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Providing integrated health and social care for older persons issues, problems and solutions

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# Providing integrated health and social care for older persons in the United Kingdom

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# **Developing Joined-Up Thinking and Seamless Care: National Report on Integrated Health and Social Care Provision for Older People in the United Kingdom**

Andy Alaszewski, Jenny Billings, John Baldock, Julia Twigg, Kirstie Coxon

May 2003

*The Government has made it one of its top priorities since coming to office to bring down the 'Berlin Wall' that can divide health and social care and create a system of integrated care that puts users at the centre of service provision (DoH, 1998, chapter 1 section 6.5).*

## **Introduction**

This report provides an overview of the development of integrated health and social care provision for older people in the UK. It explores why integration is important, identifies the main impediments to effective integration, considers failed past attempts and current initiatives designed to promote joined-up thinking and seamless care for older people, identifying the main models.

In the first two sections of this national report, we examine the national context within which health and social care provision has developed, and consider the extent to which recent policy changes encourage the move towards seamless health and social care. In the third section we review existing models that have evolved in response to the challenges facing these services today. In the annex we provide more detailed descriptions of specific initiatives that provide exemplars of the main models identified in the third section.

## **Defining 'Integrated Care'**

Section two of this report illustrates that increased 'integration' of health and social services has been a policy objective of UK governments since the 1960's. A variety of terms have been used for this, including 'joint working', 'partnership' and 'collaboration', but the actual meaning of 'integrated care' has never been clearly defined within policy documents – there is a sense that understanding of this and other related terms is taken for granted or assumed. As part of their remit to support the modernisation process within public bodies in the UK, the Audit Commission has produced a paper on integrated care. Within this document, a 'systems model' of organisational partnership is employed, and the following definition of partnership or 'whole system working' is proposed:

“Whole system working takes place when:

- Services are organised around the user
- All of the players recognise that they are interdependent and understand that action in one part of the system has an impact elsewhere
- The following are shared:
  - Vision
  - Objectives
  - Action, including redesigning services
  - Resources, and
  - Risk
- Users experience services as seamless and the boundaries between organisations are not apparent to them.” (Audit Commission 2002 Section 1.2)

## **1. The National Context**

In this section we will describe some relevant demographic issues, the main components of the service delivery system and consider the unique features of the political and policy-making system.

### **Demography of the UK – an ‘aging society’ (DoH 2001a p.1)**

The current population of the UK is approximately 59 million. The most recent census in 2001 found that about 20% of the population is aged over 60, with about 1.1 million people are aged 85+ (Summerfield and Babb 2003) and the numbers of very elderly people (80 and above) is predicted to double by 2025 (DoH 2001a). This increase will directly affect the health and social care services that provide care to vulnerable persons in this age group. In the UK, public funds pay for about 80% of health care (OECD 2002). Already, about 40% of the healthcare budget and 50% of the social care budget is spent on older people, amounting to an annual cost in excess of £15 billion (about 21 billion EUR).

**Table 1. UK Demography and Health Expenditure**

	<b>1980</b>	<b>1990</b>	<b>2000</b>
<b>UK Population (millions)</b>	55.9 (approx)	57.8	58.8
<b>% UK population over 65 years</b>	15%	16%	16%
<b>Public Expenditure on health (as % of GDP)</b>	5%	5%	5.9%
<b>Total Expenditure on health (as % of GDP)</b>	5.6%	6%	7.3%
<b>Expenditure per capita £ (EUR)</b>	£270 (409 EUR)	£590 (897 EUR)	£1071 (1627 EUR)

Sources: OECD Health Data 2002 (4<sup>th</sup> Ed), Social Trends 2003, no.33 ‘Population’ (Chapter 1) pp31-35

## 1.1 Health and Social Care Service Delivery – Organisation and Process

In the UK, the state plays a key role in funding and providing health and social care. The state has delegated the prime responsibility for service planning and resource allocation to two discrete organisations, the National Health Service (NHS) and Local Authority Personal Social Services Departments. However, in contrast with much of the rest of Europe, both these agencies operate in the short term, within fixed, cash-limited budgets. That is to say, resources are supply-determined and not a function of demand. There are fundamental differences in the ways these two sets of agencies are funded and operate (see 1.2), and this has been a major contributory factor to the health and social care divide in the UK.

### Access to health services

Individuals may refer themselves to their own general practitioner (GP), a community-based doctor who specialises in all aspects of family health. The GP will assess their medical needs and should also recognise where social needs are becoming an issue, and is obliged to refer a patient to acute hospital services, where necessary. The GP is effectively a gatekeeper for acute medical services, and screens individuals according to clinical criteria before making a referral to secondary services (Ham 1997). All health services including GP consultation and hospital treatment are free to the patient, and secondary services are effectively ‘accessed’ by the GP on the patient’s behalf. In emergencies older people or their carers can bypass their GPs and gain direct access to more specialist services through A & E or through direct contact with a social services team.

### UK Provision of Health Care

**Table 2 – Health Care Provision (UK) – 1980-2000**

	<b>1980</b>	<b>1990</b>	<b>2000</b>
<b>Physicians per 1000 people</b>	0.9	1.4	1.8
<b>Acute beds available</b>	3.5	2.8	3.3
<b>Average (acute care) length of stay (days)</b>	8.5	5.7	6.2

Source OECD (2002)

As Table 2 suggests, there is a trend in the UK for a reduction of acute care beds, and also in hospital ‘length of stay’, despite an overall rising admission rate for chronically ill elderly people. In common with the rest of Europe, this has led to increasing pressure on acute care beds with concomitant cost increases (Saltman 1998), and policies directed towards greater provision of community and social care resources. Recognition of these challenges has led to many initiatives, such as intermediate care (DoH 2001a), pooled funding (Health Act 1999) and ‘partnership proposals’ (DoH 2003b), all of which are designed to reduce the use of in-patient services and increase the availability of ongoing care in the community, and these services are discussed more fully in Section 3 of this report. These new and developing services necessarily involve closer working between health and social care professionals at every organisational level, and it is perhaps worth commenting that their genesis is a result of financial and service pressures upon the health service rather than a desire on the part of these professions to work in a collaborative manner.

### **Access to Social Services.**

Recent statistics suggest that about 13% of social services referrals are generated the community by GP's or district nurses. Individuals or their carers can also contact social services directly, and about 31% of referrals to social services comprise either self-referrals or referrals made by families (or informal carers) of vulnerable clients (DoH 2000b). This means that the majority of social services referrals are actually generated by acute hospitals, and therefore occur after some crisis event, such as a fall or a period of illness, has led to hospitalisation.

Thus, the need for integrated services is often first identified in the health setting. In cases where the physical and mental condition of an older person worsens gradually, then the general practitioner should recognise that immediate carers are no longer able to cope and refer the older person for an assessment of care needs. When there is an emergency such as a fall, then hospital plays a key role. In a hospital setting, a multidisciplinary team comprising nurses, doctors, physiotherapists, occupational therapists and social workers should start discharge planning as soon as an older person is admitted and in consultation with the older person and their carers, assess the person's need for continuing care and agree a package of care. The main aim is to identify a package of community health service (district nursing), social care and adaptations to the home, which will enable the older person to return home and maintain independent living.

A key factor in achieving this is of course the availability of suitable housing for older people with increasing needs. This issue leads to a further need for integration between local housing providers (often local authorities, but many 'social housing' and 'sheltered housing' schemes are privately funded and managed) and both health and social care providers. The importance of housing within integrated care has been highlighted within current government policy statement (DoH/DETR 2001), with a view to improving both provision of appropriate housing and increased information to users, carers and professionals about what is available. This is particularly important because when the risks of discharge home to existing accommodation, or simply remaining at home, are considered too be too high then a temporary, or permanent, residential placement may be recommended.

The decision to implement a package of community care, or residential placement, is generally achieved by conducting a 'joint assessment'. These are one-off meetings held either in the hospital or community setting (depending on where the patient is), specifically to assess care requirements and plan provision accordingly. The key professional members present at these meetings are a qualified nurse (ideally the named nurse for that patient), a care manager, occupational therapist/physiotherapist (depending on the need for input from either profession), the patient themselves and very often their immediate family or informal carers. This group considers the professional assessments of the multidisciplinary team together with the thoughts and wishes of the patient as part of the process of care planning.

