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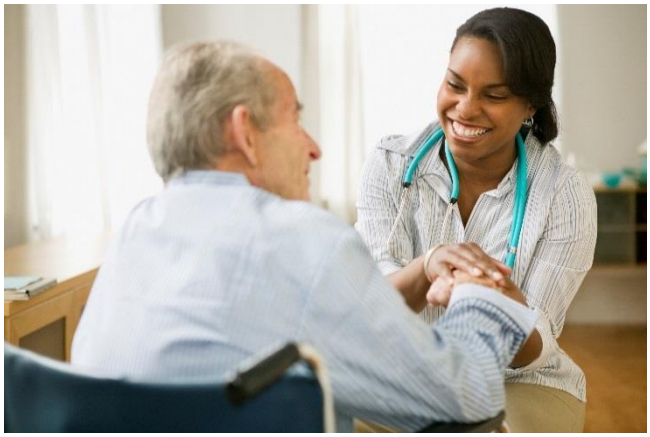
Integrating health and social care



An ageing population and the increasing prevalence of long-term conditions are putting pressure on health and social care services. The four UK nations have committed to better integration between health and social care as one solution to these challenges. This briefing outlines what integration is, examines policies to enable it and gives examples of integration in England. It also looks at the evidence on the challenges of achieving integration and assessing the effectiveness of approaches.

Overview

- Integration aims to put the needs of people at the centre of how services are organised and delivered. Models of integration vary.
- Co-ordinating resources or pooling budgets between health and social care services can enable joint working. The four nations of the UK have introduced different financial arrangements to support integration.
- Data sharing, as well as different incentives and employment terms between sectors, pose challenges for integration.
- Assessing the effectiveness of integration schemes is difficult. Evaluation tends to focus on whether integration has relieved pressure on services, such as reducing emergency hospital admissions, which data suggest is not routinely achieved. However, integration may improve user outcomes and experiences, but data to assess these are not consistently collected.

Background

Health and social care services are facing two major population challenges. First, the UK has an ageing population. In 2010 there were three million people aged over 80; by 2020 this figure is expected to double.[1] Second, life expectancy has risen over the past 50 years. However, self-reported healthy life expectancy has not risen at the same rate and increasing numbers of people have multiple long-term conditions, such as diabetes or dementia.[2,3] In 2008 there were 1.9 million people with three or more long-term conditions; this is likely to rise to 2.9 million by 2018.[4]

The effect of this population shift on health and social care services is significant; over-75s use more than 60% of bed days in acute hospitals and 70% of the health and social care budget is spent on chronic conditions.[3,5] Increasing demand is one of the key factors causing funding gaps, estimated at £30 billion in the NHS and £4.3 billion in social care by 2020 in England alone.[6,7] Older people are likely to require both health and social care to meet their needs.[8] Better integration between health and social care has been put forward as a way to reduce costs, relieve pressure on services and improve user outcomes and experiences.[9,10]

Defining integration

Integration is a broad term and definitions vary. Recent policies across the UK that have encouraged greater integration between health and social care have tended to define it as care that is person-centred and coordinated across care settings. Integration can be within different healthcare settings (e.g. primary and secondary) or between health and social care services.[11] This POSTnote focuses on integration across health and social care. It also briefly covers broader models of integration, which seek to extend integrated care to include improving population health.

For care to be integrated, organisations and professionals must bring together all of the different elements of care that a person needs. Approaches to achieve this form a spectrum, from loose networks to full structural integration.[12] For example, health and social care staff working in separate locations may share electronic patient data. Alternatively, health and social care professionals may be physically integrated in a single location to improve multidisciplinary working. Integration schemes can seek to integrate care for a whole local population, or for specific sub-populations, such as older people or those with a

particular condition. Many schemes also include partnerships with voluntary and third sector organisations.[13]

Policies to enable integration in the UK

Integrated care policy in the UK has a long history. From case management in the 1980s, through inter-agency working in the 1990s, to integrated care pathways in the 2000s, successive governments have tried to bridge the divide between health and social care.[14] Across the four UK nations, health and social care systems are funded and operate differently; however, all have free healthcare at the point of access and all have committed to better integrated care. Coordinating resources or pooling budgets between health and social care is seen as an enabler for joint working.[15] However, integrating separately funded systems is challenging, especially in situations where healthcare is funded through taxation and social care is means-tested.[16] Recent policies across the home nations have established varying financial arrangements to support integration.

