

History and hindrance: the impact of change and churn on integrating health and social care

Ray Jones

Kingston University and St. George's, University of London

Abstract

Governments over the past 40 years have sought to close the divide, begun in the 1940s at the time the welfare state was being created, between health and social care services. Various mechanisms have been introduced from the 1970s onwards to get services to work better together. In the late 1990s and early 2000s, there were moves to integrate the services organisationally. But, in 2010, this still remains a largely unachieved ambition shared across all the main political parties. But government-demanded, frequent NHS and local government reorganisations have, in themselves, been major hurdles, disrupting local commitment to bring services together. The lessons of centrally-imposed organisational change undermining local health and social care integration have still to be learnt.

Keywords: Health, social care, integration, organisational change, impact

Introduction

It has long been government policy (see, for example, Department of Health and Social Security, 1973; Department of Health, 1998, 2006) that health and social care services be brought together. While the joining up of health services with social care services is argued to generate greater economy, efficiency, and effectiveness, ensuring that combined resources are better used and that there are improved outcomes for service users (Frost, 2005; Glasby, 2007), it is also not without its difficulties (Cameron & Lart, 2003; Peck & Dickinson, 2008; NHS Confederation, 2010).

The coalition government of 2010 reiterated its commitment to the integration of health and social care services. The white paper 'Equity and Excellence: Liberating the NHS' (Department of Health, 2010) proposed a major restructuring of the NHS. The responsibility to commission services would be devolved to consortia of GPs and GP practice teams, with more choice of provider to be given to patients but, importantly in the context of this paper, it was stated that 'local authorities will promote the joining up of

local NHS services, social care and health improvement' (Department of Health, 2010, p.4) and 'to achieve greater alignment with local government responsibilities, the Government will transfer PCT (NHS Primary Care Trust) health improvement functions to local authorities and abolish PCTs. Local Directors of Public Health will be appointed by local authorities and the Public Health Service' (Department of Health, 2010, p.34). New 'health and wellbeing boards' will be established to, amongst other responsibilities, 'promote integration across health and adult social care, children's services, including safeguarding, and the wider local authority agenda' (Department of Health, 2010, p.34). All this from a new coalition government where the parties previously promised no top-down major change for the NHS.

This was not the promise of the outgoing Labour government in 2010 where the then Secretary of State for Health, Andy Burnham, stated that "the next few years require more NHS reform than ever before" (Lister, 2009). There was, however, cross party political agreement about the importance of bringing health and social care together in local areas. The previous government's commitment to

bring health and social care services together, albeit with the means less radical but still with a leadership role for local councils (DCLG, 2006a; DCLG, 2006b), was emphasised in the care and support green paper 'Shaping the Future of Care Together' (Department of Health, 2009). It noted the intention that 'people receive more appropriate care in the right setting, reducing costs, improving outcomes and ensuring that services work together to keep people healthy and active wherever possible' (p.11). A 'ministerial group for the integration of health and social care' was established and 'will identify barriers to integrated working which government will need to remove' (p.12). This paper focuses on one such barrier - policy and organisational turmoil - which is created by government itself. It is a barrier about to be raised again, and even higher, by the considerable organisational upheaval promised for the NHS.

History

The divide between health and social care was extended in the post-war welfare state reforms (see Kynaston, 2008; Means & Smith, 1998; Timmins, 1996) with the National Health Service Act 1946 establishing a health service which removed from local government many of its previous health responsibilities, such as the running of local hospitals, but also left with local government - through the National Assistance Act 1948 - responsibilities to care for disabled and older people, primarily at that time in residential care homes which were part of the replacement for the Poor Law workhouses.

The divide was widened in the early 1970s when the Local Authority Personal Social Services Act 1970 established social services departments within local government. These new departments had within their remit welfare responsibilities for disabled and older people, which were previously often under the control of medical officers of health in local councils, and community mental health services. At the same time, the Chronically

Sick and Disabled Persons Act 1970 gave local councils the lead responsibility for identifying and then providing for disabled people. However, the National Health Service Reorganisation Act 1973 took from local government its public health lead responsibilities (which the 2010 coalition intends forty years later to return to local councils) and placed these within the NHS whilst transferring from the NHS to local councils the responsibility for hospital social work services.

Then, as now, it is sometimes difficult to track the motivators and intentions of national policy, which may be influenced by vested political, professional and organisational interests (see, for example, Klein, 1995, on political and professional considerations and the development of the NHS, and Hall, 1976, and Cooper, 1983, on the debates and discussions leading to the social services and health reforms of 1970 and 1974) as much as by clear, coherent and consistent planning. The consequence can be overly complicated, and sometimes conflicting, allocations of responsibilities requiring considerable time to overcome the complexities created.

