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‘They Made an Excellent Start . . . but After a While, It Started to Die Out’, Tensions in Combining Personalisation and Integration in English Adult Social Care

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This article seeks to understand the challenges of combining the distinct aims of personalisation and integration in adult social care. Addressing the local context of service delivery in England through interviews with key stakeholders, we identify how personalisation and integration activities require different, and potentially conflicting, approaches. We observe direct tensions when structural integration with health systems distracts focus from achieving personalised delivery of care or where a focus on clinical outcomes takes precedence over broader wellbeing aspirations. Integration can entail the prioritisation of health over social care and a population rather than personal orientation. We suggest that personalisation and integration are in ‘policy conflict’ (Weible and Heikkilä, 2017) and that policy-makers need to acknowledge and address this rather than promise the ‘best of both worlds’.

Keywords: Policy, personalisation, integration, health and social care.

Introduction

Personalisation and integration have become familiar themes in long-term care policy in the UK and across OECD countries (Gadsby *et al.*, 2013; Gori *et al.*, 2016). The policy goal of personalisation broadly seeks to enable people who use care services to participate in and design their own support. Integration approaches look to bring together different stakeholders and facilitate collaboration between them, particularly in health and care. The personalisation agenda has had an international impact on long-term care systems (Gadsby *et al.*, 2013); countries with separate health and care systems are increasingly also looking at how to achieve better integration (Cumming, 2011; Ministry of Health, 2011; WHO Regional Office for Europe, 2016; Dickinson and Carey, 2017; Needham and Dickinson, 2018). UK policy in particular has concentrated on personalising care services whilst also ensuring structural and systemic integration, across all of its four nations (Reed *et al.*, 2021).

Social care (the UK name for long-term care) encompasses home and residential provision, along with community support, for frail older people and working age people with a disability or mental health condition. It includes personal care (help with washing, dressing and food) as well as support for accessing education, employment and broader community activities. Achieving personalisation of care services and integration with

health services are long-standing policy goals in the UK's four nations, despite different structures and approaches. In the last decade, Scotland has taken an ambitious approach to full structural integration of health and care governance, combined with a commitment to self-directed support (Pearson *et al.*, 2018). Northern Ireland has the oldest system of health and care integration, dating back to the 1970s, although has been the slowest at implementing forms of personalisation such as individualised care payments (Heenan and Birrell, 2017; Atkins *et al.*, 2021). In Wales the *Social Services and Well-being (Wales) Act 2014* established a legal duty on local government to promote self-directed support and integration, implemented through seven Regional Partnership Boards (RPBs) (Reed *et al.*, 2021).

We focus in this paper on England, which, with a population much larger than the other nations of the UK, has a particularly complex job to do in moving health and care organisations closer together. In England the *Care Act 2014* advanced personalisation by requiring that all those assessed as being in need of care and support have a care plan, a personal budget and choice and control over their support. In addition, there were specific new responsibilities for local authorities around co-production in commissioning and sustaining a diverse range of support options. New duties were established relating to information and advice to support choice and control. Alongside this promotion of personalisation, the English *Care Act* also made a strong commitment to integration as newly established local Health and Wellbeing Boards were asked to integrate services and authorities were required to undertake functions in a way that ensured integration of care with health. This was seen as vital in addressing a key divide in current institutional arrangements in which people with 'health' needs get free care from the National Health Service, whereas people with 'care' needs receive a means-tested service from local government. In many cases, particularly for people with long-term conditions such as dementia, the boundary between health and care is contentious. Institutional gaps between services make it hard to deliver holistic support and can mean that, for example, people cannot leave hospital because social care arrangements are not yet in place (Glasby and Littlechild, 2016)).

Social care is a local government responsibility, and the new duties set out in the *Care Act* brought new local challenges such as shaping a diverse and accessible market of social care provision, whilst promoting closer working between care and the NHS (Barnes *et al.*, 2017). These changes came at a time when the sector was experiencing the financial effects of austerity measures and reduced funding, alongside staff recruitment and retention issues linked to a deterioration in working conditions (Skills for Care, 2018/19). It is within this challenging context that English local authorities had to make sense of how to implement a wide-ranging *Care Act* incorporating multiple policy agendas and principles.

