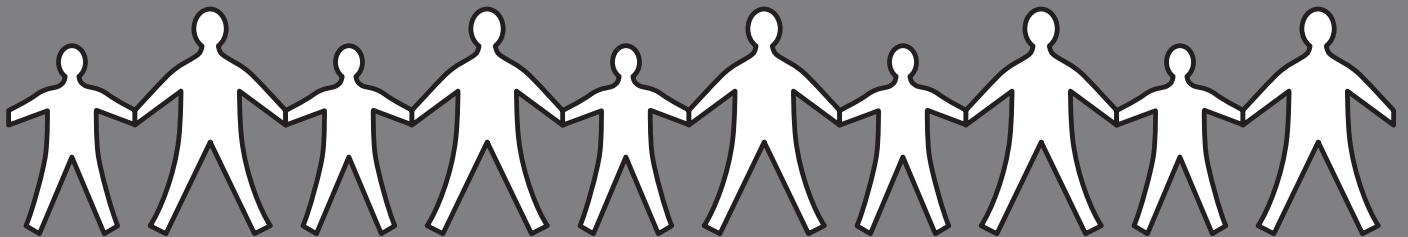


the new  
landscape  
in social  
care and  
health



## introduction

Over recent years, local authorities have reconfigured their social care, separating children's from adult services and creating new forms of partnerships with Primary Care Trusts and other parts of the NHS. As a result, there is now a wide variety of organisational arrangements in place, and new ones on the way. A new landscape for health and social care is being created.

The emphasis on place shaping and the creation of healthy and sustainable communities, the requirement for Joint Strategic Needs Assessments and Local Area Agreements and the push for better commissioning and greater productivity are important drivers which have accelerated the pace of change. There is now a much greater emphasis on prevention through local partnerships for health and wellbeing, and the children and young people's plans also demonstrate this shift in focus. How should local partners respond?

There are two schools of thought about this. One school, the "incrementalists", have decided to concentrate on making the existing systems work for them by a process of mutual adjustment and realignment, building on shared values and goals. Their focus is on securing better outcomes for the local population without the distraction of organisational change. This is to be achieved by building on long-term working relationships and creating a local consensus about priorities and action.

The other is more radical. The argument is that organisational form should follow function. The imperative for better local outcomes implies a major change in working processes, and organisational designs should therefore be changed to reflect them. The requirement is for transformational change in how the partnerships are organized. In an earlier wave of reorganisations, the establishment of the Care Trusts represented such a transformation. The intention was to bring together related services for the same particular groups of service users. Currently, there is an even more ambitious proposal to establish a "Super Authority" in Herefordshire by merging the PCT and the Council. In this case the proposal looks at the whole of the local population, and some seventy percent of the resources of the partners. It takes the debates about partnerships to a different level.

In recent years, therefore, different localities have responded to the imperative for closer partnership working with a variety of local solutions. There are some key questions about these arrangements which may be answered only with hindsight:

- how far should form follow function in the design of our public services?
- do new technologies make this thinking irrelevant in the age of 'virtual' organisations?
- will organisations that have not changed their structures prove capable of responding to new demands by incremental and mutual adjustments, or prove to be too

slow and inefficient to cope with the new agenda for productivity and improvement and risk getting left behind?

- will the more radical new forms of organisation really be capable of delivering better outcomes for local people - more efficiently and at a faster pace?
- or will they get tied down by the effort required to reorganise when there are still so many difficult and unresolved issues of governance, finance and human resources associated with such joint ventures and mergers?

These are important and debatable questions, with only limited evidence available to help us answer them at this stage. The first thing that is needed is to identify the models of organisation that have emerged so far. What are they like? How can they best be described and understood? This paper offers a preliminary and very personal picture of the emerging ecology of organisational forms, and picks up some of the more obvious and immediate issues associated with each of them.

## understanding the new organisations

Expectations are rising that local partnerships should be able to deliver far better results, and so they should, because the geographical and social variations in key indicators for health and wellbeing are simply unacceptable, and there are wide differences in access to local services and in their quality. The inequalities in life expectancy and health between the best and the worst areas remain stark, and these are linked more generally to the broader social determinants of health and wellbeing, as well as to lifestyles and access to services. Tackling these issues to produce better outcomes requires strong alignment between public agencies at the local level, as well as productive engagement with local communities. So a great deal more is now to be expected from local partners. It is timely, therefore, to take stock of developments so far and ask what kinds of organisations have been developed to support more effective outcomes and better joint working.

