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LEARNING FROM DOING: IMPLICATIONS OF THE BARKING AND DAGENHAM EXPERIENCE FOR INTEGRATING HEALTH AND SOCIAL CARE

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ABSTRACT

Local government and the NHS in Barking and Dagenham embarked on a bold inititiative in 2001 to integrate health and social care management structures. Although it was not sustained, this local experience is an important source of learning as the search for improved partnership working enters yet another new phase. In particular, it demonstrates that the route to better outcomes depends on managing not only the tension between structure and culture but also that between national targets and local discretion in services based on fundamentally different principles of governance: central management and local accountability.

KEY WORDS

Partnerships; central/local relationships; PCTs and local government; reconfiguration; integrated governance

INTRODUCTION

Local government and the NHS are poised to embark on a new phase of what has been a long journey from joint planning to integrated provision. This next stage is being driven by a series of policy initiatives, including universal Local Area Agreements (LAAs), the future of Local Strategic Partnerships (LSPs), the implementation of 'Commissioning a Patient-led NHS' (CPLNHS) and the White Paper on 'care outside hospital'. Much less clear is how far it is being informed by experiences gained since the implementation of the 1999 Health Act Flexibilities and, from 2000 onwards, the creation of Primary Care Trusts (PCTs). Nor should it be assumed that the current set of policy drivers are themselves, internally

coherent or, even, consistent with the closer integration of commissioning or service delivery.

In this paper, we address these questions with particular reference to a case study we conducted in Barking and Dagenham and have subsequently located within a wider pattern of evidence and experience. Most especially, we are focussing on how that experience can be drawn on to help shape the implementation of this new phase of policy development.

Barking and Dagenham is an outer London Borough with high levels of mortality and social need. In 2001, 75 GPs were working in the area in 45 practices but there were no hospitals within the Borough, a situation which was seen as perhaps elevating primary and social care to even greater levels of significance (LBBD and BDPCT 2001). Previously part of the Barking and Havering Health Authority, the Borough secured one to one coterminosity between the NHS and local government in 2001 through the establishment of Barking and Dagenham PCT. At this point, the NHS and council took the then unique step of creating a joint post of PCT Chief Executive and Director of Social Services. The existing holder of the latter post was appointed to the new role. A number of others followed, including joint Directors of Public Health and of Organisational Development and Corporate Support, as well as a number at operational management level.

The arrangement covered the residents of the Borough and those registered with GPS within it, a total of some 160,000. Two other localities, Southwark in Inner London and Knowsley on Merseyside

subsequently adopted a similar approach. However, the Barking and Dagenham model remained a rare example of organisational integration covering both the commissioning and provider functions of health and social care. The council and PCT had, therefore, elected to undertake two demanding tasks simultaneously, the creation of a PCT and its integration with local social services. In the medium term, it might be argued that the two tasks would not only be mutually reinforcing but facilitate the development of more cost effective organisational arrangements capable of delivering locally integrated services and achieving better outcomes. In the short term, however, the creation of PCTs was, in itself, a major challenge to management capacities and capabilities in the NHS.

Moreover, the approach adopted in Barking and Dagenham cut across the grain of a national policy, personally driven by the Secretary of State, to promote the establishment of care trusts as vehicles for achieving the integration of health and social care (see below).

MANAGING the HEALTH AND SOCIAL CARE INTERFACE

As indicated above, developments such as those in Barking and Dagenham are merely the latest in a long line stretching back to the 1973 Collaboration Working Party (DHSS 1973) and related joint planning circulars. That governments continue to search for new ways of strengthening collaboration might be seen as, at best, representative of the scale of challenge involved and, at worst, indicative that the attempt is built on fundamentally flawed foundations. Since the passage of the 1999 Health Act, the period with which we are dealing here, we can identify four approaches to improving the management of the interface between health and social care: care trusts; Section 31 Health Act ‘flexibilities’;

joint management; and joint commissioning. These arrangements are not all mutually exclusive. Some elements can be, and have been, used in combination.