Wales

Health and social care services are separate in Wales. NHS Wales is responsible for healthcare, and Local Authorities (LAs) for means-tested social care. The 2014 Social Services and Wellbeing Act requires LAs, Health Boards and NHS Trusts in Wales to work together to look after the health and wellbeing of their local areas. In 2013, Wales established the Intermediate Care Fund. This fund (totalling £60 million in 2016/17) is used to support people to maintain their independence and remain in their own home, to avoid delays in discharge from hospital. It may be used by LAs, health and housing organisations and the voluntary sector.[17]

Scotland

Until recently, health and social care services were separate in Scotland. NHS Scotland is responsible for healthcare, and LAs for social care. Although most social care is means-tested, personal care costs for people aged over 65 years are not, following the recommendation of the 1999 Royal Commission on long-term care for the elderly (Sutherland report).[18,19] The 2014 Public Bodies (Joint Working) Act requires Health Boards and LAs in Scotland to enter into joint financial arrangements, either by one delegating functions and resources to the other, or both delegating to an integrated joint board. The Act also specifies expected health and social care outcomes for which Health Boards and LAs are jointly responsible. The Act came into force in April 2016 and 31 local partnerships have been established.

Northern Ireland

Since 1973 Northern Ireland (NI) has had one organisation responsible for healthcare and means-tested social care.[20] However, health and social care have continued to operate separately. A Government-commissioned review in 2011 suggested that the system was unsustainable and recommended a shift towards community care.[21] The report led to the formation of 17 Integrated Care Partnerships across NI, joining together GPs, social care, voluntary bodies and other services.[20] These built on pilots conducted in 2010.[22]

Box 1. The Better Care Fund in England

In 2013 the Government announced the Better Care Fund (BCF), a £3.8 billion pooled fund for Clinical Commissioning Groups (CCGs) and Local Authorities (LAs) to commission jointly health and social care services starting in 2015/16. The fund is not new money. It is £3.46 billion ring-fenced from NHS England's budget topped up with the Disabled Facilities Grant (DFG) and the Social Care Capital Grant (previously both paid directly to LAs). The BCF is allocated to local areas based on a formula derived from the CCG allocation formula, the social care formula and the DFG distribution formula. LAs, CCGs and Health and Wellbeing Boards agreed on plans for spending their BCF allocation in April 2015. Around half of local areas contributed additional funding, adding another £1.5 billion to the fund.[23] In 2016/17 the BCF increased to £3.9 billion, and from 2017/18 the Government will make an extra £1.5 billion available for the scheme.[24,25]

England

Health and social care services are separate in England. NHS England is responsible for healthcare, and LAs for means-tested social care. The 2014 King's Fund-established commission on the future of health and social care (Barker report), recommended that health and social care funding in England should be brought together in a single ring-fenced budget.[26] Policies in England have focused on encouraging local areas to coordinate resources. For example, in 2013 the Better Care Fund (originally known as the Integration Transformation Fund) was introduced to encourage financial integration between health and social care services (see Box 1).

NHS England's 2014 Five Year Forward View launched new models for different types of integration tailored to local needs (see below).[6] The 2015 Spending Review made a commitment to integrating health and social care further. It stipulated that every part of the country must have an integration plan by 2017, to be implemented by 2020, noting that the approaches taken by local areas will differ. Devolution to local government is likely to provide new approaches to integration between health and social care. For example, Greater Manchester Combined Authority (GMCA) was granted full control of its £6 billion health and social care budget in April 2016.[27] Although in early stages, GMCA has committed to a wider population health approach (see Box 2 for examples).[27]

Examples of integration in England

From 2009, the Department of Health (DH) and NHS England used three schemes to support local areas across England in developing plans for integration within healthcare settings and, in some cases, across health and social care. These schemes are outlined below, because they represent the largest dataset available on integration between health and social care in the UK. However, the broad approaches described have been used more widely across the UK.

Integrated Care Pilots

In 2009, DH launched a two-year integration pilot programme focusing on primary care. 16 local areas tested various integration schemes. Five schemes included efforts to integrate social care with GPs. For example, in Cockermouth, GPs, dentists, diagnostic teams and voluntary and community sector services co-located to

Box 2. Population health system approaches

The term 'population health systems' describes approaches that seek to improve the health of local populations, including tackling the wider determinants of health.[28] This requires coordination between organisations that provide not only health and social care services but also services such as housing support, education programmes and employment advice. It also requires coordination between different governance levels, from central government to local communities. These systems are emerging in a number of countries, including New Zealand and the US. A long-established system is Kaiser Permanente (KP) in the US. KP is a 'health maintenance' organisation, with over 10 million people on its register across nine regions.[28] KP integrates primary and secondary healthcare, focusing on prevention of illness as well as treatment, and uses risk stratification (analysing population data to identify possible future ill health) to tailor lifestyle interventions. Integration of social care services is currently limited to 'integrator' roles, where KP staff support members to connect with community-based social services, and more recently, institutional partnerships, such as KP medical care in assisted living facilities.[29]