Once agreement is reached, the resulting package of care is accessed in a fragmented way. The nurse refers to district or community services, and any services provided by this professional group will be free to the service user. The care manager accesses the domiciliary care services, and the therapists will liaise with their own bureau to effect



adaptations or request equipment - for both of these groups, the provision of care is means-tested, and the recipient may have to contribute to the cost or even pay the full cost, depending on income and level of savings. Rehabilitation care becomes even more confusing –if the service is provided by health (for example a ‘hospital at home’ scheme or community hospital ‘step down’ bed) it will be free to the patient, but if social services are the provider (e.g. residential rehabilitation beds) then the client may be means tested – and this is in turn dependent on local funding and commissioning agreements. This fragmentation of service provision is compounded by the restriction of information. The record of the assessment is usually held as a hard copy in the patient’s hospital notes rather than being held by the patient, (and hence not accessible to any community practitioner at a later stage). The government is committed to the development of electronic records which users and health professionals can access to enable health professionals ‘maintain continuity of care and knowledge of their patients’ (DoH, 2000a, p. 19).

The different definition of and approach to individuals in receipt of services is one of the key observable differences in culture between health and social services. Social services refer to their users as ‘service users’ or ‘clients’ (O’Hagan 2001), and have tended to develop models of service provision that attempt to involve the user as an autonomous person (Davies 2000). Whilst health services have also become increasingly aware of the disempowering nature of medical jargon, even health policy documents continue to refer to ‘patients’ (e.g. DoH 2000a).

In addition, the relationship between health and social services is asymmetrical, with the NHS being the senior and dominant partner (Hudson 2002, Roberts 2002). The NHS enjoys considerable public and political support, created as it was in 1948 as one of the major pillars of the welfare state in the UK. Its main service providers, doctors and nurses, continue, despite some high profile disasters, to enjoy high public esteem and trust (Finley 2000). In contrast social services have, since their formation in the 1970s, been subject to a continued media and political criticism. In part this relates to the ‘residual’ nature of the services provided to vulnerable groups who can be victimised and portrayed as ‘welfare scroungers’ (Finlay 2000). It is also connected to highly visible failures, especially the failure to protect vulnerable children from abuse for which social services and social workers take the main responsibility and blame. The relatively low standing and status of key service providers including social workers, home helps and care staff at residential units further demonstrate the unequal power balance between these two agencies.

This asymmetrical relationship between health and social services is one of the major impediments to effective collaboration between the two agencies. It is a source of tension, even mutual antagonism between the two agencies. Longstanding inter-professional ‘turf wars’ have led to what might be considered mutual incomprehension between health and social care workers, a situation which in Hudson’s view is mediated by the extent of disagreement between two or more professional groups (Hudson 2002). This type of environment is not conducive to effective collaboration and provides one of the major impediments to the development of joint working.

A further significant difference is that the level of funding for the NHS and for Social Services is not equal (see Table 1, p.4). The health service currently receives 70% of



the £35 million total budget for health and social care. About half of all social service expenditure is likewise spent on older people (DoH 2003). The health service is therefore perceived as being both better funded and a relatively more deserving recipient of public funds (DoH 2001a, p.1). Table 3 (below) suggests there has been a 50% increase in social services expenditure since 1990, and also an increase in the number of individuals receiving social services assistance, and Table 4 illustrates the shift from public to independent provision of social care that has occurred in the UK.

## **UK Provision of Social Care:**

**Table 3 – Social Services Expenditure 1990-2000**

	<b>1990</b>	<b>2000</b>
<b>LA personal social services expenditure</b>	<b>£5.3 billion</b>	<b>£10.1 billion</b>
<b>Expenditure on residential care (elderly)</b>		<b>£3.45 billion</b>
<b>Expenditure on non-residential care (elderly)</b>		<b>£1.72 billion</b>
<b>Number of households receiving domiciliary social care</b>		<b>400,000</b>
<b>No of individuals in LA supported residential care (nb all care groups – elderly account for 80% of bed usage)</b>	<b>125,000 (approx)</b>	<b>261,800 (approx)</b>

Source: DoH (2003)

**Table 4 Increased Use of Independent Sector for Personal Social Services 1997-2001**

	<b>1997</b>	<b>2001</b>
<b>Contact hours</b>		
Provided by Local Authority	1.5 million (56%)	1.16 million (44%)
Provided by Independent sector	1.1 million (39%)	1.7 million (61%)
<b>Total Contact Hours</b>	<b>2.6 million</b>	<b>2.86 million</b>
<b>No of households receiving home help/personal care</b>		
Provided by Local Authority	335,100	194,300
Provided by Independent Sector	144,000	205,300
<b>Total no of households receiving support</b>	<b>479,100</b>	<b>399,600</b>

Source: DoH (2003)

## **1.2 Government and Policy-Making in the UK**

In relation to health, policy making for older people has been largely influenced by a ‘policy community’ or ‘iron triangle’ (Haywood and Hunter 1982) centred on the Department of Health. This involves ministers and professional expertise within the department, as well as national groups such as the British Geriatric Society. The use of professional expertise in developing policy can be clearly seen in the development of the National Services Framework for Older People, a recent document setting out

national standards of care (DoH 2001a). The Department used ten reference and task groups to provide expertise for the development of the framework. These groups were chaired by senior professionals or academics and included experts with diverse backgrounds and institutional affiliations (DoH, 2001a, pp. 161-171).

With respect to fiscal policy, the UK has a highly centralised system. While there is some devolution to national assemblies in Scotland, Wales and Northern Ireland, the control of the Treasury over fiscal policy and allocation of public expenditure means that effective decision making is concentrated in the so-called ‘Whitehall Village’. Within this village there is fragmentation and competition between the major spending departments, for example between the Department of Health and the Department of Education.

The NHS is a centrally directed service accountable to the Secretary of State for Health who sets the budget. It is ‘universalistic’, providing a service for all citizens who have a health need (mainly) free at the point of delivery funded from the central exchequer. Under current service provision arrangements, health care is ‘commissioned’ or bought, by local Primary Care Trusts (PCTs). These are groups of health and social care professionals (e.g. G.Ps, nurses, social workers) with responsibility for identifying health needs for a given population (between 46,000-257,000). PCTs are freestanding organisations accountable for both commissioning and providing community healthcare for local populations. These trusts must identify the healthcare needs of the population they serve, recognise local inequality issues and purchase appropriate services, mainly from NHS bodies such as Hospital Trusts or from community based general practices (DoH 2001c).

Social services form part of local government and there is accountability to locally elected councillors as well as to the Secretary of State for Health. Councillors set budgets for the social services, predominantly based on central funding but using some resources from local taxation and charges. This service is not ‘universalistic’ but means-tested (Lewis 2002). While social services provide assessment and care management as needed, users usually have to make a contribution to some of the services they receive if they have the financial resources to do so. There is strong managerial control within social services of resource allocation through the nationally and locally set eligibility criteria, but care managers also play a role through assessing individual need and agreeing packages of care to meet those needs within available budgets. Care managers are individuals who take on a case management role, and who may hold a social work qualification or alternatively a professional qualification in either nursing or occupational therapy. Social services are responsible for commissioning social care but unlike NHS fund-holding bodies, commission domiciliary support and residential care mainly from the private sector (Stanley et al, 1998).

The different organisation and roles of the NHS and social services give the UK a distinctive character. While the main objectives are to provide older people with services that maintain their dignity, security and independence (DoH, 2000a) there is particular concern with deprivation and inequalities creating socially excluded deprived groups. In contrast with most other European countries, the central direction of policy and allocation of funding of health and social care provision means that there is a strong emphasis on ‘best value’. Where new services are created, these

must be capable of demonstrating their strengths and efficacy against existing models, in order to secure ongoing funding. The combination of a finite budget with such clinical uncertainty has perhaps contributed to the speed and breadth of recent health care reform in the UK, culminating in comparatively radical changes to health and social care policy (Koko et al 1998). This will be expanded upon in the following section.

## **2. The Development of Health and Social Care Integration**

The boundary between health and social care has been disputed since 1940's (Lewis 2002). Since then there have been repeated attempts by central government to overcome this boundary but few of the resulting initiatives have achieved effective action. Many of these attempts have been characterised by rhetoric and exhortation rather than action (Griffiths 1988). In this section we place the various initiatives in context.

