Research that makes a real difference

The vanguard of integration or a lost tribe? Care trusts ten years on

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Executive Summary

In the year 2000 the option of a single organisation leading on the commissioning and/or delivery of health and social care services was proposed in England in the form of care trusts. The government of the time was hopeful that care trusts would become common vehicles to provide integrated care across the country and prove successful in achieving better access, co-ordination and efficiency. There was also a 'threat' that they would be imposed on areas in which partnership working between health and social care was seen to be failing. Despite these ministerial aspirations there were concerns from commentators and academics that organisational structure in itself would not deliver better working on a strategic or operational level and that the costs of such a large scale 'merger' could outweigh the benefits, particularly in the short term. These mixed views led the Chief Executive of one of the new organisations to comment that it was not clear if the initial pilots would prove to be the 'vanguard of integration' or 'a lost tribe'.

Ten years on, this paper captures the view of leaders within a number of the current care trusts regarding their experiences of managing this type of integrated organisation. They reported that an organisational solution will not by itself generate integration on strategic and operational levels and that the complexity of bringing together the functions, staff and budgets of health and social care on such a large scale is indeed fraught with difficulties. As integrated organisations care trusts experienced difficulties working within the 'silos of national policy and performance systems, and suffered common logistical headaches regarding shared IT systems and different Terms and Conditions between health and social care staff. However, despite these limitations and barriers, all the care trusts we interviewed (even those who would not repeat the venture in retrospect) were positive about the future. This was either through the opportunity to expand and develop their provision in other localities and/or through taking on delivery of other community services, or in the 'ripples' that the care trust will leave in the local partnership environment.

Overall the lesson from care trusts appears to be that structure can provide additional benefits but only if there is a history of joint working and trust, a clear vision and the active engagement of prospective users, local community and staff. Furthermore their experiences underline that the historic differences and tensions between health and social care remain, and that integrating with one service can lead to a greater distance from another. These are important lessons for Health & Well-being Boards to build on as the English system moves to the new world of GP led commissioning, a national public health organisation and community services being delivered by a range of organisational forms.

Introduction

The description of care trusts as either the 'vanguard' of integrated organisations or a 'lost tribe' was made by the former Chief Executive of a care trust at an HSMC learning event soon after their creation. It nicely captures the mixed views of care trusts as either the cutting edge of integration between health and social care or as a band of individuals and organisations that have happened upon a clumsy structural solution as a way of shielding themselves from other agendas. Whatever your view of care trusts, it is undoubtedly true that they are a rich case study of a national policy attempt to encourage and facilitate local integrated working between health and social care. The Health Services Management Centre has had an interest in care trusts since their initial conception and the launch of the first of these new organisations, and we maintain on-going ties with a number of care trusts. To mark the 10 year anniversary we want to reflect on what has been learnt by these integrated organisational forms and identify what knowledge can be taken forward into the new policy environment that health and social care now faces.

The next section sets out the background to care trusts in more detail, before moving on to set out the methodology we adopted to collect data for this paper.

What are care trusts?

Better partnership working between health and social care services has been a source of considerable aspiration, application (in terms of new initiatives, directives and incentives) and frustration for national and local policy leaders for a considerable period (Glasby & Dickinson 2008). As far back as 1990, the Community Care reforms not only brought in the 'purchaser-provider split' within social care but also sought to integrate services around the needs of an individual (through the new role of 'care managers') and on a strategic level (through Community Care Plans) (Edwards & Miller 2003). Early in their term of office the Labour government pledged to 'break down the Berlin Wall' between health and social care, and the Health Act (passed in 1999) introduced new powers that health and social care could use to strengthen and/or develop partnership working through the provision for *lead commissioning*, *pooled budgets* and *integrated provision* (Greig & Poxton 2001). Care trusts were proposed the following year in *The NHS Plan* (Secretary of State for Health 2000) as a vehicle for delivering and/or commissioning integrated health and social care. As NHS bodies, they would have delegated authority from Local Authorities for social care, and would have increased representation of Local Authority elected members on their Boards to ensure democratic involvement in their governance.

The NHS Plan generally envisaged their establishment in areas where there was joint agreement about care trusts as a beneficial organisational model. However, there was also a threat that they could be imposed in areas where effective partnership was not in evidence. The hope was that bringing together health and social care practitioners, managers and commissioners into a single organisation would lead to 'tailored and integrated care, greater accessibility, and one stop shops for services that used to entail repeated conversations and a procession of different faces at times of illness, stress and vulnerability' (Department of Health 2002: p 1). There would be better career opportunities

for staff, and engagement with health and social care practitioners in developing and implementing care pathways that would enable people to be successfully transferred from acute care into the community. Single IT systems could also be developed with benefits both in relation to patient information and performance management. Whilst they could be introduced in any area, it was envisaged that they would lend themselves more readily to communities with co-terminous boundaries between the local authority and primary care trust and/or to services for people with mental health difficulties.

