users, and how they were to be achieved, were also identified, to reinforce this central
purpose and ensure it stayed central to all activities. Likewise, the NHS Future Forum has acknowledged that integration is only valuable insofar as it improves experience and outcomes for the individual. Evidence from the Integrated Care Pilots shows that the initiatives that were most successful in engaging local health and social care professionals were those that had clear, explainable links to improvements in patient care. Therefore, to reassure doctors of the value of schemes to integrate health and social care, strategies must be clearly based on the benefits being sought for patients and service users. This should be the starting point for any scheme to integrate, and should be clearly communicated from the outset. Otherwise, there is a danger that doctors and other staff will become disillusioned with integration.

It is important that this includes a strong focus on clinical outcomes, as well as on more general wellbeing outcomes and patient experiences. Patients may report positive experiences of an intervention, but it must also be clinically effective to reassure doctors that they are working in their patients’ best interests. To make this possible, it is necessary to collect the relevant data.

Data collection
The ability to measure outcomes and experiences should be central to any plan to integrate, to make it possible to determine success or identify areas where further improvements are needed.

Collecting the right data makes it possible to monitor the impact of the initiative and assess whether potential benefits are being achieved. This in turn can help to maintain support and momentum for the scheme, as staff, and patients and service users, can see where integration is making a positive difference. However, this is not always easy. The evaluation of the Integrated Care Pilots shows a lack of monitoring mechanisms identified for both quantifiable user outcomes and outcomes around improvements in experience. This lack of local data made it difficult for staff in projects to link outcomes to integrated working. It is an area that needs serious thought, from the outset of discussions around integration. The ability to measure outcomes and experiences should be central to any plan to integrate, as without the right mechanisms, it is not possible to accurately determine success or identify areas where further improvements are needed. Future integration schemes should examine experiences from the Integrated Care Pilots, and other areas where integration between health and social care has been implemented, to inform decisions about how to monitor progress and measure data. Ultimately, without this in place these potential benefits of integration cannot be known.

28 Ibid.
Cost-savings

The benefits of integration to patients must be stressed and must not be drowned out by messages highlighting the benefits to the system in terms of costs.

Our survey shows that 38 per cent of those responding felt cost-savings was one of the three most important criteria when measuring the success of efforts to integrate for the NHS as a whole. Yet only 13 per cent identified cost savings as a top three priority for them as a doctor. Doctors as individuals place much greater priority on care-related measures of success than on those which might be prioritised by other groups in health and social care services. This reinforces the point that, in order for initiatives to appeal to doctors, the benefits to patients must be stressed and must not be drowned out by messages highlighting the benefits to the system in terms of costs.

Furthermore, the evidence around the potential cost savings of integration is unclear, as explained previously. Our survey shows that doctors are already fairly unreceptive to cost-related arguments around integration. Without clear evidence to show that integration can be financially beneficial to the system, it will be difficult to use cost savings as an incentive to get doctors involved with integration projects.

6.4 Leadership

Managerial leadership

Effective, stable managerial leadership is essential to develop partnership arrangements, show commitment to partnership working and bring staff on board.

It has been established that effective leadership is required to facilitate integrated care. This is clearly felt by doctors: when asked to identify the barriers to achieving integration through joined-up care pathways, over half of doctors responding to our survey felt that a lack of managerial leadership was a key barrier. Almost 44 per cent identified lack of clinical leadership as a barrier. This is replicated by findings from other areas. The evaluation of the Integrated Care Pilots found that staff generally showed the most reluctance to engage with a given pilot when there was uncertainty surrounding the potential benefit of the intervention or where staff felt insufficiently supported in carrying out the pilot’s work. One of the fundamental lessons identified from experiences at Knowsley was to focus on the vision and on developing leadership, rather than on structures.

This shows the importance of putting effective, stable managerial leadership in place before embarking on any initiatives to integrate. Strong leadership is essential right from the start, to develop partnership arrangements, show commitment to partnership working and bring staff on board.

