Title: Trust matters for integrated care?

Abstract
Integrating the health and social care sectors continues to be a strategic policy objective in England particularly in relation to meeting the care needs of an ageing population presenting with multiple and variable health conditions. Recently, the concept of locally determined integrated care and support has been widely premised as the means by which pressures on services can be reduced through a flexible ‘whole system’ approach to care commissioning. However, problems with inter-agency relationships resulting in or generated by low levels of trust relations are believed to be undermining progress with older people ‘falling through gaps’ between services. Building trust between the different organizations is presupposed as essential for developing the collaborative ethos necessary for successful integration. For example, the idea of trust as an ‘asset’ that can be harnessed to overcome embedded division and facilitate reform was arguably a facet of the previous government’s modernisation by partnership agenda. The role of trust in engendering more cooperative practices is difficult to discern as there is little evidence available for assessing its influence and importance and a detailed analysis of the salience of trust relations in this context has been neglected. Commissioning stands in a unique position to inform and be informed by events in the wider care environment. Thus, this paper explores why the nature of trust relationships within the commissioning process might be important for understanding the whole care system and the inconsistencies in progress in integrating care services.

Keywords: integrated care, health and social care, commissioning, trust, systems

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Introduction: Integrated Care on the policy agenda
The concept of ‘integrated care’ emphasising community based care models has recently gained broad support as a practicable and economical response to the pressures on acute sector resources in the English NHS particularly from a growing cohort of older people presenting with multiple and variable health conditions and personal care needs. For example, a recent projection suggests that around 2 million ‘unnecessary’ - non-emergency or unplanned – ‘hospital admissions of people aged 65 years and over could be avoided if preventative and supportive primary and community based services were better organised’ (Imison et al, 2012). Thus a ‘core business’ of integrated care for the old is also to contain or cut operating costs by reducing recourse to emergency services and dependency on major hospital centres and redirect monies into alternative care models. It aims to deliver quality ‘patient-centred’ care and ‘population oriented’ health improvements facilitated by a ‘combination of processes, methods and tools’ that evidence the needs of local communities (Goodwin & Smith, 2011). An expectation in moving towards a more integrated ‘whole system’ (Ham & Walsh, 2013) is that entrenched relational and organizational conflicts will be replaced by more cooperative alliances.

For example, the junctures where ‘generalist and specialist medicine or adult social care and health care’ meet (Shaw et al, 2011). have long been plagued with problems of poor coordination, duplication and inefficiency; the so called gaps or ‘fragmentation’ (Shaw &
Rosen, 2013) within which care of older people and other vulnerable groups is left wanting. Policy makers explored the full merger of health and social services in 1968 but rejected it because economic uncertainties and the ‘implacable hostility’ from doctors to the prospect of local authorities being involved in decisions on patient care were deemed insurmountable (Crossland, R, cited in 1968, Cabinet Memorandum, 13 January 1970, Section: 3, 4, 5, 9). This policy approach re-emerged in 2001 when New Labour pressed formal mergers between local health and social care organizations in authorities with established and effective inter-agency relations (DH, 2000, DH 2001). But government commitment lost momentum as academics and other observers questioned the lack of empirical evidence that large scale re-configurations would make any overall significant difference (Rummery & Coleman, 2003).

How integrational concepts are communicated shapes stakeholder understanding and response (Kodner and Spreeuwenberg, 2002) and the multitude of definitions across the literature (see Armitage et al 2009) may have delayed progress. Many emphasise organizational interaction; for example, ‘joint working’ or ‘whole system’ (see Shaw et al, 2011) rather than the purpose of care. New Labour used the term ‘partnership’ (DH, 1998), a term Rummery and Coleman, (2003:1774) propose ‘construct(s) an inherent rhetoric of trust’ and suggests a first attempt by central government to steer change across care services by tapping into social processes and normative inferences. More recently “person-centred coordinated care” has replaced ‘integrated care’ in a number of agencies to give clarity to the narrative and purpose (NHS England, 2013) and simplify what the abstracted meanings in the numerous definitions of ‘integrated care’ have arguably over-complicated and rendered ambiguous.