### **2.1 The 'Health and Social Care Integration Problem' and Structural Reform**

When the welfare state in the UK was set up in the 1940s, it had a highly fragmented structure. While it was possible to identify broad services such as the health service, personal social services and social security, there was little coherence between and within these services. The NHS was internally divided into a hospital service, primary care service and community health services. Personal social services were fragmented between client-based departments in local authorities, children's departments, welfare departments for older people and health departments for maternity services and people with mental illness and learning disability (Lewis 2002).

In the early 1960s central government initiated a programme of welfare reforms requiring improved co-ordination. For example the successful implementation of 10-year plans for hospital and social services, especially the closure of long stay or 'chronic' hospitals, depended on the development of alternative services for vulnerable adults within local authorities and community care (Ministry of Health 1962, 1963). However the Ministry had neither the means nor the inclination to ensure that the two sets of plans were brought together at a local level and the initiative was short-lived (Challis et al 1988).

By the end of the 1960s fragmentation both within and between services was recognised as a major defect of the welfare state and the government undertook a radical programme of reform involving both a restructuring of the health services and social services and improved collaboration within and between services. In England, social services departments were established in 1971 bringing together services for a range of vulnerable users and fostering a new conception of a generic social work profession. In 1974 the NHS was reorganised and new Area Health Authorities (AHA) were created with responsibility for planning, delivering and co-ordinating services. The AHAs brought together health professionals responsible for delivering primary care, community health services and hospital services. There was a strong emphasis on co-ordination between health and social services. Not only did AHAs and social services departments share the same boundaries (co-terminosity), they had to create Joint Consultative Committees to co-ordinate their activities, and share

membership (one third of the AHA members were local authority councillors). Also, there was a legal duty on AHAs to collaborate and the new planning system brought together interdisciplinary joint care planning teams to create integrated plans. While AHAs and social service departments maintained separate budgets, some resources were ring-fenced as joint finance to provide an incentive for collaborative and integrated services for older people (Hudson 1998).

## 2.2 Funding and Economic Incentives

By the 1980s it was generally acknowledged that the structural reform programme of the 1970s had not improved the integration of health and social care. The co-ordinating mechanisms were not sufficiently robust to overcome the increased gap between health and social care, as well as other services that contributed towards the health and well being of older people (Ottewill and Wall 1990). Initial reports of the effectiveness of joint planning were disappointing, due in part to complex processes that were difficult to navigate and the small amounts of money ultimately handled by joint finance (Nocon 1994).

The government response to these perceived failures was to initiate a number of reviews and develop new policies. A common theme can be identified in these reviews and initiatives, the centrality of finance and the importance of using monies to create incentive for more effective collaboration and service provision. In 1990, the 'NHS and Community Care Act' (DoH 1990) introduced the principle of 'government by the market'. This involved administratively separating the responsibilities for funding or 'purchasing' health and social care, from the responsibility of provision. The responsibility for 'purchasing' was given to health authorities and fund-holding GPs (for health care) and social service authorities and care managers (for social care). For those agencies that provided the care, the notion of competition entered the arena, providing an incentive for increasing responsiveness to the needs of service users and attending to cost and quality. It was anticipated that for users who needed both health and social care such as older people, purchasers would co-ordinate their activities through 'joint commissioning' (Hudson 1998).

For older people the principles underlying the 1990 Act were actually not implemented until 1993 (Lock 1996). In practical terms, this Act was designed to ensure that older people should remain in their own homes for as long as possible, funded if necessary by money which was previously used to fund residential, nursing home or hospital care (Lock 1996). Service provision therefore was to become needs led rather than service-led and resulted in some flexible initiatives, such as the 'out of normal hours' caring service, and evening 'meals on wheels' deliveries (Dobson 1994).

The introduction of competitive markets posed many challenges to the effective integration of services. The competitive dimension injected considerable rivalry between agencies supplying care (Wistow et al 1996). This had the effect of reducing inter-agency communication as organisations became reluctant to share information, and made the management of complex networks essential to effective collaboration difficult (Wistow and Hardy 1996). In the absence of a single health and social care budget, managers were not able to commit resources for a unified package of care and there was a lack of clarity in relation to the purchasing of 'continuing care' for

patients with long-term support needs (Hudson 1998). At the same time, acute hospitals were under pressure from the Department of Health to reduce waiting lists and increase throughput. Tensions between acute hospitals and other services rose over ‘bed-blocking’ in patient discharges arising from delays in assessments, development of care packages and funding of social care support (Hudson and Henwood 2002). Even if agencies were prepared to work more closely together, there were many legal ambiguities around contracts and data protection that could prevent them.

There emerged particular issues in relation to the professional demarcation of work. The 1990 Act distinguished between ‘health care’ and ‘social care’ (Lock 1996). Social services were given the lead role in assessing need and funding packages of care and some health care agencies challenged their competence to assess health care needs (Duggan 1995). In addition, health authorities became reluctant to continue to pay for the social care they had been providing (Lock 1996). As a consequence, the boundary between health and social care was characterised by conflict between agencies and professions, rather than co-operation and collaboration (Hudson and Henwood 2002).

### **Paying for community care**

Under current arrangements, health services are provided free to clients wherever these are provided. This includes district nursing services, ‘day-hospitals’ and support from mental health specialists for older people with cognitive impairment. Prior to the 1990 Act, district nursing services were able to provide personal care services to chronically disabled clients, but this is now entirely the domain of Local Authority social services departments. If a client requires help with personal care, such as washing or dressing, or help with shopping or housework, the care is provided by mainly private agencies. The client makes a contribution to the cost, and this can extend to the full cost of care if the client’s income and savings are above a particular threshold. The average cost of this service is about £10 per hour, and ‘care packages’ tend to range between 4 to 14 hours per week, depending on the dependency of the client, and the availability of ‘informal’ support from family and friends.

### **Benefits for disabled individuals**

‘Attendance Allowance’ is a tax-free social security benefit, available to people over 65 years of age who are living in their own homes, who need help with personal care, and have needed such help for at least six months. It is intended to help the client afford the care required. There are two rates payable, the lower rate (£37.65, 54 EUR per week) and the higher rate (£56.25, 81 EUR), depending on the extent of help an individual needs, and whether they need support during the night as well as the day. At present, about 1.3million people claim Attendance Allowance, and just under 50% receive the higher rate (DWP 2003). There is also an allowance called Disabled Living Allowance, which assists with mobility costs.

### **Benefits for Informal Carers**

A slightly different allowance is the ‘Invalid Care Allowance’, which is intended for carers and may be claimed by people who are caring for a relative or friend for more than 35 hours a week. This benefit is means-tested, and payable at £42.45 (61 EUR) per week. It is intended to recompense the carer for loss of paid employment, but the

amount is really quite small- working the same hours even at the minimum wage would generate an income of about £ 160 (230 EUR) per week.

### **3. Current Models of Health and Social Care Collaboration**

When the Labour government came to power in 1997, the government recognised that the development of public services in Britain had not kept pace with public expectations and that there was a need for a major programme of modernisation. This programme has involved additional allocation of funding, including from 2003 an increase in direct taxation and a major new ideology, the so-called ‘Third Way’ (Means et al 2002). In health and social care the third way involves replacing the competitive relations of internal or managed markets with collaborative partnerships both within the public sector and between the public and private sectors (Hudson and Henwood 2002). In the NHS the major visible sign of this new approach was a shift from purchasing by health authorities and GP fund-holders to ‘commissioning’ by newly created Primary Care Trusts (DoH 1997). In this section we will focus on the main elements of the reform programme as they affect joint working. We will start with a brief overview and then provide more detailed consideration of each aspect of joint working.

#### **3.1 Current Initiatives**

When the Labour Party was elected in 1997 it followed a long period in opposition and it was committed to making its mark. There followed a rapid programme of reform and modernisation, which has had major implications for the health and social care divide. *The New NHS: Modern, Dependable* policy document (DoH 1997) outlined a raft of key partnership initiatives. The NHS Plan published in 2000 (DoH 2000a) was a major stock taking exercise summarising the achievement of the government’s first term in office and outlining the aims for its second term. The chapter on ‘Changes between health and social services’ outlines the main framework of the modernisation programme, with innovations in structure, incentives, audit and service delivery.

#### **Structure**

The NHS Plan outlines the legal changes which the government had introduced in the 1999 Health Act (DoH 1999) to facilitate ‘Partnership Working’ and looks forward to new integrated structures, ‘Care Trusts’, which will be elaborated upon later.