Such was the position in the late 1970s, with the NHS Reorganisation Act 1973 introducing a range of national mechanisms to promote joint working across the health and social care divide. Joint Consultative Committees, Joint Care Planning Teams and Joint Finance were introduced to stimulate service planning and development between health and social care. Essentially, these were mechanisms and manoeuvres to span across and to simplify some of the chasms and complexities which had been created.

The intention was to have health and social care services working better together but the failure to achieve better joint working and improved shared performance of health and social care services, despite thirty years of prompting, planning and procedures (see, for example, Jones, 1995, on joint commissioning), led to a change of political script. No longer was the text about joint

working. It was now about joining up by building integrated services.

This was a change in political script which was tracking, rather than leading, what was already happening on the ground in many areas. But, it is not unusual for national legislation and government policy to respond to, rather than create, change. For example, the Community Care (Direct Payments) Act 1996 was a response to the argument made by disabled people since the early 1980s that they should be given the cash to allow them choice and control over how they received the assistance they needed, with an increasing number of local councils then creating the means (trust funds; third party payment schemes) to get around the then restrictive legislation which made it illegal for councils to give cash to disabled people.

It was in the late 1990s that the argument about integrating health and social care services started to gain momentum. In 1997, the House of Commons Health Select Committee considered whether and how health and social care services might be brought together and one of the submissions argued for the creation of 'community health and social care trusts' (Jones, 1997). Subsequently, some of the legal hindrances to bringing health and social care services together were addressed in the Health Act 1999 which introduced the legal powers to allow pooled budgets, lead commissioning and purchasing agreements, and integrated service providers.

It was in 2000 (Department of Health, 2000) when the then Secretary of State (Alan Milburn) and the then Minister of State for Health who was leading on social care (John Hutton) started to promote 'care trusts' as the mainstream future. Integration was starting to be seen not as an option but as the predetermined way forward. 'Care trusts' were to be located within the NHS but would provide both health and social care services, with funding transferred from local councils and councils contracting with the care trusts,

to deliver the council's social service responsibilities.

The problem was that no governance framework was created which balanced the responsibilities of care trusts between the NHS and local government. Care trusts were to be NHS bodies, accountable to the NHS nationally and centrally. Even if councillors were appointed to care trust boards as non-executive directors their first responsibility and accountability was then to the NHS. This dilemma was never addressed, maybe because the political champions for care trusts moved on and the new national health and social care political leaders had their own interests to follow, new imperatives to address (such as tackling increasing NHS overspends) and their own marks to make.

More recently, in 2005-2006, despite a continuing rhetoric about integrating health and social care, the politically-determined imperative that within one year the overspending NHS should achieve financial balance was having a significant impact. This led to rapid local NHS reorganisations and managerial and service changes. This undermined commitments to bring NHS and local government social care together and led to a significant cost-shunt from the NHS to local government (ADSS, 2006; Golding, 2006). In areas which had been at the forefront of establishing integrated health and social care services but where there were significant NHS financial deficits, such as Barking and Dagenham (Wistow & Waddington, 2006) and Wiltshire (Brindle, 2006; Chorley, 2006; Glasby, 2006a; Thistlethwaite, 2006), there was an unravelling of established integrated arrangements.

Lessons for building and sustaining integrated health and social care services

So what are the lessons for building and maintaining integrated health and social care services? The main lesson is that it requires at least some stability within the NHS and local government. This was recognized by

Gill Morgan, the then chief executive of the NHS Confederation and now a principal civil servant, who commented that:

A starting point for improvement must be honest discussion of shared problems, responsibilities and solutions, as well as the alignment of planning cycles ... It also requires a period of stability from reorganisation, as delivering imaginative solutions depends on trust and long-term relationships. (Morgan, 2006, p.10)

Shared agendas, commitments and trust take time to build but little time to undermine. For example, in a national review of the partnership flexibilities enshrined in the Health Act 1999, it was noted that ‘the fine-grained relationships which have to be built at local level need to be better understood and supported’ (Glendinning *et al.*, 2002, p.10) and, in a review of research on partnership working, Balloch (2007) concluded that ‘the trust that has to be built between individuals in a community of practice takes time to establish and requires a degree of stability in the workforce’ (p.74). This is reinforced by Cameron and Lart (2003) in their systematic review of the evidence about joint working which found that a history of good partnership working is, maybe not surprisingly, an indicator of likely future success. There is also a requirement for continuity and stability so that attention is given to detail when health and social care services are brought together. For example, Hudson (2006) has commented (based on the experience in Sedgefield in the north of England) on the fine tuning of processes and procedures which may need to be introduced to support front-line practice integration.