Care Trusts

The establishment of care trusts was proposed in the NHS Plan as a '*new level of Primary Care Trust…… (to) provide for even closer integration between health and social services'* (DH 2000 para7.9). Although voluntary in the first instance, they were to be imposed when partnerships failed. (ibid. para.7.11) and the Secretary of State told the 2001 social services conference: '*eventually I hope that they will be in place in all parts of the country'* (Milburn 2001). In practice, only eight have been established, four as providers of services for specific user groups and four with commissioning as well as provider functions.

This organisational form is based within NHS governance and performance management frameworks. Largely as a result, it has found few supporters in local government, where it has been perceived as a 'health takeover' and a reduction of local democratic accountability. In addition, the Department of Health appeared to allocate to PCTs the integration of health and social care as an additional core task, while also suggesting that they had 'a responsibility to ensure social care needs are met' (Department of Health 2002, para 2.1.14). Similar statements were not made in relation to local authority responsibilities. This asymmetry of roles also influenced local government perceptions of the centre's governance objectives.

However, the care trust experience provides important messages for those seeking to develop other forms of joint governance. Most particularly, these issues relate to the statutory responsibilities and accountabilities of individual organisations which are not removed by entering into arrangements for integrated governance, whether of the care trust form or other kinds of partnership (Glasby and Peck 2004).

In addition, the creation of new organisations consumes substantial amounts of time and energy. A 2002 CHI report on allegations about the abuse of patients in the Manchester care trust concluded that *'establishing the care trust diverted scarce management time away from service issues and quality of care'* (quoted Samuel 2005). One of the Northumberland Care Trust directors has also acknowledged they '*probably lost 18 months….through organisational change'* (ibid.). It is perhaps unsurprising that so few PCTS embarked on the care trust route, especially as a potential vehicle for commissioning, given the demands of creating what was already a novel organisational model, not to mention local authority reluctance to travel in this direction at all. Moreover, the 1999 Health Act offered other opportunities for closer partnership working which were less time consuming to implement and had scarcely yet been explored. The notion that care trusts were a necessary next step because other options either did not exist or had already failed was not sustainable.

1999 Health Act Section 31 Flexibilities

This legislation removed what were perceived to be legal and bureaucratic barriers to partnerships through statutory provision for lead

commissioning, pooled budgets and integrated services. The underlying philosophy was one of enabling more flexible arrangements rather than imposing new organisations on potentially unwilling partners. Its weakness, certainly for politicians and managers in a hurry, was that it depended on partners being able and willing to recognise the opportunities it provided. Its strength is in allowing for local solutions when partners are ready to make more formalised partnership agreements. Reconciling this need for the emergence of genuine cultural change with the urgent requirements for better outcomes is a challenge which has defeated many localities and governments. Yet, the evidence about the flexibilities is not unpromising.

When introduced in April 2000, the initial take up was slow, but has steadily grown. By October 2004, 414 flexibilities had been established covering partnerships worth more than £3.4bn. Some authorities have applied the flexibilities to whole services, mixing and matching lead commissioning, pooled budgets and integrated provision options. Others have applied specific flexibilities to parts of services such as continuing health care, palliative care, respite or intermediate care. Decisions about how to take advantage of the flexibilities have often been closely related to the robustness of local partnership working. Not surprisingly, the more established the partnership working, the more risks agencies were willing to take. A national evaluation concluded that they had led to significant developments in the '*closer coordination of structures, protocols and processes' as well as less tangible changes* (Glendinning et al 2002, p vi). Significantly, it also identified the importance of *'organisational and professional cultures……. (as) the necessary foundations on which policy instruments like the…flexibilities can be made to work'.* More

specifically, high levels of 'local trust, commitment and successful leader ship' were all found to underpin their implementation (ibid).

JOINT APPOINTMENTS and JOINT MANAGEMENT

The establishment of joint posts at directorate and middle management level has not been uncommon. For example, a number of localities have jointly appointed Directors of Public Health (for example Hartlepool, Kent and Wolverhampton) and/or Directors of Commissioning (for example, Stockton and Salford). Some localities have used joint management arrangements at middle management level to secure clearer managerial arrangements for multi-agency teams (most often in services for people with mental health needs or learning disabilities). Such teams have on occasions operated with a devolved budget which may have been pooled using the Health Act flexibilities, or kept separate but delegated to the team manager, regardless of the employing agency. This approach has increasingly been a feature of intermediate care services. For instance, Salford in Greater Manchester used its Partnership Board for older people to approve an older persons' strategy and phased action plan. Stage 1 involved co-locating intermediate care staff, as an agreed first step in moving towards a jointly managed service. Stage 2 saw the appointment of a single manager for the joint service and a pooled budget is being introduced from April 2006.