The NHS Plan notes that the 1999 Act is designed to enable the NHS and local authorities work more closely and has reduced the impediments to joint working by allowing:

- pooled budgets: this involves local health and social services putting money into a single dedicated budget to fund a wide range of care services
- lead commissioning: either the local authority or the health authority/primary care group takes the lead in commissioning services on behalf of both bodies



- integrated providers: local authorities and health authorities merge their services to deliver a one-stop package of care (DoH, 2000a, p. 70).

The Plan notes that these changes create the conditions for more innovative collaboration, such as social care staff working in GPs surgeries alongside GPs and other health care staff (DoH 2000a).

### **Audit**

Long-standing central government concerns about the cost and performance of the public sector have underpinned the development of an audit culture in the UK. The Treasury as the major funding of the public sector is only willing to increase allocation to health and social services if it receives evidence that these resources achieve agreed service aims. Thus the Treasury has created ‘service agreements’ with major spending departments. These Departments have to produce evidence that they have indeed achieved the aims and have created systems for measuring performance including performance indicators and inspectorates as well as demonstrating that spending will be limited within the government’s budgetary planning. The Department of Health uses a combination of three overlapping inspectorates, the Audit Commission that assess performance of all the public sector, the Commission for Health Improvement for the health care and the Social Services Inspectorate for social care. In the NHS Plan, the Department indicates that these three inspectorates will jointly inspect health and social care organisations to assess their joint working and the performance measurements will include:

- reducing the number of cases where an older patient’s discharge is delayed from hospital
- reducing preventable emergency admissions and readmissions of older people and those with mental health problems
- increasing the speed at which the needs of older people are assessed (DoH, 2000a, p. 72)

### **New service delivery structures: Intermediate care**

Central to the government’s strategy for improving health and social care services for older people, is a new type of service, intermediate care. In October 1997 the government made available £300 million for hospital trusts to develop services to ease ‘winter pressures’ and ‘bed-blocking’ through innovative schemes to either reduce ‘unnecessary’ hospital admissions or to facilitate early discharge of mainly older people who no longer required acute hospital care (Scrivens et al 1998, Doran 1997). Many of the resulting initiatives have matured into ‘Intermediate Care’.

Intermediate care is designed to ‘promote independence and improve quality of care for older people’ (DoH, 2000a, p. 71) by either preventing their admission to acute hospital or by facilitating their discharge. Intermediate care is a generic name used to describe a range of different services that may include primary care (eg rapid response teams), secondary care (e.g. intensive rehabilitation) or social care (e.g. integrated home care teams). There is no prescribed format for intermediate care rather a menu



of possible services that health and social services can use. The NHS Plan describes the menu in the following way:

- *rapid response teams*: made up of nurses, care workers, therapists and GPs working to provide emergency care for people at home and helping to prevent unnecessary hospital admissions
- *intensive rehabilitation services*: to help older people regain their health and independence after a stroke or major surgery, normally situated in hospitals
- *recuperative facilities*: many patients do not always need hospital care but may not be quite fit enough to go home; short-term care in a nursing home or other special accommodation eases the passage
- *arrangements at GP practice or social work level to ensure that older people receive a one-stop service*: this might involve employing or designating key workers or link workers, or basing case managers in GP surgeries
- *integrated home care teams*: so that people receive the care they need when they are discharged from hospital to help them live independently at home (DoH, 2000a, pp. 71-72).

The development of intermediate care represents the greatest investment of resources. The NHS Plan indicates that the government is committed to investing £900 million in the development of intermediate care by 2003/04 (DoH, 2000a, p. 71).

It is clear that the government in Britain sees the health and social care divide as a major impediment to the development of integrated seamless care for older people. The major programme of reform initially outlined in 1997 and restated in 2000 has major implications for the health and social care interface. Some of the proposed reforms involve changes to financial systems and monitoring arrangements and will therefore only have an indirect effect on joint working. Others such as intermediate care are having a direct impact on joint working and we will explore these developments in more detail in the next section.

### **3.2 Development of Current Models**

Some of the developments outlined in the NHS Plan (DoH 2000a) and National Service Framework for Older People (DoH 20001a) build on and develop established initiatives. For example the various intermediate care initiatives developed in response to funding criteria for ‘Winter Pressures’ money. Such schemes tend to be relatively well established and it is possible to explore their implications for joint working and we discuss these schemes in the first part of this section. Other schemes are more recent, for example the Single Assessment Process and the ‘Care Trusts’. It is likely that they will stimulate joint working but since there are only limited pilot schemes it is at this stage difficult to explore the full implications of these initiatives for

joint working. We will consider the ways in which these schemes are developing in the second part of this section.

### 3.2.1 Intermediate Care and Joint Working

While intermediate care in England has developed to meet specific service needs, especially those of acute hospitals experiencing ‘bed-blocking’ problems, they represent a major investment in and development of joint working between health and social care. A review of intermediate care published in 1999 identified examples in over 70 trusts in England and this was only a sample of existing schemes (Vaughan and Lathlean 1999). To date there has been no comprehensive survey of intermediate care provision, although a national survey is in progress at present (DoH 2002a). Given the Department of Health’s expectations that all agencies will participate in intermediate care, it seems likely that intermediate care will become established as a major component of service provision for older people.

#### Joint working

While there are several different models of intermediate care, these share one common feature in that they all involve joint working to some extent. Early definitions of intermediate care tended to emphasise the function or purpose of intermediate care, such as reduced pressure on acute hospitals, rather than joint working. For example in 1997 Steiner defined intermediate care as:

‘That range of services designed to facilitate the transition from hospital to home, and from medical dependence to functional independence, where the objectives of care are not primarily medical, the patient’s discharge destination is anticipated, and a clinical outcome of recovery (or restoration of health) is desired’ (Steiner 1997, p.18).

The Department of Health has developed Steiner’s objective, making it clear that joint or ‘cross-professional’ working is a key feature of intermediate care. The National Service Framework for Older People (DoH 2001a) specifies that intermediate care services should:

- be targeted at people who would otherwise face unnecessary prolonged hospital care stays or avoidable admission to acute in-patient care, long term residential care or continuing NHS inpatient care
- be provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active treatment and rehabilitation
- be designed to maximise independence and to enable patients/users to remain or resume living at home
- involve short-term interventions, typically lasting no longer than 6 weeks and frequently as little as 1-2 weeks or less

- involve cross-professional working, within the framework of the single assessment process, a single professional record and shared protocols (DoH 2001b, p. 43).

The Department emphasised the importance of joint-working and inter-agency collaboration in the following way:

‘An essential component of intermediate care services is that they should be integrated within a whole system of care including primary and secondary health care, health and social care, the statutory and independent sectors. This creates challenges for the commissioning, management and provision of care entailing complex multi-sectoral working’ (DoH 2001b, p. 43).

### **3.2.2 Diversity of Approach in Intermediate Care Service Models**

While joint working was a feature of intermediate care from the start, it tended to be joint working within the context of and led by acute hospitals. This is reflected both in the prime purpose and funding of early schemes. Vaughan and Lathlean’s (1999) sample of schemes identified three main types, early discharge, community based rehabilitation and hospital at home. These schemes were designed to reduce pressure on acute hospitals by increasing discharges or reducing admissions of older people.

With the focus of intermediate care being mainly around the shortening of hospital stays after an acute episode, (and of course expediting discharge where the cause of admission is lack of social support coupled with loss of self-care abilities), or preventing admission and re-admission in the first place, it is perhaps not surprising that many of these schemes originated in acute hospitals. Drawing on the examples listed in a directory of intermediate care schemes (Vaughan and Lathlean 1999), of 30 early discharge/ discharge preventions schemes, 19 were funded entirely by health agencies, 10 jointly funded and only 1 was funded by social services alone. Of 27 community based rehabilitation projects, 12 were funded by health alone, 13 by joint finances and 2 by social services. The 7 ‘hospital at home’ schemes mentioned were all funded by health trusts. This sample was selected by the authors to represent the range of services available at that time, but it does not necessarily follow that the above figures are truly representative, partly because much has changed since this directory was published. However, the picture that emerges is one of multi-disciplinary team development within the established hospital workforce.

There has therefore been a demonstrable policy shift towards expanding rehabilitation service provision in the UK, accompanied by a substantial funding investment into ‘intermediate care’. However, it should be recognised that such services to a large extent exclude older people with complex medical needs, cognitive impairment or dementia and chronic, long term conditions which are not amenable to short-term input. This means that this policy only addresses one particular aspect of older people’s health and social care – perhaps to the detriment of more dependent individuals.

