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What have we learnt about joint working between health and social care?

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Abstract

Joint working between local authorities and the NHS has been an integral part of health and social care policy in the United Kingdom for many years. Using evidence from two literature reviews this article argues that there is little indication that joint working delivers the outcomes envisaged in policy. While recent reforms may be beginning to influence improvements, they are undermined by constant reform and professional scepticism.

Key words: joint working; integration; evidence

Introduction

Joint working, or its more recent variant integration, has been an integral part of health and social care policy in the United Kingdom (UK) for decades. Indeed the quest for more effective collaboration is regarded as a 'wicked issue' (Rummery 2006). Over the years successive governments have used a range of strategies to encourage improvements, focusing their attention on different aspects of joint working to reflect their various aspirations. Hudson (1987) has characterised these strategies as: co-operative (based on mutual agreement); incentive mechanisms (inducements) and authoritative strategies (mandates). Using evidence from two reviews this article argues that there is little evidence to suggest that these reforms have met the outcomes envisaged in policy. While recent administrations have focused on reforming the mechanism that support joint working, this article suggests that scant attention has been paid to deep seated differences between professions which appear to undermine these efforts.

Policy context

The 1970s saw the UK government introduce a series of reforms designed to encourage local authorities and their NHS partners to jointly plan and finance health and welfare services. Evaluation of these initiatives identified a series of problems including a lack of consistent planning mechanisms; poorly defined responsibilities; concerns about cost shunting and an emphasis on structures rather than process (Sumner and Smith, 1969, cited in Wistow 2012). The Audit Commission (1986) characterised these difficulties as a type of 'culture shock' frustrating joint working.

During the 1980s and 1990s the UK government, in common with other countries, introduced a series of reforms underpinned by a belief that welfare services could be made more efficient if features of private sector management were introduced. Concerns about the lack of responsiveness and flexibility of statutory social care services led to the establishment of what became known as the mixed economy of care. In response to these developments research explored not only whether the introduction of market reforms fostered greater collaboration or competition between agencies but also how care was co-ordinated within the mixed economy (Knapp et al 2001). Furthermore, in order to improve

the co-ordination of care at the interface between the community and secondary care settings the Conservative government encouraged the development of intermediate care services (Vaughan and Lathlean, 1999).

While the New Labour government was keen to draw a line under their predecessors' preoccupation with the marketization of welfare, its reforms show remarkable consistency. The Health Act 2000 introduced specific mechanisms (known as 'flexibilities') that enabled local authorities and NHS partners to work closely together, for example the act sanctioned the use of pooled budgets as a means to jointly fund and merge services to provide a single point of access. New Labour then turned its attention to emphasise the need for greater structural integration. The NHS Plan 2000 gave local authorities and their NHS partners the opportunity to integrate social care, mental health or primary care services into Care Trusts. Such reforms responded to concerns that structural obstacles related to the different organisational arrangements of local authorities and health authorities undermined collaboration. At an operational level the introduction of the Single Assessment Process (SAP) saw attempts to improve the way in which professionals assessed individuals in the hope that service users would experience a more streamlined assessment (DH, 2001), while a call for greater role flexibility reflected a belief that professional boundaries inhibits person centered care (DH, 2000). New Labour also targeted specific 'pinch points' in the relationship between local authorities and NHS. For example the Community Care (Delayed Discharges, etc) Act (DH, 2003), mandated that social services departments had to pay the NHS up to £120 per day if they failed to arrange the discharge of patients from hospital.

Against a backdrop of concern about the need to reduce welfare spending and concerns about an ageing population the Coalition government, elected in 2010, continued with these reforms, although the emphasis given to joint working as a strategy to reduce public spending was more prominent. The 2010 White Paper 'Equity and Excellence, Liberating the NHS' emphasised the importance of the Health Act 'flexibilities' suggesting that these arrangements could unlock 'efficiencies' (DH 2010). The Health and Social Care Act 2012 saw the coalition initiate statutory health and wellbeing boards as a means to bring together locally elected councillors with commissioners of services from the NHS and local

government. These boards are charged with publishing a Joint Strategic Needs Assessment to inform local commissioning. In an effort to incentivise organisations to work together more effectively the government announced the introduction of the Better Care Fund to support transformation and integration of health and social care services, with part of the payment 'dependent on performance' (DH, 2013). Although this policy has at its heart a narrative of integration that reflects the experience of users it emphasises a belief that 'there is real potential to achieve improved outcomes for less money …' (DH, 2013:14).