Knowsley also complemented its joint Chief Executive/Director of Social Services post with a range of joint appointments at different levels. In addition, it used the Health Act flexibilities in 2004 to establish an over-arching partnership agreement between the PCT and social services. The agreement contains an integrated management structure and details of integrated support provision across a wide range of services with the

intention of improving strategic and lead commissioning arrangements, and the management of any pooled budget arrangements. It is overseen by a Health & Well-being Partnership Board under Section 2 of the Local Government Act 2000 and Section 10 (2) of SI 2000 (617) – NHS Bodies and Local Authorities Partnership Arrangements. The Board is chaired jointly by the Leader of the Council and Chair of the PCT, each sitting as the chair alternately. Peterborough has similarly used the flexibilities as the formal basis for a partnership agreement under which a pooled budget and unitary management structure were established for the PCT and social services (Cole 2005).

JOINT COMMISSIONING

The essence of lead commissioning is that one authority exercises responsibilities on behalf of another. By contrast, joint commissioning involves the pooling of such responsibilities and was promoted by the Department of Health. A document published in 1995 sought to clarify how far health and local authorities could proceed within their then statutory responsibilities (Department of Health 1995). It has normally involved the creation of joint boards, often client group specific and underpinned by jointly agreed commissioning machinery and shared budgets. In Durham for instance the County Council, three PCTs and six District Councils have formed a partnership to develop integrated assessment and commissioning for adults (Hudson 2005). The emphasis is on the creation of localities where staff from SSD, Community Health and Housing work as integrated commissioning teams under a single manager responsible to a Partnership Board which sets the strategic direction. The team provide an integrated front line response with shared budgets, policies and procedures.

THE BARKING AND DAGENHAM EXPERIENCE

The establishment of the joint post of PCT Chief Executive and Director of Social Services was intended to be the first stage in a wider process of structural integration. A number of other joint appointments were made, arrangements for joint/integrated governance began to operate and the integration of service delivery was further developed. The adoption of organisational integration as the vehicle for the health and social services partnership in Barking and Dagenham was a local decision, as was the particular form adopted there. It was seen as leading to a joint board of councillors and PCT directors *'similar to a care trust but…not an NHS organisation'*. The Barking and Dagenham model covers all groups (including children). This was thought to be essential because '*the most vulnerable individuals and their families tend to cluster in the more deprived neighbourhoods'* (LBBD and BDPCT 2001).

Nonetheless, as a local response to a local situation, the approach lacked the status of a nationally promoted and owned innovation. Although endorsed by the Department of Health, it also lacked the developmental support and resources available to infant care trusts which, politically, could not be seen to fail.

In the event, the Barking and Dagenham initiative proved to be short-lived in its original form. The joint chief executive post was disaggregated into its two component parts in September 2003, following the PCT's zero star rating that year. The joint post holder remained the Director of Social Services and an acting PCT Chief Executive was appointed prior to a substantive appointment being made the following spring. However, other joint appointments were retained and both

organisations sought to secure the benefits of integration, albeit through other organisational forms. Moreover, they wished to ensure that the new relationship built on learning from their initial experience. Consequently, we were invited to undertake a forward looking study of the experiences of integration locally and in the context of relevant practice elsewhere. The focus of the study was integration at a strategic level across the organisations. Whilst we are also aware of examples of integration at an operational level, these were not examined in any detail during the course of our study.

The study was based on three principal sources of data: 18 completed questionnaires based on the Partnership Assessment Tool (PAT); 16 semi structured interviews; and the analysis of relevant literature. The PAT questionnaire (Hardy et al 2000 and Hardy et al 2003) is a standardised instrument, developed for the DH and ODPM, and based on findings from a long-term research programme at Loughborough and Leeds Universities. The interviews were conducted using a topic guide developed for the purpose. Its design enabled responses to the PAT questionnaire to be followed up in greater detail. Potential interviewees were identified through a combination of local knowledge and external experience.