Whilst, conceptually, the goals of making social care more person-centred and more integrated are not in tension, the requirement on care systems to deliver both at the same time can create strain. In the Scottish context, Pearson *et al.* (2018) draw attention to the ways in which the demands of new integration legislation came to overshadow a prior commitment to self-directed support (the Scottish approach to personalisation). The idea that certain policy goals compete rather than sit together is at the heart of this article as we examine the interplay between personalisation and integration in the context of adult social care commissioning in England. These are two key policy commitments, and the article makes an original contribution in highlighting the interplay and tensions between

them from the perspective of local authority practitioners and care providers. We draw on findings from a broader study that looked at how local authorities are discharging their market shaping duties under the *Care Act 2014* (Needham *et al.*, 2022a), and focus here in particular on how local authorities foster personalisation and/or integration activities. The English care system is highly marketised, with seventy-eight per cent of provision being in the private or not-for-profit sector (Oung *et al.*, 2020), meaning that the key role of local authorities is to commission services from the market and ensure sufficiency of supply, rather than to deliver services themselves. The article looks first at the importance of the two concepts in relation to English social care and their definitional ambiguity, and then goes on to explore how they are being implemented in local settings.

Personalisation and integration: definitional ambiguity

Both personalisation and integration are multidimensional concepts, with international resonances as well as specific policy meanings in particular contexts. Personalisation has been defined as a ‘way of working that respects and tailors services to the uniqueness of the individual’ and emphasises the importance of person-centred working and the co-ordination of services (Gridley *et al.*, 2014: 592). The aspirations for greater choice and control were first articulated by the international disability movement before being co-opted by government (Needham, 2011). The policy of individualised payments was an initial victory for the disability movement, but one that has been diluted through the shift to personalisation, the onset of austerity and the pandemic, which has cut budgets significantly (Dickinson *et al.*, 2020). In England, the aspiration to offer choice and control to people using services is central to person-centred support and has been a formal ambition of English care services since the Putting People First Concordat (HM Government, 2007). Statutory guidance on the *Care Act* describes a personalised approach as looking ‘at a person’s life holistically, considering their needs in the context of their skills, ambitions and priorities (...) The focus should be on supporting people to live as independently as possible for as long as possible’ (Department of Health, 2017: para 1.15).

To embed the personalisation of care services into the legal framework for adult social care, the *Care Act* used the mechanism of individualised funding, requiring local authorities to give all eligible users – including carers – a personal budget. Where possible, this should be a direct payment where people control the money themselves. However, there have been concerns about incomplete implementation. Several years after the *Act* of those who are eligible, only forty per cent of working age adults and seventeen per cent of older people receive a direct payment, and numbers have been falling over the last three years (Bottery and Ward, 2021). Scepticism has been expressed about whether having a personal budget does actually lead to genuine choice and control (Slasberg and Beresford, 2020).

Integration is similarly understood in a variety of ways. Integration with health has been a policy goal in England for several decades, with various attempts at new structures and funding incentives (Mangan *et al.*, 2016; Reed *et al.*, 2021: 3). In particular, initiatives have often been focused on how to get people out of hospital more quickly, through better alignment of health and care services. The *Care Act 2014* established a legal duty on local authorities to promote integrated services with local NHS bodies through Health and Wellbeing Boards. Place-based integration of health and care commissioning has been

fostered through ‘Sustainability and Transformation Partnerships’, moving more recently into more formal ‘Integrated Care Organisations’. The government has now introduced proposals for Integrated Care Systems (Miller *et al.*, 2021), which would become legal structures (Department of Health and Social Care, 2021). However, as with personalisation, implementation of integration has been disappointing. A review by the Nuffield Trust found ‘a persistent mismatch between some of the stated objectives of integration, and what better collaboration between health and social care can meaningfully achieve’, with policy-makers continuing to focus on structural change rather than paying due attention to culture, norms, systems and processes (Reed *et al.*, 2021: 3).