Conceptual confusion

Despite the level of activity, this field is characterised by a lack of conceptual clarity about the nature of relationships government seeks to encourage. Whether talking about joint working, partnerships, collaboration or intermediate care the precise nature of these models is often unclear (see for example Steiner's 2001 discussion of intermediate care). The same confusion is apparent in policy regarding integration, with Goodwin (2013:1) noting 'the polymorphous nature of the term that has been applied from several disciplinary and professional perspectives and one that is associated with diverse objectives.' Similar confusion is noted in the international literature (Armitage et al 2009). While such concerns may appear esoteric, they are important. The different forms of activity that government wishes to encourage may require different supporting mechanisms. More worryingly, government aims may have conflicting outcomes; the push for greater structural integration for example, may undermine joint working within the wider health and social care economy.

The reviews

In order to investigate what impact these reforms have had on joint working between local authorities and their NHS partners in the field of adult services, colleagues and I were commissioned to conduct two reviews of the literature, the first in 1999 and the second in 2012, details of the methodologies are discussed elsewhere (Cameron et al, 2000, Cameron et al, 2013). Taken together they provide an opportunity to consider the evidence base in relation to the different policy aims of successive governments over a 30 year period in order to tease out whether or not the objectives have been met. Let us now consider the results of these reviews.

Models of joint working

The models of joint working identified were consistent across both reviews although the emphasis given to them in each reflected trends in policy. In the first review the most frequently identified model was the 'placement scheme' where staff from one agency are placed in a setting run by another, for example social workers located in a GP practice. The next most common model was the 'team', which included multi-agency or multi-disciplinary teams, the majority in mental health. There were also examples of studies evaluating strategic initiatives such as joint planning and joint commissioning.

In the second review the most frequently evaluated model were teams, including specialist teams, for example crisis intervention teams, as well as generalist teams such as community mental health teams (CMHTs). It also included evaluations of intermediate care services, structurally integrated services as well as a small number of studies evaluating SAP. Finally there were evaluations of the use of the Health Act flexibilities.

Evidence of effectiveness

A significant finding of the first review was the lack of studies exploring the effectiveness of joint working. The first review reported only one study from the UK that met the inclusion criteria. Corney (1984) evaluated the impact of social workers, placed in GPs practices, working to alleviate depression amongst women patients. Findings did not suggest that there were any statistical differences in terms of clinical or social outcomes between women receiving this intervention and those that didn't.

A similar message emerged from the second review. However, trends in the data suggesting that improvements could be achieved were apparent. Several studies reporting evaluations of integrated care noted that patients experienced improvements in quality of life, health, and coping with everyday living (Asthana and Halliday, 2003, Clarkson et al, 2011; Kaambwa et al, 2008). Although in studies using more robust study designs, for example comparing different types of integrated and non-integrated care, only marginal differences in outcomes were reported (Carpenter 2004, Rutter et al, 2004). Evaluations of intermediate

care services , such as rapid response teams, that were designed to support people to remain in their homes rather than be admitted to residential care or hospital, found that these outcomes could be achieved (Brooks 2002, Beech et al, 2004; Kaambwa et al, 2008). However, these findings appeared to reflect the different levels of need amongst patients as well as their access to support at home. Significantly, in studies that compared outcomes for older people using new integrated health and social care teams with those receiving standard care, no statistical differences were found (Brown et al, 2003, Davey et al, 2005). In other words the way in which services were organised did not influence whether or not older people were admitted to residential care or hospital.

The review revealed that studies that attempted to assess costs and cost-effectiveness of joint working or integration were hampered by a lack of economic data, as well as data that was dated. Additionally the different approaches to integration made such evaluations more complicated. As a result studies found it difficult to draw any conclusions about the cost impact of different services. For example Ellis et al's (2006) study comparing a joint NHS/Social services rehabilitation unit for older people on discharge from community hospital, with 'usual' community services found that costs were almost identical for both models of care. Similar findings were found in other studies that compared integrated services provision with traditional models of care (Davey et al 2005; Denniston et al 2000). However there were indications that intermediate care services can be cost saving. Kaambwa et al. (2008) compared the cost of five intermediate care schemes in relation to health outcomes for older people against patients admitted as part of a supported discharge scheme and found that patients admitted as part of hospital avoidance schemes experienced greater health and functional gains. Additionally these hospital avoidance services cost less compared to supported discharge cases.

Although there is little 'hard' evidence of effectiveness either in relation to clinical outcomes or cost, the second review suggests that initiatives, particularly those related to integrated or intermediate care, have the potential to improve patient outcomes and reduce cost.