A further, as yet unacknowledged issue is the ‘knock-on’ effect on family and informal carers when an older person is discharged as soon as possible from hospital, or maintained at home with increased support. Such carers frequently provide the mainstay of daily support and assistance to older persons, and an assumption underlying the current policy is that these carers can maintain (or even increase) a high level of input, often including being available overnight to their relatives for an unspecified amount of time.

### **Models in Practice**

There are a number of intermediate care models across the UK, but the types of services provided tend to be fairly similar. What the following examples demonstrate is that while intermediate care is an important and significant development, it does not necessarily mean that ‘joint working’ in its full sense is taking place. The extent of joint working and the creation of a ‘seamless’ service would appear to depend upon the practicalities of geographical location, such as whether teams work in the same building, and the budgetary arrangements with respect to the financial leadership and accountability within the services. Although there is a drive towards ‘pooled budgets’, financial organisation has tended to be more loosely arranged within joint finance schemes funded through NHS or social services budgets. On-going access to funds for service requirements can become a lengthy bureaucratic process, and particularly in the NHS, budgets can become vulnerable to diversion into other more resource intensive areas. Increasingly however, financial management of joint-working schemes are being managed through newly formed Primary Care Trusts, which may limit these potential difficulties.

### **Early Discharge or ‘Hospital at Home’ schemes**

As would be expected, these schemes are targeted at individuals who are already in hospital, but who have recovered from their immediate ‘acute’ phase. Social service packages of care are initiated and funded by hospital care managers using NHS money in order to expedite the patient’s discharge, instead of waiting for social service initiated assessments to take place. The details of care packages are agreed with professionals, patients and carers following joint assessments pre-discharge. Some care packages offer mainly social support for discharged patients - such as help with personal care, assistance with shopping, or emotional support. Others offer therapeutic intervention, especially after orthopaedic admissions, with occupational therapists or physiotherapists visiting the patients at home and instigating a rehabilitation programme, which may then be maintained by rehabilitation assistants. A third variation is to offer community nursing services, perhaps with GP backup. There is normally collaborative professional involvement, and all schemes are time limited, from 2-6 weeks.

### **Admission Prevention/Rapid Response Teams (example – see Annexe 3)**

These teams are designed to prevent admission to hospital or residential homes. Teams are comprised of nurses and social workers, with nurses responsible for the initial assessment and referral. Overall management of the teams can be either through the NHS or social services, but workers have separate professional line management. Again, the service delivery is variable within areas, but a common pattern is referral to a rapid response team, either from A&E staff, or from GPs or other community sources, and a fast-track assessment and implementation of health or therapies and social care which is delivered in the person’s own home. The timeframe

within which help is offered is normally up to 3 days, therefore quick responsive referral to other agencies is a vital component of this service. With nurse and social worker roles intrinsic to the team and funding being increasingly managed through Primary Care Trusts, the conditions for joint working to occur would appear to be in place. However, teams tend to be ‘virtual’ and with nurses and social workers housed in different geographical locations, the implications for communication are clear. In addition, for seamless care to be effected, quick referral response from agencies outside of the rapid response team (such as therapies) must come about.

Unlike other schemes where joint working is intrinsic to the service delivery by virtue of the multi-agency team development, this method maintains a degree of professional separatism. The financing of the care packages through the NHS also creates further ‘rifts’ in professional collaboration in care and can cause considerable disruption for clients. Once the period of intervention is over (2 to 6 weeks depending on the scheme), the responsibility for financing and providing care is passed back to the community social services or health services who operate independently from the acute hospital, necessitating another round of assessment and intervention for the client. Cornes and Clough (1999) have identified this as a problem, and suggest that rather than contributing to joint working, there is a risk that intermediate care can simply add another layer to an increasingly complex assortment of services and providers, causing confusion and disruption to the client and actually moving away from what joint working is supposed to achieve.

**Community Assessment and Rehabilitation Teams (CART). (*example – see Annexe 1*)**

This service model was one of the earliest developments in intermediate care, with many schemes set up during the mid 1990s, prior to the ‘winter pressures’ funding (Vaughan and Lathlean 1999). With respect to joint working, the important difference is that a multi-professional team is central to the service design and is housed in one location, usually in a health service setting. CARTs take referrals both from hospital and community settings, both pre-admission and post-discharge. The intention is that the intervention be available before a point of crisis requiring hospital admission is reached. The teams are usually made up of nurses, occupational therapists and physiotherapists, and should conduct an integrated assessment of the individual. One professional will take the lead role, depending on which therapy is most needed - for example, if the person has had a number of falls, and the assessment suggests that physiotherapy would be the most appropriate intervention, the physiotherapist will take on the lead role of assessment and evaluation. Other specialities such as speech therapy or a dietician may be either on the team, or available to them. Social services care managers form part of some teams, and liaise externally with others. Although variable, these are jointly funded schemes managed either through the NHS or social services.

**Residential Rehabilitation Units (*example – see Annexe 2*).**

The provision of residential rehabilitation is a service that can be difficult to differentiate from traditional rehabilitation wards within hospitals, although this type of care may be offered by community hospitals, residential or nursing homes, in nurse-led units, or within social services residential units. A number of regions have started to provide such a service. In order to fit in to the policy definition of

intermediate care, such units should be offering time-limited rehabilitative (enabling) care, with discharge home being a feasible and anticipated objective.

This is also a service area which has suffered from the different charging arrangements for health and social services - health based units are able to offer rehabilitation programmes free at the point of delivery, whilst social services units and residential/nursing homes have, until recently, had to charge the individual in accordance with the normal means-testing criteria. This is currently subject to regional variation, and also subject to negotiation with local social services authorities.

Residential rehabilitation programmes are most appropriate for older people who are medically stable, but need intensive therapeutic input to regain their functional independence. Most units specify the need for '24 hour supervision' as part of their admission criteria, reflecting that this client group is likely to be at high risk of either hospital or residential home admission. Where such a service is provided, it is normally part of a wide spectrum of intermediate care provision, and tends to be accessed by the most heavily dependent clients.

### **3.2.3 Future Directions – The Single Assessment Process and the new ‘Care Trusts’**

This section provides an account of new areas of development, namely single assessment and Care Trusts. Potentially these schemes will have a major impact on the quality of support received by older people and joint working. However given the early stage of these developments it is only possible at this stage to outline their likely impact.

#### **Sharing Information: Towards a Single Assessment Process**

A major impediment to the development of seamless care has been the separate collection and storage of information. Currently, each professional group involved in older person's care has their own method of assessment and record keeping. This means that not only is information not shared but also that older people are subject to repeated assessment and questioning. To improve co-ordination, the Department of Health is committed to the development of a single assessment process whereby agreed information is collected and shared between all the main caregivers:

‘By April 2002, we will introduce a single assessment process for health and social care, with protocols to be agreed locally between health and social care. Initially this will be introduced for those older people who are the most vulnerable, for example, those who live alone or those who are recently bereaved or those discharged from hospital or entering residential or nursing homes’ (DoH, 2000a, p. 125).

The planned development of a single assessment process is perhaps one of the most ambitious areas of current policy. The government's guidance describes a record of core needs assessment that is carried out once, on behalf of all the health and social care providers involved, with a particular client. Ideally, this should be an electronic record (DoH 2002e). However, there is a question around whether the necessary



infrastructure exists for such an undertaking. John Hudson (2002) comments that both the health service and social services have multiple information technology problems, including poor resources, limited financial support and cultural negativity within the workforce towards IT systems. Such factors, together with other issues such as the cost of training a workforce in an IT system and the financial implications of developing a universally accessible database, may explain why the current guidelines are fairly low-key on the subject of an electronic system.

A further practical (and legal) issue is that the consent of the client must be secured, because the information gathered will be shared across the traditional boundaries of care provision - that is, between hospital trusts, community (primary health) teams, and social services providers. Local arrangements must also be made to agree an assessment format, clarify which professional should make the main assessment, and ensure that the information is subsequently available, 'around the clock' to any other agency which requires it (DoH 2002e, p.34). In addition, a written record of any resulting care plan should be copied to the client. To achieve such an ideal seems far from possible at present, as the practical problems it presents mean that how professionals from numerous organisations communicate at every level needs to be completely re-thought.

