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**Integration – reflections from Northern Ireland**

Michael Donnelly and Ciaran O'Neill

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Recognition of the need for organisations to collaborate to meet the changing needs of the population has led to the development of *Sustainability and Transformation Plans* (more recently referred to as *Sustainability and Transformation Partnerships*, STPs) in the English National Health Service (NHS). These five-year plans detail how local organisations will work together to implement local health and social care services in their area<sup>1,2</sup>. The STPs represent a fundamental shift potentially in the way in which services will be commissioned and provided. It is proposed that the current model, which is based on a separation of purchaser and provider functions as well as the separation of responsibility for health and social care services, will be replaced by a model which integrates these functions and responsibilities.

In assessing this change, it is helpful to consider the experience of other care systems. The Northern Ireland Health and Social Care System, a variant of NHS England, has a long history of integrated health and social care provision (dating back to 1973) as well as a model of commissioning in which the purchaser-provider split is less prominent. In Northern Ireland, health and social care services have been integrated since 1973, at least in 'structural' or administrative terms. The care system was reformed in 2009<sup>3</sup> to give increased emphasis to integration. For example, five Health and Social Care Trusts (HSC Trusts) were merged from 19 previous Trusts. The HSC Trusts are responsible for the provision of care (across the full hospital-community-primary care spectrum) in discrete geographical areas to an overall population of approximately 1.8 million. Currently, the planning and commissioning of services is the responsibility of a single Health and Social Care Board (HSC Board) (merged from four previous HSC Boards) and the new Public Health Agency, who co-operate and work jointly to meet population need.

Health and social care commissioning are integrated organisationally in the HSC Board which operates its commissioning and expenditure functions via 'Programmes of Care' (acute care, maternal and child health, family and child care, care of older people, mental health, learning disability, physical disability, primary health and adult community and health promotion and disease prevention). Programmes of Care are examples of the administrative structural features of the Northern Ireland model that, potentially, provide a platform for inter-professional, cross-disciplinary and inter-agency working, although the extent to which this organisational arrangement operates seamlessly and consistently across programmes is unclear. The Board in consultation with the PHA and Local Commissioning Groups (LCGs) commission services from Trusts in a mainly cooperative arrangement - there is no attempt to generate between-provider competition. Regarding 'mechanisms', the Board responds to DoH directions and priorities by producing an annual Commissioning Plan (CP); and each Trust receives an indicative allocation and is required to respond to the CP with a Delivery Plan about how it will meet health and social care needs.

In addition, LCGs with a strong general practitioner (GP) presence and representation from other care professions, voluntary sector care providers, service users, carers and local councillors, work as committees of the HSC Board and in parallel with their co-terminus HSC Trust. The HSC Board has responsibility also for the performance management of the integrated system. Debate is ongoing about duplication surrounding commissioning functions (despite the relatively recent nature of the reforms) where, for example, the role of LCGs is not realised fully due to the operation of the HSC Board with its large staff and established procedures relative to the newer LCGs. There have been proposals for the

abolition of the HSC Board or for it to be incorporated into the government DoH and the PHA in an attempt to reduce bureaucracy and devolve accountability functions to local populations.

There is limited research about how well Northern Ireland's version of integrated care and commissioning 'works'; what research there is, together with government commissioned reports and audits, do not provide clarity regarding benefits or otherwise. However, there are concerns with the performance of the system. Several studies have shown that productivity in Northern Ireland is lower than in England<sup>4,5,6,7,8</sup>. For example, Appleby<sup>5</sup> found that unit costs for day case, elective and non-elective inpatient treatments and all other activity in 2008 were higher in Northern Ireland than in England, just over one-fifth higher in the case of all activity; and that acute activity per head of hospital and community health service staff was between 17% and 30% lower in Northern Ireland than in England. It may be argued that the emphasis on cooperation rather than competition in the NI HSC system has adverse consequences for performance. It has also been suggested that the Northern Ireland care system appears lacking in strategic direction<sup>8</sup>. The extent to which differential needs, scale, geography or efficiency are sacrificed for political reasons (as politicians avoid difficult decisions about, for example, hospital closures) may explain the 'performance' of Northern Ireland's care system is unclear and requires research attention.

Conditions conducive to integrated care include, for example, agreeing goals and functions that reflect the importance of the separate and combined contributions of health and social care to well-being and an incentive structure that encourages the pursuit of goals and that rewards success. There may be a tendency for individual agents and agencies to unequally

share in the costs and benefits of integration, when responsibility is diffuse and accountability is unclear. Also, there is a need for capacity to move resources between previously distinct budgets and to plan resource utilisation strategically. Current structures and practices may be sources of resistance to change and it is important to be mindful that policy implementation does not tend to occur in an orderly fashion. Unintended consequences may emerge and policy adaptation may be required when the interests of different agents misalign, incentives do not work, risk management proves difficult or local conditions present challenges. A pragmatic developmental approach that involves testing what works and using lessons to develop programmes and systems in specific conditions may be suited better to serving the public interest than perhaps has been the case regarding policy formulation in the past<sup>9</sup>.

The limited available empirical studies regarding the Northern Ireland model of integrated commissioning and care provision suggest that there may be benefits in terms of, for example, a single budget, sharing of information across professional boundaries, and the development of integrated care pathways but that an administratively integrated structure *per se* is insufficient to bring about substantively positive outcomes for patients or health and social care system efficiencies. There is a need to give priority attention to whole-system thinking, inter-professional education and, generally to cultural values and differences between health and social care and hospital and community and primary care in order to achieve genuine integrated commissioning and service delivery<sup>10,11</sup>. Reflecting on policy history, it is difficult to disagree with Bevan's view that, "*We shall never have all we need. Expectations will always exceed capacity. The service must always be changing, growing and improving – it must always appear inadequate.*"<sup>12</sup>. It is important that future

policy and service organisation and delivery reconfigurations such as proposed STPs should be subjected to empirical inquiry and be research-informed.

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