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Is integration or fragmentation the starting point to improve prevention?

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Summary

The importance of health, social care and other sectors working together has been recognised for many decades by governments of all political persuasion. This is true within the current policy environment, in which integration has been proposed as the binding force to connect an increasingly diverse range of providers around individual patients and their families. Initiatives to promote integration are being introduced at all levels of the system, with a patient experience based narrative setting the standard against which success should be judged. This integration is being encouraged not only in respect of statutorily funded clinical, public health and social care services but also with other policy areas such as housing and leisure and other sectors (in particular the third sector).

One of the expected impacts of a better integrated health and social care system is that it will facilitate the transition to more preventative models of support. Such a shift in resources has also been a long-held aspiration of national health and social care policy, on the basis that successfully providing early and re-abling interventions will reduce the number of older people from requiring more intensive and long-term types of support. This shift is seen as a means to improve the quality of life of older people through enabling them to remain in their local community and retain their level of independence, and to address or at least soften the financial pressures resulting from the changing demographics.

Despite this continued belief in policy that integration will lead to a more preventative focus there is not strong research base to support this view This reflects the evidence for integrated care and prevention in general, with recent reviews highlighting both the limitations of the research available regarding these areas and the ambiguous messages that they can present. This does not mean that integration is not a key building block of preventative services, but rather that we are still trying to understand what types of integration will make the greatest impact in different contexts and for which beneficiaries. In part this is due to methodological difficulties of undertaking research regarding prevention and this is made even more complex when trying to work across sectors with differing (and at times conflicting) priorities in respect of individual outcomes, performance frameworks and resource priorities.

Accepting the limitations of the evidence base, five key lessons can still be drawn for national policy makers with responsibility for promoting integration and prevention.

1) *Start with what is fragmented*

Firstly, integration is the wrong starting point for local areas to achieve a more preventative approach. Rather, this should begin with the Joint Strategic Needs Assessment in which current and future needs are mapped, and the key challenges and opportunities that these present. In developing more preventative models to respond to these local identified priorities, the required linkages within the system need to be mapped out with people who access services and frontline staff, and a gap analysis undertaken to identify which are already in place. If

strengthening is required, then whenever possible this should be through improving communication and co-ordination of current structures rather than developing new organisations or major disruptions to minimise the upheaval required and consequential delay in impact.

2) *Be clear what is meant*

We need greater precision as to exactly what type of integration is being proposed and between what services. At present there is often a dense conceptual and definitional fog accompanying integration. The term is being used nationally (and indeed locally) in relation to a diverse range of collaborative arrangements between a host of different organisations, services and professions in order to (hopefully) address a variety of complex issues, although often there seems to be a default that integration implies a structural merge. In promoting integration national bodies should be supporting local areas to be precise regarding what model of integration they are considering and between which services.

3) *Know what success looks like*

There needs to be a clear vision regarding the desired outcomes of integrated preventative approaches. Ultimately of course these should be locally determined by the Health & Wellbeing Boards. However it would be helpful for national bodies to develop a framework which local areas can use as a basis to develop their specific outcomes. Potentially this framework could combine the 'triple aims' of integration (Berwick et al 2008) (*Improving the experience of care*, *Improving the health of populations* and *Reducing per capita costs*) with the 'triple aims' of prevention (Francis et al 2011) (*Promoting independence*, *Preventing or delaying the deterioration of wellbeing resulting from ageing, illness or disability*, *Delaying the need for more costly and intensive services*) to provide the 'triple aims' of preventative integration.

4) *Understand the impact*

Fourthly, whilst there can be no one way to evaluate the myriad of preventative approaches that will involve integration, it would be helpful for greater support and guidance to be available to local areas This should include processes to undertake the mapping of contexts, mechanisms and impacts, and identifying potential outcome measures and methodological approaches that may be relevant. This would be helpful for commissioners and providers, and enable peer comparison and challenge regarding the effectiveness of different models. It would therefore both improve local evaluation and also offer the potential for learning to be transferred between different contexts through providing greater clarity regarding the initiatives and their implementation.