From the outset care trusts had their detractors as well as their supporters. Concerns raised included - the lack of evidence that they would deliver improved and efficient care; potential difficulties in combining financial systems and through the LA delegating control for a large area of their expenditure; the danger that health ideology and approaches would dominate social care; and a loss of local democratic control over a major service area (Hudson 2004). Other commentators were concerned that they would rely on top-down approaches to 'force' practitioners to work together and this could be at the expense of more innovative and creative solutions that could be developed at the 'frontline' (Greig & Poxton 2001). Furthermore, other partnership options such as pooled budgets and jointly managed teams were viewed by many local areas as potentially delivering better outcomes with less disruption, avoiding the considerable organisational effort and costs that would be required in developing a new NHS body and transferring LA staff (Glasby et al 2005). In particular there were a series of practical barriers early on around issues such as pensions, Terms and Conditions and VAT. More fundamentally, over time, central government also appeared to have had mixed views of care trusts. They did not, for instance, use opportunities such as the introduction of Agenda for Change to harmonise social care staff Terms and Conditions with those of health employees, and care trusts were not initially promoted as a potential organisational form under the Transforming Community Services initiative (DH 2009) (although they were subsequently included in later guidance (DH 2010a)).

It was initially envisaged by ministers that Care Trusts would be the predominant model for the delivery of social care services within five years (Neate 2000). An initial list of nine care trust pilots was announced in July 2001 to which a further eight were added in September 2001(Hudson 2002). Several of the initial pilots did not come to fruition, and since then there has only been a limited take up of the new organisational form (see Box 1). Furthermore several Mental Health Care Trusts have subsequently evolved into Foundation Trusts (although retained their focus on health and social care services).

Box 1 - Number of care trusts launched each year since 2002
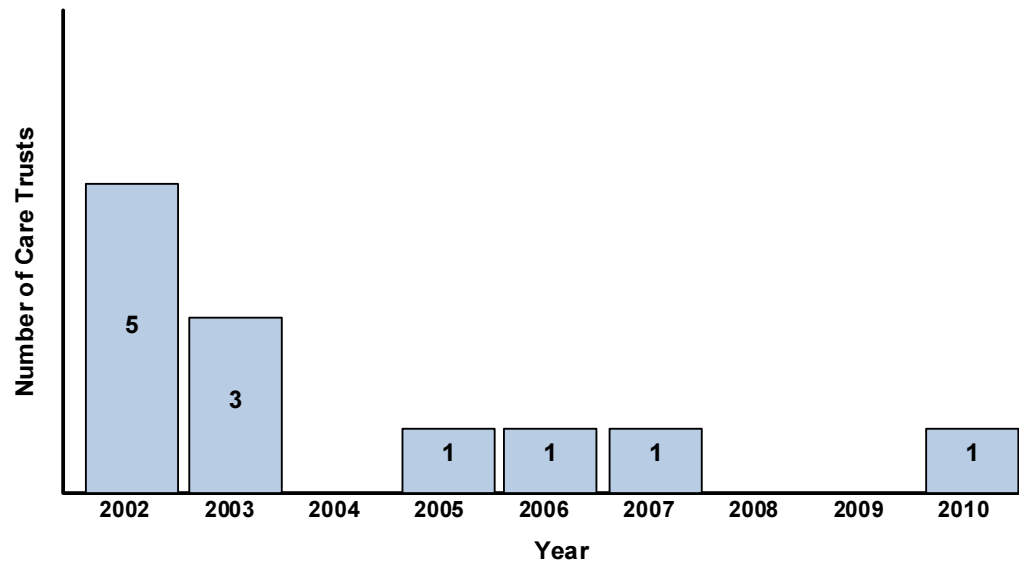
To date there has been limited evaluative research into the strengths of care trusts as an organisational form, with almost all of the articles identified through the literature search focussing on the 'concept' of care trusts and issues regarding their development rather than evaluating the outcomes they have delivered. Dickinson *et al* (2007) undertook an action research study which sought to evaluate the effect to which local aspirations had been achieved. They found that at that point the move to the care trust had not had significant impact on the work of the staff at all levels of the organisation either in a positive or negative sense. This could be due to the previous history of partnership working in the locality and a perception that national policies such as the National Service Framework for Mental Health were more pressing drivers. Some improvements were noted (such as speedier decision making and creation of some joint processes) but the majority of improvements that the local organisations had set out to make were not realised in practice. It had been anticipated for example that the care trust would produce more innovative services and relate to more partners, but these were not achieved as the act of setting up the organisation had resulted in leaders becoming more inward facing in practice.

