

An evidence base for the delivery of adult services

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and Innovation in Social Services)

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FOREWORD

I am delighted to offer this document for your consideration and am deeply grateful to Professor Alison Petch and the Institute for Research and Innovation in Social Services for this wide ranging review of the evidence from Scotland, the UK and further afield.

During the winter of 2010/11 it became apparent that the future organisation of adult social care was going to have a raised profile in the 2011 Scottish Parliamentary elections. First, the Labour Party announced a proposal for a national care service at their Scottish conference and then the Conservative Party and the Scottish National Party took up distinctive positions on the future of this crucial area of social policy and service delivery.

While the positions adopted by these parties differed in detail, they all presented structural reorganisation of health and social care delivery as a method of improvement. In addition none of the models proposed by the parties was based on evidence of what works.

The Association of Directors of Social Work was quick to realise that while there were legitimate political concerns, there was a danger that the approaches the parties were looking to adopt would be costly, unsettling and in all likelihood not lead to improved services to people.

ADSW had just published a manifesto 'Challenging Systems, Changing Lives' which contained this promise:

The Association of Directors of Social Work will provide professional leadership to this change and will offer Scotland a positive narrative for the future of our work. To do that we will have to challenge long held ideas and models of service delivery.

At the same time, the Association held fast to the belief that local leadership and governance of social work and social care were key components of the best of our work. We are also acutely aware of the importance of making the correct choice given that some 650,000 people rely on these services each week in Scotland. Accordingly we decided to commission a piece of independent research to contribute to the debate, support this positive narrative and provide sound evidence on which to base proposals for the improvement of adult care.

The work carried out by IRISS has revealed a strong body of evidence pointing to the importance of local partnerships, local leadership and outcomes based commissioning in improving services for the people who need them. ADSW believes that this piece of work can offer the reflection and the evidence we need to best inform our progress.

Andrew Lowe, President ADSW



This independent evidence review was commissioned by ADSW to inform current debates on the future delivery of adult services. It seeks to ground such debate in a firm understanding of the conclusions that can be drawn from initiatives evaluated both within the UK and elsewhere, ensuring that any future developments can be based on a clear understanding of the likely impact. The review has accessed a major body of literature, the majority from within the last decade; the evidence from these sources is both robust and consistent. Much of it is the product of work by established independent bodies such as the King's Fund and the Health Services Management Centre. The debate is not academic; it is motivated by the aspiration to establish the optimum conditions for the provision of support to the 650,000 people in Scotland who have contact with social services. Such contact should assist individuals to achieve a good quality of life, to achieve the personal outcomes which they value. Although the review focuses primarily on adult social care, the principles and evidence relating to partnership and integrated working are equally applicable to children's services or to partnership working in the context of criminal justice social work.

The following are the key conclusions from the review.

- The need to ensure the most effective configuration for the delivery of adult health and social care is imperative given the current financial and demographic challenges. It has a high profile within the current policy context, exemplified by the *Reshaping Care for Older People* agenda.
- This profile is heightened in the current context of wider debates on the future role and configuration of public services in the wake of the Christie Commission.
- Social services for adults have delivered major achievements over the last two decades. There have been major shifts in the models of support from dependency and institutionalisation to greater choice and control by the individual. At the same time there has been recognition of key areas such as the needs of family carers and the demands of dementia that were previously invisible.
- The large majority of those receiving care and support express high levels of satisfaction. In any discussion of change or transformation it is essential to clarify the issues that are being addressed and to define the outcomes that are being sought.
- There is a range of terms used in the discussion of partnership working and potential models of integration between health and social care. It is essential that such discussion clarifies the meaning being attached to specific terms and that this meaning is clear to all the parties involved. Of particular value is

the concept of a continuum of partnership working, extending for example from relative autonomy to structural integration. Equally important is clarification of the level at which partnership working is being discussed, whether the *macro* structural level, *meso* service system level or *micro* service user level. Care also needs to be taken to distinguish discussions of integration *within* an organisation (eg health) from integration *between* organisations (eg health and social care).

- There is a relatively small number of core issues which feature in much of the debate around working across health and social care. Of particular prominence is a group of repeat and emergency hospital admissions which could have been averted by appropriate interventions, and enduring issues at the boundaries between systems, most notably between hospital and community.
- An NHS Confederation/ADASS survey revealed that the top five factors considered to enhance integrated working were all local and within the control of the partnership organisations; conversely all those deemed to hinder integrated working were external, the majority nationally determined.
- Much of the initial evaluation of partnership working focused on the *process* of such working – for example how individuals and teams operated together, levels of trust and reciprocity. Only relatively recently has consideration been given to the *outcomes* of partnership working for individuals. Establishing the impact of specific models of partnership working on personal outcomes for the individual addresses the operation of a complex system and is therefore challenging. Some potentially encouraging findings, however, are starting to emerge. In particular there are a number of demonstration programmes from North America and Europe which have demonstrated improved outcomes in terms of targets such as length of institutional stay.
- Consideration of the evidence for partnership working highlights the need to adopt a more nuanced approach, namely ‘what sort of partnerships can produce what kinds of outcomes for which groups of people who use services, when and how’.
- There is a strong body of evidence demonstrating that *structural* integration between health and social care does not deliver the effective service improvement that had been anticipated. Differences in culture and in values and differentials in power tend to distort any blueprint and to undermine any projected model. Moreover major financial and time resources can be absorbed by attempts to implement such structural change without demonstrating effective outcomes.
- Care Together in Perth and Kinross and the CHCPs in Glasgow both suffered from confusion and tensions through insufficient attention to governance issues and lack of agreement on common objectives.

- There are high expectations that enhanced partnership working and structural integration would be economically effective. The evidence however is thin: a review commissioned by Scottish Government concluded in respect of financial integration that ‘robust evidence for improved health outcomes or cost savings is lacking’ (Weatherley et al, 2010). Moreover, despite permissive legislation, models of financial integration have rarely been progressed. For example the Audit Commission found that the opportunity to develop jointly funded initiatives created by the Health Act Flexibilities and the Care Trust model in England had been adopted for less than four percent of the health and social care spend.
- Early adopters and pilot projects from the UK and further afield demonstrate that it is not structures per se that determine the degree of success for health and social care integration but the detail of local implementation. For example the integrated model in Torbay was initiated following a poor rating for social services delivery; it has developed over a lengthy period, building incrementally and maintaining a central focus on how delivery could benefit ‘Mrs Smith’. Likewise the development of Knowsley Health and Wellbeing Partnership has been very much based on local needs, driven by high levels of commitment and trust and carried forward by high quality leadership. Conversely, areas where initiatives have been less successful have evidenced clashes in culture and insufficient preparation and commitment.
- These examples reinforce the need for any consideration of delivery mechanisms to be outcomes driven. Strategies for delivering the desired outcomes for individuals should be the core driver of any health and social care configuration. Outcomes based commissioning should be at the heart of support planning.
- The evidence suggests a number of dimensions that are key to effective service delivery across health and social care: the importance of culture; the role of leadership; the place of local history and context; time; policy coherence; the need to start with a focus on those who access support; a clear vision; and the role of integrated health and social care teams.

It is clear that in securing the future delivery of adult services, closer and more effective working between health and social care will best be progressed by a focus on partnership working at the team and organisational level rather than structural change at the macro level. Local configurations (as emphasised by the Christie Commission) which address the key dimensions highlighted above – culture, leadership, local context, vision - are most likely to deliver enduring outcomes. Outcome based commissioning is key.

August 2011

1. INTRODUCTION: THE AGENDA FOR THE FUTURE

This evidence review has been commissioned by the Association of Directors of Social Work (ADSW) to inform the current debate in Scotland as to the most effective arrangements for the delivery of care and support for the adult population. It builds on the core principles of social care in Scotland which are underpinned by the promotion of social welfare and social justice, and seeks to highlight the robust conclusions that can be drawn from experience both within the UK and more widely. It aims to clarify a debate which is often beset by confusion of terminology and unfounded assumptions, and to provide a basis for an evidenced way forward. Although it focuses primarily on adult social care, the principles and evidence relating to partnership and integrated working are equally applicable to children's services or to partnership working in the context of criminal justice social work.

The evolving demographic profile as the proportion of older people in the population increases and the current financial challenges mean that a successful resolution of these pressures is essential. A framework is required which is both robust and principled, concerned to deliver on the fundamental tenets of social welfare. These are expressed in the Manifesto of ADSW, the commissioners of this report, as:

- support people who are most vulnerable and most at risk of social exclusion
- encourage people to make positive changes in their lives, achieve their potential and become active citizens
- assist people to live fulfilled and independent lives
- keep people safe from harm or from harming others.

This report is in four sections. This introductory section sets the context for the debate, highlighting key achievements over the last twenty years and identifying the challenges to be addressed. A second section seeks to clarify the range of definitional issues, providing a summary table to draw out the essential elements. The third section, the main body of the report, analyses the existing evidence base. The concluding section highlights the key evidence that should be embraced in the development of any strategy for moving forward in order to ensure that it is likely to prove effective. By way of background, a brief sketch of the current policy context is provided at Appendix A.

There is always a danger that in seeking to respond to pressures and challenges of the future that the achievements of the past are overlooked. In particular a focus on immediate operational issues can obscure major progress over the longer term. It is instructive therefore to reflect on the shifts that have been achieved over the last decades. For example:

- the closure of long-stay hospitals for people with learning disabilities or mental ill-health – for people with learning disabilities for example from 7000 in long-stay beds in 1980 to 149 in 2008

- the development of housing and support options offering flexible and responsive services as real alternatives to care homes
- the implementation over ten years of initiatives related to *The Same as You?*
- the recognition of the role of family carers, acknowledged for example in *Caring Together: The Carers Strategy for Scotland 2010-2015*
- the introduction of Direct Payments, precursor to the current Bill focusing on self-directed support and co-production
- the achievements of joint working and of the Joint Future Agenda
- the reduction in delayed discharges from over 2000 a decade ago to their current low figures (albeit a small recent increase)
- the promotion of independent living and a rights-based approach to support
- the increase in the volume and intensity of homecare – for example a rise in total hours from 375,299 in 1999 to 666,400 in 2010, and from 9.0 to 18.1 per 1000 population for those 65 plus receiving 10+ hours of homecare
- the growth of telecare and of a reablement philosophy within homecare
- the diversification in the range of support providers and the emergence of a more robust mixed economy of provision – the latest available figures suggest the social services workforce of 198,000 is 37.8% private sector, 35.6% public sector, and 26.6% voluntary sector
- the increasing regulation, organisation, qualification and training of the social services workforce
- the development and implementation of progressive legislation on mental health, adults with incapacity, and adult support and protection
- the implementation of multi-agency public protection arrangements to manage sex offenders in the community
- the development of Scotland's National Dementia Strategy.

Threaded through the majority of these initiatives is a focus on close partnership working wherever this appears appropriate to the needs to be met. For example there is a range of models for mental health and learning disability teams, some multi-professional, others both multi-professional and multi-agency. Rapid response teams in various configurations are a feature of many partnerships, focusing both on prevention and on early discharge, and the development of the generic (health and social care) worker is a joint focus of NHS Education Scotland (NES) and SSSC. The critical distinction for the current context is between these team level ('micro') collaborations designed to achieve optimum provision for the population requiring support and wholesale ('macro') structural change.

The inspections of the former Social Work Inspection Agency, including the review of the programme between 2005-09, *Improving Social Work in Scotland*, provide an important resource for appraising the quality of social work practice. The key findings have been well rehearsed: the value placed on services by those who use them and their carers and the levels of commitment amongst staff. For example 88% of a sample of people receiving services reported that they were treated with dignity and respect, and 77% felt that social work services had made a positive difference to their lives. At the same time the lack of a relationship between quality of delivery and resources, the need for stronger leadership, and the paucity of

services for dementia were highlighted, the latter now being addressed through the National Strategy. A fundamental area was the extent to which older people were being supported through intensive home care to remain within their own homes and to avoid repeat, unplanned hospital admissions. The review identified the essential role of local partnerships:

the most critical factor was how well local partnerships worked together to strategically manage their combined resources, and deliver joined up health and social care to people in their own homes, as an alternative to having to move into a care home (p5).

The importance of local authorities taking a strategic approach to managing social work resources and investing in the areas that are most likely to make a difference to individual outcomes is underlined.

In any discussion of change or transformation it is essential that there is clarity on the issues that are being addressed. Without such clarity the likelihood is high that disappointment will ensue, that new arrangements will not deliver the desired solutions. More particularly, wherever possible the challenges that it is hoped to overcome should be expressed in the form of the outcomes that it is the intention to achieve.