It was immediately clear that there was a broad recognition of the need to move on rather than become '*obsessed with what had clearly been a very painful process'.* However, a need was also recognised to look back but only as an integral part of a forward looking process based on the promotion of understanding rather than the allocation of blame. The same commitment to learning from experience was evident in the decision to look outwards at practice being developed in other localities.

The PAT responses and our interviews generated rich data from and about many perspectives: officers and clinicians in the PCT and across the local authority; the SHA; non executive directors; and Borough councillors. We organised our findings into four categories derived from the research underpinning the PAT. In each case, we identified both their contribution to the breakdown of the original approach and their lessons for the future. We discuss these messages below.

UNDERSTANDING PAST EXPERIENCES

1. **Pace and scope of change:** the introduction of the integration initiative coincided with the PCT's establishment, its organisational development agenda and high stakeholder (especially GP) expectations about developing primary care. As a result, the agencies were required to manage a change agenda which presented substantial demands of scale, complexity and time. This issue was raised more frequently by NHS respondents, reflecting the PCT's situation at the earliest stage of organisational development compared with the Council's long established position. NHS concerns clustered around the belief that the locality had attempted to travel *"too far too fast"*. Thus, the decision to seek structural integration was seen as a step too far:

   > *"In principle, (integration) is the right thing but the degree to which it took place was too great"*.

   It proved more difficult than anticipated to 'disentangle' the PCT from the Health Authority and put basic organisational policies, systems and procedures to be in place. The situation was compounded, from this perspective, by the integration agenda absorbing managerial time and effort which might better have been devoted not only to creating a

PCT with robust foundations but also to advancing higher order NHS priorities. A respondent argued:

> *"Integration is the icing on the cake and the foundations must be rock solid*".

Such views were not restricted to the NHS. A local authority respondent considered the authority had:

> *"Probably underestimated the size of the job and its complexity, particularly at the strategic level……(Moreover) our core business is not interface issues"..*

2. **Clarity of purpose:** as the above comments imply, there was a lack of consensus about the centrality of the integration agenda. Insufficient attention was also seen to have been paid to agreeing partnership outcomes. A respondent argued "*we need to be clear about why we are working together"* and particularly suggested that the reasons needed to be expressed in terms of benefits to individual service users and patients. Another respondent elaborated this perspective:

> *"Social services and the PCT must be very clear (not only) about what they want integration to do (but also) what they do not want it to do."*

Finally, a number of those interviewed suggested that there had been too much emphasis on structural integration both absolutely and also compared with the need to combine structural approaches with less formal mechanisms focussed on relationship building or '*winning hearts and minds'.*

3. **Organisational compatibilities:** basic incompatibilities largely derived from the mismatch in cultures, understandings and behaviours of the two services were a major source of difficulty. An example cited was that the local authority was perceived as wishing to develop a local strategy for addressing the causes of coronary heart disease in a deprived population. However, it was considered far less interested in meeting the four hour wait target in A and E. More critically, it did not appear to understand the full significance of such targets in the NHS performance management system: nor did it appear to understand fully how that culture operated:

   'you can't " just miss" a national target in the NHS……We have to deliver what is required of us from above and make sure local delivery fits into national priorities'.

Similarly, the significance of national policies, objectives and performance regimes for local government did not seem fully appreciated in the NHS. For example, social services' responsibilities to the Comprehensive Performance Assessment 'as part of a bigger organisation' paralleled the PCT's accountability for delivering national access targets. Moreover, local government performance regimes focussed attention on how far its services are 'meeting local needs well'. Thus, this objective was seen as a national target for local authorities.

The different emphases on national standards and local needs created a degree of mismatch in priorities. In addition, the two organisations seemed to understand their respective behaviours from the perspective of their own performance regimes. Interpreting partners' actions through the lens of performance systems which are not applicable to them almost inevitably leads to confusion if not disagreement.