Studies of the policy process differentiate between ‘uncertainty’ and ‘ambiguity’ (Cairney, 2019). Uncertainty is conceptualised as the state of lack of knowledge about policy problems and solutions, whereas ambiguity addresses how stakeholders possess and negotiate more than one interpretation of a problem. Part of the challenge in implementing personalisation and integration is the conceptual ambiguity surrounding both terms, which creates challenges for local government in being asked to design services that promote them. Even if these concepts were more clearly defined there would still be different options and limitations around how outcomes can be achieved in practice, responding to local contextual factors such as population demographics and social care workforce capacity. What are even less clear are the best strategies to combine the two objectives and where there are tensions and trade-offs to be made between them. The *Care Act 2014* and its guidance make clear that both personalisation and integration are to be pursued simultaneously:

The vision is for integrated care and support that is person-centred, tailored to the needs and preferences of those needing care and support, carers and families (Department of Health, 2017: para 15.1).

However, Pearson *et al.* (2018: 662) in their work on Scotland note that the Scottish policy of self-direct support ‘has been caught up in a policy overload and ultimately overshadowed by new legislation for health and social care integration’. This policy overload is in part connected to a lack of resource to attain dual policy goals, but also stems from issues in partnership working and co-production. There is a temporal sequencing here – that the older focus on choice and control has been lost due to a new and vigorous commitment to integration – as well as recognition of policy overload. We explore the implementation of integration and personalisation in England in order to consider whether similar patterns are evident.

Methods

This article is informed by study findings from a project funded by the National Institute for Health Research that evaluated how local authorities enacted adult social care market shaping duties under the *Care Act*. Approval was granted from the NHS Research Ethics Committee (17/LO/1729) and the Association of Directors of Adult Social Services (ADASS) (RG17-05).

In 2017 twenty-eight senior leaders and opinion formers in high profile organisations in care policy were interviewed e.g. charities, think tanks and membership bodies.

Interviews and focus groups were then conducted in eight local authority case sites. Sites were selected to cover variation in care outcomes, political control, geographical coverage, urban/rural, type of council and population demographics. In 2018 we interviewed sixty-six local authority commissioners, fourteen local stakeholders (e.g. from health or the voluntary sector) and sixty-six care providers. We identified local authority contacts from organisational websites, and used a snowballing approach through which local authorities identified providers. People were interviewed face to face or by telephone by one of the authors. The research was undertaken alongside nineteen people with lived experience of using social care services, who worked with the academic researchers to design interview questions, interview participants, and decide practice recommendations.

Data were analysed in QSR-NVivo 11, using a two-stage thematic coding process adopted by other applied studies of complex care approaches (Park *et al.*, 2019). An initial phase of the study used a realist literature synthesis and national stakeholder interviews to generate a conceptual framework that conveyed four approaches used in adult social care market shaping (Needham *et al.*, 2022a). In particular, this approach identified two approaches that were promoted by the *Care Act*: an ‘open market’ approach, which aimed to increase personalisation through enhancing individual choice and control; and a ‘partnership’ approach, which aimed to build long-term relationships with key organisations such as the NHS in order to develop more integrated forms of support.

In coding the local case site data, five members of the research team coded using a consensus coding approach (Cascio *et al.*, 2019). Consensus was developed in group coding meetings, then individual coding was undertaken with the team regrouping for regular discussion of coding decisions. We used a set of indicators to assess care market shaping in each locality:

- Who was setting market rules (e.g. access to tenders, care specifications)?
- What were the dominant patterns of commissioning/provision (e.g. spot purchasing, block or framework contracts, direct payments)?
- Were local authority commissioners seeking to diversify the market to increase user choice and control?
- What mechanisms existed for local authorities and health providers to integrate?

Local authority commissioners provided a ‘member check’ on our preliminary findings as a process of validation as well as to support a peer learning network between the sites (Koelsch, 2013). For this article we look at the parts of this larger data set that relate to personalisation and integration, to explore the key implementation issues in both domains and the extent to which they sat in tension.