The government has not designated a particular assessment document for this purpose, and indeed its guidance paper (DoH 2002e) shows that, at present, no such document exists. Instead, the Department of Health has published an extensive list of domains and sub-domains for assessment, together with guidance on involving clients and carers in the assessment. There are however a number of assessment formats which come close to meeting the policy criteria for single assessment, and the government recommends that service providers can either choose one of these and extend them for this use, or design their own assessment tool, using a number of recommended and externally validated scales (DoH 2002c).

The development of a single assessment format has attracted the attention of researchers, particularly in the medical domain, and several studies have been undertaken to validate the various data gathering instruments that are being developed to meet the Department of Health criteria for a single assessment tool (DoH 2002c, Carpenter and Challis (in press), [www.interrai-uk.org](http://www.interrai-uk.org)). The government has set out a timetable for achieving a single assessment process, commencing in April 2002, with a projected date of April 2005 by which time all localities are expected to have assessment systems which are compliant with the single assessment guidelines (DoH 2002e).

The current situation is that no region has managed to achieve consensus on a single assessment process, although a number of localities have begun moving towards this goal. Three regions have been suggested as resource points for other agencies due to their progress on this area of practice. Cambridgeshire agencies are ready to pilot an electronic data collection tool, which, it is anticipated, will eventually be used across the whole region (see Annexe 4). In Leeds, five Primary Care Trusts (PCT's) have established 'Joint Care Management Teams (JCMT's)', which work with a 'whole systems' approach. One of these teams is developing and piloting an electronic record system to improve information sharing and documentation. In Surrey, an initiative from primary care agencies (GP's, district nurses, practice nurses, health



visitors and care managers) established a basic assessment by drawing on the common areas used by both health and social care practitioners. This initiative is being expanded across the county of Surrey, and an electronic version is being developed concurrently.

Commenting on these evolving schemes, the Department of Health (DoH 2002c) identifies a number of lessons that other agencies can learn from the experience of these ‘trailblazers’. In Cambridge, the key areas were IT training, and addressing the cultural changes necessary for the IT to be acceptable to the workforce. The Leeds project highlighted the process of obtaining consent, and includes work on joint consent and confidentiality protocols. In West Byfleet (Surrey), issues of professional culture were addressed, and this area offers the following guidance:

‘Professionals have to understand and respect each other’s roles and responsibilities. They must be prepared to lose individual ownership of processes and information, and replace it with joint ownership of the responsibility to meet the needs of service users/patients’ (DoH 2002c, p.22).

It would seem that there are a number of hurdles to be overcome on the road to achieving a single assessment process. The above comments refer to issues of professional identity and accountability, which are construed by social scientists to explain why the professions (and ‘semi-professions’) display territorial behaviour when working within a multi-disciplinary framework (Hudson 2002). It is unclear whether health and social care professionals are ready to lose individual ownership of information and assessment processes.

There is also a perceived lack of financial resource for this policy - no grants or funds have been made available specifically for funding the single assessment process. Despite this perception, the funding issue has partly been addressed by the Department of Health, which announced a new national strategy for IT within the NHS (DoH 2002f) with earmarked funds to assist in the development of electronic records (Dodson 2002). However, what this initiative does not address is the resources required for each region to develop inter-agency teams to reach consensus on single assessment, develop the appropriate documentation and practice protocols, obtain the informed consent and co-operation of service users (many of whom have sensory and/or cognitive impairment) and train the relevant professionals and support staff. At present, it cannot be assumed that the ‘single assessment process’ is universally viewed as an achievable goal by key health and social care professionals.

### **Moving Towards Care Trusts**

The NHS plan (DoH 2000a) provides a structural joint working framework for the development of ‘Primary Care Trusts’, which are stand alone units, capable of both commissioning and providing integrated primary and community care for the designated local population. Many of these are now in place. The NHS Plan also outlines the structure of a new type of organisation, the Care Trust (see Annexe 5). These are ‘new single multi-purpose legal bodies... to commission and deliver primary and community healthcare as well as social care for older people and other client groups...’ (DoH 2000a, p.73). While the Department of Health sees the

introduction of these new Trusts as essentially voluntary, presenting them as a vehicle that local agencies can choose to use, it also reserves the right to impose such structures where it has evidence that collaboration is not taking place:

‘Where local health and social care organisations have failed to establish effective joint partnerships – or where inspection or joint reviews have shown that services are failing – the Government will take powers to establish integrated arrangements through the new Care Trust’ (DoH, 2000a, p. 73).

The creation of new structures provides the opportunity for pooling resources. Indeed the NHS Plan acknowledges that the 1999 Health Act initiatives have created joint schemes with budgets of over £200 million (DoH, 2000a, p.71). In addition the Department has set aside or ‘ring fenced’ a budget to provide ‘incentive payments to encourage and reward joint working’ (DoH, 2000a, p.72). In the NHS this budget will be allocated through a National Performance Fund, while local authorities will be rewarded through a separate fund with £50 million allocated for 2002/3 and £100 million for 2003/4.

Given the chequered history between health and social services, it is however this reform that has been the source of much critical debate, especially from social service quarters who fear that Care Trust are an NHS ‘takeover’ and may be unsympathetic to social service priorities (Hudson and Henwood 2002). This NHS ‘takeover’ may be increased if the management of Care Trusts is linked to the hospital bed and waiting list agendas. In addition to this, the development of National Service Frameworks for Older People (DoH 2001a) may also lock local government into an NHS-led system. Others have expressed concerns in relation to the upheaval of yet more major structural change, the consequences for service users, and the potential for ‘empire building’ of whichever care-giving agency dominates. However, these proposals are still evolving, and in the meantime the move to Primary Care Trusts is seen as a suitable means for potentially bringing about integrated services (Hudson and Henwood 2002).

### **3.3 Comment on Models of Joint Working in the UK.**

The current Labour Government in the United Kingdom is committed to reforming public services. It has accepted that the development of public services has lagged behind public expectations and a government priority is increased investment in public services. However if such investment is not to be wasted, it must be accompanied by a programme of reform and modernisation involving the development of greater co-operation and collaboration within and between sectors and joint working practices. There have been a range of initiatives such as intermediate care for older people and while most of these initiatives are at a relatively early stage in their development, some preliminary evidence is beginning to emerge about the impact on joint working and the quality of services received by older people.

## 4. Conclusion

### 4.1 The Development of Joint Working in the UK

In this final section we highlight the factors that have shaped the development of joint working in the UK and consider the current state of play.

#### **The Policy Context**

The distinctive features of the British political and welfare system have heavily influenced the development of services for older people in the UK. The British polity is highly centralised both in terms of policy-making and financial allocation. Policy-making tends to be dominated by a ‘policy community’ or triangle of key decision-makers, ministers, civil servants and major pressure/expert groups. The Treasury forms a part of this community, as it is the source of responsibility for ensuring that public funds are properly allocated and effectively used. It has developed a system of formal service agreements with spending departments such as the Department of Health, which subsequently form the basis of the audit process.

At a local level, services for older people are predominantly funded and delivered by public agencies such as the NHS and social services, though Governments since the 1980s have encouraged the independent sector to take on the delivery of health and especially social care. However, the majority of community care is provided free by informal carers (relatives and friends) and the UK government could be said to rely heavily on family provision of care. Given the dominant position of the public sector within ‘formal’ care provision, mechanisms for managing the private sector such as regulatory frameworks established by law have historically played a relatively minor role in the UK, although the recent development of new inspection and regulatory bodies under the Care Standards Act (2000) appears to be impacting significantly on the private sector. Instead, the main mechanism for providing direction and therefore the main source of evidence for reviews are central government policy statements such as the NHS Plan (DoH 2000a) and the National Service Framework for Older People (DoH 2001a). It is important to note that central government in the UK not only controls the policy agenda, but also has a major influence on evaluative research as it is the main source of funding for this type of research.

#### **The Health/Social Care Divide**

In the United Kingdom there is a long-standing problem of co-ordination between health and social care services. The government is partially responsible for the creation of the ‘Berlin Wall’ between health and social services. In restructuring the welfare state at the end of the 1960s, the government fostered health and social care professions and provided them with dominant positions at the core of the major agencies designed to plan, fund and deliver health and social care. Differences of status, ideology, funding, and at times mutual hostility between professions have tended to reinforce the competitive elements in the system and have provided little incentive for collaboration or joint working.