Whilst not being formally evaluated as such, Torbay Care Trust has been recognised by a number of bodies as a care trust that has been able to deliver improved care (for instance through winning a Highly Commended Award in the Health Service Journal Primary Care Trust of the Year Award in 2009 and the Managing Long Term Care Award in 2008). They are able to evidence improvements in social care process targets (e.g. delivery of community equipment and assessment timescales) and in reducing emergency admissions to hospitals (Ham & Smith 2010; Ham 2009), although it is not clear whether being integrated *per se* is causally related to these outcomes or whether other factors may also be significant. Although it is tempting to attribute these changes to the structures of the care trust, without more evidence this would be a syllogism (i.e. where a conclusion is inferred rather than proven) There are equally a number of other commissioning care trusts who do not have a good track record in this area.

Methodology

At the time of this study we estimated that 11 care trusts were operating in England. There is difficulty establishing an exact cohort as a number of care trusts have evolved into Foundation Trusts delivering health and social care; some of these describe themselves as care trusts but others do not. Five of the current care trusts are largely provider organisations, delivering health and social care services for people with mental illness (and in some cases health and/or social care services for people with a learning disability). The other six commission and provide community health services and adult social care services.

Our aim was to capture the views of people responsible for currently leading care trusts regarding their experiences of managing an integrated health and social care organisation and what they would advise those areas considering an integrated form in the future. A literature review on 'Care Trusts' was completed through searching the following databases - HMIC, Medline, Embase, Cinahl, Psycharticles, ASSIA, Social Sciences Citation Index and Social Care Online. Themes identified from the literature review were used alongside those from publications on integrated working in general to develop a semi-structured interview schedule. In view of the small number of care trusts in existence we contacted all of the current Chief Executives and invited them to either take part in a telephone interview or to nominate another member of staff. In total seven care trusts participated (three mental health providers and four joint commissioning/community service providers). In terms of those participating in the research three Chief Executives and four other Executive Team members acted as interviewees.

The interviews were taped and transcribed. Transcripts were coded according to the major themes that arose in terms of the development of the care trusts, their experiences of partnership working and implications for wider health and social care communities. We have set the findings out according to these themes in the section below, which is followed by a discussion that seeks to pull out the implications of these findings for the future of care trusts and integrated working. In reporting these findings we have used direct quotes from participants, but these have been anonymised in view of the relatively small community that the research draws from.

Findings

In this section we set out the findings according to a number of themes which were prevalent during the research. In interviews we asked respondents to describe to us why it was that their care trust had been established, what it had hoped to achieve, the barriers and complexities involved and how they were hoping to develop in the future.

Motivation for care trust development

All respondents reported that the local history and context in which their care trust evolved were an important determinant in realising the potential of an integrated organisation. We can categorise the motivation of an area deciding to develop a care trust into two drivers: either as the "next logical step" to build on a local history of partnership and joint working; and/or to avoid another organisational form that would have involved health services being delivered and/or commissioned by an organisation that was not as connected with the local area:

'A care trust seemed a natural progression to build upon integrated working and the positive experience of being a health action zone'

'Reorganisation of the PCTs could have led to co-terminosity with the Local Authority being lost'

A local history of partnership working was seen as a providing an enabling environment for the new integrated organisation to develop (even if this was combined with a need to avoid another organisational form). However if the care trust was being used as a vehicle to force integrated working in an area where there was not a strong history then the new organisation faced significant challenges to achieving its potential benefits. As one respondent remarked:

'I would only recommend a care trust in an area with a strong history of partnership working which include clinicians and practitioners operating together around integrated pathways'

Linked to a history of partnership working were the initial governance arrangements in place with the Local Authority when the care trust was launched. If (in the view of the respondent) sufficient time and capacity had been invested in developing governance arrangements and these reflected a two-way relationship between partners, then they provided a supportive framework on which to build. In one area the care trust commissioned children's health services from the Council and there was therefore a reverse 'purchasing' arrangement which encouraged an equal relationship. If governance, accountability and the relationship between care trust and Local Authority were not (in the view of the interviewees) well developed initially, then a number of

issues subsequently arouse. These included the care trust not being able to influence and collaborate with the Local Authority; the care trust being put in a financially disadvantageous position; a lack of clarity regarding the relationship with the Council (i.e. was it a 'contractual relationship' in which the care trust was a provider responding to a purchaser or was it a partner agency working in collaboration?); and, separate reporting of budgets to Council and to health commissioners which led to a lack of flexibility over use of funding around patients' needs. These were described by interviewees in terms such as:

'The council pulled a 'fast one' – passing over responsibility with no process for addressing subsequent overspends in social care budgets'

'The difference between success and failure is the strength and nature of the relationship with the Council'

