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**Article (Accepted version)
(Refereed)**

Original citation:

Wistow, Gerald (2011) *Integration and the NHS reforms*. [Journal of integrated care](#), 19 (4). pp. 5-13. ISSN 1476-9018

DOI: [10.1108/14769011111164241](https://doi.org/10.1108/14769011111164241)

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This version available at: <http://eprints.lse.ac.uk/40083/>

Available in LSE Research Online: May 2013

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Integration and the NHS Reforms

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Accepted (15th June 2011) for publication in Journal of Integrated Care August 2011¹

As professional, managerial and political opposition to the NHS White Paper became more organised and vocal during the spring of this year, so uncertainty grew about its implications for integrated care and relationships between the NHS and local government. By April, not only was the Secretary of State seen to have lost control of his policy but so were Downing Street and the coalition as a whole. In an effort to regain control of the agenda, the government announced an eight week 'listening exercise' at the end of the House of Commons committee stage of the Health and Social Care Bill. This exceptional intermission in the legislative process was accompanied by handing control of its conduct to a group established for the purpose, the NHS Futures Forum, chaired by the immediate past President of the Royal College of General Practitioners, Steve Field.

At the time of writing, the ultimate legislative outcome is unknown. The Forum's Report has been published (Field 2011) and the government's initial response has been to accept what it describes as the document's 'core recommendations'. From the perspective of the Journal's interest in integration, that assertion must be considered problematic. In practice, the government has not accepted the Forum's recommendation to strengthen Health and Wellbeing Boards by enabling them to veto local commissioning plans. By not agreeing what is arguably the Report's most substantial recommendation affecting NHS and local authority integration, the government's position is open to the interpretation that it does not see the Forum's recommendation as core to either the Forum's overall package of proposals or to the improvement of integrated care and governance locally. We consider the implications of the government's position below.

Nonetheless, it is important to begin by recognising that the publication in July 2010 of the White Paper, *Liberating the NHS* (DH 2010a), was a notable event in the history of the health service's relationship with local councils. The White Paper was clear that the achievement of NHS goals depended on that relationship, arguing for example that it was 'essential for patient outcomes that health and social care services are better integrated at all levels of the system' (DH 2010a para. 3.11). As a result, an expanded role for councils

¹ Wistow G. (2011b), 'Integration and the NHS reforms', *Journal of Integrated Care*, Vol. 19 No. 4, pp. 5-13

and local democracy in the NHS was at the heart of the White Paper's vision for a service which:

- puts patients and local communities at the heart of decisions, 'no decision about me, without me'
- focuses relentlessly on outcomes for patients, rather than on measurement of narrow processes;
- enjoys greater local democratic legitimacy, with a new role for local government in joining up health, social care and public health services, and a lead role in health improvement;
- liberates professionals at every level to take decisions in the best interests of patients through GP commissioning..... (DH 2010a)

There are numerous examples of NHS responsibilities being re-interpreted as falling within the domain of local government, as the history of community care and continuing health demonstrate (Wistow 1995). Yet this was the first time since the creation of the NHS that the Department of Health had advanced firm proposals for councils and the local democratic values they represent to be given a greater rather than a diminished role within the decision making processes the health service. Both the White Paper and an accompanying consultation document directly addressed the widely perceived local democratic deficit in the NHS. The latter, entitled *Local Democratic Legitimacy in Health* (DH and CLG 2010) envisaged that local authorities would have 'an enhanced role in health' as a result of being allocated 'greater responsibility in four areas:

- leading joint strategic needs assessments (JSNAs) to ensure coherent and co-ordinated commissioning strategies;
- supporting local voice, and the exercise of patient choice;
- promoting joined up commissioning of local NHS services, social care and health improvement through Health and Wellbeing Boards; and
- leading on local health improvement and prevention activity' (DH and CLG 2010 para.10)

The same consultation document also saw local authority members bringing greater local democratic legitimacy to health, especially through the Health and Wellbeing Boards proposed for upper and single tier authorities. Though these boards were apparently to be pivotal in 'joining up' commissioning plans, they were also expected to have a substantial role in securing local political and public support for the reconfiguration of hospital services (to the exclusion of Scrutiny Forums in the initial proposals). In summary, councils would be responsible for taking on health improvement functions from PCTs, coordinating local

commissioning and injecting local democratic accountability into a service from which it had been progressively removed between 1974 and 1991.