Since the 1970s there have been repeated attempts to overcome this divide. In the 1960s the emphasis was on the development of plans that were mutually adjusted. When there was little evidence of mutual adjustment, the emphasis shifted to

structural reforms. The divisive tendencies of the restructuring of the 1970s were to be counteracted by a range of collaborative initiatives, co-terminosity, common membership, joint planning and joint finances. When in turn these initiatives failed to deliver improved collaboration and joint working, increased emphasis was placed on financial incentives. In the 1980s and 1990s there was an ideological commitment to the ‘invisible’ hand of the market, and internal markets in which ‘money followed patients’ were adopted as a panacea. Again there was little evidence that ‘internal markets’ improved collaboration and joint working and in 1997 a new government identified them as the problem and placed collaboration and partnership at the centre of its commitment to modernise health and social care services.

### **Modernisation, Collaboration and Joint Working**

Following repeated failure to create a seamless health and social care system in the UK, the current government has initiated a major programme of reform. It has indicated that it will not tolerate resistance to reform and is willing to reconfigure both welfare agencies and the professions that work in them to ensure that older people and other users receive continuity of care.

The current reform programme does not rely on one single approach but brings together a number of different changes. It includes:

- *structural changes* to services creating the opportunities for new integrated ‘Care Trusts’
- *improved financial incentives* with monies being used to facilitate and reward collaboration and joint working,
- *audit* with joint audits by the Audit Commission, Commission for Health Improvement and the Social Services Inspectorate to ensure closer collaboration and joint working
- *shared* information with the introduction of a single assessment system facilitating the sharing of information between agencies and professionals
- *new service models* with intermediate care combining features of social care, primary care and hospital care and enhancing joint working.

## **4.2 The Current Position of Joint Working in the UK**

The current government in the UK is committed to a major programme of modernisation at the core of which is a commitment to the development of joint working between public services and especially between health and social services. It is already possible to see the impact of this programme on services for older people especially in the development of intermediate care. Intermediate care is an umbrella term, which includes different models of support. The government expects joint working and collaboration to form a prominent feature of all models of intermediate care. In some models joint working between health and social care is an intrinsic element, for example community assessment and rehabilitation teams. However in other models it is less central and joint working takes place amongst health care workers rather than between health and social care, for example early discharge schemes and hospital at home. Other parts of the reform programme, such as the single assessment process and Care Trust are at an earlier stage in their development and as yet it is difficult to assess their full implications for joint working. These

initiatives are more recent than intermediate care. However it is also possible that their slow pace on developments is a reflection of both the intrinsic complexity of the proposed changes, especially in the case of joint assessment where key components of the infrastructure are not in place, and resistance, especially in the case of Care Trusts where local government is concerned about an NHS take-over.

Since this modernisation programme is at a relatively early stage of its development it is perhaps too early to assess the extent to which it will enhance collaboration and create joint working. It is not clear whether the current labour government will succeed in breaking out of the historical cycle. Since the 1950s all governments in the UK have sought to enhance collaboration and create joint working in services providing support for older people. However to date there is very little evidence that any of the initiatives have successfully overcome the divisive and competitive tendencies within the public sector.

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## Annexe 1

### Model: Community Assessment and Rehabilitation Teams

#### Exemplar: Gloucester Community Rehabilitation Team

<b>Name</b>	<b>Gloucester Community Rehabilitation Team (South-west England)</b>
<b>Provider</b>	<b>Jointly funded by Gloucestershire Health Authority and Gloucestershire Social Services</b>
<b>Objectives</b>	<ul style="list-style-type: none"> <li>• <b>To improve health and social care through partnership working</b></li> <li>• <b>To avoid inappropriate admissions to hospital</b></li> <li>• <b>To reduce admissions to residential and nursing homes</b></li> <li>• <b>To slow the rate of complex community care packages</b></li> <li>• <b>To reduce length of stay for medically stable in-patients</b></li> </ul>
<b>Target group</b>	<b>Hospital patients in need of home rehabilitation. Clients at home with a crisis (e.g. fall, chest infection), or short-term rehabilitation need.</b>
<b>Practice Domain</b>	<b>Acute hospitals/clients own homes</b>
<b>Joint Working Initiatives</b>	<b>Qualified nursing staff and occupational and physiotherapists (from health sector) work alongside social services care manager. Specialist generic rehabilitation assistants also employed (care assistants trained to give rehabilitative care using an enabling/social care model).</b>
<b>Methods</b>	<ul style="list-style-type: none"> <li>• <b>Provide rapid intervention for clients at home, or support after hospital discharge, with rehabilitation/therapy input (for up to 6 weeks).</b></li> <li>• <b>Interdisciplinary approach, with shared work-base for whole team.</b></li> <li>• <b>Overnight on-call care provision</b></li> <li>• <b>Individualised assessment, care planning and evaluation.</b></li> <li>• <b>Timely, smooth and seamless discharge from team</b></li> <li>• <b>Ongoing service-user evaluation and audit</b></li> </ul>

<p><b>Strengths and Weaknesses</b></p>	<p><b>Strengths:</b></p> <ul style="list-style-type: none"> <li>• <b>A positive approach to joint working between health and social services personnel. Protocols, admission criteria, intervention and evaluation all jointly agreed.</b></li> <li>• <b>Service available over 24 hours, and discharge planned to provide ‘seamless’ care.</b></li> <li>• <b>Reflective approach allowed changes in service provision to be made in response to service user and provider needs</b></li> <li>• <b>Continued evaluation of outcomes and user satisfaction</b></li> </ul> <p><b>Weaknesses:</b></p> <ul style="list-style-type: none"> <li>• <b>Pilot scheme - therefore long term funding uncertain, causing initial recruitment problems</b></li> <li>• <b>No external evaluation</b></li> </ul>
<p><b>Evaluation Results (Local Audit)</b></p>	<ul style="list-style-type: none"> <li>• <b>Community Rehabilitation Teams have prevented admissions (78% of referrals ‘could have been admitted to hospital’ but only 11% required hospital admission).</b></li> <li>• <b>Dependency improved in 40% of those on the scheme</b></li> <li>• <b>A small rise in formal care (i.e. social services care at home) was documented following discharge from the team</b></li> <li>• <b>Treatment given by CRT’s has been well received by users.</b></li> <li>• <b>Although hospital admissions fell during the study period, there were no measurable differences between admission rates for areas with or without CRT’s.</b></li> </ul> <p><b>Source of Information:</b>  <b>Gloucestershire Health Authority/Gloucester Social Services/East Gloucester NHS Trust/Severn NHS Trust (1999) ‘Final Evaluation Report of the Rapid Response Community Rehabilitation Team Pilots in Cheltenham, Gloucester and Stroud’ (unpublished report)</b></p>

## Annexe 2

### Model: An Integration Project (Intermediate Care)

#### Exemplar: Community and Recuperative Care Beds

<b>Name</b>	<b>The Limes and Livingstone Integration Project (Dartford, Kent, South-East England)</b>
<b>Provider</b>	<b>A partnership agreement (pooled funding and integrated working) between Kent County Council and Dartford, Gravesham and Swanley Primary Care Trust.</b>
<b>Objectives</b>	<ul style="list-style-type: none"> <li>• <b>To work in partnership and develop a seamless service to promote independence for older people</b></li> <li>• <b>To decrease preventable hospital admissions and reduce length of hospital stay</b></li> <li>• <b>To promote rehabilitative care on a short term basis and enable people to resume living at home by maximising their independence</b></li> </ul>
<b>Target group</b>	<b>Clients over 65 years who are medically stable, in need of rehabilitation or recuperative care, and who are expected to return home, given appropriate support.</b>
<b>Practice Domain</b>	<b>Residential beds – community hospital and social services rehabilitation unit, housed on same site.</b>
<b>Joint Working Initiatives</b>	<b>Health Services nursing staff work alongside Social Services therapists and care assistants. A new post of ‘Generic Rehabilitation Worker’ has been developed so that support staff can work in both settings. Joint management of all staff.</b>
<b>Methods</b>	<ul style="list-style-type: none"> <li>• <b>Integration of ‘The Limes’ recuperative care centre and The Livingstone Community hospital, (which co-exist next door to each other) under one management structure, with pooled budget development.</b></li> <li>• <b>Provision of a full range of social and health rehabilitation, either as a ‘step down’ intermediate care facility or a ‘step up’ from home, avoiding acute hospital admission.</b></li> <li>• <b>Provide inter-professional working with a single assessment framework, single professional records, shared protocols and shared admission and discharge criteria.</b></li> </ul>