Findings

An analysis of how well integration and personalisation are working together in English adult social care reveals a set of tensions. Our initial interviews with national stakeholder interviews alerted us to a wariness about attempting both at the same time:

I think some of the integration initiatives potentially could work against personalisation, particularly the ones that are very large scale and focused on organisations rather than individuals. (National stakeholder)

The bio-medical culture within health was seen as a threat to the values of social care services and organisations, which have tended to take a more holistic view of people's lives:

I think we need to be really clear about what the outcomes are that we're expecting integration to deliver . . . I think people are talking about it who don't really understand the system. My fear around integration is that the NHS culture is so strong it will just suck up and subsume social care, so anything around lifestyle or family or that bigger picture will be lost. (National stakeholder)

Others reported variance in the extent to which people working in the health system understand the personalisation agenda:

I'm having some fantastic health-driven conversations . . . where it seems to me that health are pushing a strong values-based choice agenda. And I'm also having some conversations [elsewhere] where I think that health wouldn't know choice and control if they fell over it. (National stakeholder)

Working in partnership and cultural barriers to personalisation

Moving to local case study sites gave us the opportunity to explore how these perceived tensions were being experienced in practice, from the social care perspective. Local authority interviewees in the sites expressed a strong commitment to personalisation and to making choice and control a reality:

My strategic goal is to put people in charge of their own destiny, as mini-micro-commissioners, so that they can choose the forms of care and support they want. (Local authority)

This was seen as requiring a new approach to the care market:

So if they are fully going to give somebody their own personal budget, to manage that personal budget, to manage their outcomes differently, the market has to be there for the individuals to be able to have some choice about what they want . . . Because if you're just going to buy the same old with the same old money, then to me there's no sense in that. Personalisation is about doing things differently. (Local authority)

However, this commitment to diversity was felt to clash with an NHS agenda of standardisation:

This personalisation approach that is focusing on the individual, the NHS isn't very good at that. They do personalisation, but it has to be in a uniform standard way because everybody of course is the same. (Local authority)

Scale and standardisation were frequent themes used to describe the way that integration could work against personalisation in practice. This social care provider describes NHS organisations' focus on identifying nationally generalisable best practice

and how this can sit in conflict with the more subjective, community-based approaches of other partners:

I think the NHS does very little locally and small, they tend to think big and it has this fixation on everything needing to be the same, no matter where you are. Whereas, you know, you do need to be able to recognise a locality or geographical sensitivity and indeed some communities have different preferences. (Care provider)

There was also a sense that clinical judgement and guidance from the National Institute for Health and Care Excellence (NICE) was expected to trump everything else:

When you start talking about clinical stuff, then the [health commissioners] go into this kind of state where the clinical stuff becomes supreme over everything else and NICE guidance becomes everything. And they can't really understand what else there is that they need to think about and talk about' (Local authority)

There was a sense then that there was a different set of priorities between health and care, and a different scale of operation, which hampered joint working.

Structural and financial issues that hinder progress towards personalisation

The battle to decide whether something was a 'health need' or a 'social care need' continued to be a barrier to joint working:

[T]here's a lot of fighting between us and the NHS around who should fund people's care, and whether their needs are health needs or social care needs. And that will basically continue as a battle until the day the funding is integrated... They've got a different agenda, really. It's to basically get people physically well and out of their service rather than ongoing support, to be honest. (Local authority)

Our interviews were with people on the social care side of the divide, which is a limitation we discuss further below. However, not all of the blame for lack of collaboration was put on health partners. One interviewee from local government described how her managers were not willing to pay for anything that looked like a health expense, even though longer term there might be a social care benefit:

So you've got a health budget, and the social care budget are disjointed. And from this perspective, what you can find is that certain managers will say, "Well it's health, prevention of the deterioration of health. We will not pay for it." What I'm saying is, yes it is prevention of deterioration of health, but... we have to prevent deterioration of the health needs, because it will trigger increase in the social care needs. (Local authority)