Accountable Care Organisations (ACOs)

An ACO is a type of population health system. It is a network of independent health and social care providers sharing financial and medical responsibility for people on their register. Developed in the US in 2006, ACOs receive payments from the federal government for meeting cost efficiency and quality of care standards. Evaluations of ACOs in the US suggest that they are successful at delivering high quality care. However, financial results are mixed, with some reporting savings and others losses.[30] The model has been criticised for failing to integrate long-term care providers.[31] NHS England's Five Year Forward View states that some local areas will operate through similar arrangements to ACOs, for example Northumberland.[7]

provide care for older people. They also used virtual wards, where high risk patients were treated and monitored at home rather than in hospitals (see POSTnote 456).[32,33]

Integrated Care Pioneers

In 2013, 14 local areas (pioneers) were chosen through competition as exemplars of integrated approaches. 11 more sites were added in 2015.[34] The pioneers' approaches varied. For example, Greenwich Coordinated Care took a person-centred approach where people with high service use were assigned a care navigator to help individuals express their needs in specific 'I' statements (e.g. 'I would like to stop smoking' or 'I would like help with the damp in my home').[35] The care navigator then organised a multidisciplinary team meeting (including GPs, housing services and mental health workers) to develop an action plan to meet the 'I' statements.[36] Other pioneers worked with voluntary organisations to improve care provision, such as NHS Kernow's Living Well programme to improve care for older people in partnership with Age UK.[34] DH has commissioned a long-term independent evaluation of the Pioneers, which will run up to 2020.[37]

New Care Models

NHS England announced the 'New Care Models' in 2014.[7] Five models are being trialled across 50 local areas (vanguards); three of which include integration between health and social care.

- **Enhanced Health in Care Homes** is focusing on integrating services for older people in residential care.
- **Integrated Primary and Acute Care Systems** are trialling ways to join up GPs, hospitals, community services and mental health services. Some will operate like Accountable Care Organisations, a type of population health system (see Box 2).
- **Multispecialty Community Providers (MCPs)**, also a type of population health system, are testing ways to move specialist care out of hospitals and into the community. MCPs provide primary care as well as community-based health and care services.

Within each of these models, the approaches taken by the vanguards differ. For example, Calderdale MCP and Birmingham & Sandwell MCP have the same care model, but use different interventions. Calderdale MCP is co-locating a variety of community-based services (including GPs, social care and mental healthcare) in one place. Birmingham & Sandwell MCP is developing a health and social care system accessed through GPs, who assigns users a care coordinator who manages their care plan and access to services as outpatients.[38]

The challenges to integration

Research on integration schemes in the UK suggests that there are three key challenges, outlined below.

Data sharing

Health and social care providers regularly collect personal and confidential information about people in their care. This is regulated under the Data Protection Act 1998 and various other legislation (see Box 6 in POSTnote 474). Data sharing is vital for high quality integrated care. For example, social care workers assisting with medication management need access to NHS data on prescribed drugs. Sharing data also prevents duplication of effort, where providers unnecessarily take the same user information (e.g. allergies).[39]

Sharing data requires providers to ensure that it is used appropriately and legally. Integration schemes have reported problems with contradictory guidance around information governance from different government and NHS bodies.[16,34] Evaluation of the integrated care pilots in 2012 suggested that there is a culture of risk aversion, where some services are reluctant to share data because of continued uncertainties around lawful practice.[32] Data sharing between sectors can also be difficult as it requires information to be collected and coded following agreed practices before being stored on interoperable IT systems.[32] Steps have been taken to improve data sharing. In 2014, the Government appointed a National Data Guardian to build trust in the use of data across health and social care, including encouraging clinicians and care workers to share information to enable joined-up care.[40] The 2015 Health and Social Care (Safety and Quality) Act also introduced a legal duty for health and social care bodies in England and Wales to share information when it can facilitate care.

Incentives and targets

Health and social care providers have different audit systems and payment models, which can result in conflicting interests and a lack of incentives for building services

around users rather than organisations.[41] For example, tariff systems, where hospitals are paid for treating certain conditions, do not have a financial incentive for preventive care that reduces the need for hospital admission.[39] The UK nations have tried to reconcile these differences. In England, the BCF implemented financial risk sharing between providers.[25] In Scotland, the 2014 Scottish Public Bodies (Joint Working) Act legislates for shared accountability between providers.