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29 Nuffield Trust Removing the policy barriers to integrated care in England September 2010
31 Op cit. Only connect: Policy options for integrating health and social care April 2009
board. This strength of leadership must continue throughout the initiative, to clearly communicate key messages across organisations, maintain the momentum of the initiative, provide staff with the support they need to deal with any changes they experience and to enable organisations and individuals to work through any problems.

The previous existence of relationships between managers has been seen to help schemes progress more rapidly than those in areas where relationships have to be built from scratch\(^{32}\), but these existing relationships still have to be strengthened further to embed trust and understanding in cross-organisational working. Managers in health and social care organisations that do not enjoy good relationships with others might wish to build these relationships and create stronger links between their organisations before embarking on any discussions around integration.

**Senior and middle management should be engaged with each other from the outset, so they can set and agree the aims and objectives of the scheme and communicate these to other staff.**

Where integration is already being discussed, senior and middle management in health and social care organisations should be engaged with each other and with the initiative from the outset, so they can set and agree the aims and objectives of the scheme and communicate these to other staff. Clearly stating the shared aims and objectives of the initiative will help staff to overcome concerns about conflicts in organisational priorities, reassuring them that both organisations are pulling in the same direction. This will take time and effort. In Torbay, an existing member of staff was seconded to become the project manager for integration, while other staff were released from normal duties to support his work\(^{33}\). Other areas should consider this approach.

Another essential task for project leadership is to find ways to keep staff engaged. Lessons from Torbay indicate that specifying the benefits of integration in advance, communicating them constantly, listening to staff experiences, sharing results and encouraging further improvement are among the most effective ways to maintain a good level of staff engagement\(^{34}\). Team level leadership is also important, as these are the managers who are most frequently in contact with staff on the ground and most likely to deal with any disruption and practical problems created by new approaches. One idea that has arisen from existing initiatives and that could be replicated elsewhere is to identify a ‘champion’ within teams, to remind colleagues of the benefits of the project and to help sustain motivation\(^{35}\). This would help staff to stay engaged with the scheme and prevent it from being seen as a management only activity, removed from the rest of the staff.

\(^{32}\) Op cit. *National Evaluation of the Department of Health’s Integrated Care Pilots March 2012*
\(^{33}\) Op cit. *Integrating health and social care in Torbay: improving care for Mrs Smith March 2011*
\(^{34}\) Ibid
\(^{35}\) Op cit. *National Evaluation of the Department of Health’s Integrated Care Pilots March 2012*
National leadership

The NHS Commissioning Board and Monitor should provide clarity of expectation and examples of good practice to assist local partners in developing their integrated care schemes.

At the other end of the spectrum, national leadership should be provided by the NHS Commissioning Board and Monitor. However, this highlights one of the major difficulties in achieving integration: the need for schemes to be locally-led and responsive to local communities versus the desire for national direction and guidance to help areas identify what they should be trying to do and how they should be trying to do it.

The current prevailing direction of policy is to encourage integration to be locally driven, with less prescription from the centre. This reflects the Government’s Big Society agenda, which is designed to reform public services by taking power away from central Government and putting it in the hands of people and communities. Evidence shows that flexibility and freedom are indeed essential in enabling local partners to get on with developing integrated care 36, but there is also a need for national level support for local leadership. It is possible that this lack of national leadership is one of the reasons few localities have made significant progress with integrating health and social care services. Without national guidance and support, it is feasible that local leaders either would not prioritise integration or, if it were a priority, would not feel confident in developing and implementing plans in isolation. There are also some examples where local partners have been committed to examining how they could work together to re-design services but have had plans for reconfigurations blocked by the centre.

If integration is to become more widespread, national leadership and collaboration are vital to support local developments. The NHS Commissioning Board and Monitor should provide clarity of expectation and examples of good practice to assist local partners in developing their integrated care schemes. This should detail what forms of integration have worked where and why, and what kinds of conditions and which groups of patients and service users benefit most from integrated care. This would not only provide local partners with evidence and ideas as to what could work for their area. It would also help to avoid hugely different patterns of service delivery between different localities, which could prove unpopular with patients and politicians, and would likely hasten progress as integration would be seen as a greater priority and local stakeholders would feel more confident in starting discussions.