<p><b>Strengths and weaknesses</b></p>	<p><b>Strengths:</b></p> <ul style="list-style-type: none"> <li>• <b>Positive ‘can-do’ management approach to joint working</b></li> <li>• <b>Commitment to meeting the practical challenges of collaborative working</b></li> <li>• <b>Involvement and training of staff to facilitate ‘enabling’ culture with a clear training and development pathway</b></li> <li>• <b>Able to expand the ‘entry gate’ for rehabilitative care, by drawing on the combined skills of nursing and therapy staff, so that higher dependency clients can be taken on.</b></li> </ul> <p><b>Weaknesses:</b></p> <ul style="list-style-type: none"> <li>• <b>This project is still being established, and is a ‘trailblazer’ in the sense that it uses innovative funding and management approaches. Its true impact on the local target population is as yet unknown.</b></li> </ul> <p><b>The above information could not have been included without the assistance of Christine Ballard, Development Manager for Partnerships and Project Manger for the ‘Limes/Livingstone’ development.</b></p>
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### Annexe 3

#### Model: Rapid Response Teams

#### Exemplar: Community Care in Cumbria

<b>Name</b>	<b>Rapid Response Teams (Cumbria, North-West England)</b>
<b>Provider</b>	Morecambe Bay Health Authority
<b>Objectives</b>	<ul style="list-style-type: none"> <li>• Promote user independence</li> <li>• Reduce dependency on continuing health and social services</li> <li>• Prevent inappropriate admission to hospital</li> <li>• Facilitate early, safe discharge from hospital</li> <li>• To work in partnership with existing services and agencies in a collaborative and integrated manner</li> </ul>
<b>Target group</b>	Patients medically fit for hospital discharge but awaiting ‘social care’ arrangements, or patients at home experiencing an acute illness episode.
<b>Practice Domain</b>	Acute NHS hospital wards, client’s own homes
<b>Joint Working Initiative</b>	Teams of qualified nurses assess care needs, and purchase ‘social care’ from local agencies on behalf of service users.
<b>Methods</b>	<ul style="list-style-type: none"> <li>• Facilitate hospital discharge (or prevent hospital admission) by offering home-based personal or social care for up to 2 weeks.</li> <li>• Liase with mainstream Social Services agencies to establish continued care after this period.</li> </ul>
<b>Strengths and weaknesses</b>	<p><b>Strengths:</b></p> <ul style="list-style-type: none"> <li>• Qualified nursing staff able to assess care needs and organise a package of care quickly, circumventing delays in ‘mainstream’ system.</li> <li>• Evaluation study suggests that early discharge may have been facilitated, and that unnecessary hospital admissions (particularly for clients ‘at risk’ with social care needs) prevented, although the methodology did not permit a true comparison with existing care methods.</li> </ul>



(Continued overleaf)

**Weaknesses:**

- **Scheme operated in addition to existing social services framework, rather than in collaboration with this.**
- **Intervention time limited to 2 weeks - carers were not able to remain involved throughout the recovery period, and transferring care to social services after this time meant that users had to adjust to a different team of carers.**
- **Interventions concentrated on giving supportive personal care rather than enabling a return to independence - described as a ‘stop-gap’ measure to address the organisational problem of providing community support quickly rather than a client-centred approach to maximise independence at home.**

**(The above comments are derived from a descriptive evaluation study commissioned by the scheme providers (Cornes and Clough 1999). The ‘Rapid Response’ model was only one of three models involved in the study. It is not the intention to suggest that all Rapid Response Teams have the same problems, but for the purposes of the ‘Procure’ study, it seems useful that these issues were identified.)**

**Annexe 4**  
**Model: Single Assessment Process (electronic database)**  
**Exemplar: Cambridgeshire Common Assessment Tool**

<b>Name</b>	<b>Common Assessment Tool (CAT) (Cambridgeshire, South England)</b>
<b>Provider</b>	<b>Cambridgeshire Social Services Department Cambridgeshire Health Authority</b>
<b>Objectives</b>	<ul style="list-style-type: none"> <li>• <b>Collaboration amongst health and social care providers, to develop a single comprehensive assessment for older persons.</b></li> <li>• <b>Establish a shared, person-centred approach to care provision.</b></li> <li>• <b>Ensure that assessment format would be useful and acceptable to different professionals, and explore user views on information sharing.</b></li> </ul>
<b>Target group</b>	<b>Older people in Cambridgeshire requiring comprehensive assessment of social and health care needs.</b>
<b>Joint Working Initiatives</b>	<b>IT departments from health and social care agencies work together to create and test a single assessment form.</b>
<b>Methods</b>	<ul style="list-style-type: none"> <li>• <b>Collaboration between health and social care agencies to develop a common assessment tool</b></li> <li>• <b>‘Action Learning Approach’ used, to test acceptability across different professional groups.</b></li> <li>• <b>Explore user views on information sharing, and establish procedure for obtaining consent and maintaining confidentiality.</b></li> <li>• <b>Electronic version of ‘CAT’ now ready to be piloted.</b></li> </ul>
<b>Strengths and Weaknesses</b>	<p><b>Strengths:</b></p> <ul style="list-style-type: none"> <li>• <b>A nationally recognised unit, leading the field of single assessment</b></li> <li>• <b>Able to advise other areas on the process of achieving single assessment</b></li> </ul> <p><b>Weaknesses:</b></p> <ul style="list-style-type: none"> <li>• <b>At present, this project has not been evaluated</b></li> </ul>

## Annexe 5

### Model: Strategic Development

### Exemplar: Bradford District Care Trust

<b>Name</b>	<b>Bradford District Care Trust (near Leeds, North East England)</b>
<b>Provider</b>	<b>Bradford Health Partnership (Bradford Metropolitan Council and Bradford Health Authority)</b>
<b>Objectives</b>	<ul style="list-style-type: none"> <li>• <b>Creation of a ‘Care Trust’, to meet the health and social care needs for a defined population</b></li> <li>• <b>Improved, client-centred services, sensitive to the ethnic and cultural diversity of the population</b></li> <li>• <b>Improved use of resources and facilities, with increased flexibility and pooling of expertise</b></li> <li>• <b>An enhanced, stable working environment</b></li> <li>• <b>An integrated information system</b></li> </ul>
<b>Target group</b>	<b>The Care Trust has four directorates, and provides services for users with mental health needs (including elderly mental health services) and learning disabilities. The target population is within the Bradford District (approximately 500,000 people).</b>
<b>Joint Working Initiatives</b>	<b>Existing community mental health services to be merged with Social Services, to create the new organisation</b>
<b>Methods</b>	<ul style="list-style-type: none"> <li>• <b>Formation of Care Trust (2<sup>nd</sup> September 2002)</b></li> <li>• <b>Build on history of collaborative working</b></li> <li>• <b>Extend availability of ‘home treatment model’ for mental health users (a service which has NHS beacon status)</b></li> <li>• <b>Quality assurance through multidisciplinary clinical governance groups and user focus groups.</b></li> </ul>
<b>Strengths and weaknesses</b>	<p><b>Strengths:</b></p> <ul style="list-style-type: none"> <li>• <b>Organisational power – the ‘Care Trust’ model has been developed specifically to enhance collaborative working between health and social care services.</b></li> <li>• <b>Built on a successful history of joint working.</b></li> </ul> <p style="text-align: right;"><b>(continued)</b></p>

	<ul style="list-style-type: none"> <li>• <b>Realistic timeframe in place, to allow planned programme of integration</b></li> <li>• <b>Application for ‘Care Trust’ status based on ‘an extensive consultation process involving public, staff, users and relatives/carers’ (Bradford District Care Trust 2002 p.1)</b></li> </ul> <p><b>Weaknesses:</b></p> <ul style="list-style-type: none"> <li>• <b>Whilst elderly mental health services are to be provided by the Care Trust, the ‘social care’ component for this particular client group will remain external to the new organisation. The reasons for this decision are unclear, but it suggests that even within an organisation designed to promote joint working at regional level, the boundary between health and social care provision may remain intact.</b></li> </ul>
<b>Source of Information</b>	<b>Bradford District Care Trust (2002) Application and Prospectus for the new organisation.</b>