Thomas et al, (2008) suggest vertical integration across primary, secondary and tertiary services is more readily suited to process driven ailment specific medical interventions along pre-determined care pathways. Horizontal interactions are more strategically oriented towards preventative, re-ablement or self-management objectives requiring multi-agency collaboration alongside the care recipient. No centrally determined model is being rolled out instead authorities are being encouraged to ‘innovate’ in response to local need. Arguably the ‘holy grail’ (Thomas et al, 2008) of a whole system perspective for integrated care requires effective commissioning frameworks that not only place the end user at the forefront of care decisions but also bridge the organizational and relational gaps across and between the horizontal and vertical axes.

**Commissioning and integrated care: towards a whole system perspective?**

Commissioning is the arena where information and communication processes can brief and ‘mediate’ (Shaefi, et al, 2013) ‘planning, purchasing and provision, funding, monitoring’ and delivery decisions in line with national and local care priorities and financial constraints (Wade, 2011:35). It stands in a unique position to inform and be informed by events in the wider care environment and interest in its role within integrated care has grown (Ham et al, 2011, Dickinson et al, 2013). Central to the success of integrated care is unlocking the ‘functional isolation’ (Taylor, 1988:40 in (ed) Maxwell) or silos of the formative organizational models and the resultant embedded divisions between services and clinicians (Ham et al, 2012). However, commissioning has generally lacked expertise and full policy support (Ham, & Nuffield Trust, 2007) weakening its influence to effect significant improvement in care quality or re-direct the locus of care away from the dominant hospital-based model (Flynn, 1992) towards community and at home solutions. Furthermore, the introduction of competition into
provider services following the purchaser/provider split in the 1990s exacerbated division, diverted commissioning activity onto provider market expansion, (Johnson, et al, 2003, Wade, 2011) and arguably compromised the objectivity required to act in the best interests of patients and social care recipients. Shaeff et al (2011) note that there is also a specific challenge of control inherent in ‘patient choice’ when commissioning policy is reliant on competition to shape provider services. But the idea of competition is not just a matter of choice of provider it may also manifest as competing interests between the wider public and commissioning particularly when service planning seeks to re-configure local hospital services.

For example, when integration is associated with the term ‘reconfiguration’ it tends to be perceived by the public as a threat to the ‘cherished NHS’ and a precursor to hospital closure rather than redesign for service efficiencies and improvement (The Academy of Medical Royal Colleges, et al, 2013). Moreover, Members of Parliament (MPs), ‘reluctant to place themselves in the firing line of public opinion’ (Nuffield Trust & King’s Fund, online 2013) are accused of “trying to exploit confrontations for short-term political gain” (Dorrell, cited by Nuffield Trust & King’s Fund, online 2013). Interestingly, despite scathing reports highlighting poor quality care or inefficiency, local populations and MPs will oppose recommendations to close a failing hospital if they believe it ‘will put people’s lives at risk’ or even “destroy a whole town” (see BBC News, 2013a for example). The physical presence of the hospital building appears reassuring, symbolically and visually representative of NHS activity. Public consultation of proposed changes aims to engage local people in commissioning redesign but faces challenges in communicating rationale and alleviating the public’s concerns (BBC News, 2013b). By way of contrast relatives of older people affected by the proposed closure of four local care homes in Hampshire are joined in opposition by union representatives concerned for the potential loss of employee jobs, and petitioning members of the public to call on the council to refurbish rather than relocate residents. The proposal is being put to consultation but the council is clear that discussions centre on ‘alternative means of care and accommodation’ (BBC News, 2013c).