The successful exercise of these new roles and responsibilities depended on whether sufficient powers and other resources would be available to local authorities. At the pre-legislative consultation stage, many details remained to be clarified. Nonetheless, the various consultation documents did contain a number of specific measures apparently designed to secure comprehensive improvements in integrated working 'right along the care pathway - from prevention, treatment and care, to recovery, rehabilitation and reablement - (which) aimed to strengthen integration in many other ways' (DH and CLG 2010 para.20). The following were explicitly listed and can be seen as primarily operational proposals to complement the more strategic focus of the enhanced roles identified above:

- giving people more choice and control so that they would have more power to decide what matters most to them;
- extending the availability of personal budgets with joint assessment and care planning;
- systematic development of quality standards across patient pathways, for example the NICE dementia standard;
- promoting the CQC as an effective inspectorate of quality standards across span health and social care;
- introducing payment systems to support joint working, for example PBR and hospital Readmissions;
- freeing up providers to innovate and focus on the needs of people using services, for example, enabling foundation trusts to expand into social care'. (DH and CLG 2010 para 21)

The Legislative Framework

The central importance of more effective relationships between the NHS and local government was re-asserted in the government's response (DH 2010b) to the normal pre-legislative consultation processes which took place from July to October 2010. For example, it emphasised better NHS commissioning arrangements were insufficient in themselves to achieve better outcomes 'because the successful pursuit of better health and wellbeing will only come from increased co-operation between the NHS and local authorities' (DH 2010b para.5.1). The Public Health White Paper had argued similarly for a bigger role for local government because it was 'best placed to influence many of the wider factors that affect health and wellbeing' DH 2010c para. 2.5). This reference to the health service's

dependence on local government as a whole and not merely adult social care may yet require clarification: there have continued to be some inconsistencies in descriptions of the scope for the strategic coordination of commissioning and the extent to which it extended beyond social care.

Nonetheless, the strength of these interdependencies and the responses to consultation on the White Paper's proposals for managing them was such that in December 2010 the government announced that it had 'decided to expand, strengthen and adapt significantly its proposals for legislation in this area' (DH 2010b para. 1.13). Respondents were 'near unanimous' that Health and Wellbeing boards should be put on a statutory footing (ibid, para. 5.6). This view was accepted and the introduction of HWBs was to be accelerated 'through a new programme of early implementers.' (ibid. para. 1.13). There were also to be statutorily based requirements for GP consortia to participate in Joint Strategic Needs Assessments (JSNAs) and for all commissioners to 'have regard to' these documents in local commissioning plans (ibid. para.5.20). In addition, 'and building on the enhanced JSNA, the Government announced that it would specify in the legislation that 'all health and wellbeing boards should have to develop a high-level "joint health and wellbeing strategy" (JHWS) to which local authority and NHS commissioners would be required to have regard (ibid. para. 5.22).

Another New Beginning for Integration?

The White Paper, supporting documents and subsequent legislative framework had proposed a wide range of measures to improve integration. These proposals were, however, only the most recent of repeated attempts to secure more fruitful relationships between local government and the NHS by creating frameworks to overcome barriers to joint working and bridge the boundaries between them. With the exception of occasional beacons of good practice, these previous initiatives have produced generally disappointing results. Inevitably, therefore, the new proposals raised questions about whether they might be capable of achieving any better results. This question led the Local Government Association (LGA) to commission a review of the historical evidence in order to determine how well founded the new framework was and whether integration might be more successful this time.