The issues that appear to hover behind discussions of structures and delivery models can perhaps be classified into four main groups. Firstly there are a small number of enduring and seemingly intractable issues. Often these occur at the boundaries between systems, most notably between hospital and community. Delayed transfers of care, despite their high profile, are now, as discussed above, much less of a challenge than in the past; nonetheless there can still be disjunctures and inefficiencies in the discharge process itself – long waits for medication or transport, communication failures in accessing social services. Closely associated is the rise in emergency and repeat admissions and the extent to which these could be averted through more effective preventive and home-based supports and interventions. It is suggested that a quarter of these admissions have no clinical reason at all for being hospitalised, while a further quarter have clinical needs that would normally be met outwith a hospital setting. Decision-making within this context primarily lies with health; the challenge is to ensure that each professional and each sector recognises both their contribution to the operation of the whole system but also the potential for collective awareness and a coordinated approach that will achieve the optimum outcome.

Secondly, and closely related, there are the changing demands contingent on the shift in the health focus from provision for acute care to the management of long term conditions. Acknowledged in the White Papers *Designed to Care* (1997) and *Partnership for Care* (2003), the challenge is succinctly summarised in *Building a Health Service Fit for the Future* (2005):

the mismatch between the needs of the population for proactive, integrated and preventive care for chronic conditions and a healthcare system where the balance of resources is aimed at specialised, episodic care for acute conditions (p43).

It is estimated that four out of five GP consultations are with people with long-term conditions.

A third group of concerns could be seen as focusing on organisational features and inefficiencies which should be amenable to judicious intervention. In this category can be placed factors such as differential charging, confusion over eligibility, and unnecessary duplication. Finally, and more proactively, there are the opportunities associated with the transformation of support provision, be it the changing nature of the market and the challenges for commissioning in a climate of self-directed support and co-production, or the opportunities to be developed in accessing and promoting community capacity.

2. DEFINING PARTNERSHIP WORKING AND INTEGRATION

Clarity is essential in all discussion of health and social care arrangements. Any debate which ventures into the arena of partnership working between health and social care very soon enters a territory where definition of what is being discussed is of the essence. Otherwise there is a real danger that people are talking about the same arrangement using different terms or, conversely, using the same term to refer to different configurations. The Audit Commission (1998) characterised a ‘slippery concept’, while Ling (2002) has portrayed ‘methodological anarchy and definitional chaos’, and Leathard (2003) cites a ‘terminological quagmire’. The table below by Leathard maps a range of common words distinguished by context.

Concept-based	Process-based	Agency-based
Interdisciplinary	Teamwork	Interagency
Multidisciplinary	Partnership working	Multi-sectoral
Multiprofessional	Merger	Trans-sectoral
Trans-professional	Joint working/planning	Health alliances
Trans-disciplinary	Collaboration	Confederation
Holistic	Integration	Federation
Generic	Local planning	Consortium
	Coordination	Forum
	Unification	Interinstitutional
	Liaison	Locality groups
	Shared/joint learning	

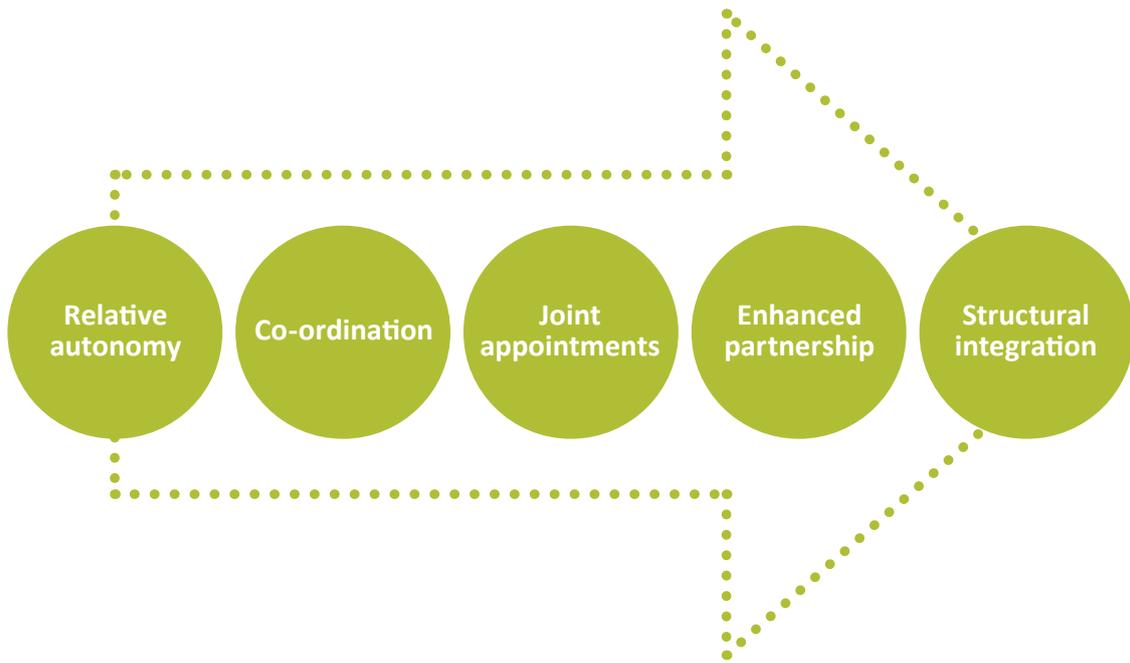
It can be useful to characterise partnership working as the process and integration as a potential outcome. Moreover a common strategy is to consider the options for partnership working along a continuum from autonomy through co-ordination to integration. These are the definitions used in a WHO framework; this also identifies a number of key features associated with each of these stages.

	autonomy	co-ordination	integration
vision of system	individual perception	shared commitment to improve system	common values, all accountable
nature of partnership	own rules, occasional partnership	time limited or similar co-operative projects	formal mission statements, legislation
use of resources	to meet self determined objectives	to meet complementary objectives, mutual reinforcement	used according to common framework
decision-making	independent	consultative	authority delegated, single process
information	used independently	circulates among partners	orients partners work towards agreed needs

Two other presentations of this continuum can be highlighted. Edwards (2010:90) adopts a model defined by Fine of the different degrees of collaboration across organisational boundaries. This extends from autonomy to integration:

- *Autonomy* is when agencies act without reference to each other, although their actions may affect one another.
- *Cooperation* is when parties show a willingness to work together with an emphasis on communication.
- *Coordination* is when considerable effort is put into harmonizing the activities of agencies so that duplication is minimized. This is often characterised by the activity of a third party to coordinate and the existence of agreed protocols.
- *Integration* is when the boundaries begin to dissolve and new work units emerge.

Secondly there is the analysis presented diagrammatically below which was developed for a survey conducted by the NHS Confederation and the Association of Directors of Adult Social Services (ADASS) in England in 2010 (NHS Confederation 2010; Gleave et al, 2010).



The characteristics for each of these categories were:

- Relative autonomy: the local authority and NHS meet statutory requirements for formal partnership working, but most co-ordination is largely informal
- Co-ordination: there is a reasonable level of formal commitment to joint working, with co-ordination around some areas of strategy and/or commissioning depending on circumstances
- Joint appointments: health and the local authority have some key joint appointments and the teams collaborate but are not integrated/combined
- Enhanced partnership: a system-wide commitment, shared vision and integration across most strategic and commissioning functions, senior and middle-tier joint appointments, formal high-level backing, but separate entities remain
- Structural integration: health and local authority care services have formed a single integrated legal entity (a care trust in England) or a combined service (joint PCT and social care department in England).

Ninety-seven of 150 localities responded to the NHS Confederation/ADASS survey using this typology. 'Joint appointments' was the most common category (39), followed by 'enhanced partnership' (29) and 'co-ordination' (13). Only three classified themselves as 'structural' and only three as 'relative autonomy' (a number of responses were invalid).

Respondents were also asked to identify the factors that they considered had helped or hindered integrated working locally. The findings were revealing. The top five factors considered to enhance integrated working were all local and within the control of the partnership organisations: friendly relationships; leadership;

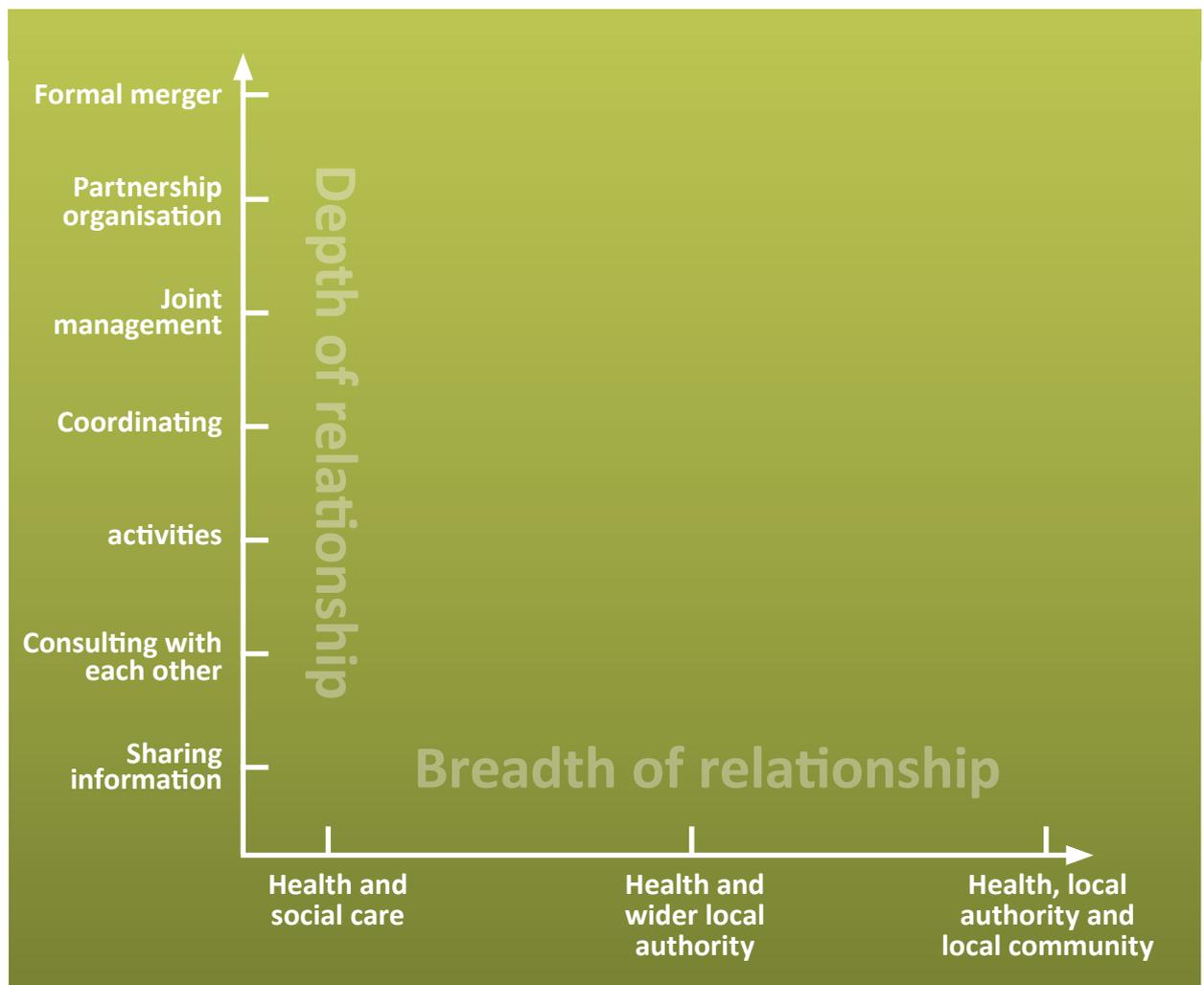
commitment from the top; joint strategy; and joint vision. Conversely, all those which were seen to hinder integrated working were external, the majority nationally determined: performance regimes; financial pressures; organisational complexity; changing leadership; and financial complexity. The NHS Confederation report (2010) highlights from these results what they see as 'the importance of softer, relational aspects of partnership as a catalyst for integrated working' (p4). They suggest that national initiatives that seek to enforce structural change are likely to be less effective and counter-productive to the more informal conditions considered important by local leaders. Asked about their aspirations in relation to integrated working two years hence, the majority of respondents referred to processes rather than outcomes, focusing most frequently on integrated approaches to commissioning as a key mechanism for improvement.