Adult social care services ‘commission and provide home care, meals, equipment and adaptations, day services, residential and nursing home care’ and reportedly ‘most councils have systems in place for joint working with health’ (Bostock & Humphries, 2011). But ‘the role of family is most evident in social care’ (Mitton, 2009, in Schubert et al, (eds), 2009:491). In England the state capitalises on gendered social norms to contain the function and cost of social care for older people within the family domain. Evidence points to a societal expectation, particularly in the United States and the United Kingdom, for women to assume responsibility (Szinovacz & Davey, 2012). It is estimated that around six million people in Britain provide informal care to old, frail and disabled friends and relatives at an annual saving to the public purse of around £119 billion in contrast to the loss of revenue from benefits and taxes of around £1.3 billion (Carers UK, 2011). Consecutive governments have been reluctant to alter the status quo particularly as research suggests family take up of the caring role increases or decreases relative to the availability of state support (Pickard, 2011).

For example between 1985 and 1995 following the expansion of community based and privately managed residential and nursing homes (Walker & Naegle, 1999) and when a formal assessment of need was not required (Glendenning & Means, 2006 in (eds), Bauld et al, 2006) ‘intense and very intense care for older parents’ or parents moving in with adult relatives declined (Pickard, 2011:1). Evidence from Sweden further
corroborates the link between state expansion/retrenchment and adult family member involvement in parental care (see Gunnarsson, 2009 for example). Recent predictions posit that reliance on family and friends will continue to increase as access to and provision of local authority funded social support is further restricted under the current economic austerity measures imposed on services. Consequently, pressure on primary and secondary health care may well increase if integrated solutions are not forthcoming. (Social Care Institute for Excellence (SCIE), & The King’s Fund, 2011). National Voices (2013) contends as a matter of principle that informal carers be included in the integrated care debate. But commissioning strategies also require reliable information on local populations to identify how limited resources might be better utilised.

In 1958 a Commons policy debate, prompted in part by Peter Townsend’s "The Family Life of Old People" linked a lack of information on vulnerable and isolated older people or those dependent on family carers to ‘fall(s) through the administrative net’ until ‘discovered…in extremis.’ Family practitioners at the time, or the Ministry of Pensions had access to such data but collation would overburden already pressured services. Confidentiality of personal information across ministerial departments and concern that despite the good intention older people would not welcome ‘state sponsored surveillance’ halted further exploration (Thompson, cited in House of Commons Debate 1958). The ‘registered list of patients’ held by GP surgeries is identified as a useful tool for ‘commissioning integrated care:’ by providing information on the ‘health status’ of local communities (Ham et al, 2011:6). For example, detailed data capture of co-morbidities in the older population may better target clinical interventions that reduce recourse to further services including social care (see Tian et al, 2013 for example). The 1958 debate wondered if information on social status could be collected through the GP registry. Age UK (2013) report that many people ‘are reluctant’ to make preparations for future social care needs. But it is unclear if modern GP surgeries or other agencies hold knowledge on social determinants which might support preventative integrated health and social care strategies to encourage for example more people to plan ahead or flag up isolated individuals who might benefit from social care contact and advice. Nonetheless the notion of state intrusion remains an issue.