Workforce practices

Integration schemes have reported 'hard' and 'soft' issues relating to integrating different professional groups.[42] 'Hard' issues include different employment terms (e.g. contracts and pension schemes), which can make transferring and sharing staff across sectors challenging. 'Soft' issues include different organisational cultures and attitudes towards collaboration and professional status. For example, social care professionals have reported that their skills are underutilised by healthcare staff, while healthcare workers report perceiving social care staff as unwilling to adapt to new practice.[43,44] High rates of staff turnover in the social care sector has also been reported as a challenge.[43] A rapid evidence assessment in 2013 for the Skills for Care charity found that training to meet new requirements and develop new skills and competencies was effective in helping to overcome some of these issues.[45] Quality and style of leadership have also been found to be important for delivering change and maintaining an integrated approach.[45]

Assessing effectiveness

Integration is sometimes suggested as a way to reduce costs.[9,10] However, there is little robust evidence that this is commonly achieved, with available reviews even reporting higher costs associated with some integration approaches.[16,46,47] Research suggests that this may be, in part, because integration can result in the identification of previously unmet need.[48,49] The dominant rationale for integrated health and social care is twofold:

- **Improving efficiency and value for money**.[50] This includes making more effective use of existing infrastructure to curtail rising costs. These outcomes are typically reported using organisational and infrastructure measures (see Box 3).
- **Improving users' experience, health and wellbeing**.[50] User outcomes are assessed by some schemes but are not consistently required and there are currently no nationally agreed measures (see Box 3).[25] The British Medical Association and the British Association of Social Workers consider that improved outcomes and experiences for users should be the primary objective.[51,52]

Evaluating schemes

Of the measures outlined in Box 3, reductions in non-elective admissions (NEAs) and delayed transfers of care (DToCs), both primarily NHS measures, are widely used to assess whether schemes have been effective.[24,25] Evidence from the integrated care pilots and other schemes suggests that a significant reduction in NEAs or DToCs is unlikely in the short-term.[32,53] Current evaluations of the BCF have also not shown sustained reductions in NEAs or DToCs.[54] This may be because there are long-term upwards trends in NEAs and DToCs for a number of reasons, and reversing these will take time.[55,56] Research also suggests that integration schemes may not reduce NEAs and DToCs if social care is underfunded.[57] Furthermore, assessing schemes via measuring DToCs and NEAs does not capture whether they have improved user outcomes and experiences. Research suggests that a combination of organisational and person-centred measures will provide a more accurate picture of effectiveness.[32] In addition, integration may have wider benefits in reducing health inequalities;[58] however, this is rarely measured despite the availability of indicators (e.g. Marmot Indicators).[59]

Integrating health and social care is complex and evaluation can be difficult because of policy and budget changes, which can make it challenging to attribute results to a specific intervention.[48] Experts generally agree that long-term evaluation is necessary because the effects of integration may take a long time to become apparent.[60,61] Intermediate markers of progress may be beneficial to assess whether schemes are making progress. The lack of an agreed set of measures for assessing integration schemes across the UK makes comparison between schemes very difficult.[62]

Box 3. Measures of effectiveness

Organisational and infrastructure measures

Two widely reported measures are:

- **Non-elective admissions (NEAs)**: The number of people who are admitted into hospital as an emergency. NEAs cost the NHS £12.5 billion annually and have risen by 47% in England over 15 years.[63]
- **Delayed transfers of care (DToCs)**: The number of patients ready to move from hospital care into social care but are unable to do so because of infrastructure delays between services (see CLB 7415).

Person-centred measures

Measures reported by some schemes, which could be used more widely are described below. Some schemes, such as those funded through the BCF, are required to report user experience, but there is no requirement to report health or wellbeing measures.[25]

- **User experience**: There are national measures used by the NHS to capture patient experience (e.g. the GP patient survey), which could be used or adapted to assess user's experience of integrated health and social care services. However, currently most schemes are using locally-developed measures.[24,25]
- **Health measures**: Relevant measures vary with the aims of the integration scheme, but can include survival rates and specific clinical measures, such as lung capacity for people with respiratory disease. Some studies also measure functional outcomes, such as the ability to perform daily activities.[64]
- **Wellbeing measures**: Improved wellbeing is an aim of multiple integration interventions but outcomes are rarely reported, even though various measures are available (see POSTnote 421).[6]

POST is an office of both Houses of Parliament, charged with providing independent and balanced analysis of policy issues that have a basis in science and technology. POST is grateful to Rowena Bermingham for researching this briefing, to ESRC for funding her parliamentary fellowship, and to all contributors and reviewers. For further information on this subject, please contact the co-author, Dr Abbi Hobbs.

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