The review (Wistow 2011) summarises findings from a historical overview of arrangements and experiences of joint working between local government and the NHS since the foundation of the latter in 1948 (Wistow, forthcoming). Its conduct was consistent with standard historical research methods (Brundage, 1997). Sources included a review of key texts including relevant legislation, policy statements and formal guidance, advice from participants in the events and other experts, review of evaluation of primary material quoted in the secondary literature and attempts to discover new evidence supporting or denying emerging arguments (Rumbold and Shaw 2010 p.46). Topics identified in the literature fell into three broad categories: definitions of integration; official documents and

chronological accounts; and theoretical frameworks for understanding and prescribing approaches to integration.

Principles of Integration

This overview of literatures generated the following ten 'principles of integration'

1. **There is no single silver bullet for successful integration (1):** the search for single causes has tended to lead to over simplistic solutions dealing with limited aspects and levels of the inter-dependencies between local government and the NHS.
2. **Expose the question to which integration is believed to be an answer (i.e. if integration is the answer, what's the question?):** definitions and understandings of integration (and related terms) vary widely and create confusion about the purpose and focus of joint working. Particularly important distinctions are those between: integrated care and integrated governance, on the one hand; and between vertical integration and horizontal integration, on the other.
3. **Design a proper balance between means and ends:** integrated services and integrated governance are primarily required to secure better (specified) outcomes for people and places. However, integration structures and processes have tended to be treated as ends in themselves rather than the means to better outcomes. Similarly, intended outcomes and financial means have not been consistently aligned in terms of the overall adequacy or location of budgets.
4. **Integration must be multi levelled because organisations and their purposes are multi levelled:** mechanisms for horizontal integration are needed at each organisational level (for example whole systems, community and individual levels) but vertical mechanisms are also necessary to integrate the various levels. A core complexity in securing improved integration is synchronising the operation of vertical and horizontal arrangements so that end users can access the 'right' services and the 'right' time from the 'right' person and in the 'right' place.
5. **The NHS and local government operate from hardened silos because that has been an intended and fundamental characteristic of their design:** the two services were successively constructed to operate in parallel rather than interdependently and from structures built around the skills of providers rather than the needs of end users
6. **As the barriers to integration are systemic in organisations designed for separation rather than integration, the historic paradigms of building bridges and tearing down walls is inherently flawed and of limited effectiveness:** a better metaphor is one of weaving integration into the fabric of organisational life. It accepts the

inevitability of separate structures built on services and professions but treats them as the warp of integration across which the weft of person and place centred systems and processes must be woven. Horizontal mechanisms are person and/or place centred. The latter include whole systems planning, pathway planning, place-based budgets and personal budgets.

7. ***Effective personal relationships based on continuity, trust and mutual confidence are important lubricants of integration but are undermined by organisational restructuring:*** they form a psychological contract based on shared commitments to better outcomes for the same people and places which, in turn, shape day to day behaviours. Reorganisations tend to break up such relationships and they can only be rebuilt over time.
8. ***Accountability mechanisms can strengthen or undermine integrated care and integrated governance but effective horizontal relationships tend to be in tension with the strengthening of vertical accountability.*** Organisations that are separately accountable will tend to produce separate outcomes unless each accountability system is carefully aligned around their respective roles in collectively producing specified outcomes. The proper balance between vertical and horizontal partnerships and accountabilities is critical but complex.
9. ***Responsibility for initiating, supporting and progressing local horizontal mechanisms should be situated in a single organisation to ensure it does not fall between potential partners:*** this responsibility for regulating or synchronising whole systems commissioning is an aspect of the convening and community leadership roles of local government. However, the latter role does not immediately read across to systems leadership in the NHS, a responsibility for which councils currently have little knowledge or experience
10. ***There is no single silver bullet for successful integration (2):*** sophisticated national and local leadership is called for to understand these lessons from past experience, develop them into a coherent framework and operate it as an interlocking whole.