The Health and Social Care Act 2012 aims to equalise commissioning relationships across key players and improve democratic accountability at the community level through new Health and Wellbeing Boards (HWBs) operating a Joint Strategic Needs Assessment (JSNA) (DH, 2013). Core membership includes: a locally elected councillor; the director for adult social care, the director for adult public health, the director for children’s care, a lay representative from the local public platform Healthwatch and a representative from each neighbourhood Care Commissioning Group, (CCG), (DH, 2013) comprising ‘federations’ of all local GP practices (Charlton, 2013:24). HWBs can also bring in other agencies with the relevant expertise, such as the NHS, to inform and target local priorities. Member agencies have a duty to comply with requests for ‘relevant’ information from another member if they have it although such requests must not ‘override the common law duty of confidentiality and the requirements of the Data Protection Act (DH, 2013:7). Responsibility for decisions is shared across the members who have to agree their own arrangements for sign-off (DH, 2013:5). However, many GPs do not want the associated extra ‘financial responsibility’ and have concerns that the new arrangements will ‘compromise’ patient-practitioner relationships. (Charlton, 2013:25) suggesting conflicting interests remain.
In summary what constitutes a whole care system is yet fully determined. Healthcare systems have been described as ‘complex adaptive systems’ wherein planning, control and bringing about change is made less predictable because of the different operational levels, functional units and individuals involved (Ham et al, 2013:40-41). Luhmann (2013:250), for example, posits that integration is often associated with stability and cooperation. Mitigating the potential for conflict or uncertainty can be a precursor to system integration and maintain a ‘strong integrative effect’ if supported by a ‘mediating’ structure such as the law. In the context of health and social care the call for integration is a response to embedded organizational and relational divisions and economic uncertainties manifest as fragmentation and poor quality care. Commissioning as a mediating mechanism for developing closer collaboration as well as a ‘policy tool’ for controlling and containing the mixed health economy (Dickinson et al, 2013:6) appears central to the success of integrated care. Good information and clear communication are notably important for effective planning and for reaching consensus for unpopular reforms across a wide audience that includes employees, professionals, academics, representative groups, patients, carers, politicians, the media and the public. The decision-making process is now more complex and challenging and previous attempts at joint commissioning were compromised by competing agendas. The less hierarchical structure in the HWBs requires agencies to cooperate and be adaptable to changing demands. A whole system perspective requires a broader understanding of the inter-dependencies across the different organizational levels and the wider care environment noted above. Trust is a recent inclusion in the integrated care debate viewed as one of a number of solutions to the protracted progress (see Jacob’s et al, 2009 for example). The next section explores why trust might be important for integrated care.

The emergence of trust

What trust is remains still under debate but most commentators agree that it is important for social cooperation and social integration and thus is a basis of social order or a stable social system (Luhmann, 1979, Misztal, 1996) suggesting cooperation is ‘a by-product of trust..rather than a source of trust’ (Misztal, 1996:17). Uncertainty increases the importance of trust (Misztal, 1996) and is therefore associated with complexity. Thus Luhmann (1979) argues that decisions to trust or distrust always serve to reduce specific problems of social complexity between individuals and wider social systems suggesting trust is a calculated act, a matter of optimising on available choices within a specific context. In contrast confidence is distinct from trust in that it implies no presupposition of an unexpected outcome whereas inherent in trust is the potential for the unexpected that realises regret for ones decision (Luhmann, 1979).

This literature review suggests that the appeal to ‘trust’ as a solution to the relational and organisational problems across health and social care is fairly recent and might be attributable to the protracted nature of change across the services and/or a reflection of widening activity in it as a focal topic across the social sciences in response to the destabilising effects of rapid change in wider society; the ‘crisis of late modernity’ (Brown & Calnan, 2012:1) and the idea that we live in ‘uncertain and confused times’ (Misztal, 1996). This observation arises in part because research into trust in the health and social care literature has generally tended towards the changing nature of relational interactions between health professionals and patient or between professional autonomy and managerial imperatives (Brown & Calnan, 2012, Alaszewski & Brown, 2007) and not specifically to problems of integration across the divisions. Nonetheless trust is perceived to be an issue. For example Jacob’s et al’s 2009 (:511) systematic review of the state of
Wistow (2011:9) for example suggest ‘trust and mutual confidence are important lubricants but are undermined by organisational restructuring.’ More recently, leaders are advised to develop ‘strong relationships’ ‘built on trust and experience’ (The Academy of Medical Royal Colleges et al, 2013) and take the time to develop trust to make use of ‘soft skills’ such as persuasion to progress change (Ham & Walsh, 2013).