A further expression of different understandings was to be found in descriptions of the services' respective roles. Significantly, most respondents who commented on this issue did not identify shared or common responsibilities. Rather, they highlighted differences which we summarise below with the characterisation of the NHS preceding that of social services:

- *treatment/care;*
- *national targets/local needs;*
- *must dos/local discretion;*
- *universal service/focus on vulnerable;*
- *procedurally regimented and very top down in style/practical focus but has difficulty in strategy and planning.*

Each of these points of contrast is illustrative of the different cultures, understandings, behaviours and external expectations that characterise the NHS and local government and which form inherent barriers to partnerships. Many of these differences are rooted in the fundamental differences between nationally administered and locally governed services. As a result the council may have underestimated the role of the SHA. There was some recognition it *"really didn't do the ground work with the SHA"* and that *"it was more opposed than (we) had realised"*. They experienced the SHA as *"breathing down our necks"* and for at least one respondent the *"key issue is how independent the PCT can be of the SHA".* Raising this issue is itself potential evidence of misunderstanding the role of hierarchy in NHS central-local relations compared with local government. When difficulties arose there seems to have been too little support from an NHS hierarchy focussed on failure in delivering national access targets. With frontline

clinical staff sharing concerns about the level of attention given to the local primary care development agenda, local support was also muted.

Similar difficulties arose from the NHS underestimating or not fully understanding the role of politics and politicians at local level. For example, in a statement which parallels the council's misunderstanding of NHS hierarchy, a PCT respondent reflected critically that *"there was an emphasis on what members want"*. For their part, however, at least some councillors saw their elected status as justifying greater control over the NHS.

4. **Equality of ownership:** as the new PCT had not had the opportunity to establish its own identity and organisational capacities, there was the tendency to see it as a "junior" partner compared with the established Local Authority. In a reversal of the perceptions attached to care trusts, perceived agendas of 'control' and 'take over' influenced difficulties between elected members and non executive directors. The experience of the partnership as not one of equals was prominent in the PCT:

> *"The (joint) post was not really perceived as a partnership but as the local authority, not taking over the PCT, but having a larger influence than expected. It did not feel like an equal partnership"*.

However, the importance of history and context was also recognised:

> "*We were a partnership of 2 organisations, one which was completely new (PCT) and the other was an intrinsic part of another, much larger organisation, and well established. It*

made it harder to be a partnership of equals, although I believe we did the best we could"

LEARNING from the PAST

The categories in which we have located our findings serve two purposes. They enable us both to organise our analysis of respondents' perceptions and also to structure learning points to help address the reported problems. We identify those learning points below:

- **Pace and scope:** balance ambition about aims with realism about what can be achieved in the light of all the other demands on management time and other capacity.
- **Clarity of Purpose:** focus on outcomes for local residents while also establishing an appropriate balance between ends and means (function and form),
- **Organisational compatibilities:** openly identify areas where differences between organisations potentially work against partnership objectives and develop agreed strategies for managing them: recognise the legitimate existence of separate as well as joint objectives
- **Equality of Ownership:** equality of ownership is the essence of partnership but this does not necessarily imply equality of contribution; 'senior' and 'junior' roles may legitimately vary by theme/topic and at different stages in joint processes without necessarily undermining partnerships; the language of control and take over is corrosive and should be surfaced immediately

BUILDING for the FUTURE

Our respondents also readily identified a number of strengths on which their agencies could build:

- Growing organisational maturity and robustness in the PCT, leading to internal greater self confidence and a growing sense of potential equivalence between it and the SSD
- Recognition of strong leadership at the top of the PCT and SSD, supported by mutual respect and good relationships between the two leaders
- The willingness and commitment to commission this study jointly and as a basis for moving on rather than for self justification or identifying blame
- Largely new senior management teams in both agencies which lack the baggage of the past and, in several cases, were attracted to the locality by its integration agenda
- Some effective partnerships at operational level and a belief that, even after their past experience, they were still ahead of the game at directorate level
- Sufficient willingness and trust at senior officer level to contribute to the others' agenda, confident in the knowledge that a quid pro quo would be forthcoming but without needing advance specification
- Recognition that national and local policy imperatives would increasingly push them together rather than pull them apart to the previous extent
- Ability to begin to debate and develop a specific joint agenda aimed at securing improvements in the health and well being of their local population.