Difficulties in agreeing which partners should invest and where the benefits would be felt were also felt to be a barrier:

[F]undamentally we have a huge amount of challenge, as does every other area, in that the areas where integration works best is where you can identify a common priority and it's very clear the

benefits to the end users and all parties of investing in that current priority. A lot of the issues are that it might take one partner to do the investment but the benefit of that might be seen by another partner and that's obviously where the struggles are. (Local authority)

Some of the local sites were attempting structural integration programmes (for example, a move to shared staffing or joint commissioning of services) and the logic of personalised outcomes was often at the heart of the vision on paper:

It has a great vision. To have a single [health and care] commissioning function and one team, in terms of people being able to be more in control, in terms of their aspirations, goals and well-being, to co-produce and to be able to do more self-care for themselves will be formidable. (Local authority)

In another authority, a single commissioning structure covering both health and social care was seen as a necessary initial step required to ultimately facilitate a more user-led approach to care choices.

I think if integration's done well and done for the right reasons, so not simply for a structural back-office efficiency reason, but actually to provide better, joined up, coordinated care that keeps people at home living healthier, happier lives and more connected to the community, then actually I think that could only be a good thing. (Local authority)

However, the complex realities of setting up new structural organisations was an issue for many interviewees:

We recognise that if we really get personalisation right, we will have the greatest impact on health and care provision . . . What we're struggling to work through is . . . when you're putting that into practice, what does that mean in terms of statutory legal obligations and duties . . . [T]rying to deliver truly integrated health and social care and personalised health and wellbeing offers locally, we're coming up against these square peg round holes type things. (Local authority)

Relationship management, legal processes, tax implications and inclusion of all relevant partners were major challenges. One interviewee described the problems encountered when health and care staff were co-located:

[T]here was a plan to trial a small team of social workers working in the same offices as some health and social care, community district nurses and people like that. But then, there were so many issues around confidentiality that it was deemed a no-go thing, really. (Local authority)

Even where structural integration had been achieved, local government interviewees conceded that it did not feel like a partnership of equals:

[W]e've still got some organisational silo working, under the banner of, "Oh well, we've created a single commissioning function." Yeah, but really, we're not living and breathing that. And I would say that there's a lack of recognition from health in particular of social care . . . You've still got a dominance of health people in more senior positions. (Local authority)

It was clear then that even in areas where joint working or co-location had been tried, barriers remained. Unwillingness to share data and a sense that health tried to dominate proceedings speaks to a lack of trust between partners.

Dual policy goals and the dilution of the personalisation agenda

There was a sense that personalisation might be a waning agenda, despite the prominence of individualised approaches in the *Care Act*. One interviewee reflected:

Personalisation seems to – Whether it's just been absorbed into the psyche of everybody, but it kind of seems to no longer have the presence, the front and centre ground that it maybe had a few years ago. (Local authority)

A care provider noted:

They made an excellent start [on personalisation] about nine, ten years ago. People were encouraged but after a while, it started to die out. (Care provider)

Talking about personalisation, one local authority commissioner noted, 'it's a diluted form isn't it, of what was envisaged at the outset.' (Local authority).

In contrast, some felt that integration was just beginning and was at too early a stage to expect results, particularly given the scale of the task:

Obviously the integration is embryonic . . . I think what we have almost tried to do is a clash of two cultures integration. So, we've tried to integrate two organisations as are and that creates a friction. (Local authority)

However, for another interviewee, the problems were unlikely to be resolved over time:

And integration is seen as, in some ways, perhaps it's oversold as the saviour. And you know, a lot of the benefits have been seen around cash benefits. But I think we're coming to the realisation that they're not going to be great cash benefits.' (Local authority)

Overall, then, local sites had found it difficult to develop the personalisation agenda in a context of integrating with health. Structural and financial barriers, and a perceived prioritisation of health over care goals, meant that there was less interest in how to foster individual choice and control. Cultural barriers around attitudes were exacerbated by issues relating to budgets, data and staffing.