Box 3 – Mrs Smith

'Mrs Smith' was a fictional character devised as a representation of what Torbay Care Trust hoped to achieve. 85 years old and living alone 'Mrs Smith' would require support from a range of health and social care services, and would have been likely to encounter the issues regarding access and co-ordination that had been identified through community consultation. The care trust aimed to redesign the way in which services were offered and provide more integrated and flexible models of delivery. 'Mrs Smith' was a 'concept' that the range of stakeholders could identify with – service users, carers, staff and the wider community. 'She' became the symbol of the new organisation and also the benchmark for considering any new developments – 'how would this benefit Mrs Smith?'. Over time the concept of Mrs Smith and what she would expect from services has evolved to encompass the needs of her family and a wish for more 'personalised' services (from Lavendar 2006 & Torbay Strategic Plan 2008-13)

A clear vision of what the care trust would achieve provided both momentum and a framework to bind the organisation together and make decisions on what would be prioritised. This vision worked best when it could be articulated both on a strategic level and to frontline staff, and was developed in consultation with local communities. 'Mrs Smith' is perhaps the best exemplar of a vision that could speak to all levels of the organisation, to stakeholders and to the wider community (see Box 3). In order to be effective a vision has to be backed by a strong and committed senior leadership team who are willing to be 'open, honest and flexible' in their dealings with staff, partners and the local community. Evidence of the support of elected members is also useful in establishing credibility and helping to address difficulties that arise with Council Officers:

'Involvement of councillors helped to keep us on the front foot for anything on the horizon and sort out issues where council departments have made decisions without our involvement'

In a number of care trusts, engagement with local communities and with service users / patients was seen as strengthening both the direction and legitimacy of the organisation (see Box 4).

Box 4 – Community Engagement in NE Lincolnshire

NE Lincolnshire Care Trust recognised the importance of meaningful and on-going community engagement at an early point of its development and set up 'Accord' as a Community Membership Body to facilitate and oversee this activity. Membership is open to anyone who lives in North-East Lincolnshire and/or who is a registered with a GP in the area. Members (of which there are currently over 2500) have stated interests that are recorded so when the Care Trust is considering a care pathway change or service change they are able to seek representation from the membership to inform their decision making. Members also provide a wider perspective on the quality of services they receive and on wider health and social care issues. The membership can be analysed to confirm if it is representative of the communities in NE Lincolnshire whether by sex, ethnic origin or geographical area.

Members can be involved as much or as little as they would like, with opportunities ranging from receiving information, attending consultation days or standing to be a Public Representative on one of the four Commissioning Groups. These Groups oversee how all of the commissioning budgets held by the care trust are spent and comprise of 7 Public Representatives, 6 Care Trust Plus Representatives and 1 Neighbourhood Representative (from local partner agencies). The Public Representatives are elected every 3 years by local members. A comprehensive board development programme is provided to allow the public members to be able to function as equals with the care trust members such as GPs and Nurses.

To access a wider community representation Accord also links closely in with other citizen groups in the local area. These include 'community collaboratives' (which work with 'hard to hear' groups that may not be well represented), the Local Involvement Network, the foundation hospital trust membership group and the council's citizen panel.

See **http://accord.nelctp.nhs.uk/index.php** for further information on the work of Accord.

What factors have hindered the development of care trusts?

Regional and national bodies were largely seen as obstructive in setting up care trusts, with several interviewees reporting a bureaucratic application process in which requirements could change over time:

'The health authority were extraordinarily obstructive initially – then became more supportive but still required a series of hoops to be jumped through'

Once care trusts were launched, the 'silo' working of health and social care performance regimes was seen to be time consuming and complex. A number of national policies were felt to not recognise integrated organisations. For instance in one care trust implementing the 'purchaser – provider' split required in health services led to a separation between social care commissioners and the care management teams. This led to considerable role confusion between the two social care functions, took up considerable time with internal discussions about a Service Level Agreement between 'commissioner' and 'provider', and led to delays in addressing service pressures and gaps. The lack of integration at a national level was mirrored regionally and locally, and care trusts had to respond to the different expectations and requirements of Local Authorities and Strategic Health Authorities. In some cases this led care trusts to be criticised by the Health Authority for prioritising social care and the Local Authority for prioritising health care. Linked to the difference in performance systems between health and social care was the issue of developing and implementing an efficient IT system. This had proven to be a complex and time-consuming issue and even where care trusts had a workable system in operation the inputting continued to take up considerable time for frontline staff. As one respondent reflected:

'The on-going difficulties around the information systems continue to present a real barrier to integrated working'

Different employment Terms and Conditions were mentioned by all, as both a time consuming issue to address and as a factor that could cause tension between staff who had been transferred from the Council and those employed on Agenda for Change. If Terms and Conditions were harmonised then this was cited as a positive factor in promoting affiliation with the care trust. Developing harmonised Terms and Conditions was an opportunity for care trusts to consider new roles for social care staff, which in one area was proving a recruitment tool:

'We inherited a situation in which there were numerous social work vacancies – as an area we were not attractive for staff and had no 'product' to sell. We have revised job roles and can evidence a positive approach to the needs of service users and our vacancy rate is now much lower'