5) *Be wary of further change*

History tells us that many worthwhile national initiatives to promote integration and prevention are ultimately disrupted or side lined by competing policy interests, power dynamics between different bodies, and pressure from unfavourable financial environments. Such cracks are already in play within

the current arrangements, for example through the uncertainty of how best to promote integration and competition, tension in the relationship between NHS England and Health & Wellbeing Boards, and the many restructurings within local authorities which are disrupting key relationships. There needs to be an on-going sensitivity regarding the potential of national developments therefore to waylay local progress.

In conclusion, the need to develop a health and social care system that can successfully integrate different preventative approaches around individuals, their families and local communities has never been greater . To understand how and when to integrate though, we first need to be clear what links are required and how they could operate in practice. That is why fragmentation, rather than integration, should be the starting point to achieve a prevention orientated health and social care system.

Introduction

The initial coalition programme for government (2010) mentions integration on only two occasions (neither of which relate to health and social care), and its billing in the original Equity & Excellence paper is limited to the role of local authorities. However its centrality is now been established following the 'listening exercise' undertaken during the gap in the legislative process for the Health & Social Care Bill. Overseen by the Future Forum, this gap aimed to provide an opportunity to 'pause, listen and reflect' through 'listening events' with patients, professionals and partner organisations, and on-line engagement including web chats, social networking and email repositories. The initial brief was to focus on four key-themes (none of which were directly related to integration), but the Future Forum rapidly became concerned about potential fragmentation in the new system –

> *'There has been too much focus on different parts of the system – GPs, hospitals, public health – and insufficient attention to how they all join up to provide the integrated care that patients need' (Future Forum 2011a, p6)*

Such was the importance that the Future Forum placed on this issue that it was subsequently dispatched to undertake a further round of discussions focused on this aspect in particular. The resultant report set a tone of urgency and priority–

> *'Integration is a vitally important aspect of the experience of health and social care for millions of people (p3)..... Poor integration results in delays, duplication and defects in care, and impacts on the quality, safety, productivity and the patient's and carer's experience of the journey of care. Given that patients with the most complex journeys are often those with the greatest need, poor integration places a significant and unnecessary burden on them, their families and the system.' (Future Forum 2011b, P14)*

Whilst not all of the Future Forum recommendations were adopted (for example to combine the separate outcome frameworks for health, social care and public health (DH 2012a)), there has been a considerable expansion and strengthening of initiatives and requirements relating to integration. A key narrative behind this emphasis has been the potential of integration to facilitate a more preventative focus across the system–

> *'… if we want to see the overall shift in the pattern of services that we all talk about all the time, which is that we need to move health and care services to a more community focus, to support earlier intervention and preventive services, which will in its totality involve a better use of resources across the entire system, if we are to achieve that big picture, which unquestionably will be a better use of resources and more*

efficient, the integrated working between health and social care and indeed other partners is an absolutely essential component.' (DH Evidence to Joint Committee 2013, p34)

This connection between integration and prevention is not though a new focus within health and social care policy . For example, in 2000, the *NHS Plan* committed the NHS to 'focus efforts on preventing………[through] work with other public services to intervene not just after but before ill health occurs' (p5); in 2005, *Independence, Wellbeing & Choice* encouraged social care to collaborate with universal as well as specialist services – 'transport and leisure services are obvious examples of services that contribute to the wellbeing and prevention agenda by fostering independence and social inclusion, but others, such as planning and design, can also play their part' (p38); and in 2006, *Our Health, Our Care & Our Say* highlighted the potential of GP-led commissioning and user held budgets to 'act as a driver for more responsive and innovative models of joined-up support within communities, delivering better health outcomes and well-being, including a focus on prevention' (p8).

Such continuity of policy could be interpreted positively (i.e. does it indicate a sustained focus that will enable the health and social care system to progressively learn and improve?) or negatively (i.e. does it actually we are still none the wiser in how to use integration to achieve a preventative approach?). Perhaps though it begs a more fundamental question – whilst common sense tells us that integration is a powerful tool within prevention, is this actually the case? This paper seeks to explore this question through reflecting on the evidence regarding prevention and integration, and uses the learning from this evidence to consider the role that national government could play

How are prevention and integration understood in current policy?