PARTNERSHIP WORKING

For the purposes of clarity, this current report will use the generic term partnership working unless the specific reference is to structural integration. As is clear from the discussion above, however, this usage is by no means universal and it is essential to clarify definitions in all debate. A number of the key commentators on partnership working between health and social care have concurred in adopting the definition of partnership put forward by Sullivan and Skelcher (2002). This suggests that partnership involves:

- negotiation between people from different agencies committed to working together over more than the short term
- aims to secure the delivery of benefits or added value which could not have been provided by any single agency acting alone or through the employment of others
- includes the formal articulation of a purpose and a plan to bind partners together.

Glasby (2003b) highlights the importance of clarifying the level at which partnership working is being addressed. He visualises a series of concentric circles: the innermost represents the individual level (professionals working together); the next one the organisational level (seamless service); and the outermost the structural level (planning of health and social services in a holistic way). Indeed he argues that all three levels are essential for effective partnership working. Glasby et al (2011) have also drawn attention to the various options of breadth and depth that both individuals and agencies can embrace in terms of partnership working.



from Glasby et al (2011)

It is important to distinguish integrated organisations from integrated care, which very often operates at the level of the team. Integrated care also, however, is a broad church.

Like a Rorschach test, integrated care has many meanings; it is often used by different people to mean different things. It is most frequently equated with managed care in the US, shared care in the UK, transmural care in the Netherlands, and other widely recognised formulations such as comprehensive care and disease management. (Kodner and Spreeuwenberg, 2002:1)

Indeed the same authors refer to integrated care as a 'modern-day Tower of Babel' (p4). Partnership working can apply to both contexts, top-down as an organisational process or bottom-up from a user-centred focus.

A review of integrated care for older people by Reed et al (2005:2) offers a useful typology. They identify integration:

- between service sectors (ie health and social care)
- between professions (ie nurses, social workers, doctors, physiotherapists)
- between settings (ie institutions and community, primary and secondary care)
- between organisation types (statutory, private and voluntary)
- between types of care (ie acute and long-term care)

and suggest a distinction between *macro* strategies (taking place at the societal level), *mezzo* strategies (at a service system level), and *micro* strategies (occurring at an individual service user level).

A similar three-fold distinction is also drawn by Curry and Ham (2010) in their discussion of clinical and service integration. They review examples of integration at three levels. At the *macro* level, providers, either together or with commissioners, seek to deliver integrated care to the populations they serve. At the *meso* level, providers seek to deliver integrated care for a particular care group or population with the same disease or conditions. Finally, at the *micro* level, the focus is on the delivery of integrated care for individual service users and their carers. Curry and Ham (2010) also refer to a typology developed by Fulop which distinguishes between organisational, functional, service and clinical integration. It is important to note, however, that as with several discussions of integration (for example Ramsay and Fulop, 2009), much of this analysis relates to integration *within* health rather than *between* health and social care (for example Kaiser Permanente, managed clinical networks, virtual wards). A useful distinction which informs such debate is between *vertical* and *horizontal* integration. Horizontal integration refers to services or organisations coming together to deliver care and support at the same level (eg mergers of acute hospitals, formation of care trusts); vertical integration occurs when services (again single or multi-agency) come together to deliver care and support at different levels (eg secondary and tertiary care).

OVERVIEW

The diagram overleaf seeks to draw together the various definitions presented above to provide a coherent overview. It has settled on a typology identifying six main categories (extent of partnership working) and has sought to map onto this typology a number of the examples which will be outlined in the context of the evidence in the next section. As with any typology, the boundaries between categories are not absolute and interpretations may vary. It may, however, be a useful summary tool for clarifying discussion.



It may also be useful at this point to locate two particular developments in Scotland. Care Together was an initiative implemented with Treasury 'Invest to Save' funding in Perth and Kinross from 2002. Through a partnership agreement, NHS Tayside, Perth and Kinross Council and Perth and Kinross Local Health Care Co-operative sought to jointly resource, manage and deliver integrated health and social care services. All LHCC services and all adult social work services, 1500 wte staff and a budget of £50 million, were incorporated into integrated management arrangements. Within two years however there was a retreat from the original model, and following a review of the governance and accountability arrangements, Care Together was disbanded in 2004. Adult social work services were reintegrated into the Council structure; subsequent developments were in line with the national Joint Future agenda.

More recently NHS Highland and Highland Council have embarked on the development of a lead agency model. Under plans approved in May 2011, from April 2012 there will be an Integrated Adult Service with NHS Highland as the lead agency, and an Integrated Children's Service with the Council as the lead agency. Underpinning these proposals for integration is a concern to improve outcomes. The lead agency arrangements leave both organisations jointly accountable for determining outcomes and the resources to be committed. The lead agency for the service takes responsibility for all aspects of business delivery, strategy, internal governance and operational delivery or commissioning of services, and will be fully accountable for the delivery of the agreed outcomes. The total resources for the specific group are committed to a pooled budget held by the lead agency from which they are to commission or provide all support for the particular population. Development of the detail for this proposal is ongoing; its progression, and hopefully a systematic evaluation, will be of considerable interest to the current debate.

3. THE EVIDENCE BASE FOR PARTNERSHIP AND INTEGRATED WORKING

Although clarity of definition is an essential prerequisite, the critical consideration must be the impact of different forms of partnership working - what difference, if any, does working in partnership make (Hudson and Hardy, 2002; Glendinning, 2002; Glendinning et al, 2005). An early systematic review of the factors promoting and obstacles hindering joint working by Cameron et al (2000) concluded that there was a 'dearth of research evidence to support the notion that joint working between health and social care services is effective' (p23). However El Ansari et al (2001) have highlighted the complexities of establishing the evidence base for partnership working: micro versus macro scale; short term versus long term; the challenge of capturing an evolving process; the uncertainties of attribution in the complex mix of factors that contributes to partnership working. They conclude that:

collaboration is complex and enquiries into its effectiveness by different parties will be on the basis of different agendas with contrasting criteria and potentially conflicting perceptions (p223).

A key distinction was crystallised by Dowling et al (2004) who explored the interpretations of success, implicit or explicit, which are applied to partnership working. Their search of bibliographic databases for publications post 1997 identified 36 relevant articles. The large majority of these, however, focused on the *process* of partnership working – how individuals and partners worked together, the extent of common agreement as to purpose, levels of trust and reciprocity. Few had considered partnership working from the perspective of whether it made a difference to those on the receiving end, on the *outcomes* of partnership working for individuals. This is a critical distinction and must be central to any discussion of the effectiveness of partnership working.

Initial exploration of this territory did not provide the definitive evidence that intuitively perhaps might be expected. One of the first studies focusing on outcomes compared two integrated health and social care teams for older people in Wiltshire with a traditional non-integrated team (Brown et al, 2003). Outcomes for individuals were compared eighteen months after referral. Surprisingly, fewer people (rather than the anticipated increase) remained in their own homes by this stage; moreover quality of life scores were lower and depression levels higher for those supported by the integrated teams. The authors concluded that:

this research has not produced any findings which suggest that the integrated primary-care-based health and social care teams are more clinically effective than the traditional non-integrated method of service delivery (p93).

Not surprisingly, Brown et al found that:

users had little interest in who organised or delivered their services as long as they received what they felt they were entitled to. What was of utmost

importance was the quality of the relationships which they experienced with service providers at every level of service delivery. (p93)

A range of subsequent studies produced not dissimilar findings both within the UK (for example Kharicha et al, 2004; Townsley et al, 2004; Davey et al, 2005) and wider afield (Hultberg, 2005).

A number of international studies, however, have had somewhat more promising results, leading to a (modest) number of projects which are often cited (Ham et al, 2008; Glasby and Dickinson, 2009; Curry and Ham, 2010). In North America (Kodner, 2006; 2009) these include the OnLok demonstration project which became the PACE (Program for All-Inclusive Care for the Elderly) in the USA, the Quebec-based SIPA (Système de Soins Intégrés pour Personnes Âgées), and the Canadian PRISMA (Programme of Research to Integrate Services for the Maintenance of Autonomy) (Tourigny et al, 2004). High profile programmes in Europe (Leichsenring and Alaszewski, 2004; Billings and Leichsenring, 2005) include CARMEN (Care and Management of Services for Older People in Europe Network) (Nies and Berman, 2004), PROCARE (Providing Health and Social Care for Older Persons) (Coxon, 2005), and the Vittorio Veneto and Rovereto projects in Italy. Unlike the experience reported by Brown above, evaluations of the OnLok, Vittorio Veneto and Rovereto initiatives all suggested that integrated working reduced the cumulative number of days older people stayed in institutional care. Johri et al (2003) attempted an early synthesis of the evidence from international experiments in integrated care in the OECD countries. Focusing primarily on rates of institutionalisation, this suggests that common features of these projects are case management, geriatric assessment and a multi-disciplinary team; a single entry-point; and financial levers. The challenge, as ever, however, is in the translation from the demonstration project to the mainstream.

Ovretveit et al (2010) explore the introduction of a comprehensive integrated model in Norrtälje in Sweden, a local authority area of 60,000 population. This provides for one organisation (TioHundra Forvaltningen) which administers a combined (pooled) budget for all health and social care and one service organisation (TioHundra AB) which provides all the health and social care for the population. There is a joint political governing board, the three bodies together forming the Norrtälje Integrated Organisation. The case study, based on documentary analysis and on interviews with key players at two time points, focused primarily on the process of integration rather than on patient outcomes and costs. Four key findings are of relevance. The initial structural integration at the macro level facilitated but did not on its own result in improved care coordination at the micro level. Such changes were hindered by traditional barriers such as occupational cultures and professional protectionism and did not happen without further input over an extended period. The incentives for coordinated care were weak, and management underestimated the need for and lacked the time and resources to develop the coordinating projects at the clinical (micro) level. Operating at the two levels simultaneously appeared problematic. Finally, there was some support for theories suggesting the importance of a 'receptive context' and a 'readiness to change' at both macro and micro level. The

review concluded that ‘coordinated actions at different levels and of different types were needed to achieve care coordination for patients’ (p113), and considered that it would be at least five years before significant improvements to individual experiences and outcomes could be expected.

The broader context in Sweden is examined by Ahgren and Axelsson (2011) in their analysis of the development of integrated health care during the first decade of the current century. Currently 21 county councils have responsibility for health provision while 290 municipalities deliver housing, care and social support of older and disabled people. A particular feature has been the emergence of ‘chains of care’, integrating all the services provided for a specific group of patients within a defined area. Although the majority of these have been health focused, a number have embraced social care and legislation has been introduced allowing the development of local associations which pool budgets across council and municipality. Nonetheless Ahgren and Axelsson highlight the complexity of local developments and report tensions between fragmentation and integration.

The somewhat contradictory nature of the research messages on individual outcomes has led in recent years to arguments for a more nuanced approach:

evaluating service user outcomes of partnerships is a complex task. One possibility, therefore, is that the lack of unequivocal evidence linking partnerships to service user outcomes might be an expression of this complexity, rather than a lack of impact per se. (Glasby and Dickinson, 2009:157)

The focus it is suggested should be on ‘what sort of partnerships can produce what kinds of outcomes for which groups of people who use services, when and how’ (Dickinson, 2006). Some tentative conclusions are offered by a DH funded study exploring the extent to which partnership working achieved the outcomes identified as important by users and carers (Petch et al, 2005; 2007). Working with three service user research organisations, this built on the work on individual outcomes initiated at the Social Policy Research Unit (Qureshi, 2001) which had characterised three types of outcomes: quality of life, process and change. Minor revisions following a series of focus groups suggested that the specific outcomes within each of these groups were *quality of life*: safety, having things to do, social contact, staying as well as you can be, living where you want, living life as you want, dealing with stigma; *process*: being listened to, treated with respect, having choice, and reliability; and *change*: reducing symptoms, improving mobility, and restoring skills and confidence. The extent to which these outcomes were achieved were then explored in interviews with 230 individuals across 15 partnerships, three in Scotland and twelve in England. The partnerships including examples supporting older people, individuals with learning disabilities and those experiencing mental ill-health. Although the complexities of partnership evaluation and attribution highlighted earlier do not allow definitive conclusions, some tentative associations that can be explored further are shown below.