Clinical leadership

Opportunities for clinical leadership should be made available in all integration schemes and should extend to doctors working in different settings.

Clinical leadership is another important element of the overall leadership requirements for successful integration and is of obvious interest to doctors. It is accepted wisdom that good clinical

Leadership is vital to leading service improvement right across the NHS. Sir Bruce Keogh, NHS Medical Director, has stated in the past that, “In order to improve local services it is crucial that the clinicians who deliver these services are instrumental in their transformation”\(^{37}\). Innovation from doctors on the frontline promises genuine improvement to levels of care and to the patient experience in the NHS. The same is true for schemes to improve integration.

Clinical leadership was identified as critical to success in the evaluation of the Integrated Care Pilot sites, echoing the findings of our survey. This was primarily seen as being due to the ability of GPs and other clinicians to engage with peers in other professions regarding the credibility and feasibility of interventions and to motivate participation. This should be built upon. Opportunities for clinical leadership should be made available in all integration schemes and should extend to doctors working in different settings, i.e. primary, secondary, community care and public health. This might require giving clinicians time away from their usual commitments to dedicate time and effort to integration and develop further ideas. This would enable clinical leaders to communicate the value of, and maintain support for, the scheme among their clinical colleagues. It would also ensure that clinicians were able and encouraged to input their expertise into the development of any initiatives and create channels of communication between clinicians on the frontline and management. As experts in the needs of their patients and communities, with the technical knowledge to make sound strategic choices about long-term patterns of service delivery, it is essential that doctors are involved at all levels of leadership and management. However, in order to retain credibility, clinical leaders must still have significant patient contact and remain clinically active.

BMA research has revealed that doctors aspire to give ‘expert’ leadership to the health service, driven by their clinical skills, deep knowledge and advocacy of patient interests. The perception doctors have of leadership as being dislocated from everyday medical practice suggests that more must be done to explain the relevance of leadership to all doctors from a variety of backgrounds if they are to be encouraged to provide the type of ‘expert’ leadership they espouse\(^{38}\).

**Local leadership**

Doctors may also want to consider how they can influence the development of integration through their local health and wellbeing board. Tasked with becoming “the crucible of health and social care integration”\(^{39}\), it is intended that boards will take the lead on delivering social care in partnership with health. Membership of health and wellbeing boards will include a representative from each relevant clinical commissioning group as well as other representatives the board or local authority thinks appropriate. Individual doctors with expertise or a strong interest in integration might wish to seek out opportunities to engage with their local board, as the body responsible for the joint health and wellbeing strategy in the area.

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38 BMA Doctors’ perspectives on clinical leadership April 2012
6.5 Information technology

The Future Forum’s recommendation that NHS organisations should strive for interoperability, to enable the provision of more joined-up care, should be extended to include social care.

Our survey also highlighted other barriers to integration that echo previous findings. A lack of coherent IT systems was the third biggest barrier to achieving integration through joined-up care pathways in our survey. The NHS Future Forum states that, without IT systems that can ‘talk’ to each other, it is difficult, sometimes impossible, for professionals to share information about patients, service users and services across organisational boundaries. As it stands, there are many system providers, most of which use different applications for entering, storing, analysing and sending information. As a result, professionals are unable to access the kind of information they need to create and provide integrated care journeys. Similarly, participants in the Integrated Care Pilots commonly cited IT resources and the systems, policies and practices within which they were used as barriers to communication and data exchange, both of which are key to achieving integration. It is vital that IT differences can be overcome in order to enable better information sharing, and therefore better integrated working, across services and organisational boundaries. As the Future Forum report on integration comments “without information, integration will only ever be a pipe dream.”

The Future Forum’s recommendation that NHS organisations should strive for interoperability, to enable the provision of more joined-up care, should be extended to include social care. This may require additional funding from central government.