The government does appears to have taken on board many of the concerns that were raised through the Future Forum and elsewhere to the risk of fragmentation in the new health and social care arrangements. Integrated initiatives have been targeted at all levels of the system, i.e. *macro* (e.g. the new National Collaboration and linked outcome frameworks), *meso* (e.g. development of Health and Well-being Boards and duty on Clinical Commissioning Groups to engage with these) and *micro* (e.g. exploration of patient / user held integrated budgets), with a range of incentives and structures being deployed. These include a greater emphasis on patient experience including both 'carrots and sticks' than has previously been the case through the development of national performance measures capturing personal experience of integration, and an individually based 'narrative' on what 'person centred co-ordinated care' feels like in practice –

'I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.' (National Voices 2013, p3)

One of the benefits of integration that has been promoted within these initiatives is its ability to move to a more preventative support model. The National Collaboration underlines that this not only requires integration between health and social care, but also with other statutory services (in particular housing), community based third sector organisations and patients / service users' informal networks. The necessity of considering social, environmental and economic factors in developing the preventative aspects of Joint Health & Wellbeing Strategies is further underlined in the statutory guidance for Health & Wellbeing Boards, including 'access to green space, the impact of climate change, air quality, housing, community safety , transport, economic circumstances and employment' (DH 2013a, p7). Addressing these factors is seen to require engagement with services outside those traditionally involved in health and social care. Boards are encouraged to consider broader representation including 'local employer organisations, Job Centre Plus, Work Programme Providers, criminal and justice agencies or housing services' (DH 2011a, p15). Integration is also seen as a defensive response to the negative impacts of fragmented services, which are described as leading to a 'failure to take steps to prevent or delay onset of needs' and causing 'emergency admissions to hospital e.g. after avoidable worsening condition or avoidable fall' (National Collaboration 2013, p11).

This connection between integration and prevention also features within the policy guidance for the separate functions in health and social care. The mandate to NHS England (which sets out its priorities and in turn that of the Clinical Commissioning Groups) requires 'prevent[ion of]] ill health .. so that more of us can enjoy the prospect of a long and healthy old age' (DH 2013b, p5), with the mandate suggesting that this will require all parts of the system to 'invest time now in developing strong partnerships, so that rapid progress can be made' (*ibid*, p8). The Public Health strategy is framed around the recommendations of the Marmot review to improve overall health and wellbeing and address health inequalities across the life stages through tackling the wider determinants of health (DH 2010b). Public Health England is tasked with facilitating integration between public health functions by 'bringing together a fragmented system, strengthening the national response on emergency preparedness and health protection and supporting public health delivery across the three domains of public health' (DH 2011b p 15), and through engaging the wider system. This will be achieved by providing national leadership to 'enable local government, the NHS, and the voluntary, community and social enterprise sector , among others, to: invest effectively in prevention and health promotion so that people can live healthier lives and there is reduced demand on health and social care services, as well as on the criminal justice system' (DH 2011b, p1).

Integrated working with other agencies is an 'essential, not optional' part of the Vision for Adult Social Care (DH 2010c, p13) to enable a more prevent ative model. Again this is seen to include external integration with other statutory services such housing, employment and criminal justice, and internal integration between local authority departments such as children and adult services. Third sector organisations are also highlighted as an important element as they may be better able to enhance the capacity of local communities to identify and respond to those who at risk of declining health, isolation and frailty –

'We also know that prevention is best achieved through community action, working alongside statutory services. We need to inspire neighbourhoods to come together to look out for those who need support. In other words, we need a Big Society approach to social care – one that gives people the power to support each other and meet the challenges they face.' (DH 2010c, p9)

This focus on prevention has been further developed in Caring for our Future (DH 2012), with a key pledge being that people who use services will report that-

'I am supported to maintain my independence for as long as possible.' (ibid, P10)

A duty to integrate is to be imposed on local authorities through the Care & Support Bill, mirroring that already imposed on NHS England, Monitor and Clinical Commissioning groups, and local authorities will also have a duty to prevent or delay the development of needs for care and support. Following the report of the Select Committee (2013), prevention will underpin all local authorities' social care responsibilities, including the provision of information, and integration with housing seems likely to get a particular emphasis (DH 2013c).