It may be helpful to think in terms of the three organisational levels of operational delivery, strategy and governance. Examples of inter-organisational integration can be found at all three levels. We can imagine organisations that have virtually no contact at any of these levels, and those that are so fully integrated at all three that they have merged, as happened with Care Trusts. In between these polarities, a number of positions

are possible. The organisations could be coupled together only at one level and for very specific and limited purposes, or the coupling could extend across a much wider range of joint activity and involve all three levels. They could form loose alliances or be much more tightly bound together to create 'virtual' organisations which feel real to their service users and staff, despite the limited nature of their legal form. Finally, the partners might engage in a significant level of shared governance and real power sharing at the level of their boards and executive teams, possibly reshaping their structures to create new types of partnership which fall short of merger.

It may also be helpful to think about these questions in terms of the division between commissioning and provider functions. Most local authorities have developed sophisticated approaches to planning, procuring and providing services and have built up considerable experience over the past twenty years. Even so, in a recent report, "Safe as Houses? What drives investment in social care", published this month by the Commission for Social Care Inspection, there are criticisms of the failure of councils to change their contracting arrangements to shape social care provision in more innovative ways. This is what will be required in future to offer more personalised support. For PCTs, the experience of commissioning from a plurality of providers has been more recent and less extensive. Most of the joint commissioning so far has been for a restricted range of health and social care services, and some health

promotion schemes in the voluntary sector. Now the challenge is to apply the lessons learned from best practice far more extensively, given the new environment of direct payments, individualised budgets and patient choice.

PCTs and Local Authorities are both commissioners of closely interdependent services, very often for the same groups of people. Much of their money goes on intensive health and social care services for older people, where the demographic pressures are considerable for both organisations. Increasingly the advantages of closely aligned budgets have been recognised, although it has still proved difficult to move funds from relatively inefficient downstream areas into systematic programmes of upstream prevention. Relatively little money goes on the promotion of healthy ageing, despite the common responsibility of the agencies and the proven benefits of this type of investment. Local Authorities are in a key position to mobilise services such as libraries, cultural and leisure facilities to strengthen the promotion of good health and active ageing. This would be a good investment. It would probably involve moving only small amounts of money from other service areas into such schemes, and yet this has been difficult to achieve because commissioning has not been sufficiently determined in the face of the intensive demands.

There are practical benefits in joint commissioning across the whole spectrum of health and local authority

services, from better access to mainstream council services and their redesign to meet new needs and expectations, to improving the quality and value for money in very specialist health and social care services. In many areas inter-organisational developments like these are already happening, but often as localised projects rather than mainstream programmes. Progress has been slow. Good practice in one field or locality has not always been adapted systematically and spread to others fast enough. The key local partners now need to find ways of enhancing the impact of their joint commissioning, not only for urgently needed health and social care services, but also for wider population health and wellbeing, which is fundamentally about the quality of life of individuals and families in their local communities. Whatever organisational models are in place, they will need to rise to the challenge of strengthening local outcomes and building healthy and sustainable communities.

## the new 'standard' model: adult social care and children's services

We will look first at the most common model for organising council services that has emerged in recent years. It has become the new orthodoxy. Over the past decade, most local authorities have separated the management of their services for children and adults. This development emerged from the ground up over several years of local experiment, with a number of pioneering authorities leading the way when it became apparent that the horizontal synergies between age-related services were probably more important than the maintenance of unified social service departments. Subsequently, the requirement for a single Social Services Director was removed and separate departments for children and adults were created in most places. The children's service arrangements were the first to be introduced in most authorities. They usually incorporated responsibility for education, early years and youth services, social work, social care and other services for children and young people. It took most authorities a little longer to decide how best to organise their adult services, and to determine the scope of the Director of Adult Social Services. Most now have a wide range of responsibilities, often including housing and neighbourhood services as well as social care. Places

like Hertfordshire and Liverpool were up and running with their new arrangements very quickly, whilst it took others some time to implement the new model once the requirement to have a single Director of Social Services was removed.