It is not claimed that this set of principles is necessarily complete or, indeed, the only possible perspective on half a century of experience. However, it provides at least an initial framework, informed by empirical and theoretical understandings of history and practice, for analysing the scope and potential of the proposed arrangements to improve integration. More generally, they suggest that what is needed to increase the chances of success is a multifaceted change programme with at least the following characteristics:

- Abandonment of quick fixes in favour of capability to understand and manage complexity across institutions and agency
- Prioritisation of purpose above process

- Strategies for integrated care and governance across all organisational levels and interdependencies
- Acceptance of the inevitability of structural fragmentation, balanced by interweaving and alignment of mainstream systems and processes
- Balance of horizontal and vertical accountabilities compatible with securing agreed local outcomes including a single point for authorising local commissioning
- Comprehensive programme for introduction and prioritisation of integrated care and governance where needed to improve health and wellbeing of people and places.

Integration Principles and White Paper Proposals

The principles were then used as a framework for analysing the relevant provisions of the government's current proposals. As Table 1 shows, there is a relatively good fit between our principles and the proposals to improve integration. These similarities do not guarantee more successful integration and the delivery of better outcomes. As the Government, itself, recognised, legislating for change 'is not at all the same as making change happen: it is a necessary step, but insufficient' (DH 2010b para.5.49). Indeed the NHS and public health reforms are identified as being about 'wholesale (and) long-term cultural change' (ibid). In addition, as Table 1 suggests, there are some critical gaps and a number of potential implementation difficulties have surfaced (including the attempts to resist change and maintain established cultures and behaviours) as legislative and management preparations for introducing the NHS changes got underway.

One difficulty was the tendency for transition management to focus on internal agendas as indicated, for example, by the creation of PCT clusters and the related potential to disrupt personal relationships established through coterminosity and other joint arrangements including some Care Trusts. The establishment nationally of separate NHS and local government transition boards is unfortunate given the need for joint transition arrangements locally to compensate for the known disruption to relationships created by restructuring. Similarly, the formation of separate pathfinder schemes for GP consortia and Health and Wellbeing Boards has a certain, pragmatic logic but again does not directly help re-build relationships and understandings to support integration: nor does it begin to create the local conditions for implementing the local integration arrangements as a coherent whole.

Another emerging problem is uncertainty about the balance between the responsibilities of the National Commissioning Board and of local GP consortia. The evidence to the Health

Committee from the future Chief Executive of the NCB on the need for “Stalinist” Whitehall controls (White 2010) to implement the changes again has a pragmatic logic but equally raises questions about the extent of culture change and GP commissioning freedoms in the longer term. In addition, it is currently unclear how readily councils will be able to coordinate local commissioning plans in a context where the same source has described his aim of building ‘an integrated system between consortia and the Board, which supports the delivery of national accountabilities as well as local priorities’ (ibid.). He has sought to square this circle by emphasising that ‘while GP consortia ‘would provide the engine for the commissioning system locally.....they will need support and direction in order to carry out this critical role effectively and providing and shaping that support’ will be the central role of the NHS Commissioning Board (ibid.)

The more recent announcement that PCT clusters will be required to work within a single operating framework (Santry and West 2011) also suggests limited scope for local flexibility in a context where the financial environment is seen to require the maintenance of a tight grip from the centre. Some might argue that the integration proposals could be successful if it were not for a financial climate that is likely to drive protectionism. This argument is a ‘special case’ of the more general proposition that the wider NHS reforms are impracticable at the same time as the NHS is facing the smallest levels of growth since the early 1950’s and required to meet the so-called ‘Nicholson challenge’ of saving and re-investing £20 billion over four years. Others might emphasise that this climate is one which can only be accommodated by radically reshaping services and budgets across as well as within organisational and professional boundaries. Both arguments have merit, though the NHS Chief Executive has particularly argued ‘that leadership is not about building walls around your organisation, it’s about seeing beyond them.....’(Nicholson 2010). The actual outcome will depend on how understandings are structured and behaviours are incentivised at all levels.