Historic tensions between 'social care' and 'medicine' were raised by the care trusts delivering mental health services, with a proportion of social care staff feeling that their trusts were dominated by a medical viewpoint. This appeared to be particularly expressed by social workers who worked as Allied Mental Health Practitioners (previously Approved Social Workers), which in some ways could be expected as this role is often seen by practitioners as providing an alternative view to that of the psychiatrist. Interviewees did not agree with these concerns and one reported that they also had consultants complaining that the social work view was starting to dominate:

> *'Social care staff perceive that they have been taken over, their opportunities limited and their work devalued'*

> *'Social workers have always given a mixed view of the care trust – whilst undoubtedly there are pro's and con's they will assess these subjectively depending on their personal perspectives'*

Alongside issues particularly related to the development of an integrated organisation, other more general factors were also mentioned that had affected the care trust's progress. These included – serious incidents regarding the care provided by one care trust (which led to organisational focus on addressing these concerns rather than integration), changes in the senior management in the council and / or the commissioning Primary Care Trust (in the case of the mental health providers) that required a repeat 'selling' of the care trust's vision, and financial pressures on both health and social care systems.

Learning from care trusts

As we outlined in the methodology, participants were asked whether they could identify any salient issues from their experience of integrated working that would be relevant to other areas who are currently grappling with the complex issues of collaboration. As one would expect, lessons that the interviewees would share include addressing local issues listed in the sections above (e.g. ensure governance arrangements are adequately addressed and provide a 'fair' deal on both sides). These more local issues are not duplicated in this section but this does not make them any less applicable to other settings.

The common lessons that the interviewees would share with other areas considering the development of an integrated organisation can be summarised as the "4Cs" of:

- 'consultation';
- 'culture';
- 'collaboration'; and
- 'client/patient focus'.

Consultation with staff and wider stakeholders was seen as a vital component of the initial consideration of a care trust and also in its continued development. Where this was achieved it provided legitimacy to the care trust and also provided a direction and focus for what should be prioritised. A strong community voice also proved helpful in addressing objections from professionals regarding changing previous working patterns where such changes could be directly linked to concerns raised by local patients/service users. In areas in which the development of the care trust had (in the views of the interviewees) been rushed it was felt that there was insufficient consultation both about potential options for integration as well as what the new organisation could focus on. Some care trusts felt that they had been able to go beyond 'consultation' to 'involvement' of patients/service users and the local community in the shaping the future direction of the organisation (see Box 4 above).

The importance of considering and addressing **cultural** issues was mentioned by all interviewees. Even areas with histories of strategic and operational partnership working reported that in retrospect they recognised that they did not initially spend sufficient time and energy on the organisational development issues of such a 'merger' and had focussed on 'transactional' issues such as budgets and TUPE transfers:

> *'When the care trust was launched there was insufficient time spent on aspects such as 'culture' …the hope was that by putting people in the same office they would work well together – this didn't happen'*

> *'We needed a clear programme of organisational development at the outset that would have delivered a strong strategy and culture'*

A number of care trusts began with a structure in which social care services were managed through a separate 'division' from health services. In hindsight they recognised that, whilst this provided social care with a clear 'place' in the organisation, it was also a barrier to staff perceiving that health and social care practitioners were now integrated. This led to the organisational equivalent of multi-disciplinary staff being 'co-located' but not working closer together. To assist the senior leadership team with being sensitive to the 'culture' of the organisation, one Trust had used an external consultant to act as a 'critical friend' throughout the care trust's development. As an 'outsider' they were able to talk to frontline staff and middle managers (along with external stakeholders) and gain a picture of what was being discussed on the ground – this proved an invaluable source of information to the senior team. Alongside 'culture' communication with staff was seen as vital to develop and maintain their positive connection with the new arrangements. Providing examples of how the new arrangements had improved patient/sevice user care had the greatest impact in shaping the views of staff.

One of the consequences of integrating services is that they become distant from other services and partners. This was reported by a number of interviewees, particularly in relation to the Local Authority and led (in varying degrees) to adult social care being seen as the responsibility of the care trust rather than the Local Authority. This led to tensions about how budget pressures were managed, as well as a lack of clarity about decision making processes and who would take responsibility for difficult decisions such as service reconfiguration. This proved operationally difficult for the care trusts, but of most concern to interviewees was the impact on service users. In particular it was felt in some instances that Local Authority departments had not been as committed to inclusion of vulnerable adults within mainstream services such as leisure, housing and employment. This had a negative impact on their quality of life as well as on national performance indicators:

> *'In the early days social care was no longer in the 'heartbeat' of the Council'*

Where care trusts had been able to continue or redevelop a close collaboration with the Local Authority then significant advantage could be achieved in tackling long-standing and complex issues for the local population. The positive consequence of a care trust '**collaborating'** with wider local partnerships was also reported by a number of interviewees, and in their view the care trust was a 'role model' of an integrated organisation that successfully brought together different responsibilities and roles inspired other organisations in what could be achieved.