Service user experience

The second review also explored service users' experiences of joint and integrated services. Once again the evidence was limited but it indicated that the quality of an individual's experience can be enhanced. Evaluations of structurally integrated services reported high levels of satisfaction with joint working arrangements (Carpenter et al, 2004). In particular studies noted that service users appreciated: more timely initial assessment and subsequent interventions; improved co-ordination and communication between agencies and help to navigate services (Brooks 2002, McLeod et al, 2003, Freeman and Peck 2005). Disappointingly, studies that reported dissatisfaction noted poor communication between agencies and a lack of choice in the services received (Asthana and Halliday 2003, Beech et al, 2004).

Factors that support or hinder joint working

Across both reviews there was a high degree of uniformity in the factors that were identified as either supporting or hindering joint working. These factors are classified as: organisational issues; cultural and professional issues and contextual issues.

Organisational issues

Both reviews revealed a range of difficulties related to organisational structures and cultures that appeared to confound joint working. The first review noted that the different agenda and interests of the NHS and their local authority partners, as well as the complexity of planning processes, made strategic agreement difficult to achieve (Costongs & Springett 1997, Hudson et al 1997). Similar concerns were apparent within the second review with Drennan et al (2005) and Regen et al (2008) noting the problems of establishing a shared vision as well as difficulties turning divergent strategic agendas into operational reality. While the existence of different funding mechanisms could frustrate attempts to develop joint assessment mechanisms (Gibb et al, 2002), the use of unified or pooled budgets, introduced under the Health Act, were thought to have made the process of strategic resource allocation more transparent and equitable (Drennan et al, 2005).

The importance of professionals understanding the aims and objectives of any joint initiative was a theme that emerged in both reviews. However in the second these concerns were

noted almost exclusively in studies exploring the introduction of integrated services, including intermediate care (Glasby et al, 2008, Clarkson et al, 2011). Both reviews highlighted difficulties associated with a lack of clarity and understanding about the roles and responsibilities of the agencies and professions involved in joint working (Abbott 1997, Glasby et al, 2008). Such problems led to inappropriate referrals and delays in treatment (McCormack et al, 2008) as well as confusion and protectionism amongst staff (Dickinson 2006). Importantly the second review identified the importance of role flexibility in supporting the aims of intermediate care, ensuring that services were more responsive to the needs of service users (Regen et al, 2008, Rutter et al, 2004).

The complexity of management, particularly within multi-agency teams and integrated care services, was thought to impede working. The existence of separate management structures created tension between professional and service management (Higgins et al, 1993) and reinforced uni-professional responses (Rutter et al, 2004, Christiansen and Roberts 2005). In contrast strong management and appropriate professional support was essential to staff feeling confident in their new team or role (Henwood et al, 1997, Gibbs et al, 2002, Asthana and Halliday 2003) and contributed to better outcomes for users of services (Clarkson et al, 2011, Brooks 2002).

Communication and information sharing difficulties was a significant feature of both reviews. However, while the first review noted that poor communication was often compounded by complex and inappropriate documentation (Henwood et al 1997) as well as a lack of adequate or compatible IT systems (Higgins et al 1993 Ross and Tissier 1997) the second emphasised concerns about the appropriateness of electronic information sharing (Drennan et al, 2005, Kharicha et al, 2005). When effective communication and information sharing processes were established studies reported improvements, including speedier and timelier assessments (Brown et al, 2003, Brooks 2002, Rutter et al, 2004). In both reviews the co-location of staff was regarded as facilitating improvements in understanding (Rutter et al, 2004) and communication (Gibb et al, 2002).

Cultural/ professional issues

Differences in professional philosophies and ideologies were a feature of both reviews. In the first review Higgins et al (1993) identified problems caused by different degrees of professional autonomy which were acceptable amongst the various professions working in multi-agency teams. Such differences resulted in the emergence of distinct professional working practices, including working to different assessment procedures (Abbott 1995). Similar problems were identified in the second review with Gibb et al, (2002) noting that staff working for the NHS or social services differed in terms of the type and level of decisions they could make, additionally Burch and Borland (2001) found that different understandings of concepts such as 'risk' led to divergent practice in relation to the discharge of older people. Such differences led to the emergence of distrust, professional rivalries and professional defensiveness (Hudson and Willis 1995, Glasby et al, 2008, Scragg 2006).

One of the over riding themes to emerge from both reviews was the damaging impact of professional stereotypes and negative assessments of the different professions working together (Auluck and Iles, 1991). These were particularly, but not exclusively, apparent between health professionals and their social work colleagues. Challis et al, (1991) for example described district nurses' lack of confidence in home care assistants while Carpenter et al, (2003) noted that social workers based in multi-professional teams experienced higher levels of stress and role conflict compared to their health colleagues due to a perception that their professional values were under threat working in health dominated CMHTs.