What prevention interventions have been found to be most effective within the integration context?

It is clear then that integration is being heavily promoted within current policy, that a strong connection is being made with more preventative approaches, and that this integration is seen to require engagement with a broad range of services and agencies. This connection with prevention has been a recurring theme within national and local aspirations for integrated delivery and commissioning of services for many years (see e.g. Dickinson et al 2013, Hudson 2011). Despite this, evidence regarding the prevent ative benefits of integration is in fact weak. This reflects the evidence for integration in general, with several recent reviews highlighting the patchy and inconclusive state of the current evidence base (see Box 1). That should not be seen as a basis on which to infer that integration is never a powerful facilitator of improved and more preventative care, as there is evidence that when applied well within certain contexts it has had a positive impact (see for example Curry & Ham 2010, Goodwin et al 2012, and any edition of the Journal of Integrated Care). However it is clear that integration does not always achieve the expected outcomes, and that there is price to be paid in relation to the required investment and opportunity costs. This complexity is highlighted through the example of care trusts, once thought of as the future for health and social care services for older people. Whilst Torbay in particular was able to make significant improvements in the local system in relation to quality and ef ficiency, others had little or no impact (Miller et al 2011).

Box 1: Key findings from reviews of integrated care

'The evidence base underpinning joint and integrated working remains less than compelling. It largely consists of small-scale evaluations of local initiatives which are often of poor quality and poorly reported. No evaluation studied for the purpose of this briefing included an analysis of cost-effectiveness…. The voice of service users and carers remains largely absent. Their views are not routinely collected in evaluations, which makes it almost impossible to comment on the outcomes that matter to the people who use services themselves. Where they are included, service users and carers are treated as a homogeneous group. This makes it difficult to unravel the impact of integrated services on groups who may have different and sometimes competing needs.' (Cameron et al 2012)

'Logic would require that engagement with the integration agenda is predicated on the assumption that it is a preferable alternative; moreover it would not seem unreasonable to presume that some form of integration is likely to be more effective in delivery than two or more agencies operating on their own. The available evidence base however suggest s not only, inevitably, that the picture is complex, but that cert ain elements may be counter-intuitive.' (Petch 2012 80)

'there is very little evidence that links the use of such services with what might be termed real and sustained outcomes for users: no demonstrable or measurable improvements in social or cognitive functioning, independence or quality of life.' (Rummery 2009 p1802)

These criticisms of the evidence base for integration can also be made in relation to preventative studies. Curry (2006) synthesised UK and international evidence relating to three levels of preventative services *low-level* (e.g. assistance with gardening, cleaning and shopping or minor adaptations), *formal* (e.g. intermediate care and hospital at home schemes) and *wider community services* (e.g. housing, transport and policing). The review found that there was insufficient evidence to confirm that interventions at any level could deliver all of the expected impacts, but that there was support for certain interventions preventing resource usage or decline in quality of life in some contexts (see Box 2).

Box 2: Summary of Evidence regarding Preventative Services (Curry 2006)

Low-level interventions:	May not be cost-effective but appear to maintain independence and are often valued by older people
Formal interventions:	Can be more cost effective than generic services but only if they are targeted at a particular event or condition rather than the population as a whole
Wider community services	Demonstrate weak evidence on the whole, although those that promote social inclusion do appear to have considerable benefits to overall well-being.

Allen & Glasby (2009, 2010a, 201 0b) sought to identify ten 'high impacts' in health and social care prevention through combining a UK based literature review with discussion with national experts and evidence from a pan-European study on ageing and prevention. Partnership working was seen as one of the 'top ten', however a link between integration and prevention was described as 'almost entirely a matter of faith at present' (Allen & Glasby 2010 p13). Looking in more detail at the other 'top nine', many of these would be difficult to achieve without some aspect of integration, and/or would be likely to be more impactful if relevant integration were in place. For example, best practice in both intermediate care and falls prevention services suggests the importance of integrating these within the broader health and social system and engaging a range of disciplines in their delivery (ibid). Similarly, a study of the 'top 3' preventative investments made by local authorities found that many of these required integration in some form. This was present within primary preventative approaches (e.g. multi-agency falls prevention strategies), secondary preventative examples (e.g. dementia cafes which combined social networking, talks from health professionals and advice surgeries), and rehabilitative services (e.g. vertical pathways between hospital discharge and housing support services (Miller & Allen 2013). Third sector organisations often promote their ability in particular to facilitate integration between statutory and community resources and to guide people as they seek to access and navigate the myriad of statutory services available (ACEVO 2013), and this view appears to be commonly shared by local commissioners (Miller et al 2013).