Key features of partnership	Related service features	Personal outcomes delivered
Co-location of staff	Providing a single point of contact, improving access and communication	<ul style="list-style-type: none"> • Process outcomes, especially responsiveness • Quality of life outcome: feeling safe
Multi-disciplinary team	Providing holistic care	<ul style="list-style-type: none"> • Change outcomes • Quality of life outcomes • Process outcomes
Specialist partnership	Providing specialist, non-discriminatory treatment	<ul style="list-style-type: none"> • Process outcomes, especially being treated with respect
Extended partnership	Providing access to other agencies, and partnership with service users	<ul style="list-style-type: none"> • Quality of life outcomes, including activity and contact with other people • Process outcome: having choices

The successful development of Talking Points across Scotland led by the Joint Improvement Team has built on this work and has had some success in embedding a consideration of individual outcomes within the agenda of service delivery. The POET (Partnership Outcomes Evaluation Toolkit) developed by Dickinson (2007) presents a more comprehensive attempt to marry both a detailed analysis of the working of the individual partnership with the outcomes it generates. This seeks through specification of detailed aspects of operational aspects of the specific partnership and analysis of their links to individual outcomes to start to provide some of the specificity that will start to provide answers to the question posited above.

The POET project aims to offer a more nuanced account of partnership, offering practical advice on the kinds of support mechanisms and development opportunities which aid partnership working and the potential impacts different sorts of partnership might have, moving the debate to a more mature and subtle level concerning the ways in which health and social care services can be improved for the individuals receiving them. (Dickinson, 2007:89)

Dickinson et al (2009) reports on the application of POET in the Sandwell Integrated Support Service and Dickinson and Glasby (2010) in the evaluation of a forensic mental health partnership. The latter highlights a number of failings common in partnership working:

- not being clear about outcomes
- calling something a 'partnership' to make it sound better
- not being honest about organisational drivers
- not being clear about unstated drivers
- being unrealistic and over-ambitious
- failing to attend to practical details.

It is the endurance of factors such as this, they argue, rather than inherent inadequacy in the concept itself that has made partnership working so challenging. If the partnership concept is not to lose credibility, they suggest, there needs to be understanding of the support mechanisms and processes necessary to overcome the repeated shortcomings.

THE FINANCIAL EVIDENCE

Any discussion of partnership working, whether focusing on outcomes or more broadly, needs to acknowledge the centrality of the financial context. In the context of the development of the Integrated Resource Framework, Weatherly et al (2010) were commissioned by Scottish Government to conduct a rapid review on the evidence on financial integration across health and social care. The review encompassed international literature on financial and resource mechanisms to integrate care within health and across health and social care. The authors concluded that there was 'tentative evidence that financial integration can be beneficial. However, robust evidence for improved health outcomes or cost savings is lacking' (p3). In particular 'there is no robust evidence on whether improved outcomes can be achieved in the longer term' (p31). Moreover, 'the cost of integration can be substantial and costs may increase in the short term' (p31). The review identified two factors that it considered critical for any success in this area. Firstly there needs to be a clear, joined-up vision. Different perspectives need to be acknowledged if any partnership is to flourish. Secondly, a one-size-fits-all approach should be avoided: 'the type and degree of integration should reflect programme goals and local circumstances' (p30).

Similarly tentative conclusions are drawn by a review of economic evaluations of the impact of integrated health, housing and social care conducted by Turning Point (2010). The work was completed in the context of their development of Connected Care, an integrated approach to community wellbeing being piloted (and evaluated) in a number of sites (Wistow and Callaghan, 2006; Bruce et al, 2011). Three key areas were explored in the Turning Point review: early intervention, structural integration, and joint processes. The importance of early intervention and prevention is evidenced, for example by the experience of the POPPS (Partnership for Older People Projects), LinkAge Plus and housing related support. Financial savings can be demonstrated for each of these initiatives. In respect of structural integration, defined to include case management programmes (including Evercare and Unique Care), integrated care teams, intermediate care, and care trusts, evidence of financial benefits was more mixed. Moreover, the report highlights, 'good quality case management and integrated team work may reveal unmet needs, rather than resolving them, thus resulting in higher costs' (piii). Cost evidence is least developed for integrated processes, such as joint commissioning and integrated assessment processes. Overall the authors conclude that there is evidence that 'integration in health and well-being services can be cost effective. However, the evidence base is still relatively small and there is need for more comprehensive and large scale evaluations' (p36).

INTEGRATED CARE PILOTS

Following the Darzi *NHS Next Stage Review* in 2008, the Department of Health established 16 integrated care pilots in England to run for a two year period from July 2009. The aim was to explore different ways of providing health and social care to help drive improvements in local health and well-being. Reference to these pilots requires the reiteration of the note of caution around the use of the term 'integration'. As Ouwens et al (2005) have highlighted:

integrated care programmes have widely varying definitions and components. Failure to recognize these differences leads to inappropriate conclusions about the effectiveness of these programmes and to inappropriate application of research results. (p145)

The introductory guide for the pilots emphasizes this dimension: 'integration may refer to partnerships, systems and models as well as organisations; crossing boundaries between primary, community, secondary and social care'. For a number of the pilots the primary emphasis is on vertical integration within health (Ramsay and Fulop, 2009), bringing together primary and secondary care. One of the pilots for example is focusing on the seamless delivery of primary care, secondary care and community health services during end of life care in Cambridgeshire. Not all the pilots therefore directly involve social care and all are clinically led. A number however involve partnerships with social care and are of direct relevance; in Norfolk for example the pilot aims to establish a fully integrated local health and social care team comprising GPs, community health staff and adult social care staff to provide 'cohesive, proactive and personalized care for older and vulnerable people'. The national evaluation of these pilot initiatives is due to report to the Department of Health at the end of 2011 and should provide useful intelligence, albeit that the conditions of such 'boutique pilots' (Ramsay and Fulop, 2009) very often differ from the mainstream.

A progress report offers some initial impressions (RAND Europe and Ernst and Young, 2010); in addition to 'living documents' whereby each of the pilots reflect on progress, six are being examined in more detail ('deep dive'). Five key themes are identified:

- Context matters: 'each ICP is deeply influenced by the personal journeys of its leaders, the inter-institutional histories of the partners, local geography, social and economic circumstances and the evolving policy context' (p4).
- Clusters not models: rather than distinctive models of integrated care, the pattern emerging is of a more fluid process of adaptation to the changing environment as broad overarching aims and values are pursued.
- Appetite for collaboration: despite anxieties about standards, professional accountability and governance, there appears a willingness to find integrated solutions.

- Building the infrastructure can be demanding: much of the energy to date has been expended on this aspect and there needs to be a shift to a focus on changing the experiences for those who use services.
- Decision makers work with limited cost data: those in key roles 'struggle to find reliable and readily available cost data'.

THE LIMITS OF STRUCTURAL CHANGE

Northern Ireland offers an interesting case study of a unified health and social care system, 'one of the most structurally integrated and comprehensive models of health and personal social services in Europe' (Heenan and Birrell, 2006:48). There has however been less evaluation than might be expected of this distinctive system, introduced in 1973 'not based on any evidence that it would result in added value for service users or providers but [w]as a political imperative created by the failure of local government' (Heenan and Birrell, 2006:64). Prior to 2007, Northern Ireland had a two-tier structure with four commissioning boards and 18 delivery trusts. Eleven of these trusts were integrated and some included hospitals; however seven major acute and training hospitals had separate trust status. Following review, the former provider trusts have been amalgamated into five large, integrated and fully comprehensive health and social care trusts. Four commissioning boards have been replaced by one centralised but integrated commissioning body, the Regional Health and Social Care Board. The key characteristics of the system are therefore:

- a single unified trust providing all health and social care
- trusts are employing bodies
- each trust has a financial system
- each trust has a single strategic approach with an agreed set of aims and objectives.

A unified system with a single employer and a single budget offers considerable promise, removing the potential for buck passing and blame. Heenan and Birrell (2009) suggest that there have been achievements in respect of reducing delayed discharges and pursuing new investment in intermediate care and domiciliary care specialists; in developing integrated teams, for example community mental health teams for older people; in progressing resettlement from long-stay hospitals; and in enhancing integrated working, offering for example improved access, referral and assessment and in reducing waiting times and duplication. All trusts are developing Gateway Teams, receiving all referrals and providing a single assessment process.

They identify however a number of significant limitations. Importantly a *hegemony of health* appears to persist, with health continuing to dominate the agenda. Social care values and priorities appear to be subsumed by a dominant health system. Likewise the resource focus is on the acute sector, with evidence of funding being diverted to this agenda with its higher public and media profile. The new structures are large bodies with their membership dominated by health. A second concern is the *priority attached to health agendas and targets*, for example the focus on the prevention and control of hospital infection. The performance targets set by the

Department of Health, Social Services and Public Safety (DHSSPS) relate almost exclusively to health, focusing for example on reduced mortality for cancers and reducing the rise in obesity. A further concern is the *limited focus of the integrated approach*. While developments in domiciliary support for older people and in community services for mental health, learning and physical disabilities are welcome, there appears to be a reluctance to innovate in other areas. There is little evidence, for example, of progressive development of direct payments and individual budgets, of personalisation, and of children's services. Finally, *integration has not realised its full potential*. There has been little interest in strategic review and little attention to the potential opportunities offered by an integrated structure.

Heenan and Birrell (2009) suggest that any achievement of the promised potential of structural integration in Northern Ireland would require:

- a higher profile for social care in the modernisation initiative
- joint initial training session for health and social care professionals
- a focus on outcomes for service users
- a renewed debate on social models of care
- the composition of the new bodies to reflect a more equal status between health and social care
- a systematic programme of research and evaluation in integrated working to provide a robust evidence base.

These authors highlight from the experience of Northern Ireland the critical importance of a 'culture of integration', a theme which will be further discussed below.

This culture must permeate all levels of service planning and provision in order to provide an integrated mindset. What was apparent from this study was that the integrated structure itself had not automatically led to integrated practices... Integration was not really about structures or patterns of working; it was fundamentally a way of thinking. It required a shared vision and a mutual willingness to change and compromise. (Heenan and Birrell, 2006:63)

A comparative study which explores care management in mental health services in England and in Northern Ireland is reported by Reilly et al (2007). They sought to answer the question 'do integrated organisations promote integrated practice', comparing evidence on dimensions such as the involvement of health care staff in care management and a more integrated approach to assessment and care planning. They conclude that the structurally integrated services of Northern Ireland are more conducive to integrated working but that the structure in itself is not sufficient to ensure better service outcomes – 'organisational structures alone are not sufficient to produce integrated practice' (p241).

Experience in the Republic of Ireland reinforces that reported above. As recounted by Cate Hartigan at the ADSW Conference (18 May 2011), despite having the Health Services Executive which oversaw the delivery of health and personal social services,

there have been major challenges. Indeed the policy of the new Government formed in February 2011 has been to remove the Executive, to introduce a separate agency for child protection and welfare, and to *separate* health from personal social services. The operating model was judged to be too centralised; the pattern had been one of continuous discontinuous change; and there was a need to avoid the distraction of further restructuring.

Field and Peck (2003) have made an interesting contribution to the debate on health and social care structures through their analysis of mergers and acquisitions in the private sector. These they suggest do not paint an optimistic picture. Mergers are potentially very disruptive to managers, staff and people who use services and can give a false impression of change. They can stall positive service development and productivity for at least eighteen months and typically do not save money. Moreover the evidence from the private sector suggests that strategic objectives are rarely achieved. The case study of Somerset, presented below as a health and social care merger, confirms these findings from the private sector, with cultural issues playing a central role. Glasby et al (2011) suggest that factors more likely to lead to successful mergers include:

- clarifying the real (as opposed to the stated) reasons behind any merger
- resourcing adequate organisational development support
- closely matching activities to intentions to reduce cynicism amongst key staff groups whose support is essential (p6).

PROGRESSING PARTNERSHIP

There has been extensive scrutiny of the detail of partnership working, often building on the Partnership Assessment Tool developed by Hardy et al (2000). At the same time Poxton (2004) presented the key components of what he termed the Partnership Readiness Framework. This identified key building blocks or prerequisites for partnerships to flourish.

- Building shared values and partnerships
- Agreeing specific policy shifts
- Being prepared to explore new service options
- Determining agreed boundaries
- Agreeing respective roles with regard to commissioning, purchasing and providing
- Identifying agreed resource pools
- Ensuring effective leadership
- Providing sufficient development capacity
- Developing and sustaining good personal relationships
- Paying specific attention to mutual trust and attitude

Most recently, Glasby et al (2011) have summarised from this history the key factors that may help or hinder partnership working:

Barriers:

- Structural – fragmentation of service responsibilities across and within agency boundaries
- Procedural – differences in planning and budget cycles
- Financial – differences in funding mechanisms and resource flows
- Professional – differences in ideologies, values and professional interests
- Perceived threats to status, autonomy and legitimacy

Principles for strengthening strategic approaches to collaboration:

- Shared vision
- Clarity of roles and responsibilities
- Appropriate incentives and rewards
- Accountability for joint working.