These arrangements are now in place in most parts of the country, providing the opportunity for better integrated planning, commissioning and service delivery for the relevant cohorts of the population, and with a much stronger focus on outcomes, partnerships and prevention. Both services for children and adults have often been redesigned specifically to strengthen commissioning and to reinforce joint working inside the council and with the NHS. (The depth of NHS involvement with local authority children's commissioning and localised delivery of services is still very variable). What had seemed revolutionary only five or six years ago in clustering public services around the lives of children and adults in their local communities has now become the "standard" model.

The model has common features and is easily recognisable although it comes in distinctly different local flavours. There are, for example, different models for children and young people. In Brighton and Hove, for example, the Children's Trust incorporates directly-provided health, education and social care services as well as planning and commissioning. In Leeds, where there is a separate public-private partnership (Education Leeds) running the services for schools, the Children's Trust arrangements are focused on

the commissioning and performance functions, with a strong core team and a range of diverse providers commissioned by them. These differences are clearly the product of scale, history and local aspirations, and they indicate the value of local flexibility so that local solutions can emerge in response to common policy initiatives.

On the adult side, over half the Directors of Adult Services have housing responsibilities and oversee the Supporting People programme. They are also likely to be responsible for a mixture of other services, which might include culture and leisure, community and neighbourhood services, health, crime and disorder partnerships and environmental services. Despite their title, most have a broad view of what needs to be done to secure long-term improvement in many areas of daily life, and a commitment to promoting health and wellbeing rather than meeting only immediate social care needs in a crisis. This rich and very varied mix of responsibilities has been tailored to local circumstances and needs, and illustrates the strength of local government in creating organisational solutions that are appropriate for each individual place and set of circumstances.

The business of adult care can be successful only if sound working arrangements are in place to link health, social care and other related services. Effective joint commissioning is of fundamental importance

A wide variety of approaches has been taken to the commissioning function.

### Liverpool

**Liverpool City Council pioneered the new model soon after Hertfordshire, establishing an Executive Director for Children's and for Adult Services within a major redesign of the whole of the local authority's business processes. The Adult post extended well beyond the traditional field of care management and social care provision, to embrace housing and a wide range of community services. Tony Hunter, the current Executive Director, stresses the importance of enabling people to participate fully in community life as active citizens, not simply as passive recipients of care. The wider remit designed into the new Liverpool structures has made it more flexible and responsive to changing needs and expectations, and helped it to take a holistic view of local needs. One example is that when older people in the City described what concerned them most about staying active, they were as interested in street lighting, transport and city centre toilets as barriers to mobility as much as the provision of specialist care. Attending to the basics will probably help to reduce the pressure on care services in the longer-term. The City, like most other areas, is working hard to balance the provision of services for those with immediate care needs with the longer-term agenda for wellbeing. This breadth of vision allows Liverpool to make important connections between urban renewal, employment, housing, education and the reduction of health inequalities as well as health and social care services.**

Most often, there are parallel structures in place to link health and social care staff through joint plans and service agreements. In Stockton, for example, there have been no proposals to integrate commissioning management, although joint planning and service delivery are highly effective. In Barnsley, joint commissioning posts have been created to support a successful drive for improvement by the Local Authority and PCT working together after critical inspections several years ago. In many places, there are mutually agreed lead commissioning responsibilities which weave the organisations together and

share out the local responsibilities. Most areas have some pooled budgets, despite all the difficulties encountered in establishing them - mostly for learning disability, some for mental health and a few for older people's services.

The standard model has a number of benefits. It recognises the different policy and legislative frameworks for children and adults, and places social work and social care alongside the more generic services for the respective age group. Clearly, education, early years and the youth services need to

be planned closely together with social care and social work for children and young people, child health services, school nursing and CAMHS. Adult social care, equally, needs to be developed alongside housing, leisure and culture and the relevant local community health services. Even more important, these all need to be seen in the wider context of more holistic planning for the whole population living in that particular place. The best way to improve health long-term is probably to improve educational attainment, and the best way to keep older people out of hospital is to help them keep active. Service commissioning needs to be flexible enough to respond to this broad agenda for health improvement and sustainable living. The new “standard” model allows this re-focusing to happen by mutual adjustment between organisations without requiring any major redesign of their governance, HR or finance framework. It has proved to be a very flexible and adaptive approach, supporting incremental change and joint learning, and cultivating common aspirations.