It was striking, given the history of the period 2001 to 2003 that respondents were able to build up a relatively positive view of the foundations on which they could now build. For at least some, this perspective was influenced by what were seen to be the continuing

development and consolidation of integrated working at the level of service users, as this comment from an operational manager demonstrates, "*How we moved forward on asylum seekers was a good partnership model*" The endorsement of integrated teams in learning disabilities and mental health, together with the establishment of such teams for older people and the joint work on intermediate care, were seen as positive indicators of productive partnership working despite the difficulties of strategic integration. Our study did not, however, enable us to explore in the same detail the extent to which these strengths were well founded or have since been realised.

CONCLUSIONS

We turn now to some implications of the Barking and Dagenham experience against the background of developments elsewhere. First, it is difficult to see how a different short term outcome could have resulted by adopting any other mechanism. The flexibilities, joint appointments and joint commissioning all operate in an environment which provides 'no stars for integration' and where NHS priorities have effectively been non-negotiable. A care trust, however, would not have been disestablished. It might just have been given longer to prove itself but internal NHS performance management systems would undoubtedly have prevailed, albeit less publicly, as in Northumberland where the Chief Executive and Chair both moved on in the face of financial difficulties. Moreover, some of that Care Trust's commissioning responsibilities are already being exercised by a consortium and will be removed entirely if the SHA's initial, 'preferred option' for re-configuration is ultimately accepted in

2006 (Northumberland, Tyne and Wear and Durham and Tees Valley SHAs 2005)

The proposed incorporation of the Peterborough Partnership into a much larger PCT similarly suggests that even successful initiatives in integration can be subordinated to internal NHS agendas. Notwithstanding the growing emphasis nationally on public health and reducing hospital admissions since the joint post was ended, integrated commissioning (through whatever mechanism) is not seen as part of the solution to current NHS commissioning difficulties in all parts of the country. Even where, as in London, coterminosity is to continue, it is not clear that local commissioning powers and budgets will be fully retained. More generally, the apparently quite separate processes and timetables for consulting on the future of NHS commissioning and the future of LSPs is a matter for concern.

Second, the models for partnership working identified above do not help address the conflicting patterns of central local relations inherent in partnerships between centrally managed and locally governed services. As they are essentially designed to address difficulties in horizontal rather than vertical relationships, this is unsurprising. Care Trusts do internalise this pressure to some extent but do nothing to align the still separate NHS and local government based central/local accountability and priority setting mechanisms. This problem is becoming more pronounced as ODPM sponsored LSPs and LAAs are expected to take on stronger roles. A more recent study has also demonstrated the need for a unified performance management and accountability system to support cross sector targets (Wistow 2006). Until such a framework exists, locally

integrated systems will be subject, as in Barking and Dagenham, to conflicting demands of integration and separatism from above.

Finally, this case study and the other models reviewed highlight the tension between structure and culture. Neither is unimportant but the challenge is to find an appropriate balance. In Barking and Dagenham, too much emphasis on structure was reported at the apparent expense of either 'winning hearts and minds' or overcoming professionally and politically located differences in objectives and priorities. The flexibilities evaluation similarly emphasised the importance of cultural change (Glendinning et al 2002). The growing take up, however, as exemplified in Peterborough and Knowsley, supports the evaluation's findings about the critical role of local commitment, trust and leadership.

The same evaluation concluded that *'the fine-grained relationships which have to be built at local level need to be better understood and supported'* (ibid). The case study and other evidence presented here all provide further insights into the dynamics and influence of such relationships. They also demonstrate that the route to improved outcomes depends on managing not only the tension between structure and culture but also that between national targets and local discretion. We are still some distance from designing an integrated governance system capable of reconciling either of these tensions and certainly not both of them. Yet that, we would argue, is precisely the lesson of the last five years. It is one which the implementation of 'Commissioning a Patient-led NHS' (Crisp 2005) and the consultation on the future of LSPs (ODPM 2005) must together accommodate if the long journey to integration is to get significantly closer to its destination. It is, however, an accommodation that the ODPM

consultation should theoretically be equipped to meet, if the opportunity is recognised and seized by central and local government alike.

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