Exhortations to encourage collaboration and structural innovations to enhance partnership have been a common feature of the policy landscape for some decades (Hudson and Henwood, 2002; Glasby, 2003; Petch, 2008; Evans and Forbes, 2009; Ball et al, 2010; Perkins et al, 2010). Although a detailed review of these developments is not the purpose of this document, it is worth highlighting the evidence from a number of the more recent initiatives both in Scotland and in England.

Section 31 of the Health Act 1999 in England introduced what have become known as the Health Act flexibilities (Audit Commission, 2008). The removal of legal barriers has allowed the promotion of three initiatives: pooled budgets, lead commissioning and integrated services. *Pooled budgets* involve the allocation of funds to a mutual pot which can then be accessed through the budget manager without the need to determine whether the proposed use should be defined as health or social care. Under *lead commissioning*, one agency delegates responsibility to the other for all or part of the agenda and this lead agency can then purchase the necessary provision irrespective of whether it would be classified as health or social care. The facility for *integrated services* allows provision to be integrated within a single organisation, a 'one-stop-shop' with the aim of delivering accessible and coordinated support.

The operation of the Health Act Flexibilities has been explored in two major evaluations. The first (Glendinning et al, 2004; 2005) examined the early notifications from April 2000. Early take-up was slow, with pooled budgets the most popular initiative and integrated provision the most challenging. Areas which proved problematic included the sharing of information, in part due to IT incompatibilities; cultural differences between partners; and resource constraints. The authors concluded that three factors were key to success: strong, visible leadership and commitment; time; and attention to local condition and histories. The second evaluation (Phelps and Regen, 2008) confirmed the dominance of pooled budgets as the preferred mechanism (involved in over three quarters of the notifications, 45% on their own and 34% in combination). A number of case studies identified the important role of government policy drivers, senior management commitment and the adoption of a whole systems approach in progressing the use of the Flexibilities.

Barriers included resistance from senior management and the time-consuming and bureaucratic nature of the notification procedures. Moreover Glendinning et al (2004) reported that despite operating pooled budgets, agencies were required to report separately on activity and expenditure, a procedure that seemed to undermine the core principles behind the introduction of the flexibilities.

A further development in England has been the creation through permissive legislation in the 2001 Health and Social Care Act of the Care Trust model. This allowed for the creation of a new level of primary care organisation able to commission and deliver both health and social care, designed (DoH, 2000) to 'remove the outdated institutional barriers between health and social services which have got in the way of people getting the care they need when they need it'. Care Trusts were to be formed only where there was agreement between the partners, although there was a proposal (dropped before legislation) to enforce the creation of a Care Trust where health and social care organisations failed to establish an effective partnership. The Health Minister in 2000 declared that he expected all adult social care services to be delivered by Care Trusts within five years; the possibility of including housing was also mooted. The reality has been somewhat different (Glasby and Peck, 2004); ten years on the number of Care Trusts stands at less than twenty, with a focus in the early trusts on mental health services rather than a more comprehensive agenda. Common to much of the experience is that the key element is the extent to which developments are rooted in a solid history of partnership working.

The Audit Commission (2009) has looked in detail at these opportunities for jointly funded initiatives, highlighting that in 2007-08 formal joint expenditure accounted for only 3.4 per cent of the total health and social care spend (Goldman, 2010). They made a range of recommendations designed to enhance accountability and governance and to reduce perceived complexities. The Commission was also concerned about the focus on process rather than individual outcomes and concluded:

Analysis of the limited national data available suggests that formal partnership arrangements have had little or no impact on reducing the number of older people who fall and break their hip, or on the length of time they spend in hospital for some common conditions. The same is true for the length of time those with mental health needs stay in hospital. (Audit Commission, 2009:4)

The focus for any joint financing arrangements, they suggest, should always be on 'value for money and improving the user experience'.

Parallel developments in Scotland will be familiar to those engaged with this debate: initial opportunities in the (voluntary) involvement of social care in the Local Health Care Cooperatives (LHCCs); the pilot initiatives of the Local Care Partnerships Scheme; the establishment from April 2005 of Community Health Partnerships (CHPs) and later Community Health and Care Partnerships (CHCPs). These were presented as a whole system service redesign to deliver integrated services and

enhanced partnership working, 'bridging the gap between primary and secondary care and health and social care'. In parallel to these structural initiatives, there has been the focus on joint working prompted by the review conducted by the Joint Future Group (2000), the series of initiatives promoted through the Joint Future Team, and the evolution in 2004 into the Joint Improvement Team (JIT). This Team, now part of the SG Directorate for Health and Social Care Integration and itself a partnership between Scottish Government, NHS Scotland and CoSLA, works both locally with individual partnerships to progress key dimensions of joint working and at the national level to promote major developments, for example telecare.

The Community Care and Health (Scotland) Act 2002 introduced provisions similar to the Health Act Flexibilities: Section 13 allows payments from the NHS towards certain local authority functions; Section 14 covers the reciprocal arrangements for payment from local authorities towards NHS functions; Section 15 addresses pooled budgets and lead provision; and Section 17 made provision for Ministers to enforce joint working arrangements if they deemed that services were failing. The approach of the Joint Improvement Team, however, has been one of critical friend rather than enforcer, working with the local partnerships to progress effective delivery, service improvement and a personal outcomes focus (Petch, 2011). The concept of an Integrated Resource Framework (IRF) is currently being piloted in four test sites in Scotland (Highland, Tayside, Ayrshire, Lothian). This is designed to provide greater understanding of local resources use across health and social care for different populations groups. Local mapping of patient and locality level cost and activity information is being completed and the test sites are implementing mechanisms to allow resources to follow the individual. An evaluation of the pilot is due to report at the end of 2011.

A recent report on the operation of Community Health Partnerships has just been published by Audit Scotland (2011). At the time of the audit there were 36 CHPs in Scotland, 29 health only and seven integrated (Community Health and Care Partnerships or Community Health and Social Care Partnerships). In addition to their general overview, Audit Scotland looked in detail at six case studies: the replacement of five CHCPs in Glasgow by one health-only CHP; the CHPs in Fife, East Renfrewshire and Western Isles; the pooled budget for integrated mental health services in Clackmannanshire, and the devolved responsibilities held by Argyll and Bute CHP. They conclude that there is a 'cluttered partnership landscape', with duplication and lack of co-ordination; CHPs were often established in addition to existing health and social care partnership arrangements. Governance and accountability arrangements are not always clear, particularly in respect of the integrated CHPs, and joint workforce planning is limited. There has been limited progress in joint funding of services, all by way of aligned rather than pooled budgets save for the mental health service in Clackmannanshire, and information sharing remains a problem. Perhaps most significantly, the audit concludes that there has been no large-scale shift in the balance of care, despite this being a key priority since 2000. They do highlight, however, a number of promising initiatives. Overall the report highlights the need for strong, shared leadership and makes a number of key recommendations, including that the Scottish Government should work with NHS boards and councils

‘to undertake a fundamental review of the various partnership arrangements for health and social care in Scotland to ensure that they are efficient and effective and add value’ (p23).

This report also draws broader lessons from a case study of the Glasgow situation where the five integrated CHCPS were dissolved. An independent review by Arbuthnott in 2010 identified fundamental problems with governance arrangements. These included lack of any clear strategy or formal agreement on what services and functions were to be delivered through the integrated CHCPS and the absence of a financial framework. No partnership agreement, joint financial framework or joint scheme of delegation was put in place between NHS Greater Glasgow and Clyde and Glasgow City Council. There were also tensions between the Board and Council corporate strategies in terms of where responsibilities for services lay; for example the Board devolved responsibility for all primary and community care services and budgets to the integrated CHCPS but the Council did not do likewise for all social care services. Despite recommendations from Arbuthnott designed to resolve the difficulties, a decision was finally taken to dissolve the CHCPS when agreement could not be reached on key issues.

Audit Scotland (2011) identify a number of key principles for partnership working (listed below) and contrast the associated features of partnership working when things go well and not well.

Behaviours

- Personal commitment from the partnership leaders and staff for the joint strategy
- Understand and respect differences in organisations’ culture and practice

Processes

- Need or drivers for the partnership are clear
- Clear vision and strategy
- Roles and responsibilities are clear
- Right people with right skills
- Risks associated with partnership working are identified and managed
- Clear decision-making and accountability structures and processes

Performance measurement and management

- Clearly defined outcomes for partnership activity
- Partners agree what success looks like and indicators for measuring progress
- Partners implement a system for managing and reporting on their performance

Use of resources

- Identify budgets and monitor the costs of partnership working
- Achieve efficiencies through sharing resources, including money, staff, premises and equipment
- Access specific initiative funding made available for joint working between health and social care

Audit Scotland, 2011

These principles can be read alongside an earlier study of drivers and barriers to joint working in Scotland, conducted for the then Joint Future Group (Stewart et al, 2003). Based on mapping of 253 local initiatives which featured some element of partnership working and on nine more detailed case studies, key features that can drive effective partnership working at the three levels of national policy frameworks, local planning context, and operational factors were identified. Within operational factors, for example the importance of relations between partners, organisational culture, change management, enabling staff, professional behavior, attitudes and outcomes was highlighted. Within each of these areas respective drivers and barriers were identified. As an example, organisational culture could be 'can do'; promote a collective responsibility; value difference; consider partnership working to be everybody's agenda, including accountants and administrators; be organic, flexible and supportive of delegated responsibility; and be willing to share. Alternatively it could see institutional and legal barriers; senior figures could devalue or disown common purpose; value uniformity; consider partnership working to be professionals' business only; be rigid, with high bureaucratic controls; and be competitive.

EARLY ADOPTERS

There are a number of examples of moves towards integrated working in England which merit further examination (Ham and Oldham, 2009).

Torbay

The experience of Torbay, a small unitary council area in south west England, illustrates the significance of local history and context. This has been documented in detail by Thistlethwaite (2011) and featured as a case study in a Nuffield Trust seminar series reported by Ham (2009). Innovations in health provision in the area had emerged from the beginning of the last decade and by 2003 meetings were being held between the Torbay Primary Care Trust (PCT) and adult social services with a view to increasing collaboration. A number of joint appointments were made. It should be noted that social services in the unitary Torbay Council were performing poorly, awarded only 'one star' under the national rating system. The following year an integrated, co-located team of community health and social care staff and services was piloted, centred on three local GP practices in Brixham with a population of around 23,000. A locality general manager was appointed; Thistlethwaite reports that the individual's background in social services finance and the management of homecare services offset perceptions amongst local authority staff that social care was being 'taken over by the NHS'. In 2005 a post of health and social care coordinator for Brixham was created, with a particular remit to streamline referral pathways. At the same time, at the governance level, a merged post of PCT chief executive and director of social services was created (secured by the former PCT chief executive) and the decision was made to become a Care Trust.

Key to this period of change was a focus throughout the negotiations on 'getting it right for Mrs Smith', a persona for an 80-year-old user of a fragmented range of services. Discussions with staff explored the challenges for Mrs Smith in navigating the local health and social care system, including multiple assessments, lack of shared information and the complexity of the system. In his account of the creation of the Care Trust, Lavender (2006) highlights the centrality of this image.

The original vision was how the care trust would help Mrs Smith, and that then became the standard benchmark everyone used in the project; every proposed development was questioned for how it would benefit Mrs Smith. This principle has been continued into the care trust, and the current Board still ask how we have benefited Mrs Smith – to ensure that the organisation stays focused on the key reason for our creation. (p17)

Torbay Care Trust was created in 2005, contracted to provide all social care functions for the council and with a single budget. The board for the Trust includes two nominated council members. It should be noted that the Care Trust model does not transfer accountability for adult social care from the council; this remains its statutory duty, with external scrutiny of finance and performance (specified in an annual agreement of the resources to be transferred to support social care and the associated performance expectations). A single commissioning team was formed from existing staff in the council and Torbay PCT, while at provider level an integrated management structure for the PCT and adult social services was developed and implementation began.

At the local level, following independent evaluation of the Brixham pilot, the model was replicated across Torbay through the creation of four further integrations of community health and social work based on clusters (or zones) of GP practices. Subsequent developments have included an integrated IT system for sharing information, ward-based health and social care coordinators, and improved access to intermediate care including the creation of generic health and social care assistant posts.