The lack of detailed and comparative evidence has not been lost to policy makers, and there have been two major national initiatives which sought to promote integration and to evaluate the resultant outcomes and to learn from the process. The first is the Partnerships for Older People Projects (POPP) in which the Department of Health invested £100 million in 29 local authority areas. The partnerships were required to integrate the third sector alongside statutory health and social care organisations, and to engage older people in their planning. In total 146 core projects were developed, with approximately one third having a primary aim of avoiding admission to hospital or care home (e.g. falls-prevention, case-finding and discharge pathways) and two thirds with a focus on promoting

healthy living, reducing social isolation and expanding the capacity of community supports. The POPP evaluation highlights the potential influence of other factors such as income, declining health and change in social situation, and the variation of impact between projects delivering a similar service (Windle et al 2009). However, it is able to suggest that interventions focused on exercise and those that provided practical help such as minor repairs and small adaptions led to a 'notable improvement'. The principle measure in relation to reduction of resource usage was hospital emergency bed days, with an estimate that for every £1 spent on POPP services there has been an approximately a £1.20 additional benefit in savings. The community facing projects required a 'critical mass' and once this was reached showed greater savings for larger investments, however the opposite was true for hospital facing projects. The report suggests this may be due to there being a limited number of people who can benefit from such targeted services. It is also worth noting that a second analysis was completed of a subset of eight of the POPP interventions through matching the individuals concerned with control groups (Steventon et al 2011). This reached a different conclusion regarding impacts on hospital usage, with only one intervention being deemed to have reduced the number of bed days (in contrast with Windle et al 2009 who reported reduction across all interventions).

The second national initiative was the Integrated Care Pilots (ICP), in which 16 initiatives were supported to 'explore different ways of providing health and social care services to help drive improvements in local health and wellbeing' (DH 2009b, p3). Local areas were able to determine their own aims, but a common theme within these was to provide more preventative support and so reduce usage of hospital beds (Rand / Ernst & Young 2012). The majority of the projects focused on older people or conditions that would principally affect older people, and on horizontal integration between community health services, social care and primary care. Ten of the projects included third sector organisations and three private sector organisations. The evaluation report highlights that whilst staff could identify improvement in integrated processes, patients and service users did not share this positive perception. They reported that it was harder to access the professional of their choice, that they were listened to less frequently and that they were less involved in decisions over their care. In relation to resource usage, the evaluation estimated that there was a 4% reduction in elective admissions and a 20% reduction in outpatient attendances, but a 2 % increase in emergency admissions.

Research also consistently highlights the considerable difficulties that relate to comparing preventative initiatives based on integration with those without an explicit focus on integration, and in researching the area of prevention in general (e.g. Dickinson 2008, Allen & Glasby 2010b). These difficulties include-

Timescales   Population level outcomes are often only achieved in the medium-long term whereas research and policy interest is often based in the short term.

Attribution   Preventative integrated services are introduced alongside other interventions and there are other personal, social and health factors that can have contributory and indeed often greater impacts, making it hard to connect positive or indeed negative outcomes with such services in particular

Counterfactual   There is a fundamental difficulty in forecasting what would have happened if the intervention had not been available.