6.6 Budgets

One of the other barriers to greater integration between health and social care worthy of mention is that of separate budgets. At present, the majority of funding for social care services and health services comes from different sources. In a bid to increase opportunities for sharing resources and to break down traditional barriers, the Government has committed to transferring funding, growing to £1 billion by 2014, from the NHS capital budget to adult social care. Despite this emphasis, less than five per cent of the combined NHS and public social care budgets is spent through joint arrangements. Pooling budgets for joint initiatives remains a complex, time-consuming and sometimes impossible task. Given that two-thirds of doctors in our survey said that pooled budgets are either important or fairly important to achieving the integration of health and social care, this is a problem that needs to be tackled.

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42 Op cit. Spending Review 2010 October 2010
43 King’s Fund Integrating health and social care: Where next? March 2011
7. Conclusion

Doctors are an influential and important section of the NHS workforce. They are equipped with a unique and diverse range of knowledge and skills, whilst being ethically bound to act in their patients’ best interests. They have a deep understanding of the needs of the local community and their patients and, as such, can make a valuable contribution to improving and developing more integrated services, in the wider management and leadership of their organisations and in the NHS generally. Furthermore, doctors’ concern with clinical standards, outcomes, effectiveness and audit mean they can be relied upon to lead the drive to improve quality and are central to its assurance.

Given the obvious attributes doctors bring to the health service and to the care and support of patients and communities, it is reasonable to suggest that gaining doctors’ support for a scheme to integrate would be beneficial to securing success. Our surveys have shown that doctors have strong feelings about what integration should achieve, but are less concerned with how this should be done. The will to achieve greater integration exists among doctors, but more work needs to be done to overcome the plethora of existing barriers and promote integration in ways that will enable doctors to get involved.

Crucially, a period of stability in the NHS and the political surround is needed to persuade doctors of the value of investing time and effort into getting integration off the ground. This is particularly important in the context of the Government’s ongoing programme of health reforms in England. Major changes are occurring to NHS organisational structures and lines of accountability, new organisations are being created, responsibilities are shifting to different bodies, and experienced managers and staff are leaving the NHS, particularly at PCT level. NHS staff are having to cope with the instability and uncertainty caused by the implementation of the reforms, which is likely to continue throughout the transitional phase. Amid all of this change, integration is being pushed as a priority for the NHS. A significant period of stability is needed if this is to occur.

Doctors will not want to get involved if they think they will be subject to yet more changes in structure or policy direction or if new, urgent priorities will be introduced. Furthermore, if schemes to integrate are not given the proper time to be developed, established and improved, doctors and other professionals will be reluctant to put themselves forward. Without the promise of stability, it is not in their interests as professionals, nor is it in the interests of their patients and service users, to promote integration.

Doctors can play a key role in helping to achieve integration between health and social care, provided the right conditions are created. The points raised in this report seek to provide a useful platform for their creation.
Summary of key points

- Policy and system stability is essential to enable integration to become established.
- Communicating a collective vision, built on a strong foundation of evidence-based thinking and staff involvement and engagement, should be fundamental to any integration project.
- The creation of co-located integrated teams of professionals should be considered in all areas where integration is being discussed.
- To reassure doctors of the value of schemes to integrate health and social care, strategies must be clearly based on the benefits being sought for patients and service users.
- The ability to measure outcomes and experiences should be central to any plan to integrate, to make it possible to determine success or identify areas where further improvements are needed.
- The benefits of integration to patients must be stressed and must not be drowned out by messages highlighting the benefits to the system in terms of costs.
- Effective, stable managerial leadership is essential to develop partnership arrangements, show commitment to partnership working and bring staff on board.
- Senior and middle management should be engaged with each other from the outset, so they can set and agree the aims and objectives of the scheme and communicate these to other staff.
- The NHS Commissioning Board and Monitor should provide clarity of expectation and examples of good practice to assist local partners in developing their integrated care schemes.
- Opportunities for clinical leadership should be made available in all integration schemes and should extend to doctors working in different settings.
- The Future Forum’s recommendation that NHS organisations should strive for interoperability, to enable the provision of more joined-up care, should be extended to include social care.
Appendix 1

The history of health and social care integration
1948-1997

The National Assistance (NA) Act of 1946, implemented in 1948, abolished Public Assistance (previously known as the Poor Law) and established instead the National Assistance Board (NAB), which took over institutions and responsibility for means-tested benefits. At the same time, all hospitals were absorbed into the NHS, established in the same year. Older and disabled people were divided into those deemed to be sick, who were placed in hospitals, and those needing ‘care and attention’, who were placed in residential homes.