Attribution of impact in a complex delivery system such as health and social care is difficult. Moreover data such as bed occupancy on its own should be used with caution. Nonetheless there has been a reduction of a third in the average number of occupied beds in Torbay over a ten year period; emergency bed day use for 75+ fell by 24 per cent between 2003 and 2008, and for 85+ by 32 per cent; and delayed transfers of care are negligible. Twice the regional average of people aged 65+ receive some form of social care package, with some homecare targeted on preventive low level support. The use of Direct Payments is one of the highest in the region. It is interesting to note however that learning disability services in the area are not functioning effectively and concern has been raised about the performance of children's services. Moreover current policy developments proposed for England in respect of health care commissioning are likely to introduce new challenges.

The experience of Torbay highlights a number of key elements:

- The need for a vision that is led by the benefits for the individual requiring support
- The importance of the 'bottom-up' approach which built on the initial pilot
- The use of GP registration rather than home address to allocate work to integrated community support services
- The prioritisation of continuity of care at home
- The transparency of the process – for example quarterly seminars were held for staff from both organisations, independently chaired and with management response to questions within a week
- The key role of the health and social care co-coordinator posts
- The need for a common understanding of integration.

Ham (2009) emphasises the importance of working with elected members, the challenge of getting managers from the NHS and local authority, as opposed to front-line staff, to work in new ways, and the benefits of assimilating all staff in new contractual arrangements.

Finally Thistlethwaite (2011) concludes,

... people in Torbay examined evidence from elsewhere, appraised their own performance, built communication and teamwork between stakeholders, made choices, managed risks and reaped rewards: these things are replicable. There is no textbook to guide the process because local context (especially the interplay of people, relationships and processes) is a key variable. Anyone embarking on this process needs to conceive of it as a learning process. (p24)

Knowsley

The vision behind partnership working in Knowsley, an area of significant social, economic and health needs, is of 'working together for a better, healthier life for everyone in Knowsley'. Originally focused on health and social care, the initiative has more recently been extended to embrace leisure and cultural services.

Knowsley Health and Wellbeing Partnership was established in 2004 under the s31 Health Act flexibilities. This followed the appointment to a joint post of PCT Chief Executive and Council Executive Director in 2002. A Partnership Board, jointly chaired by the Council leader and the PCT chair, provides overall direction; day-to-day responsibility lies with the Partnership Management Board chaired by the joint post. The partnership agreement provides for single accountability with dual governance and membership of the Management Board includes managers, clinicians and user representatives as well as elected members and PCT non-executives. There is a single executive team with commissioning leads for secondary care, prevention, community services, primary care and urgent care. This provides for a single set of strategic objectives, a combined business plan, and joint resource planning.

A Joint Strategic Needs Assessment identified a number of key priorities including alcohol harm, teenage pregnancies, mental health including dementia, support for carers, and independence and inclusion for older people. Associated with the priorities are agreed health and wellbeing outcomes. A number of achievements are cited for the Partnership. These include a review of provision for people with learning disabilities that enabled £1 million in savings through joint work between the commissioners and providers, and flexibility in the use of resources as exemplified by £4 million of NHS resources directed to neighbourhood projects focused on worklessness. The facility for pooled budgets has been managed flexibly to respond to the varying budget pressures of the two partners. There are also a range of shared sites and buildings that offer a variety of integrated provisions.

A summary of the Knowsley experience by Ham (2009) suggests a number of lessons. Key facilitating factors have been:

- High levels of commitment, trust and goodwill amongst the partners
- An integrated communication strategy to ensure key messages are relayed
- Leadership at all levels of the organisation, achieving 'buy-in' and nurturing creativity.

At the same time however challenges remain, including:

- Human resource and workforce issues, most particularly difference in contracts, pensions and terms and conditions
- The need to sustain integration when key individuals move on by ensuring that partnership working is robustly built in.

The Knowsley experience suggests the need to build trust and commitment before tackling the challenges of legal and governance issues.

A fundamental lesson is that the focus needs to be on the vision and on developing leadership, rather than on structures. (Ham, 2009:6)

Indeed perhaps the most significant feature of the Knowsley model is that through local leadership and long-term commitment it has achieved service integration without structural integration.

North East Lincolnshire

As in Torbay, the story in North East Lincolnshire is of an evolving response over a number of years in an area characterised by poor local authority leadership. An early development of an out-of-hours cooperative initiated by local GPs was followed by a pilot for locality commissioning. Health and social care were co-located, work progressed on an integrated IT strategy, and from 2005 integrated mental health provision was developed. In 2007 the North East Lincolnshire Care Trust Plus was established. A care trust plus differs from a care trust in that all services are involved in the partnership. In North East Lincolnshire, responsibility for

adult social care commissioning and provision transferred from the local authority to the PCT; responsibility for public health was transferred to the local authority. Four localities provide the basis for commissioning, each around 40,000 in population.

Barking and Dagenham

Further lessons can be learnt from the experience of Barking and Dagenham where in 2001 the London Borough and the newly created and co-terminous Barking and Dagenham PCT sought to integrate health and social care delivery under a joint post of PCT Chief Executive and Director of Social Services. The former Director of Social Services was appointed to the role and a number of other joint appointments were made including a joint Director of Public Health. Delivery embraced both commissioning and provider functions, for all groups including children. Provision was to for all those registered with GPs in the Borough. By 2003 however the joint Chief Executive post had been disaggregated, following a zero star rating for the PCT.

Wistow and Waddington (2006) conducted a retrospective case study. Based on interviews and completion of the Partnership Assessment Tool (Hardy et al, 2000) with key stakeholders, they highlighted four key considerations. They conclude that in Barking and Dagenham the *pace and scope of change* was 'too far too fast', coinciding with the creation of the new PCT structure – 'integration is the icing on the cake and the foundation must be rock solid'. They suggest there needs to be a balance between the ambition of aims and the realism about what can be achieved. There also needs to be a *clarity of purpose*; in Barking and Dagenham there was a lack of consensus about the purpose of the integration agenda – 'we need to be clear about why we are working together'. The focus, they suggest, should be on the outcomes for individuals (users and patients), establishing an appropriate balance between ends and means rather than majoring on structural integration.

Another key dimension that emerged related to *organisational compatibilities*. This reflects the 'different cultures, understandings, behaviours and external expectations', in summary the tension between national standards (health) and local needs (social services).

Interpreting partners' actions through the lens of performance systems which are not applicable to them almost inevitably leads to confusion, if not disagreement. (Wistow and Waddington, 2006:14)

If such barriers are to be overcome, they suggest, areas of difference and potential conflict need to be openly identified and strategies for managing them agreed. There should also be recognition that it is legitimate to have separate as well as shared objectives. Finally, an important factor is *equality of ownership*. In Barking and Dagenham the newness of the PCT led to it being seen as the junior party – 'it did not feel like an equal partnership. The authors recommend there needs to be equal ownership of the agenda – 'the language of control and ownership is corrosive and should be surfaced immediately' (p15). Unlike Torbay this initiative lacked a

strong history, highlighting in its initial failure the tension between culture and structure. Wistow and Warrington (2006) conclude from their appraisal that:

in Barking and Dagenham, too much emphasis on structure was reported at the apparent expense of either 'winning hearts and minds' or overcoming professional and political differences in objectives and priorities (p17).

Somerset

The importance of culture has been referenced on a number of occasions. The detailed evaluation of the Somerset Partnerships Health and Social Care NHS Trust, established in 1999 as the first integrated provider for mental health, offers further insight into this dimension (Peck et al, 2001). The evaluation sought to identify the impact of joint commissioning and combined service provision on people using services and their carers, on professional staff, and on the agencies involved. A range of dimensions was explored at baseline and at one and two years post-implementation. Responses varied for the three groups. Service users, for example, reported improved mental health status and were more positive about the services they were receiving; they were critical, however, of the availability of support and access to buildings and had concerns over the attitudes of staff. Unpaid carers reported that some aspects of service delivery had improved, but felt that there were continuing problems around their own involvement, both at the individual and agency level.

Responses from staff were varied. In the initial months there had been a reduction in job satisfaction, in morale, and in role clarity. Two years on some of this was recovering, but a number of concerns remained: organisational identity; role clarity and inter-disciplinary working; and leadership and management. Some staff, for example, were concerned at a lack of identity for the Trust, disgruntled with the management structure, and discomfited by the potential for changed relationships with colleagues. Likewise, although there were reports of some improvements in team environments and accounts of picking up skills from colleagues, boundaries between professionals remained. Workload and bureaucracy were perceived to have increased, there was concern as to the pressure on team managers, and anxiety among the smaller disciplines, for example occupational therapy, as to the inclusion of their views. Indeed there was a suggestion that, at least in the short term, structural change may have strengthened attachment to existing professional cultures rather than supporting transformation.

There was concern also as to the extent to which the Joint Commissioning Board was able to play a proactive role in the setting and monitoring of policy and priorities. The Board was valued as a symbol of the interagency partnership, as a vehicle for sustaining commitment to mental health, and as a mechanism for bringing additional elements of public accountability to the commissioning and provision of health and social care (Peck et al, 2002). There was a sense amongst respondents, however, that core business was conducted elsewhere. Users and carers in particular questioned the extent to which they were being involved. There was considered to

have been a lack of preparation for primary care involvement and uncertainty around the identity of the Trust. A fundamental issue was the 'culture' to be adopted by the partnership – whether it should be a new and different culture or an enhancement of the cultures already in place in the merging bodies.

Is the desired result one entirely new culture, albeit comprised of elements taken from all the current professional cultures – the melting pot approach to culture? Or is the desired result the enhancement of the current professional cultures by the addition of mutual understanding and respect – the orange juice with added vitamin 'c' approach to culture. (Peck et al, 2001:325).

Sedgefield

The final example to be detailed is at a more local level: the integration of social workers, district nurses and housing officers on a locality basis in Sedgefield, County Durham. Three core partners (Sedgefield PCT, Sedgefield Borough Council and Durham County Council) collaborated to establish five co-located front-line teams to serve the area. Resources were pooled between social services and the PCT, the joint operational teams were under single management, and a local partnership board was created to oversee the arrangements. Provision embraced most adult services, including mental health services for older people and housing and accommodation.

Hudson (2006a; 2006b) conducted an action research evaluation of the experience of the first Sedgefield team over an eighteen-month period, including 70 individual interviews and tracking of six individual cases. In the main the study focuses on process rather than individual outcomes. It examines three precepts of an 'optimistic model' of Interprofessional working, an alternative to his earlier formulation of a 'pessimistic model' whereby partnership working is inhibited by issues of professional identity, professional status and professional discretion and accountability (Hudson, 2002). The first hypothesis of the new model suggests that *promotion of professional values of service to users can form the basis of Interprofessional partnership*. The study provided evidence to support the integrative nature of a focus on the whole person, nurtured by the mutual understanding emerging from the co-location. This, Hudson (2006a) argues, can generate the 'holy grail of integration: acceptance of collective responsibility for a problem, as opposed to the pursuit of narrow professional concerns' (p16).

The second hypothesis explored is that *socialisation to an immediate work group can over-ride professional or hierarchical differences among staff*. The three staff groups appeared to inhabit an egalitarian culture with parity of esteem and re-orientation of professional affinities. The co-location and shared information system were seen as critical, although it should also be noted that membership of the team was primarily through self-selection. The final hypothesis was that *effective inter-professional working can lead to more effective service delivery and user outcomes*. Three key factors were identified: speed, flexibility ('role bending', for example a social worker delivering incontinence pads on a visit), and creativity – proactive and

collective problem solving. As Hudson characterises, ‘the main issue for service users is that complex, integrated processes of service delivery look simple to them’ (p19). A second article by Hudson (2006b) examines in more detail the mechanics of the core processes needed for transformational change: a leadership process; a design process; a logistic process (including critical workstreams on HR, information systems and administrative support); and a consultancy process.

The critical importance of the Sedgefield experience for this review is the focus on the development of effective teams rather than on structure. Targeting structures is unlikely on the basis of the evidence presented here to lead to an optimum delivery; creating a streamlined delivery based on integrated teams is much more likely to deliver on the desired objectives.