To address these dif ficulties, evaluations need to explore process and outcomes, and take a phased approach in which expected markers of success are investigate at the connected timescales (Dickinson 2006). They should incorporate patient, service user and carer experience in addition to utilisation and cost (Goodwin et al 2012), and be realistic over what can be achieved within the resources and time available. For example, statistically significant findings will requiring sufficient number of participants, robust data and adequate timescales (Steventon et al 2011). Finally, in planning the evaluations and more importantly the preventative approaches themselves, there is a need for clarity regarding the overall purpose –

> *'things labelled preventative often had no clear idea of what they were preventing, for whom and how they knew whether they prevented it ... …Things that are genuinely preventative leave people better informed, better connected and more able to live with dignity themselves. .. The more that we can help people connect and embed into a community, the more empowered and resilient, and the less dependent, they are. That tone is a much more helpful idea of what prevention is that applies at an early stage and is relevant at end-of-life care. There is no stage of life at which we want to be dependent and isolated.'(Alex Fox in evidence to Joint Committee 2013, p38)*

This has been highlighted as a particular issue in relation to integrated services in particular, with clashes between the priorities of services and the people who access them –

> *'The aim of such initiatives appears to keep users in, or move them to, cheaper parts of the health and social care system rather than to improve outcomes. Of course, a reduction in delays in accessing services, an increase in the user centredness of those services and a reduction in the stigma associated with service use would no doubt be welcomed by users and their families. Nevertheless, there is compelling evidence from this review that if users were in a position to be able to exercise power over service development their priorities would differ significantly from those of both policy makers and practitioners' (Rummery 2009, p1802)*

This has also been found in relation to the emphasis for third sector organisations and the public sector organisations who commission them (Miller et al 2013).

How should national organisations encourage localities to focus their efforts on integration and prevention and evaluate their impacts?

Arising from the messages above, the current evidence base raises five key lessons of relevance for the current policy regarding integration and prevention.

Firstly, integration is the wrong starting point for local areas to achieve a more preventative approach. Rather, this should begin with the Joint Strategic Needs Assessment in which current and future needs are mapped, and the key challenges and opportunities that these present. In developing more preventative models to respond to these local priorities, the required linkages within the system need to be mapped out with people who identified access services and frontline staff, and a gap analysis undertaken to identify which are in place. If strengthening is required, then whenever possible this should be through improving communication and co-ordination of current structures already rather than developing new organisations or major disruptions to minimise the upheaval required and consequential delay in impact. At times it will be right to merge two services or indeed organisations or to undertake a major retendering but such interventions need to be used sparingly. The National Collaboration (2013) does clearly underline that integration is the 'means not the end', however history tells us that a local areas commonly experience a pressure to deliver an expected service model even if it is not the most apt for their locality.

Secondly, we need greater precision as to exactly what type of integration is being proposed and between what services. At present there is often a dense conceptual and definitional fog accompanying integration. The term is being used nationally (and indeed locally) in relation to a diverse range of collaborative arrangements between a host of different organisations, services and professions in order to (hopefully) address a variety of complex issues, although often there seems to be a default that integration implies a structural merger. This vagueness of definition is not a new problem (and one that is raised again by the National Collaboration), but that does not mean it is not an important one or indeed one that cannot be addressed. In promoting integration national bodies should be supporting local areas to be precise regarding what model of integration they are considering and between home, and perhaps it would helpful in this regard to develop standard typologies and definitions of both integration and prevention.

Thirdly, there needs to be a clear vision regarding the desired outcomes of integrated preventative approaches. Ultimately of course these should be locally determined by the Health & Wellbeing Boards. However it would be helpful for national bodies to develop a framework which local areas can use as a basis to develop their specific outcomes. Potentially this framework could combine the 'triple aims' of integration (Berwick et al 2008) (*Improving the experience of care*, *Improving the health of populations* and *Reducing per capita costs*) with the 'triple aims' of prevention (Francis et al 2011) (*Promoting independence*, *Preventing or delaying the deterioration of wellbeing resulting from ageing, illness or disability*, *Delaying the need for more costly and intensive services*) to provide the 'triple aims' of preventative integration.