The final lesson that many care trusts would share with other areas thinking about developing an integrated organisation was to **keep the focus** on the needs of the people who access the service either now or in the future. Where this was in place prior to the organisation being developed (either through integrated 'care pathways' and/or a vision based clearly on individual needs) then this successfully gave a framework to determine what work would be prioritised and an aspiration that frontline staff of all disciplines could relate and commit to. Where a 'client focus' had not been strongly instigated at the beginning of the process then it took considerable time and energy to develop it subsequently (although it was possible).

What does a care trust model achieve?

All of the interviewees could identify a range of improvements made by their care trust since its launch, and in some cases they believed that an integrated organisation had made these considerably easier to achieve. By itself greater integration between health and social care professionals was cited by most as one of the most significant achievements, and this was on the level of the professionals working at a particular time with an individual patient/service user as well as in the organisation and management of multi-disciplinary teams. For care trusts with commissioning responsibilities the ability to work across and influence the whole of the health and social care system had been beneficial in relation to achieving major pathway and service reconfigurations. There were

also advantages cited in terms of workforce development (such as developing new roles and opening up training opportunities for social care staff) and recruitment and retention (through being seen as an 'innovative' and therefore attractive organisation and offering mental health social care staff in particular a wider range of potential promotions). In some cases care trusts could back up these positive views with evidence of impact on national performance targets and CQC ratings (although again whether these changes were directly related to changes in structures is difficult to demonstrate).

Interviewees were split over the advantages of developing a new organisation rather than using other frameworks to achieve integrated working. Of the seven care trusts that participated, the representatives from four said that in retrospect they would recommend that a care trust was developed. However, representatives from the three other care trusts said that they would strongly advise that other options were explored. For those organisations which would not in retrospect recommend care trusts, it was felt that the time, energy and money required to address the transactional costs combined with a lack of connection with the Local Authority had detracted, rather than added, to their ability to integrate services and achieve mainstream inclusion for their patients/ service users. Those who believe it was the right option to have taken were from areas where there had already been a culture and history of integration and partnership in place and the establishment of a care trust was seen as the logical 'next step' of the journey.

The future of care trusts

Whilst care trusts were an acceptable organisational form under the Transforming Community Services programme, the Department of Health was clear that single organisations being responsible for commissioning and provision of community services would only be permissible in exceptional circumstances. This meant that care trusts that are responsible for both functions were unlikely to continue and the subsequent decision by the new coalition government to abolish Primary Care Trusts by April 2013 means that these organisations will not continue beyond this point. Despite the impending demise of their organisations the interviewees were on the whole upbeat about the future of health and social care delivery in their local areas. This was on the basis that the care trusts had been able to demonstrate the importance of taking a whole systems approach across health and social care and they were hopeful that the local learning and experience this had generated would continue to be applied in the new world post-Primary Care Trust.

The future for care trusts that do not commission but provide mental health/ learning disability services appears considerably rosier. They seem to have convinced commissioners of the benefits for continued structural integration in relation to people with mental health difficulties, which may reflect that it is easier to justify the need to continue with such a 'deep' integration around the needs of a particular client/patient group or pathway. Furthermore, through Transforming Community Services they have opportunities to expand their delivery of mental health/learning disability services in other localities and/or to take on responsibility for community services previously delivered by the local Primary Care Trust. The ability to provide integrated care and their experience

in being responsible for a range of services were seen as a considerable strength in this environment. The Provider Arm of one commissioning/provider care trust was going to continue as an integrated provider organisation and was again going to take on additional services.

Discussion

In many ways the findings from this study are not surprising: an organisational solution will not by itself generate integration on a strategic and operational level where this was not strongly evidenced previously. 'Merging' two organisations is fraught with difficulty and often causes more problems than it solves in the short term, and public sector services tend to focus on the 'transactional' elements of re-organisation and neglect 'transformational' issues related to organisational culture and psychological reaction (Dickinson et al 2007). Walter Leutz (1999) presents as one of his "laws of integration" the rule that 'your integration is my fragmentation' and to some degree this is borne out by the responses from interviewees. Although a care trust structure might bring together health and social care services, this does so potentially at the cost of initial distance post integration from other Local Authority services. This reflects the inevitability of boundaries: whilst health and social care integration might be the answer for some services and some service users (and it is noticeable that this is a particular trend in relation to mental health and learning disability services), this integration may not be sufficient in supporting an entire well-being agenda.