The NA Act required local authorities to provide residential accommodation for older and disabled people ‘in need of care and attention which is not otherwise available to them’. They were allowed to register and inspect homes run by charitable and private organisations and to contribute to independent organisations providing ‘recreation or meals for old people’. They could also choose to directly provide these sorts of services, via day centres and clubs. Local authorities retained their established public health responsibilities, including for health visitors, home helps and child welfare clinics, though these were not requirements.

Unlike the NHS, local authorities could charge for residential and community social services, but not for services defined as ‘health care’, such as health visitors. They could also commission fee-charging independent services. The NAB funded residential care for those unable to afford charges. The boundary between health care and social care was far from clear.

Differences between the NHS and social care services were apparent from the start. A substantial role for voluntary action and personal payments, supplementing comprehensive basic services and protection for the poorest, was consistent with the vision of the welfare state. These principles were not explicitly endorsed by the Labour Government of 1945-51, but nor were public social services designated ‘free at the point of delivery’ like the NHS. Plus, responsibility for local government moved permanently from the Ministry of Health to a separate department in 1951, further complicating the relationship between health and social care.

Throughout the 1950 and 60s, concerns were expressed over the divisions between health and social care services and the resulting disjointed care for patients and service users. The 1970 Local Authority Social Services Act established a single social services department in each local authority, emphasising the need for a co-ordinated and comprehensive approach to social care, supporting families, detecting need and encouraging people to seek help, but failing to further integrate social care with the NHS.

In the early 1970s, there was increasing concern about the perceived division of care into a tripartite service – hospital, GP and local authority services – which organisationally and financially seemed to have little to do with each other. As many people required both the NHS and social
services, co-operation between the two was seen as desirable. Within the NHS, the medical profession argued increasingly for structural change to improve co-operation and co-ordination – health education, hospital services, GP and community services all needed to be brought together. In principle the Labour and Conservative parties at the time agreed that a unified health and local authority system would be ideal, but both felt it was not ‘practical politics’. There was an understanding that, if amalgamation was not possible, alignment of the boundaries of health authorities and the local authorities was desirable.

In 1974, both local government and the NHS were reorganised into coterminous larger, tiered units. One of the aims of restructuring was closer integration of preventive and after-care services between the NHS and local authorities. Local authorities also took over certain services from the NHS, including medical social work. In 1976 joint financial arrangements were introduced to assist co-operation, enabling NHS funds to be used on collaborative projects with local authorities. To help integrate the new health and local authorities further, the 1977 Health Act required NHS bodies and local authorities to co-operate with one another “in order to secure and advance the health and welfare of the people of England and Wales”. It also required the creation of joint consultative committees, to advise on the planning and operation of services of common concern. In some areas joint care planning teams were also created. The financial constraints of the 1970s and the further reorganisation of the NHS in the 1980s meant these efforts to encourage collaboration were not hugely successful.

The Griffiths Report, commissioned by the Secretary of State for Social Services and published in 1988, concluded that there was still poor co-ordination between health and social services. One of its recommendations was a clear framework for co-ordination between health and social care services. However, little progress was made in the years leading up to the election of New Labour in 1997.

1997-2010
The new government placed great emphasis on improving the effectiveness of the relationships between the health service and local authority social services. It talked about partnership, integration and joined-up thinking, and the interdependence of health and social care, and used legislation to try to improve integration.

The Health Act 1999 contained powers designed to strengthen partnership working, extending the 1977 Act duty of partnership between the NHS and local authorities to work together to include newly created Primary Care Trusts (PCTs). This recognised the need to work in partnership in commissioning and delivering care, as well as at the strategic planning level. The Act also contained new provisions extending the ability of health authorities and PCTs to make payments to a local authority for any health-related function, allowing funding to be used for any activity that might improve the health of the community. Further provisions allowed the NHS and local
authorities to work together in new ways by enabling them to pool their resources, delegate functions and resources from one to another and enable a single provider to provide both health and local authority services.