It is, of course, both a strength and a weakness of the model that both the local authorities and the PCTs can walk away from these arrangements with relative ease when difficulties arise, and they are often over-dependent on the personal commitments of individual senior managers, directors and councillors. Whatever else, the model is “high maintenance” in terms of the energy and commitment of senior Members and managers. There are some other disadvantages. The

formal machinery for decision-making can be complex, and decisions may take time to arrive. The transaction costs of doing business together may be high, with costly duplication of posts and effort. There are often grumbles about the amount of time spent in meetings, and about the levels of uncertainty about joint priorities across the organisations. There may also be a tendency for PCTs and local authorities to lose some of their core commitment to funding joint services to the extent that these areas may come to be seen as somewhat “external” to the rest of the organisation. When mental health and learning disability budgets, e.g., were expected by the PCTs to make a contribution to NHS financial stabilisation plans, it was very difficult for the joint commissioning managers caught between their two masters, neither of whom was willing to pay the piper – especially when the demand for these services was rising and budgets shrinking.

Despite these concerns, the model seems to be working well in most places. When arrangements are working well, one reaction is to let things rest, on the supposition that “if it ain’t broke, don’t fix it”. From this point of view, it is better to concentrate on securing outcomes directly without any further organisational change. Improvements can often be achieved incrementally without the upheaval and risks of reorganisation. Change can be time consuming and may not ultimately be productive.

## merging the senior management of health, social care and related services

Another reaction is to let the model evolve opportunistically and incrementally to the next logical stage of integration, building on the partnership working already achieved. For adult social care and health, this has often involved linking together the management of the PCT and Local Authority through different kinds of senior post. There have now been several joint appointments of PCT Chief Executives and Directors of Adult Social Care. In Knowsley, the local organisations built on a good history of joint working to set up the joint post of PCT Chief Executive and Council Executive Director of Health and Social Care. In this case, successful informal arrangements were strengthened later on by the design of a stronger joint governance framework. This was necessary because of concerns that such an important partnership should not be held together only on the basis of an individual appointment, and a more robust institutional framework was needed. The earlier example of integration in Barking and Dagenham had not proved sustainable in the longer-term in the face of conflicting priorities and performance requirements from the Local Authority and NHS. We are perhaps in a more receptive situation given that there are now several examples of successful

### Peterborough’s Joint Service Centre

A reflection of this seamless approach and commitment to improving outcomes is the city council and its partners’ recent decision to establish a multi-million pound joint service centre in the Hampton area of the city. The centre will include a library, café, meeting rooms, sports and health care facilities along with a church. The centre represents a significant commitment from partners as the city council, primary care trust, Hampton Health, Church of England and Methodist Church will all be making a financial contribution and demonstrating their determination to provide the best possible services for local residents. Consultation with residents about what the centre should contain showed strong support for this multi purpose centre in one of the city’s newest townships. It is hoped that the services and facilities provided will look after all the needs of local residents by caring for their bodies, minds and spirits.

integrated management at this level. These kinds of arrangement do need high levels of trust and the firm prospect that they will be allowed to run for some time to justify the effort and the risk.

In Peterborough, the creation of a new Unitary Authority allowed adult social care services to be taken in a different direction. They have been managed in the PCT. As well as a long-standing jointly appointed post of Director of Public Health, there is also a Director of Adult Social Care Services and Performance (covering joint responsibilities) and an Assistant Director for Integrated Community Services running both health and social care teams in the PCT. The partners stress the practical benefits for local people that have come from this very close integration of health and local authority services.

## merging the PCT and the local authority

The models presented so far have focused primarily on health and social care. The Herefordshire proposals introduce some very significant issues of organisational identity and governance.

The circumstances of Herefordshire are very particular, but it has attracted considerable interest from the Department for Communities and Local Government and raises some important questions. The proposal has been presented as the local solution to a local problem in an authority which covers a large geographical area and has a small population. It seeks to put together within one organisation the two largest public sector agencies in the county. In the process it aims to incorporate functions held by the NHS, a national body, and the unitary council at local government level. This would probably require primary legislation to create a new form of legal entity with mixed powers and duties. In the meantime, and before this could happen, the emerging partnership would have dual responsibilities and delegated authorities within the legal limits of the two statutory partners. They would continue in existence and carry all their current responsibilities. To the degree that the partnership board assumed decisions at the edge of the current delegations, it might be open to challenge about the “ultra

### Herefordshire

Recently the notion of a “Super Authority” has been suggested for the unitary council of Herefordshire. This involves appointing a single Chief Executive for both the PCT and the Local Authority. Initially, the joint Chief Executive would be separately accountable to each, with an informal public services partnership overseeing strategy and performance for a budget of some £300 million and over 3000 staff. The intention then would be to secure legislation to formalise the merger by creating a new legal entity in the form of a Public Services Board.