Discussion

From a conceptual perspective, there are no clear reasons why personalisation and integration should be in conflict. While there may be a sense of conceptual ambiguity in terms of what is meant by personalisation and integration, overall there was broad acceptance of both policy objectives across the case sites. Nevertheless, exploring how

the local case sites have pursued these two concepts in practice reveals areas of tension. 'Policy overload' has been identified elsewhere in the UK in experiences of working towards the policy goals of personalisation and integration (Pearson *et al.*, 2018). In our English case sites, progress towards personalisation slowed down as the imperative of integration took precedence.

This finding has particular significance against the backdrop of a longstanding UK critique about whether personalisation is being implemented in a way which upholds its original disability rights goals of liberation through participation (Ferguson, 2007; Spicker, 2013; Slasberg and Beresford, 2020). Early advocates of personalisation identified its 'shallow' and 'deep' modes (Leadbeater, 2004). Shallow personalisation achieves only increased access and some limited voice for people with care needs, whereas deep personalisation is characterised by people co-designing their services and a commitment to shared power (Needham, 2011). The policy tensions identified in this paper, between personalisation and integration, suggest the conditions required for the fundamental shift in power to achieve a deeper model of personalisation are lacking.

Ambiguity and gaps between theory and practice are well acknowledged challenges to policy implementation (Matland, 1995). Critical research has importantly cautioned against policy approaches that prescribe too clearly 'a definite set of products and templates' (Coleman *et al.*, 2021: 285). However, drawing out some of these areas of conflict between personalisation and integration enables us to develop an understanding of how integration and personalisation interact with one another and how these policy aims may be obstructed in practice. Within local authorities, our research found that a focus on integration with health was directing the attention of local authority commissioners away from stimulating a diverse market of care and support to allow personalisation. Instead, local authorities were looking at population-level commissioning and closer working with health. This approach can undermine the scope to ensure personalised commissioning for individuals and can create disincentives for promoting direct payments and stimulating a diverse care market. Budget disputes about what was a health or a care expenditure continued. There were also organisational challenges relating to practical matters as well as cultural clashes.

There are clear forces in tension here. Integration is focused on bringing structures and budgets together where an emphasis on structures and processes creates 'sites' of integration, whereas personalisation emphasises decentralisation whereby it is the person accessing services who is the 'micro commissioner'. Our findings demonstrate that this conflict is informed by cultural limitations and constraints forged by institutional structures. For example, in some case sites, integration appeared to entail the prioritisation of health over social care, a familiar theme in detailed analyses of interprofessional working (Glendinning, 2003; Ling *et al.*, 2012). In some sites, there were also attempts to maintain a high-degree of control within commissioning relationships and a separation of health and care needs. This control ran counter to the development of relationships between providers and people accessing services that is at the heart of personalisation. These findings reflect growing concerns about how easily integrated systems can neglect to evaluate their benefits based on the perspectives and outcomes of people that use them (Crocker *et al.*, 2020; Raus *et al.*, 2020).

These themes add to our understandings of the cultural, operational and territorial barriers observed in English care systems at a time when the context of unprecedented austerity and the Covid-19 pandemic necessitated shared vision and strong leadership

(Harlock *et al.*, 2019; Comas-Herrera *et al.*, 2020). Our findings have built knowledge about how the cultural and political dominance of health over social care continues to impede the development of shared values. Daly's (2020) analysis of English policy responses to care homes in the Covid-19 pandemic raises important socio-cultural factors such as the depoliticisation of social care and relatively higher political capital afforded to health services. In the public eye and the national policy context the NHS and health services retain an elevated status and coverage. Our findings show how the ingrained nature of this value imbalance pervades organisational cultures and challenges joint working in a way which has de-prioritised the development of personalised support.