Conversely, frequent organisational, senior management and policy churns are the antithesis of planned and well-managed change and development. Even the brightest and most sensible ideas need time to be followed through. There is a demonstrable need for ‘completer-finishers’ as well as ‘shapers’ (Belbin, 1991) and the shapers must not be given a total free rein. The building of

integrated services takes time, as noted by Rosen and Ham (2008) and Dudman (2009), and is easily disrupted and derailed by disturbing relationships and shared commitments. The impact in 2006 has been commented upon by Hugh Taylor, then acting permanent secretary at the Department of Health:

The financial shocks in the NHS, the reactions to those shocks, the restructuring of the NHS: all of these have inhibited partnership working in some places. We’ve seen good initiatives held back and I know how frustrating that’s been. (Gainsbury, 2006, p.11)

One implication of the NHS “financial shocks” was a cost-shunt of pressures to local authorities (and also to the voluntary sector), destroying trust as well as previously shared strategic intentions. This danger was anticipated by Plumridge:

Other potential sources of money [for the NHS] lie close at hand in pooling arrangements with social care budgets. When sharing a picnic, beware of the guest with a big appetite and recently reduced income. We might see attempts to raid pooled budgets or, less blatantly, to shift the burden of cost to social care organisations. (Plumridge, 2006, p.28)

But, it is not only organisational change within the NHS which may disrupt the integration of health and social care services. Local government boundary changes in 1974 destabilised the health and social care partnerships which were being established following the creation of social services departments in 1970 (Rivett, 1998). A similar disruption to local relationships and shared commitments occurred in the late 1990s following local government reform (Craig & Manthorpe, 1999; 2000). More recently, in 2009, the further move to unitary local government, building on the changes of the mid 1990s, has led in six large county areas in England to local government reorganisation, and this was noted to be

disruptive to building and maintaining local joined-up health and social care agendas (Puffett, 2009).

Progressing integrated health and social care also needs a greater balance in the attention which is given nationally within health and social care. In an, albeit small, survey of sixty seven social care managers who were asked if the Department of Health was focusing enough attention on social care, 98% 'thought social care was neglected' and 80% stated that 'social care priorities would become subordinate to health as adult social care integrates with health services' (LGC, 2005).

Integration is not a sensible aspiration if it is built on an overwhelming focus on the needs of only one partner with, for example, social care used to provide solutions to NHS difficulties such as pressures on acute hospital bed occupancy (Department of Health, 2002; Jones, 2004a) and overspends (Glasby, 2006b; Jones, 2006; Shifrin, 2006). As the Audit Commission (2006, and see also Audit Commission, 2009) pointed out within its broad review of partnerships, it may be necessary to take hard decisions to scale down involvement in partnerships if the costs outweigh the benefits or if the added risks cannot be managed properly.

There is also the danger that when there is an imbalance in the performance of partners the likelihood is that the trend in performance will be towards the lowest common denominator. For example, in 2006, the two largest of Wiltshire's three PCTs were both rated by the Healthcare Commission as 'weak' on 'quality of services' and also on 'use of resources', placing them amongst the poorest performers nationally (see Laurance, 2006). At this time, Wiltshire County Council's Social Services rating went from one of the best in England and Wales (Audit Commission/Social Services Inspectorate, 2000) and from being a top-rated three stars in 2005 to two stars and then to one star because its future prospects were 'uncertain' (CSCI, 2006).

However, bringing health and social care together locally still makes considerable sense. In Wiltshire, for example, it gave easier access to services, a quicker response to patients/service users and carers, and with some evidence of a wider range of assistance being provided (Brown *et al.*, 2002; 2003). It also improved communication and understanding between health and social care workers (Tucker & Brown, 1997).

But the lesson that needs to be learnt is that it does require a stable political policy platform and a continuing management commitment from all organisations. It takes time and is undermined by turmoil. This is the lesson of history over the past forty years and one which was emphasized in the past decade. With further rapid and radical, politically-determined change ahead for the NHS (Department of Health, 2010) it is also a lesson for the future.

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Notes on Contributor

Ray Jones is Professor of Social Work at Kingston University and St. George's, University of London, and, from 1992 to 2006, was director of social services and then director of adult social services in Wiltshire.

Address for Correspondence

Professor Ray Jones
School of Social Work
Kingston Hill Campus
Kingston University
Surrey
KT2 7LB

Email: R.L.Jones@sgul.kingston.ac.uk