Contextual issues

The context of joint working is an important influence on its success. Studies in both reviews reported that constant reform of the sector undermined relationships (Hodgson 1997) and diverted attention away from operational issues (Taylor 2001, Gulliver et al, 2002, Glasby et al, 2008). Not surprisingly the impact of financial uncertainty remained a consistent feature, for example anxieties about cost shunting between organisations was thought to lead to distrust between partners (Hudson and Willis 1995) while concerns about

a lack of dedicated funding for integrated services was reported to undermine initiatives from the outset (Regen et al, 2008).

In the first review government failure to resolve issues such as charging for social care and on-going debates about the nature of continuing care (Hudson et al, 1997) were perceived to impede collaboration. While the second review revealed that front line staff did not always understand or support the introduction of integrated services. Professionals were concerned that the needs of acute healthcare were dominating these developments at the expense of the interests of community services (Glasby et al, 2008).

Discussions

While successive governments have remained consistent in the emphasis given to joint working the evidence suggests that this strategy is not meeting its stated aims. There is no conclusive evidence that joint working or integrated services either improves clinical or organisational outcomes or that it can 'unlock efficiencies' (DH 2012). However, the most recent review did suggest that integrated services can lead to improvements in the experiences of users of services and their carers (Cameron et al 2014). Not withstanding the methodological limitations of the existing evidence base how can we explain why joint working has yet to meet the expectations of government?

<u>Shifting sands</u>

A clear message from both reviews is the importance of stability for joint working to flourish. Stability, at both a strategic and operational level, helps to build familiarity and secure more trusting relationships, as well as giving initiatives the opportunity to 'bed down' and effect change. However, constant reform over 30 years has done little to ensure this. Moreover initiatives such as the Delayed Transfer Fine may have exacerbated concerns about cost shunting inducing a climate less favourable to productive joint working, while the recent introduction of the Better Care Fund with part of the payment 'dependent on performance' may accentuate similar tensions. Additionally, recent initiatives to transform community health services may have played a significant part in unsettling key relationships (DH 2009). For example, suggestions that community health services might integrate

vertically with acute health trusts may be interpreted as further evidence of the marginalisation of community services, exacerbating the concerns reported in evaluations of intermediate and integrated care services.

Despite this turmoil there is some indication that recent attempts to support closer working, through the use of the Health Act flexibilities as well as operational initiatives such as SAP and intermediate and integrated services appear to be paying dividends, particularly in relation to improving the experience of those using services. Moreover in an effort to improve understanding of this agenda recent policy guidance (DH 2013) offers a clearer articulation of the aims of integration. So in that sense closer attention to the process of joint working and integration allied to a clearer articulation of intent may support further improvements. However, these developments appear to ignore a critical element of the problem.

Professional differences

While successive reforms introduced to support organisations to work together more effectively may have done much to lessen the 'culture shock' identified by the Audit Commission in 1986, the findings of both reviews suggest that deep seated differences in culture, philosophies and values continue to undermine effective joint working. While some of these differences may be partially ameliorated through regular team meetings and team building events which foster better understanding of roles and responsibilities or through the introduction of flexible roles that enable professionals to work across professional boundaries, they are unlikely to resolve the negative assessments and stereotypes reported in both reviews.

Such negative perceptions suggest that professionals are entering practice with little appreciation of the different professional groups they will encounter in integrated services. Sadly these difficulties will continue to frustrate attempts to improve joint working unless government, working with professional bodies and education providers, ensure that opportunities are available through which the different professions can begin to appreciate and value each other's contribution and build a shared understanding of the significance of

joint working or integration in their area of practice. As the Centre for the Advancement of Inter-Professional Education has argued, 'education and training for collaboration and cooperation/ working in this different way is essential' (CAIPE 2012:2). Without such investment we may endure further decades of missed opportunities.

Conclusion

While effective joint working in the field of health and social care for adults has long been a holy grail of government, the evidence presented in this article suggests that it remains elusive. Successive governments have introduced a range of initiatives focusing on both strategic and operational levels and have used co-operative, incentive and authoritative mechanisms to encourage improvements. However, while some of these initiatives may now be beginning to bear fruit, they are undermined by constant reform of the sector. Additionally a preoccupation with the process and mechanisms of joint working has diverted attention away from the central role played by the professions, who appear sceptical of the aims of these initiatives and distrustful of their professional colleagues. Perhaps it is now time to turn attention to these professional differences.

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