As ever, the devil is in the detail and much remains to be resolved. The design of performance and accountability systems is still in progress and much will depend on the outcome. However, the local balance between vertical and horizontal influences remains critical to better integration and, thus, better outcomes for people and places. The Future Forum clearly had some understanding of this dilemma and tried to strengthen further the arrangements for integration by matching integrated care for patients and communities with effective systems of accountability and governance (Alltimes 2011 p.4).

Before, considering its recommendations, however, we should observe how ‘integration’ had become a central element in the controversy about the future of the Health and Social Care Bill, including one of the Prime Minister’s five promises about the future of the NHS (Cameron 2011). As we noted above, the term is capable of many definitions and meanings which, in turn, can be a source of confusion and conflict (Williams and Sullivan 2010). We also noted that one of the dimensions of differences in definition was whether the term was

being used to describe horizontal or vertical forms of integration. The historical overview identified four usages of this kind

- a. Horizontal integration between the NHS and Health and LG
- b. Vertical integration within the NHS supply chain
- c. Vertical integration between commissioners and providers
- d. Integration (vertical or horizontal) through collaboration rather than fragmentation through competition

In practice, much of the concern about the Bill's impact on integration has focussed on the perceived implications of competition for the fragmentation of services and responses to needs (though the Future Forum makes the point that 'services under the existing system are currently highly fragmented across the NHS, public health and social care; and within the NHS, between primary, secondary and tertiary care' (Field 2011 p.20). In this respect, therefore, integration and fragmentation have become code words for collaboration and competition. In addition, integration has become a code for overcoming the historic gulf between primary and secondary care, together with an associated questioning of the continuing need for the purchaser/provider split or at least how far it should reach at the level of individual patients (Health Committee 2010 and Ham et al 2011).

There has also been continuing debate about the extent to which local government will be able to exercise its responsibilities to integrate (horizontally) commissioning plans across different agencies and services in their localities. A particular concern has been the proposal that the various parties merely have the authority to write letters to each other about the extent, to which they have had 'adequate regard' to each other's commissioning plans, mandates and needs analyses. The Department recognised that a number of respondents wanted to go further; including the Local Government Group which suggested that "health and wellbeing boards should have the authority to sign off GP commissioning plans"(DH 2010b para5.25). However, the government rejected this suggestion on grounds that the NHS Commissioning Board will not have the authority to agree and sign off GP consortia commissioning plans but only to monitor the robustness of their financial forecasting. Consequently, 'formal approval rights for health and wellbeing boards would put them in a more powerful position than the NHS Commissioning Board, to whom the consortia are primarily accountable, in line with the Government's plans for the NHS to remain a national service, funded out of national taxation and accountable to Parliament' (DH 2010b paras 5.26 -5.27).

There are some solid constitutional issues here that constrain the extent of localisation (and thus horizontal integration between national and local services), though it is not clear whether there is a desire to push such constraints to their limits. The early descriptions of the NHS National Commissioning board's philosophy and approach seem more focussed on

establishing strong vertical relationships as we have seen. Nonetheless, the specific point about HWB powers was picked up by the Future Forum which recommended:

‘Health and Wellbeing Boards must be the focal point for decision-making about health and wellbeing, bringing together NHS and local authority commissioners with patient representatives. The Bill needs to strengthen their role:

- a. Health and wellbeing boards should agree commissioning consortia commissioning plans which should be developed in line with the joint health and wellbeing strategy.
- b. If it is not possible to secure agreement locally on the plans, the health and wellbeing board should be able to refer their concerns to the NHS Commissioning Board’

(Alltimes 2011 p.5; see also Field 2011 p.12)

However, the government’s immediate response to the Forum included a specific rejection of the first recommendation, though it has accepted recommendation b and also agreed to extend the role of HWBs in a number of other ways including their involvement in the authorisation of commissioning consortia, The prospects for transforming both central/local and local/local relationships continue to look problematic, therefore, in at least this respect. It remains to be seen whether the Future Forum’s overall package of recommendations can resolve the tensions between localism and national accountability, though the initial omens do not look promising in relation to the balance between vertical and horizontal integration.