Despite the difficulties of governance, the realities of working in a 'siloed' national policy and performance system, the logistical headaches of joint IT systems and different Terms and Conditions, all the care trusts that participated (even those who would not repeat the venture in retrospect) were positive about the future. This positivity was either in the sense that they would be afforded the opportunity to expand and develop their provision, or in the sense of the 'ripples' that the care trust will leave in the new world of GP commissioning and the Health and Well-being Board. It is to this new world that we now turn as we consider what the experience of care trusts can tell us about the current policy environment and the proposed or actual changes that will arise in the coming years.

The Wall is down but the divisions remain?

The experience of care trusts highlights the cultural differences and tensions between health bodies and local authorities, and the professions within them. These are not new issues (see Peck and Crawford 2004), but remain stubbornly in place throughout health and social care communities. In a number of the care trusts involved in this research, a proportion of their social workers maintained a strong 'identity of difference' to health professionals, despite the values and beliefs of social care and health care becoming closer (e.g. it is generally accepted that the social impact on patients of suffering from long-term conditions must be considered and that social support is a vital component of a successful hospital discharge). Furthermore a significant proportion of social care staff believed that health professionals, and in particular doctors, dominate care trusts (and this echoes the previous findings of Dickinson et al 2007). At an organisational level there was evidence of care trusts being able to

work successfully with Local Authorities, but also that if this was not actively pursued then they would tend to drift apart and return to health and local authority silos. This is despite care trusts having responsibility for a large proportion of the Local Authority's duties and budget. On a national policy level most of the care trusts interviewed expressed their frustration with the different performance regimes and reporting requirements between health and social care. If integrated working is to become further entrenched in the future then this will be an issue that will be faced by organisations beyond care trusts.

The new policy agenda does build in requirement that social care and health will work together at a strategic level with a statutory duty for councils and GP consortia to work together being proposed in the Health and Social Care Bill (Secretary of State for Health, 2010a). However there are a number of features of the new system that are likely to impact negatively on the ability of Local Authorities and health bodies to work together. Firstly, there is the impact of the major health service reorganisation and cuts to Local Authority (and Health) management infrastructure. Restructuring has been shown to have a negative impact on external organisational relationships to and lead a loss of momentum in new service developments (often an initial opportunity for joint working (Edwards 2010)). Identifying areas to work together requires managers to have capacity to contact their counterparts in other organisations and to spend time understanding their respective roles, pressures and aspirations. To develop creative partnership plans requires trust that your counterparts and their organisations will deliver their side of the bargain, and such trust can only be built by experience and time. Such a large scale reduction in capacity and 'changing of the guard' is therefore bound to have an effect on partnership between health and social care. Secondly, the emphasis on 'competition' in the health service and the potential for multiple providers in an area providing the same service is likely to make the development and implementation of integrated pathways more complicated (Ham and Smith, 2010). In social care, 'personalisation' will have a similar effect through devolving service design to the level of the individual service user and health professionals could potentially be presented with a myriad of individual packages with which to provide integrated care (although personalisation could lead to greater integration by enabling the service user to guide how different disciplines and agencies should integrate around their unique circumstances (Glasby 2008, Glasby et al 2009)). Finally, the ability of GP consortia to set their own boundaries, combined with patients having greater choice over which GP practice they register with are likely to lead to consortia being responsible for patient populations that are different to Local Authority boundaries.This lack of co-terminous boundaries will make both planning and responding to the needs of individual patients more complicated.

On a positive note, the lesson from care trusts is that integrated working is achievable at both individual and strategic levels, but this requires a whole system approach that encompasses practitioners, managers, commissioners and indeed national policy makers. We therefore need a continued focus on encouraging and enabling partnership working at all levels: practitioners (and those training to be the practitioners of the future) require opportunities to understand each other's role, value their different contributions and insights and develop trust and respect; organisations require incentives to look beyond their single agency boundaries and priorities to explore partnership solutions;

and national policies and regulators need to encourage and facilitate co-operation as the norm rather than the exception. These issues are well recognised within the literature (see Glasby and Dickinson, 2008) and the observations of the participants confirm that effective integrated care is not simply formed by merging organisations and functions. Effective integrated working is a good deal more difficult than this in practice.

Out of sight, out of mind?

An experience of several care trusts was that once social care was transferred from the Local Authority, the commitment of the Local Authority to this area of responsibility declined (at least initially). This led, for example, to vulnerable adults not being as actively considered within mainstream council initiatives and social care overspends being seen as a care trust responsibility. In the new policy environment Public Health will be leaving the local health family to be managed as part of the national Public Health England organisation with Local Authorities having the lead responsibility in their areas (Secretary of State 2010b). There is considerable potential in this transfer through the opportunity for better integration of the public health function with other council services and within their lead responsibility for strategic partnership. However there is a risk that the new GP commissioning consortia, with the complex responsibilities that they need to take on and undoubted worries about making their budgets balance in the short term will take their eye off the public health agenda. The lesson from care trusts is that this 'distancing' post-integration can be overcome if there is clear and shared vision, a focus on outcomes and leadership within the partner organisations that is willing to engage with and be guided by the needs of the local community. There are opportunities in the new arrangements to strengthen such engagement, through for instance the new HealthWatch groups and GP commissioning consortia considering innovative approaches to community engagement and membership, but these will require capacity and energy dedicated to them if they are going to have real impact.

