Integrated services:

evidence and perspectives from UK adult social care

Paul Jays

This paper attempts to draw some lessons from recent developments in UK adult social care that are relevant to disease management strategy in both developed and less developed countries. In particular, the impact of integrated and preventative strategies on health outcomes for older people will be considered. A whole systems approach can bring cost and efficiency benefits as well as positive outcomes for patients.

The paper draws on work and research undertaken at the Department of Health's Care Services Efficiency Programme (CSED)[1] in England and current work being undertaken with the Northern Ireland Health and Social Care Commissioning Board. Northern Ireland has different demographics and governance from the rest of the United Kingdom, having come into being, through partition in 1922, at the same time as the independent Republic of Ireland (Eire). The province has around 1.7 million inhabitants (comparable to what the Commonwealth terms 'small states' populations). There is consensus among historians that inequalities in public health and social care provision (housing, welfare, education) were contributory factors in the conflict from the 1950s onwards.[2]

An integration strategy that recognises the value of voluntary and informal community services may challenge hierarchical and authoritarian attitudes of health and social care professionals and contribute towards a 'democratisation' of services, encouraging a wider contribution to the development of health and social care policy. Policies that make available social care and health-care budgets that are controlled by the individual patient and schemes that make use of 'patient experts' to support other patients highlight the opportunities for patients themselves to contribute to as well as benefit from a broad-based, integrated approach to the delivery of health and social care services.

Clarifying the purpose of services for older people

Being clear about purpose and outcomes (and how to measure those outcomes) should inform and shape the structures and processes of any successful organisation. This may seem obvious in relation to health and social care services, but it should not be taken for granted.

In a presentation on the development of a preventative and enabling strategy for the provision of services to older people to a multi-disciplinary audience in Northern Ireland, the author suggested that their fundamental purpose was not to provide services that only respond to illness and vulnerability but to promote people's independence and well-being and that the services provided should be judged against that fundamental purpose.

Health and social care services may not always effectively promote independent living. Research undertaken by CSED looked at the impact of intensive reablement[3] intervention aimed at helping older people regain independence in activities of daily living following discharge from hospital or health crisis in their own homes. The results were quite significant: 60 per cent of those who went through the home-based reablement programme (lasting up to six weeks) required no home support package compared to 5 per cent for the control group. Furthermore, the improvement was sustained for two years for two thirds of the patients, many of whom also self-reported general health benefits.

It is clear that the professionals involved in delivering the traditional service believed they were doing their best for patients, but in reality they were missing the opportunity to promote this independence. There are also reports from a number of English local authorities that home-based reablement schemes have reduced hospital bed days for older patients, re-enforcing that value of a whole systems approach to the delivery of health and social care services. This reablement approach is now being adopted by the majority of local authorities in England.

A broader concept of integration

It is sometimes assumed that integration of health and personal social services will automatically produce better outcomes for patients, but integration is not an end in itself. It only has validity if it produces added value in the promotion of independence and well-being. Furthermore it is clear that integrated organisational structures are not sufficient – or possibly even necessary – to provide what is described in the 1991 Community Care Act as a 'seamless service' for patients.

A key question is who should be integrating with whom.

Integration should not be restricted to working relationships between health and social care professionals and their organisations but needs to be a much wider integration between statutory organisations, voluntary organisations and informal community support. The impact of effective investment in voluntary organisations and other forms of community support can have a significant impact on health and social care outcomes. Relative poverty and social isolation amongst some older people in the UK appears to have a negative impact on physical and mental health. Loneliness may not be a recognised clinical illness but it would appear to be a significant factor in influencing health. The

Campaign to End Loneliness website refers to research suggesting that loneliness has a similar health risk to life-long smoking and also has links to the onset of degenerative diseases such as Alzheimer's as well as to heart disease and depression. Loneliness can be a particularly problem within the context of migration from smaller rural communities to large urban centres where older people can feel even more anxious and isolated.

The evidence from the CSED research and the practical experience of local authorities such as Shropshire (see Box 1) demonstrates that cost efficiencies can be achieved at the same time as achieving quality improvements in health and social care outcomes. The capacity to better manage the demand for services will be crucial in dealing with the existing and future pressure on services arising from demographic changes, in particular the increased proportion of older people who may be living longer but not necessarily healthier. The expectations of older people are also changing, with many wishing to continue living active independent lives and being clear that their health and social care needs should not be met by fitting them into a narrow range of traditional solutions.

Yet, the value of community investment may be overlooked in post-industrial societies where it could be argued that there has been an over-emphasis on individual clinical and scientific advancement and that there is some distance still to go in the transition from an illness service to a preventative health service.

The concept of integration also needs to have reality for the patient receiving care. The patient is the only person to experience the complete care pathway, while professionals can over-emphasise individual steps. The key issue is to retain a strong focus on the actual outcome at the end of a period of care. For example, timely discharge from hospital is in the patient's interest but discharge into an inappropriate setting may meet discharge targets but may not promote the patient's independence. Rigid target setting may result in 'hitting the target but missing the point'.

Box 1

Prevention and reablement strategies: the example of Shropshire

Shropshire, an English rural local authority with a relatively large and growing older population (approx 58,000 being over the age of 65), large geographical area and resource pressures, has in place a long-term investment strategy in low-level, practical and social support services for older people provided by community and voluntary organisations. This approach has contributed to a reduction of more than 50 per cent in the number of older people admitted to long-term care over a 10-year period. Part of the aim of this strategy is to respond to social isolation.

A delegation from the Northern Ireland Health and Social Care Commissioning Board and voluntary sector representatives visited Shropshire in March 2012 to look at the excellent outcomes that are being achieved for service users through their prevention and reablement strategy. Lessons learned are also being shared with counterparts in New Zealand.

Conclusions

Organisation structures are not sufficient in themselves to bring about an integrated approach. Also critical is signing up to a common purpose and developing a joint understanding of what a good service looks like that can be incorporated into a joint performance framework. Where health and social care services are provided through a single integrated organisation, tensions may still exist between the professional roles of hospital- and community-based professional staff, particularly around the concept of risk management, and between professional and 'non professional' staff.

Evidence referred to in this paper suggests that effective prevention and reablement social care strategies may well have an impact on demand for health-care services and individual health outcomes for older people. Such strategies will better position statutory agencies to meet future demand, particularly from changes in population structure. Integrated working between health and social care services can contribute towards these outcomes, but a shared understanding of purpose, values and goals is probably more important than integrated organisational structures. Integrated working requires a much broader definition and application in which the importance of investment in voluntary and community services is recognised.

Despite the significant evidence of the impact of life-style factors on physical health and the positive benefits of social care prevention strategies, the pattern of investment in health and social care services does not reflect this. One of the key existing and future challenges is to achieve the right balance between investment in medical science and individual therapies on the one hand and in social care and community support on the other.

Reference

The Campaign to End Loneliness (undated). About loneliness. www.campaigntoendloneliness.org.uk/about-loneliness/

Endnotes

[1] See www.csed.dh.gov.uk.

[2] The most protracted phase of violence being 1968–1998.

[3] Reablement is defined by the UK Department of Health as 'timely and focused intensive intervention to maximise long-term independence and appropriately minimise ongoing support required, through learning or re-learning the skills for daily living'.

Paul Jays is Advisor to the Health and Social Commissioning Board Northern Ireland and a Panel member of the General Social Care Council. He was formerly Head of Adult Social Care at Worcestershire County Council and a senior consultant with the Department of Health (England) Care Services Efficiency Programme.