Getting that balance anywhere near ‘right’ calls for early and intensive joint transition programmes locally, supported by a national willingness to refine further the balance of influences where necessary. The more a vision for local people and places drives relationships and structures, the more likely better outcomes will be achieved.

Theoretically the possibility of improved integration ‘this time’ is credible and realistic. Practically there is an equally credible and realistic possibility that we will fall short yet again and that professional or organisational interests will remain stronger than the commitment to better local outcomes. Ultimately, the outcome will turn on the extent to which the NHS is enabled to become a fuller part of the local family of public services and how far it remains a single-purpose, non-elected and nationally controlled service. In the latter circumstances, the space for locally structured policies and behaviours is inevitably circumscribed. Yet both our health and wellbeing and the sustainability of a comprehensive health service free at the point of delivery almost certainly depend on how far that circle can be squared. Thus the future of the NHS may depend as much on the future of integration between it, local government and other community services as future outcomes from integration depend on the future of the NHS.

Table 1: Principles and Proposals

Principles of Integration	'Liberating the NHS' Proposals
1) There are no silver bullets	Comprehensive package of measures potentially covering whole policy and practice interface between local government and NHS.
2) Clarify the question to which integration is the answer	Recognition that delivery of NHS objectives for quality, inequalities, prevention and productivity is 'not in the gift' of the NHS acting alone implies question: How can the interdependencies between local government and the NHS be better managed to improve outcomes for people and places with maximum cost effectiveness across organisational interfaces?
3) Focus on ends before means	White Paper architecture designed to deliver improved outcomes for people and places; intersecting outcomes frameworks and shared performance measures to replace micromanagement through organisation specific process measures
4) Integration must be multi-levelled	Proposals cover, at least to some degree, strategic commissioning, community planning, pathway planning and personal budgets but lack recognition of need for all to be managed as a coherent whole.
5) NHS and local government operate from silos because they were explicitly designed to do so	The White Paper represents the first weakening of silo structures since the creation of the NHS in 1948. Sharing of public health function extends interface with NHS to local government as a whole as well as potentially giving each service a stake in the other. NHS commissioning is to be explicitly, if partially, brought within framework of local democratic accountability.
6) Weave together the warp and weft of integration	Local government and NHS retain vertical structures and accountabilities but potentially woven together by wide range of cross cutting mechanisms as noted in 4 and 5 above (and also e.g. NICE standards for health and social care, joint personal data systems.
7) Effective personal relationships are critical but are	Explicit recognition of the importance of personal relationships and behaviours together with need for supporting incentives. Final nature of local incentives

undermined by restructuring	(and sanctions) is still being determined. Restructuring/transition processes will and already are undermining established relationships.
8) A place making and convening role is necessary to animate integration through a single point for commissioning	Local government convening role for strategic commissioning based on local strategic needs assessment and outcomes. HWB provides single point for potential alignment of commissioning for interdependent activities though not for approval and resource allocation.
9) Establish a balance between vertical and horizontal accountabilities capable of delivering locally integrated outcomes	Performance is to be judged on overlapping outcome frameworks and common measures at points of intersection between them. Respective weight of vertical organisation based accountabilities and horizontal outcome based accountabilities still emerging.
10) There are no silver bullets	Transition management nationally appears to be service or organisation based with limited cross representation from local government to NHS and vice versa e.g. separate national Transition Boards and Pathfinders. There is an apparent absence of requirements for joint implementation programmes locally.

Acknowledgement: I am grateful to the Local Government Association for their funding of this work. The views expressed, however, are my own and not those of the Association

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