JOINT COMMISSIONING

It is perhaps worthwhile at this point looking specifically at the emergence of joint commissioning, or in its most recent branding ‘integrated commissioning’ (Hudson, 2010), the process whereby ‘two or more commissioning agencies act together to co-ordinate their commissioning, taking joint responsibility for translating strategy into action’. It is easy to forget that it is only in the course of the last two decades that the commissioning of support has been separated for its delivery. The DH in 1995 made specific reference to joint commissioning; in 2007 it introduced a ‘commissioning framework’ and local statutory agencies in England were required to undertake a Joint Strategic Needs Assessment (JSNA). In Scotland the priority given to joint commissioning has been less pronounced; moreover the production of data hungry workbooks on commissioning for older people and people with learning disabilities may have both deterred partnerships and distracted the focus from the Joint Improvement Team on this issue (Petch, 2011).

Hudson (2011) identifies policy imperatives which accord with a strategy of joint commissioning: efficiency and value for money; the ‘place’ agenda – addressing the needs of the locality as a whole; personalisation; prevention; care closer to home; and the overlap in users of health and social care and hence the need to ensure that support is jointly planned and commissioned. He outlines also, however, four key factors that may have contributed to relatively modest progress, albeit the oft-cited achievements of Knowsley (above), Bath and North East Somerset (BANES) and Herefordshire. These he defines as policy ambiguity and conflict – for example the potential tension between the promotion of individual budgets and strategic commissioning; organisational turbulence, particularly in respect of the locus of commissioning within the NHS; performance management frameworks, where local attempts to work jointly are undermined by separate performance arrangements at the centre; and power imbalances, health commissioning in England generally being the weaker partner alongside the provider. More vigorous progress requires concerted attention to overcoming these inhibiting factors. Given this context, and prefaced by the lack of evidence for structural solutions outlined above,

the answer may be to focus less upon legislation and organisational structures and restructures, and more upon the relationships between front-line managers and professionals who (in effect) are taking many of the commissioning decisions anyway – an emphasis upon networks rather than hierarchies, and upon *patterns* or ‘pathways’ of care rather than *episodes* of care (p6).

OUTCOME BASED COMMISSIONING

The introduction of outcomes based thinking means that it is logical to reframe strategies for joint commissioning in terms of outcomes based commissioning and contracting. This can be defined as:

any commissioning that links investment to outcomes, which may include shaping and facilitating the market for services. It moves the focus to results that may be achieved for individuals served by programmes and services (RiPfA, 2007).

The aim is to enable providers to innovate and to create support services better tailored to the needs of individual service users. Outcomes based commissioning requires the overall strategic direction to be defined, together with the provision that it is anticipated will deliver the benefits for individuals that are the ultimate goal. Outcomes based commissioning has emerged from two parallel developments: the contracting out of public services and the spread of performance management. The rationale for outcomes based commissioning (and contracting) has variously been to:

- refocus attention on the goals of social care services
- provide greater opportunities for flexibility and responsiveness
- give greater control to people who use services
- encourage creativity and diversity
- improve quality
- foster change
- improve service user satisfaction
- increase efficiency and effectiveness.

To date outcomes based commissioning has been focused on programme areas such as drugs and alcohol where it is relatively easy to define and measure outcomes and there is often a clear baseline. A review by SCIE (Social Care Institute for Excellence) in 2006 of outcomes focused services for older people identified only three schemes concerned with outcome based commissioning and contracting. When coupled with outcomes based contracting, experience in the US suggests that an outcomes approach leads to a greater focus on performance, stimulates re-evaluation of service delivery models and improves effectiveness. In particular, a focus on outcomes based commissioning should switch the focus from service configuration and boundaries as the responses needed to meet the defined outcomes will often transcend boundaries. This should very often lead to a natural development of for example joint commissioning. For example the development of an outcomes based

commissioning approach by Birmingham's Children and Young People's Board is cited as having accelerated the process of joint commissioning.

The benefits of an outcomes based approach are highlighted in the CSIP Commissioning e-Book (Kerslake, 2006).

- A focus on outcomes should mean a better service for the end user. At the moment it is possible to deliver the volumes of service required, in the manner agreed, at the right time, to high quality standards, but still not achieve the desired outcomes.
- It makes the commissioning partnership focus on exactly what they want the provider to achieve and why. This may be of particular help where services are to be jointly commissioned.
- For both commissioner and provider it encourages a knowledge driven approach to practice.
- Both sides need to know and understand the rationale behind each outcome and to identify methods of practice that can achieve demonstrable results.
- It can help to focus agencies on the purpose of the task, both at a general level and at that of individual workers. Overall outcomes can link into personal targets and appraisal systems, eg, what are you doing to achieve the outcomes the agency is required to meet?
- Achieving outcomes can be both collectively and individually motivating, particularly where the absence of clear achievements, goals and targets in the past has tended to produce an approach which spurns the concept of success.

4. CONCLUSION

Despite a tendency to focus on structural 'solutions', evidence and experience suggests a series of more important processes, approaches and concepts that might help to promote more effective inter-agency working—including a focus on outcomes, consideration of the depth and breadth of relationship required and the need to work together on different levels. (Glasby et al, 2011:1)

There are two clear messages that can be taken from this evidence review. Firstly, that **structural integration does not deliver effective service improvement**. There is the temptation that major structural change gives an impression of 'bold, decisive action, sweeping away the old and bringing in the new' (Glasby et al, 2011:6). Repeated experience, however, demonstrates that in the longer term it fails to deliver. Moreover repeated reorganisation may generate a workforce that is resistant to change. As Rosen and Ham (2008) concluded, structural integration is not a key requirement for a holistic service; the emphasis should be on service integration rather than on organisational integration.

The second conclusion addresses the relationship between partnership working and the delivery of personal outcomes. As the review makes clear, the focus until recently has been on the *process* of partnership working rather than on the *impact* for those receiving support. **The extent to which partnership working delivers effective outcomes for the individual is therefore currently best described as unproven**. As highlighted in the review, the focus has to be on which aspects of individual partnerships deliver which particular outcomes for which specific groups. Indeed as recognised by Glendinning et al (2002) it is this local specificity which needs to be nurtured: 'the fine-grained relationships which have to be built at local level need to be better understood and supported'.

Against this backcloth, the review also provides clear messages on a number of key dimensions which contribute to effective service delivery across health and social care. These include:

- **The importance of culture**
- **The role of leadership**
- **The place of local history and context**
- **Time**
- **Policy coherence**
- **The need to start with a focus on those who access support**
- **A clear vision**
- **The role of integrated health and social care teams**

It is important, however, also to acknowledge that the integrated delivery of care and support is one of the enduring issues that is resistant to any instant solution or 'quick fix'. As Wistow and Waddington (2006) observe:

Reconciling this need for the emergence of genuine cultural change with the urgent requirements for better outcomes is a challenge which has defeated many localities and governments. (p10)

Nonetheless there is a clear basis on which to proceed, reinforced by Ham (2009) from his review of English case studies.

A clear message from this work is that the journey towards integration needs to start from a focus on service users and from different agencies agreeing a shared vision for the future, rather than from structures and organisational solutions. (p9)

The two diagrams below seek to summarise this clear steer from the evidence base. This puts the delivery of outcomes for the individual at the heart of the process and seeks to incorporate the core elements for effective delivery highlighted above (Figure 1). There is also the requirement to manage the tension not only between structure and culture but between national targets and local discretion (Wistow and Waddington, 2006). Figure 2 represents this interplay between these two sets of drivers, bottom-up and top-down.

Figure 1.



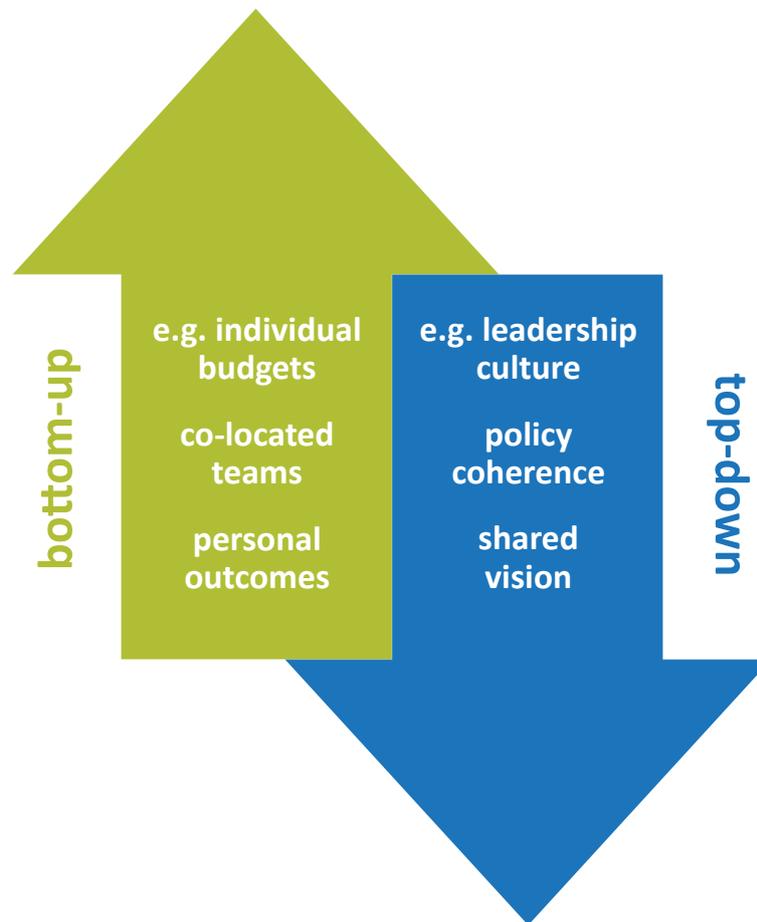


Figure 2.

The challenge has been neatly encapsulated by the NHS Confederation (2010):

- Integration based on outcomes not targets
- Integration based on cultures not structures
- Integration based on place not organisation
- Integration based on delegation not transfer of functions
- Integration based on clinical and professional engagement.

It is appropriate to conclude this evidence review with the oft-cited laws for integrating medical and social care developed by Leutz (1999; 2005) following lengthy observation. The initial five laws were supplemented by a further four. Leutz's formulation of the partnership continuum was from linkage through coordination to full integration.

- You can integrate some of the services for all of the people [linkage], or all of the services for some of the people [full integration], but you can't integrate all the services for all the people.
- Integration costs before it pays
- Your integration is my fragmentation
- You can't integrate a square peg and a round hole
- The one who integrates calls the tune
- All integration is local
- Keep it simple, stupid
- Don't try to integrate everything [danger of upwards substitution of pooled resources into the more powerful acute system]
- Integration isn't built in a day.

In seeking to deliver on the agenda highlighted at the beginning of this report, the emphasis must be on those strategies most likely to deliver on the desired outcomes. While the complexity of the processes involved in health and social care delivery can rarely guarantee certainty, it is evident that the focus must be on nurturing the partnership working at the professional and practice level that ensures that the outcomes for the individual are at the heart of the process. Effective working strategies and synergies that support this delivery should be at the core of workforce development. To be distracted into structural change cul de sacs would be to renege on the fundamental commitment to the delivery of social justice for all citizens, but most particularly those at risk of poverty and social exclusion. The personalisation agenda overall, and opportunities for self directed support in particular, hold the promise of a transformation in the future configuration of support and engagement; maximum energy and resource needs to be directed at the local detail of how this can be attained rather than in remodeling the global structures.

APPENDIX ONE: KEY POLICY DRIVERS

Demographic and financial pressures have combined to ensure that the provision of care and support for adults is a current political and policy priority. From the range of recent strategies and policies a number can be highlighted to characterise the current debate.

SHIFTING THE BALANCE OF CARE AND RESHAPING CARE FOR OLDER PEOPLE

Demographic factors have prompted one of the major current policy drivers, *Reshaping Care for Older People*, www.scotland.gov.uk/Topics/Health/care/reshaping A two-thirds increase in the number of older people is projected over the next 20 years, with the number of people over 65 expected to be 21 per cent greater in 2016 than 2006. For those 85 and over, the group particularly likely to require care and support, the numbers are expected to rise by 21 per cent by 2016 and by 144 per cent by 2031. If the current baseline of health and social care provision were to be continued, this would require an annual increase in health and social care investment of £1.1 billion by 2016 and £7.5 billion by 2031. Moreover, of the current annual expenditure of £4.5 billion on health and social care for people over 65, emergency admissions absorb £1.4 billion. Homecare accounts for less than seven per cent of the total.

Reshaping Care for Older People is set within the broader context of *Shifting the Balance of Care*, www.shiftingthebalance.scot.nhs.uk This programme, defined within health in 2008, has eight improvement areas and directly supports the delivery of HEAT targets and Community Care Outcomes. Shifts are sought in the focus of care, in ways of working, and in the location of care. Four of the eight improvement areas can be cited by way of illustration:

- Maximise flexible and responsive care at home, with support for carers
- Integrate health and social care and support for people in need and at risk
- Reduce avoidable unscheduled attendances and admissions to acute hospitals
- Improve joint use of resources (revenue and capital).