Fundamental to successful integrated care and effective commissioning is cooperation and the literature is replete with generally qualitative reports exploring the nature of inter-agency relationships and tensions. The above discussion already notes tensions between local authorities and primary care and between the NHS and local authorities. More specifically Johnson et al’s (2003) case studies into cooperation between commissioners and providers in primary and secondary health and social care found problems across the sectors but observed they were particularly fraught between health and social service managers. For example managerial style was an issue: social care managers being described by their health counterparts as ‘un-businesslike’ and vice versa health managers as ‘hierarchical’ and inflexible. Financial and resource disputations were common across primary and secondary health, and health authorities (my italics, suggesting health in general) and social care commissioning. Issues specific to care of frail older people included: ‘a fear of cost shifting’ (:78) between purchasers and ambiguous policy directives obfuscating lines of responsibility. A more recent study found social care operative’s defensive of their professional status and claim to socially oriented expertise in response to perceptions that a health agenda was dominating local integrated care decisions (Miller, et al, 2011a). The reports suggest that policy and organizational structures, management styles, reputation, identity, and willingness on the part of the individual to participate in the wider care collective may influence the nature of trust relations. And the issues appear to permeate across and between the different levels of organization and interactions from management to the frontline.

Johnson et al (2003) propose the notion of ‘collective efficacy,’ wherein a willingness to participate in and work towards a particular goal supports cooperation and resonates with Powell’s (1996) study into how cooperation and trust emerges in interpersonal networks in organizations and the notion that ‘collective identity’ or ‘common association’ “thickens cooperation” which may over time develop into trust. Actively becoming a member of a group indicates ‘an initial commitment to a relationship’ although individuals are more willing to be a part of a group or organization with a good reputation (Powell, 1996:53, 55). Acceptance as a full member of a collective rather than a visitant further validates the member role and reduces the potential for tensions and presupposes a willingness to trust (Luhmann, 1979). Trust therefore appears in part grounded in motivation to cooperate with others that over time manifests as trust. However, other ‘motivational’ mechanisms are widely deployed by institutions towards a specific aim: for example close monitoring and contracted performance management objectives supported by incentives and sanctions to counter the possibility of non-compliance. Organisational change creates uncertainties raising the potential for negativity and uncooperative behaviours suggestive of low trust. Where resistance is encountered strict controls and performance monitoring regimen can maintain operational activity and negate a need for trust (Giddens, 1990). Consequently trust may not be necessary for “participation in functional systems” but Luhmann (1979:39) amongst others suggests it “is crucial for interpersonal relations.”
The rationalisation inherent in the rapid recourse to implement tighter structural controls by way of more rules and regulations, and professional protocols in response to the failures at Mid Staffs for example aims to increase public perceptions of trust in care professionals and the organizations. Luhmann (1979:64) posits trust between individuals or groups is placed in the ‘socially visible’ attributes of the others personality or role performance eliciting for example evidence of competence. ‘In system trust one is continually conscious that everything that is accomplished is a product, that each action has been decided on, after comparison with other possibilities’...‘it counts on explicit processes for the reduction of complexities and ‘hardly becomes an open matter for public discussion’ (Luhmann, 1979:57-58). Luhmann’s interpretation suggests trust in systems, at least in the first instance, is a cognitive action, a matter of choice contingent on evidence on the nature of the system. The idea of transparency and evidence may be important in the debate over re-configuration and the shift from hospitals to alternative integrated care models: Bringing community services more keenly into view may open up public perceptions towards the legitimacy of re-configuration proposals to facilitate improvement rather than pose a threat to the cherished NHS. The role of public trust and failing hospital services is complicated but suggests that there is a public confidence in the NHS that prevails; a ‘generalization of expectations’ (Luhmann, 1979:81) in its unique position in the populations’ psyche that does not appear to extend to social care services. Giddens (1990:90) suggests trust in systems is more abstract founded on a knowledge gap between the lay public and the respect they subconsciously vest in sources of expertise.