This radical proposal has been presented as a response to the local search for greater cohesion and effectiveness across the two organisations. The argument is that this would better protect local services and allow more sensitive long-term development in the county than some of the possible alternatives. It would also be more efficient, reducing the costs of management and governance very considerably. At the same time, it would restore a measure of local democratic control to health services, through the Trust Board. The local fear was that because of the relatively low population of Herefordshire (180,000), the PCT might have been pushed towards merger with one of its neighbours, and the Local Authority might eventually have been driven by the need to secure greater efficiency to similar mergers with neighbouring authorities for shared services. Taken together, it is believed, the scale of a Local Public Services Trust would make for a viable local organisation.

vires” rules for public bodies, in the way that has happened to some other partnerships over the years, most recently to some Local Strategic Partnerships that have acted as the conduit for grants to the voluntary and community sector.

Despite all the issues associated with the proposal, it is a brave attempt to create new variety in the range of options available to local partners, and there is a sound organisational logic behind the proposal.

## local authorities that have chosen to retain a single director for both adults’ and children’s services

A small handful of local authorities have taken the decision to appoint a single Director to the two statutory posts of Director of Children’s and Adult Social Services. It should be stressed that they do not run Social Services Departments, and the authority has decided in each case that this is the most suitable local arrangement. The list includes the City of London, Ealing, the East Riding, Redcar and Cleveland, Stockton on Tees, Surrey, Wakefield and Windsor & Maidenhead. These include authorities of different size, organisational history and political complexion. They have all been concerned, in considering their local arrangements, to ensure good family support and to handle transitions from adolescence into adult life effectively, whilst using resources efficiently.

These local authorities with a single director now stand in marked contrast to those using the new standard model, although it is difficult to describe from the outside whether they tend to operate internally as distinct and separate departments or more integrated organisations at the lower tier. It would be unwise to think of this group as resistant to change, or to see

### Surrey

The County Council is led by its Executive Team of ten County Councillors, supported by the Chief Executive and Management Team. There are four groups of services:

- Services for Families
- Services for Communities and Customer Services
- Corporate Services
- Policy and Performance

Surrey is of particular interest because the decision was made to recreate a single post covering both adults and children within a County Council that was seeking to radically transform itself through business process redesign. There is a strong emphasis in the county on access through integrated customer service points and on using new technology to support council services. The aim is to improve services and become more productive by engaging in a step-jump transformation. Since a considerable amount of social care provision is already outsourced and back office functions streamlined, it is argued, there is no need in future to have two directors of separate departments.

them as completely different from the others, and they do include some high performers. Leaving aside Surrey, they are relatively small and coterminous with the smaller PCTs.

## care trusts

In the early years of the century, a small number of integrated Care Trusts were set up. They were for the most part designed to integrate local authority and NHS services for people with severe and enduring mental illnesses and learning disabilities. The Northumberland Care Trust, however, was more comprehensive.

Although enthusiasm for the Care Trust model waned for several years, not least as a result of NHS top-slicing of budgets to help stabilise finances, there has been some renewed interest lately. North East Lincolnshire has recently created a new “super” Care Trust incorporating adult social care and community health, and, at the same time, has brought public health services into the local authority. The claim is that this should allow the new Trust to operate in a more focused and coherent way to improve health and social care services whilst strengthening public health as a result of the more direct links within local government.

### The Northumberland Care Trust

Northumberland Care Trust covers England’s most northerly county with a population of 317,000 people living in rural and urban areas. It was set up in April 2002 and was the first primary health, community health and adult social care based Care Trust in England and Wales. It was developed in partnership with Northumberland County Council. Around 1,800 health and social care staff are employed by the Care Trust and has a budget of just approximately £440 million.

The Care Trust is responsible for tackling health inequalities across the county, developing primary and community health services as well as commissioning and paying for health and social care. In addition to this promotion of healthy lifestyles and communication of health messages to local people are an important part of the Care Trust’s activities.