Acquiring, merging or joining?

It is anticipated that Transforming Community Services will lead to approximately 27% of community services being transferred to Acute Foundation Trusts and 28% being transferred to Mental Health Foundation Trusts (DH 2010b). Evidence from private sector mergers and acquisitions, and previous health service restructuring, tells us that this is a path that can lead to declining performance and a cultural clash between existing and new staff groups (Field & Peck 2003a; 2003b; Dickinson et al 2006). The example of care trusts underlines these messages; even though they are by their nature integrated health and social care organisations there was a common tendency for the social care staff to believe that the health perspective (whose disciplines comprised the majority of staff at all levels) continued to dominate. This was a similar finding to that of Dickinson et al (2007), whose research into a care trust found that social care colleagues felt dislocated from what they believed was a "health" dominated environment. These researchers found that it was not necessarily that it was an entirely health dominated context, but that a number of senior posts had

been filled by individuals from a health background and this had served as a symbolic message to the organisation that health was seemingly valued above social care.

All of the care trusts would, in hindsight, have spent more time and resources on Organisational Development to facilitate a new culture and identify where tensions were likely to arise (again, this is something previously noted by Dickinson et al (2006)). It is therefore vital that Foundation Trusts taking on community services proactively address these issues and ensure that the new arrangements are perceived by the transferring staff as a positive opportunity to improve patient care through providing an integrated pathway between acute and community and/or mental health and physical health services, rather than simply being a convenient way to address the problem of finding a home for community services and enabling the Foundation Trust to expand its business. The structure of the new organisation is also an important consideration – should the new community services be amalgamated with the existing services or managed through a separate community service 'division'? The lesson from care trusts is, if an integrated organisation is desired it is helpful to develop a new structure and culture that 'builds on the best' of what went before (Peck & Dickinson 2009).

Reorganisation - a mirage for cost saving in a financial desert?

Common sense tells us that bringing together two or more organisations will enable savings to be found through reducing duplication and taking the most efficient processes from each partner. There is some evidence of this (e.g. Turning Point (2010) although it does depend on the parameters one puts on such an evaluation (see Jöel & Dickinson 2009). A single organisation employing disciplines that contribute to a care pathway seems an obvious catalyst to enabling greater joint-working and communication. If the care pathway relates to avoiding more expensive care or treatment options and/or enabling the patient/ service user to regain independence then the single organisation should lead to a better use of resources across the system and better outcomes. However the evidence is that structural efficiencies take time to find and that simply employing people as part of the same organisation will not lead to more streamlined and efficient integrated working (Field and Peck 2003a, 2003b, Fulop et al 2002, 2005, Ramsay & Fulop 2008). Further the costs of such a structural approach are considerable both in relation to the management time that it involves and also the potential opportunities that are lost. Another of Walter Leutz's laws of integration is that 'it costs before it pays', and the practical experience of previous mergers is that the savings may never be released. The view of several of our interviewees that they would not in hindsight recommend the development of a care trust reflects the costs of disruption and development. This does not mean that structure cannot play an important part, but it is not the strongest determinant of success and often provides an inefficient return on the resources invested. Furthermore to achieve these outcomes requires the new organisation to have sufficient longevity.

Conclusions

Care trusts may not have become the common organisational form that was initially envisaged by ministers, and many of the difficulties and limitations that were raised by commentators and academics were found in practice. However, whilst there has been no robust evaluation that quantifies the overall benefits against the financial and opportunity costs of their development, it is clear to those who lead care trusts that there has been advantage to having a single integrated organisation delivering health and social care. The key debate therefore seems to be not – 'does an single organisation approach deliver integration better than partnership arrangements between different organisations' but rather 'how do we identify and respond to the local context and circumstances and the needs and aspirations of our local community?' Key to this is being able to imbed best practice in the everyday working of frontline practitioners and lining up the management, budgetary and governance processes behind these to support rather than hinder integration. Above all, we need to be clear what success would look like and aware of the upheaval of reorganisation so that we know what we're doing and why, we're clear that this is the best way of achieving those outcomes and we're clear it's worth it.

Transforming Community Services will see the care trust 'Tribe' dwindling, but a number will survive. Furthermore there are discussions in one area to develop a new care trust by 2011 and a large social enterprise being launched through the Right to Request initiative is considering the delivery of both community health and adult social care services. So, whilst the first care trusts have not yet proved to be the vanguard of a new generation of integrated organisations, they will continue to provide fertile ground for understanding the 'nuts and bolts' of integration, and it is vital that we capture and share this learning for a wider audience as we enter a time of radical and cash strapped change.

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