Similarly to Luhmann’s ‘generalization’ it is institutionalised or ‘incorporated into the continuity of day-to-day activities’ across wider society as a sort of ‘blind trust.’ Indeed for Giddens ‘all trust in a certain sense is blind!’ (1990:88, 33). Unlike social care where family or friends are often able to provide assistance alternative sources of healthcare tend to be limited to those who can afford to pay. Thus the respect conferred on hospital services may be a matter of ‘pragmatic acceptance’ (:90) because of a perception that other effective options are unavailable. However, commissioning for integrated care demands a new way of thinking about how services interact with each other and with care recipients and the wider care environment. Its focus on the person in need as the motivational mechanism and basis for consensus for generating cooperation challenges both established interpersonal expert/lay relationships and those between the wider public and institutionalised notions of health and social care. The addition of commissioning policy geared towards competition into the mix may generate a dis-integrating influence wherein the idea of dis-continuity leaves ‘blind trust’ wanting, and increases uncertainties thus raising the importance of trust but suggests that in this context trust has somehow to be earned.

Moreover, the utilisation of regulatory mechanisms to engender trust is expensive and bureaucratic (Misztal, 1996) and arguably counter-productive (Brown and Calnan, 2012) as it may stifle innovative ideas for commissioning integrated care looking to evidence of governance structures and conformance to specific professional role identities instead. In the context of healthcare organizations, trust is believed to be intrinsically important in its own right for the provision of effective health care and has even been described as a collective good, like social trust or social capital. Specific organizational benefits that might be derived from trust as a form of social capital instead of tight regulatory controls include the reduction in transition costs due to lower surveillance and monitoring costs and the general enhancement of efficiency (Calnan and Rowe 2008).
While the evidence suggests social obligations within families and friends effect the majority of adult social care in England how that kinship attachment translates into working practices is unclear although evidence from Torbay for example where the visual cue ‘Mrs Smith’ was used shows improvements in inter-agency cooperation (see Goodwin & Smith, 2011). However, in the context of person-centred integrated care interactions between the different agencies, the care recipient and their close associates may be brief, one-off, infrequent or temporary and therefore lack the historicity of time and space in which trust in more permanent organizational forms emerges from reoccurring shared experience (Meyerson, 1996). Under these conditions, traditional bases that support cooperation and cohesion are weakened increasing the importance of trust. Meyerson, et al, (1996) observe that highly organized temporary groupings are increasingly being deployed by organizations to carry out specific and finite projects. These project teams tend to form around a pre-determined shared goal and appear to ‘exhibit behaviour that pre-supposes trust.’ Such a ‘readiness to trust’ is for Luhmann (1979:83) indicative of the nature of the supporting operational structures in place thus relational or inter-personal trust and institutional or systems based trust are inter-connected: one cannot emerge without the other.

Conclusion
This discussion raises a number of questions about the salience of trust to integrated care and the notion of a more cooperative whole system at the heart of which commissioning appears to be central to success. Services have been challenged with uncertainty and increasing complexity over several years of ongoing change. Integrated care is premised as a means by which the uncertainties inherent in the complexity of multi-layered health and social care need can be better managed. The literature observes a number of instrumental and relational problems between health and social care services that intersect with care policy and issues in the wider public domain. There are several competing but interconnected themes including questions of stability, autonomy, professional identity, reputation and most notably cooperation is widely held fundamental for overcoming the issues holding back progress. Central to cooperation is willingness on the part of individuals to become involved and be accepted as full and legitimate participants.

Misztal (1996:3) writes, ‘trust as a valuable asset develops in the mutually formative interplay of public institutions and individuals’ suggesting that its salience and meaning in the structural and interpersonal interactions between and across the HWBs, NHS England, the CCGs and wider social and political environment is important for understanding how local integrated care strategies and frontline care decisions are influenced to elucidate a whole system perspective. If we accept the notion that trust presupposes cooperation and cooperation is essential for successful integrated care trust does matter and there is now a need for substantive empirical evidence about its salience.

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