Building on this context, a Ministerial Strategic Group on Health and Community Care was established in March 2009, the focus on 'optimising the independence and wellbeing of older people at home or in a homely setting'. Following a series of eight workstreams, a *Programme for Change 2011-2021 for Reshaping Care for Older People* has been produced. This addresses the following core elements:

- Co-production and community capacity building
- Care services and settings
- Complex care and care pathways
- Workforce
- Demography and funding
- Planning, improvement and support.

It seeks to address a number of challenges identified in existing practice: eligibility thresholds versus prevention; risk adversity, with a tendency to focus on incapacity and dependence; insufficient support to carers; lack of service redesign leadership; and lack of incentives to promote change. *Reshaping Care for Older People* operates within the broader context of community planning, the key overarching partnership framework which seeks to co-ordinate the range of initiatives operating within the local area and ensure they collectively address key structural challenges.

A priority of the Programme is to value older people as an asset. Indeed it should be remembered that it is the minority who require formal support; 60 per cent of those aged 85 and over make no use of continuing care, care home or homecare provision accessed through social care. Moreover while 3000 individuals over 65 receive more than 20 hours of paid care per week, 40,000 in the same age group provide more than 20 hours per week in their role as unpaid carers. The underpinning objectives of *Reshaping Care for Older People* can be encapsulated in the shifts that are envisioned.

Old care model

- Geared towards acute conditions
- Hospital centred
- Episodic care
- Disjointed care
- Reactive care
- Patient as passive recipient
- Self care infrequent
- Carers undervalued
- Low tech

New care model

- Geared towards long-term conditions
- Embedded in communities
- Team based
- Integrated, continuous care
- Preventative care
- Patient as partner
- Self care encouraged and facilitated
- Carers supported as partners
- High tech

Moreover the delivery of care and support is to be outcomes-focused, helping older people to achieve a good quality of life through feeling safe; having opportunities to meet and support each other; ensuring no-one is socially isolated or lonely; staying as well as they can; living where and how they want; being free from discrimination or stigma; and being listened to, having a say in the services they receive and being treated at all times with respect and dignity.

A Reshaping Care Improvement Network has been established for this programme of change and a number of targets to be achieved by 2021 have been set:

- double the proportion of the total health and social care budget for older people spent on care at home – 6.7% to 13.5%
- build the capacity of third sector providers
- the Change Fund to shift the balance of care
- shift of resources to unpaid care

- reduce emergency bed days used by 75+ by a minimum of 20% by 2021, by at least 10% by 2014-15
- no direct admission from acute hospital to long-term care
- all over 75 offered a telecare package.

A critical group within *Reshaping Care for Older People* are those with dementia; *Scotland's National Dementia Strategy* was published in 2010, www.scotland.gov.uk/Publications/2010/09/10151751/17. Two key change areas are identified for the next three years: excellent support and information to people with dementia and their carers post diagnosis; and an improved response to people with dementia in general hospital settings, including alternatives to admission and better discharge planning.

CHANGE FUND

In order to support the implementation of *Reshaping Care for Older People*, a Change Fund has been created, www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/. This will provide £300 million over the next three years, with £70 million allocated to the 32 local partnerships for 2011-12 on the basis of local plans designed to embrace the NHS, local authority, third and private sectors. Partnerships are also expected to develop joint commissioning strategies for 2012-2020. In a report on its Strategic Vision for *Reshaping Care for Older People* (ref), ADSW has looked at the detail of the individual Change Fund plans. In particular it identifies proposals from individual plans which link to key priority areas. It also stresses the need to ensure that the outcomes-focused pledge highlighted above is achieved in practice and that personal outcomes are not ousted by more traditional performance measures.

PERSONALISATION AND SELF-DIRECTED SUPPORT

2010 saw the publication of *Self-Directed Support: A National Strategy for Scotland*, www.scotland.gov.uk/Publications/2010/11/05120810/15. Consultation on the Self-directed Support (Scotland) Bill concluded in March 2011. The Strategy seeks to advance the personalisation agenda in Scotland as part of the wider reform agenda, with independent living one of four areas set as priorities for co-ordination of action across the public sector. The key principles of choice and control are to be achieved through a process of co-production, with resource allocation in the form of a Direct Payment, Individual Service Fund or some combination of the two. This represents a major cultural shift and progress is currently being evaluated in three test sites: Highland (where the focus is on transition for young people), Dumfries and Galloway, and Glasgow. Three specific issues are being explored at these sites: bridging finance, reducing red tape, and leadership. A fourth site, NHS Lothian, is exploring the use of health monies in SDS packages. The evaluation of the test sites is due to report in summer 2011. ADSW has published a position paper, *Personalisation: principles, challenges and a new approach* (ref). A key consideration as the Strategy is implemented must be the congruence between self-directed support and commissioning, including the development of outcomes-focused commissioning.

LONG-TERM CONDITIONS

'Gaun Yersel!' *The Self Management Strategy for Long Term Conditions in Scotland*, www.ltcas.org.uk/documents/SelfManagementStrategydocument-GaunYersel.pdf, offers a not unrelated strategy led by health. It reflects the emergence of a focus on long-term conditions, supported by the Long Term Conditions Collaborative (LTCC) and the Long Term Conditions Alliance Scotland (LTCAS). Anticipatory care planning and the adoption of an assets based approach are also gaining currency, www.ltcas.org.uk/documents/AssetsAllianceScotlandEvent13Dec2010Reportpdf.pdf. A proportion of those with long-term conditions are those who fall within the SPARRA group (Scottish Patients At Risk of Readmissions and Admissions) and experience emergency repeat admissions to hospital.

An interesting innovation in England (for example Croydon, Wandsworth and Devon) is the 'virtual ward', targeted at those at risk of frequent admission as identified through predictive models such as PARR (Patients at Risk of Readmission). Multidisciplinary preventive care is provided to individuals within their own homes, delivered through the same staffing, systems and daily routines as in hospital. The Nuffield Trust is currently conducting an evaluation of the virtual ward model, due to report in November 2011. This will focus on comparative costs and the effect (if any) on the use of health and social care services.

COMMISSION ON THE FUTURE DELIVERY OF PUBLIC SERVICES (CHRISTIE COMMISSION)

The Christie Commission on the Future Delivery of Public Services in Scotland was established to set a road map for the future reform of public service delivery over the next five to ten years. The specific remit was to:

- address the role of public services in improving outcomes, what impact they make, and whether this can be done more effectively
- examine structures, functions and roles, to improve the quality of public service delivery and reduce demand through, for example, early intervention
- consider the role of a public service ethos, along with cultural change, engaging public sector workers, users and stakeholders.

The Commission was to pay heed to the importance of local communities and to the geography and ethos of Scotland, and 'should have clear regard to joint work already underway to take forward the increasing integration of health and social care and to develop sustainable police and fire services for the future'.

The Commission reported at the end of June 2011. Following consideration of the challenges facing public services, the Commission identified four key objectives to be achieved by any reform programme:

- public services are built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience
- public service organisations work together effectively to achieve outcomes
- public service organisations prioritise prevention, reducing inequalities and promoting equality
- all public services constantly seek to improve performance and reduce costs, and are open, transparent and accountable.

A number of priorities have been identified. These include the need for co-designed services; the effective co-ordination of scarce resources; support to enable individual and community resilience; ‘delivering integrated services that deliver results’; prioritising preventative measures; targeting underlying causes of inter-generational deprivation and low aspiration; tightening accountability; and ‘driving continuing reform across all public services based on outcomes, improved performance and cost reduction. Of particular significance in the context of this current review is their conclusion that:

Scotland’s public service landscape is unduly cluttered and fragmented, and that further streamlining of public service structures is likely to be required. But any specific proposal for reform needs to be driven by how best services can achieve positive outcomes, based on a comprehensive cost-benefit analysis. Otherwise we risk bearing the significant costs of structural change, without reaping any real rewards (px).

Recommendations from the Commission include a common set of statutory duties for all public bodies focused on improving outcomes; legislative provision to embed community participation in the design and delivery of services; a concordat between central and local government, backed by integrated funding provision, for the development of joined-up services; and promotion of service integration and a common public service ethos through joint training arrangements. Of particular relevance for the current review is the reference to proposals that ‘support the local integration of service provision’ (8.21) and of the priority in service reform for preventative measures and greater integration of services to reduce the numbers and costs of unplanned admissions (8.28).

COMMUNITY CARE OUTCOMES

Following the Concordat of 2007, the Single Outcome Agreement (SOA) was introduced as the key reporting mechanism for public service delivery. The SOA requires local authorities to report to central government on their progress towards meeting the 15 national outcomes, drawing as appropriate to their local priorities on 45 local indicators. The National Community Care Outcomes Framework has been developed at a voluntary level below the SOA requirements. It had been devised prior to the Concordat as part of the National Performance Framework linked to the NHS HEAT system (the measures and targets on which NHS Boards base their local delivery plans). The Framework identifies four national outcomes – improved

health, improved well-being, improved social inclusion, improved independence and responsibility - and 16 key measures, with a specific focus on how NHS and local authority partnerships are improving outcomes for those who access community care services. The measures include, for example, the percentage of community care service users feeling safe; the percentage of users satisfied with their opportunities for social interaction; the number of patients waiting in short stay settings, or for more than six weeks elsewhere for discharge to an appropriate setting; and the percentage of carers who feel supported and able to continue in their role as a carer. A review of the Community Care Outcomes Framework is currently being led by the Scottish Community Care Benchmarking Network (SCCBN) to ensure it addresses the extent of improved outcomes for individuals. The review is due for completion in June 2011.

The extent to which personal outcomes are addressed has also been the focus of the Talking Points methodology (Miller et al, 2008). This adopts an outcomes approach rather than a service-led approach to assessment, planning and review and has now been implemented in some form in all but one of the 32 local authorities. Rather than a focus on deficits, the emphasis is on assets, strengths and aspirations. There has been a range of attempts to marry the more qualitative and experiential approach of Talking Points with the more traditional quantitative approaches of performance measurement. Case study details of the use of Talking Point in the form of digital stories can be accessed via the Joint Improvement Team website (www.jiscotland.org.uk).

A key initiative from England should also be highlighted.

DILNOT COMMISSION ON FUNDING OF CARE AND SUPPORT

The Dilnot Commission was appointed in July 2010 to undertake the latest in a long history of reviews of the funding for care and support in England. Addressing funding for all adults, both working age and older people, the remit for the Commission was to address:

- How best to meet the costs of care and support as a partnership between individuals and the state
- How people could choose to protect their assets, especially their homes, against the cost of care
- How, both now and in the future, public funding for the care and support system can be best used to meet care and support needs, and
- How any option can be delivered, including an indication of the timescale for implementation, and its impact on local government (and the local government finance system), the NHS, and – if appropriate – financial regulation.

The three Commissioners agreed a number of key criteria against which options were to be assessed. These were sustainability and resilience; fairness; choice; value for money; and ease of use and understanding. The Commission reported in July

2011, highlighting the need for 'urgent and lasting reform'. Their core proposal is for a partnership model for the funding of care and support, with a cap on the lifetime cost contribution required from any individual. The suggested level for this cap is £35,000. At the same time it is suggested that the threshold below which a contribution would not be required be raised from the current £23,250 to £100,000. Those with care and support needs from birth or developed during childhood will be eligible for non means-tested support on reaching adulthood. A standard contribution towards living costs (food and accommodation) for all is suggested, in the range of £7-10,000 per year.

The report argues also for a more objective eligibility and assessment framework, standardised on a national basis to improve consistency and fairness. Individuals assessed in one area should be able to carry that assessment to a different authority. Improved assessments for carers are recommended, with support for the Law Commission's proposals for new rights for carers to services as a result of assessment. A further recommendation is for easy access to information and advice, with again support for the statutory duty on local authorities to provide information, advice and assistance (irrespective of the individual's funding) proposed by the Law Commission. Finally, the Dilnot Commission recommend that in reforming the funding of social care, the scope for improving integration of adult social care with other services in the care and support system should be reviewed – 'in particular, we believe it is important that there is improved integration of health and social care in order to deliver better outcomes for individual and value for money from the state' (p7).

Scottish Government indicated that following the delivery of the Commission's Report it will prepare a second volume for the *Reshaping Care for Older People* Programme.

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