The Care Trust provides a wide range of primary, community and intermediate health care services, including community nursing, child health services, occupational therapy, palliative care and a wheelchair service. Social care provided by the Care Trust includes care management services for older people and for adults with physical disabilities or learning disabilities. Furthermore, it manages other social services on behalf of Northumberland County Council, including day care, home care and residential homes.

The Care Trust commissions all NHS services for the population of Northumberland. This is done in partnership with Newcastle Primary Care Trust (PCT) and North Tyneside PCT. The Care Trust also commissions social care services for adults. The Trust provides some services directly and agreements are in place with a range of other service providers, including NHS trusts and other statutory, voluntary and independent sector organisations.

## new provider arrangements

There are several other important new currents running in relation to provider arrangements for health and social care, in addition to Care Trusts. Many local authorities have supported local social enterprises and cooperatives on a relatively small scale to provide training and employment services, as well as home care, cleaning and gardening services. These have often been highly localised, operating alongside voluntary and private sector services. Attempts are being made to extend the scope of these types of organisation, most notably in Surrey and Milton Keynes. It has proved quite difficult to transfer larger and more professionalised NHS and council services into these models. Professional staff have been reluctant so far to exchange the relative security of local government and NHS employment for the opportunity to build more flexible and responsive services. The personal risks seem high and NHS staff have a passionate attachment to the NHS “brand”. Over time, we may see a transformation in these attitudes as the social enterprises find their feet and grow, whilst the NHS diversifies its provision.

There are some other new kids on the block. The LIFT schemes were intended to help GPs replace poor quality surgeries, especially in inner city areas. They involve local partnerships with councils and other partners to set

### Sunderland Home Care Associates

Sunderland Home Care Associates (SHCA) is a domiciliary care agency, providing personal care within service users’ own homes. Care is provided primarily for older people and also for younger adults and children. SHCA provides support to just fewer than 300 service users and employs 112 care staff. The agency provides domiciliary care services under contract to Sunderland City Council (Social Services), by private arrangement, and with local colleges (for Student Support). It has recently expanded its care services to the South Shields area.

SHCA is an employee-owned social enterprise; staff members play a vital role in the decision-making process and own a share in the company. This means profits are spent on providing a better service and towards rewarding the staff. SHCA organisational structure of allows staff members the opportunity to take part in democratic general meetings every other month and help set the budgets, pay and conditions.

Initially, SHCA was set up as a co-operative. It converted to an employee-owned company in 1998, and each worker is allocated shares according to their length of service and the hours they put in. The work is flexible allowing the employees, 85% of whom are women, to balance work and family lives.

In 2006, SHCA was the overall winner of the Enterprising Solutions Award organised by the Social Enterprise Coalition. This success is down to strong team-working, high standards and great commitment from the staff.

Priorities and commission work from the LIFT companies, which are powerful public/private partnerships. As these companies find their feet, they will be on the lookout for new business opportunities, possibly moving on from supplying maintained buildings to offering the fuller package including health and care services. This could be done in partnership with primary care through the consortia created for practice based commissioning or

independently. The more innovative and entrepreneurial consortia may in any case begin to develop new types of provision as alternatives to in-patient care, and this could include social care provision.

Finally, once direct payments and individualised budgets are firmly established, we might expect to see the user-led charities up the scale of their service provision, and service users will surprise us with their demands.

## conclusions

The examples given above show that there is a huge natural experiment going on as each area tries to find the most suitable way of organising local services to secure better outcomes for the population. Solutions have a strong local flavour even though the policy agenda is national. We should be able to learn from all this variety and use it to improve. There seems to be relatively little systematic research going on so far to identify what helps and what hinders, never mind exploring the links between the diversity of local arrangements and the outcomes they produce. Will the incrementalists be able to keep up the pace as the drive for productivity becomes more intensive? And will the radicals be able to stay focused on outcomes as they deal with all the legal and personnel issues that are likely to arise? Is it really about structures at all, at the end of the day, or more to do with distributed leadership and common values, coupled with the drive for improvement? These are important and exciting questions that deserve to be discussed widely.

This paper has been intended to start up some debate, and your comments can be sent to the author. This is one new stream of work commissioned by the IDeA, and other important work is going on in relation to Third Sector Commissioning, Local Area Agreements and Healthy Communities, along with other topics that can be viewed on Knowledge, the IDeA website, at [www.idea.gov.uk](http://www.idea.gov.uk)

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