Weible and Heikkilä's (2017) Policy Conflict Framework offers a way of conceptualising these tensions and understanding the effects that this conflict may have on service-delivery. The framework provides a conceptual structure that seeks 'to support contextually appropriate theoretical description and explanations about policy conflict' (Weible and Heikkilä, 2017: 25). The framework emphasises the implications of the policy setting, viewed to be the wider contextual factors that can inform policy conflict, along with the way in which this context may influence the cognitive characteristics of conflict. In other words, the different policy positions actors may hold, the perceived threat of others' policy positions, as well as the extent to which actors are willing to compromise on a policy position. These cognitive elements then feed into the behavioural elements of conflict and the strategies or tactics (both overt or covert) that actors may pursue to influence policy outputs or outcomes. The outputs and outcomes generated from policy conflicts are likely to feedback and influence future conflict.

Applying Weible and Heikkilä's framework to the exploration of the tension between integration and personalisation highlights the enduring impact that organisations' structural boundaries and cultures can have on policy. For example, attempts to pursue collaborative working were found to be dominated by an NHS approach in which there was an over-emphasis on clinical outcomes and short-term goals. Our findings highlight how these 'ways of thinking' (or the cognitive characteristics of policy conflict) can generate tensions between the pursuit of integration and personalisation. These examples highlight the continuities within actors' behaviours that are informed by the different dimensions of the policy setting. In Weible and Heikkilä's terms, integration and personalisation are pursued at the level of 'policy action situations', which are the 'formal and informal policy venues' (2017: 27) where actors congregate to tackle policy issues (e.g. hospital discharge meetings, co-located staff). Interactions with other actors will also be influenced by policy actors' interpersonal attributes that refer to the cross-network relations and level of collective resource that can be accessed.

Across the case sites, there was recognition that the sense of the importance of personalisation was waning. The policy conflict framework highlights the different factors that may have informed this prioritisation. The foregrounding of the health system within integration may represent the perceived higher-stakes of integration, the more generous funding of the health system, as well as limited public awareness of the social care system (Cameron and Balfour, 2018) compared to health care. Weible and Heikkilä (2017: 30–31) highlight that the behavioural dimensions of conflict can be both overt and covert. Therefore, the conflict between integration and personalisation does not necessarily need to result in public dispute and disagreement, and conflict can have the subtler qualities we find within the tensions between personalisation and integration. While there may be

public endorsement for the principles of integration and personalisation, there remains tension between these concepts.

Our work has focused on the English care system, and the distinctive context of English local government and the NHS is part of the cultural and structural explanation for the tensions we have found between personalisation and integration. Nonetheless, many of the issues highlighted here have wider resonance. For example, in Australia the 2013 introduction of individualised funding (National Disability Insurance Scheme) has struggled to combine person-centred support with integrated services (see Needham *et al.*, 2022b). This suggests a future comparative research agenda looking at these two dynamics in a wider set of health and care systems.

Conclusion

This article has considered how well personalisation and integration work together as policy goals for those leading and delivering adult social care services in England. Both policy themes have clear importance in contemporary health and social care planning. As we enter a post-pandemic era, many governments are moving forward to reform social care, at least in part acknowledging the need for investment and reconfiguration. In England, the government published an Adult Social Care Reform white paper in autumn 2021 affirming that it ‘...puts wellbeing and personalised support front and centre’ (Department of Health and Social Care, 2021: 8) and restating a commitment to integration with health, including regional governance systems with specific partnerships and boards. Both of these dynamics retain their symbolic dominance in government policy papers, despite the tensions between them.

Our findings about the extent to which these policies are in conflict contain learning for policy-makers and those shaping care delivery. Examining when ‘policy action situations’ were led by either personalisation or integration allowed the identification of tensions that arise in the pursuit of one aim and inhibit the realisation of the other. The key features of policy conflict to address for those making and implementing integration policy include: that approaches focussed on structural integration distract resource from planning personalised delivery; in partnerships the culture of larger health organisations can dominate more personalised approaches that are often more embedded in social care; and that joint strategic approaches can overemphasise solutions at a population needs level, rather than truly personalising care provision at an individual level. There may be ways to combine the two more productively, if integration can be detached from the grand ambition of system overhaul and be brought to the scale of the individual, but without this policy conflict will endure.

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