Diagram 1: The Triple Aims of Preventative Integration (after Berwick et al 2008 & Francis et al 2011)
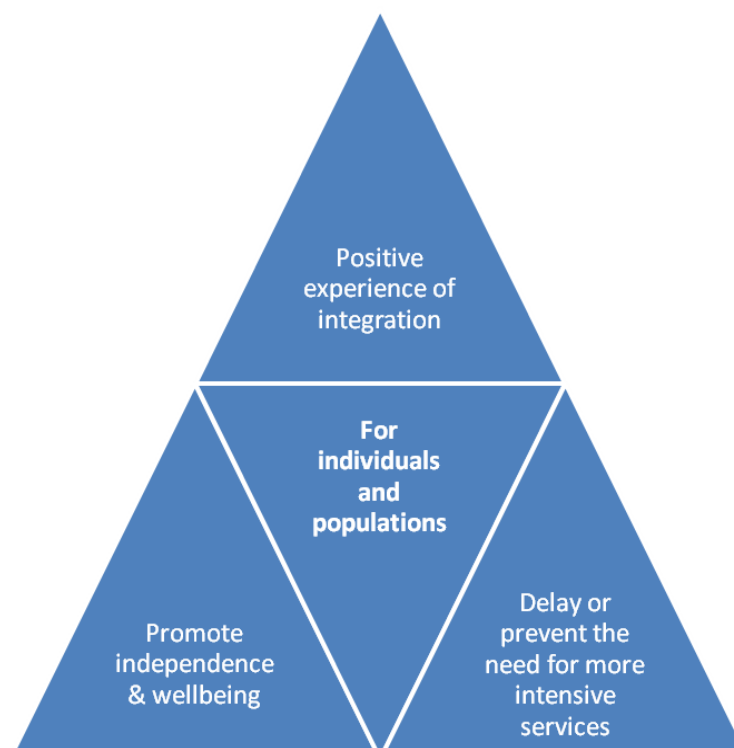
Fourthly, whilst there can be no one way to evaluate the myriad of preventative approaches that will involve integration, it would be helpful for greater support and guidance to be available to local areas. This should include processes to undertake the mapping of contexts, mechanisms and impacts, and identifying potential outcome measures and methodological approaches that may be relevant. This would be helpful for commissioners and providers, and enable peer comparison and challenge regarding the effectiveness of different models. It would therefore both improve local evaluation and also offer the potential for learning to be transferred between different contexts through recognising the particular histories, connections and incentives that were deployed. This work is being developed by the School for Social Care Research and the Integration Collaboration at present and it is vital that it draws upon the range of relevant research traditions and experience.

Finally, history tells us that many worthwhile national initiatives to promote integration and prevention are ultimately disrupted or side lined by competing policy interests, power dynamics between different bodies, and pressure from unfavourable financial environments. Such cracks are already in play within the current arrangements, for example through the uncertainty of how best to promote integration and competition, relationships between NHS England and Health & Wellbeing Boards (with e.g. 77% of the latter believing they had no influence on NHS England (Humphries & Galea 2013)), and the many restructurings within local authorities which are disrupting key relationships. National work appears to be underway to address a number of these emerging cracks, but there needs to be an on-going sensitivity regarding the potential of national developments to waylay local progress.

Conclusion

Patients and service users have to integrate support from statutory services, community resources and their personal networks to improve their quality of life and maintain their health and independence. Similarly there are few health and social care services whose outcomes do not require or would benefit from positive integration with other services, and it is therefore understandable why integration has been promoted as a 'good thing' in relation to prevention. Current national policy has embraced the potential of this connection, and has embedded prevention within integration related strategies. This included integration with a broader range of community agencies than those which are delivered by the statutory sector and those which work outside of the health and social care. However, we must be realistic regarding the challenges of introducing more integrated working, be clear about the expected outcomes, and be confident that the proposed integration model is the most apt approach for the local context and available resources. National bodies can support local areas in developing their understanding of potential interventions and associated evaluation processes but should be wary of pressurising them to rush to adopt a particular model of integration. On-going engagement with Health & Wellbeing Boards, Local Authorities and Clinical Commissioning Groups will help to identify further opportunities for national bodies and the National Collaboration to co-ordinate appropriate frameworks and guidance, and to work together to address uncertainties and barriers caused by other national policies. The need to develop a health and social care system that can successfully integrate different preventative approaches around individuals, their families and local communities has never been greater. To understand how and when to integrate though, we first need to be clear what links are required and how they could operate in practice. That is why fragmentation, rather than integration, should be the starting point to achieve a prevention orientated health and social care system.

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