Building on this, the Health and Social Care Act 2001 introduced Care Trusts, a new body able to commission and/or provide integrated services covering health, social services and other health-related local authority functions. They allowed for a greater level of integration between health and local authority services “enabling patients’ needs to be addressed holistically, the synergies of joint working to be exploited and patients to benefit from a seamless provision of their care needs”. Four new care trusts, in Northumberland, Bradford, Manchester and Camden & Islington, united mental health trusts and social care but comparatively few were created.

In January 2006, the Labour Government published the White Paper ‘Our Health, Our Care, Our Say’, which set a new direction for the health and social care system via personalisation and putting the needs of patients and service users at the heart of service improvement. It set out plans to develop an information prescription for people with long-term health and social care needs and their carers, and to introduce a personal health and social care plan as part of an integrated care record. Yet once again, little progress was made towards achieving significantly greater levels of integration on the ground.

The following year the Government’s vision for transforming adult social care was published, containing an emphasis on partnership working to create a more seamless system. ‘Putting People First’ set out the expectation that local authorities should undertake ‘authentic’ partnership working with the local NHS, other statutory agencies and third and private sector providers to create a new, high quality, fair, accessible and responsive care system. Specifically, local authorities were instructed to adopt an integrated approach with NHS commissioners and providers, to achieve specific outcomes on issues including the management of long-term conditions and the co-location of services, bringing together social care primary care and other relevant professionals.

‘High Quality Care For All’, published in June 2008, identified the need for previously fragmented services to be better coordinated and integrated in order to provide supportive, person-centred care that would facilitate earlier and more cost-effective intervention. These interventions, it stated, should benefit the individual, their carers, the wider system of health and social care and, ultimately, society as a whole. It also set out plans to create new integrated care organisations (ICOs), designed to bring together health and social care professionals from a range of organisations. Following this, a two year Integrated Care Pilot, featuring 16 sites, was set up in 2009.

45 HM Government Health and Social Care Act 2001 May 2001
46 The evaluation of the pilots was published in March 2012.
2010 onwards

The Coalition Government has continued the drive to achieve greater integration of health and social care services. It quickly set out its intention to “break down barriers between health and social care funding to encourage preventative action”, recognising the interdependence between the NHS and social care services. As a first step, it was announced that an additional £1bn funding per year, to be available by 2104/15, would be set aside from the NHS budget for partnership working between the NHS and social care. In January 2012 the NHS Future Forum published its report into integration, which featured a set of recommendations to “make integration happen”. These included:

- The DH should seek greater alignment and coherence between the national outcomes frameworks for the NHS, public health and local authorities;
- Local commissioners should fully and properly explore the potential benefits of joint commissioning and pooled budgets for key populations; and
- The NHS Commissioning Board should work with local commissioners to introduce measures of service interoperability in contracts.

The Government accepted all of the recommendations and has used the Health and Social Care Act (the Act) to introduce measures to further promote integration. The Act creates a duty for clinical commissioning groups, the NHS Commissioning Board and Monitor to promote integrated services for patients between the NHS and social care (and other local services) where this would improve quality or efficiency or reduce inequalities of access and outcome. The NHS Commissioning Board will be required to promote innovative ways of demonstrating how care can be better integrated, for example by exploring moves towards single budgets for health and social care. Local authorities will be responsible for promoting partnership working, joint strategic needs assessments, some aspects of public health and health improvement, meaning local government will be required to play a much larger role in integration of health and social care services. Furthermore, health and wellbeing boards will be expected to promote integration across the NHS and social care.

The Government has committed to publishing a White Paper on social care in 2012, following on from its vision for adult social care, which highlighted the need for more personalised, preventative services focused on outcomes. The White Paper should further address the integration of health and social care services, including tackling how social care services should be funded, with the recognition that the NHS cannot function properly while the social care system remains inadequately resourced.

As can be seen, integrating health and social care services has been on the agenda, with varying degrees of urgency, since the 1950s.

47 Op cit. Equity and excellence: Liberating the NHS July 2010
48 2010 Spending Review